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MILLENNIUM DEVELOPMENT GOALS AND HEALTH TARGETS

This document outlines PAHO's role in support of Member States for the attainment of the Goals of the Millennium Declaration and other related targets commonly known as Millennium Development Goals (MDGs). The MDGs reflect the outcomes of decades of consensus building within the United Nations system and of UN world summits and global conferences. They are a summary of the key commitments agreed to by Heads of State on the occasion of the Millennium Development Summit in the Millennium Declaration.

In 2005, the UN General Assembly will assess the global progress towards the Goals of the Millennium Declaration five years after the Summit. The attainment of the health-related goals will be central to this assessment, and Member States will have to sustain concerted action to go in this direction. The MDGs have brought the investment in people's health to the very center of the new global development agenda.

Both the United Nations system and the inter-American system are giving utmost priority to the MDGs framework in their work. In this regard PAHO/WHO is advancing some strategies to rise to the challenge and seeks to utilize this opportunity as a key entry point to put health high on the political agenda of countries, subregional bodies, and regional organizations and to strengthen cooperation with its many partners.

The health-related MDGs are now an integral part of PAHO/WHO's priorities and are connected with its commitment to health equity between and within countries and to the development of health policies with measurable outcomes. They are part of the national health development process and rely importantly on the degree of extension of social protection in health.

The Organization has been engaged in a significant effort to integrate and mainstream the MDGs into its program of work at regional and country levels. This document describes the major developments in this direction and discusses some future steps.

The Executive Committee adopted Resolution CE134.R8 for consideration by the Directing Council.

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Millennium Development Goals (MDGs): a Focused Common Agenda

1. In adopting the United Nations Millennium Declaration in 2000, 189 Heads of State endorsed a global strategy in which the member states commit to significantly reduce poverty and spearhead key actions for development by the year 2015. This strategy was operationalized in a road map that defined eight specific goals, referred to as the Millennium Development Goals. The strategy and goals were reaffirmed at the UN Monterrey Conference for the Financing of Development in March 2002 and the World Summit on Sustainable Development in September 2002, in Johannesburg.
2. In doing so the member states reconfirmed agreements reached at earlier UN Summits, such as the International Conference on Population and Development in Cairo (1994), the World Summit for Social Development in Copenhagen (1995), the Earth Summit in New York (1997), the World Food Summit in Rome (2002), and the General Assembly Special Session on Children in New York (2002).
3. Since the adoption of the Millennium Declaration, its major goals have been summarized as a package of 8 goals and 18 targets, which are now commonly referred to as the Millennium Development Goals (MDGs). A set of 48 indicators has been proposed to measure progress (see Annex A). Many international organizations and donor agencies have since refocused their programs of work towards the achievement of the MDGs. The road map as proposed by the United Nations Development Program (UNDP) underlines the synergy among the eight MDGs; indeed, they are presented as an indivisible package. Such an approach reinforces the Health for All and Primary Health Care (PHC) principles and strategy and places health at the center of economic and social development.
4. The development goals of the Millennium Declaration have brought investment in people's health to the very center of the development agenda of the twenty-first century and provide the public health community with an invaluable entry point to raise the profile of health. Three of the eight MDGs explicitly refer to health issues—reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. Seven of the 18 targets are directly related to the responsibility of the health sector—Target 2: Malnutrition, Target 5: Child mortality, Target 6: Maternal mortality, Target 7: HIV/AIDS, Target 8: Malaria and other infectious diseases, Target 10: Safe drinking water, and Target 17: Essential drugs. This high priority assigned to health underlines the new consensus that health is not only an outcome of increased development but lies at its core.

Commitment to the Goals of the Millennium Declaration in the Americas: Country Ownership

5. Strengthening the political commitment to the Goals of the Millennium Declaration in the Region of the Americas is still a challenge; and very few countries have fully integrated the Goals into their policy process. As of June 2004, nine countries in the Americas had produced an MDG report and the Eastern Caribbean had prepared a subregional report. In addition, 11 country reports are under way and five countries have started the elaboration of their national documents. Canada and the United States of America have undertaken special efforts as international partners with regard to the MDGs in the Region. For example, Canada has made a significant financial commitment to the WHO “3 x 5” strategy. Bolivia, Honduras, and Nicaragua have been selected in the first group of countries to receive development aid from the United States through the Millennium Challenge Account.

6. Country ownership of the MDG process is essential and was addressed at the high-level conference in Brasília on 17 November 2003, initiated by the Inter- American Development Bank (IDB), World Bank, UNDP, and Economic Commission for Latin America and the Caribbean (ECLAC), jointly with the Brazilian Government. The conference brought together political leaders and representatives of regional organizations from throughout the Americas and highlighted the importance of achieving a political consensus for the implementation of the Goals of the Millennium Declaration in the Americas. The resulting Brasília Declaration is a call to action and implementation,¹ reinforces the partnership principle inherent in the Goals of the Millennium Declaration, and spells out the responsibilities of governments, legislators, civil society, and the international community. It also highlights how the objectives and targets of the Millennium Declaration, among them the health-related targets, support and reinforce the mandates and priorities adopted in the Summits of the Americas.

7. Indeed, the First Summit of the Americas in Miami, in 1994, endorsed a strong commitment to equitable access to basic health services, in agreement with PAHO’s recommendations.² At the Santiago Summit in 1998, emphasis was placed on the development and implementation of effective low-cost health technology, with the

¹ Inter-American Development Bank, United Nations Development Program, Government of Brazil, Economic Commission for Latin American and the Caribbean, World Bank. *Brasília Declaration: Proposal for Implementing the Millennium Development Goals*. 17 November 2003.

² Summit of the Americas Information Network. Health: First Summit of the Americas, Miami, United States (December 1994) [Internet Page]. Available at: <http://summitoftheamericas.org/Miami%20Summit/Health.htm>. Accessed on 23 July 2004.

technical support of PAHO, as a means towards poverty eradication.³ The Third Summit of the Americas in Quebec City, in 2001, gave priority to the elimination of poverty within a context of equity, democratic governance, and environmental sustainability, and requested continued technical cooperation in health from PAHO and other international organizations.⁴ During the Special Summit of the Americas in 2003, the Governments of the Region agreed on the Declaration of Nuevo Leon, which delineates three closely linked objectives to improve the well-being of the people of the Americas: economic growth with equity to reduce poverty, social development, and democratic governance. In relation to health, social protection for health was recognized as a key element for national progress and countries committed to broaden prevention, care, and promotion strategies, with a particular focus on the most vulnerable segments of society. HIV/AIDS was considered of particular concern, as well as emerging and reemerging diseases, including malaria, tuberculosis, and others. Reinforced technical cooperation from PAHO to implement integral public health activities for the control of these diseases was requested.⁵ A process is under way to ensure that the MDGs will constitute an important component of the next Summit of the Americas in 2005, in Argentina. This will provide an excellent opportunity to underline the importance of investments in health.

Where Does the Region of the Americas Stand in Relation to the Health MDGs?

8. A recent analysis suggests that no country in the Americas will likely reach all of the MDG targets. Indeed, some of the greatest challenges for the countries of the Americas lie within the health area. Presently, the Region as a whole does not seem set to reach the ambitious targets for infant and maternal mortality, although the situation varies markedly among the countries of the Region and different population groups, as well as among the target indicators. The definition of critical measurable thresholds provides a new sense of urgency and a perspective that goes beyond the sectoral lens through which issues such as education, health, and the environment are usually approached.

9. *Goal 4: Child mortality.* Trend analysis shows that if current trends continue, the reduction in infant and under-5 mortality in the Region would reach 54%, well below the two-thirds established in the goals.⁶ As Graphs 1 and 2 illustrate, the situation of both

³ Summit of the Americas Information Network. Second Summit of the Americas: Health Technologies. [Internet Page]. Available at: <http://www.summitoftheamericas.org/Health-Malnutritio/health.htm>. Accessed on 23 July 2004.

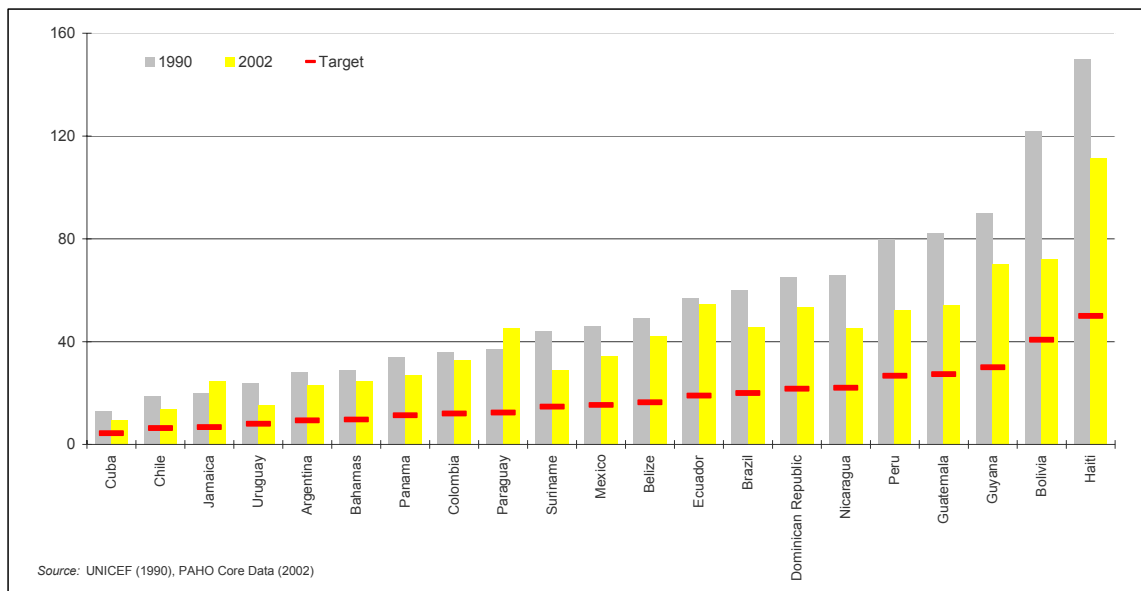
⁴ Summit of the Americas Information Network. Plan of Action. [Internet Page]. Available at: <http://www.summitoftheamericas.org/Documents%20for%20Quebec%20City%20Summit/planofaction-template-eng.htm#Health>. Accessed on 23 July 2004.

⁵ Summit of the Americas Information Network. Special Summit of the Americas, Monterrey, Mexico. Declaration of Nuevo León. Available at: <http://www.summit-americas.org/SpecialSummit/Declarations/Declaration%20of%20Nuevo%20Leon%20-%20final.pdf>. Accessed on 23 July 2004.

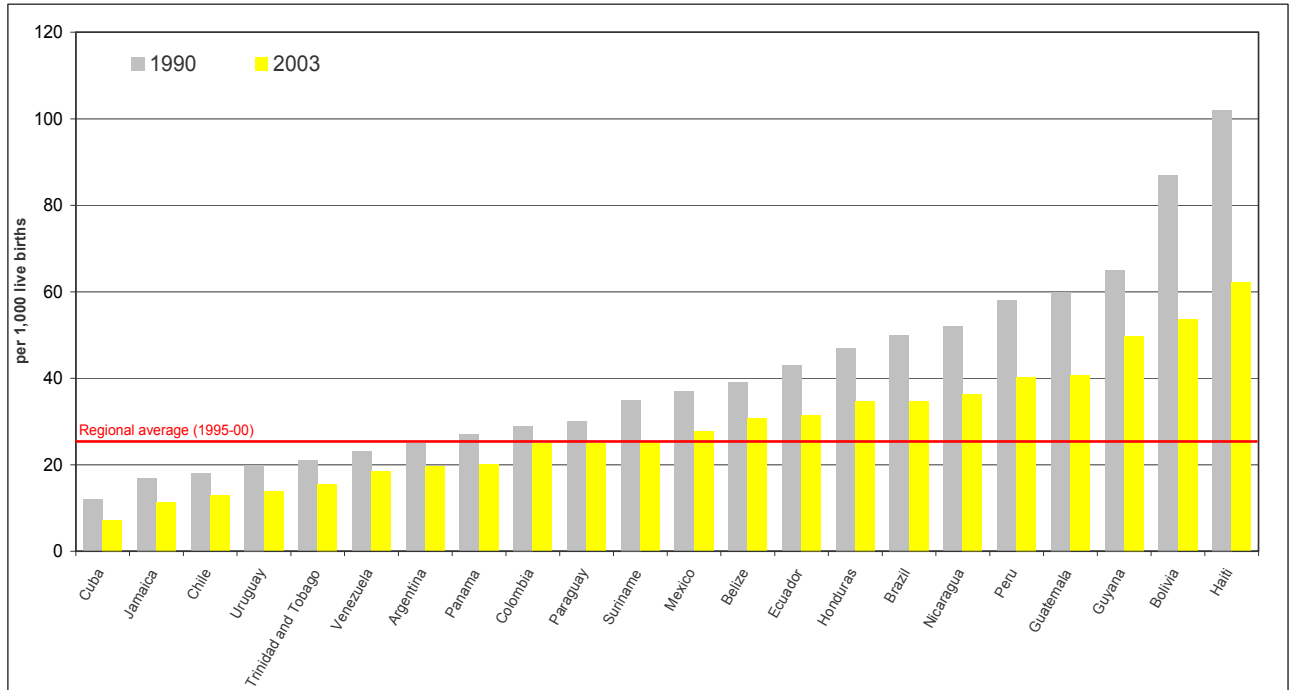
⁶ Torres C, Mujica OJ. Health, Equity, and the Millennium Development Goals. *Pan American Journal of Public Health* 2004;15(6):430-439.

indicators in the Americas, as well as progress towards the target between 1990 and 2002, are diverse. In 2003, infant mortality varied between 5.3 per 1,000 live births in Canada to 80.3 per 1,000 in Haiti. The situation of measles vaccine coverage, presented in Graph 3 for 2001, is also contrasted, with a regional average of 91%.

Graph 1. Under-5 Mortality in Selected Countries of the Region of the Americas, 1990, 2002, and 2015 MDG Target

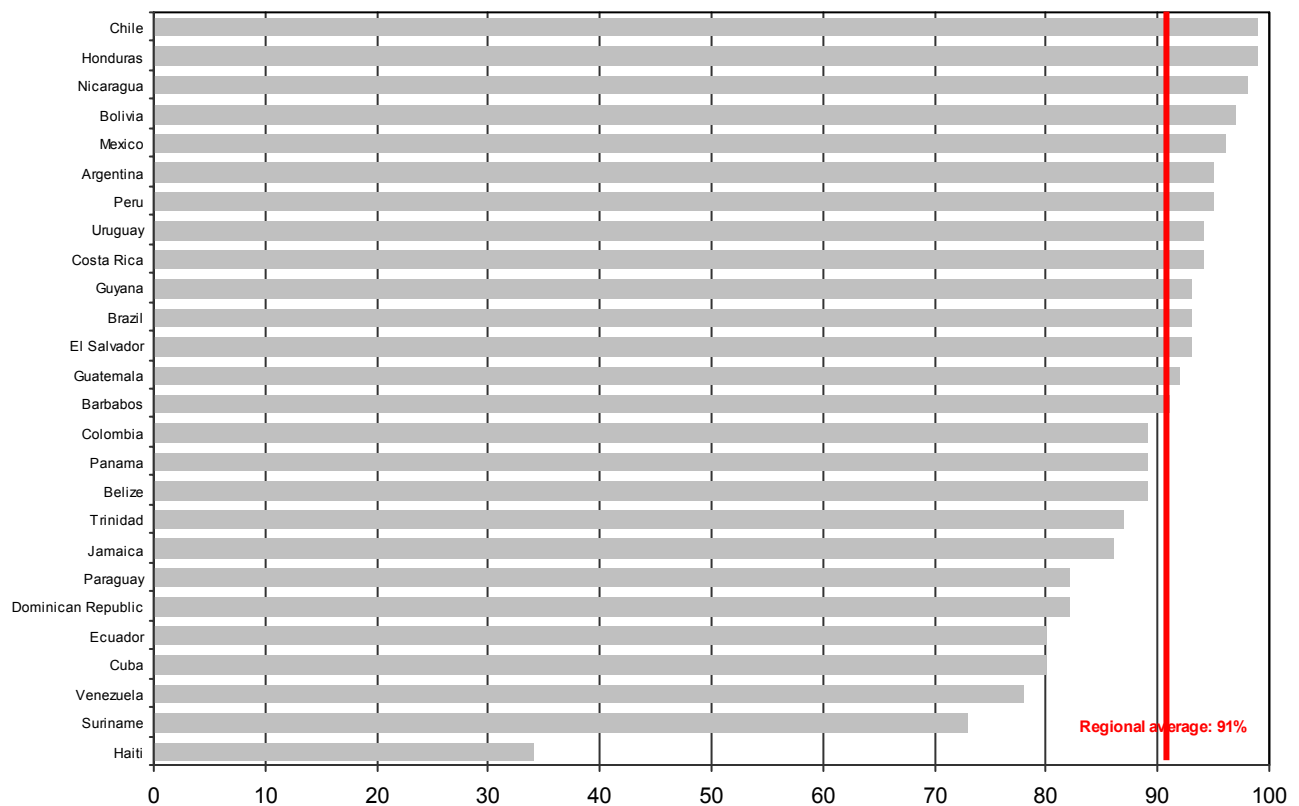


**Graph 2. Infant Mortality Rate in Selected Countries of the Americas
1990 and 2003**



Source: UNICEF (1990), PAHO Core Data, 2003

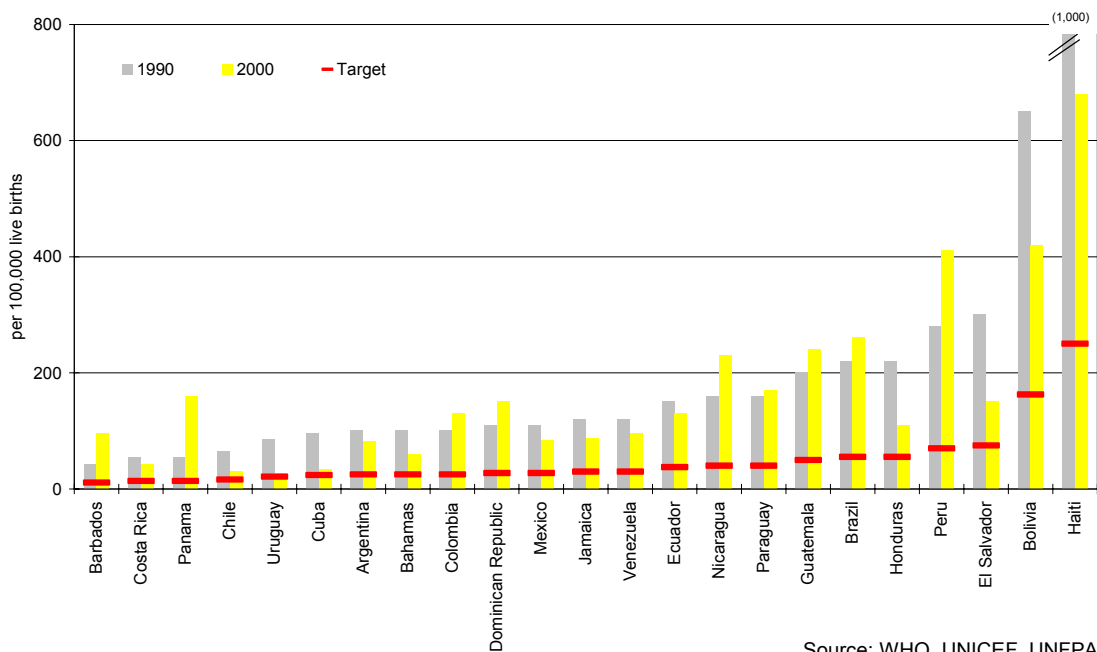
Graph 3. Measles Vaccine Coverage in Selected Countries of the Americas, 2001



Source: PAHO Core Data, 2003

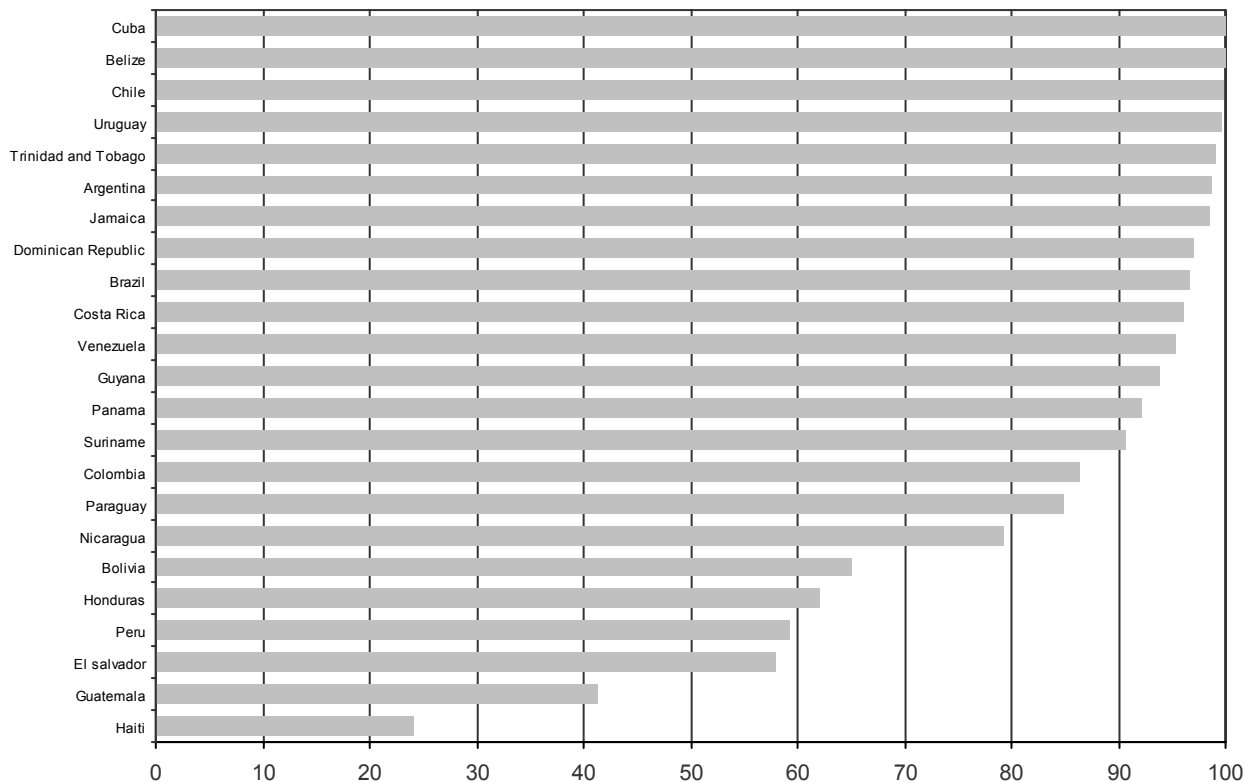
10. *Goal 5. Maternal mortality.* Estimates presented in Graph 4 show that the situation of maternal mortality is also extremely varied, as is the access to trained personnel at the moment of giving birth (Graph 5). In 2000, the maternal mortality ratio was estimated at 16 per 100,000 live births in Cuba and 680 per 100,000 live births in Haiti. Over the past decade, some countries saw an increase in maternal mortality and some others a significant decrease. Further, calculations from the IDB show that the annual reduction needed between 2000 and 2015 to reach the target varies enormously, with 1.6% in Uruguay and 15.1% in Panama.⁷

Graph 4. Maternal Mortality in Selected Countries of the Americas, 1990, 2000, and 2015 MDG Target



⁷ Inter-American Development Bank. *Los Objetivos del Milenio en América Latina y el Caribe: Retos, acciones y compromisos*. Washington, DC: IDB; 2004.

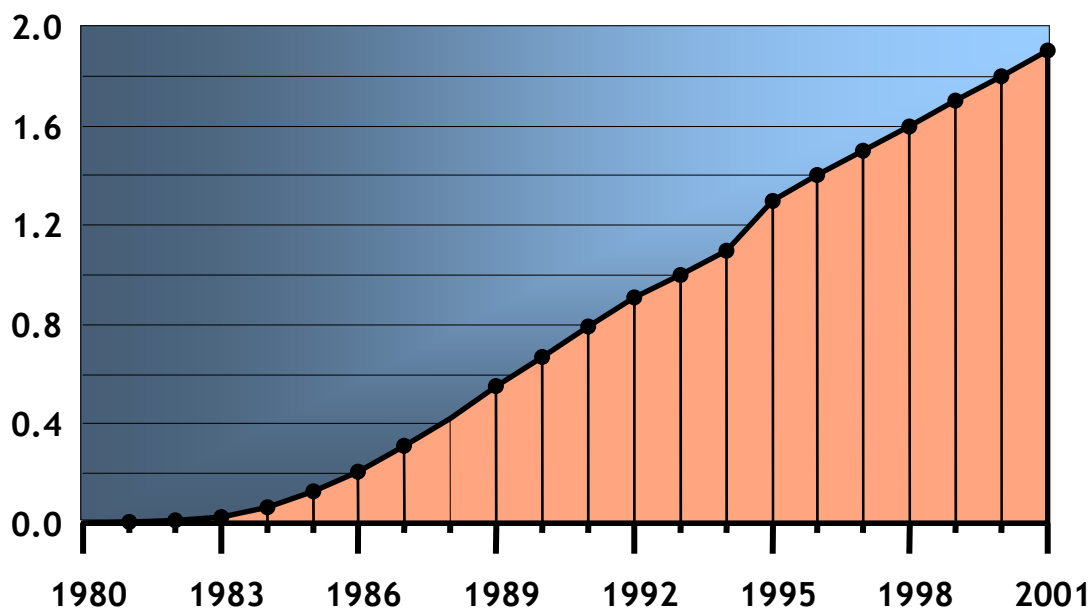
**Graph 5. Percentage of Births Attended by Trained Personnel
in Selected Countries of the Americas, circa 2000**



Source: PAHO Core Data, 2003

11. *Goal 6. HIV/AIDS.* The HIV/AIDS epidemic is well established in the Americas, with a national HIV prevalence of at least 1% in 12 countries, all of them in the Caribbean, with HIV prevalence among pregnant women exceeding 2% in six of them. In most of the other countries of the Region, the epidemics are more concentrated in certain areas or population groups. The deceleration needed to halt and reverse the epidemic by 2015 and reach the goal is currently not seen in the Region (Graph 6).

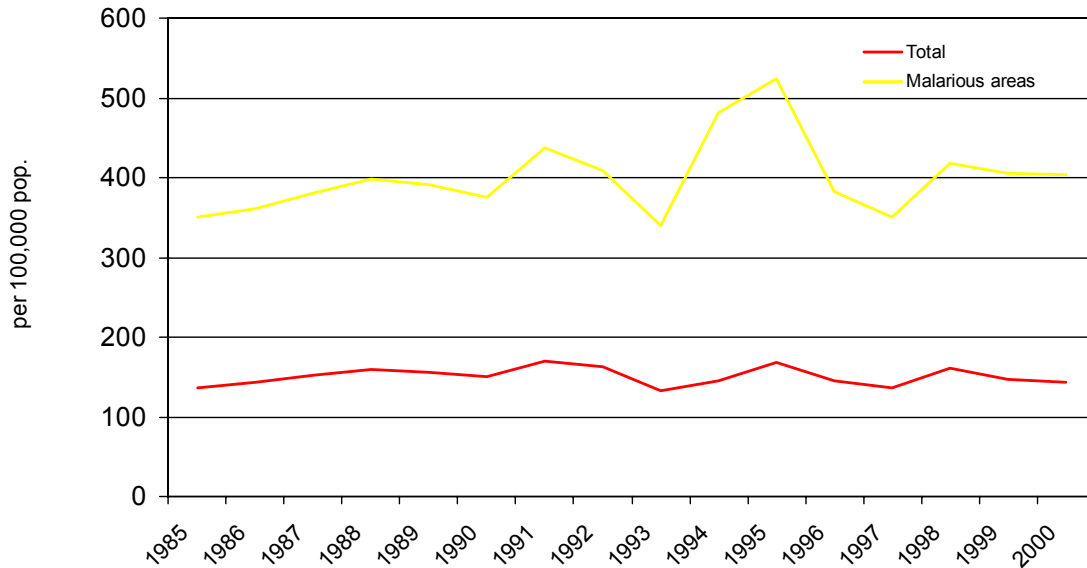
**Graph 6. Number of Persons Living with HIV/AIDS
in Latin America and the Caribbean, 1980-2001
(millions)**



Source: UNAIDS

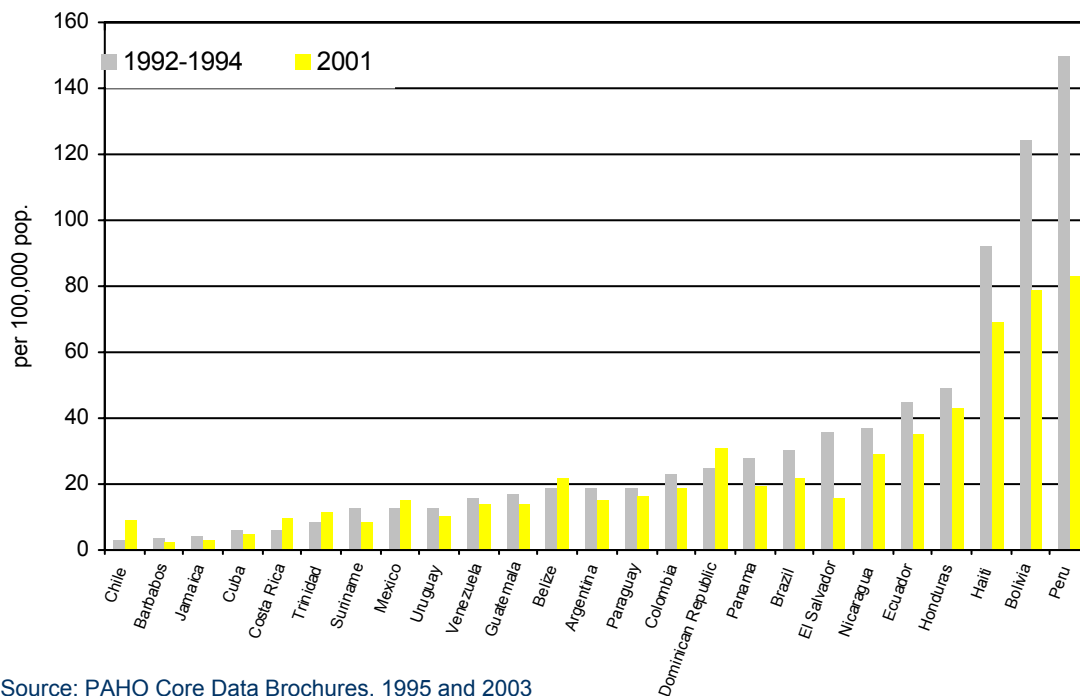
12. *Goal 6: Malaria and tuberculosis.* The incidence of malaria varies enormously in the countries of the Region, but it is estimated that in 2002 31% of the population of the Americas lived in areas with some potential risk of transmission of the disease. Over 80% of the currently reported cases originate in the nine countries that share the Amazon rain forest in South America. Given the wide variations in incidence over the last decade, it is difficult to say whether the goal of reversing the epidemic is under way (Graph 7). In 2002, there were 223,057 cases of tuberculosis in the Americas, 50% of them in Brazil and Peru. The incidence rates for selected countries in the Region are presented in Graph 8. The total of number of cases in the Region has been slightly decreasing since 1999. Within the WHO strategy to control tuberculosis, efforts in the countries of the Americas have been concentrated on implementing and expanding the Directly Observed Therapy Short-course strategy (DOTS), which will contribute to reaching the MDG tuberculosis target. There is therefore a significant role and scope for joint action by Member States and PAHO—with the support of other partners at the country level.

Graph 7. Annual Malaria Incidence Rate in the Region of the Americas, 1985-2000



Source: PAHO. Health in the Americas, 2002

Graph 8. Incidence of Tuberculosis BK+ in Selected Countries of the Americas, 1992-1994 and 2001

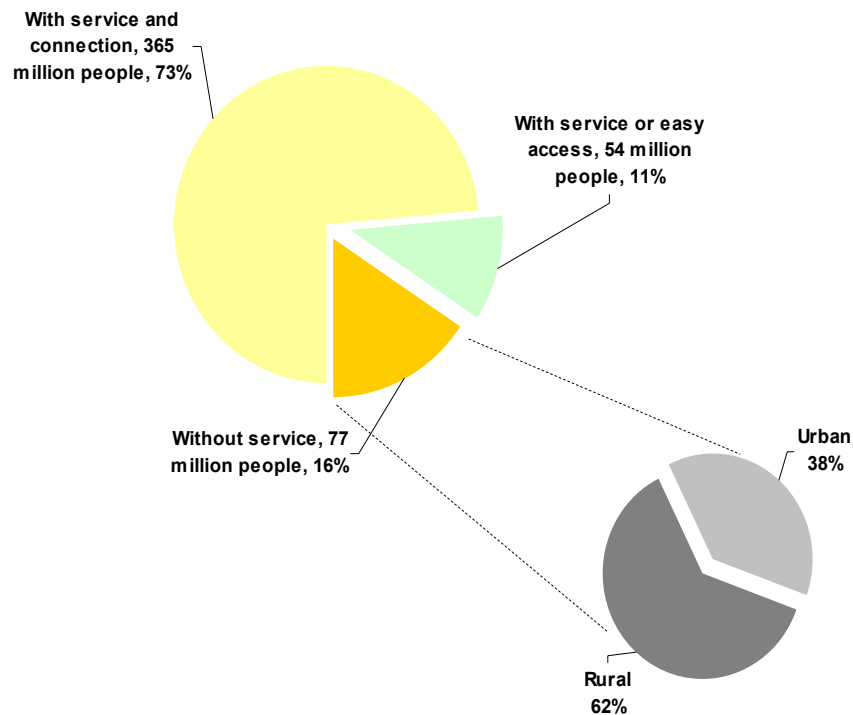


Source: PAHO Core Data Brochures, 1995 and 2003

13. *Goal 7: Water and sanitation.* The 2000 regional evaluation carried out by PAHO in the Americas showed that water supply and sanitation coverage in Latin America and the Caribbean were 84.59% and 79.21%, respectively, around 2000. This situation is preoccupying when looking at absolute numbers, because in the Region 77 million people have no access to water supply (Graph 9), and 103 million are without any sanitation facilities for the elimination of wastewater and excreta. The situation could be critical in terms of vulnerability, because about 54,000 of the people considered covered receive water through “easy access” systems and 152 million people are served with sanitation facilities in situ, such as latrines and septic tanks, among others. These technological alternatives do not guarantee quality service provision, including access to safe water. In 1995, only 23 countries notified that water supplies in urban areas met the WHO safety guidelines. This is not applicable to rural areas. Indeed severe inequalities in access to water are found in the Region, usually linked to income and place of residence.⁸

⁸ Pan American Health Organization. Division of Health and Environment. Informe Regional sobre la Evaluación 2000 en la Región de las Américas. Agua y Saneamiento, estado actual. Washington, DC; 2001.

**Graph 9. Drinking Water Coverage,
in Latin America and the Caribbean, 1998**



14. *Goal 8: Essential drugs.* In the Americas, only five countries (Brazil, Chile, Honduras, Nicaragua, and Panama) have policies specifically dealing with pharmaceuticals. Twenty-one countries have basic drug lists and have incorporated the concept of essential drugs. However, access to medicines continues to be limited as, for example, is the case of 31% of the population in Brazil.⁹

15. While it is important for the health sector and a technical agency such as PAHO to have a clear focus on the achievement of the health MDGs as outlined above, this is of course not possible without also taking into account key macroeconomic factors and other determinants. Given the very strong and dynamic interface between poverty and health, a major challenge to the achievement of the MDGs lies in progress on Goal 1—halving poverty and hunger by 2015—since the achievement of all other goals depends on poverty reduction and economic growth. For the Americas, a focus on the reduction of

⁹ Pan American Health Organization. *Health in the Americas, 2002 Edition*. Washington, DC: PAHO; 2002. (Scientific and Technical Publication No. 587).

inequalities, particularly inequalities in health, is of particular importance and will be a focus of the PAHO approach to support Member States in the attainment of the MDGs.

16. The Region of the Americas is already one of the most unequal in the world. Some of the Gini coefficients for income inequality in 1999 were 0.5 in Peru, 0.6 in Bolivia, 0.59 in Nicaragua, and 0.64 in Brazil.¹⁰ The regional Gini coefficient for infant mortality in 1997 was 0.33;¹¹ a recent report of ECLAC/UNDP shows that the number of poor people in the Region is increasing.¹² Simulation models on 18 countries of Latin America and the Caribbean indicate that if present trends were to continue only 7 of the 18 countries would reach the objectives for reduction of poverty in 2015. These countries are: Argentina (before the crises), Chile, Colombia, Dominican Republic, Honduras, Panama, and Uruguay. A second group of six countries would continue to reduce the incidence of poverty but at a very slow rate. These countries are: Brazil, Costa Rica, El Salvador, Guatemala, Mexico, and Nicaragua. The other five countries—Bolivia, Ecuador, Paraguay, Peru, and Venezuela—would see an increase in the levels of extreme poverty and will never reach the targets unless their poverty rates experience a major trajectory change.¹³

17. Ill health is a dimension of poverty, and beyond that aspect, closing inter- and intra-country gaps between the poor and the better-off is also a question of social justice and equity. On the other hand, the fact that ill health and its correlated factors generate poverty is another dimension of the equity and health debate that is linked to poverty.¹⁴ In that regard, addressing the disease burden of poor and vulnerable populations in the Americas, including MDG and non-MDG related conditions, will make a significant contribution to poverty reduction.

18. Finally, the way forward lies in a Pan American approach to the MDGs which addresses the sentiment expressed in the Millennium Declaration for a shared responsibility for health and social development among countries. The UNDP *Human Development Report 2003* refers to this shared responsibility among major stakeholders as the Millennium Development Compact. Governments, civil society, the private sector, and international organizations need to develop new types of partnerships to ensure progress. The countries of the Americas have the opportunity to spearhead such developments.

¹⁰ Economic Commission for Latin America and the Caribbean, Instituto de Investigación Económica Aplicada, United Nations Development Program. *Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean*. 2002. (Libros del CEPAL No. 70).

¹¹ Pan American Health Organization. *Health in the Americas, 2002 Edition*. Washington, DC: PAHO; 2002. (Scientific and Technical Publication No. 587).

¹² Ibidem, footnote 10.

¹³ Ibidem, footnote 10.

¹⁴ Commission on Macroeconomics and Health. Working paper WG1.5: Poverty and Health. March 2001.

MDG Policy Context and Implications for PAHO's Approach

19. Only if collective efforts at national and international levels are intensified will countries be able to fulfill the MDG commitments and goals. This is due in part to lack of good governance at the country level or insufficient development aid. The world is still grappling with the differential impact of economic restructuring in the face of rapid globalization. For example, more than 50 nations worldwide grew poorer over the past decade, and a number of countries in the Region of the Americas are facing significant economic decline or reduced growth. Highly uneven development and increasing inequities on a global scale have been one of the signature themes of the last decade. This is the case in the Region of the Americas during the period 1999-2002, where the average poverty rate decreased, but where there is great heterogeneity in poverty projections. If some countries saw the income per capita increase, the majority saw significant decreases in that indicator during that period.¹⁵

20. Achievement of the health-related MDGs and other health goals and targets will require countries to examine the impact of many of their macroeconomic frameworks on national health development, for example, how to reconcile external and internal flows, how to reorient the focus of national investment plans, and how to reconcile the social dimensions of development with the various plans to expand trade and the free flow of people, goods, and services. Finally, in order to address inequality and redistribution, many countries will need to reconsider their approaches to taxation.

21. Another concern for many countries in the Americas lies in those key areas of the Millennium Declaration on shared responsibilities that are addressed in Goal 8, in particular access to global markets and new technologies. A special reference is made in the Declaration to the particular needs of landlocked countries and small-island developing states. With their focus on equity, the MDGs are important to all countries in the Americas, not just to the poorest. As the Region of the Americas is defined by some of the highest social inequalities in the world, it is essential that its middle-income countries address inequities and gaps in development within a framework of human rights and with a gender perspective, given that these frequently find their starkest expression in health inequalities. For example, the infant mortality rate in Brazil shows a significant gap when analyzed by race: in Bahia, a state in which the afro-descendant population is predominant, the rate is 51 per 1,000 live births, double that of those states with a Caucasian population majority, such as São Paulo or Rio Grande do Sul (24.63).

22. Over the last decade, countries in the Region have been exposed to increasing social and economic risks in the context of global restructuring and political instability, as well as civil strife in a number of countries. Therefore, the role of PAHO will imply

¹⁵ Ibidem, footnote 7.

not only the support for the implementation of health-related interventions and the monitoring of progress achieved on the respective health goals and targets but also a systematic analysis of the impact on health of larger contextual and policy determinants—trade agreements, economic policies, immigration policies, etc.—and their impact on health. PAHO's work on the central role of establishing expanded systems of social protection in the Region thus gains new importance. Similarly, the cooperation among PAHO, the World Bank, and the IDB through the Shared Agenda and the development of strategic alliances and partnerships gain increased relevance.

23. The Millennium Development Compact as proposed by the UNDP applies a new principle: rather than allowing the present level of resources to set the pace of development, governments of rich and poor countries, as well as international institutions, should start by asking what resources are needed to meet the MDGs. Most estimates point to a figure of at least US\$ 50 billion annually at the global level in additional aid or a doubling of current aid levels. Increasingly these analyses are being carried out at the country level in order to assess the country's absorptive capacity and the potential for scaling-up interventions. Several pilot activities in costing the MDG effort, led by the UN's Millennium Project, are under way in the world; and one is planned in a country of the Region of the Americas, the Dominican Republic.

24. In view of the unfinished health agenda in many of the countries, there is significant concern about the shift of overseas development assistance (ODA) away from the Region of the Americas. A recent analysis of the development committee of the International Monetary Fund and the World Bank¹⁶ shows clearly that even modest increments of ODA could play a significant role in helping lower middle-income countries to progress more rapidly towards reaching the MDGs. A closer look at the insufficient investment in health of some countries as a percentage of the GDP and the role of ODA in supporting sustainable development solutions is required. PAHO's work in assisting countries to improve and scale up their health systems will help in the rationalization of resource allocation practices for both domestic investment and ODA for health.

25. For upper middle-income countries, this analysis argues that while the bulk of resources to reach the MDGs must come from domestic sources, ODA should complement and support clearly expressed national policies that address social exclusion and focus on particular regions, issues, or population groups. This highlights, especially for large countries, the need for ODA to support action at the subnational level.

¹⁶ International Monetary Fund and World Bank. Achieving the MDGs and Related Outcomes: A Framework for Monitoring Policies and Actions, 26 March 2003. (No. DC2003-0003).

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

- the operational gap in scaling-up health systems and public health infrastructure;
- the structural gap in extending social protection in health;
- the governance gap in involving wide segments of government and society in a truly intersectoral and participatory effort;
- the equity gap in addressing the health needs of the poorest.

How Is PAHO Moving Forward?

27. PAHO is presently engaged in a significant effort to integrate the MDGs into its program of work at country and regional levels in order to strengthen the support to countries in the achievement of the MDGs. Clearly the MDG orientation on equity in policy and strategy has implications for PAHO's work at the country level.

28. Eight overarching strategic goals have been identified:

- Advocacy: Increase awareness of the health priorities set by the MDGs through a wide range of policy dialogues, partnerships, and intersectoral action throughout the Region of the Americas.
- Policy: Intensify action on national health development, addressing issues of underfinancing of the health system in the priority countries and ensuring social protection in health to support MDG progress and integrate the work on MDGs with health policy initiatives on health goals and targets and outcome-oriented health policies in the Americas.
- Technical Cooperation: Support countries in implementing their national strategies as applied to the MDGs that focus on health.
- Integration: Integrate the work on MDGs with other strategic efforts in health development in the Region of the Americas, such as the formulation of national health targets and regional health initiatives. Examples are the regional strategy

for maternal mortality and morbidity reduction, or the Shared Agenda on health of the IDB, World Bank, and PAHO, among others.

- Partnerships: At the national level, engage in and increase cooperation with various stakeholders in addition to the health sector, particularly with legislators, finance ministers, planning and development coordinators, social policy, and others identified as key institutions and actors for implementation and accomplishment of the MDGs at the country level. At the international level, enhance interagency cooperation in the MDG-related work in support of Member States.
- Empowerment: Increase health literacy and empowerment of communities through a strong civil society involvement at all levels to reach the MDGs—with a special view to the inclusion of ethnic groups, indigenous populations, and women.
- Monitoring: Improve measurement and monitoring of progress through high-quality disaggregated health data at regional, subregional, and country levels.
- Research: Initiate research to strengthen the evidence base and generate new knowledge, study the synergies for health and development among the goals and develop policy studies that track the political process to ensure commitment to the health MDGs as well as the impact on health of the targets outlined under Goal 8.

29. All levels of PAHO—country offices, centers, and Headquarters—are working together in new ways and in close cooperation with the governments of the countries to respond to the urgency dictated by the MDG process. A key factor is to contribute to the national response and strategic associations and alliances needed in the countries, for which the country offices will provide support at the national level. At the country level, PAHO has a dual role: that of articulating the MDG process in health with the efforts of the whole UN system, as well as that of supporting Member States for advancing national health policies towards reaching the MDGs.

30. The process and product of monitoring the MDGs must be country-owned and driven. It includes the definition of how the MDGs apply to the country situation and how their achievement needs to be addressed through national development strategies, policies, and programs. In many countries, the follow-up of the health MDGs requires the development of sustainable statistical systems and skills to analyze and use data for policy-making and programming. This is being addressed by PAHO in many countries through the Core Health Data Initiative and other technical cooperation activities in support of the development of national health information systems. National planning and policy frameworks defined by United Nations and Bretton Woods institutions—such

as the Country Common Assessments (CCA) and United Nations Development Assistance Framework (UNDAF), both involving the whole UN system, and Poverty Reduction Strategy Papers (PRSPs) of the World Bank—while having different purposes, timing, and contents, can also assist in the implementation and monitoring of the goals of the Millennium Declaration.

31. Within its approved program of work, PAHO understands the MDGs as an additional entry point to strengthen investment in health and put health high on the political agenda of countries; subregional bodies, such as the Amazonian Cooperation Treaty (TCA), Andean Community of Nations (CAN), Caribbean Community (CARICOM), Central American Integration System (SICA), Southern Common Market (MERCOSUR); and regional organizations. For example, the MDGs were topics of discussion at the last Special Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD), held in the Dominican Republic, in July 2004. An increased effort is required in the Region to work with the many organizations and stakeholders to create the political and financial commitment that is needed at the country level.

32. Cooperation with the MDG initiatives of WHO is being strengthened. During the last meeting of the High Level Forum on the Health MDGs in January 2004, hosted by WHO, in Geneva, several organizations discussed key issues, such as resources and aid for the MDGs, human resources for health, and monitoring. These efforts will also be closely linked to the process of developing the 11th General Program of Work of WHO, which—precisely because of the WHO commitment to the MDGs—will have a longer deadline, that is, 2015 as its goal. In November 2005, a WHO interregional meeting on the MDGs will take place in Costa Rica, with the participation of all WHO Regions, to develop a common MDG strategy and vision and learn from the experience of the Americas.

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

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

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

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

Focusing on Equity: Priority Countries and Populations

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

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

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

often also border areas means that any strategy will need to build on bilateral coordination and even on subregional strategies involving a group of countries.

Ensuring an Integrative Approach to the MDGs

39. Achieving the MDGs implies significant reorientation of policy priorities and resource flows within countries. This highlights the need to link the work on the MDGs clearly to PAHO's work on health systems, essential public health functions, health services, human resources development, and disease- and population-specific programs. PAHO will concentrate in particular on supporting countries in developing an integrated approach to the MDGs, building on its work not only in the respective program areas, such as maternal and child health or infectious diseases, but will integrate this work with its efforts in health systems and services development and social protection. The focus will be the synergy needed among the different health dimensions that are addressed in the goals and the different levels of sectoral responsibility. A series of working groups have already been established to allow for this interface, including the links to the "3 by 5" and PHC strategies.

40. PAHO's primary health care working group has defined the MDGs as a main point to include in its discussions and sees the MDGs as a major political opportunity for the renewal of Health for All and the PHC approach in the Region. At the same time, PHC is considered as a fundamental strategy for the attainment of the MDGs. It provides a good platform for the scaling-up of health systems, focusing on equity issues, integrating vertical approaches at the point-of-service delivery, and strengthening intersectoral collaboration and social participation in health.

41. PAHO's work on social protection is also key for the MDGs. Indeed, in spite of the health sector reforms in the Region in the last 20 years, an important percentage of the population of the Americas is still excluded from mechanisms of social protection against disease risks and their consequences, and social exclusion does not appear as a clear priority in the political agendas.¹⁷

42. PAHO's technical work will also look in greater depth at issues of efficiency within the health and social sector. In the 1990s, a majority of countries of Latin America increased the percentages of GDP devoted to social spending, but this increase did not obtain the expected results. This means that PAHO will need to support countries to not only increase spending in the health sector and/or on specific programs but also to assess which mix of allocations provides both the most cost effective interventions and the greatest reduction in inequities. Of central importance is the issue of human resources in

¹⁷ Levcovitz E, Acuña C. Elementos para la formulación de estrategias de extensión de la protección social en salud. *Revista Gerencia y Políticas de Salud* 2003;2(5).

health, which has been a long-standing concern of the PAHO office and for which the High Level Forum on the Health MDGs has now established a working group to explore the issue in more depth at the global level. As a clearinghouse of information in health through the Core Health Data Initiative, PAHO will be able to provide some of the data required for monitoring and analyzing activities of the MDGs.

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

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

Fostering a Commitment to Health Policies with Measurable Health Goals and Targets

45. The MDGs underline the need to have clear measurable goals for global challenges and give a clear message of the priority need to invest in people through health and education. A key policy principle of the MDGs is that external assistance is to be better aligned with a country's own development priorities and that countries improve the quality of their policies, institutions, and governance in moving to implement the action necessary to reach the MDGs. For PAHO, this means that the MDGs constitute an additional entry point in support of good health governance and outcome-oriented health policies appropriate to the specific regional, subregional, and country context. They coincide with PAHO's ongoing commitment to a public health policy orientation based

on universality, solidarity, and equity as well as to accountability and transparency through common indicators and efficiency through synergy, collaboration, and partnerships.

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

47. Having for the first time a set of clearly identifiable health goals at the global level which are part of an overall development strategy and have been endorsed by Heads of State is of great value for the health sector. This is an acknowledgment of the understanding of health as a key factor for social and economic development and provides inroads to finance, planning, and development ministries. For the poorer countries in the Region, the health MDGs—which have overall government commitment and will be an integral part of any country strategy to address the MDGs—will also provide an invaluable entry point to get health on the agendas of economic and social development strategies and international development aid negotiations.

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

49. The better-off countries in the Region who have reached the MDGs with respect to national averages can develop broader health goals and targets to integrate the MDGs by setting targets with special reference to disadvantaged groups and regions—and

provide an incentive to set more ambitious goals in population health with a focus on equity. A study by the World Bank¹⁸ suggests that a strategy directed towards disadvantaged groups would make it possible to meet the health-related MDGs while generating complementary benefits in terms of distributive equity. An ECLAC study indicates that the MDG poverty reduction targets are only feasible if countries succeed in becoming both progressively richer and less unequal, for example, through the combination of a GDP annual growth rate of 3% and cumulative reductions in inequality of about 4%.¹⁹

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

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

52. A meeting on Healthy Municipalities and the MDGs in Ecuador, in June 2004, with the participation of PAHO, UNDP, the United States Centers for Disease Control, the German Technical Cooperation Agency (GTZ), and mayors and directors of municipality networks from various countries of the Region, contributed to defining the

¹⁸ Gwatkin D. Who Would Gain Most from Efforts to Reach the Millennium Development Goals for Health? In: *Health, Nutrition and Population*. World Bank; December 2002.

¹⁹ Ibidem, footnote 10.

role of municipal authorities and networks in advancing the MDGs. It explored local points of view, identified good practices, and initiated the development of a joint plan of action for advancing the attainment of the MDGs at the local level.

53. The Brasília Declaration acknowledges the important role of civil society in attaining the MDGs and expresses the hope that the MDG process helps strengthen democratic institutions and supports social inclusion, a culture of peace, and human rights.

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

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

Efforts within PAHO

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

57. A mainstreaming effort is under way with all organizational units in PAHO. The goal is both a reorientation of the work of technical units, the development of special partnerships among programs to contribute to the attainment of the goals, as well as the creation of an integrated regional technical support team that can backstop the efforts of the country programs in this direction. A range of units and programs within Headquarters, centers, and country offices is being encouraged to adjust programs accordingly.

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

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

60. Finally the MDGs have been discussed with the PAHO/WHO Country Representatives at all three subregional meetings held over the last few months, and an effort is presently under way to analyze and systematize the experience at the country level with the monitoring and implementation of actions to support the MDGs. In short a

significant effort is under way both to align PAHO's work with the MDG mandate and to make PAHO's work, and the work with partners, more MDG sensitive.

61. PAHO technical cooperation activities to support countries in the attainment of the health-related MDGs include:

- Until June 2005, support the preparation and realization of the Meeting of Ministers of Health and Environment in Mar del Plata, Argentina, in preparation for the upcoming Summit of the Americas.
- Maintain and increase cooperation with the partners of the Shared Agenda, the World Bank and IDB, in monitoring and implementing the goals at the country level, as well as with other partners such as UNDP, UNICEF, United Nations Population Fund (UNFPA), UN World Food Program (WFP), and ECLAC. In particular, by the end of 2004, collaborate with ECLAC in an interagency publication on the MDGs.
- Engage the public health community of the Americas, public health associations, and schools of public health in the achievement of the MDGs. Specifically, by November 2004, plan an international workshop on the MDGs, involving the schools of public health and public health associations in the Americas to develop a framework for their contribution to the MDGs.
- Mainstream the MDGs in the national health technical cooperation development process, particularly in programming and target setting. Recent technical cooperation experiences in El Salvador and Nicaragua have gone in this direction.
- Pursue municipal action plans for the MDGs to involve the many healthy municipalities throughout the Americas in a strong MDG initiative with a special focus on the poorest communities. By the end of 2004, have a specific plan of action for the healthy municipalities, based on the outcomes of the meeting in Ecuador, in June 2004.
- By June 2005, carry out specific in-depth case studies of the health MDGs that will provide a situation analysis on which countries and PAHO may base actions towards the MDGs.
- Engage the subregional groupings, parliamentarians, and civil society throughout the Americas Region in a dialogue on the importance of the health goals for the achievement of MDGs.
- Engage in an intensive dialogue among ministries of health and other ministries,

such as ministries of labor, on initiatives to improve work conditions and workers health in relation to Goal 8, and ministries of education on synergies to reach the MDGs for a high-level intersectoral policy initiative throughout the Region.

- Make a concerted effort to increase the health literacy of the poorest communities with a focus on MDG priority areas, with strong links to Goal 2 (education) and Goal 3 (women's empowerment).
- Undertake the initiative on accountability for health in the Americas, whose goal is to apply and improve PAHO monitoring and information systems and use innovations such as Geographic Information Systems (GIS) for mapping the progress achieved. Links of course exist to the national health accounts project as well. Such an initiative would include not only measuring health progress with regard to the MDGs but also monitoring the support and partnership developments outlined in Goal 8, which calls for increasing resource flows and increasing donor coordination at country and local levels.
- Strengthen PAHO's intellectual and strategic leadership role, for example, in areas such as health and human security, health and trade, health and democracy, etc.
- By the end of 2005, formulate PAHO's Biennial Program Budget 2006-2007 with explicit reference to the support to Member States for the attainment of the MDGs.

Action by the Directing Council

62. The Directing Council is requested to consider the annexed resolution (Annex B) recommended by the Executive Committee.

Annexes

The 48 Indicators of the Millennium Development Goals

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

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

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

^a For monitoring country poverty trends, indicators based on national poverty lines should be used, where available. The recommended indicator for this purpose is "Poverty headcount ratio (percentage of population below the national poverty line)".

^b An alternative indicator under development is "Primary completion rate".

^c Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. Because the condom use rate is only measured amongst women in union, it is supplemented by an indicator on condom use in high-risk situations (indicator 19a) and an indicator on HIV/AIDS knowledge (indicator 19b). The indicator "contraceptive prevalence rate" is also useful in tracking progress in other health, gender and poverty goals.

^d This indicator is defined as the percentage of population aged 15-24 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. However, since there are currently not a sufficient number of surveys to be able to calculate the indicator as defined above, UNICEF, in collaboration with UNAIDS and WHO, produced two proxy indicators that represent two components of the actual indicator. They are the following: a) Percentage of women and men 15-24 who know that a person can protect herself from HIV infection by "consistent use of condom"; b) Percentage of women and men 15-24 who know a healthy-looking person can transmit HIV. Data for this year's report are only available on women.

^e Prevention to be measured by the percentage of children under 5 sleeping under insecticide treated bed nets; treatment to be measured by percentage of children under 5 who are appropriately treated.

^f An improved measure of the target is under development by the International Labour Organization (ILO) for future years.



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



134th SESSION OF THE EXECUTIVE COMMITTEE

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

CD45/8 (Eng.)
Annex B

RESOLUTION

CE134.R8

PAHO'S CONTRIBUTION TO THE ACHIEVEMENT OF THE DEVELOPMENT GOALS OF THE UNITED NATIONS MILLENNIUM DECLARATION

THE 134th SESSION OF THE EXECUTIVE COMMITTEE,

Having seen the report, "Millennium Development Goals and Health Targets"
(Document CE134/10);

Recognizing the importance of the goals of the United Nations (UN) Millennium Declaration as a focused strategy to improve the health of the peoples of the Americas and reduce the existing inequalities within and between countries;

Acknowledging the central place of the goals of the UN Millennium Declaration in PAHO strategic priorities, and

Recognizing the PAHO strategy to reach the Millennium Development Goals,

RESOLVES:

To recommend that the Directing Council adopt a resolution along the following lines:

THE 45th DIRECTING COUNCIL,

Having seen the report, "Millennium Development Goals and Health Targets"
(Document CD45/8);

Acknowledging the goals of the UN Millennium Declaration and the strong commitment of the governments of the Region to their attainment;

Recognizing the close link between the goals of the UN Millennium Declaration and PAHO/WHO's vision of health for all; and

Understanding the importance of the achievement of the goals of the UN Millennium Declaration for the reduction of health inequalities in the Region of the Americas,

RESOLVES:

1. To request the Members States to:
 - (a) strengthen the political commitment to the goals of the UN Millennium Declaration at all levels of governance and consider the achievement of the goals a priority in regional, subregional, national, and local economic and social development plans;
 - (b) increase awareness and ownership of the health priorities set by the goals of the UN Millennium Declaration at the country level through a wide range of policy dialogues, partnerships, and intersectoral action;
 - (c) foster partnerships on the attainment of the development goals of the UN Millennium Declaration in subregional political and economic fora in order to strengthen Member States' commitment to health and social development with shared responsibility;
 - (d) intensify action on national health development and social protection in health, particularly at national and subnational levels to support progress on the goals of the UN Millennium Declaration;
 - (e) better integrate national efforts to attain the goals of the UN Millennium Declaration with initiatives on health goals and targets and outcome-oriented health policies in the Americas;
 - (f) engage and increase cooperation with other partners to advance the agenda of the goals of the UN Millennium Declaration at regional, subregional, and country levels;

- (g) support a strong civil society involvement at all levels to attain the goals of the UN Millennium Declaration, with a view to especially include women, ethnic and racial groups, and indigenous populations;
- (h) improve measurement and routine monitoring of progress of the attainment of the goals of the UN Millennium Declaration through high-quality, disaggregated health data;
- (i) initiate, facilitate, and support research to strengthen the evidence base for the attainment of the goals of the UN Millennium Declaration and generate new knowledge, in particular relating to synergies for health.

2. To request the Director to:

- (a) renew efforts to support countries in the development and implementation of national plans of action for the attainment of the goals of the UN Millennium Declaration and in the effective programming of development assistance resources;
- (b) continue to utilize the goals of the UN Millennium Declaration as a critical element of PAHO's cooperation in all relevant technical areas, particularly for those countries and population groups with the greatest need to attain the development goals of the UN Millennium Declaration;
- (c) continue to integrate and mainstream the goals of the UN Millennium Declaration in the PAHO program of work and in the results-based management;
- (d) intensify efforts for mobilizing human and financial resources and partnerships to support the countries in the Americas in implementing their national strategies as applied to the goals of the UN Millennium Declaration that focus on health;
- (e) integrate PAHO's work on the goals of the UN Millennium Declaration with other strategic efforts in health development in the Region of the Americas, including the efforts by subregional and regional bodies, the poverty reduction strategies of the UN and development banks, and investment in health systems strengthening;
- (f) provide technical support to the regional meeting of ministers of health that will take place in Argentina, in June 2005, to assess progress on the health-related goals of the UN Millennium Declaration;

- (g) continuously monitor the national and regional advancement towards the health-related goals, evaluate experiences, and share best practices among countries.

(Eighth meeting, 25 June 2004)
