

PAHO IN THE 21st CENTURY

**PRELIMINARY CONSOLIDATED DOCUMENT
DELIBERATIONS OF THE
EXECUTIVE COMMITTEE WORKING GROUP
PAHO IN THE 21st CENTURY**

(Contributions up to January 31, 2005)

This document has been issued by the Secretariat upon request of the Working Group Chairman

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HIGHLIGHTS

I. INTRODUCTION

Preliminary Note

1. This document of progress has been prepared upon request by the Executive Committee Working Group PAHO in the 21st Century (WG) and aims to consolidate: a) documents prepared by the WG as inputs to move forward to an integrated proposal¹, b) contributions made in the four meetings, as well as the document of progress presented to the last Directive Council², c) comments made to the documents by some countries, d) contributions made as a complement to the documents developed³.

2. This document has been organized in five parts and a final note. The first chapter is the present introduction. The second chapter describes the strategic challenges in public health in the Americas that were identified by the WG as the defining axis to move forward in the development of the proposal. The third chapter shows progress made by the WG regarding some aspects of the global agenda and the role that PAHO/WHO should play in the context of current trends in international cooperation in health. The fourth chapter gathers the WG progress on PAHO/WHO's governance and resources, and the fifth chapter presents the discussions of the WG on the technical cooperation strategies encouraged by the Organization. At the end of the document some important aspects of the progress made by the WG are highlighted. In order to facilitate the reading of this document, sources of the information are not mentioned in each paragraph since the sources are the documents elaborated in the context of this initiative.

3. This document does not include a chapter of recommendations since the WG will discuss recommendations at the next meeting. The chapter of recommendations will be included in the next version of the consolidated document.

¹ Documents are

- The Evolutionary Nature of Associations and Alliances in International Health Development that are pertinent to PAHO's Function, prepared by Peru.
- Regional and World Public Health Assets in the 21st Century and their Relationship with the Mandate of the Pan-American Health Organization, prepared by Argentina.
- Modalities of Technical Cooperation in the Area of Health, prepared by Costa Rica.
- PAHO Governance, prepared by Barbados.
- PAHO's Human Resources, prepared by the United States.
- Public Health Challenges in the 21st Century, prepared by PAHO's Secretariat.
- Health Work and Education Management in Health, prepared by Brazil.
- Science, Technology, Strategic Inputs and Information in Health, prepared by Brazil.
- Health Scientific Research in the Countries of the Latin American and Caribbean Region, prepared by Chile.
- Science, Technology, and Strategic Inputs: Contributions from the Ministries of Health of Brazil and Chile (it consolidates aforementioned documents by Brazil and Chile on Science and Technology).
- Health Financial Resources in the Americas, prepared by the Secretariat.

² Report about Progress Made by the Working Group in relation to PAHO in the 21st Century: Document on Progress and Status of the Reflection CD45/18, September 17, 2004.

³ This is the document prepared by Mexico. Public Health Challenges in the 21st Century and other comments prepared by other countries.

Activities of the Working Group

4. PAHO's 44th Directing Council, held from September 22 to September 26, 2003 resolved to request the Executive Committee: “a) to establish an open-ended working group comprised of selected Members of the Executive Committee; representatives of organizations with experience in the area of institutional and/or organizational reform in the United Nations system and in the public/private sector; and representatives of Member States wishing to participate, ensuring equitable distribution among the sub regions; b) to ask the working group for the review of PAHO’s situation in the 21st century to prepare its terms of reference and work plan with input from the Member States and present its report to the 134th session of the Executive Committee; c) to review the report of the working group and make recommendations to the 45th Directing Council.”⁴

5. The Executive Committee, in compliance of this mandate established a Working Group, "PAHO in the 21st Century," appointing Argentina, Barbados, Costa Rica and Peru as its members. At the 1st meeting, the WG appointed the Minister of Health of Barbados as its Chairman. Likewise, the WG has encouraged the participation of PAHO's Member Countries⁵. Thus, besides the four countries mentioned, other countries participated during the full process or part of the process that began in September 2003⁶.

⁴ Resolution CD44.R14, ninth meeting of the 44th Directing Council.

⁵ WG held the following meetings:

- First WG working session, held in Dominica on February 26 and 27, 2004, with the participation of Antigua and Bermuda, Argentina, the Netherlands Antilles, Bahamas, Barbados, Chile, Costa Rica, Dominica, France, Mexico, Peru, the United States of America and Uruguay.
- Second WG working session, held in Washington D.C. on March 23, 2004, with the participation of Argentina, Barbados, Mexico, Peru and the United States of America.
- Third WG working session, held in San Jose on July 26 and 27, 2004, with the participation of Argentina, Barbados, Brazil, Chile, Costa Rica, Mexico, Nicaragua, Peru and the United States of America.
- Fourth WG working session, held in Rio de Janeiro on December 14 and 15, 2004, with the participation of Argentina, Barbados, Brazil, Canada, Chile, Costa Rica, Cuba, United States of America, France, Mexico and Peru.

⁶ Antigua and Bermuda, the Netherlands Antilles, Bahamas, Brazil, Canada, Chile, Cuba, Dominica, the United States of America, France, Mexico, Nicaragua and Uruguay. Dr Bill Kean, WHO Governance Director, attended the first, third and fourth meetings, and in the forth meeting Dr. Pascale Brudon, Task Manager of the GPW of WHO, also participated. Dr. Georgio Solimano attended the first meeting on behalf of the Latin American and Caribbean Association of Public Health Education. Likewise representatives of PAHO's Secretariat collaborated in the four meetings.

6. To facilitate the work of the WG and public access to the material issued (reports of meetings, documents, comments made to documents, different document versions), PAHO opened a virtual space on its website⁷.

7. In the 38th Session of the Subcommittee on Planning and Programming, the WG Chairman presented an oral report⁸ about the progress of the group; in the 134th Session of the Executive Committee, the WG delivered a summary of the documents prepared up to that time⁹. In the 45th Session of the Directing Council, the WG presented a report on the progress made up to that time¹⁰; and in the 135th Session of the Executive Committee, the working plan of the WG to September 2005 was presented and reviewed.

8. WG's next steps for 2005 include the presentation of the progress report of its activities before the Sub-Committee on Planning and Programming in March, a meeting of interchange of information and consultation during the World Health Assembly in May, and the presentation of a final report during the next Executive Committee and Directive Council meetings.

II. PUBLIC HEALTH STRATEGIC CHALLENGES IN THE AMERICAS

9. The WG has considered that the defining axis to progress in the creation of the proposal about PAHO in the 21st Century should be the identification of the public health challenges that countries are facing.¹¹ Public health challenges are built on a scenario characterized by: a) the deep transformations that have occurred in the society, State and health systems during the last twenty-five years; b) a worldwide tendency toward a convergent position related to the challenges faced by the world and the strategies to face them; c) the certainty that major progress can be achieved with a national and international political leadership, the appropriate management and distribution of international resources available for health and development, and the coordination of international, national and local matters into the health agenda; d) an approach on health based on the population that requires not only intersectoral action but also the participation of a large range of social actors.

10. WG identified different dimensions that include the major challenges in public health. These dimensions include both determining factors of health and the situation of morbidity and mortality in the Region, and the responses that the health systems offered to take care of it¹².

⁷ www.ops.org/GoverningBodies/Working Group of PAHO in the 21st Century.

⁸ 38th Session, March 24-26, 2004. See CD134/INF/1.

⁹ 134th Executive Committee Session, June 21-25, 2004. See CE 134/6, Add.I.

¹⁰ Report on Progress Made by the Working Group about PAHO in the 21st Century: Document on Progress and Status of Reflection. CD45/18, September 27 to October 1, 2004.

¹¹ See the Report on Progress Made by the Working Group about PAHO in the 21st Century: Document on Progress and Status of the Reflection. Presented in the 45th Directing Council September 27 to October 1, 2004. CD45/18.

¹² See document prepared by the Secretariat for bibliographic references supporting the statements included in this chapter.

Challenges Related to the Differential Impact of Health Problems

11. Among the major health problems that, in a differential manner, the countries of Latin America and the Caribbean face are the persistence of high rates of infant and maternal mortality, high rates of fertility, malnutrition, communicable diseases and emerging problems, non-communicable diseases, increase of injuries, obesity and new diseases, spreading of drug addiction and violence (including domestic violence).

12. The health problems show a differential impact according to the life cycle, if the person belongs to a vulnerable group, and/or to a minority or disadvantaged ethnical group. Also, the distribution model of health benefits is unequal, and the health situation reflects social and economic inequalities, that is, societies with smallest income gaps (not necessarily the ones with higher income) tend to have both better health indicators and better access to water and basic sanitary services.

13. In spite of the complex health situation in Latin America and the Caribbean, it is necessary to consider that life expectancy at birth increased almost six years in the last two decades and that infant mortality decreased significantly, while population growth rate and fertility rates decreased in almost every country. Smallpox and poliomyelitis have been eradicated, and measles will soon be a disease from the past.

14. Challenges faced by public health in Latin America and the Caribbean countries are related to three agendas or, if preferred, three dimensions of the health agenda: a) to face major problems that still produce unacceptable rates of morbidity and mortality (because there are knowledge, resources and conditions to combat them), b) to preserve major achievements obtained in spite of unfavorable economic conditions that have characterized these countries in the last twenty-five years, c) to face emerging and re-emerging problems and those that have intensified as the result of the major changes that have occurred in the context of economic globalization.

Challenges related to Poverty and Social Exclusion

15. In Latin America 43.4% of the population lived in poverty in 2000. In absolute terms this means 220 million poor people, out of which 95 million are indigents. The situation is worsening since in the last five years poverty has increased both in absolute and relative terms in Latin America. Measuring poverty and inequalities in the Caribbean is more difficult because of the lack of home surveys and comparable data. Poverty incidence is higher in Haiti. Poverty rates in Dominica, Guyana, Saint Vincent and the Grenadines, and Surinam are lower than the ones in Haiti, but higher than the poverty rates in the rest of the countries. On the other hand, Bahamas' poverty rate is very low, even if compared with the rates of developed countries. In Caribbean countries poverty tends to be higher in rural areas, and unemployment rates are considered high.

16. Poverty persistence and income inequality are generalized obstacles that aggravate social and health exclusion. In general terms, Latin America and Caribbean countries are characterized by a slow and unstable growth, adverse structural models,

irregular income distribution, and employment deterioration, as well as differential opportunities for trading. These countries, taken together, have the highest gross national income per capita from all regions, but they show the greatest inequalities of all regions; poverty is also four times greater than poverty in other regions with a similar gross national product. Income concentration shows regional variations, but it has remained mostly unchanged or it has increased during the last decade in almost every country.

17. Life expectancy is higher in countries with high income and in countries with levels of similar income where gaps between incomes are small. More than 54 million poor people in Latin America and Caribbean countries suffer from some degree of malnutrition, and around 20% have suffered it in some countries (Bolivia, Dominican Republic, Guatemala, Haiti, Honduras and Nicaragua). In spite of national and international initiatives to face such a situation, progress is slow.

18. Conditions of social exclusion and health have worsened, partly because of the deterioration of working conditions and the increase of unemployment; the non-structured sector has expanded, and seven of every ten employments created in urban areas belong to this sector. There are important gaps between unskilled and skilled, and between formal and informal workers (who lack social and health protection). At the same time, women have even more likely to be unemployed, overrepresented in the unstructured sector, concentrated in low- wage jobs and subject to salary discrimination.

19. Working to eradicate poverty and exclusion has been recognized as a public health challenge. It has been shown from this field that certain interventions have had a positive effect in mitigating the differential burden of disease and death. In conjunction with the challenge of keeping achievements, and improving and expanding interventions in this field, there is a growing recognition of the need to work and influence other social and economic sectors, at the national and international level, in order to fight poverty and to expand social protection. National and international sectors related to development have made the same recognition, which is expressed in the first of the Millennium Development Goals.

Challenges related to Political and Governmental Factors

20. Governments of the Region are committed to the search of a better performance, a greater transparency and social responsibility. Democracy is strengthening and there is a growing valuation of its institutions. Social aspects of development have been recognized at the highest levels of the governments. In spite of this, social unrest, social and economic instability and insecurity undermine people's reliability in the system. In the social area, this could increase because of the possibility that public institutions reduce their capacity to state and enforce social and health policies, particularly distributive or regulatory policies whose aim is to improve equity and to protect the population.

21. The majority of the governments of the Region face the enormous challenge of assuring governability based on legal and ethical principles of equality, besides facing vast economic inequalities observed inside and among countries.

22. Public health challenges in this area are important; they begin with the need to identify and address health disparities through formulation and implementation of intersectoral public policies. In its turn, it is an important challenge to succeed in managing political pressures coming from the increase of social actors participating in health decision-making. And also considered a factor linked to the challenges in this area is the need to increase the capacity of allocating and using resources in innovative ways.

23. These public health challenges are presented in a context where a new era has been defined for public policies, where health is increasingly combined with national and foreign politics, sovereignty, governance, multilateral and bilateral strategies, and national and international interests. By decision of the Member Countries, human safety has been placed in the first level of the world program of international organizations, and it is conceived as a complement of the traditional concept of state safety understood in geopolitical terms. This integrated approach is focused on several issues of action aimed to protect fundamental freedom of the people and to promote its decision power, based on the principles of human development and human rights.

Challenges related to Health Systems and Universal Access to Health Care Services

24. The 1980s and 1990s witnessed profound structural changes in health systems, meeting with variable results in terms of the health situation of the population of the Region of the Americas, but falling short of reaching international goals in this area. In addition to pending issues related to these goals, new problems emerged, thus increasing the challenges faced by governments, health and health training institutions, and international cooperation agencies, particularly in the least developed countries, not to mention societies in general. A new agenda took shape at that time, encompassing work still left to be done, emerging problems, the constant risk of losing ground on advances already made, and the new alternatives and experiences from that period, highlighting the growing awareness of the central role played by work in health in guaranteeing the right and universal access to quality health care.

25. Although the health sector reforms promoted during the nineties were oriented to perform positive financial, structural and institutional changes, important aspects of public health were forgotten. Public health was neglected as a social and institutional responsibility. This situation, together with the effects of other factors, affected the capacity of the governments to fully enforce their steering role and basic functions of public health. The consequences of these processes, in a context of growing difficulties and profound socio-economical crisis, caused regression or put at risk advances already made, especially regarding health services coverage.

26. A preliminary assessment of the repercussions of the sectoral reforms indicates that with regard to **equity**, there is little indication that reforms contributed to reduce gaps in the coverage of some basic services and programs and in most countries they are not affecting the reduction of gaps in the distribution of resources. With regard to **effectiveness and quality**, little progress has been attained in improving the global

effectiveness of the system, adherence to normative aspects of quality of care or user satisfaction with quality. In regard to **efficiency**, more gains are registered in and development of purchasing practices than in reorienting resource allocation. With regard to **sustainability**, there are attempts to adjust expenditures to the revenues of the system, but very few countries are improving the medium or long-term generation of resources for expanding or sustaining the current level of service provision. An aggravating factor seems to be the high dependency of many countries on external financing and the lack of mechanisms to replace these flows of resources once they end. With regard to **social participation**, governments seem more receptive today as a result of health sector reform plans; however, it remains to be seen whether greater social participation actually affects the reorientation of health sector reforms.

27. Segmentation of health system persists; while some countries have very low health expenses, some others depend excessively from external resources. Even when countries increased public resources for health, this increase represents a relatively small percentage when compared with the increase of out-of-pocket expenditures necessary to access these services. These trends have exacerbated the regressive impact on the poorest populations, and few countries have been able to break away from their historical allocation of resources.

28. In spite of the aforementioned, health systems are progressing, although in an incomplete way, in several important dimensions. Public health continues evolving to increasingly include an approach based on population, disease prevention and health promotion strategies. Bioethical aspects of medical care and the function of psychological, social and cultural factors on health are being recognized and there is a greater awareness of traditional and alternative medical practices.

29. Most of Latin America and Caribbean countries face the challenge of strengthening the leadership of the health authority at all levels of the State, as well as improving the public health practice, as a condition, among other factors, for improving the coverage and quality of the health systems. One of the important factors for reinforcing the steering role function of the health authority consists in replacing public health in the agenda of the sector, and with it, the fulfillment of the Essential Public Health Functions (EPHF) that correspond to the State at the central, intermediate, and local level. In view of all this, it is critical to improve both practice in public health and the instruments for assessing the situation and identifying the areas that require attention.

Challenges related to Human Resources in Health

30. A growing awareness emerges about the central role played by the health workforce in guaranteeing the right and universal access to quality health services. It is important to point out the convergence of different initiatives to create a new human resources for health agenda, reflected in the decision to devote World Health Day and the *2006 World Health Report* to this subject, thus generating conditions for a broad alliance around a human resources for health decade.

31. One of the main obstacles to the attainment of health goals for the peoples of the Americas has been the absence of policies that view health workers as active, critical agents with the ability to sustain projects and processes of change. The lack of such sectoral policies, which stress working relationships, the active participation of workers in processes aimed at changing the health management and health care structure and the education and professional development processes, results in the proposal of grand managerial and technical measures, leaving behind the objective agents responsible for executing and fulfilling these goals. Workers must be moved from the condition of resources and be considered social actors in the transformation of work, in the struggle for the right to health and for a system of sound, patient-friendly health care management practices.

32. It is necessary to revert the tendency to the political abandonment of the workers, retaking the role of the State as inductor and formulator of orientations capable of producing political transformations in the policies that guide the management, education, qualification and regulations of the health sector's workers, with a better valuation of the workers in the search for quality health care.

33. The management of work and education in health is divided into two main lines: 1) The need to regulate work relationships and make them less insecure, with a view to progressively consolidate careers in the health sector with stable work relationships, recruitment via selective public procedures with the ability to generate the desired job descriptions, as well as professional evaluation, promotion of a good quality of life in the workplace, and career promotions; 2) the permanent education in health as a key strategy for reformulating practices in training, care, management, policy-making, and social participation in the health sector. Aside from the political element, which involves strategic decisions regarding the formulation of major guidelines, management functions with respect to work and education in health also have an important technical and operational dimension that demands a specialized organizational structure to fulfill these functions.

34. The access of managers to up-to-date comprehensive information is crucial to success in the formulation and implementation of policies for managing the work of the health sector; its development is one of the challenges that public health presently has.

35. Specifically in the health area, the practices of rationalizing expenditures, promoting efficiency, and optimizing the cost/benefit ratio had profound consequences for the quality of health care. The outlook for the health sector in the Americas shows: 1) the clear outsourcing of essential activities that should be protected by the State; 2) insecurity of work relationships with a substantial loss of labor and social guarantees; 3) the gradual loss of jobs in the public sector, undermining the public health sector's importance as a direct provider of health care to the population; 4) loss of health workers' perception of health as a government career path; 5) deregulation and lack of regulation of work and activities in health; 6) movement of health professionals among countries without any management of this movement; and 7) disorganization and loss of prestige in the area of managing work and education in health, among other issues.

36. In this context, some problems must be tackled by the governments of the Region of the Americas and by international cooperation agencies, including: 1) Need to develop policies to foster careers in public health. This approach seeks to reorganize workers into careers that meet professional accreditation requirements, allocate staff based on the needs of the system, and target the cities and regions hardest hit by staffing shortages. 2) Need to formulate policies to regulate work and provide job security, progressively consolidating more stable work relationships. 3) Need for policies to improve workers' quality of life and the humanization of work relationships in health (some groups of professionals are subject to extended work hours, poor distribution of responsibilities, and high tensions among members of the health team; health care activities rank high among the professions that pose higher workplace risks and stress, and are well known for generating the conditions for burnout syndrome, attributable to the physical and emotional exhaustion of workers).

37. Regarding education, fragmented sectoral action should be avoided. The education of health professionals in Latin America continues to be oriented to the private practice, centered in the hospital and utilizing complex technology.

38. Problems of the last century—i.e., limited availability of professionals, irregular distribution with high concentrations in urban centers and more developed regions, growing specialization and its consequences for costs and dependency on more sophisticated technologies, the predominance of hospital training rooted in the biological and technological aspects of care—call for ambitious reform initiatives centered on the education and management of workers. To succeed, it is necessary that the education and health sectors come together in the definition of any reform to confront old and new problems.

39. New, more powerful approaches geared to breaking down the persistent dichotomies on which previous reform initiatives were based (individual vs. group, private clinic vs. public health facility, specialist vs. generalist, technological sophistication vs. simplified approaches) become urgent. A new approach would help to translate the complexity of the situations involved in health care and mark the beginning of a new era on national and international cooperation agendas.

Challenges related to Financial Resources

40. Relative importance of national health care expenditures across countries and regions varies greatly. In the year 2000, worldwide spending on health care related goods and services represented approximately 7.5% of the world Gross Domestic Product – GDP, while in the Latin America and Caribbean region the amount of resources spent on health care related goods and services represented around 7.2% of the regional GDP. In general, there is a positive correlation between the level of income per capita and the importance of national health expenditures as percentage of the GDP. The share of NHE as percentage of GDP increases with the level of income.

41. Large differences in the level of income per capita and in the NHE/GDP ratios explain the large variations in annual per capita expenditures in health care related goods

and services across countries and regions: from US\$ 177 in Low and Middle Income countries to more than US\$ 4,000 dollars in the USA. For Latin America and the Caribbean per capita expenditures of approximately US\$ 498 dollars, annually.

42. There is a positive association between the level of income and the importance of public expenditures as a proportion of the overall national health expenditures. The importance of the share of public expenditure as percentage of the overall national expenditures increases with the level of economic development or income per capita of the country or region, with the exception of the United States. For the European Union countries that have national health care systems providing universal coverage, the ratio of public to private expenditure was 74/26, while for Latin America and the Caribbean region this ration implies US\$ 0.70 of public expenditures for every US\$ 1 dollar of private out-of-pocket expenditures.

43. The national health care expenditures as a proportion of the GDP varies greatly among the countries of the Americas: from less than 1% to about 13%.

44. The average ratio of public spending on health as a percentage of GDP in Latin America and the Caribbean also varies greatly (from around 9% in Cuba to under 2% in Guatemala, Ecuador and Suriname). The positive association in the share of public expenditure as percentage of the GDP and the level of income of the countries results in wider variations in the level of per capita public sector expenditures on health across countries (it ranges from less than US\$ 20 dollars in Haiti and Nicaragua to more than US\$ 200 dollars in Chile, Costa Rica, Panama and Uruguay).

45. There are large variations in the ratio of public-private expenditures across countries. In the Latin America and Caribbean region, the public-private ratio ranged from around 0.6 in low-income countries with relatively low coverage of national health care systems to more than 2.0 in countries with better organized and relatively high coverage of their national health care systems.

46. Over time, from 1980 to the year 2000, the rate of growth in medical expenditures has been slightly above the rate of economic growth in Latin America and the Caribbean countries. This pattern of growth in national health care expenditures in relation to income is consistent with the patterns observed in developed economies and the increase in expenditures associated to emerging diseases, development of new technologies and the aging of the population. From 1980 to the year 2000 the amount of resources spent in health care services almost doubled.

47. There has been an important change in the composition of private expenditures; particularly since the nineties there has been a considerable increase in the amount of resources spent in health care services throughout pre-paid health schemes and private health insurance plans (indirect expenditures). From almost non-existent in 1990, expenditures in pre-paid health schemes and insurance plans now represent approximately one-fifth of the financial resources spent in health.

48. Presently, the principal challenges that Latin America and Caribbean countries have regarding health expenditure are related to the design and implementation of public policies directed to optimize the national health expenditure with equity criterion. It is necessary to take into account that: a) the policies of state reform and modernization directed to improve the operational efficiency of the health sector institutions have had a limited effect, given the composition public/private of the national expenditure of the countries; b) the reform policies that are limited to the reform of public institutions will affect only a small part of the total of the national health expenditure, and c) social security reform will have greater impact on countries with compulsory systems of health insurances, administered by public and private institutions that have high health coverage; d) the rising trend to the increase of the costs of health care has not been controlled, and it is not foreseen that this will happen soon.

49. Furthermore, there is a trend in Latin America and the Caribbean toward the inequitable distribution of the public expenditure. The major variations in the distribution of public expenditure in health services and public health programs indicate that in the majority of the countries there is a long way to go before public expenditure is an instrument that facilitates equitable access to health care. It is necessary to better use the existing fiscal tools to address matters of health and equity, and increase the expenditure on programs and health services in all the public institutions. Many countries use to a limited degree public policy instruments to improve health results and achieve a more equitable access to health care.

Challenges related to Natural Resources and Quality of the Physical Environment

50. Population movement, technological changes and technologies, and social and economic transformations contribute to configure environment quality as well as the quality and quantity of natural resources. Although many effects are difficult to quantify or to foresee correctly, there is a generalized consensus regarding the fact that the progressive deterioration of the environment, loss of biological diversity and pollution of vital resources damage health and well being, and that they can also generate social and economic costs in the long term, as well as irreparable damages to the ecosystem.

51. Communicable diseases like dengue and malaria, work injuries and chronic diseases associated with chemical and physical agents reflect the effects of environment on health. Climate changes contribute to air contamination, allergens concentration, appearance and food distribution, water supply and vector-borne diseases, the risk of malnutrition, droughts and famines, water shortage and the increase of the frequency or seriousness of natural disasters. The latter cause devastation, population movements, diseases, accidents, deaths and economic losses of such magnitude that they often cause a step backwards of several years in national development.

52. Public health challenges in this issue require intersectoral action as a condition and, in many cases, international action. It is necessary to reduce gaps regarding drinking water supply and basic sanitary services, and to reduce the risks of chemical and biological contamination of resources. To prevent environmental deterioration, it is necessary to improve the normative system and make it succeed. With regards to physical

environment, the most important challenge is to reduce the harmful effects of urbanization on the health of the inhabitants who live in big cities.

Challenges related to Science, Technology, Research and Information

53. A number of factors come together to demonstrate the urgency of including health research, science, technology, inputs and information as a basic item on the agendas of the international organizations and ministries of health responsible for organizing the promotion of health research. Some of this factors are: growing awareness of the key role of health, science, and technology as requirements for economic and social development, and not merely its consequences; need to improve the health conditions of poor and marginalized populations, which is essential for attaining the UN Millennium Development Goals; disconnect between the burden of the diseases affecting disadvantaged populations and the concentration of global investment in health research on problems affecting the industrialized countries; few resources for health research on the diseases of poverty, requiring financing agencies to prioritize and select programs; acceleration of discoveries and scientific advances in the biomedical field, notably in genomic science and the immense potential of its applications for human and animal health; growing participation of the private sector and philanthropy in the financing and conducting of health research; little participation by the least developed countries in the global production of scientific and technological knowledge; the “brain drain.” which siphons off the limited human health resources of the poor countries, thereby increasing inequity; limited access by the most disadvantaged populations to drugs, vaccines, and diagnostic tools, due to patent protection; recent international emphasis on the areas of bioterrorism and biodefensa and the insufficient attention paid to the urgent problems in public health; and need to study the various national health research systems to orient them to the needs of each country.

54. In the Region of the Americas, there are major differences in the countries’ development, the distribution of needs, institutional organization, and the capacity of respond to needs in the fields of health science and technology, strategic inputs, and health information. However, evidence points to some situations that the countries have in common. Among them are the lack of policies in the areas of science and technology that are compatible and associated with health policies in the countries, and lesser involvement by the ministries of health in managing policy on science, technology, strategic inputs, and health information. It is necessary

- To increase the visibility of national health authorities in the countries of the Region in scientific and technological efforts. The absence or marginal presence of those authorities hinders harmonization of health research activities with the needs of national health policies. The disconnection between these two components is one of the main obstacles for most countries of the Region to putting excellent knowledge at the service of best practice in health.
- To promote the preparation of national policies in health science and technology, under the leadership of the Ministries of Health, in keeping with the national and regional health needs of the population as defined by health objectives. This policy

should be firmly supported by a commitment to combat inequality in health, contributing in this way to raising standards of equity in the health systems, based on ethical principles in health research. This policy will face the challenge of increasing the effectiveness and efficiency of national systems and promoting the advancement of scientific knowledge in the health sector, especially in fields neglected by scientific centers that are more developed in terms of the production, absorption, and use of scientific knowledge and technology and the training of human resources for health research.

- To increase the selective and catalytic capacity of the system for the promotion of science and technology to set a national agenda of health research priorities. Assembling this agenda should be a technical political process with democratic participation. The priorities should approximate the health needs of the population. However, they will not necessarily be superimposed on them, since addressing health needs does not depend directly on the solutions proposed by scientific research, just as there are not always adequate concepts or methodologies in terms of scientific and technological knowledge and practices. The agenda will also include research on the full range of knowledge in health, from basic research to operations research. The Declaration of Mexico on Health Research recently signed by the Ministries of Health and participants of 58 countries of the world represent a progress toward the aforementioned, and requests the intervention of the national governments, WHO, sponsors of health research, the international community, the research community and other stakeholders to confront this challenges¹³.
- A science and technology policy should pay special attention to technology development and innovation. Thus, it should include proposals and actions specifically geared to the health industry complex, since the countries have a great need for primary health industry inputs—prescription drugs, vaccines, sera, blood products, diagnostic kits, and equipment—and that adequately addressing these needs requires the highest level of technical training and, in several areas, technological autonomy and self-sufficiency. Each of these health inputs includes specific industry and marketing characteristics, but what they all have in common is that they are part of a very dynamic and highly profitable global industry. With respect to drugs and vaccines, we have witnessed a real technology revolution in recent decades. In terms of industrial organization, this revolution has prompted a movement toward the concentration of capital and technology that makes necessary to draft a policy on technology and innovation in health. These guidelines should directly follow the principles of the Doha Declaration, which states that public health considerations should prevail over industrial intellectual property rights..
- Promote the adaptation of national legislation in order to make the maximum use of flexible areas in international agreements on patents, with a view to facilitating bilateral agreements for the procurement of drugs and inputs, and to expand and improve the productive capacity of the countries of the Region, which can effectively ensure the full exercise of internationally negotiated safeguards;

¹³ *Declaration of Mexico on Health Research. Knowledge for a Better Health.* Summit of Health Research, Mexico 16-20 November, 2004.

- Strengthen the regional exchange of initiatives that fortify the governments' capacity for managing access to drugs and inputs, involving the processes of research and development, production, distribution, dispensing, and rational use, with emphasis on generic drugs and antiretrovirals;
- Information assumes strategic importance in the scientific interface between health and society in terms of the impact of policies and their results on the health situation of individuals and populations. Information is vital for formulation, execution and evaluation of policies, management of health system, management of human resources, scientific and technological development, and research. It is necessary to continue the development of important information systems, as BIREME, Human Resources Observatories, Health Database, etc.

Challenges Related to Changes Produced by Economic Globalization

55. Economical globalization refers to a group of transformations that intensifies process that was present in what was already a highly internationalized global system. As part of this transformation the asymmetric integration of sub-regional and national economies has been intensified through trade, finances and production in a world market that works through interactive communication and producers, suppliers and customers' networks.

56. International transfer of health risks is accentuated with globalization. These risks can be environmental risks, they can be risks associated to the movement of individuals through the borders, risks associated to the export of harmful life styles, occupational risks associated to the export of risky working processes, risks associated to the increase of substances (legal and illegal) international trade that is harmful to health, and risks associated to the export of medical technologies. Besides the increase on the international transfer of risks, a noticeable increase of international trade of health services is observed, especially with regards to cross border mobility of health services and cross border mobility of health services consumers, as well as of service providers.

57. In its turn, with globalization, there is a spiraled increase of exchange opportunities of cooperation between countries and regions at all levels as well as the opportunities to direct resources toward technical areas and zones in most need.

58. Challenges stated by globalization are related to the need of the countries to strengthen national governance in order to control negative effects and to optimize positive effects. The countries need to increase their capacity to identify cross border risks of diseases, environmental pollutants and safety. It is necessary to take advantage of the benefits of a higher interconnection to improve knowledge exchange, cooperation regarding health and management of technology transfers.

Challenges of the Countries of the Region related to International Cooperation in Health

59. WG identified the challenges that the countries have to face with regard to international cooperation in health. The main challenges are

1. Generally, countries do not have appropriate policies regarding international cooperation; in many countries, human resources are not properly trained to represent a strong and fruitful partner for the cooperation process.
2. One of the main challenges is to align national, regional and world aspects. It is necessary to integrate world goals, like the Millennium Development Goals, into countries' priorities and programming in order to assure that national and world goals agreed by the countries are really met.
3. To strengthen national capacity to plan and manage international cooperation, considering current trends towards a greater bilateral cooperation and towards the change of the system to move from short-term projects to support programs and sectoral approaches.
4. To improve multilateral approaches and collaboration regarding preparedness and mitigation as part of the national program.
5. To strengthen promotion in order to improve the place of health in international programs of politics and economy, to raise awareness about the links between health and development, and to establish efficacious associations.

60. The countries of the Region face multiple challenges related to health and citizens well being. A big part of such challenges suppose action in public health, either because they can be faced in this field or because, from it, it is possible to contribute to the configuration and implementation of an intersectoral agenda. Likewise, countries of the Region support and participate in inter-governmental organizations of technical cooperation in health in order to, by means of a joint action among peers, improve their national competencies of health management: to face in a more effective way the most important health problems, to find a forum, and to relate with other countries and organizations to exchange (to offer/to receive/to share) cooperation. International technical cooperation must represent a strengthening of the country, its development; and it must be performed within the framework of social, economic processes, and the proper history of each nation.

61. Global or regional agendas in the area of health that have emerged in intergovernmental organizations represent the identification of a common ground on behalf of Member Countries where priority to reach specific goals is recognized. Efforts are added and empowered to reach those specific goals. At this point, countries and international health and development organizations have acquired commitments in some basic directions.

62. The next chapter will include the revision of the challenges in international cooperation in health; the role-played and/or to be played by PAHO in such context will also be addressed.

III. INTERNATIONAL COOPERATION IN HEALTH AND THE ROLE OF PAHO/WHO

Toward a Common Agenda

63. Since the historical International Conference on Primary Health Care of Alma Ata, promoted jointly by WHO and UNICEF in 1978, where the goal of Health For All in the Year 2000 was officially launched, international agreements have multiplied promoting objectives and goals in health. All of them have made an explicit call to the participation of multisectoral actors, because of the conviction that, without this participation, this goal will not be reached.

64. The “Millennium Declaration” approved in the Millennium Summit, held September 6-8, 2000 in New York, with the participation of 191 countries, including 147 heads of State and Government, represents a noticeable convergence of world leaders opinions in relation to the challenges the world faces. In the Millennium Declaration, countries reaffirm their reliability on the UN to get a more pacific, more prosperous and fair world. Likewise, they recognize some fundamental values that are essential to international relations in the 21st century: Liberty, equality, solidarity, tolerance, respect for nature, and common accountability. Besides, it proposes to strengthen UN for a better performance of this institution in this new century.

65. In this Summit, participating leaders defined eight concrete objectives, the “Millennium Development Goals” for 2015 that include: 1) to eradicate extreme poverty and hunger; 2) to get universal primary education; 3) to promote gender equality and women autonomy; 4) to reduce mortality among children under 5 years old; 5) to improve maternal health; 6) to combat HIV/AIDS, malaria and other diseases; 7) to assure environmental sustainability. Objective 8: To foster a World Association for Development, reaffirmed in Monterrey and Johannesburg Meetings, it encourages rich countries to adopt measures to soothe the debt, to increase economic assistance and to allow the access to market and technology to the poorest countries. These objectives provide a framework for the work of the UN system in a more organized way towards a common goal.

66. The International Conference on Financing for Development, a major summit convened by the United Nations in Monterrey, Mexico in March 2002, had the purpose of promoting and elicits the financial commitment of developed and developing countries toward the achievement of the goals contained in the UN Millennium Declaration. To this end, a major focus of this Conference was the need to increase substantially the level of Official Development Assistance that developed countries provide to the developing world¹⁴.

67. Countries of the Region of the Americas, besides having participated through their governments in the formulation of global objectives for health and development,

¹⁴ In the document Health Financial Resources in the Americas, prepared by the Secretariat, the trends of the ODA are analyzed.

ratified their commitment with them through the mandate given to PAHO/WHO to renew or to integrate into its agenda such objectives as a priority. This is how PAHO/WHO, in the present time, by mandate of its Member Countries and by mandate of WHO, works for its policy and actions through its technical programs, to reflect these commitments. During these last two years, Member Countries entrusted PAHO/WHO to support them in the task of redoubling efforts to assure extension of social protection in health¹⁵; they renewed their commitment with Health for All, entrusting PAHO/WHO to control that all technical programs emphasized the principles of Primary Health Care (particularly, regarding the achievement of the Millennium Development Goals¹⁶). Likewise, Member Countries resolved to entrust PAHO to expand its participation in the integration of the MDG within the framework of national health policies¹⁷.

68. The Resolution CD45.R3 about the MDG and health targets request the Member States to:

- a) prepare and execute national plans of action for the attainment of the United Nations Millennium Development Goals and the effective programming of development assistance resources;
- b) strengthen the political commitment to the goals of the United Nations 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;
- c) increase awareness and ownership of the health priorities set by the goals of the United Nations Millennium Declaration at the country level through a wide range of policy dialogues, partnerships, and intersectoral action;
- d) foster partnerships on the attainment of the development goals of the United Nations Millennium Declaration in sub-regional political and economic in order to strengthen Member States' commitment to health and social development with shared responsibility;
- e) intensify action on national health development and social protection in health, particularly at national and sub national levels to support progress on the goals of the United Nations Millennium Declaration (UNMD);
- f) better integrate national efforts to attain the goals of the UNMD with initiatives on health goals and targets and outcome-oriented health policies in the Americas;
- g) engage and increase cooperation with other partners to advance the agenda of the goals of the UNMD at regional, sub-regional, and country levels;
- h) support a strong civil society involvement at all levels to attain the goals of the UNMD, with a view to especially include adolescents, women, persons with disabilities, ethnic and racial groups, and indigenous populations;

¹⁵ 26th Pan American Health Conference, CSP26.R19, Washington DC, September 23 to 27, 2002.

¹⁶ 44th Directing Council, CD44.R6, Washington DC, September 22 to 26, 2003

¹⁷ 45th Directing Council, CD45.R3, Washington DC, September 27 to October 1st, 2004.

- i) improve measurement and routine monitoring of progress of the attainment of the goals of the UNMD through high-quality, disaggregated health data;
- j) initiate, facilitate, and support research to strengthen the evidence base for the attainment of the goals of the UNMD and generate new knowledge, in particular relating to synergies of health.

69. The effort implies, in the first place, moving at a faster pace toward a substantial reduction in inequities in health and access to basic services. Second, it implies significant progress in social protection in health, without which it will be impossible to expand the coverage of the most critical interventions necessary to raise the health status of the population. Third, requires an increase in the sector's current expenditure and investment and a substantial improvement in the quality of sectoral resource allocation. Fourth, it demands a reorientation of health services based on a renewal strategy of primary health care. Fifth, it requires a sustained improvement in the public health infrastructure. Sixth and last, it requires progress in the formulation and implementation of intersectoral policies and activities that will have a real impact on the economic and social determinants of the health goals contained in the MDGs.. All this is necessary to strengthen social cohesiveness and citizens' rights in health. Consequently, it must be integrated into the health policies, plans, and programs of the countries of the Region so that, converging with the action required in other sectors, it will be possible to reverse the secular trends observed in many of the MDG health indicators; if the reduction of these indicators is not accelerated, it will be impossible to meet the commitments for 2015.¹⁸

PAHO/WHO's Possibilities and Challenges

70. In recent times, there has been an upsurge in the amount of national, regional and global stakeholders in Health in the Region. International organizations like PAHO/WHO that provides technical support to countries have an important role to play, as it is not just Member States that need strong technical guidance, but also the partners who are assisting the countries.

71. PAHO/WHO must continue showing leadership and coordinative capacity, which will help to rationalize the distribution of work between the various partners for more harmonious technical cooperation alliance. Within these new types of partnerships, resource mobilization, sharing of knowledge, technology and expertise, networking, planning, testing and evaluation must continue to be important functions of PAHO/WHO and its Member States' work.

72. Both PAHO/WHO and the member governments must develop systems for greater transparency and to improve their accountability. The effective coordination of health initiatives will include strengthening global partnerships and national health systems and ensuring that there is coherence between all the national, regional and global strategies and cooperation efforts. Well-coordinated technical cooperation orientated by PAHO/WHO will be essential for countries to operate effectively and efficiently, since a

¹⁸ Presentation by the Director of Program Management of PAHO/WHO. Fourth Meeting of the WG, Rio de Janeiro, December 14-15 2004.

fragmented regional health landscape will lead to duplication of efforts, increased wastage, inefficiency, combined with a regional failure to achieve the global targets and the inability to overcome the preceding challenges.

73. WG has a strategic vision of PAHO/WHO as an institution exercising international leadership in the area of health, with an accurate focus and a clear definition of its areas of service, and contributing to the formulation of national policies with a role of support and guidance to the countries.

74. PAHO/WHO must play a dual role of facilitator agent to link different actors involved in issues related to health, including Member Countries, combined with the strengthening of its own capacity to provide technical cooperation in a variety of topics where PAHO/WHO is the best actor to perform it directly (that is, the one with the most developed capabilities).

75. WG visualizes an institution working with a high degree of transparency that optimizes resources, making a larger use of national resources and reducing bureaucracy; with a financial administrative system reinforced with the participation of Member States in the control and assessment, with clear criteria of efficiency and equity to allocate financial resources.

76. WG visualizes a PAHO/WHO with robust alliances and established associations and with a greater presence at WHO, getting stronger in its role of agent of the new partners in health and playing an active part in the technical orientation toward other international organizations.

77. PAHO/WHO is visualized as managing the performance of an arranged effort in favor of health and development as the appropriate mechanism for stakeholders to face the challenges. As the impossibility of managing the different political circles independently becomes more and more evident, the public health challenges will generate a gradual increase of cooperation in the international community.

78. WG made a SWOT analysis about PAHO. Overall, characteristics identified contribute to visualizing particular features as well as features that PAHO shares with other organizations¹⁹.

Strengths

- Prestige as technical agency specializing in health.
- Legitimacy (mandate) among governments as a sectoral agency that sets standards in health.
- Organizational structure in all the countries.

¹⁹ Peru developed the SWOT analysis in order to visualize PAHO's capability to develop alliances; however, the analysis can be applied in a larger manner. Some changes were made following the United States suggestions (Comments of the United States to the document from Peru)

- Extensive international experience in various aspects of health, particularly in normative matters and matters related to partnerships and alliances.
- Agency with both inter-American and international representation.
- Ability to convene countries at the regional and sub-regional levels to address health and health sciences matters of concern.
- PAHO's source of financing: the fact it receives quota contributions from Member States, in addition to funds from WHO (like other WHO regional offices), puts the Organization and its members in an advantageous position.
- PAHO is also a recipient of extra budgetary investments, which help to support its program and budget.

Opportunities

- Qualitative and quantitative improvement of intesectoral vision and participation.
- Capacity to provide advice about the best use or direction of financial resources coming from national and international sources in order to promote health in the Region.
- PAHO's ability to help the Member States strengthen their capacity to define costs and benefits of health investments as well as repercussions of these investments into the economy in general and other sectors.
- Potential to obtain new ideas from new actors.
- Influence over actors with little familiarity of the social aspects of economic policies.
- Participation in matters with a major impact on health, such as the effects of drug patents on economic trade agreements.

Weaknesses

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

Threats

- The dispersion and multiplicity of actors, agendas, objectives and interests.

- Actors with contradictory visions to those of PAHO's mandate who manage higher financial resources.
- Possibility of losing ground in the accumulations made regarding health achievements in the countries and/or the place acquired by health matters in the national, regional, and world agenda.

PAHO/WHO's Roles and Strategies in Alliances for Health

79. Alliances and Associations are part of a long tradition in the political, social and economic history of the countries with important realizations for public health. The constitution of the Pan American Sanitary Bureau over a century ago is the unmistakable expression of the perception of the advantages of coordinated work in health among the countries in the Region of the Americas, and it corresponds to the historical moment where the fundamental actors were mainly the States. It is thus foreseen that Alliances will continue expanding along this century and will continue affecting the health policies.

80. Associations and Alliances respond to the particular interests of stakeholders of a different nature, and they are fundamentally geared towards responding, in a more organized and effective manner, on issues of interest for the partners.

81. The public-private associations have become an issue of growing importance because the global sanitary panorama has become more complex, and it includes the participation of a greater number of actors. There is a growing consensus that health is a global public good. In addition to the national programs, the sphere of health around the world includes the new technical cooperation associations, integrated by the private sector, the organizations of civil society, the multilateral organizations, the regional development banks, the regional integration and political institutions, and different bilateral stakeholders.

82. In turn, in the civil society, the role of the associations has been multiplied, especially with regard to, for example, the direct provision of health services, and the renewal of the strategy for the promotion of the basic sanitary rights and the access to health resources. The activities of the civil society organizations have increased in response to what is perceived as the weakening of the national authorities in the context of globalization and the increase of power among the transnational enterprises. The network of associations from the civil society now include the non-governmental organizations, the community groups, the private foundations and the humanitarian organizations created in a particular country or in a group of countries, in order to promote a broader support to the public interests on world policy issues such as human rights, environmental problems, debt relief, socio-economic development and health. The increasingly important role of civil society in the developmental processes is a recent phenomena.

83. In Latin America and the Caribbean the alliances of sub-regional integration that were strengthened during the nineties as a response to globalization from the countries have set new demands on technical cooperation by PAHO/WHO and other multilateral

and bilateral organizations. Some of them are the result of new challenges, which can be approached by applying conventional procedures of cooperation among countries. In turn, the satisfaction of others requires the collective support of the countries committed with the creation of consensus and the formulation of supranational policies and instruments.

84. At this moment it is recognized that there is a wide range of actors who could participate in different types of alliances with PAHO/WHO. With many of them—especially those directly linked to the health sector, but not only limited to it—PAHO/WHO has worked in a great number of initiatives of different scope and duration.

85. It is possible that the main role for PAHO/WHO in the issue of Alliances and Associations is the coordination and promotion of dialogue between the different actors for the defense of public-health goods. This is a task that is in the boundary between advocacy and direct participation. It demands the cooperation with stakeholders from different organizational cultures, values, and objectives, and the recognition of the institutional weaknesses and strengths. The Organization should undertake more alliances to promote the generation of scientific knowledge and research, with the purpose of setting the necessary bases for the formulation of health policies at the national and regional levels.

86. One of the areas where alliances become more necessary is with regard to the health determinants, since facing them demands the inclusion of extra-sectorial actors. Another very important issue is the need for a greater involvement with the civil society in order to promote complex agendas such as the right to health and citizen participation in the social control of the services. The growing evidence that the efforts to extend the coverage and the access to service to the poorest groups are not being sufficiently inclusive is another issue that demands the participation of actors with a profile complementary to that of PAHO/WHO.

87. Finally, it is necessary to state that keeping alliances and associations requires different types of resources, such as time, financing and human resources. In any case, it is imperative to plan and provide the necessary means to maintain the alliances in operation.

88. The issue of associations and alliances is highly relevant, possibly vital, for PAHO/WHO to remain as a key Organization in the changing health panorama in the Region.

89. It would be useful to explore how PAHO can help get bilateral resources for the countries. Analogically, the representations of PAHO/WHO in the countries can also help negotiating strategic alliances at the national or sub-regional level that could have local results.

90. Some of the issues to debate within the WG are: What is the impact of the new forms of associations and alliances in international cooperation for health (for example,

public-private alliances, new philanthropic entities, etc.), and in the work and program of the associates and the traditional actors in this domain (for example, PAHO and WHO)? How will the member governments relate, from the technical point of view, with the different actors, which health programs, financing policies, funds and options of sanitary programs are different? What kind of personnel, infrastructure, normative mechanisms, normative structures and actions are needed to coordinate these strategic alliances and associations at the country, regional and international scales?

91. The World Health Organization promoted a civil society initiative to establish better relations between WHO and the civil organizations, in order to understand and clarify its functions, as well as those factors that influence them and the health results. There is also a manual on the work with the civic organizations, and a database was created for the management of the information about these organizations. What would be the impact of an initiative like this for PAHO/WHO? How can this initiative be adapted to satisfy the needs of PAHO/WHO?

92. The topics that require further study are the following: What would be the new functions and responsibilities of PAHO/WHO, the Member States, and the different partners regarding the evolving nature of the associations and alliances? How can we support the capacity of these direct actors to establish strategic alliances and associations?

Regional and Global Public Health Goods and their relation with PAHO/WHO's Mandate

93. It is necessary to make the joint identification and characterization (Member States – Secretariat) about what are the Regional Public Health Goods most required by the countries in the Region and the diagnosis about the trends, current situation of production and provision, and the possible contribution in achieving the MDG.

94. The introduction of the issue of public-health goods has the objective of strengthening public, regional and global health, since it proposes the definition of Global Public Goods and Services as an instrument to discuss, with the international financing entities, the allocation of resources and the financing of some strategic activities.

95. New sanitary threats linked or driven by globalization are manifested, not only through infectious diseases, but also in the propagation of life styles that are not healthy or that involve risky behavior.

96. Within the framework of opportunities that globalization can bring, it is possible to identify Global Public Goods and Services, which benefits go beyond the national borders. These are public goods whose benefits should be available to all population groups, independently of social, economic, ethnic, cultural and gender condition, and through several generations.

97. It can be stated that the achievement of peace, equity and justice carry along results and widely shared benefits that deserve global interventions and efforts. Another

case is the struggle against poverty which, although not a global public good per se, it can contribute with other global public goods, since its benefits not only the poor, but also the rest of society by strengthening peace and stability, improving health and the efficiency of the market mechanisms, and reducing environmental degradation.

98. Many public goods became global, which means that they cannot be adequately provided through national policies and efforts, thus requiring some type of international cooperation to make them locally available. A precise definition of these is fundamental for efficient public policies in the growing conditions of economic opening and interdependence between the countries.

99. A public good is the one that presents two characteristics: there is no rivalry in its consumption and there is no possibility of excluding anybody from its benefits. Food safety, protection from environmental risks, fluorination of water and public health are, in general, from the economic point of view, public goods. Research is also a public good.

100. The best conditions to generate and distribute Public Health Goods and Services are found at the regional and sub-regional levels.

Classification of the Global Health Goods and Services

Pure Global Goods and Services	In addition to peace, equity and justice that have a demonstrated impact on the health of the population, the struggle against poverty, epidemiological and sanitary surveillance, environmental measures against risk factors, prevention of communicable diseases, fluorination of water, food control, ...
Global Goods and Services by Merit	Vaccines, essential medicines for the treatment of communicable diseases, health research, the new technologies for diagnosis and treatment. In general, these goods by merit are highly subsidized by the State, and by virtue of their externalities, they transcend the borders and could be subsidized by regional blocks, global funds, international NGOs.
Other Global Goods and Services	Technical cooperation in public health, international agreements as intermediate goods that produce final goods, trade control of legal and illegal products that are harmful...

101. From the current debate on the impact of globalization on health derives the need to find practical answers on how to manage the provision of Global and Regional Public Health Goods. Currently, many of the challenges are rather intersectorial, while the international cooperation is more directed to countries than to problems. This situation has implications for the cooperation directed to the provision of global public services that demand research and debate, new instruments, innovative political responses, and additional financing sources and methods.

102. An adequate financing of world public goods requires special means; for example, the creation of Funds with an emphasis on such goods. Moreover, as the financing of global public goods means an increase of expenses, resources could be released in reducing perverse fiscal incentives or incentives that encourage “public evil” (UNDP, Human Development Report, 1998). Examples of this could be a world tax on carbon emissions or on international airfares.

103. In the specific case of PAHO, it should promote and participate in the debate on financing methods, and promote the consensus and joint negotiation in the acquisition of regional public goods and services.

104. One of the essential functions of the international health organizations should be to promote the international public goods of research and development (especially regarding problems of regional or global importance), information, generation of norms and standards for national use and for the regulation of international transactions with impacts on health, and consensus around health policies—the best examples here are the Alma Ata Declaration and the efforts for disease control.

IV. PAHO/WHO’S GOVERNANCE AND RESOURCES

105. Organizational governance may be understood in two dimensions. The first refers to the means through which authority is exercised in the management of the organizational resources; where issues of participation, legitimacy, accountability and transparency are essential. The second refers to the ability to discharge functions effectively, efficiently and equitably through the design, formulation and implementation of policies, which is an act of protection and enhancement of the Organization. In general, governance can be understood as the structure and processes of policy and decision making that involves both the internal and the external actors and stakeholders.

106. In relation to PAHO/WHO, with reference to the aforementioned dimensions, the first refers to the Constitution of PAHO (legal framework and regulations) as it relates to its capacity to promote and guide policy in the interest of the Member States. PAHO governance is exercised through its Governing Bodies: the Pan American Sanitary Conference which is composed of all thirty-five Member Governments, the Directing Council which is also composed of all the Member Governments, and the Executive Committee of the Directing Council, which is comprised of only nine of the Member Government. The second dimension, although overlapping with the first, is more directly related to the Secretariat. This dimension of PAHO’s governance refers to the protection and enhancement of the Organization on behalf of the Member States. This is expressed through the managerial process (planning, programming, budget approval and execution), while emphasizing accountability, performance and efficiency in processes and in staff development and appraisal. Being centered on the ability to discharge functions effectively, efficiently and equitably through the design, formulation and implementation of policies links PAHO’s organizational development to governance in this case.

107. PAHO’s Governing Bodies Sessions can be viewed as an international service facility for the Member States. The sessions provide an arena in which Member States

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

108. To guarantee good governance, Member States ascertain that their collective will to improve the health in the Americas is manifested in the Organization's daily work. To achieve this end Member States fund the Bureau and establish health priorities at the national, sub-regional and regional levels, which is reflected in PAHO/WHO's budget and programs. Additionally, Member States assist the Organization to fulfill its mission, mandates and targets.

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

110. In February 2003 the Pan American Sanitary Bureau initiated an ambitious institutional renovation process directed at offering greater responsiveness to countries, more efficient use of resources and improved results, greater transparency and accountability, improved working environment, strengthened country offices in accordance with a country focus cooperation strategy. To accomplish the aforementioned, a broad organizational change is taking place, as well as a change in the budgetary structure toward a program budget regional policy, a result-based management, decentralization process, resource mobilization and strategic alliances, and a human resources strategy that includes changes in personnel distribution and identification of essential competencies.

PAHO/WHO's Mission

111. The Pan American Health Organization/World Health Organization (PAHO/WHO) is an institution with international leadership in the area of health that is constituted by States and Territories of the American Continent. Its Secretariat, the Pan American Sanitary Bureau, is the oldest international health organization in the world. PAHO/WHO works simultaneously as Regional Office of the World Health Organization for the Americas (and consequently, it is part of the United Nations system) as well as the specialized public-health agency of the Inter-American System.

112. PAHO's Constitution, in its First Article, defines as PAHO's fundamental purposes "...to promote and coordinate efforts of the countries of the Western Hemisphere to combat disease, lengthen life, and promote the physical and mental health

of the people”²⁰. In PAHO’s Constitution the functions of the Directive Bodies and the Bureau ...”will be those specified in the Pan American Sanitary Code, and those which are assigned in the future by the Conference or the Council in fulfillment of the purposes expressed in Article 1 of this Constitution”²¹. However, PAHO’s Constitution does not define the functions that correspond to the Organization as a whole and that are related to the fulfillment of its mission. The 22 functions which WHO defines in its Constitution are, in fact, the base of PAHO/WHO functions.

113. PAHO's **values** are the following: **Equity**: Striving for fairness and justice by eliminating differences that are unnecessary or avoidable. **Excellence**: Achieving the highest quality in what we do. **Solidarity**: Promoting shared interests and responsibilities and collective efforts to achieve common goals. **Respect**: Embracing the dignity and diversity of individuals, groups, and countries. **Integrity**: Assuring transparent, ethical, and accountable performance²²

Relation Between PAHO and WHO

114. The most outstanding point of the legal framework that defines the institutional relationship between PAHO and WHO is the agreement signed between PAHO and WHO in 1949 in which their formal relationship is defined, while the identity of the two organizations is preserved. Since then, PAHO’s Directing Council is also WHO’s Regional Committee, and the Pan American Sanitary Bureau is also the WHO Regional Office for the Americas (AMRO). The functions that the Constitution of WHO defines for the Regional Committees are consistent with PAHO’s Directing Council functions, since –in accordance with the Constitution of WHO- the Regional Committees can meet as frequently as they consider necessary and should adopt their own rules of procedure. Regional Committees have, among other functions, to formulate policies governing matters of an exclusively regional character, to supervise the activities of the Regional Office and to recommend additional appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allotted to that region is insufficient for the carrying-out of the regional functions (Articles 48, 49, and 50 of the Constitution of WHO).

115. WHO’s Programs of Work are prepared with the contribution of the regions. Currently the process of formulation of the Eleventh General Program of Work includes the consultation with PAHO/WHO’s Governing Bodies. This process started last year, when the Regional Office for the Americas (AMRO) and the Headquarters of WHO presented together some initial drafts before the Subcommittee on Planning and Programming, the Executive Board, and the Directing Council; this year consultations on the Eleventh Program will be carried out with the Member States and other stakeholders.

²⁰ Constitution of PAHO, adopted by the Directing Council in its First Meeting in Buenos Aires, September 24-October 2, 1947.

²¹ Article 20. Functions of the Bureau.

²² 26th Pan American Health Conference, PAHO's Strategic Plan 2003-2007, CSP26.R18. Washington DC, September 2002.

116. Since 1986, PAHO/WHO embarked on a process of formulation of multiyear regional policy frameworks called Strategic Plan (this was called first Strategic Orientations and Program Priorities and later Strategic and Programmatic Orientations), that is the framework from which the regional policy is defined every five years (previously it was quadrennial). These strategic plans have been consistent with WHO's general programs of work, while at the same time express specific health challenges for the Region of the Americas and other aspects of the PAHO/WHO's mandate as part of the Inter-American System. These plans are compatible with those of WHO, since Regional Committees, as was mentioned above, define their own regional policy.

117. In turn, PAHO and WHO have multiple articulations with regard to the management and administration of programs, and currently they share a common results-based approach regarding the management of their respective program budgets. In the Americas, the Pan American Sanitary Bureau submits biannually a proposal of budget consolidated by programs to the Directing Council. This budget consists of the budget of PAHO and the part of the budget of WHO that corresponds to the Region of the Americas (the part of the budget that corresponds to WHO contributions has already been approved by the World Health Assembly). At present, there is complete consistency among the Global Expected Results and the Regional Expected Results. In turn, WHO's and PAHO's program budgets practically have an identical structure of areas of work.

118. Currently all of WHO is working closely together in the renewal of a common managerial framework, including a streamlined and improved results-based management process. The aim is to provide greater organization-wide program budget coherence that will not only be more transparent to Member States, but will also allow a more efficient and effective transfer of resources from WHO Headquarters to regions and countries.

119. The Pan American Sanitary Bureau is not exclusively limited to initiatives and activities within the Region of the Americas. Although its roles and responsibilities are primarily centered on the implementation of the lines at national, sub-regional and regional scale, they also encompass participation in global initiatives and in sporadic contributions to extra regional initiatives of both global and interregional nature. The Office participates periodically in interregional and global consultations aimed at defining policies and strategies, formulation, implementation and evaluation of WHO's programs and administrative procedures. Several aspects related to the technical and administrative areas that were developed over the years by the Pan American Sanitary Bureau have been appropriated by WHO.

120. The relationship of PAHO with WHO is not limited to the interaction with WHO HQ in Geneva. It also involves the exchange and collaboration among the Regional Offices.

121. An essential aspect of the relationship between PAHO and WHO is currently the adoption of a common approach to technical cooperation, that is one of the central elements to have materialized the formulated policies. This will be commented in the next chapter.

122. The relation of PAHO and WHO has acquired a greater dynamism in recent years. This joined together at the multiple levels of articulation that have been developed between the two organizations, makes it necessary to grant priority attention and, therefore, more time and more analytical effort to that relationship. Attention should be paid to the fact that contributions are bidirectional; this means that WHO's policies, strategies and systems of management have and can have an impact on PAHO, and PAHO's policies, strategies, and systems of management have and can have an impact on WHO.

123. At present, PAHO and WHO are carrying on renovation processes that are parallel and interrelated, both in the objectives that they pursue and in the type of exchange that is presented between PASB/AMRO and WHO HQ²³: On one hand, at the regional level, "PAHO in the 21st century" and the process of organizational change in the Office; on the other hand, at the global level, the Eleventh General Program of Work and the process of WHO's organizational change.

Institutional Development and Transparency

124. The matters of transparency and accountability are related to the management of the economic and financial resources but are not reduced to them since they include the management of personnel, management of the external relations and the relations with the Member Countries.

125. It has been pointed out both by the WG and the authorities of the Office the need for achieving a greater transparency and accountability at PAHO/WHO. It is necessary to continue with the identification of the areas that do not comply with the best-accepted practices (either in regard to the formulation of adequate standards or to its application) and carry out the required changes. This will result in an increase of the climate of institutional confidence with regard to the personnel, the Member Countries and the external relations.

126. In the last Directing Council this subject was discussed and the steps that the Office would fulfill in search for the formulation, implementation, and evaluation of effective, formal and uniform standards to manage its resources and relation to third parties were agreed upon. The 45th Directing Council assigned to the Executive Committee the task of taking the necessary steps for monitoring the application of the External Auditor special report recommendations. In March 2005, the Director of Administration, jointly with the Legal Adviser and the Manager of the Area of Human Resources of PASB/AMRO, will communicate a proposed action plan, a chronological table and the concrete measures adopted by the Office to the Subcommittee on Planning and Programming, in order to apply the recommendations in the following subjects: ethical standards and code of conduct, recruitment of employees and consultants,

²³ Review document prepared by the Office of the Director of Program Management to be discussed in the GW 5th Meeting.

complaints procedures, complaints investigation and reporting, management of external relationships and IT Security.²⁴

Elaboration of Consensus

127. WG considers that it is necessary to strengthen the communication in the Governing Bodies and between the Member States. In order to do this, PAHO/WHO could encourage a greater and timely exchange of information between the members elected to the Executive Committee and the other Member Governments, as well as feedback mechanisms to request observations, recommendations and suggestions from other Member States on the activities presented to the Committee.

128. It would be important to see if the Member States can participate even more with a bottom-up approach in the creation of the agenda of the Secretariat for the Governing Bodies and also in the fields of policies, planning and decision-making. Regarding also the meetings of the Governing Bodies, it would be important that the Secretariat ensures that the documents to be presented reflect the interests, concerns and suggestions of the countries themselves.

Organic Structure

129. The representations of PAHO/WHO should become the center for the coordination of the support that PAHO/WHO provides to the governments. In this status the organizations should help the countries define and reach their goals in health and adopt and adhere to the norms. In addition to this, the representations of PAHO/WHO should help the Member States plan and manage the cooperation activities in the countries, coordinate the issues related to health (in the countries and with the external partners), and mobilize the resources and make rational use of them.

130. The Pan American centers should be evaluated with the purpose of analyzing their contributions to the challenges of public health faced by the countries, and especially to analyze the possibility that the centers coordinate their programs with PAHO/WHO representations, and with the national programs of the country and/or sub-region where the center is located.

131. In order for PAHO/WHO representations to satisfy the needs of the Member States and of the Organization efficiently, the Bureau and the Directive Bodies of PAHO should: 1) Support the development of guidelines for the operation of relationships between the PAHO/WHO representations and the ministries of health, as well as the other health institutions to promote a multisectoral approach for sanitary development; 2) elaborate an integrated program for the countries in collaboration with the Pan American centers of PAHO, which define the needs, policies and priorities of each country; and 3) evaluate the priority health needs and elaborate the Country Plan in consultation with its directors and other partners from the international community.

²⁴ See CE135/5, October 1 2004 and CE135/FR.

132. The Country Cooperation Strategy that WHO and PAHO are promoting at present is oriented to give account of the aforementioned and other critical points related to the cooperation processes, which will be reviewed in the next chapter.

Budgetary Structure and Financial Resources

133. PAHO/WHO's program budget is primarily financed by four sources of funds: 1) Regular Budget - PAHO, 2) Regular Budget - WHO, 3) Voluntary Contributions – PAHO, and 4) Voluntary Contributions – WHO. At current levels, the PAHO regular budget accounts for approximately 50% of total funding, while the WHO regular portion makes up about 20%. The remainder 30% comes from voluntary contributions. Voluntary contributions from PAHO sources have grown slightly over the last ten years and have been relatively steady for the last two biennia, accounting for about 27% of all resources to PAHO. Voluntary contributions from WHO sources, although steady over the last three biennia, are very low, accounting for about 4% of PAHO resources. When compared to the regular budget levels received from WHO, which represent approximately 8.5% of all of WHO regular budget resources, voluntary contributions from WHO sources represent less than 1% of all voluntary contributions made available to WHO. This is the most striking of all comparisons and is currently being discussed with WHO HQ so this trend can be reverted.

134. Over the last three biennia, the PAHO budget has remained steady, increasing very slightly but not enough to cover all inflationary costs. This has resulted in a decrease in the program of the Organization in real terms. During this period the share of regular budget funds coming from WHO has decreased by a little over US\$ 10 million as a direct result of Resolution 51.31 passed by the World Health Assembly in 1998. This resolution called for the reallocation of resources among WHO's six regions, favoring two of them (Africa and Europe), while reducing the budgets of the other four regions. The reduction to the Region of the Americas was the highest of all the regions, both in absolute terms as well as in percentage terms compared with the 1998-1999 base biennium.

135. The consequence of WHA51.31 to PAHO Member States has been an increased pressure in the levels of assessments for PAHO regular budget. Increases in assessment over the last two biennia were higher than would otherwise have been expected. In 2000-2001 and 2002-2003, the PAHO/WHO regular budget was faced with mandatory and inflationary cost increases related to posts. Consequently, PAHO Member States passed budget resolutions increasing the PAHO share of the regular budget resulting in assessment increases of 3.9% and 4.5% respectively. In both of these biennia, the PAHO share of the regular budget has had to absorb the cost increases to the PAHO/WHO regular budget, despite the program reduction in the WHO portion of the regular budget through the regional reallocation exercise. As a note of reference, if the WHO portion of the regular budget would have remained without change from the 1998-1999 level of US\$ 82,686,000, the same PAHO/WHO regular budget levels approved for 2000-2001 and 2002-2003 would have yielded assessment increases to PAHO Member States of 1.6% and 1.8% respectively.

136. It is important for PAHO Member States to note the relevance of decisions made at the World Health Assembly and their potential impact on PAHO itself. With respect to resolution WHA51.31, the impact on PAHO's budget is very clear.

137. The decision adopted by the 57th World Health Assembly of stopping the application of resolution WHA51.31 and defining new principles for allocation of resources among WHO regions, in addition to the policy formulated by the Director General of WHO of shifting resources from WHO HQ to regions and countries to adhere a 20%/80% ratio by 2008, can conceivably make the Organization recover the losses experienced as a consequence of resolution WHA51.31.

138. In September 2004 a new Regional Program Budget Policy was approved by the 45th Directing Council, mandating the allocation of at least 40% of resources to country programs, at least 7% of the resources to sub-regional programs and the rest to regional allocations. The policy also approved a needs-based model that will redistribute resources among countries based on criteria of equity and solidarity.

139. Regarding extra budgetary resources (EB), these have grown steadily. Three sources can be identified: bilateral institutions (71%), multilateral institutions (6.5%), and private/non-profit organizations (17%).

140. Among the bilateral partners, the United States of America is the main contributor, followed by the United Kingdom, Sweden and Canada. Among the bilateral and multilateral organizations, the World Bank is the main contributor, followed by UNEP, UNOAH, IDB and the European Union. With regard to the Private/Non-Profit sector, which is the fastest growing source of EB, PAHEF and PROMESS are the main partners. PAHEF is a foundation which supports the work of PAHO and channels funding from private sources including the Gates Foundation; PROMESS is a special international mechanism established to purchase basic drugs for the public health service in Haiti (PAHO/WHO administers the program since 1992). The areas of PAHO/WHO that benefited from EB funds were Universal Access to Health, AIDS and Humanitarian and Emergency Aid.

141. Roughly two-thirds of the EB resources mobilized in 2002-03 were spent in country-controlled allotments. It is important to note that this is an underestimation of the actual impact on countries. Thus, although regional in nature, there is a specific impact of regional activities in specific countries, but that impact is difficult to evaluate.

142. Analysis by destination shows that WHO EB expenditures are predominantly regional in nature: 67% correspond to regional allocations and 33% to country allocations. For practical purposes there are no EB resources in PAHO that can be considered non-earmarked. All grants define either the country (or sub-region) of intervention or the substantive contents acceptable to the partner.

143. Planning for the 06-07 biennium centers around developing ONE Program Budget into which all source of funds will be fit, and this will allow a more efficient use of

resources. It is to be noted that until the recently adopted Regional Budget Policy, there was no formal recognition or structured approach to sub-regional budgetary allocations on an organization-wide basis. The health agendas of the various sub-regional political and/or trade groupings were recognized and generally supported through the work of the regional centers and country offices. It is only in the case of CARICOM, and to a lesser degree Central America, that some formal or structured support has been provided.

144. The allocation of funds derived from the new Regional Program Budget Policy will generate a change in the distribution of the contents of the resource envelope, regardless of the size of the envelope. There will be a significant impact on the operations of the organization, not only in terms of changes in the distribution of financial and human resources, but even more importantly, in terms of modes of operation and cooperation. The policy clearly articulates one budget financed by funds from all sources: regular and voluntary contributions.

145. In the first instance the shift of resources from the regional budget to the sub-regional and country allocations will require the relocation/redesignation of posts from/within Head Office and the regional centers. The extent of such changes has not yet been determined, but it is certain that there will be an impact on Head Office operations and the regional centers, which would call for more innovative and efficient modes of doing business. Secondly, with the redistribution among countries, there will be the challenge of mitigating any adverse impact on those countries suffering losses and of assisting those with greater gains to productively absorb such increases.

146. It would be important to disseminate the results and put into practice the recommendations of the study made on the distribution of budgetary allocations and other strategies of PAHO to increase the rate of quota collection. The participation of the Member States should be strengthened in terms of audits, surveillance and evaluation of the operational, managerial and financial practices, finding the adequate mechanisms (Resolution of the 45th Directive Council and 135th Executive Committee).

147. The WG deems it necessary to support the development of links between the financial evaluation and the execution of the Program Budget. It is recognized that the project of Policy of the Regional Budget by Programs (recently presented in the Executive Committee session) makes reference to PAHO/WHO commitment with result-based-management and the importance of follow up and efficient evaluation.

PAHO/WHO's Human Resources

148. The institutional renovation that is being carried out in PAHO/WHO implies the realization of changes with respect to the composition, distribution and management of human resources in relation to two criteria: a) search for consistency between the distribution and composition of human resources and the strategy of Country Focus Technical Cooperation (CFTC), and b) the identification of a set of core competencies desirable in the Organization in relation to the aforementioned approach to technical cooperation.

Evolution in the Distribution of Human Resources

149. Until the 1970s the Organization responded to the needs and demands for technical cooperation of the member countries through a contingent of regular staff, complemented with the contracting of short-term consultants and temporary advisers, whose contracting conditions were clearly regulated in the statute, regulation, and manual of procedures of the personnel. The regular staff was distributed among the offices of the Headquarters and the so-called Field Offices, made up of the offices of area (that later were turned into area offices, country offices) and the Pan American centers.

150. With the exception of a small group devoted to tasks of cleaning, maintenance, messaging and transportation, the staff members of the Headquarters have been traditionally regular staff; both the professionals and those of the category of general services called in practice support personnel. In the country offices, also at that time, the staff members of both categories were for the most part regular personnel, contracted under the regimen of United Nations, complemented with some employees assigned by the Ministry of Health and other official institutions, in order to support secretariat, messaging, maintenance and transportation tasks. In the case of the centers, the majority of the professionals were hired as regular staff members, covered by the regimen of United Nations, while the support personnel was comprise of a mixture of regular staff members and others subjects to various forms of local hiring. In accordance with the financing, administrative and legal conditions of some of the centers, and in accordance with resolutions of the Governing Bodies of the Organization, significant changes have been made in the last two decades with regard to the recruitment of personnel.

151. In general and in accordance with the regimen of United Nations, professionals exhibit the rank of international civil servants, although some Pan American centers appointed some national professionals before the seventies.

152. The most significant change in the traditional forms of hiring is given in the 1980s. Starting in 1983 the decision was adopted to incorporate skilled national professionals in the technical cooperation carried out by the country offices, taking advantage of the introduction of a new policy emerged within the United Nations System. It should be pointed out that this alternative emerges as a response to the need for having skilled professionals to collaborate in national projects of limited time (usually from 1 to 3 years of duration), for the most part financed with extra budgetary funds. Nevertheless, over time PAHO/WHO began to resort progressively to this type of appointment in order to meet ordinary needs for technical cooperation, both in the country offices and the centers. Currently, this national personnel represents one-third of the total contingent of professionals in the Organization and, as this type of contracting has not been done at PAHO HQ, they represent half of the professionals in the field.

153. A similar formula was given in the case of the staffing of general services in the country offices and in the centers where they began to give various forms of hiring of staff members under the local work regimens. This contracting modality was officially

incorporated in the policies and personnel management standards through a resolution of the Directing Council in September 26, 1986.

154. The aforementioned is of great importance since, in addition to significant quantitative changes regarding the staffing between the Headquarters and the field, a drastic change in the typology of the personnel in the country offices and centers is also given. This had profound implications in the management of human resources. Mainly at Headquarters, it has been frequent the practice of contracting personnel as short-term consultants. Often, these consultants are incorporated progressively as part of the regular professional teams in the units. These temporary contracts, the great majority located in the technical units, represent around 15% of the provision of professionals at Headquarters. This presents challenges to the management of human resources in general and, particularly, to the subject of recruitment and selection of personnel, since the appointments are not subject to a rigorous selection process. This problem is being faced presently; it is one of the components of the institutional renovation process and a component of the action plan that the Bureau authorities will present before the next Subcommittee on Planning and Programming.

155. At mid-year 2002 significant changes occurred regarding the types of personnel appointments in the Organization. The Executive Committee, in its 130th Session of May 2002 modified several staff rules standards. Among them, it eliminated the career appointments, replacing them with service appointments, and defined in a better way the short-term appointments under the categories of short-term and term-limited appointments, along with fixed-term appointments, regulating in each case the conditions of selection, extension, remuneration, evaluation, as well as the conditions to be able to pass from one category to another. It is to be expected that the application of these new standards will provide the necessary flexibility for adapting the short and medium-term appointments to the programmatic dynamic of the Organization, without sacrificing neither the principles of excellence in the recruitment and selection nor the principle of equity in the remuneration and other conditions of employment.

156. It is necessary to point out that between 1975 and 1995 PAHO HQ increased its personnel (including professionals and general services) by 46% while the personnel underwent a decline of 7% in the field. Since then, the distribution of the personnel has remained relatively stable, although there is a long-term trend of the Headquarters to grow and the field to diminish. The reduction in the number of personnel in the field was compensated by a progressive increase of national professionals at country offices and centers, causing a partial substitution effect. PAHO/WHO's institutional renovation process implies the realization of significant changes, necessary for advancing toward decentralization.

Competencies and Training

157. Competencies are a combination of abilities, attributes, and behavior that are directly related to a successful performance in the job/work. They are the know hows (to be, to know and to act) of a person's good performance. The identification of

competencies is a process that consists of establishing what the competition will be and the form in which it will be evaluated in order to know what has been achieved. The standardization of the competencies consists of converting the identified competence into a norm or agreed standard as a common valid referent so that it is assumed by a group (that it can be an institution, a group of institutions, a national government, or a supranational conglomerate). The identified and standardized competency is in a position to be evaluated in order to confirm if a person has the competency and the degree to which it exists (evaluation of competencies). A positive outcome of the evaluation results in certification or formal recognition of the competencies. The management of competency-based human resources is the process that uses the competencies as a referent from the recruitment and selection up to the retirement and/or the separation. Progress in using competency approaches is variegated: organizations that implement an all-competency-based management coexist with others who use competency approaches in some aspects such as recruitment, selection or training and development of personnel.

158 Besides what the United Nations is accomplishing at the New York HQ, different agencies are making important developments, such as the United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF) and, more recently, WHO HQ.

159. Working with competencies-based approaches is not new to PAHO/WHO. The Organization has used these approaches in the context of: a) technical cooperation (the Human Resources Development Program has collaborated with other programs mainly for the identification of technical competencies in various fields of work and its utilization as an input for the design of competency-based training and development), b) conceptualization and methodologies of application, c) work from the Staff Development Unit where progress concerning corporate competencies was made between the years 2001 and 2002, and d) development of the Competency Maps for the personnel of the Organization during 2004.

160. Recently the Staff Development Unit (HRM/SD) provided PAHO Competency Maps to all staff in the Organization. This set of maps identifies the critical knowledge, skills, and attitudes needed by the staff to perform their daily duties. The maps are a product of collective thinking and reflection about PAHO's work - in the framework of an organization that provides technical cooperation in the area of health. The PAHO Competency Maps were developed taking into consideration the following: recommendations made by the Working Group on Human Capital established by the Director in 2003, input from focus groups composed of professionals, administrators, and support staff at PAHO HQ and in country offices, input from questionnaires completed by staff across the Organization, and individual interviews with key personnel. Three Maps were elaborated. Each of them presents a conceptual definition for each of the competencies as well as an operational definition indicating behaviors that make them observable. Also included is a list of behaviors for staff with managerial responsibilities, as well as for professional and support staff. Map A presents core competencies for all staff; Map B presents competencies for professional staff working directly in technical cooperation; Map C presents competencies for staff who provide administrative support

for technical cooperation interventions. The Competency Maps are considered as a living document that needs to be continuously aligned with the goals and strategic priorities of the Organization. The Area of Human Resources Management (HRM) is beginning to integrate these maps into the recruitment, selection, classification, and learning processes at PAHO/WHO. In the future, these competencies will also be an integral part of the revised Performance, Planning and Evaluation System (PPES). The Competency Maps represent a significant progress to respond to the challenges that PAHO/WHO has to face; represent progress in diminishing the limits among professional and non-professional levels, and the areas of technical cooperation and support. The Maps serve also as an input to strengthen the process of recruitment and selection, description and post classification, performance evaluation, training and development, so that competency functions are the axis of human-resources management.

161. The projections of working with competencies are attractive to the Organization from several standpoints: a) the UN, WHO and other distinguished agencies of the United Nations, together with many other institutions in various parts of the world are simultaneously using competencies-based approaches, b) the Organization's units have shown genuine interest in working with competencies. The momentum that the Organization is currently experiencing constitutes an extraordinary opportunity to make technical progress with the strategic backing that it requires.

162. WG identified the need to strengthen the capability of human resources in the countries and the sub-regions. The PAHO/WHO staff can perform a crucial function in this matter. To this end PAHO/WHO should ensure that its personnel is adequately trained to contribute to the development of the capabilities of the countries' human resources. PAHO/WHO must support its personnel so the personnel can support the development of national capabilities. A competency-based approach is very helpful to reinforce human resources in this area.

Contracting of PAHO/WHO staff members

163. The contracting system of PAHO/WHO's staff members at Headquarters and in the field is being adjusted based on a competencies approach, both at Headquarters and in the field

164. WG expressed concern about the process to hire and retain the consultants, both in the countries and Headquarters. It is important that PAHO makes sure that the consultants hired have the profile required in the general strategic areas identified by the Member States. PAHO currently encourages women to apply for positions; however, there is little action to hire and retain women in higher positions. Being promoted in PAHO usually implies movements from one country to the other, or from one sub-region to Headquarters. For women this implies considerable difficulties due to family obligations.

165. Young personnel constitute a pool of institutional and technical expertise that PAHO could capitalize if there were ways for professional promotion. This would also help increase the moral of the personnel.

166. As part of the constant effort to generate a high quality collaboration, it is necessary to make a continuous evaluation of human resources. Since many Member States are not familiarized with the way in which the personnel of PAHO is examined and evaluated, they should be informed about the procedure that is currently used. Evaluation is fundamental to maintain a well-trained labor force with a high level of performance. The systems to evaluate the performance of the personnel, including the short and mid-term consultants, are necessary in order to reach this objective.

Decentralization of resources and personnel from Headquarters to the Representative Offices

167. PAHO/WHO's country offices should be empowered to have the corresponding delegation of financial and programmatic powers. This should be accompanied by a greater decentralization of the personnel from Headquarters to the countries and by the development of a system that allows the officials settled in a country to be in charge of a sub-regional area, if necessary.

168. The personnel required in each country office should be adapted to the country in particular. In turn the national counterpart should be well prepared; if this is not so, it is essential to promote the creation of these counterparts, and PAHO can play a very important role to accomplish it.

169. It is vital to identify carefully the specific functions of Headquarters and country offices and to establish the appropriate use of human and economic resources. According to the characteristics of the work, it might not be appropriate to decentralize certain areas. Evidently, it would be necessary to have a centralized structure in charge of achieving the regional collaboration and connectivity. Any decision or recommendation related to decentralization should consider the impact that drastic changes in human resources could have over the employees. There should also be appropriate measures to reduce, to the minimum, any negative effect that this could have on the individuals.

V. APPROACHES AND TECHNICAL COOPERATION STRATEGIES

Articulation with WHO in the Development of a Common Approach to Technical Cooperation

170. In addition to the already mentioned aspects relative to governance, policy-making, mechanisms of management and others, PAHO and WHO also work together in the common search for approaches and strategies relating to technical cooperation that make it possible to better fulfill its purposes and mission.

171. The search for greater effectiveness and efficiency in international cooperation – including both technical and financial cooperation- is one of the issues that primarily concerns agencies, governments, beneficiary institutions, and non-governmental organizations presently. The lessons learned are showing throughout the world the results that cooperation interventions have had, sometimes revealing a waste of resources, but also revealing the enormous contribution that can be made with a strong national and international leadership, and an appropriate management and allocation of international resources.

172. Some bilateral European cooperation and United Nations agencies have developed approaches for achieving a system of cooperation that is more integrated, stronger and especially, more democratic. More integrated in the sense of: a) walking toward the preparation of a common agenda of cooperation built and endorsed by all the participating actors (countries, agencies, national and international institutions) and b) coordinating the interventions under the leadership of the country. Stronger, in the sense of seeking: a) the increase in the management capacities of all actors involved in the process of cooperation, and b) the simplification of the intermediate and administrative processes of cooperation that sometimes take an important part of the time and the resources. More democratic in the sense of seeking greater involvement in the identification and confrontation of the challenges from governments, institutions, national organizations and communities.

173. WHO has developed an internal strategy to ascertain that the approach to cooperation focuses on the countries' needs and demands. This strategy was called Country Focus Initiative and in our Region is known by the name Country Focus Technical Cooperation (CFTC). Within this perspective, WHO and PAHO try to respond to the specific and particular needs that the countries have, while complying with their global and regional mandates.

174. The adoption of the Country Focus Technical Cooperation Strategy does not mean that previously technical cooperation meant the opposite for PAHO and WHO. On the contrary, many PAHO/WHO programs have been successfully working with a country focused approach for decades. What is now emphasized is the need to strengthen the work in that direction, making this approach explicit, Organization-wide, assessable, and a key concept in working with the partners.

175. Within the framework of the CFTC, WHO developed the Country Cooperation Strategy (CCS), that is a process of construction of a medium-term vision (from 4 to 6 years) developed as a result of a joint effort among various actors of the country, PAHO/WHO and other agents involved in technical and financial cooperation. CCS's objective is to prepare an integrated proposal of cooperation. The results of the CCS exercises become the reference of PAHO technical cooperation with the country, providing a comprehensive vision of the Organization's work and the means to implement it. The CCS should become the framework for the analysis and definition of the dimensions and modalities in which PAHO/WHO should work in a country, as well as for the planning and allocation of resources of the entire Organization, mobilization of

other national and external resources, and for the development of the national capabilities.

176. The CCS was adopted by the Office; the exercises of CCS are advancing in several countries. Furthermore, PAHO is working to make the Biennial Program Budget consistent with the orientations agreed during the CCS exercises.

Expectations About Country Focus Technical Cooperation (CFTC) and the Country Cooperation Strategy (CCS)

177. WG considers that this is a very rich moment for PAHO to display to its maximum the possibilities to develop, together with the Member Countries, very efficient technical cooperation processes. Two processes coincide: on one hand, the renovation that PAHO started two years ago to achieve a better execution of its mandate; on the other hand, the central role that the Country Cooperation Strategy (CCS) will have on PAHO's cooperation structure and practices.

178. In the context of the reorganization that PAHO is going through at this moment, the initiative of Country Focus Technical Cooperation as a unifier approach together with the Country Cooperation Strategy will have extraordinary effects on all levels of the Organization.

179. The Country Cooperation Strategy will allow linking the efforts of civil society and the private sector with those of PAHO/WHO and its Member States. Through the focus on CCS, the State will not only be represented by its government, but it would also include different social sectors. This re-conceptualized State will perform a fundamental steering role and should serve as the support for mutually strengthening alliances with respect to the national, regional and international goals. With this approach, it would be possible to obtain data about the evolution of the health of the population and the performance of the health systems. The fact of focusing on the national needs and priorities, together with a greater presence in the country, should contribute to improve the coordination and collaboration with other organizations of the United Nations System and the international community. It would be necessary to analyze the functions and other aspects of the renovation of PAHO with regard to the CCS strategy.

180. CCS will help the countries make an internal analysis of the challenges, weaknesses, trends, and critical events, new opportunities in terms of health, as well as strengths and capacities in their responses. Likewise, CCS will allow the achievement of a better orientation of resources from PAHO/WHO and other international actors with respect to technical and financial cooperation. WG recognizes that the implementation process of this strategy has already begun and that several countries have progressed significantly, as is the case of Barbados, Bolivia, Costa Rica, Guyana, Nicaragua, Mexico and Venezuela.

181. CCS will allow identifying both the areas where the countries need support and their areas of strengthen. This, in the field of technical cooperation, represents a great

opportunity for the countries, together with PAHO/WHO, to identify the areas where their capacities have been developed further and better, and could be offered as cooperation to other countries.

182. In order to support the implementation of CCS, it will be necessary to go deeper in the process of programmatic and financial decentralization toward country offices, to strengthen them. In turn, it will be necessary to reorient and adjust some of them. Special attention should be paid to operational aspects. The Organization has to improve the mechanisms for connectivity, cooperation and communication among country offices, Pan American centers and national health institutions. The former can be facilitated by exploiting the advantages of information technology to reach the optimal management of knowledge, creating innovative mechanisms for technical cooperation, elaborating specific plans for the developing country, combining activities of different programs, and ensuring the coherent technical support based on the national needs.

183. One element to consider is the necessity for PAHO to develop an effective evaluation system. This is important both in the operational aspects, and especially with regard to its policies and technical cooperation programs. WG considers that it would be important to try to progress in this area, by developing adequate methodologies that could provide information to assist in correcting the errors, controlling the problems and ensuring that the direction followed is the most efficacious in facing public-health challenges.

184. At the national level it is necessary that the national health authorities work to develop policies coherent with the external cooperation in general, and with the technical cooperation in health in particular. A good number of countries in the Region lack explicit policies and institutional support structures to adequately coordinate the different interests, actors and resources involved in the international cooperation processes. Likewise, it is necessary to recognize that in the countries, in general, there is a lack of financial resources to strengthen this area; it would be important to incorporate those resources in the budgets. It is also critical to analyze in depth how the technical cooperation processes and their results have been affected by this lack of national policies, especially when, in addition, there are national situations with no continuity of technical teams or health authorities.

185. WG considers that one of PAHO/WHO's future key functions should be to facilitate, in the framework of the CCS, the collaboration among countries, as long as it is feasible, while PAHO/WHO consolidates the efforts in the development of more direct activities geared to producing better health results in the Region.

186. PAHO/WHO can make important contributions, both regionally and at the country level. The activities of PAHO/WHO as the caller of experts and ministers of health are well known. Perhaps more attention should be given to the way in which PAHO/WHO's personnel can be more useful, at the country level, to improve health and well-being among its inhabitants.

187. In order to progress in this discussion, it is necessary to have more information concerning the technical cooperation activities performed by PAHO/WHO and how they were inserted into the cooperation processes, which were the areas that showed better results and which were the ones that hindered or made it impossible to meet the objectives of the projects or the programs.

Human Resources for the Development of International Cooperation in Health

188. For the technical cooperation processes to increase their efficacy and efficiency proper policies from part of the countries, international organizations and the other agents involved, and proper approaches are needed. More importantly, a strong political and technical leadership is necessary, both in the countries and the cooperation organizations. That leadership will be in the hands of human resources that have the adequate political vision, technical capacity and experience to conduct those processes.

189. WG identified as part of the public health challenges for the countries a series of issues related to the international cooperation in health. Although all the public health challenges imply confronting important aspects of human resources development, it was mentioned that the countries generally lack proper policies regarding international cooperation. In many countries human resources do not have the proper training to represent a strong counterpart for the cooperation process. In the area of international cooperation in health, the issue of human resources development is as important as in other areas of the health sector and implies national and international human resources.

190. In this regard, it bears mentioning that it is impossible to separately analyze human resources staff needs for PAHO/WHO itself from those of its member countries. In reality, experienced professionals form part of a continuum that includes the exercise of activities in their own countries, international action, and activities related to the implementation of actions within PAHO Headquarters.

191. The model that took shape over time, with the consolidation of the personnel rosters of the international cooperation agencies, grew out of the origins of the technical assistance process itself—initially philanthropic and paternalistic in nature—as a way the more developed countries could support development in the most disadvantaged countries. Obviously, these technical experts were also from the affluent countries and were supposed to aid their less fortunate colleagues. In a way, these international consultants could be considered as a surplus of the work force in their own countries, which already had an abundance of experienced technical personnel.

192. With the development of Latin America and Caribbean countries, international organizations increasingly looked to recruit the most qualified personnel in those countries; these individuals had the added advantage of being fluent in the languages of the countries in need of technical cooperation. Recognizing this situation is critically important and requires a major structural reorientation of international cooperation, with a view to continuing reliance on highly qualified personnel without causing a drain of excellent professionals from the member countries.

193. In order to establish the aforementioned continuum between national action and that of the specialized international organizations, efforts have been made to introduce new recruitment mechanisms, such as the adoption of Technical Cooperation among Countries (TCC), the recognition of Collaborating Centers, the creation of international centers linked directly to a particular international body, and even the establishment of international networks for sharing information and experience, which have received relatively little financial support.

194. Thus, it is necessary to join forces in a collective approach to cooperation and make a commitment to its ultimate objectives, facilitating an environment in which actors can come and work together on transforming a given reality.

195. In order to facilitate cooperation among countries, it is required to have: a) a strengthened PAHO/WHO that supports and facilitates the encounter among professionals and institutions of the countries, through the formulation of an explicit policy inspired by the cumulative experience and leadership of the Organization; b) countries that have identified or are in a position of identifying, not only its needs and weaknesses but also its strengths, in order to offer them to the countries, institutions and teams that may require them; c) in addition to the international personnel required for the fulfillment of PAHO/WHO's mission, consultants coming directly from the countries should be brought together, for utilizing highly skilled personnel that could devote part of their time to answer the neighboring countries' requests. Obviously, this applies to the different spheres of activity in human resources development, including personnel planning and management and all training at their different educational levels, up through the permanent education of existing staff, taking advantage of distance education resources.

196. This strategy, together with the aforementioned cooperation strategies, would help to maximize resources for cooperation projects, increase efficiency and productivity in this field, strengthen the institutional capacity of the cooperating countries, develop strategic partnerships, and promote networks with innovative approaches. Building such networks would facilitate the formation of small, multinational committees or working groups, which could in turn act as PAHO/WHO technical advisory bodies.

197. The development of a process that finds PAHO/WHO successfully promoting the technical cooperation among countries and the country focused technical cooperation, along with the changes that are being promoted through its organizational renovation and the contributions of the WG will bring, at the end, the Organization closer to the countries, the institutions and the people of the Americas.

HIGHLIGHTS

198. It is important to take into account that PAHO's Secretariat, under the leadership of its Director, initiated on March 2003, a process of change related to its structure, functions and technical cooperation strategies, known as "PAHO's renewal for the 21st Century". Member Governments are informed about the progress of this change. Several working groups were organized for this purpose. Some of them addressed topics that are also addressed by the WG.

199. At the same time, WHO has called on its Member States and its Regional Offices to participate in the preparation of its Eleventh General Program of Work. This program includes within its goals to analyze functions WHO must perform in relation to the long-term strategic vision stated in that program. The concern of the WG in this matter enriches and complements the aforementioned efforts.

200. This preliminary consolidated document highlights a series of contributions made by the WG. They are

- ✓ The WG has a strategic vision of PAHO as an institution with international leadership in health, a precise focus, a clear definition of its service areas, participating in topics related to health that are not currently areas of its influence, participating in the formulation of national policies with a supportive role and orientation to the countries, facilitating the link of the different stakeholders that act in areas related to health. An institution that operates with transparency, optimizes resources, uses the national resources and decreases bureaucracy, with a financial administrative system strengthened with greater participation of the Member States, with clear criteria of efficacy and equity for the allocation of financial resources, which establishes solid alliances and associations, and with a greater presence in WHO, being strengthened in its role of agent for the new associates and playing an active role in the technical orientation to other international organizations.
- ✓ The task of PAHO is developed according to the mandate received by the Member Countries and by WHO, in a historical moment when there is a world trend towards a convergent vision, both with respect to the challenges the world is facing and with relation to the broader strategies to face those challenges.
- ✓ PAHO should support the countries to face the challenges in public health, either by providing direct cooperation or by facilitating and encouraging cooperation processes between the countries and with other actors. These challenges are presented in the areas of: a) the processes of health-disease which have a differential impact according to the socio-economic, ethnic, and age characteristics of the population, b) the political and governmental factors, c) the coverage and quality of the health services, d) the human resources in health, e) the financial resources, f) the natural resources and the characteristics of the physical environment, g) science, technology, research and information, h) the changes produced by the process of economic globalization, i) the capacities

developed by the countries to orient and widely use the contributions of the international cooperation.

- ✓ PAHO should strengthen its capacity to support the formation of alliances with a wide range of actors to pursue common goals. These alliances could have different complementary modalities that would serve to multiply the results of the cooperation actions, to increase the international awareness about the importance of health, both as an end in itself and as critical part of development. One of PAHO's priorities should be the promotion of global public goods.
- ✓ In the framework of the elements mentioned so far, the purpose, the mission, the values and the vision of PAHO should be analyzed in more detail to, in this process, be re-confirmed or re-considered.
- ✓ PAHO is renovating, and within this process it is very important to take into account its governance: There are several areas that require further analysis, and others whose need and direction toward change have already been identified. Among the latter, some that come out are the importance of strengthening the relation between PAHO and WHO, improve the capacity of PAHO for the elaboration of consensus, support the idea of going deeper into the decentralization process in order to strengthen PAHO's Country Offices, bring PAHO closer to the countries, and improve the opportunities of success for the country-centered-cooperation strategy.
- ✓ In order to ensure the transparency and the good practices regarding accountability, it is important to achieve a greater participation of the Member States through the Governing Bodies of the Organization. In this sense, the 45th Directive Council and the 135th Executive Committee recently made significant progress.
- ✓ The structure and function of the human resources of PAHO requires adjustments related to the decentralization process (that will bring consequences regarding the distribution of the personnel), to the strengthening of some competences needed for the work in the Headquarters and the countries, which in turn require a greater analysis of the system to contract and promote the officials, as well as the possibility to make a progressive generational change that will allow giving continuity to the technical cooperation processes.
- ✓ The renovation process started by PAHO is enriched in the framework of the adoption of the CCS strategy, which will have a positive influence in the approach and the technical cooperation practices and, therefore, in the possibility of supporting the ambitious objective of complying with the unfinished agenda, while the achievements made are consolidated and the new agenda is put into practice.
- ✓ It is necessary to articulate the WHO's 11th General Program of Work, the process of institutional change that is occurring in the Bureau "PAHO's Renovation for the XXI Century", and the results of the work of this group from the Executive Committee "A PAHO for the XXI Century", in order to articulate

those three processes and find coherence and complementarity in the recommendations and decisions.
