Country Office/Brazil

Technical Cooperation Strategy
for PAHO/WHO and the Federative Republic of Brazil, 2008-2012

Pan American Health Organization

Regional Office of the World Health Organization

BRASIL
BRAZILIAN GOVERNMENT

Technical Cooperation Strategy
for PAHO/WHO and the Federative Republic of Brazil, 2008-2012

Pan American Health Organization

Regional Office of the World Health Organization

Brazil, 2007

© Pan-American Health Organization/World Health Organization

Country Office/Brazil

Representative
Diego Victoria

Editorial coordination
Carlos Wilson de Andrade Filho
Luciana de Deus Chagas

Administrative support
William Rodrigues

Secretarial support
Alessandra Sorôa
Susana Damasceno

http://www.opas.org.br

Graphic design: Formatos design gráfico
Translation into English: Positive Traduções
English text editing and proofreading: James Fitzgerald
Revision: James Fitzgerald
Print run: 250 copies

Elaborated by PAHO/WHO - Country Office / Brazil –
Documentation Center

Pan-American Health Organization.

Technical Cooperation Strategy for PAHO/WHO and the Federative Republic of Brazil, 2008-2012. / Pan-American Health Organization. – Brasilia, 2007.
76 p.: il.

1. Brazil – Technical Cooperation. 2. International Technical Cooperation – health. I. Pan-American Health Organization. II. Title.

NLM: WA 530

Contents

Foreword 5

Acknowledgements 7

Section I 9

Introduction

Section II 13

Challenges for development and health in Brazil

Section III 35

Cooperation for development and strategic alliances:
trends, tools and coordination

Section IV 39

PAHO/WHO current cooperation activities

Section V 45

PAHO/WHO political framework for technical cooperation with Brazil

Section VI 49

Strategic agenda: PAHO/WHO priorities in
cooperation with Brazil for 2008-2012

Section VII 55

Implementation of the Strategic Agenda: implications
for PAHO/WHO Secretariat, follow-up and
next steps at each level

Term of Commitment signed between the Brazilian Government
and the Pan-American Health Organization/World Health Organization
on August 20th, 2007 59

Annexes 67

Foreword

There is clear synergy between PAHO/WHO activities in Brazil and the priorities of the Brazilian Government and society, as expressed in the 2008 – 2011 Health Plan and the 2007 Health Pact. Such synergy is also evident between the priorities defined at the global level by the World Health Assembly in the WHO´s XI General Program of Work for 2008 – 2015 , at the regional level in the Health Agenda for the Americas 2008 – 2017 recently approved by countries of the Americas, as well as in the PAHO Strategic Plan 2008 – 2012 and the Millennium Development Goals.

Within this context, PAHO/WHO has worked intensively on the elaboration and definition of the strategy for technical cooperation with Brazil during 2008 – 2012. This document was signed in August 2007 by the Directors of WHO, Margaret Chan, of PAHO, Mirta Roses, and by the Brazilian Government represented by the Minister of Health, José Gomes Temporão. The main goals of the strategy are:

- To seek balance between the priorities of the country and those of PAHO/WHO.
- To guide PAHO/WHO actions in Brazil, in accordance with the Common Country Assessment/United Nations Development Assistance Framework (CCA/UNDAF).
- To initiate the PAHO/WHO Single Program Budget.
- To define roles and functions of PAHO/WHO in support of Brazil.
- To develop a joint learning process.
- To coordinate consultations with the country and within the three levels of PAHO/WHO.
- To develop flexibility within processes, rapidly adjusting to change.

During the period 2008 – 2009, and following the guidelines presented in this document, PAHO/WHO Technical Cooperation with Brazil will be structured based on projects developed to strengthen and improve the Brazilian Unified Health System (SUS), this combined with the systematic development of South – South cooperation. The strategic actions of the Organization aim to strengthen core functions in support of the Brazilian government and

other partner countries, increasing the participation of national and international institutions, PAHO Country Offices, Centers and Technical Units, as well as other agencies of the United Nations System in the program of work.

Our principle goal is to articulate PAHO cooperation using sufficient intelligence, being flexible in the approach, and acting in a timely manner. In this way, it is expected that PAHO/WHO technical cooperation with Brazil during the period 2008 – 2012 will contribute to the socioeconomic and political development of the country, through an improvement both in the individual and collective health of all Brazilians.

Diego Victoria
PAHO/WHO Representative in Brazil

Acknowledgements

The content of this document has been greatly enhanced through discussions with recomendations and orientations of national and international experts. Our thanks to the members of the PAHO/WHO Joint Mission (Abel Packer, Albino Belotto, Carlos Florencio Corvalan, César Vieira, Daniel Purcallas, Guillermo Mendoza, Hernán Montenegro, Janis Karlin Lazdins-Helds, Juan Manuel Sotelo, Lucimar Coser Cannon, Michael Boorstein) and to the PAHO/WHO Interprogrammatic Group in Brazil (Diego Victoria, James Fitzgerald, José Antonio Escamilla, José Paranaguá de Santana, Julio Suárez, Luis Fernando Rocabado, Rubén Figueroa, Guillermo Gopcevich). We would also like to thank several national and international institutions which have collaborated in the approval process of this document: the Ministries of Health, Municipalities, Education, Women's Policies, Environment, National Integration, Social Development, Science and Technology; The Institute for Applied Economic Research (IPEA), the National Supplementary Healthcare Agency (ANS), the Executive Office of the Ministry of Health and the Committee of International Affairs of the Ministry of Health (AISA), the State Division for Health of Minas Gerais, the United Nations Development Program (UNDP), the Food and Agriculture Organization (FAO), the International Monetary Fund (IMF), the International Labor Organization (ILO), the Joint United Nations Program on HIV/AIDS (UNAIDS), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Children's Fund (UNICEF), the United Nations Development Fund for Women (UNIFEM), United Nations Office on Drugs and Crime (UNODC), the German Technical Cooperation (GTZ), the International Bank for Reconstruction and Development (IBRD), the Inter-American Institute for Cooperation on Agriculture (IICA), the United States Agency for International Development (USAID), the Department for International Development of the United Kingdom (DFID), Amazon Cooperation Treaty Organization (ACTO), BIREME, PANAFTOSA. A special acknowledgement should be made in recognition of the contributions provided by the group that identified the basis for the document during the meeting on the challenges facing the SUS: Carlyle Guerra de Macêdo, César Vieira, Eugênio Villaça Mendes, Gilson Carvalho, Helvécio Magalhães, José da Rocha Carvalheiro, Nelson Rodrigues, Antônio Ivo de Carvalho, Sérgio Piola, Sônia Fleury, Gisele Bahia and Claunara Mendonça.

Section I

Introduction

This document is a statement of the PAHO/WHO strategy for technical cooperation with Brazil for the period 2008 - 2012. It addresses priorities, the strategic approach and types of such cooperation.

It was developed in consultation with Brazilian government, state and city government representatives, health-related NGOs and other international organizations that cooperate with Brazil in areas where development intersects with public health. Moreover, the negotiation of the strategy also meant working side by side with different PAHO/WHO departments and units at the national, regional and global levels.

The formulation of the Country Cooperation Strategy (Strategy) was carried out by means of a detailed review of the priorities and policies in health and development that will be implemented in Brazil during the next few years. In this respect, its development is an important component of the United Nations Development Assistance Framework (UNDAF).

The Strategy was prepared based on a careful evaluation of the advances, challenges and opportunities for improvement in PAHO/WHO cooperation with Brazil, as well as on the assessment of priorities and policies that the Organization and Country are to implement in the near future, within the framework of national, regional and global commitments for development.

One aspect that greatly facilitated this process – and will continue to support the achievement of the Strategy objectives – is the fact that the formulation of the Strategy coincides with that of the Brazilian Government´s Pluriannual Plan (Plano Plurianual – PPA) and the Program for Growth Acceleration (Programa de Aceleração do Crescimento – PAC) in the area of Health – PAC/Saúde[1]. Furthermore, the PPA, the PAC/Saúde and the PAHO/WHO Strategy for Cooperation coincide in their respective periods of implementation.

This Strategy benefits from the 2006-2015 WHO XI General Working Program and the 2008-2015 PAHO Strategic Plan, as well as from the Common Country Assessment and the United Nations Development Assistance Framework (CCA/UNDAF). Accordingly, there is clear evidence of an increasing synergy between Brazil's policies and priority programs, and the PAHO/WHO cooperation framework for the next four years.

As part of a country-focused global initiative, the Strategy shall guide all cooperation activities that PAHO/WHO will develop with Brazil during the period 2008 - 2012. The Strategy will be made public by the PAHO/WHO Country Office, and disseminated among other agencies that cooperate with Brazil in the area of health in order to align respective activities with the contents of this document.

Brazilian priorities for technical cooperation with PAHO/WHO have been identified based on the 2008-2012 Pluriannual Plan, the Program for Growth Acceleration and health priorities set for the 2nd term of office for the current Government. They also reflect priorities that may be formalized in the PAC/Saúde and PPA, currently under formulation.

The contents of the Strategy are presented in six sections, covering: Challenges for development and health in Brazil (Section II); Cooperation for development and strategic alliances: trends, tools and coordination (Section III); PAHO/WHO current cooperation activities (Section IV); PAHO/WHO political framework for technical cooperation with Brazil (Section V); Strategic agenda: PAHO/WHO priorities in cooperation with Brazil for 2008-2012 (Section VI); and Implementation of the Strategic Agenda: implications for PAHO/WHO Secretariat, follow-up and next steps at each level (Section VII). At the end of the document several annexes are presented, which complement or detail the contents of the previous sections.

The Strategic Cooperation Agenda for 2008-2012 (Section VI) has been agreed between Brazilian Government and PAHO/WHO. In negotiating this agreement, the Brazilian Government was represented by authorities from the Ministry of Health, the Ministry of Foreign

1 This is a working title, until the Plan is made available.

Affairs and other ministries working in the area of health.[2] PAHO/WHO was represented by professionals from Geneva, Washington and Brasilia.

2 Ministries of: Agriculture; Cities; Science and Technology; Social Development; Education; Integration; Environment; Planning, Budget and Administration; and Women's Policies.

Section II

Challenges for development and health in Brazil

1. Health: general and determining context

The Federative Republic of Brazil borders with all South-American countries, except Chile and Ecuador. Its constitutional system of government is presidential, with three independent branches: the Executive, the Legislative, and the Judiciary. Its political and administrative structure comprises of a Federal Government, 26 States divided into five macro-regions, 5,561 municipalities, and the Federal District.

Brazil is ranked 63rd in the United Nations Human Development Index ratio, with its ratio increasing from 0.71 in 1990 to 0.79 in 2003. The state of Alagoas reports the lowest HDI ratio (0.65) with Santa Catarina reporting the highest (0.82).

Brazilian GNP per capita in 2003 reached R$ 8,694 (approximately US$4,350), ranging from R$4,305 (US$ 2,150) in the Northeastern Region to R$ 11,257 (US$ 5,628) in the Southeastern Region. In 2004, 32% of the national population was classified as poor, with a ratio ranging from 55.5% in the Northeast Region to 17.8% in the South Region. 5.7% of the population were reported to be living in extreme poverty (with less than US$ 1 PPP/day) in 2003, ranging from 13.5% in rural areas to 4.2% in the urban areas.

In recent years, poverty levels have been decreasing both at the regional and national levels. As a consequence, the Gini Coefficient Index rose from 0.593 in 2001 to 0.569 in 2005. In spite of this, the disparity between high and low income population groups did not significantly decrease in the same period. Poverty is concentrated mainly in black and pardo populations (from the Portuguese pardo, a chestnut-brown color, as of the skin).

The illiteracy rate for persons over 15 years of age was 11.1% in 2005, ranging from 8.4% in urban populations to 25.0% in rural areas. While this rate was reported as being 21.9% in the Northeastern Region, it was only 5.9% in the Southern Region. The rate of illiteracy is much higher in the black population than in the white population group.

Unemployment rose from 6.2% in 1993 to 9.3% in 2005, while in metropolitan areas it increased from 9.2% to 13.0% in the same period. Regular employment levels in the economy descreased from 55.5% to 49.7% of the Economically Active Population (EAP) during this period. Increases in unemployment have been most dramatic among women, blacks and population groups with a lower level of education.

As the proportion of the population classified as low-weight decreased, the number of persons classified as overweight increased, especially in the poorest regions and in rural areas. In 2004, 34.8% of households – equivalent to 72 million people – lived in a situation of nutritional insecurity, particularly observed in families headed by women or of African descent.

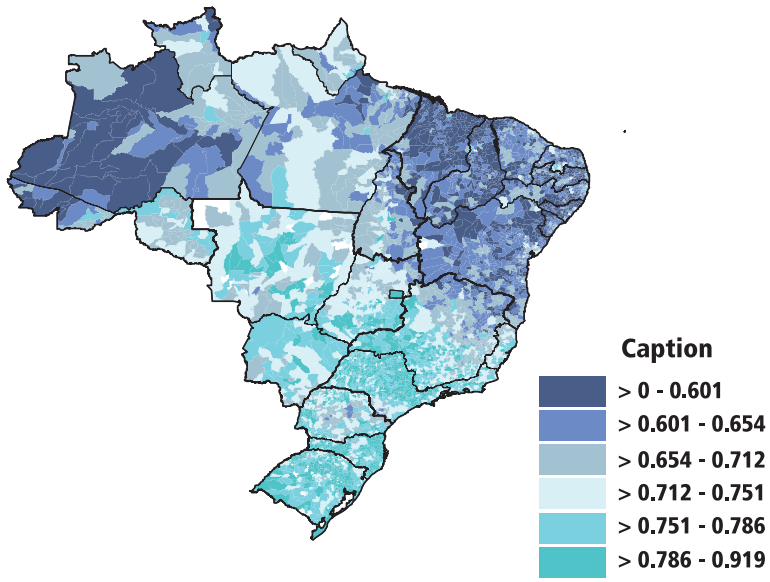
The percentage of the urban population with access to safe drinking water rose from 88.3% in 1992 to 92.0% in 2005. In the same period, the percentage of the rural population with access to safe drinking water increased from 12.3% to 26.8%. The percentage of population with sanitary sewerage systems or septic tanks increased from 66.1% in 1992 to 77.3% in 2005. More than 70% of sewage is returned to the surface water source and 64% of the municipalities continue to dispose of solid waste into inadequate open-air landfills. The use of pesticides has increased considerably, while natural disasters, deforestation and periods of drought continue.

The above data indicates that Brazil is not a poor country; nonetheless, it displays important socioeconomic inequalities amongst population groups and regions (Figure 1). Moreover, urban violence has increased alarmingly, affecting the quality of life and security of the population. In spite of government efforts to resolve the problem, positive results have been slow in forthcoming.

Figure 1

Brazil shows significant disparities in human development

Municipal Human Development Index
2000



Source: Human Development Atlas, UNDP.

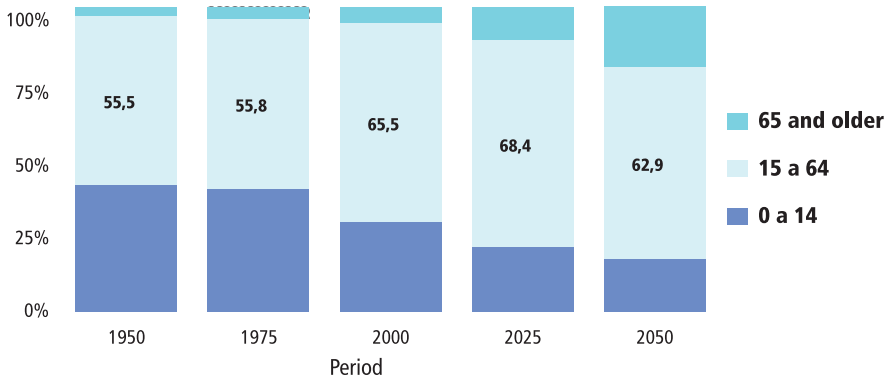
2. The health situation of the population[3]

In the last few decades, Brazilian demographics have been undergoing major change, characterized by a change in age structure and the rapid decline in the rate of population growth, this in turn due to a decline in mortality and fertility rates. This trend presents considerable challenges for the development of social policies in the next three or four decades, due, above all, to the aging of the population. (Figure 2)

3 A summary of indicators and basic data on the health situation and health system in Brazil is available at http://www.datasus.gov.br/idb.

Figure 2

Brazil: population distribution, for major age groups (%), 1950-2050



Source: Laura Rodríguez Wong, José Alberto M. de Carvalho, Ignez H. Oliva Perpétuo. Basic Data, United Nations (2005)

In 2005, the Brazilian population reached 184 million inhabitants, 83.0% living in urban areas and 17.0% in rural areas. Population growth decreased from 1.93% in the 1980's to 1.64% in the following decade. White people (Caucasians) represented 51.4% of the population, the black population group represented 5.9% of the total population, and pardo population group represented 42.1%. These rates vary greatly from region to region within the country.

The total fertility rate declined from 2.7 children per woman in 1991 to 2.0 in 2004. This decrease was higher among white women than among black and pardo women. The level of education is also directly related to the fall in fertility.

Life expectancy at birth rose from 67.0 years in 1991 to 72.1 years in 2005, and the life expectancy of women is seven years greater than that of men. The white population reported a higher increase in life expectancy when compared with the black population.

In the same period, while the percentage of children under five years of age fell from 11.3% to 8.9% of the total population, that of males over 60 years of age rose from 6.8% to 8.3% and that of females, from 7.8% to 10.0%.

The Northeastern Region continues to show the greatest migratory flow to other regions (17.7% of the population in 2004), with the Southeast Region being the principal destination.

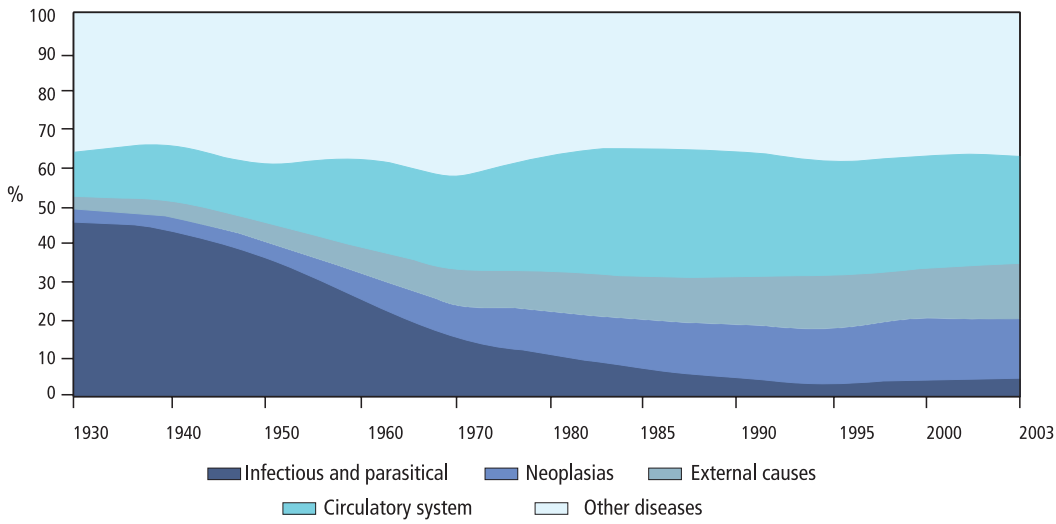
2.1 Mortality

The distribution of mortality per cause of death has undergone significant change in the last few decades due to an epidemiological transition in which non-transmissible disease and death due to external causes (specifically acts of violence) are gradually taking the place of infectious and parasitic diseases (Figure 3).

Figure 3

Brazil is clearly going through a demographic transition period

Proportional mortality between 1930 and 2003 in Brazilian capital cities



In 2004, the ten main causes of death accounting for 52.5% of mortalities at the national level were: cerebrovascular diseases (10.1%), ischemic-cardiac diseases (9.7%), homicides (5.4%), diabetes (4.4%), chronic respiratory diseases (4.3%), influenza and pneumonia (4.2%), road accidents (3.9%), heart failure (3.6%), perinatal problems (3.5%) and hypertensive diseases (3.4%). However, causes for 12.4% of the 1,024,073 deaths which occurred in the same year could not be clearly determined.

Among children of preschool age (9% of the population), infant mortality accounted for 87% of the deaths. Nearly 8% of newborn babies were underweight. Meanwhile, child mortality decreased from 33.7/1000 in 1996 to 22.6/1000 in 2004, with an increase from 57.0% to 61.0% in perinatal causes of death. These rates and proportions also vary among different races, regions, and urban and rural areas.

The main cause of hospital admission in school-age children (between 5 to 9 years, corresponding to 9% of the population) were respiratory and transmissible diseases. Among adolescents (from 10 to 19 years of age, comprising 20.3% of the population) the main causes of death were violence, accidents and maternal causes.

Within the adult population (from 20 to 59, equivalent to 52.7% of the population and accounting for 32.1% of deaths), the mortality rate among men (501.5 per 100 thousand) was more than double the rate among women (219.8 per 100 thousand). In this group, violence (12.7%), accidents (8.4%), chronic heart diseases (7.7%), cerebrovascular diseases (7.1%) and hepatic diseases (4.8%) predominate. Since 1996, the risk of death due to violence increased by 6.1%, whereas the risk due to other causes, especially HIV-AIDS (38.1%), decreased.

In 2005, the Brazilian Unified Health Care System received 11.4 million hospital admissions; 60% of those admitted were women, with 38% of admissions being related to pregnancy, childbirth and postnatal complications. Data gathered from the 3 million childbirths in 2004 indicates that 53% of mothers had had seven or more prenatal visits, while 43% of childbirths were carried out by cesarean section.

The elderly, corresponding to 8.3% of the population, represented 58.6% of total mortality. The progressive increase of this group's participation in society is due to a combination of higher birth rates in recent decades with a decrease in mortality rates among young people. The most common causes of death among the elderly are chronic diseases.

2.2 Morbidity

While the prevalence of chronic diseases continues to increase, the epidemiological importance of transmissible diseases has generally decreased. Nevertheless, transmissible diseases such as malaria remain endemic in the Brazilian Amazon region, with prevalence rates similar to those reported during the1970s.

Urban yellow fever has been erradicated since 1942, with the wild form of the disease remaining at very low levels. However, the gradual re-appearance of the Aedes aegypti has caused outbreaks of dengue fever in most states. Transmission of the Chagas' disease has been almost entirely interrupted due to a constant public health campaign in recent decades. Much the same is occurring in relation to other transmissible diseases that have been historically important in Brazil, such as filariasis, schistosomiasis and leishmaniasis.

National vaccination programs have been successful in keeping preventable immunological diseases such as measles, rubella, diphtheria, tetanus, poliomyelitis and hepatitis under control. More recent initiatives have been able to reduce the incidence of influenza, mainly amongst the elderly population.

The prevalence of tuberculosis seems to have been stabilized in the last ten years, with 45.2 cases per 100,000 inhabitants reported in 2004. At the same time, the incidence of Hansen's disease decreased from 190 to 14.8 cases per 100,000 inhabitants between 1985 and 2005.

The HIV-AIDS epidemic has steadied at a rate of 19.2 cases per 100,000 inhabitants. However, infection rates are increasing in women and in the black population group, and it is estimated that HIV-AIDS currently affects about 600,000 people. Chronic conditions that have acquired increasing relevance in public health include circulatory diseases, neoplasias, mental illness and oral health conditions.

2.3 Special groups

Among other groups that deserve special attention is the indigenous population group, comprising of nearly 770 thousand people living in 210 distinct societies speaking 170 different languages. External causes (16.8%), circulatory diseases (16.5%), respiratory diseases (13.9%), and infectious diseases (13.8%) account for the majority of deaths in this group.

Another group is the black population, represented by blacks, (10.7 million) and pardo people (76.6 million), corresponding to 48.0% of the country's population. Circulatory diseases (29.9%), external causes (20.6%), neoplasias(12.4%), and respiratory diseases (9.1%) accounted for more than 70% of the deaths in this group in 2003.

Finally, among the 31.4 million workers of the formal sector of the economy, 70% of the sick-leave granted in 2004 was due to bone and muscle diseases (30.0%), external causes (18.0%), circulatory diseases (11.0%), and mental illness (10.8%).

3. The National Health System

The National Health Policy has been developed taking into account the 1988 Federal Constitution, which established health as a right for all citizens and a duty of the State. In order to translate this basic right into practice, the Brazilian Unified Health System (SUS) was created, based on the principles of universal and egalitarian access to comprehensive care, to ensure promotion, protection and recovery of health, integrated into a regionalized and hierarchical network of services under the responsibility of the three levels of government (Federal, State and Municipal).

The private healthcare sector contributes to and supplements this effort.

The Brazilian health system is composed of a complex network of public and private institutions dedicated to

- rendering, financing and the management of services;
- the research, production and distribution of health products and technologies;
- human resource capacity building;
- the regulation, legislation and oversight of the system.

The purpose of the principle network of public institutions is to provide, finance and manage health services; the SUS provides complete coverage for 75% of the Brazilian population. The remaining 25% of the population – covered by the Supplementary System – also has the right to access services provided by the SUS. In addition, the SUS is responsible for the provision of collective services such as sanitation, disease control and regulation of the sector.

Services of the SUS are provided through federal, state and municipal public networks, including private or philanthropic entities contracted by the system. The Supplementary System consists of private companies, units and professionals, who provide services and/or health care to their clients.

The SUS is directed at the Federal level by the Minister of Health, and at the State and Municipal level by the respective Secretaries of Health. To facilitate the negotiation and agreement of policies and programs, the SUS has associate agencies: the National, State and Municipal Health Councils. Different spheres of the government, besides representatives from segments of the health sector and civil society participate in these councils. In addition, there are Bipartite (involving the Municipal and State spheres of each unit of the Federation) and Tripartite Inter-managerial Commissions (involving the three spheres at a national level).

The regulatory function is performed by the National Agency for Health Surveillance (ANVISA, dedicated to regulating health products, food, ports, airports and borders) and the Supplementary Health Agency (ANS, dedicated to regulating health insurance and private health care). States and Municipalities are responsible for the execution of regulatory functions in their respective spheres, in coordination with the Federal agencies.

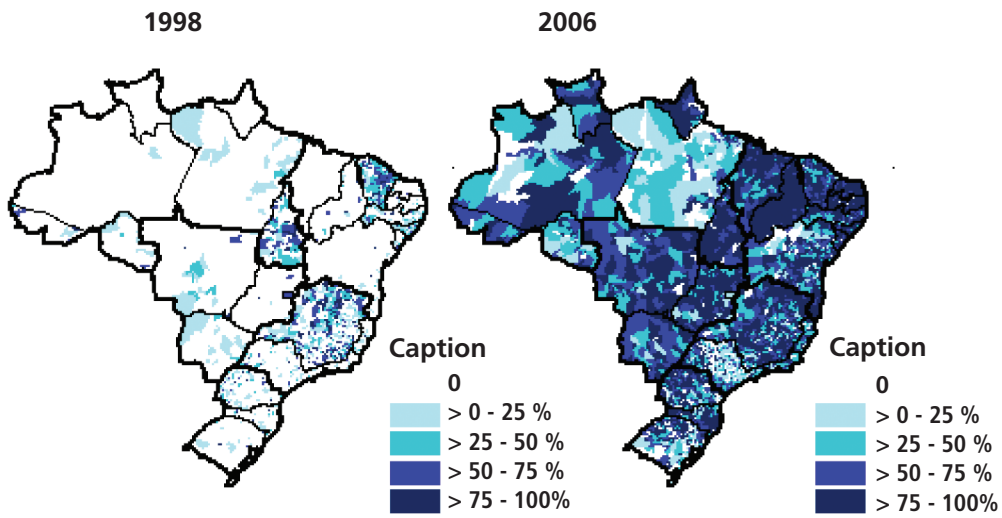
3.1 Health services

The main program providing basic care to the population is the Family Health Program (PSF), covering 73 million people in 2005 (40% of the population) in 4,837 cities through the support of 22,683 multiprofessional teams. Since 2002, the Ministry of Health, in cooperation with PAHO/WHO, has been working towards the development and strengthening of the PSF Teams (Figure 4).

SUS medical services are classified into basic health care (promotion, prevention, basic specialties and disease control), specialized medium-complexity health care, and high- complexity health care. In 2003, the system reported 2.4 medical consultations per capita/year (1.8 in rural areas). Significant disparities in medical coverage continue to exist from region to region.

Figure 4

The Family Health Program is a fundamental strategy of the SUS



Since 2004, oral health teams have been integrated into the basic care network and 137 Centers of Odontological Specialties in 86 Municipalities of 21 States, as a result of the Brasil Sorridente (Smiling Brazil) program. In spite of these efforts, studies indicate that 22% of the population between 5 and 19 years has never had access to dental services.

Environmental surveillance and sanitation measures are the responsibility of the National Health Foundation (FUNASA, which is also committed to providing care to indigenous and black communities – quilombolas, (from the tupi (Brazil) and the quimbumdo (Angola) quilombo, former communities of escaped and later freed slaves), a network of state and municipal public sanitation companies.

The control and surveillance of transmissible disease is led by the Ministry of Health through the National Epidemiological Surveillance System, Public Health and Epidemiological Information Laboratories, as well as the National Immunization Program, with the participation of State and Municipal Health Departments.

3.2 Medicines

Access to essential medicines is an important element of primary health care, and is guaranteed through special financing mechanisms and a network of public ´Popular Pharmacies´. Importation levels for the 1,028 most important drugs have increased from US$ 535 million to US$ 1,095 billion between 1990 and 2000. 83% of imported drugs in 1999 were patented prior to 1977 and 43% before 1962. The value of imported finished medicines increased from US$ 212 million to US$1.28 billion between 1990 and 2000. Domestic market medicines sales were estimated (taxes excluded) to be valued at US$ 6.7 billion dollars in 2004.

Expenditure on medicines represents one of the highest out-of-pocket family expenses, accounting for up to 76% of health expenditure for families within the lowest income level. The National Policy for Medicines was approved in 1998 to increase access and promote the rational use of medicines that meet standards of safety, efficacy and quality.

Based on this policy, Federal, State and Municipal governments allocate funding for purchase and distribution of medicines for the population. In this process the Federal government is specifically responsible for the purchase of strategic products (antiretrovirals, hemoderivatives and anti-tuberculosis, amongst others) and specialized high-cost medicines.

The National Policy of Pharmaceutical Services and Care was adopted in 2004 to promote a more integrated strategy for the development of the pharmaceutical healthcare sector, for example, encouraging the sale of generic products whose average cost is 40% lower than the cost of originator products. By 2006, 1,847 product registrations containing 310 active substances within 91 therapeutic classes, produced by 66 laboratories, had been granted. Of these products, 1,449 (79%) are produced nationally and 398 are imported, mainly from India (51%) and Canada (16%).

3.3 Immunobiological products

The production and supply of immunobiologicals for programs implemented by the SUS is the responsibility of the national network of public manufacturers which produces vaccines (against tuberculosis, measles, tetanus, diphtheria, pertussis, yellow fever, and human and canine rabies) and serum (anti-venon, antitetanus, antidiphtheria, and antirabies). The strengthening of this network has become a priority in recent years, with amounts up to 200 million Reals being invested between 2002 and 2005 by the Federal Government. The Institute of Immunobiological Technology (Bio-Manguinhos, a unit of FIOCRUZ) is the major vaccine supplier of the Ministry of Health. In 2002 alone, more than 120 million vaccine doses were produced by BioManguinhos, equivalent to 60% of the national demand for vaccines. BioManguinhos and other national public manufacturers supply the Ministry of Health with immunobiological products for the National Immunization Program.

3.4 Blood and hemoderivative products

The quality control of blood and blood products began in 1980 with the promotion of voluntary blood donations and the development of the public network of blood transfusion reference centers. The use of human blood, tissues, cells and organs for treatment is regulated by ANVISA, which coordinates the National Blood Surveillance System. In 2006 the network was comprised of 33 coordinating centers and over two thousand centers offering blood services registered in ANVISA. These centers work together with universities, to increase the number and capacity of specialized personnel and to promote the scientific and technological development of the area.

3.5 Human resources

Between 1999 and 2004, the number of doctors registered in the health system increased from 237 to 292 thousand; dentists, from 145 to 178 thousand; and nurses, from 72 to 98 thousand. In this period the availability of doctors per 1,000 inhabitants increased from 1.4 to 1.6, ranging between 2.2 in the Southeast and 0.8 in the North. At the same time, the availability of dentists increased marginally from 0.9 to 1.0; and of nurses, from 0.4 to 0.5, with similar regional inequalities.

Of the 730,000 job positions requiring a higher education degree in 2003, 64% were filled by doctors, 12.2% by nurses and 7.8% by dentists. Between 1999 and 2002, the increase in nursing positions (26.7%) was superior to the increase in positions available for medical doctors (9.7%). During this period, the public sector created 45% of all positions for medical doctors and 65% of positions in nursing. The participation of the public sector in such positions was higher in the North (76%) and Northeast (65%) than in the South (48%).

Higher education in health is available through public and private institutions, with private institutions (for profit and non-profit) assuming an ever increasing role. In 2002, 53 of the 115 medicine courses, 81 of the 275 nursing courses and 52 of the 159 courses in dentistry were provided by the public sector.

3.6 Technological and scientific development

The promotion and funding of research and technological development in health are responsibilities shared by the Ministries of Science and Technology, Health, and Education. The Ministry of Health coordinates its activities in the area of scientific and technological development in health through the Secretary of Science, Technology and Strategic Health Products, and the Oswaldo Cruz Foundation – FIOCRUZ. At the decentralized level, some individual States have financed Foundations for technological research and development.

The Council of Science, Technology and Innovation of the Ministry of Health sets priorities and promotes technological evaluation in an attempt to rationalize the integration of new technologies (products and processes) into the health services. National investment in technological development and research increased from 0.8% to 1.0% of GNP between 2001 and 2003. Published and collected scientific production in the LILACS database increased from 5,916 to 7,221 publications between 1999 and 2003. Besides, additions in the MEDLINE database doubled in this period, rising from 3,123 to 6,418 articles.

3.7 Installed capacity

In 2002, individual care services were provided by 46,000 ambulatory units, of which 76% were public and 24% private. Of the latter, only 1,619 (15%) were contracted by the SUS. Nearly 95% of diagnostic and therapeutic support units were private, only 35% of which rendered services to the SUS.

In 2002, 7,397 hospitals were reported to be in operation, of which 4,809 were private (70% of which provided services to the SUS) and 2,588 public. Of the 471,171 available hospital beds in the country (2.5/1,000 inhabitants), 146,319 were public (31%) and 324,852 were private (69%). Of the latter, approximately 269,627 (83%) were contracted by the SUS , producing a total of 415,946 SUS hospital beds representing nearly 88% of the national capacity. Given such capacity, the SUS supported about 13 million hospitalizations in 2005 with an average stay of 5.9 days. As part of the SUS, the National Transplant System is present in 22 States with 540 participating institutions and 1,338 accredited medical teams. The National Transplant System performed 13 thousand organ and tissue transplants in 2004.

3.8 Sector expenditure and funding

In 2004, Brazil dedicated 7.9% of GNP to the provision of health care, 48.1% financed using public sector resources and 51.9% financed by the private sector. Of the total public expenditure, 50.7% was financed by the Federal government, 26.6% by the States and 22.7% by the Municipal governments. The Federal government covered 62% of the public expenditure in health per capita in the Northeastern region and only 49% in the Southeastern region. Nevertheless, significant disparities still exist in the allocation of public resources in health per capita, which in 2002 ranged from R$ 168.43 in the Northeastern Region to R$ 250.56 in the Southeastern Region.

Surpassed only by Social Security, the health care sector receives the second highest level of financing from the Federal government. Even though the budget of the Ministry of Health decreased from R$ 36.8 billion in 1995 to R$ 30.8 billion in 2003, transfers to the States and Municipalities increased from 8% to 50% during the same period. In 2004, R$ 1.9 billion or 5.08% of the budget of the Ministry was committed to funding investment projects being implemented by the Ministry (40%) or by the States and Municipalities (60%).

One third of private sector expenditures can be accounted for by companies providing health services or insurance to their employees and by philanthropic donations from within

the country or from abraod. The remaining two-thirds of private expenditures were financed by direct disbursements by individuals and families – equivalent to 9% of consumption expenditure for this group – related to the purchase of medicines (37%), private insurance (29%), dental services (17%) and other services (17%).

The richest 30% of the population accounted for 68% of health care family expenditure, whereas the poorest 30% accounted for only 7% of health care family expenditure. While the proportion of the population in the highest 10% income bracket dedicated 33% of its direct expenditure in health to health insurance and 24% to the purchase of medicines, the proportion of the population in the lowest 10% income bracket dedicated 54% to the purchase of medicines and 6% to health insurances.

4. Health priorities and policies of Brazil

In January 2007, President Lula began his second term in office as President, recently concluding the appointment of his Cabinet of Ministers. Currently, the process of appointing positions at the second echelon within different ministries, including the Ministry of Health, is underway.

At present the Government is redefining its priorities for the socioeconomic development of the Country, as well as reviewing and developing policies that will be adopted in order to accomplish these priorities. A review of these priorities and policies has been carried out based on documents which are referred to throughout this section.

In the investiture cerimony for his 2nd term of office, President Lula announced the launch of the Program for Growth Acceleration (PAC)[4] to increase investment in infrastructure during the period 2007 - 2010 and overcome barriers limiting current growth levels.

The investment contemplated by the PAC will total R$ 503 billion, principally targeting the sectors of basic sanitation, housing, energy, transport, water resources and ports. In order to be implemented, the PAC must first receive the approval of the National Congress.

Following the announcement of the PAC, several Ministries including those of Education, Justice and Tourism, also announced the launching of programs of medium-term investment for their respective sectors, which are being referred to as “Sectoral PACs”. It is expected that

4 http://www.agenciabrasil.gov.br/noticias/2007/01/22/materia.2007-01-22.1909859633/view

in the near future a similar program will be launched for the health sector, as has already been proposed by the Minister of Health.[5]

The Federal Government has also been developing and formulating a proposal for the 2008-2011 Pluriannual Plan (PPA) since early last year, a proposal which will constitute a medium-term policy and planning instrument for the next four years.[6] As soon as it is concluded in the 2nd semester of this year, the proposal will be submitted to the National Congress, so that the PAC may commence in 2008.

The Ministry of Health has been working on the 2008-2011 PPA since 2006, in accordance with an ordinance from the then Secretary for Health Care, who is currently the Minister of Health.[7] The ordinance provides indication of the degree of complexity of the chapter relating to health that has to be developed for the 2008-2011 PPA. Such complexity can also be observed in the review of the 2004-2007 PPA (which is currently in its last year of implementation) and the evaluation of preliminary results reported for 2006.[8]

In light of this context, it is noted that priorities and policies for the next quadrennium – including those related to health – are still being defined. Nonetheless, and recognizing the need to complete the formulation of the Strategy, this document aims to broadly identify health priorities for the future that will guide the future cooperation strategy.

The main source of reference used for the identification of health priorities was the inauguration speech of the Minister for Health, José Gomes Temporão, in which 22 priorities for the health sector were outlined for the period 2008 - 2011.[9] These priorities include, amongst others: the pursuit of greater justice, improved effectiveness and efficiency within the health sector; improved care and services for vulnerable groups and special health problems; improved administration of sector resources; cooperation with other development sectors; scientific and technological development in the field of health; and the active presence of Brazil in the international field of health.

Another source of reference for the definintion of priorities and policies used in this document was the report published in December by the Institute for Applied Economic Research

5 http://clipping.planejamento.gov.br/Noticias.asp?NOTCod=343339

6 http://planejamento.sir.inpe.br/boletins/Boletim-n5-novembro06.pdf

7 http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2006/PT-451.htm

8 http://www.planejamento.gov.br/arquivos_down/spi/Modelo_Gestao.pdf e http://www.planejamento.gov.br/planejamento_investimento/conteudo/relatorio_ppa/index_relatorio_ppa.htm

9 http://www.planejamento.gov.br/planejamento_investimento/conteudo/relatorio_ppa/index_relatorio_ppa.htm e http://portal.saude.gov.br/saude/visualizar_texto.cfm?idtxt=25744

(IPEA),[10] (linked to the Secretary for Long-term Planning, Office of the President of the Republic) entitled "Challenges and Perspectives of Social Policy".[11]

A third document was taken into consideration :"The real SUS: Universal, humanized and qualified,"[12] prepared by NGOs committed to health including: the Brazilian Association of Graduate Studies in Collective Health (ABRASCO);[13] the Brazilian Center for Health Studies (CEBES);[14] the Brazilian Association of Health Economics (ABRES);[15] the United Network (Rede Unida);[16] and the National Association of the Public Prosecution Office for the Defense of Health (AMPASA).[17]

As is demonstrated in the matrix presented in Annex 1, there is clear convergence between these three documents in the identification and analysis of priorities and policies for the health sector for the 2007-2010 period. In a sense, each of the priorities stated by Minister Temporão is somehow supported by part of the priorities stated by the IPEA or the NGOs of the sector. It is therefore expected that both the PAC/Saúde and the health chapter of the PPA will emphasize priorities identified in these three documents, and consolidate the convergence observed.

5. Priorities and policies from other sectors relevant to the health sector

Priorities and policies from other sectors of the Federal government working directly or indirectly with the health sector have also been reviewed.

These sectors are under the remit of the Ministries of Agriculture, Livestock and Food Supply[18]; of Muncipalities[19]; of Science and Technology[20]; of Development, Industry and Foreign Trade[21]; of Social Development and the Fight against Famine[22]; of Education[23]; of the Envi-

10 http://www.ipea.gov.br/default.jsp
11 http://www.ipea.gov.br/sites/000/2/publicacoes/tds/td_1248.pdf
12 http://www.redeunida.org.br/arquivos/manifesto_final.pdf
13 http://www.abrasco.org.br/
14 http://cedoc.ensp.fiocruz.br/cebes/
15 http://www.abres.cict.fiocruz.br/
16 http://www.redeunida.org.br/index.asp
17 http://www.ampasa.org.br/
18 http://www.agricultura.gov.br/
19 http://www.cidades.gov.br//index.php?option=content&task=category&id=433
20 http://www.mct.gov.br/
21 http://www.desenvolvimento.gov.br/sitio/inicial/index.php
22 http://www.mds.gov.br/institucional/secretarias/secretaria-de-articulacao-institucional-e-parcerias
23 http://portal.mec.gov.br/ai/

ronment[24]; of Social Security and Assistance[25]; of Planning, Budget and Administration[26]; of Foreign Affairs[27] and of Labor and Employment[28]; the Secretariats of Policies for the Promotion of Racial Equality[29]; of Policies for Women[30] and of Human Rights[31]; as well as to the National Council of Alimentary and Nutritional Security[32]; the National Congress[33]; and the Judiciary Branch[34].

As a result of this review, it was possible to identify several priorities and policies from other sectors which are directly linked to those of the health sector, as displayed in the annexed chart 2. As can be seen on this chart, each priority and policy area from other sectors is related to at least two priorities from the health sector. Several of these fields, however, converged with three or more priorities from the health care sector.

In this way, for the next few years the list of priorities and policies from the health sector in Brazil will also take into consideration those from other sectors which are relevant to the development of health care in the country. In addition, based on this list from other sectors, the demands for international cooperation concerning health in Brazil will be made explicit.

6. Discussion on the challenges facing the SUS

6.1 Introduction

As an additional input for the preparation of the Strategy, on April 27, 2007, a Group of Experts met at the PAHO/WHO Representation in Brasilia, to debate the Challenges facing the SUS, under the coordination of Dr. Carlyle Guerra de Macedo, Director Emeritus of PAHO, as detailed in Annex 3.

24 http://www.mma.gov.br/index.php?ido=conteudo.monta&idEstrutura=2
25 http://www.mpas.gov.br/
26 http://www.planejamento.gov.br/
27 http://www.mre.gov.br/
28 http://www.mte.gov.br/
29 http://www.planalto.gov.br/seppir/
30 http://www.presidencia.gov.br/estrutura_presidencia/sepm/
31 http://www.presidencia.gov.br/estrutura_presidencia/sedh/
32 https://www.planalto.gov.br/consea/exec/index.cfm
33 http://www.brasil.gov.br/pais/estrutura_uniao/poder_legislativo/senado_federal e http://www.brasil.gov.br/pais/estrutura_uniao/poder_legislativo/camara_deputados/
34 http://www.brasil.gov.br/pais/estrutura_uniao/poder_judiciario/stf

During the meeting, specific factors were considered relevant to facilitate the identification of challenges facing the SUS, of which the following are highlighted:

a) the reform of the health sector and creation of the SUS as a result of a political movement in Brazil – the sanitarist movement;
b) parameters of the System and the historical context, the 8th National Health Conference, the 1988 Constitutional Assembly and the new Federal Constitution;
c) the reform of health care systems in other countries;
d) basic concepts for the SUS, including public participation and its complementarity with the Supplementary System;
e) the evolution and current status of the ongoing process to define and consolidate the SUS; and
f) the relationship between and contribution of the SUS to the national development process.

Based on these factors and considering the classification of challenges proposed at the meeting, the Group of Experts presented the main challenges currently faced by the SUS, as described in detail in the following sections.

6.2 Challenges in Health Production

There is still significant divergence between the changing health needs of the population and services offered by the SUS. The latter tends to maintain its historical characteristics without addressing the changes in the epidemiological profile, aging of the population and the social determinants of health. The principal challenges in health production are related to the following pending problems:

a) limitations in information, measurement and definition of prior health needs, and the demands of the population;
b) inadequate adjustment of the health care model to the needs and changing demands which vary considerably across the territory;
c) neglect concerning organization of services in the form of networks, despite the efforts of the Federal, State and Municipal Governments; it is, therefore, necessary to strengthen the health care regionalization process;
d) inability of the Primary Health Care Strategy to transform the system in its entirety, despite the fact that there has been considerable growth and development;
e) the necessity to convert the Family Health strategy into a structural axis of the SUS;

f) continuing isolation of activities in disease prevention, health promotion and recovery, in spite of the important advances made in this area;
g) the necessity to adjust the principles of universality, equity and integrality based on the analysis of the experience implementating the system, and notwithstanding the fact that they remain indisputable principles of the SUS;
h) even though equity is not mentioned in the 1988 Constitution, it was nevertheless contemplated by the Organic Law that regulated the SUS when it established equality in health care without prejudice or privilege of any kind;
i) in turn, integrality, for example, must be regulated based on a list of services, preventing irrational deviations that may be caused through legal action against the system, and
j) the necessity to increase the effectiveness of the SUS, with a subsequent improvement in social satisfaction with its services and outcomes.

6.3 Challenges in Organization and Management

Since its creation the SUS has made an enormaous effort to improve its institutional organization and its operational management. Despite these efforts, the problems below continue challenging the ability of the SUS to respond adequately to the demands of the Brazilian population:

a) insufficient regulation and separation of the functions related to regulation and execution, making it impossible to ensure adequate allocation of responsibility within the system;
b) continuing weaknesses in the negotiation and agreement mechanism established between the three levels of government, affecting direction and operation of the system;
c) the necessity to strengthen the social consensus, which is as important as the interinstitutional consensus to ensure effective operation of the SUS;
d) lack of an adequate solution to the challenges being faced in the inter-relationship between the private and public sectors, both within the scope of the SUS and the Supplementary System, and specifically regarding the transfer of resources from the public system to the private system;
e) the need toincrease efficiency and transparency, as well as reducing corruption in the management of SUS resources;
f) management deficiencies at all levels of the system, in spite of considerable advances made at the level of health care units such as hospitals;
g) limitations in planning, management and evaluation of the SUS, affecting the definition and scope of respective objectives, goals, priorities and indicators; and

h) unsatisfactory definition of regional models considering the requirements for the regionalization of the health system, despite the fact that current regional models contribute to the solution of many of the problems mentioned above.

6.4 Challenges in Funding

This is one of the principle challenges of the SUS. The 1988 Constitution affirms that health care is an integral part of the social security system and should therefore receive 30% of the resources of this system. The removal of health care from the social security system led to an immediate decrease in federal resources allocated for health, partially compensated by loans from the Workers' Assistance Fund and from other sources including the Provisional Contribution on Financial Transfers (CPMF). The CPMF currently covers other sectors as well, and only 50% of its resources are allocated to the health care sector., The volume of resources which the CPMF was expected to generate in the approval of the EC29 (XXIX Amendment to the Constitution) of 2000 fell below the expected amount. In addition, a Complementary Law regulating this amendment has not been approved, and as a result the three levels of government are now using interim sources of financing. Nonetheless, the government is unable to meet all its financial commitments within the SUS. As a consequence, the SUS is facing the following challenges in financing:

a) the health sector is underfinanced due, in part, to a decrease in federal resources – which today correspond to less than 50% of the resources of the SUS, whereas formerly it corresponded to more than 60% of resources; in addition, several States have not been complying with EC29; although it is believed that most Municipalities have been complying with the Amendment, it is difficult to accurately determine such compliance;
b) public financing of health currently is equivalent to 3.4% of the GNP, now less than private financing; this is contradictory to the consolidation of a public system based on the principles of universal access and comprehensive care;
c) in spite of the participation of the Federal Government in tax revenues of the country is greater than the sum of revenues from the States and Municipalities, and that in the last 12 years has increased from 15% to 30% of the GNP; however, transfers of federal resources to States and Municipalities are financed only through tax revenues and do not include revenues from others contributions;
d) the XXIX Amendment to the Constitution defined minimum limits to Federal, (the amount committed in 1999 plus 5%, annually adjusted by the GNP nominal variation), State (12%), and Municipal (15%) resources destined for the SUS; however, there are several ways to get around these requirements, such as withholding resources for any

sector through the Disentailment of Resources from the Federal Government (DRU) or defining – more or less inclusively – what constitutes a health expenditure; therefore it has become necessary to regulate EC29 – whose five-year term expires at the end of this year – thus creating the risk a new funding crisis similar to that experienced in the1990s;

e) Brazilian foreign debt has decreased considerably in recent years; nonetheless, the internal debt remains high (nearly 48% of the GNP) and is subject to high interest rates, the reduction of which could result in an additional source of federal resources for the SUS;

f) the SUS needs to promote a more equitable allocation of its resources, as well as improve efficiency to justify a request for larger amounts of federal resources destined for the health sector; and, finally,

g) the Federal Government transfers resources to State and Muncipal governments, based on management agreements; despite the recent consolidation of transfers between the Federal, State and Municipal levels into 5 or 6 thematic blocks, transfers remain compartmentalized because of the nature of the negotiation within the Tripartite Commission.

6.5 Development challenges

The SUS also faces major challenges in contributing effectively to the socioeconomic and political development of the country. The following challenges are highlighted:

a) the need to bring the sector out of isolation to provide more effective health care in a more wholistic and integrated manner, for example as in the case of the development of the health productive complex, which will require the effective and conscientious participation of the sector.

b) the SUS also needs to make an effort to achieve a greater and synergistic integration in public social policies which interact with health policies;

c) the SUS needs to convince society of the dangers of underfinancing health care as well as of it´s ability to manage its resources with equity and efficiency;

d) constant effort is required to improve legislation and regulation governing the SUS and the Supplementary System;

e) the SUS must objectively face the problems associated with the qualification and use of human resources in health, as well as employment and working conditions, motivating health personnel to ensure the necessary commitment required to provide services and strengthen the system in general; and

f) in particular, special attention must be given to the growing problem related to job security and outsourcing, especially in areas of the Family Health Program, and epidemiological and health surveillance activities.

6.6 Political and leadership challenges

Finally, there are the challenges of a political nature that sum up all the other challenges that the SUS currently faces. In this case, the political character of the SUS acquires a special relevance so as to:

a) transform health care into an issue of the State rather than a matter of government, and into an issue of society rather than a social issue;
b) achieve productive dialogue and effective collaboration between the Executive, Legislative and Judiciary Branches, at the Federal, State and Municipal level, so as to strengthen the SUS by increasing its ability to respond to the health problems of the population;
c) conciliate and use political, social and institutional power in order to ensure the necessary support for the SUS, guaranteeing the required resources to facilitate the accomplishment of its mission and responsibilities;
d) increase the capacity of the population to participate in policy development and management of the SUS, strengthening citizenship and the production of social capital;
e) ensure that healthcare be viewed by the population as a social concern, and that the population not only defends it´s basic right to health but also assumes its responsibilities in health, through existing negotiation and agreement mechanisms and
f) encourage society to assume control over it´s health and it´s role in the management of the system, strengthening social capital in health and addressing the weaknesses within more than five thousand State and Municipal Health Councils made up of more than eighty thousand council members.

Section III

Cooperation for development and strategic alliances: trends, tools and coordination

1. Introduction

An analysis of the national and international context for technical cooperation with Brazil has been carried out in order to formulate and negotiate the PAHO/WHO Country Cooperation Strategy for the 2008-2012 period. This analysis has taken into account the requests for international and bilateral technical cooperation in health received from Brazilian governmental institutions – both from the health sector and from other health-related sectors – and from Brazilian NGOs operating in the area of health.

In addition, policies and mechanisms adopted by the Brazilian Government relating to international or bilateral technical and financial cooperation, provided or received by the country, have been considered. The documents consulted in this analysis are referred to together with the respective institutions.

Likewise, policies and priorities of the main multilateral organizations that provide technical and financial cooperation to Brazil – such as the IDB,[35] World Bank,[36] ECLAC,[37] FAO,[38]

35 http://www.iadb.org
36 http://www.bancomundial.org.br
37 http://www.eclac.cl/brasil/
38 https://www.fao.org.br/

PAHO/WHO,[39] ILO,[40] UNDP,[41] UNEP,[42] UNESCO,[43] UNAIDS,[44] UNIFEM,[45] UNFPA,[46] UNICEF,[47] EU,[48] DFID,[49] GTZ,[50] USAID,[51] amongst others – and that support Brazilian programs and projects related to health, have been reviewed.

International cooperation prioritizes areas of collective health, disease prevention and control, management of the system and services, and human resource empowerment through the development and implementation of national projects, or projects which focus on particular States, mainly in the Northeast Region of the country. The principal areas of work noted in such cooperation activities include the reduction in child mortality through the Family Health Care Program, the improvement in the quality of services, and the improvement in access to such services.

Several international foundations also provide support to projects in the country, especially those related to the Action Program of the International Conference on Population and Development (1994) and the Millennium Development Goals.

Furthermore, Brazil participates actively in South-South Cooperation initiatives with several of its bordering countries (Bolivia, Colombia, Guyana, Peru, Paraguay and Venezuela) for the control of endemic diseases such as malaria, schistosomiasis, leishmaniasis, tuberculosis, hansen's disease and for the prevention of AIDS. There is also an intense exchange with MERCOSUR countries to establish common sanitary regulations, as well as with the Community of Portuguese Language Countries (CPLP) in different areas.

39 http://www.opas.org.br/
40 http://www.oitbrasil.org.br/prgatv/index.php
41 http://www.pnud.org.br/home/
42 http://www.pnuma.org/brasil/
43 http://www.unesco.org.br/areas/educacao/areastematicas/edsaude/index_html/mostra_documento
44 www.unaids.org
45 http://www.unifem.org.br/
46 http://www.unfpa.org.br/
47 http://www.unicef.org/brazil/
48 http://europa.eu/index_pt.htm
49 www.dfid.gov.uk
50 www.gtz.org.br/
51 www.usaid.gov

2. Priorities, policies and mechanisms of technical cooperation

Consideration must also be given to the priorities, policies and mechanisms of technical cooperation involving Brazil and defined by Government ministries and agencies responsible for such, taking into consideration the health sector and international cooperation organizations, including PAHO/WHO.

In Brazil, the following Ministries are involved in the definition of priorities, policies and mechanisms of cooperation:

- The Ministry of External Relations, through the Division of Social Matters[52] and the Brazilian Cooperation Agency;[53]
- Ministry of Planning, Budget and Administration, through the SEAIN (Secretariat of International Affairs);[54]
- Ministry of Health, through the AISA (International Affairs Office);[55] and
- Other Ministries involved in PAHO/WHO cooperation, as mentioned in Section II.5.

Policies and mechanisms of international cooperation are defined by the Brazilian Cooperation Agency (ABC),[56] which deals specifically with Technical Cooperation among Developing Countries (TCDC),[57] Bilateral Technical Cooperation Received (CTRB),[58] and with Multilateral Technical Cooperation Received (CTRM).[59]

In addition, the Ministry of External Relations recently demonstrated its commitment in the area of international cooperation in health in two separate but related declarations, the first being the Oslo Ministerial Declaration, which deals with global health as a primary area of foreign policy and which was signed last March by the Ministers of External Relations from Norway, France, Brazil, Indonesia, Senegal, South Africa and Thailand,[60] and the second being the statement of the Minister of External Relations of Brazil, Ambassador Celso Amorim, in

52 http://www.mre.gov.br/index.php?option=com_content&task=view&id=783&Itemid=351
53 www.abc.gov.br
54 http://www.planejamento.gov.br/assuntos_internacionais/conteudo/competencia/seain.htm
55 http://portal.saude.gov.br/saude/
56 www.abc.gov.br/abc/abc_cgic.asp
57 http://www.abc.gov.br/abc/abc_ctpd.asp
58 http://www.abc.gov.br/abc/abc_ctrb.asp
59 http://www.abc.gov.br/abc/abc_ctrm.asp
60 http://multimedia.thelancet.com/pdf/oslo.pdf

the last World Health Assembly, reiterating and emphasizing the relevance of international cooperation in health.[61] Both declarations have special significance for the Strategy, both in terms of their content and the moment in which they took place.

Thus, a detailed review was carried out assessing the priorities, policies and mechanisms of international cooperation in health within Brazil in order to provide a reference framework for the formulation, negotiation and implementation of the PAHO/WHO Country Cooperation Strategy for the next 4 years.

61 http://www.mre.gov.br/portugues/politica_externa/discursos/discurso_detalhe3.asp?ID_DISCURSO=3092

Section IV

PAHO/WHO current cooperation activities

1. Cooperation strategies

PAHO/WHO cooperation is built on the basic pillars of rights, equity, gender and evidence based decision-making in accordance with the policies of each country. Through knowledge management and communication, it promotes the integration of different technical areas, facilitating cooperation with the country.

Throughout 2006 and 2007, PAHO/WHO cooperation has sought to promote the development of processes that consolidate the achievement of the Millenium Development Goals and support the National Development of Health, through effective knowledge management and the rational use of human and financial resources at the PAHO/WHO Representation. These cooperation processes have been built on the core WHO functions, which are detailed in annex 4.

PAHO has just begun its second century of work in the Americas and is building a new cooperation framework with countries. Its Representation in Brazil must work coherently with institutional guidelines in cooperation with the country, contributing to the strengthening of national capacity to facilitate sustainability in health policies, plans, programs and institutions.

Recognizing the contribution of the Organization as a whole, and in particular the PAHO/WHO Representation in Brazil, it is expected that the Ministry of Health, State and Municipal Health Departments will exercise leadership to include health in the national, state and municipal agenda.

Moreover, the PAHO/WHO Representation is making efforts to mobilize new partners, promoting public awareness to ensure health and well-being for all, increasing the participa-

tion of the population so that the community may become the principle driving force for change.

Within this framework, PAHO/WHO´s technical cooperation seeks to focus its activities on the most vulnerable population groups by age, i.e., those affected by specific diseases or with specific needs, those economically less well off, and those facing problems associated with poverty.

Cooperation between the Representation and the Ministry of Health together with State and Municipal levels is enhanced through alliances that aim to maximize the impact of resource allocation, focusing on national priorities and the development of national health policies, systems and services, giving greatest attention to local needs. Inter-agency initiatives are also encouraged through the United Nations coordination system, with the leadership of PAHO/WHO through theme groups in the area of health.

The institutional strategies that guide the processes of planning and execution of cooperation include the following:

- the National Development of Health, providing support to the tripartite national levels (Federal, State and Municipal Governments) to reduce inequalities in the area of health, especially those related to management, services and health impact;
- identification and development of National Reference Institutions in Health (INR) and the creation of Technical Consortiums with specific capacities regarding health processes and disease control, in order to respond to national priorities;
- support for political and technical processes so that the country can achieve the Millennium Development Goals;
- political, strategic and technical presence in the health debate at both national and local levels;
- recognition of PAHO/WHO's capacity to mobilize partners and respond to needs based on technical excellence and cooperation guided by programmatic agreements and strategic orientations;
- institutional development of PAHO/WHO in Brazil, seeking state-of-the-art technological and human resources required for effective and efficient cooperation;
- development of synergies in cooperation between the different PAHO/WHO technical units in Brazil through an interprogrammatic, integrated and multidisciplinary approach; and
- continued mobilization of extra-budgetary financial resources, from national sources as well as from bilateral and multilateral donors.

2. Summary of cooperation projects in 2006 and 2007

PAHO/WHO cooperation with Brazil in 2006 and 2007[62] was delivered through the projects described below:

- Project BRA 0029: Strategic management of cooperation.
  Objective: To support the efficient and effective presence of the Ministry of Health in the national health agenda as the National Authority responsible for political, strategic and technical actions in health as defined by the country, in collaboration with State and Municipal levels.
- Project BRA 0030: Collective health and the environment.
  Objective: To increase national capacity in the development of public policies favoring a healthy environment and quality of life standards in specific populations, and to promote the reduction of risk within the framework of sustainable development, the Millennium Development Goals, and processes of regional integration.
- Project BRA 0031: Information and human resources for health policies.
  Objective: To strengthen public health basic functions in the areas of information and human resources for the health-sector, taking into account the formulation of strategic actions that favor the National Development of Health and the achievment of the Millennium Development Goals.
- BRA 0032 Project: Development and Strengthening of the SUS: Health Care and Management.
  Objective: to strengthen and develop the SUS with emphasis on management capacity and development of service networks throughout the three levels of the system, to provide health care to different age groups with the aim of reducing health inequalities, contributing to the achievement of the Millennium Development Goals.
- Project BRA 0033: Disease prevention and control.
  Objective: To ensure that initiatives, strategies and programs developed by the country for the management, control and prevention of diseases are of social relevance, integrated into the Brazilian Health System, maintaining clear purpose and objectives for the short, medium and long term as well as contributing to the improvement of the quality of life of the population, in accordance with the principles of equality, universality and integrality.

62 http://www.paho.org/portuguese/gov/cd/IV-Paises-sept05-s.pdf

3. The Terms of Cooperation and their role in PAHO/WHO Cooperation

The implementation of the aforementioned projects is ensured through Terms of Cooperation (Cooperation Agreements), the details of which are specified in Annex 5. Cooperation Agreements have been used in Brazil since 1973 and consist of agreements that facilitate direct cooperation between institutions of the Brazilian Government – especially the Ministry of Health – and PAHO/WHO.

The Cooperation Agreements are comprised of a project document outlining the purpose, justification, activities, work plan and disbursement timetable with the respective expenditure components as negotiated between the Ministry of Health and PAHO/WHO. To each Cooperation Agreement is added the so-called Terms of Adjustment (TA) for the purpose of introducing, whenever the parties deem necessary, modifications to the original Cooperation Agreement and facilitating disbursements of the Ministry of Health or institution with whom the Agreement has been signed.

Given the considerable increase in the number of Cooperation Agreements after 2000, and as recommended at the inauguration of the new Representative in January 2007, PAHO/WHO has implemented an analysis of the Cooperation Agreements to determine their appropriateness, effectiveness and efficiency as cooperation mechanisms.

Between January 2000 and March 2007, 51 Terms of Cooperation were signed – 28 of which are still in force – committing resources equivalent to R$ 871.3 million, of which R$ 744.8 million (85.5%) has been transferred to PAHO/WHO. Nearly 8% of the total committed resources – corresponding to Cooperation Agreements, 34, 36 and 40 – are dedicated exclusively to the purchase of essential medicines, vaccines and other strategic public health supplies.

In the same period, the Cooperation Agreements were modified through 127 different TAs, 90% of which were associated with the transfer of resources. In only a few cases TAs were implemented to extend or modify the work plans within existing Cooperation Agreements. As of March 2007, Cooperation Agreements in force must be concluded in 2007 and 2008 (one per year respectively), in 2009 (six), in 2010 (nine) and 2011 (eleven).

The following points should be highlighted in summarizing the analysis and evolution of the Cooperation Agreements as a technical cooperation mechanism.

- the privileged position of PAHO/WHO as a qualified, respected and external mediator, capable of facilitating dialogue and agreement in contexts where interests converge, ensuring continuity in processes during periods of political transition;
- simultaneous support for PAHO/WHO and for national policies and priorities related to universal access, equality, integrity, regionalization, hierarchical organization, and decentralization of health systems and services, acknowledging specifically the adaptation and incorporation of Basic Public Health Functions within the health system;
- PAHO/WHO participation in tripartite meetings (of the Federal, State and Municipal Governments) in which decisions are taken concerning the management of the SUS, the coordination, evaluation and review of administrative and legal procedures, and other important activities related to the improvement of quality management;
- demonstration of the Ministry of Health's confidence in PAHO/WHO, not only in managing the large volume of transferred resources, but above all, to cooperate in the development and implementation of projects and activities of important political-technical content and strategic interest to the country and the Organization, for example, in the case of the Inter-Agency Health Information System (RIPSA);
- in general, the Cooperation Agreements comply with a series of basic principles to ensure effectiveness and efficiency in cooperation, in accordance with national and PAHO/WHO policies and priorities, and international agreements;
- in some cases, the increase in Cooperation Agreements after 2000 with the subsequent increase of activities and resources allocated has not been reflected in programmatic and management processes currently used by the Organization. This may inadvertently affect the achievement of priorities in some areas of work given that the additional funding has not been adequately integrated into the strategy of a single budget-program defended by PAHO/WHO;
- the decentralization process aimed at the strengthening PAHO/WHO capacity to cooperate more effectively and efficiently with countries, demands a greater degree of responsibility and a more stringent application of norms on the part of Representations, to ensure that cooperation responds to both PAHO/WHO and national policies, as well as to regional and international commitments undertaken by the countries and the Organization;
- PAHO/WHO cooperation in general, and Cooperation Agreements specifically, must be developed based on priorities, objectives, strategies, and results that integrate commitments undertaken by the Government and by PAHO/WHO, as well as those incorporated in regional and international agreements, such as the United Nations Millennium Development Declaration, the UNDAF/Brazil, health priorities of the Brazilian Government and mandates from Global and Pan-American Conferences.

In view of the above, the definition and implementation of Cooperation Agreements must remain guided by the following principles:

- the establishment of priorities in accordance with regional and international commitments with the country;
- results based management, essential to guarantee efficacy and efficiency in the development of cooperation. This requires that planning and evaluation be carried out by a joint committee, to ensure coordination of regular and extra-budgetary activities and resources. For this reason, Cooperation Agreements must be formulated by the Organization together with National Authorities, and be incorporated into the biennial budget-program (BPB) and semestral working programs (PTS) for the corresponding periods. Furthermore, the initial transfer of resources shall be incorporated into the principle Cooperation Agreement, and not transferred separately in the form of a TA subsequent to the signing of the Cooperation Agreement;
- permanent monitoring with annual evaluations to ensure the effective and efficient use of resources available and to evaluate future needs. The evaluation may result in the reduction or cancellation of some activities, as well as the incorporation of new activities that are considered priority in accordance with the changing needs of the country;
- integration of the Cooperation Agreements within the BPBs and PTSs to facilitate an inter-programmatic approach, preventing duplication, combining strategies and resources, improving both the efficacy and efficiency of cooperation.

In summary, the use of the Cooperation Agreement as a mechanism of cooperation is considered appropriate whenever it corresponds with guidelines presented in the evaluation of PAHO/WHO 2002-2003 budget-program and with the observations made by Member-States during the Regional Committee meetings in 2005 and the 115th Meeting of the Executive Board in January 2005.

Section V

PAHO/WHO political framework for technical cooperation with Brazil

1. Global and Regional Guidelines

The Strategy shall be guided by the priorities and policies of international cooperation at global and regional level defined within the framework of the United Nations and Inter-American System. Furthermore, it shall also take into consideration the definition of priorities and policies by other multilateral technical and financial cooperation agencies with interventions relevant to the health sector.

Within the scope of the United Nations System, orientation is provided through the joint planning framework for the United Nations, Brazil, that is, the CCA[63] and UNDAF[64] processes. In addition, it will be necessary to assess cooperation priorities and policies of the different specialized agencies within the United Nations System, whose action is relevant to the health sector.

Bilateral/interregional cooperation and integration agreements of which Brazil is a party to, shall also be analyzed, including those involving the Community of Portuguese Language Countries and the BRIC Group – Brazil, Russia, India and China. Similarly, policies adopted by the World Bank and its financial cooperation with Brazil within the scope of the health sector shall be considered.

63 http://www.onu-brasil.org.br/doc/CCABrasil2005_por.pdf, http://www.onu-brasil.org.br/doc/PNUD_livro_portug_curva.pdf e http://www.onu-brasil.org.br/doc/PNUD_livro_ingles_curva.pdf

64 http://www.onu-brasil.org.br/doc/UNDAFBrasil2002%20.doc, http://www.UNODC.org/pdf/brazil/UNDAF%20Versao%20Final%20-%20Brazi.pdf e http://www.onu.org.cu/uunn/c_interagencial/Brazil%202002-2006.pdf

From the perspective of the Inter-American System, it will be necessary to seek the relevant references within the scope of the Organization of American States[65] and Agreements of Regional and Sub-regional Integration to which Brazil is a party, such as MERCOSUR, OCTA and others. Moreover, the policies of the Inter-American Development Bank that may have an impact on its operations in the field of health shall be equally revised.

Regarding sector-wide frameworks, the strategic orientations adopted by WHO at the global level, specifically within the 2006-2015 XI General Work Program[66] and the 2008-2013 Medium-Term Strategic Plan,[67] shall be considered. At the Regional level, the corresponding framework references shall be provided by the 2008-2012 PAHO/WHO Strategic Plan[68] and by the 2008-2017 Health Agenda for the Americas.[69]

2. Comparing the international cooperation framework with health priorities

An evaluation is initially carried out between the medium-term priorities of the Brazilian health sector and the technical cooperation priorities defined by WHO in the 2006-2015 XI General Work Program, and by PAHO in the 2008-2017 Health Agenda for the Americas and the 2008-2012 Strategic Plan.

As is observed in Annex 6, there is coherence between the health priorities defined by Brazil and PAHO/WHO technical cooperation policies to be implemented during the next few years. It is reasonable therefore to anticipate that the cooperation to be offered by PAHO/WHO may adequately respond to the corresponding demands of the sector as a whole, as well as responding to demands from extra-sectoral agencies and NGOs operating in the health area.

In Annex 7 a comparison is made of cooperation priorities as defined by the United Nations System (CCA/UNDAF), WHO (XI General Work Program),[70] PAHO (2008-2017 Health

65 www.oas.org
66 http://www.who.int/about/finance/en/index.html
67 http://www.who.int/gb/e/e_amtsp.html
68 http://www.paho.org/portuguese/gov/cd/CD47-08-p.pdf
69 http://www.paho.org/English/DD/PIN/Health_Agenda.pdf
70 http://www.paho.org/spanish/d/csu/CCSGuide-2005.pdf

Agenda for the Americas[71] and the 2008-2012 Strategic Plan[72]), the World Bank[73] and the Inter-American Development Bank,[74] with health priorities of the Brazilian Government for the 2008-2011 period. It can be said that there is reasonable convergence between the offer and the demand for cooperation.

In this analysis, it is observed that multi-sectoral agencies of technical or financial cooperation tend to concentrate on sector priorities and policies. This is possibly due to the different views that such institutions may hold with regard to the level of the development within their respective sectors of intervention. Meanwhile, PAHO/WHO, irrespective of its primary scope of intervention within the health sector, expands its offer of cooperation to include several multi-sectoral issues of relevance to health. Another possible explanation is that PAHO/WHO is more active in seeking inter-sectoral responses to address health priorities than cooperation institutions active in other sectors.

Despite these differences, the environment for cooperation between the different development sectors is conducive to the achievement of positive results including the development and implementation of policies that will support the resolution of problems being experienced in each of these sectors.

Considering the analysis of the national and international context, the perspective for technical cooperation in health in Brazil during the next few years is positive.

71 http://www.paho.org/Spanish/DD/PIN/Agenda_de_Salud.pdf

72 http://www.paho.org/spanish/gov/ce/ce140-od328-s.htm

73 http://www.bancomundial.org.br/index.php/content/view_folder/1792.html e http://www.bancomundial.org.br/index.php/content/view_folder/2683.html

74 http://www.iadb.org/countries/strategy.cfm?language=Portuguese&ID_COUNTRY=BR&PARID=3

Section VI

Strategic agenda: PAHO/WHO cooperation priorities with Brazil for 2008-2012

PAHO/WHO shall focus its cooperation on the priorities defined below in order to consolidate achievements in the area of health, address pending issues and support international activities in health that have been prioritized by the Government. In addition, it will be necessary to maintain a level of preparedness to address an outbreak of disease – such as influenza – and other emerging threats – such as climate change. These priorities directly impact areas such as health policy, health care for specific social groups, as well as the management of the health sector and its resources.

1. Priorities

1.1 Priorities in health policies

a. To collaborate in consolidating the SUS as the base political project in health in Brazil, aligned with the development of health systems and based on the values of the Primary Health Care Strategy.
b. To support strengthening social participation in health development, building national awareness of the social determinants in health, enhancing the focus on rights, equality, justice and social oversight of these determinants, meeting the targets of the Millennium Development Goals.
c. To promote a systematic and integrated approach with regard to public health policies and the other sectors of development, geared towards improving the level of social inclusion and protection.

d. To promote the acknowledgment of health as a productive sector by means of policies and processes supporting the development of the health industrial complex.
e. To accompany Brazil in international initiatives, political processes and fora related to health, promoting the development of partnerships based on shared principles of equity, universality, social participation and integrality and on the strengthening of public health.
f. To contribute to the strengthening of Brazil's capacity to cooperate in the development of health systems in the Americas and in Portuguese speaking countries of Africa, within the framework of South-South Cooperation.

1.2 Priorities in assistance to social groups and in addressing health problems

a. To collaborate in the strengthening of Primary Care and the Family Health Program as the central strategy for reorganization of the system, based on the principles of integrality, equity and universality, within the framework of the Renewed Primary Health Care Strategy.
b. To collaborate in the prevention of disease, addressing principle risk factors in vulnerable populations, as well as in health surveillance.
c. To prioritize health promotion and address problems arising from violence, work-related and traffic accidents, degradation of the environment, use of psychoactive drugs and alcohol, unhealthy eating habits and smoking, among others.
d. To cooperate in the improvement of quality health care, the development of people-friendly health services and patient safety.
e. To foster the development of healthy cities and local districts, encouraging local policies to improve the quality of life and promoting pro-health behaviour within the population; the development of a movement in favor of peace and nonviolence in which the values of justice, freedom, dialogue, solidarity and respect for citizenship prevail.
f. To contribute in strengthening the health authorities within the three levels of the SUS to ensure effective management and regulation of the health sector, both public and private, in order to guarantee universal and integral access to quality health services.

1.3 Priorities in health sector management

a. To contribute to improving the management of the SUS based on principles of participation, mutual agreement and decentralization, by strengthening the mechanisms

established for deliberation, social oversight and agreement between representatives of the three levels of the System.

b. To contribute to strengthening the performance of essential public health functions within the three levels of the SUS, with emphasis on health surveillance and regulatory capacity.
c. To support the establishment of new management models that respect the principles of the SUS but also allow health institutions to operate with more efficiency and quality.
d. To collaborate with national counterparts in the development of a human resource policy for the health sector, to improve work management, the qualification and education of professionals and employees within the SUS.
e. To promote the use of scientific knowledge and evidence to support management processes and the formulation of public policies.

2. Strategic Focus for PAHO/WHO Cooperation during the period 2008/2012

PAHO/WHO cooperation with Brazil during the 2008/2012 period will be delivered in accordance with the strategic focus described below.

1. Cooperation shall: a) require intelligence management based on the receipt of adequate information; b) require know-how to act with flexibility and at the appropriate time; and c) facilitate the development of national capacity to mobilize national and international resources (human, scientific, technological and financial) to adequately implement health actions of high political, epidemiological and managerial value.
2. Cooperation shall also bridge the gaps in knowledge and technology in health. In addition, it shall support the development and maintenance of institutional memory, as well as the management of high value strategic information for the development of health.
3. Cooperation shall guarantee continuity and stability during the processes of change that contribute to the development and improvement of the Brazilian Health System. To this end, it will strengthen the institutional relationship between the Ministry of Health – responsible for the management of public health policies – and PAHO/WHO.
4. The Terms of Cooperation (Cooperation Agreements) shall be reoriented, redimensioned, and reorganized according to the priorities and mechanisms of cooperation previously mentioned. The Cooperation Agreements will be consolidated, and gradually adjusted into two major axes of PAHO/WHO Technical Cooperation: a) government policy in South-South Cooperation in the area of Health; b) strategic programs and processes for the strengthening and improvement of the SUS.

5. South-South Cooperation will be enhanced with the "triangulated" participation of WHO, performing strategic functions of mediation and catalysis, proactively promoting sustainability in the formulation, performance and evaluation of cooperation programs to be carried out as a partnership involving the Brazilian Government, WHO and receiving countries.
6. PAHO/WHO cooperation shall be organized in three strategic lines that will serve to group and reorient Cooperation Agreements to achieve programmatic coherence and ensure political and managerial relevance. These strategic lines are:
   a) support strategic processes and projects of the SUS;
   b) support intersectoral processes, primary healthcare and health promotion taking into consideration social health determinants; and
   c) support to South-South Cooperation in Health.
7. The strengthening of PAHO/WHO Cooperation with Brazil will occur through the gradual allignment of the work program of the PAHO/WHO Representation in Brazil with the content of this Strategy document, this with the support of PAHO Regional Programs in Washington, WHO Global Programs in Geneva and PAHO/WHO Specialized Centers. To this end, the PAHO/WHO Reprsentation in Brazil shall facilitate articulation between national institutions and the various levels of the Organization, and act as a communication channel between the parties.
8. PAHO/WHO may also significantly improve the impact of its cooperation with Brazil – which has already been positively assessed – by encouraging the mobilization and strengthening of national capacity and resources, avoiding their substitution even when faced with urgent short term demands.
9. PAHO/WHO will also support the country in bridging knowledge gaps and in overcoming managerial deficiencies, assisting in the administration of a strategic information management system and the development of institutional memory that is vital for the sustainable development of the SUS. In addition, it shall support the dissemination of successful but unknown experiences, as well as contribute to ensure that positive experiences are not interrupted, and promoting and supporting cooperation between countries.
10. In this sense, PAHO/WHO shall facilitate articulation among the other agencies of the United Nations System and other cooperation agencies to achieve greater effectiveness in international health cooperation.
11. PAHO/WHO shall strengthen subregional cooperation with the participation of Brazil, taking advantage of national capacity while meeting the needs and demands of the country. Within this framework, the mechanism of Technical Cooperation between Countries (TCC) will be promoted.

12. The current agreement between PAHO and the Brazilian Government to provide support to BIREME will be reviewed and updated in order to provide BIREME with a new legal and institutional framework with an independent and flexible management system. This will be achieved through the allocation of additional funds from the Brazilian Government in order to strengthen and expand BIREME´s global, regional and national capacity as an international center specialized in technical cooperation in the field of scientific and technical information and communication in health.
13. The role of PANAFTOSA in the eradication of foot-and-mouth disease shall be reviewed to include food security and programs for zoonoses, in the interest of both health and agricultural sectors, as well as a new financing policy with the participation of embassies and ministries of foreign trade and agriculture, with complementary and differentiated functions performed by the OIE, FAO, IICA and PAHO.
14. Besides addressing priorities previously described, PAHO/WHO cooperation will be delivered within the context of, and in compliance with, Brazilian international technical cooperation policies. This implies:
    a. Focusing cooperation on technical areas of work minimizing operational processes;
    b. Not prioritizing the procurement of goods and services for public programs, except for the procurement of strategic supplies that are essential for public health;
    c. Responding to the incorporation and implementation of an agenda, increasing initiatives in three-way South-South Cooperation;
    d. Promoting and developing innovative capacity not available in the country;
    e. Developing specific cooperation programs within the context of the UNDAF that facilitate the rational use of national and international resources and capacity, besides strengthening articulation with other agencies of bilateral and multilateral cooperation; and
    f. Identifying, together with the Brazilian Government and the Ministry of Health, mechanisms to guarantee access to international cooperation for Brazilian States and Municipalities, in order to optimize resources and increase the impact of such cooperation.

3. PAHO/WHO Cooperation Modalities with Brazil

PAHO/WHO technical cooperation with Brazil, targeting priorities and focus areas defined above, shall be developed through the following cooperation mechanisms:

1. Strengthening national capacity in knowledge management in health, including the processes and mechanisms for collection, systematization and dissemination.

2. Supporting the development of scientific and technological research with emphasis on social health determinants and the dissemination of results at the national and international level, as well as the implementation of policies, projects and programs based on the results of such research.
3. Identification, systematization, assessment and documentation of best practices and experiences in the formulation, development, implementation and evaluation of health policies and programs.
4. Accompanying the process of South-South Cooperation in health, as well as the strengthening of national capacity to ensure effective participation in such cooperation.
5. Supporting Brazil in contributing to the development of the global health sector, through the creation and strengthening of political and commercial partnerships focusing on international health priorities.
6. Decentralizing PAHO/WHO cooperation, in mutual agreement with the Ministry of Health, to strengthen the capacity at the State and Municipal levels as well as the capacity of the population, in the development of policies aimed at addressing priorities of the sector.
7. Supporting the PAHO/WHO Representation in Brazil and Brazil's International Cooperation through BIREME and PANAFTOSA.
8. Mobilizing resources at the national and international levels to facilitate implementation of policies and programs that promote national development in health, including institutional development and technological knowledge transfer within the health sector.
9. Supporting dialogue and cooperation in the health sector with other development sectors such as the environment, education, energy, labour, transport and others, the performance of which impacts the achievement of health priorities. Prioritizing health in the development agendas of these sectors.
10. Increasing the number of national organizations as partners in PAHO/WHO technical cooperation, seeking synergy in their experiences and capacity, and favoring horizontal cooperation between States and Municipalities.
11. Supporting dialogue and agreement between government and civil society relevant to the sustainable development of the health sector and its policies, in order to ensure collaboration in the sector to achieve the Millennium Development Goals.

Section VII

Implementation of the Strategic Agenda: implications for the PAHO/WHO Secretariat, follow-up and next steps at each level

The country team is responsible for:

- Realigning human resources within the PAHO/WHO Representation in accordance with the approved Country Cooperation Strategy (CCS). The analysis will be executed by a team of specialists from the PAHO/WHO Regional Office,specifically from the areas of Human Resources and Country Support jointly with the Technical Units and Administration within the Representation.
- Elaborating a Plan for Institutional Development, so that the Country Office reorganization and alignment of resources is implemented according to the CCS, and so that the process of change takes place gradually and in a planned manner. The Institutional Development Plan shall take into consideration the need to consolidate basic capacities – so that the Country Office team can effectively and efficiently achieve their goals – as well consolidate the team of international and national professionals to facilitate the achievement of technical cooperation priorities.
- Reorient Cooperation Agreements in effect at the time of approval of the Strategy, in order for them to be converted into priorities of the Strategy through a joint process of analysis to be implemented by the PAHO Representation Brazil, the Ministry of Health, the ABC/Chancellery – and with the support of a mission of specialists from the Regional Office – the Director's Office and the Units of Country Support, Planning and Program Budget, Legal and Finance.
- Defining the new model for the Cooperation Agreements, considering strategic, political, legal, budgetary, financial-administrative and programmatic aspects in order to facilitate the achievement of expected results, as laid out in the 2008/2009 Biennial Workplan of the PAHO/WHO Representation, and to ensure accountability with respect to voluntary contributions.

- Continuing with the mobilization of voluntary contributions as a source for financing national and international cooperation, with the support of national and international specialists, and specific initiatives required by cooperation counterparts
- Allocating regular budgetary resources to complement and catalyze Technical Cooperation financed by voluntary contributions, supporting the management and execution of voluntary contributions, ensuring the physical and operational infrastructure of the PAHO/WHO Representation with the level of quality required to offer security and comfort to employees and other partners in cooperation.
- Implementing the Strategy with the participation of strategic partners such as institutions of excellence, specialized centers and networks of collaborative centers, bilateral and multilateral cooperation agencies, and NGOs with interventions in the health area.
- Elaborating a management model facilitating the triangulated participation of WHO/AMRO/AFRO and their respective Representations in South-South Cooperation with the Brazilian Government in the area of health. For this purpose, support will be provided by AMRO and AFRO at the regional level, and by WHO, at the global level.
- Preparing the 2008-2009 Biennial Workplans based on the Strategy, aligned with the expected results for the country at the regional and global level and with reoriented Cooperation Agreements focusing on priorities defined within the Strategy. The monitoring of performance will be based on semestral technical-financial evaluations and on the analysis of predefined indicators for each expected result within the Biennial Workplan.
- Defining and implementing a decentralized model of cooperation, for the purpose of efficiently and effectively executing the Strategy, together with the Director's Office, the PAHO/WHO Country Support Unit and the Ministry of Health, benefitting from PAHO's experience in the decentralization of Technical Cooperation in other countries and adapting these experiences to the realities and needs of Brazil.

Regional Office Support (AMRO/PAHO)

PAHO/WHO headquarters will play an important role in providing orientation and supporting the implementation of the Strategic Agenda. The regional technical programs will provide the expertise necessary to ensure coherence between the priorities defined in the Strategy and technical elements presented in the Cooperation Agreements, as well as ensuring coordination between the biennial working programs, at the national, subregional (Mercosur) and regional levels.

The Regional Office will provide support in identifying best regional practices, experiences and research in public health at the regional level. It will also promote Brazil's participation in regional events, promoting the establishment of partnerships in cooperation at the regional level between Brazil, countries and the reference institutions (including collaborating centers) in the area of health.

The Regional Office, together with WHO, will support Brazil's participation in international forums and debates, assuming a very important role in facilitating cooperation between Brazil and other Member States at the regional and global level, specifically in promoting triangulated South-South Cooperation.

The PAHO/WHO Regional Office will continue to mobilize additional resources to support the implementation of the Strategy. The analysis of technical human resource requirements at the PAHO/WHO Office in Brazil will be executed taking into consideration that the incorporation of PAHO/WHO advisors with regional experience in priority areas will strengthen South-South Cooperation, providing effective linkage between the national, subregional and regional work programs. Furthermore, the Regional Office will continue to mobilize additional financial resources for technical cooperation specifically in the identified priority areas.

The administrative units of the Regional Office will provide clear orientation regarding norms and procedures, bearing in mind the particular context of the technical cooperation structure, ensuring appropriate delegation of authority so as to guarantee the effective implementation of the work program in a manner that will ensure flexibility.

Also, the Regional Office will provide the necessary support for the development and implementation of the PAHO/WHO Brazil Institutional Development Plan, which shall improve decision-making at the political, administrative and financial levels in the reorganization of the office, the management of human and financial resources and the effective mobilization of such resources.

The PAHO/WHO Regional Office will assist and support the decentralization of technical cooperation in Brazil through the Representation in Brazil.

Support from WHO Head Office

Based on WHO directives, the cooperation strategy centered in countries, the priorities, focus and modalities of cooperation identified within this Cooperation Strategy for Brazil, the WHO Head Office will participate in this Strategy by ensuring the following functions:

1. Supporting the formulation of health policy options based on ethical principles and scientific evidence, and facilitating Brazil's participation in international forums and events geared towards the development and implementation of health policies, strategies and regulatory frameworks, especially those organized outside the region of the Americas.
2. Contributing with norms and standards in health, promoting technology transfer in public health and participating in partnerships, in accordinance with it´s global leadership role in health.
3. Together with PAHO and Brazil, identifying lines of research, stimulating and facilitating the production of knowledge, and promoting its dissemination, with emphasis on the social determinants of health.
4. Supporting and facilitating Brazil's role in South-South Cooperation with other continents, in coordination with the PAHO Regional Office, and specially the PAHO/WHO Representation in Brazil.
5. According to the Strategy, coordinating, articulating and channeling cooperation activities with Brazil through the PAHO Regional Office, particularly with the PAHO/WHO Representation in Brazil.
6. Facilitate for the PAHO/WHO Representation in Brazil, and the PAHO Regional Office, articulation and alignment of the technical relationship between national health institutions and the many levels of WHO.

Term of Commitment signed between the Brazilian Government and the Pan-American Health Organization/World Health Organization on August 20th, 2007

Technical Cooperation Strategy for PAHO/WHO and the Federative Republic of Brazil, 2008-2012

This strategy addresses the priorities, approaches and modalities of cooperation between PAHO/WHO and Brazil. It was compiled through a series of PAHO/WHO missions, a process of internal analysis and debates, and extensive consultation with national counterparts. Its preparation has taken into consideration priorities and policies defined by PAHO/WHO and Brazil for that period, including national, regional and global development commitments. It is also part of the process being developed through the United Nations Development Assistance Framework (UNDAF).

The ultimate objective of PAHO/WHO technical cooperation to be provided to Brazil during the period 2008-2012 is to contribute towards the country's socioeconomic and political development, through an improvement of individual and collective health for all Brazilians.

As part of a global initiative focused on the country, the strategy shall guide all cooperation activities developed by PAHO/WHO with Brazil in the aforementioned period. Once formalized, it will be disseminated by the PAHO/WHO field office, as well as to other agencies that cooperate with Brazil in the field of health, to achieve greater synergy between the activities and the contents presented in this document

There is significant synergy between the health priorities of Brazilian society and the State, and the priorities set forth on a global scale by the World Health Assembly as presented in WHO's XI General Program of Work 2006-2015. At the regional level, this synergy can be seen within the Health Agenda for the Americas 2008-2017, approved by the governments

of the Americas, and the proposed PAHO Strategic Plan for 2008-2012, which will be considered by the 27th Pan American Sanitary Conference. There is also a clear synergy with the Millennium Development Goals.

From the Brazilian perspective, technical cooperation priorities for PAHO/WHO are based on the 2008-2011 Multiyear Plan, on the Growth Acceleration Program, and in the area of health, on priorities defined by the second term of the current National Administration. They also reflect the priorities that will be included in the Health Growth Acceleration Program (PAC-Saúde), currently in preparation.

This Strategic Proposal was prepared through a thorough collective revision of these policies and priorities, a detailed evaluation of the advances made in previous years, and the challenges and opportunities for cooperation between PAHO/WHO and Brazil in the future. It has also benefited from an intense dialogue among authorities, specialists, and NGOs involved in the field of health, as well as with several other sectors.

TECHNICAL COOPERATION PRIORITIES FOR PAHO/WHO AND BRAZIL

PAHO/WHO will focus its cooperation on the priorities defined below, to build on Brazil's achievements in health, addressing unresolved issues, and supporting international health activities defined by the government. It is also necessary to maintain preparedness in the face of potential disease outbreaks such as influenza, and threats such as climate change. These priorities refer to the areas of health policy, health care provided to social groups, health problems, and management of the sector and resources.

1. Health Policy Priorities

a. Collaborate in establishing the Unified Health System (SUS) as the core political project for health in Brazil, in alignment with the development of Health Systems based on the values set forth in the Primary Health Care Strategy.
b. Support the strengthening of social participation in promoting health and national awareness of social determinants of health, promoting an approach based on rights, equality, equity, and social oversight, contributing towards fulfilling the Millennium Development Goals.

c. Promote a systematic and integrated approach with regard to public health policies and development sectors to achieve social protection.
d. Promote the recognition of health as a productive sector through policies and processes aimed at developing the health-related industrial complex.
e. Support Brazil's participation in international health initiatives, discussion forums, and political processes, brokering partnerships based on shared principles of equity, universality, integration and social participation, and the strengthening of public health.
f. Contribute towards the strengthening of Brazil's capacity in international cooperation to provide support in the development of health systems for countries in the Americas and for other Portuguese-speaking countries in Africa, within the spirit of South-South cooperation.

2. Priorities for social groups and health problems

a. Collaborate towards strengthening Primary Health Care and the Family Health Program as a central strategy for reorganization of the health system, based on the principles of integration, equity, and universality, in accordance with the principles of Renewed Primary Health Care.
b. Collaborate in the prevention of disease, monitoring primary risk factors and vulnerable populations, and conduct health surveillance.
c. Prioritize the promotion of health in controlling problems resulting from violence, work and traffic accidents, from environments where psychoactive drugs and alcohol are frequently used, as well as from unhealthy eating habits and tobacco addiction, among others.
d. Cooperate towards further improving the quality of health care, the humanization of services and patient safety.
e. Promote the development of Healthy Municipalities, giving incentive to local policy to improve living conditions and healthy habitats for the population, as well as to create a movement in favor of a culture that prioritizes peace and non-violence in which the values of justice, liberty, dialogue, solidarity and respect prevail.
f. To contribute to the streamlining of the health authority's capacity within the three spheres of the SUS in the orientation and regulation of both the public and private health sectors, for the purpose of guaranteeing universal access to integrated high-quality health services.

3. Management Priorities in the Health Sector

a. Contribute towards perfecting the SUS's participative and decentralized management by strengthening the deliberative mechanisms that are responsible for oversight by the society and the community, and strengthening partnerships among stakeholders within the three levels of the System.
b. Contribute towards strengthening the performance of essential public health functions within the three levels of the SUS, with emphasis on surveillance capacity and health regulation.
c. Support the creation of new management models that uphold the principles of the SUS and facilitate the efficient operation of health institutions and the delivery of high-quality services.
d. Collaborate with several national entities in the development of human resource policies in health to strengthen work management practices and in-service training for SUS workers and professionals.
e. Promote the use of knowledge and scientific evidence as a basis for managerial processes and public policy-making.

STRATEGIC APPROACH FOR PAHO/WHO COOPERATION IN THE 2008-2012 PERIOD

Cooperation between PAHO/WHO and Brazil for the 2008-2012 period will occur in accordance with the strategic guidelines outlined below.

1. Cooperation will: a) be conducted through the management of intelligence and appropriate information; b) adequate know-how in order to act flexibly and in a timely manner and; c) facilitate the development of the country's capacity to mobilize national and international resources (human, scientific, technological, and financial) and to implement health initiatives with high political, technological and managerial value.
2. Cooperation must also facilitate the provision of support to address gaps in knowledge and technology required for health interventions. Additionally, it must support the construction and maintenance of institutional memory, as well as the management of the strategic information that is essential for developing and improving health.
3. Cooperation must ensure continuity and stability in reform processes that contribute towards developing and perfecting the Unified Health System. To this end, the institutional relationship between the Ministry of Health, responsible for the

development and implementation of public policies in health, and PAHO/WHO, will be fortified.

4. Cooperation Agreements must be revised, reoriented in accordance with priorities and modalities of technical cooperation, consolidated through a progressive process, coherent with PAHO/WHO's principle cooperation priorities: a) supporting Government Policy for South-South Cooperation in the field of health and b) strategic programs and processes for the strengthening and perfecting of the SUS.
5. South-South Cooperation will be optimized and triangulated with WHO, which will fulfill strategic roles as both mediator and catalyst, in addition to its role of supporting proactively and sustainably the formulation, execution, and evaluation of cooperation programs implemented jointly by the Brazilian Government, WHO, and recipient countries.
6. Technical cooperation provided by PAHO/WHO will be organized into three comprehensive work areas which will group together and redefine the Cooperation Agreements, to ensure that they are coherent with political, programmatic and managerial priorities. The areas of work are:
   a) support for the strategic processes and projects of SUS;
   b) support for interaction between sectors, primary health care and health promotion, taking into consideration the social determinants of health; and
   c) support for South-South Cooperation in health.
7. The strengthening of cooperation between PAHO/WHO and Brazil will be ensured through a gradual adjustment of the work program for the PAHO/WHO Brazil Representation, with support from Regional Programs at PAHO Washington, Global WHO Programs in Geneva and specialized PAHO/WHO centers, in accordance with the content of this document. For this purpose, the PAHO/WHO Representation in Brazil will seek to harmonize communication between national institutions and the different levels of the Organization.
8. PAHO/WHO can further significantly improve the impact of its cooperation with Brazil – which has thus far been seen as positive – by providing support in mobilizing, strengthening and using national resources and capacity, avoiding their substitution even when faced with urgent short-term demands.
9. PAHO/WHO must also support the country by seeking to bridge gaps in knowledge and by improving overall efficiency in administration, to assist in the management of a strategic information system including the construction of institutional memory, which is essential for the sustainable development of the SUS. In addition, the Organization must support the identification and documentation of best practices, in order to prevent the interruption or failure of positive initiatives, as well as to promote and support cooperation among countries.

10. In this regard, PAHO/WHO can and must facilitate negotiations amongst other agencies in the United Nations System and other cooperation agencies to improve effectiveness in international health cooperation.
11. PAHO/WHO will strengthen Regional cooperation, with Brazil's assistance, by making full use of national capacity, while at the same time fulfilling the country's needs and demands. As such, PAHO will prioritize the use of the modality, ´technical cooperation among countries´ (TCC).
12. The current partnership between PAHO and the Brazilian government for the support of BIREME will be reviewed and updated in order to allow for more autonomy and flexibility in operations, formulating a new legal-institutional framework with additional resources from the Brazilian government, in order to strengthen and expand BIREME's capacity at the global, regional, and local level as an international cooperation center specializing in health information and communication sciences.
13. The current role of PANAFTOSA to contribute to the eradication of foot-and-mouth disease will be reviewed to include food safety and zoonoses disease control programs in addition to other areas of common interest to the departments of health and agriculture, as well a new financial arrangement with the participation of Ministries of International Trade and Agriculture, considering complementary functions among FAO, OIE, IICA and PAHO.
14. In addition to ensuring implementation of priorities previously-mentioned above, PAHO/WHO will work towards fulfilling the objectives of Brazil's international technical cooperation policies, which implies:

a) Focusing cooperation on technical capacity-building with as few operational components as possible;
b) Not prioritizing the procurement of goods and services, with the exception of the procurement of essential public health supplies;
c) Accommodating and implementing the agenda of triangulated South-South cooperation initiatives;
d) Working to promote and develop innovative techniques not yet available in country;
e) Creating specific cooperation programs within the context of UNDAF that allow for the rational use of national and international resources, and that reinforce the relationships and negotiation capacities with other bilateral and multilateral cooperation agencies; and
f) Identifying, jointly with the Brazilian government and the Ministry of Health, mechanisms necessary for ensuring access by all Brazilian states and municipalities to international cooperation, so as to optimize the use of resources and maximize the impact of cooperation.

MODALITIES OF COOPERATION BETWEEN PAHO/WHO AND BRAZIL

Technical Corporation between PAHO/WHO and Brazil, aimed at fulfilling the aforementioned priorities and focus areas, will:

1. Strengthen the country's ability to manage knowledge in the field of health, including processes and mechanisms for adequate collection, systemization, and dissemination.
2. Support scientific and technological progress with emphasis on social health determinants and disseminate results nationally and internationally; implement policies, projects, and programs based on these results.
3. Identify, systematize, evaluate, and document good practices and experiences to formulate, develop, implement, and evaluate health policies and programs.
4. Accompany the process of South-South cooperation in the field of health, as well as support capacity building at the national level in order to promote cooperation initiatives.
5. Support the country's contribution to developing health at the global level, by forging and strengthening political and commercial partnerships in international health.
6. Decentralize PAHO/WHO's cooperation with the agreement of the Ministry of Health to strengthen states and municipalities, as well as civil society, in developing policies aimed at fulfilling sectoral priorities.
7. Reinforce the support of the BIREME and PANAFTOSA centers in the implementation of the international technical cooperation program of work between PAHO and Brazil.
8. Mobilize national and international resources to provide for the implementation of policies and programs that promote national health development, including management, institutional development, and technological transfer in the field of health.
9. Support dialogue and cooperation between health and other development sectors – environment, education, energy, labor, transportation and others – whose actions are essential to the fulfillment of the health priorities outlined, and prioritizing health within the agenda of each sector.
10. Increasing involvement in the mobilization of national partners in the support of PAHO/WHO technical cooperation, to promote synergies in experiences and skills, favoring horizontal cooperation between states and municipalities.

11. Support dialogue and collaboration among government institutions and civil society in favor of the sustainable development of the health sector and its policies, to ensure sectoral collaboration in moving towards the achievement of the Millennium Development Goals.

Brasília, 20 August, 2007.

JOSÉ GOMES TEMPORÃO
Minister of State for Health

MARGARET CHAN
Director-General
World Health Organization

MIRTA ROSES PERIAGO
Director
Pan-American Health Organization

Annexes

1. Convergence of priorities of the Ministry of Health, IPEA and sectoral NGOs for 2007-2010

2. Convergence of priorities for 2007-2010 between the health sector and other sectors

3. Group of experts analyzing challenges of the SUS

4. Principle and Strategic Functions of PAHO/WHO

5. PAHO/WHO Terms of Cooperation with Brazil in force as of March 2007

6. Health sector priorities for the 2007-2010 period, and the PAHO/WHO response

7. Priorities of other cooperation agencies and of the health sector

ANNEX 1

CONVERGENCE OF PRIORITIES OF THE MINISTRY OF HEALTH, IPEA AND SECTOR NGOs FOR 2007-2010

NO.	PRIORITIES PROPOSED BY THE MINISTRY OF HEALTH	IPEA	NGOs
01	Better control in the use of public resources	6	7
02	Basic health care as the principle strategy of the system	4	3
03	Agreements in defense of life, the SUS and effective management	2	3
04	Advocacy for additional resources required by the system	6	9
05	To strengthen social oversight of the SUS	2	2, 6
06	To adopt an interinstitutional view of health	1	1
07	To strengthen the Humanization Policy of the SUS	4	2
08	National Policy for Sexual and Reproductive Rights	1	10
09	Assistance to at-risk populations	4	4
10	National Policy for Men's Health Care	1	4
11	Innovative assistance to population vulnerable groups	3	4
12	Prevalent disease prevention	1	4
13	Establishment of a "Government School for Health"	2	5
14	Greater participation of Brazil in International Health	5	1
15	To continue and improve mental health reform	1	4
16	To integrate the activities and policies of the ANS and the SUS	2	6, 8
17	To improve work policies in health	2	5
18	Research and technological development in health	5	1
19	Productive Complex for Health Services and Goods	5	1
20	Access for the population to essential medicines	5	1
21	Management for improved efficiency and quality of the SUS	2	6
22	To improve the health sector within Rio de Janeiro	4	10

ANNEX 2

CONVERGENCE OF PRIORITIES FOR 2007-2010 BETWEEN THE HEALTH SECTOR AND OTHER SECTORS

SECTORS	THEMES	MINISTRY OF HEALTH
Agriculture	Veterinary Public Health and Food Protection	5, 6, 12
Cities	Housing, Water, Sewerage and Waste	5, 6
Science and Technology	Science and Technology in Health	13, 18, 19
Industry and Trade	Production and Trade of Supplies for Health Services	18, 19
Social Development	Food and Nutrition	5, 6
Education	HR Education for Health, University Hospitals	6, 13, 17, 18
Environment	Environmental Quality, Climate Changes	5, 6
Social Security	Adult Worker's Health	5, 6
Planning	PPA 2008-2011, PAC	1, 3, 4, 13, 21
External Relations	International Cooperation	14, 18, 19
Labor and Employment	Workers' Health	5, 6
Racial Equality	Ethnicity and Health	5, 9
Policies for Women	Gender and Health	5, 8, 9
Human Rights	Health and Human Rights	3, 5, 8
Food Security	Food and Nutrition	5, 6
National Congress	Health Legislation	4, 5
Judiciary Branch	Health Legislation	4, 5

ANNEX 3

GROUP FOR ANALYSIS OF THE CHALLENGES OF THE SUS APRIL 27, 2007 – PAHO/WHO

LIST OF PARTICIPANTS

1. Carlyle Guerra de Macêdo (PAHO Emeritus Director, Coordinator)
2. Diego Victoria (PAHO/WHO Representative in Brazil)
3. César Vieira (Professor of the UFMG Medical School, Rapporteur)
4. Eugênio Villaça Mendes (Consultant, State Division for Health of Minas Gerais).
5. Gilson Carvalho (Pediatrician and Public Health Consultant)
6. Helvécio Magalhães (President of CONASEMS – National Council of Municipal Health Secretaries –, Health Secretary of the city of Belo Horizonte)
7. José da Rocha Carvalheiro (President of ABRASCO)
8. Julio Suárez (PAHO/WHO International Consultant in Brazil)
9. Nelson Rodrigues (Special Adviser of the Minister of Health)
10. Antônio Ivo de Carvalho (Director of the National School of Public Health)
11. Sérgio Piola (Deputy Director, Social Studies, Institute of Applied Economic Research)
12. Sônia Fleury (Professor at the Getúlio Vargas Foundation)
13. Gisele Bahia (Chief of Staff of the Minister of Health)
14. Claunara Mendonça (Director, Basic Health Care Department, SAS/MS – Health Care Department/ Ministry of Health)

SCHEDULED AGENDA

Opening of the Meeting

1st session: Management and Organization Challenges

2nd session: Funding Challenges

3rd session: Production Challenges

4th session: Sustainability and Development Challenges

5th session: Political Challenges of Leadership Policies

Summary and Closing

ANNEX 4

WHO FUNCTIONS: EXISTING TYPOLOGIES

WHO MAIN FUNCTIONS[75]

- articulating consistent, ethical and evidence-based **policy** and **advocacy** positions;
- **managing information** by assessing trends and comparing performance; setting the agenda for, and stimulating, research and development;
- catalysing change through **technical** and **policy support**, in ways that stimulate cooperation and action and help to build sustainable national and intercountry capacity;
- negotiating and sustaining national and global **partnerships**;
- setting, validating, monitoring and pursuing the proper implementation of **norms** and **standards**; and
- stimulating the development and testing of new **technologies**, **tools** and **guidelines** for disease control, risk reduction, health care management, and service delivery.

WHO STRATEGIC FUNCTIONS IN CRISIS SITUATIONS[76]

- measuring ill-health and assessing needs;
- coordinating joint action for health;
- filling – or ensuring that others fill – critical gaps in health response; and
- revitalizing and building capacity in health systems..

75 WHO, 2002-2005 General Working Program, http://www.who.int/gb/e/e_wha54.html

76 WHO, CAP Compendium, Health 2005, http://www.who.int/disasters/specials/cap2005/html

ANNEX 5

PAHO/WHO Terms of Cooperation with Brazil in force in March of 2007

TC	PROGRAM	DURATION	FOCAL POINT	COMMITTED RESOURCES	SUBTOTAL	%
11	Aedes Aegypti – Dengue Fever	2000-2010	Rubén Figueroa	18,500,854	105,858,148	12.1
32	Tuberculosis Control	2003-2008		16,524,750		
35	Environmental and Epidemiological Surveillance	2004-2009		49,185,884		
40	Epidemiological Surveillance – Prevention and Control	2004-2009		21,646,660		
23	CNS – National Health Council	2001-2011	Fernando Rocabado	971,900	10,971,900	1.4
44	Participatory and Strategic Management of the SUS	2006-2011		10,000,000		
24	Pharmaceutical Assistance	2001-2011	James Fitzgerald	9,100,707	67,753,185	7.6
33	Sanitary Surveillance for São Paulo	2004-2009		1,111,101		
36	The SUS Pharmaceutical Assistance	2004-2009		16,998,857		
37	Sanitary Surveillance	2005-2010		5,556,520		
47	Management and Technology in Health	2006-2011		29,998,500		
51	Blood National Policy	2006-2011		4,987,500		
8	Empowerment in Health	2000-2010	José Paranaguá	267,145,000	281,215,000	32.3
41	International Health	2006-2010		14,070,000		
39	Management of the SUS	2004-2009	Julio Suárez	10,753,473	54,864,600	6.3
42	Supplementary Health	2005-2010		6,000,000		
43	Systems of Health Services	2005-2010		18,111,927		
45	Economy of Health	2006-2010		3,259,200		
50	Quality of the SUS	2006-2011		7,140,000		
49	Nutrition, Food and Family Health	2006-2011		9,600,000		

TC	PROGRAM	DURATION	FOCAL POINT	COMMITTED RESOURCES	SUBTOTAL	%
7	Health Promotion for Adolescents and Youth	2000-2007	Zuleica Albuquerque	392,000	392,000	0.1
15	Improvement of the Management of the SUS	2003-2011	SS/RRHH/EPI	26,341,255	26,341,255	3.0
14	RIPSA	2000-2010	José Moya	13,262,603	13,262,603	1.5
12	BVS	2000-2010	BIREME	8,502,364	8,502,364	1.0
38	Public Health Engineering	2006-2011	Mara Oliveira	820,116	820,116	0.1
34	Vaccination Program	2004-2009	Cristiana Toscano	300,622,844	300,622,844	34.5
48	Health in the MERCOSUL	2006-2011	Diego Victoria	1,011,350	1,011,350	0.1
---	TOTAL	---	---	871,300,938.94	871,300,938.94	100

Note: TCs 34, 36 and 40 are dedicated exclusively for procurement of strategic health products, corresponding to 29.5% of the total resources committed in the period under analysis.

ANNEX 6

PRIORITIES OF THE HEALTH SECTOR FOR THE 2007-2010 PERIOD AND THE PAHO/WHO RESPONSE

NO.	PRIORITIES	RESPONSES	
		PAHO	WHO
01	Better control in the use of public resources	1	7
02	Basic Health Care as main strategy of the system	7	1, 5
03	Pacts in defense of life, the SUS and management	7	7
04	To fight for resources required by the system	7	1, 2
05	To strengthen social control of the SUS	1, 8	4, 7
06	To adopt an interinstitutional view of health	2	4
07	To strengthen the Humanization Policy of the SUS	6, 7	3, 5
08	National Policy for Sexual and Reproductive Rights	2, 6	3, 6
09	Assistance to at-risk populations	2, 5	3
10	National Policy for Men's Health Care	2, 6	3
11	Innovative assistance to vulnerable groups of the population	4, 5	1, 2
12	Prevalent disease prevention	2	2, 6
13	Implementation of a "Government School for Health"	8	5, 7
14	Greater participation of Brazil in international health	4, 5	2
15	To continue and to improve psychiatric reform	6	5
16	To integrate the activities and policies of the ANS and the SUS	7	5
17	To improve work policies in health	8	5
18	Research and technological development in health	3	6
19	Productive Complex of Health Services and Goods	3	6
20	Access of the population to essential medicines	3, 6, 7	2, 6
21	Management for greater efficiency and quality of the SUS	7, 8	7
22	To decipher the conundrum of the city of Rio de Janeiro	7, 8	5

ANNEX 7

PRIORITIES OF OTHER COOPERATION AGENCIES AND OF THE HEALTH SECTOR

PRIORITIES		
OTHER AGENCIES		**HEALTH SECTOR**
CCA/UNDAF	Excluded and vulnerable populations	9, 11
	Gender and racial/ethnical inequalities	9
	Reduced violence, peace, reconciliation and justice	3, 6, 12
	Transparent and participatory public management and policy	1, 4, 5
	Sustainable and equitable development	11, 14, 19
WHO	To invest in health in order to reduce poverty	1, 4
	To build individual and global sanitary security	7, 11, 12, 15
	Universal coverage, gender equality and Human Rights	8, 9, 10, 20
	To address health determinants	6
	To strengthen health systems and equitable access	2, 16. 22
	To take advantage of knowledge, science and technology	13,14,18,19
	Governance, leadership and responsibility of the sector	3,5,17,21
PAHO	To strengthen the national sanitary authority	1, 2, 3, 4, 16, 21
	To address health determinants	6, 12
	To take advantage of knowledge, science and technology	14, 19
	To strengthen solidarity and health security	9, 10, 11
	To reduce health inequalities between and within countries	7
	To reduce the risks and burden of diseases	15
	Social protection and access to health services	20
	Management and development of health personnel	5, 13, 17

PRIORITIES		
OTHER AGENCIES		**HEALTH SECTOR**
WORLD BANK	Greater autonomy and authority to manage resources	1, 21
	Management commitment with measurable results	3, 4, 5
	Planning and management for performance	21
	Financing aimed at the improvement of performance	3
	Strong monitoring and evaluation systems	5
	To strengthen and professionalize managerial capacity	21
IDB	Assistance to the poor, social inclusion and equity	2
	To increase efficiency and achieve strategic objectives	3
	To improve effectiveness of the system and services	2
	Inter-sector approach of health problems	6