PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

38th SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 24-26 March 2004

Provisional Agenda Item 5

SPP38/4 (Eng.)
18 February 2004
ORIGINAL: ENGLISH

MILLENNIUM DEVELOPMENT GOALS AND HEALTH TARGETS

The Millennium Development Goals (MDGs) reflect the outcomes of decades of consensus building within the United Nations system and of UN world summits and global conferences. The present set of MDGs consists of 8 broad goals, 18 targets, and 48 indicators (see Annex). The MDGs have brought the investment in people's health to the very center of the new global development agenda. PAHO will utilize this momentum as an additional entry point to put health high on the political agenda of countries, subregional bodies, and regional organizations and to strengthen cooperation with new partners. The PAHO strategy assigns a very high relevance to Goal 8 on partnerships in all its dimensions.

The MDGs are a part of PAHO's commitment to measurable health goals and targets, a motor for democracy and multidimensional governance at country level, and an integral part of PAHO reform and strategic priorities including national health development and social protection. Of prime importance is their focus on equity between and within countries. The Organization is presently engaged in a significant effort to integrate the MDGs into its program of work at regional and country levels and eight overarching strategic goals have been identified. A working group has been established which brings together designated MDG focal points throughout PAHO for the implementation of the MDG strategy.

The year 2004 constitutes the halfway point to the challenging deadline of 2015 for the achievement of the MDGs. This paper raises some of the key strategic issues that arise and requests input from the Subcommittee on Planning and Programming as to the direction of this effort.

CONTENTS

Page

Millennium Development Goals (MDGs): a Focused Common Agenda

1. The Millennium Development Goals reflect the outcomes of decades of consensus building within the United Nations system and of UN world summits and global conferences, starting with sectoral initiatives such as Health for All in 1978 and the first Children's Summit in 1990. Through the Millennium Declaration adopted by 189 countries in 2000 and the outcomes of the Monterrey Summit for the Financing of Development in 2002, the international community reconfirmed agreements reached at earlier UN summits but has reinforced them through the 2015 deadline. These agreements focus on poverty reduction, a setting of clear priorities, and a commitment to partnership between the developed and the developing countries through the important addition of Goal 8 of the MDGs. The present set of MDGs consists of 8 broad goals, 18 targets and 48 indicators (see Annex). Many international organizations and donor agencies have since refocused their programs of work towards the achievement of the MDGs.

2. None of the goals are new and for all of them a broad body of knowledge and interventions exist—with perhaps the exception of some of the challenges raised by Goal 8 on partnerships. But the key challenge of the MDGs is not technical but political: for the first time in history, the global community has given itself such a focused common agenda and has called on governments, civil society, the private sector, and international organizations to give priority to poverty reduction and to reduce the inequalities in access to key determining factors of development. This gives a new sense of urgency and a frame that goes beyond the sectoral lens through which issues such as education, health, or the environment are usually approached. Within the context of the MDG framework, they are understood as key investment areas for poverty reduction and human development.

3. The key challenge of the MDGs lies with progress on MDG 1—halving poverty and hunger by 2015—because many other goals depend on economic growth and reduction of inequalities. The Region of the Americas is already one of the most unequal in the world; a recent Economic Commission for Latin America and the Caribbean/United Nations Development Program (ECLAC/UNDP) report[1] shows that the number of poor people in the Region is increasing. Simulation models on 18 countries of Latin America and the Caribbean (LAC) indicate that if present trends were to continue only 7 of the 18 countries would reach the objectives of reduction of the poverty in 2015. These countries are: Argentina (before the crises), Chile, Colombia, Dominican Republic, Honduras, Panama, and Uruguay. A second group of six countries would continue to reduce the incidence of extreme poverty but at a very slow rate. These countries are: Brazil, Costa Rica, El Salvador, Guatemala, Mexico, and Nicaragua. The other five countries—Bolivia, Ecuador, Paraguay, Peru, and Venezuela—would see an increase in

[1] ECLAC, IPEA, UNDP, *Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean*, 2002, Libros del CEPAL No. 70.

the levels of extreme poverty due to the increase of inequity and the decline of the per capita income, or both.[2]

4. Strengthening the commitment to the MDGs in the Region of the Americas is still a challenge—very few countries have fully integrated the MDGs into their policy process. This was addressed at the recent high-level conference in Brasília on 17 November 2003, which brought together political leaders and representatives of regional organizations from throughout the Americas and highlighted the importance of achieving a political consensus for the implementation of the MDGs in the Americas. It reinforced the partnership principle inherent in the MDGs and spelled out the responsibilities of governments, legislators, civil society, and the international community. Its call to action[3] is reinforced by the fact that a recent analysis suggests that no country in LAC will likely reach all of the MDG targets. Indeed the greatest challenge for the LAC countries lies within the health arena as presently none seem set to reach the ambitious targets for infant and maternal mortality. There is therefore a significant role and scope for joint action by Member States and PAHO—with the support of other partners at country level.

5. The MDGs have brought the investment in people's health to the very center of the new global development agenda. Three of the eight MDGs explicitly refer to health issues—reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. Seven of the 18 targets are directly related to the responsibility of the health sector—Goal 2 malnutrition, Goal 5 child mortality, Goal 6 maternal mortality, Goal 7 HIV/AIDS, Goal 8 malaria and other infectious diseases, Goal 10 safe drinking water, and Goal 17 essential drugs. This high priority assigned to health underlines the new consensus that health is not only an outcome of increased development but lies at its core. The MDG framework underlines the synergy between the eight goals; indeed they are presented as an indivisible package. For PAHO/WHO and its Member States such an approach reinforces the Health for All and primary health care strategy, which also places health at the center of economic and social development. The MDGs therefore provide the public health community with an invaluable entry point to politics and economics.

6. PAHO is presently engaged in a significant effort to integrate the MDGs into its program of work at regional and country levels in order to strengthen the support to countries in the achievement of the MDGs. Eight overarching strategic goals have been identified:

---

[2] *Ibidem* footnote 1 page 3.

[3] IADB, UNDP, Government of Brasil, CEPAL, World Bank, *Brasilia Declaration: Proposal for Implementing the Millennium Development Goals*, November 17, 2003.

- Increase awareness of and investment in the health priorities set by the MDGs through a wide range of policy dialogues, partnerships, and intersectoral action.
- Intensify action on national health development in public health, primary health care, and health promotion, ensuring social protection in health particularly at regional and local levels to support MDG progress.
- Integrate the work on MDGs with the initiatives on health goals and targets and outcome-oriented health policies in the Americas.
- Increase health literacy and empowerment of communities through a strong civil society involvement to reach the MDGs.
- Improve measurement of progress through high quality disaggregated health data at regional, subregional, and country levels.
- Initiate research to strengthen the evidence base and generate new knowledge, in particular relating to synergies for health and development with a focus on Goal 8.
- Integrate the strategic dimensions of the work on MDGs with other strategic efforts such as the Commission on Macroeconomics and Health and the identification of global and regional public goods.
- Engage and increase cooperation with other partners—particularly at the country level—to obtain results.

7. This will allow the strategy to interface three approaches: an issue-and-priority group approach related to the specific MDG targets that have been set; a national health development approach; and an implementation approach that strengthens intersectoral action and involves civil society. Partnerships of a broad and diverse nature will be essential to these strategic directions. Close collaboration between Headquarters and country offices will be an essential component.

8. This paper raises some of the key strategic issues that arise from such a focus and reorientation and requests input from the SPP as to the direction of this effort.

MDG Policy Context and Implications for PAHO's Approach

9. When addressing the health MDGs in particular, it is essential to keep in mind a larger policy context. The year 2004 constitutes the halfway point of the challenging deadline of 2015. Only if collective efforts at national and international levels are intensified will countries be able to fulfill the MDG commitments and goals. This is due not only to lack of good governance or insufficient development aid. The world still grapples with economic restructuring in the face of globalization. For example, more than

50 nations worldwide grew poorer over the past decade and a number of countries in the Region of the Americas are facing significant economic decline or reduced growth.

10. In the face of global uncertainties the Millennium Development Compact has proposed to apply a new principle: rather than allowing the present level of resources to set the pace of development, governments of rich and poor countries, as well as international institutions, should start by asking what resources are needed to meet the MDGs. Most estimates point to a figure of at least US$ 50 billion annually in additional aid or a doubling of current aid levels. At present the international community has committed to increase aid volumes by about $16 billion annually. Similar calculations have been undertaken by the Macroeconomic Commission for Health at a global level. Increasingly these analyses are being taken to the country level in order to assess the country's absorptive capacity and the potential of scaling up interventions.

11. There is significant concern about the shift of overseas development assistance (ODA) away from the Region of the Americas. A recent analysis of the development committee of the International Monetary Fund and the World Bank[4] shows clearly that even modest increments of ODA could play a significant role in helping lower middle income countries, such as Guatemala or Peru, progress more rapidly towards reaching the MDGs. Bolivia is quoted as a country that has progressed rapidly towards several MDGs but still needs to do much on health. For example, the achievement of the health MDGs will require sustained increases in the share of public expenditures in the health sector—the cost estimate provided by the report lies at $160 million a year.

12. For upper middle income countries, this report argues that while the bulk of resources to reach the MDGs must come from domestic sources, ODA should complement and support clearly expressed national policies that address social exclusion and focus on particular regions, issues, or population groups. In the Americas, this applies to countries, such as Brazil and Mexico, where large regional differences prevail and inequalities are frequently linked to a complex history of social exclusion of indigenous groups. Positive examples such as the effort undertaken by the state of Veracruz, Mexico, in addressing inequalities in health and education can serve as guidance in other areas and merit additional support from donors to achieve the MDGs. Indeed this highlights—especially for large countries—the need for ODA to support action at the subnational level, i.e. regional governments or municipalities that commit themselves to addressing the MDGs.

13. But the concern for many countries in the Americas lies only partly in an increase of development aid, but much more significantly in the key areas that are addressed in Goal 8, in particular the access to global markets and new technologies. This is an aspect that needs to be underscored in order to strengthen the political commitment to the

[4] IMF and World Bank, *Achieving the MDGs and Related Outcomes: A Framework for Monitoring Policies and Actions*, March 26, 2003, No. DC2003-0003.

MDGs in the Region of the Americas. The MDGs matter to all countries and all regions of the world, not just to the poorest—we must not repeat the misunderstandings that hindered the implementation of the Alma Ata Declaration, which was interpreted by some to be of relevance only to the poor countries—at its worst, poor care for poor people. And given that the LAC region is defined by some of the highest social inequalities in the world, it is essential that its middle income countries address inequities and gaps in development which in turn frequently find their starkest expression in health inequalities.

14. Indeed the very fact that solutions exist but are not accessible to the poorest is one of the key driving forces of the MDG agenda and needs a special PAHO effort to create a truly concerted approach that recognizes health as a regional public good. A reorientation in policy and strategy which complements the technical solutions will need to be developed by the Organization. This will have implications for PAHO's work at the country level in support of the ministries of health, by working with other organizations and stakeholders to create the massive political and financial commitment that is needed at country level.

15. Within such a policy context, the PAHO MDG strategy will be based on two key premises:

(a) Within its approved program of work, PAHO understands the MDGs as an additional entry point to strengthen investment in health and put health high on the political agenda of countries, subregional bodies, and regional organizations. While the MDGs have a strong technical component and fit naturally into the technical work already done within the Organization, their key intention is to create a sense of urgency, political commitment, and accountability within a new strategic vision for development and cooperation between countries. In health they break new ground precisely by moving technical issues—such as maternal and child health and infectious disease control—to a new political level for countries (by having been adopted by heads of state), for donors (by moving beyond an exclusive focus on aid), and for regional bodies and international organizations. Because of this the MDGs also provide new opportunities for PAHO to work on a common agenda with multiple partners—both at the regional and country levels.

(b) The PAHO strategy assigns a very high relevance to Goal 8 in all its dimensions, including the special needs of landlocked countries and small-island developing states. Over the last decade, countries in the Region have been exposed to increasing social and economic risks in the context of globalization, which in turn have led to political instability and civil strife in a number of countries. Therefore the role of PAHO will imply not only the monitoring of the progress achieved on

the respective health goals and targets but also a systematic analysis of the larger contextual and policy determinants—trade agreements, economic policies, immigration policies, etc.—and their impact on health. PAHO's work on the central role of establishing reliable systems of social protection in the Region thus gains new importance.

MDGs As Part of PAHO's Commitment to Measurable Health Goals and Targets

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

Equity and social justice through quality of social protection;
outcome through feasible objectives and standards of excellence;
accountability and transparency through common indicators;
efficiency through synergy, collaboration, and partnerships.

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

18. Having for the first time a set of clearly identifiable health goals at the global level which are part of an overall development strategy and have been endorsed by heads of state not as a sectoral strategy of a health ministry but as a commitment to poverty reduction and sustainable development is of great value for the health sector. This is an acknowledgment of the understanding of health as a key factor for social and economic

development and provides inroads to finance, planning, and development ministries. For the poorer countries in the Region, the health MDGs—which have overall government commitment and will be an integral part of any country strategy to address the MDGs—will also provide an invaluable entry point to get health on the agenda of economic and social development strategies, and loan and donor negotiations. In consequence this means that the strategies and approaches of the health sector and of health organizations such as PAHO need to be adjusted accordingly. The MDGs challenge public health to engage in economics and politics at the same time it deploys science and medicine.

19. Placing the MDGs in the broader context, developing intersectoral national health goals and targets is a necessary prerequisite for a meaningful translation of the MDGs within a LAC context. This is essential since in the Americas the MDGs are not being introduced into a void but a policy-rich environment. In recent decades the Region has experienced a sequence of health reforms which in some countries have weakened public health systems and reduced access to health services. The difficulty in meeting some of the health MDGs reflects this clearly. Population health is stagnant if not decreasing in some countries and there is a clear danger of a reduction in adult mortality if present economic downward trends continue. For the better-off countries in the Region who have reached the MDG averages, the development of broader health goals and targets can integrate the MDGs with setting targets with special reference to disadvantaged groups and regions—and provide an incentive to set more ambitious goals in population health with a focus on equity. A study by the World Bank[5] suggests that a strategy directed towards disadvantaged groups would make it possible to meet the health-related MDGs while generating complementary benefits in terms of distributive equity. A case study developed by PAHO indicates a similar potential. An ECLAC study indicates that the MDG poverty reduction targets are only feasible if countries succeed in becoming both progressively richer and less unequal, for example, through the combination of a GDP annual growth rate of 3% and cumulative reductions in inequality of about 4%[6].

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

---

[5] Gwatkin, Davidson R., *Who Would Gain most from Efforts to Reach the Millennium Development Goals for Health,* in Health, Nutrition and Population, World Bank, December 2002).

[6] Ibidem footnote 1 page 3.

MDGs: A Motor for Democracy and Multidimensional Governance

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

22. Health plays a key role in making the MDGs tangible for communities as households and individuals experience very directly how the lack of action on one set of the MDGs—for example, poverty reduction or gender equity—is reflected in poor health outcomes. Communities also experience how the lack of investment in primary health care and the public health infrastructure holds them back from being able to ensure their livelihood. Here we find one of the key challenges of the health MDGs and targets: the improvement of health outcomes will depend significantly on a mix of strategies and the synergy that develops between them—the improvement of the public health and health services infrastructure in terms of access, quality, and efficiency; significant changes in the attitudes and behavior of communities, professionals, and policy-makers; and finally practically all other policy arenas touched upon by the MDGs. The reduction of maternal mortality will depend on concerted action that includes women's education, good roads, access to emergency obstetric care, and changed community values.

23. One of the key challenges to the health sector and to PAHO will be to find the inroads to ensure credibility with communities and to build new confidence in public institutions. The PAHO MDG effort needs to put particular focus on working with parliamentarians and regional, local, and community leaders in order to reach the poorest communities in the Region. It should also provide the Organization with a platform to work in new ways with the private sector and with civil society including professional organizations, such as the public health organizations of the Region. The action on the MDGs must work towards a reinforced commitment of the countries of the Americas to

the principle that is a hallmark of democracies—that they do not exclude citizens from access to health services independently of their ability to pay.

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

24. The MDGs clearly fit as an integral part of PAHO's renewal and strategic priorities that highlight the following objectives:

- Address determinants,
- Protect health as a public good and human right,
- Create a synergy of actors,
- Ensure fairness of distribution.

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

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

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

28. Additional aid has the most beneficial effect if it flows towards clearly set priority areas at the country level—highlighting the need for sound domestic health policies and improved governance mechanisms, including national health goals and targets. This means that development aid will need to move increasingly from project funding to a

focus on up-front costs that help establish sound policies and governance as well as capacity building and that reinforce national efforts to address poverty and inequalities within a broader policy framework. The process of implementing the MDGs therefore also supports countries in addressing a set of major gaps that are part of health policy development:

- the operational gap in building efficient and sustainable public health systems and responses;
- the governance gap in involving wide segments of government and society in a truly intersectoral and participatory effort;
- the equity gap in addressing the health needs of the poorest.

Focusing on Equity: Priority Countries and Populations

29. PAHO has defined a group of five priority countries for concentrating efforts of technical cooperation during the coming five years. These are: Bolivia, Honduras, Nicaragua, Guyana—all 'Poverty Reduction Strategy Papers' (PRSP/World Bank) countries—and Haiti. Of these countries, a recent ECLAC analysis shows that Bolivia will probably see increases in inequity and Nicaragua will make slower progress in reduction of poverty than desired. A combination of PAHO, PRSP, and ECLAC socioeconomic analysis leads to the following set of priority countries for the MDG process: Bolivia, Ecuador, Guyana, Haiti, Honduras, Nicaragua, Paraguay, Peru, and Venezuela.

30. But of course a country focus alone is not sufficient since many of the health inequalities faced in the Region of the Americas are based on geography, ethnic origin, gender, and socioeconomic status. It is crucial to address the key pockets of poverty in a region with the highest inequality in the world. These huge disparities will not be resolved by aggregate economic growth alone but will require systematic interventions to create more equity—for example, in access to health. Findings consistently show that even very small reductions in inequality can have very large impacts on poverty reduction. This criterion makes it necessary to link the PAHO MDG strategy to, for example, the rural poor in neglected regions, urban marginal groups (such as young people without work), or female-headed households. Examples are the Pacific Coast of Colombia, the Atlantic Coast of Honduras, or the Brazilian Northeast. The fact that these depressed areas are often also border areas means that any strategy will need to build on bilateral coordination.

31. The unevenness of development in the Americas will require the MDG process to develop focused strategies for specific groups that address both what has been called the "new poverty," and groups that historically have been excluded—the case of the indigenous and afro-descendent ethnic groups in the Region.

Ensuring an Integrative Approach to the MDGs

32. Such a perspective highlights the need to link the work on the MDGs clearly to PAHO's work on health systems, essential public health functions, and human resources development. PAHO will concentrate in particular on supporting countries in developing an integrated approach to the MDGs, building on its work not only in the respective program areas, such as maternal and child health or infectious diseases, but will integrate this work with its efforts in health systems development and social protection. The focus will be the synergy needed between the different health dimensions that are addressed in the goals and the different levels of sectoral responsibility. A series of working groups have already been established to allow for this interface, including the links to the 3 by 5 strategy.

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

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

35. PAHO will also take a lead role in discussions with donors on the new principles that are emerging for development assistance. A much higher percentage of aid will need to be provided in a form that can finance the incremental costs of achieving the MDGs. Aid will need to be timely and predictable in order to initiate and sustain reforms. Donors need to accept country priorities for national goals and targets, move from project

funding to direct funding and grants where appropriate, and show willingness to meet increased concurrent costs of health programs through budget- or sectorwide support or funding of well designed sectoral programs.

Next Steps

36. A group—the MDG action team—is being established within PAHO which brings together designated MDG focal points throughout PAHO for each of the directly health relevant targets, as well as an MDG focal point for monitoring, communication, and global partnerships. This group will also include five focal points representing key systems issues: social protection in health, public health, primary health care, health promotion, and environmental health. The task of this group is to get concrete programs under way in order to support countries in their effort to reach the MDGs in the Americas. This can mean both a reorientation and a reorganization of work of technical units, the development of special partnerships to reach the goals, a different time allocation in order to support the MDG process at the regional, subregional, and country levels, and the creation of response teams. Its task is to follow the strategic priorities as set by the Director of PAHO and the challenge by the Director-General of WHO. In many cases, it will mean increased creativity and no more business as usual. The MDG action team will meet regularly to discuss strategies and approaches and progress and to ensure the integration of the action proposals into the program budget. It will allow for work on the MDGs to be coordinated in-house and with country offices and to search for synergies. It will also ensure that all three pillars of the MDG work are taken into account:

- Technical
- Policy advocacy
- Social mobilization.

37. A range of individuals, units, and programs within Headquarters and the country offices will be encouraged to contribute to the MDGs and adjust their programs accordingly. They can also be important strategic partners for some of the priority targets, for example, the healthy municipalities program, the local and urban development program (see Target 11 in relation to slum dwellers), or the gender and health program. As many programs as possible will need to have the attainment of the MDGs as part of their program vision and strategy and to liaise with others. PAHO will need to move from program initiatives to synergistic MDG initiatives that have a high recognition value and can be monitored and evaluated for impact. High priority will be given to the activities in maternal and child health and HIV/AIDS.

38. Some proposals that have been put forward are to:

- Create a high-level intellectual forum/policy advisory group that will advise PAHO on its MDG strategy.

- Engage parliamentarians and civil society throughout the Americas Region in a dialogue on the centrality of the health goals for the achievement of MDGs due to their high synergistic effect.

- Create a special working party of the priority countries for developing the MDG action zones.

- Engage in an intensive dialogue between ministries of health and ministries of education on synergies to reach the MDGs for a high-level intersectoral policy initiative to strengthen school health initiatives throughout the Region.

- Make a concerted effort to increase the health literacy of the poorest communities with a focus on MDG priority areas, with strong links to Goal 2 (education) and Goal 3 (women's empowerment).

- Undertake the initiative on accountability for health in the Americas, whose goal it is to apply and improve PAHO monitoring and information systems and use innovations such as GIS for mapping the progress achieved. Links of course exist to the national health accounts project as well. Such an initiative would include not only measuring health progress with regard to the MDGs but also monitoring the support and partnership developments outlined in Goal 8, which calls for increasing resource shifts from north to south and increasing donor coordination at country and local levels.

- Pursue municipal action plans for MDGs goal to involve the many health municipalities throughout the Americas in a strong MDG initiative with a special focus on the poorest communities.

- Achieve the context conferences goal to strengthen PAHO's intellectual and strategic leadership role—for example, in areas such as health and security, health and trade, health and democracy, etc.

39. In summary, action for PAHO implies:

- Ensuring the integration of the MDG process on the overall strategic direction of PAHO and HFA;

- Providing expert assistance to countries;
- Identifying key obstacles and sharing solutions;
- Monitoring progress at global and regional levels and ensuring the high quality of data;
- Engaging actors at all levels for the MDG process;
- Mobilizing resources.

Action by the Subcommittee on Planning and Programming

40. The Subcommittee on Planning and Programming is requested to provide comments and suggestions regarding this paper so PAHO's work in this field can be further refined.

Annex

Millennium Development Goals (MDGs)

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

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

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

[a] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

[b] Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. The contraceptive prevalence rate is also useful in tracking progress in other health, gender and poverty goals. Because the condom use rate is only measured amongst women in union, it will be supplemented by an indicator on condom use in high risk situations. These indicators will be augmented with an indicator of knowledge and misconceptions regarding HIV/AIDS by 15-24 year-olds (UNICEF – WHO).

[c] To be measured by the ratio of proportion of orphans to non-orphans aged 10-14 who are attending school.

[d] Prevention to be measured by the % of under 5s sleeping under insecticide treated bednets; treatment to be measured by % of under 5s who are appropriately treated.

[e] OECD and WTO are collecting data that will be available from 2001 onwards.

[f] An improved measure of the target is under development by ILO for future years.