People's Health Movement

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WASHINGTON DC – SEPTEMBER 28TH SEPTEMBER 2014

OPEN LETTER TO THE DISTINGUISHED DELEGATES OF THE
53RD DIRECTING COUNCIL/66TH SESSION OF THE REGIONAL COMMITTEE OF THE PAN AMERICAN HEALTH ORGANIZATION

Distinguished delegates,

On behalf of the People's Health Movement (PHM) we submit the comments and suggestions included below regarding some of the items appearing on the agenda of the 53rd Directing Council of PAHO/66th Meeting of the Regional Committee of WHO for the Americas. We hope that you may find time to read and consider these comments before the relevant discussions. We hope that you find our input useful.

PHM is a global network of organizations working locally, nationally and globally for "Health for All". Our core platform is articulated in the People's Charter for Health which was adopted at the first People's Health Assembly in December 2000. More information about PHM can be found at www.phmovement.org. PHM's activity at this convening of PAHO member states is part of its Initiative for Democratising Global Health Governance which focuses currently on WHO-watch.

The following commentary was developed, through a process of consultation at national and regional levels, in response to issues that PHM country circles in the Americas viewed as particularly important in the region. We invite you to review the commentary and hope that it will further inform work in these areas.

Members of the PHM group will be attending and following the discussion at the meeting this week. We would be very interested to discuss these comments with you.

Please don't hesitate to contact us through Ms. Susana Barria <sbarria@phmovement.org>.

Warm regards,

ALAMES-Colombia
ALAMES-Ecuador
ALAMES-Mexico
PHM-Andean Region
PHM-Brazil
PHM-Mesoamerica
PHM-North America
PHM-Southern Cone

PHM Comments on Agenda Items of the 53rd Directing Council

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Agenda Item 4.3 Strategy for Universal Health Care

In focus

The Directing Council will consider a resolution recommended by the Executive Committee (in CE154.R17) which would adopt the proposed Strategy for Universal Health Coverage (UHC) and recommend a series of actions by PAHO member states and by the regional director.

The proposed Strategy to be presented to the DC is available in CD53/5 Rev.1. The original version of the draft Strategy which was considered by the EC is available in CE154/12.

Background

WHO has been promoting the concept of UHC since the World Health Report of 2010. The WHA adopted Resolution 64.9 in May 2011. In 2012 the document titled Health systems financing: the path to UHC: Plan of Action was adopted. See update report by Secretariat to the WHA in May 2013 in A66/24.

The draft PAHO Strategy was considered by the PAHO Executive Committee in CE154/12 and the EC recommended (CE154.R17) that the Strategy be adopted. This draft strategy will be considered by DC53.

PHM comment

PHM welcomes the discussion on strengthening of health systems in the Region as part of the discussions on universal access to health and universal health coverage. PHM considers these issues are closely related and interdependent. PHM welcomes the strong focus of the paper on equity and on social determination of health.

PHM welcomes the removal of the explicit reference to a 'universal package of services' as a central component of UHC, which was contained in earlier papers. However, the reference to the need for an effective use of resources (Para 5) leaves the door open for bringing back limitations to the extent of health services provided under UHC.

We welcome the emphasis in the paper for an increase in government funding of health care and its critique of user charges (Para 21). Also welcome is the reference to the risk of impoverishment as a result of poor access to health care. However, while the paper appears to recommend a 'single payer system' and a single prepaid pool with capacity for transfers from rich to poor, this is not absolutely explicit. WHO has refrained from providing advice around the institutional mechanisms through which universal coverage is to be achieved. At the centre of this absence of a clear position, is the debate between advocates of publicly funded and publicly delivered health care and the stratified public-private model supported by the World Bank and USAID.

Evidence, including results of studies from the Region of the Americas, shows that public health systems (publicly financed and provided health care), as opposed to private health systems (which develop through individual insurance systems with participation of private insurance providers and service providers), are clearly better suited to provide comprehensive, equitable, appropriate, timely, and quality health services. This results in systems that positively influence social determinants of health (Municipal Services Project, Chile and Costa Rica: Different roads to universal health in Latin America, 2014).

Given this evidence, PHM does not support a UHC model based on private service delivery, and believes that a rapid transition to a model of this type may be a route to dismantling public health services.

Para 51 stresses the need to "increase and optimize public financing for health" as a "necessary condition for reducing inequities within the framework of universal access to health," but it does not identify the role of private sector in weakening the system's financial sustainability. Solidarity and redistribution of funds without regulation of the private sector will lead to these funds contributing to the strengthening of a profit-oriented private sector. The proposal for a common public fund could be an option, provided it is government run and regulated, with very strong social oversight and allocated to implementation of a universal public health system and not to private insurance mechanisms. This would lead to restoring people's right to health, where individuals do not have to pay for service provision, given that they contribute through their taxes according to their economic capacity and receive healthcare services according to their needs.

Para 47 talks about the role of "all the sectors", an oblique reference to the private sector, in the context of the need for regulation to ensure various important objectives, but there is no discussion of the challenges of regulating the private sector, as a pre-condition to harnessing it within an unified system. The private sector is part of the health sector in almost all countries and the human and institutional resources located in it should be harnessed within a single health system. However, it is common, especially in highly unequal societies, for the private sector to primarily service the healthcare needs of the rich, usually supported by private or workplace-linked insurance plans. The culture of the private sector, in such circumstances, is usually resistant to meaningful accountability and to any significant redistributive initiatives. It also contributes to creating an understanding of health-care as a commodity to be bought and sold, and negates the understanding of health as a human right. Therefore, the emphasis should be on strengthening the capacity of the public sector, instead of the participation of all sectors in the provision of health services.

While 'comprehensive' access should be the goal of a universal system, the strategies outlined in the paper are limited to a minimal set of benefits that 'will expand according to the capacity of the country'. Such an approach would clearly lead to the promotion of a few 'selective' interventions – a strategy that has been at the root of the segmentation of our health systems. Additionally, while health is defined as a right in the introduction and general considerations, the strategies emphasize efficiency of resource use over their redistribution. Inequities based on gender, ethnicity, and socioeconomic status cannot be treated as a 'given'. It is not enough to palliate such inequities through provision of healthcare services, a comprehensive vision should also include means to prevent such inequities. Given the multiethnic and multicultural population of the Americas, equal access to health can only be achieved through a single system that includes policies that address the demands and needs of the diverse ethnic and racial groups -- such as indigenous peoples, river dwellers, forest peoples, quilombola communities, gypsy communities, and others. Fiscal policies to promote health must include redistribution of resources to address the causes of inequities, including progressive taxation systems.

Mechanisms for civil society participation in the health area are important. The paper refers to "the highly participatory process that resulted in the drafting of this strategy document" (Para 20). It is important to note that, in the case of Ecuador, for example, the consultation process was held in an event closed to the public and civil society, funded by the Ministry and which primarily involved local health authorities. It is important to ensure that consultations enable true civil society participation and that existing mechanisms for participation are implemented.

In general, the paper accurately identifies several important challenges, but fails to identify key causes of the rise of these challenges. For example, while it recognizes the challenge of access to medicines, including issues related to generic medicines use, quality, safety, and affordability (Paras 29, 39, 50), it fails to identify barriers to access. It does not, for example, mention the role of free trade agreements in reducing the capacity of the Region's countries to use the TRIPS Agreement's public health flexibilities and safeguards. It is important to recollect the case involving the seizure in the Netherlands of generic medicines, en route from India to Brazil. , as part of a U.S. strategy to deliberately create confusion between generic medicines and counterfeit products.. Free trade agreements contain provisions for customs control that seek to protect intellectual property rights, and have a direct impact on access to medicines.

Finally, the right to health is a fundamental human right (Alma Ata Declaration 1978). This means that governments have a responsibility to their citizens to ensure the realization of this right. The paper mentions health as a right, but not as a human right. The Alma Ata Declaration made it clear more than three decades ago, and it remains valid today, that "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures."

Agenda Item 4.5 Plan of Action on Disabilities and Rehabilitation

In focus:

The Directing Council is asked to review the Plan of Action on Disabilities and Rehabilitation (CD53/7) and consider approving the resolution contained in annex A in the same document.

PHM comment

The Action Plan on Disabilities and Rehabilitation reflects several different conceptual frameworks. The International Classification of Functioning, Disability and Health provides the biological framework, the Model of Community-Based Rehabilitation provides the service model, and the Social Determinants (SD) model provides the social model.

The first two models are congruent with a critical health analysis; the third model reflects a capitalist version of the Social Determination of Health (SDH) model. Within the SDH model, biological events are determined by social context. This means that care and support for individuals with disabilities or those requiring rehabilitation are limited by the neoliberal political and economic policies of current Latin American governments (with a few notable exceptions).

If we set aside our above-mentioned concerns about the Action Plan's principles and axes, and if we (uncritically) accept its methodology, the question remains: How will the Action Plan be implemented in practice? What is the overall strategy? Where are the objectives and indicators? For example, one of the principles of this Action Plan is to care for the caregivers. But, once mentioned, this goal disappears from the Plan. Further, the discussion of horizontal approaches reduces the question of gender to a matter of merely using census data to quantify the number of persons in each gender with a disability.

No consideration is given to the particular place of individuals with disabilities with respect to the right to health. The conceptualization of health is limited to access, and universality is mentioned only as a question of horizontal access. The discussion of social participation and intersectorial work open the door to the privatization of health services. We have seen corporations take advantage of persons with disabilities. For example, the Mexican television chain Televisa has collected millions of pesos to support its Teletón rehabilitation centers. This money is tax-free and unaudited. The Mexican income tax law allows Televisa to deduct these expenses. This means Televisa gets a lot of publicity and can deduct the cost from its taxes. Apart from these financial considerations, Teletóns have served the political interests of local governments. Public funds are used to create and support Teleton rehabilitation centers, leaving public centers with less money and support.

Proposal

PHM calls on the Directing Council to endorse the recommendations of the World Report on Disabilities and support their implementation.

The decision to support the resolution will contribute to progressive realization of the rights enshrined in the United Nations Convention on the Rights of People with Disabilities. Most significantly, this would pave the way for a post-2015 development agenda inclusive of disabilities.

PHM supports all of the recommendations related to the International Classification of Functioning, Disability, and Health as well as the model of rehabilitation based in the community.

PHM requests that all of the cross-cutting principles and approaches in the proposed plan are explicitly included in the strategies, objectives and indicators.

Agenda Item 4.6 Plan of Action on Mental Health

In focus

The Directing Council is requested to review the Plan of Action on Mental Health (CD53/8) and consider approving the resolution contained in annex-1 in the same document

Background

In 2013, the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013-2020 (WHO Comprehensive Mental Health Action Plan, PHM commentary). That same year the Directing Council of PAHO adopted its strategic plan 2014-2019. During this current meeting the Directing Council will be reviewing the Mental Health Action Plan, adopted in 2009, in order to update it and align it with the strategic plan of PAHO and the WHO's Comprehensive Action Plan on Mental Health.

During this meeting the Directing Council is asked to review the Plan of Action on Mental Health, which includes a draft resolution, providing pertinent observations and recommendations (para. 55).

PHM comemnt

PHM welcomes the implementation of the Comprehensive Action Plan on Mental Health (2013-2020) and its alignment with the PAHO Strategic Plan. Document CD53/8 takes into account, to some extent, the social determinants of health, such as cultural and socioeconomic contexts, which contribute to the increase in mental health problems.

However, the current document presents a plan based on a reductionist biomedical model that promotes neither comprehensive mental health nor the prevention of mental disorders. This vision promotes the development of biomedical-positivist research which aims to medicalize mental disorders, to be diagnosed by psychiatrists who may be unaware of the subjective singularities of human beings. It would contribute to a market-based approach at the expense of the health of human beings.

Regarding the definition of mental health by the WHO

Paragraph three employs a definition of mental health that depicts WHO's western perspective and understanding of mental health. It is important to take into account that there exists a definition of health and a conception of medical-health that is of a dualistic conception. This method of reasoning from evidence-based science, the Cartesian split, separates body and mind.

The document reflects a reductionist view, where mental health involves determining health and disease from the perspective of psychiatry. This is reflected in the large expenditure on hospitals and medicines that are designed to confront mental illness as an anatomical and physiological issue only. The definition should be expanded to take into account other rationales and conceptions of health models and health systems that are present in the world, such as the view of indigenous peoples where notions such as "balance," harmony" and "good living" are incorporated.

Regarding the strategic lines of action

The strategic lines of action mention important pathways to address mental health, aiming to close treatment gaps -- such as integrating mental health into general health service as well as increasing "access to services as part of a universal coverage policy". However, this does not sufficiently address the broader social and structural determinants of mental health.

The "ethnicity perspective" and "intercultural approach" in mental health services (para. 27) should not be limited to staff simply knowing and respecting different cultural beliefs. A deep intercultural and non-racist perspective must also take into account the different models of care in societies of the region. Models of care that indigenous peoples and indigenous therapists provide use different therapeutic resources to address such problems and offer the choice of a more culturally relevant care that provides therapeutic alternatives to which people belonging to these groups should have access by right.

We must also address emotional displays that are considered "normal" (grief, anxiety) as well as problematic or dysfunctional behaviors (violence, drug addiction) that develop in emergency situations. This includes an approach that

includes prevention, care, treatment and rehabilitation of these problems. With this in mind, we must take into account the role of the community – "community mental health". Changing the model's focus from psychiatric hospitals to a community mental health model requires a conceptual change and a redefinition of the problem beyond a health-psychiatric model.

Strategic line of action, number two, calls for the continued work of restructuring mental health services (para 33). Considering that mental health is part of the multiple dimensions of health, the increase in decentralization of mental health services and expanding coverage at the community level will happen only through horizontalization in politics and mental health priorities at the different levels of care, especially at the primary level.

Proposal

To achieve horizontality at the primary level of care, it is necessary to instruct primary health care teams to incorporate risk assessment, identification of mental health problems, and approaches to addressing these problems in a comprehensive manner. Specific mental health services should not be separate from other primary care services. Any service, categorized as primary care, should provide comprehensive care including the mental health component. This proposal, in addition to supporting greater integration of care, could also be more financially viable.

Along these lines, the People's Health Movement recommends that countries commit themselves to include not only the focus on mental health in health services but also develop staff training programs and design guidelines, protocols and tools for effective implementation at the primary care level. Moreover, a comprehensive approach to mental health, in a multiethnic and multicultural context, cannot fail to include the coordination and dialogue with therapists of indigenous peoples and the acknowledgment, by health workers, of their explanatory models and therapeutic resources–especially, the approach that not all mental health problems require a pharmacological approach.

PAHO should consider the multidimensionality of human beings in its approaches to mental health. This means building a new perspective that is cross cutting and integrated in all programs of the organization. These conceptual changes will allow for a more holistic approach (body and mind) to treating mental ill health and should be incorporated as a basic criterion in the plan.

Furthermore, PAHO should expect Member States to do things differently and develop the ability to drive that change, to promote empowerment in the communities and individuals. Communities and individuals should no longer be passive recipients of care and support but become active players in their health.

Also, WHO and PAHO should take into account the social, political, and economic problems generated by inequality of policies of the states. This concept should be integrated into every policy and every action.

Finally, PHM urges member states to ensure that this Action Plan is reflected in the Sustainable Development Goals. Objective 3.4 proposed in the document of the Open Working Group is the only place where the term "mental health" is mentioned. There should be more continuity between the agenda of the SDGs, Post 2015 and the Action Plan on Mental Health of WHO, as well as in regional action plans.

Agenda Item 4.8 Plan of Action on Health in All Policies

In focus

The Directing Council is invited to review the Plan of Action on Health in All Policies (CD53/10, Rev. 1) and consider approving the draft resolution contained in Annex A in the same document.

Background

The Eighth Global Health Promotion Conference was held in Helsinki in June 2013 and focused on intersectoral policy collaboration: Health in All Policies (HiAP). Finland has been a pioneer in this field for many years. PAHO had also been involved in the preparatory work for the Conference.

A follow up resolution was considered by the WHO Executive Board (EB134) in Jan 2014. It is intriguing that the Bureau of the Executive Board had initially determined not to consider the HiAP item but the decision was overturned following a motion from Finland and supporting countries to include it on the agenda (EB134/1 Add.1). The Board also had before it a Secretariat report (EB134/54) and a draft resolution, which after several iterations became (EB134.R8).

The resolution was considered at the 67th WHA in May 2014 and the final resolution "Contributing to social and economic development: sustainable action across sectors to improve health and health equity" adopted.

Following the Helsinki Conference the relevant groups within the Secretariat produced the Framework for Country Action, published in January 2014. The Framework for Country Action formed the basis for the Plan of Action on Health in All Policies scheduled for consideration at the CD53/PAHO66.

PHM comment

The approach of "health in all policies" is a desirable requirement in the formation of public policy generally; however, it seems to come from a false assumption that there is a regional consensus that health and social policies have a greater weight than economic policies.

"Health in all policies" will be possible when there is political will from governments and when civil society understands the importance of watching and comprehensively intervening in this matter–not simply by stating intentions in a declaration.

This Plan connects a collection of initiatives and strategies that have been circulating in recent years, including health in all policies as well as primary health care, social determinants of health, and more recently, universal health coverage. The text mentions all of these. Through focusing on health in policies, it links the others without any theoretical-methodological support, without putting them in a hierarchy, and assuming that these can be interconnected by the simple will of the States.

The proposal's main focus is to combat inequalities in health, which requires that there be a link between the issues of redistribution of wealth and power (as it is well noted in one of the conclusions from the report by the Commission on Social Determinants of Health).

A limiting factor in the Action Plan and its six strategic lines is that its scope is limited to: identifying needs, planning, the creation of structures and mechanisms, and the ability to include the approach of health in public policies. In other words, it discusses the problem from a technical angle only. Although processes and technical tools are useful for the formation of public policies, what defines and guides the formation is ideologically and politically determined. Because of this, the Plan of Action lacks a framework of commitment, political approach, and minimal goals, which the States should commit to in relation to this approach. For example, a policy formed from a point of view of basic packages would compete with the promise to reach universal coverage and should not be an acceptable option to reach such goal. Or, a policy for reducing malnutrition that does not contemplate the sovereignty of nations and only focuses on assisting or on mitigating would be far from an alternate solution.

The majority of the proposed indicators are not conceivable measures of significant progress of an effective action towards equality in health and improvements in the population's health. Consider the following:

1:1.1 Number of countries with established national/regional networks of multisectoral work groups, the interested parties using tools to evaluate the impact of health in all policies on health.

Baseline (2014): 6 Target (2019): 18.

3.3.1 Number of countries and territories that have incorporated measures to hold accountability or have improved upon existing measures of accountability, like audits, open access to information and the governments transparency in all of the processes of applying STP.

Baseline (2014): 4 Target (2019): 12.

The countries will evaluate these indicators, and it seems that they may have a considerable margin for interpreting these ill-defined, complex indicators.

The use of these indicators and arbitrary goals was subject to rigorous critique by the Independent Evaluation Team that performed the second level of evaluation of WHO Reform (EB134/39). The critique is directed at the "chain of results" as it is conceived by the WHO Secretariat in relation to the reform but is applied more widely.

Proposal

PHM advocates promotion of primary health care and the social determinants of health. Currently, however, PAHO and WHO focuses heavily on universal health coverage provided through 'basic packages' for the entire population. This demonstrates a difference in our approaches and positions.

It is necessary to regain a territorial-population approach to public health that allows for processes and sanitary needs to be acknowledged from productive and territorial reproductive processes. From we should redirect institutional interventions, so that responses are comprehensive and effectively address the sanitary demands and needs that populations require.

A territorial-population focus gives the possibility of a joint institutional intervention, so that in practice links among sectors can be incorporated into policies and programs, that would go beyond an approach that assumes that sectors incorporate health, disregarding the power struggles that arise when discussing topics and economic resources that are at play to make public policy feasible.

We recommend that the initiatives be placed in a hierarchy, and that at their core be the social determinants of health and primary health care; organize governments action into an effective territorial-population approach, an intersectoral action is developed whose main goal is to face social, economic, sanitary, gender and cultural inequalities as it looks to improve the quality of life and well-being of the populations.

Agenda Item 4.11 Strategy for Health-Related Law

In focus

The Directing Council is invited to review the Strategy on Health-Related Law (CD53-13) and consider the resolution contained in Annex A in the same document.

Background

The use of law is an essential part of public health just as legal frameworks mediate in significant ways the social determination of health. It would be entirely appropriate for PAHO to develop a strategy on health related law. The draft submitted to the EC leaves considerable scope for improvement.

At the instant meeting, the Directing Council will consider a Secretariat report (CD53/13) proposing a draft strategy on 'health related law'. An earlier version of this draft strategy was considered by the Executive Committee in June (Doc CE154/20 Rev.1). The Directing Council is also asked to consider adopting the proposed resolution contained in the aforementioned Secretariat report.

The Executive Committee was presented with a draft resolution prepared by the Secretariat to recommend to the CD/RC but there is no reference to a draft resolution in the Agenda for CD53. It would appear that the EC was not happy to endorse the proposed resolution and they were not able to agree on appropriate amendments.

PHM Commentary

1. Developing a PAHO strategy on health-related law to provide a framework for technical assistance and capacity building is a good project.

Effective use of the law is a core principle of public health. However, the law is complex and many public health officials have not had the opportunity to study law and its relationship to public health. Likewise many of the lawyers who contribute to health-relevant legislation (and related instruments) do not have a rich understanding of the knowledge base, principles and methods of public health.

Clearly there is scope for continued technical support and capacity building in relation to public health law in the region.

2. The draft Strategy is silent with respect to the contribution of national public health and law experts to the negotiation of international trade and economic integration agreements.

This is surprising in view of the fierce debates over the proposed FTAA agreement, the ongoing negotiations of the Trans Pacific Partnership (including Canada, US, Mexico, Peru and Chile) and the provisions of A59.26 (here, see p37) adopted by the WHA in 2006 which mandates the Secretariat to provide such advice as needed.

The strategy should provide explicit legal guidance regarding:

- the design of domestic legislation to make use of the flexibilities provided for in the TRIPs agreement;
- the use of cost-effectiveness criteria in setting prices for national procurement and/or pharmaceutical reimbursement schemes;
- the avoidance of Investor State Dispute Settlement (ISDS) provisions which reduce domestic policy space and give transnational corporations greater power to intimidate small countries.

These are, from the public health perspective, defensive issues; defending public health against provisions in treaties which threaten population health. However there is also a need to consider 'offensive' use of international law to promote public health. With economic globalisation and the growth in the size and reach of transnational corporations there are increasing limits to what individual countries can do by way of regulation for public health.

Increasingly there is a need for binding international agreements which set standards which can constrain the health damaging behaviours of transnationals. The classic case is the code on the marketing of breast milk substitutes. The data provided to the recent WHA demonstrates that, as a consequence of its voluntary nature, the code has been fully implemented by only a minority of countries. There is a clear need for binding agreements which set standards for labelling and promotion.

These are not issues which can be motivated by only one country but they do need the full participation in debates by many countries which requires developing necessary expertise in public health, law and trade. There is a lot of talk in this strategy about implementing standards and guidelines developed by WHO and other intergovernmental bodies but the strategy is silent in relation to the negotiation of new standards and guidelines into international instruments.

3. The draft strategy is somewhat selective in its consideration of the 'social determinants of health' which are listed in Clause 10(c), are considered further in Strategic line 3 and OP2(f) of the draft resolution.

There is no mention in the document of economic inequality as a determinant of poorer health; indeed the word is not used (in the English version). There is no consideration of how public health officials might engage with policy makers in economic and social protection portfolios with a view to reducing economic inequality and ameliorating its impact, nor of the role of law in this context.

One approach which may need legislative support is the inclusion of health considerations in impact assessment. There is no discussion of health impact assessment in the draft strategy.

4. There is no mention of litigation in the draft strategy. This is in contrast to the many powerful precedents for litigation having a potentially constructive role in promoting public health.

Examples of successful litigation in promoting public health include:

- the success of Ralph Nader in driving car safety;
- the role of litigation in many countries in defining the liability of public spaces for health damage from second hand tobacco smoke;
- the powerful impact that the document disclosure, associated with the Tobacco Master Settlement Agreement, had in driving the successful conclusion of the FCTC.

Litigation is a uncertain weapon and its use depends in part on the legal environment within particular countries. However, it has played an important role in public health law and consideration should be given to how to shape the legal environment so that it can play constructive role.

5. The draft Strategy appears to assume an *outreach model* for technical support and capacity building, drawing on existing centres of expertise; it does not consider *academic capacity building* at the national and sub-regional levels

While the strategy refers in general terms to significant challenges in the region (Clause 14) there is nothing in the Strategy which mandates any assessment of existing capacity with respect to public health law, nor to the priorities or strategies for building national and regional capacity across the region.

There are different ways of providing technical support and institutional capacity building. One might be called an *outreach approach*, drawing on established centres of expertise to provide technical advice and institutional capacity building, in accordance with the areas of need identified in the document. Another approach might involve *academic capacity development* to create centres of expertise at the national and subregional levels to enable ongoing engagement between local experts and government officials in full knowledge of local circumstances.

In reflecting on both of these approaches some attention should be paid to the risk of domination by the academic institutions of one country in the provision of technical advice and capacity building. Promoting national and sub-regional academic capacity would help to provide this kind of advice closer to home as well as creating a more pluralistic field of expert resources.

6. There is nothing in the draft resolution about the modalities through which the RD will 'promote the implementation of the strategy' nor about her accountability with respect to the implementation of the strategy.

The draft resolution urges member states "to promote and strengthen" [various functions and capacities] and requests the RD "to promote the implementation of the strategy".

There are no institutional mechanisms mooted to advise or guide the Secretariat in the implementation of the strategy nor are there any benchmarks or indicators mentioned through which the success or otherwise of the implementation might be measured at some stage in the future.