



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 130<sup>th</sup> SESSION OF THE EXECUTIVE COMMITTEE

*Washington, D.C., USA, 24-28 June 2002*

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*Provisional Agenda Item 3.1*

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ORIGINAL: ENGLISH

### **REPORT ON THE 36<sup>th</sup> SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING**

The Subcommittee on Planning and Programming held its 36<sup>th</sup> Session at the Organization's Headquarters in Washington, D.C., on 25-26 March 2002.

The Session was attended by delegates of the following Subcommittee Members elected by the Executive Committee or designated by the Director: Canada, Chile, Cuba, El Salvador, Guyana, Honduras, United States of America, and Uruguay. Also present were observers from Brazil, Colombia, Costa Rica, Ecuador, Jamaica, and Mexico.

Elected as officers were delegates of El Salvador (President), Guyana (Vice President), and Cuba (Rapporteur).

During the Session the Subcommittee discussed the following agenda items:

- Evaluation of the Strategic and Programmatic Orientations 1999-2002;
- Strategic Plan for the Pan American Sanitary Bureau for the period 2003-2007;
- Integrated Management of Childhood Illness (IMCI);
- Extension of Social Protection in Health - Joint Initiative of the Pan American Health Organization and the International Labor Organization;
- Health and Aging;

- Regional Strategy for Maternal Mortality and Morbidity Reduction;
- Women, Health and Development ;
- Public Health Response to Chronic Diseases;
- Pan American Centers.

The final report for the Session is attached.

Annex



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



# **36<sup>th</sup> SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE**

*Washington, D.C., USA, 25-26 March 2002*

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Annex

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**FINAL REPORT**

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## FINAL REPORT

The 36<sup>th</sup> Session of the Subcommittee on Planning and Programming (SPP) of the Executive Committee of the Pan American Health Organization (PAHO) was held at the Organization's Headquarters in Washington, D.C., on 25 and 26 March 2002.

The meeting was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Canada, Chile, Cuba, El Salvador, Guyana, Honduras, United States of America, and Uruguay. Also present were observers for Brazil, Colombia, Costa Rica, Ecuador, Jamaica, and Mexico.

### Officers

The following Member States were elected to serve as officers of the Subcommittee for the 36th Session:

*President:* El Salvador (Dr. José Francisco López Beltrán)

*Vice President:* Guyana (Dr. Rudolph O. Cummings)

*Rapporteur:* Cuba (Dr. Antonio D. González Fernández)

Sir George Alleyne (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Karen Sealey (Chief, Office of Analysis and Strategic Planning) served as Technical Secretary.

### Opening of the Session

The Director opened the session and welcomed the participants, extending a special welcome to the observers, whose presence was evidence of the Member States' commitment to the Organization. The meetings of the Subcommittee on Planning and Programming were always enormously productive and provided much useful feedback for the work of the Secretariat, and he was certain that the 36<sup>th</sup> Meeting would be no exception. As in prior years, he encouraged delegates to view the documents as "works in progress," which would be revised and enhanced in light of the Subcommittee's comments. In keeping with the Secretariat's efforts to involve its partners in many of its activities, it had sought the collaboration of a Member State, Jamaica, and another international organization, the International Labor Organization, in preparing two of the

documents. Once again, those joint endeavors had proved extremely fruitful, and he was sure that the resulting documents would elicit a rich debate.

The President added his welcome and thanked the Members for their vote of confidence in electing El Salvador to serve as President of the Subcommittee.

### **Adoption of the Agenda and Program of Meetings (Documents SPP36/1, Rev. 1, and SPP36/WP/1)**

In accordance with Rule 2 of its Rules of Procedure, the Subcommittee adopted the provisional agenda and a program of meetings.

### **Presentation and Discussion of the Items**

#### ***Evaluation of the Strategic and Programmatic Orientations, 1999–2002 (Document SPP36/3)***

Dr. Germán Perdomo (Senior Policy Advisor, Office of Analysis and Strategic Planning, PAHO) outlined the findings of the mid-term evaluation of the Strategic and Programmatic Orientations (SPOs) for 1999–2002, which the Secretariat had undertaken in accordance with Resolution CSP25.R4. That resolution, adopted by the 25<sup>th</sup> Pan American Sanitary Conference in 1998, requested the Director to apply the SPOs in programming technical cooperation and assess the impact of that technical cooperation, using the SPOs as a frame of reference, and then report to the Governing Bodies. The mid-term evaluation, conducted from April to June 2001, was intended to lay the groundwork for the final evaluation to be presented to the Governing Bodies later in the year and also provide input for the development of the strategic plan for 2003–2007.

The evaluation had three main objectives: (1) to explore the knowledge, attitudes, and practices of Bureau staff with regard to the formulation of the SPOs and their subsequent utilization; (2) to gauge the progress made towards meeting the regional goals; and (3) to determine the degree to which the strategic orientations had informed the programming of technical cooperation. Document SPP36/3 summarized the results. Among the chief findings, the evaluation had shown that a large majority (87%) of professional staff members were familiar with the SPOs and that they were being applied in a high percentage (around 90%) of technical cooperation projects and related activities. Owing to lack of information and other constraints, only 23 of the 29 regional goals established under the SPOs were analyzed. Some goals had already been met by June 2001, and most were found to be achievable by the end of 2002. All were considered

achievable in the long term, provided the necessary financial resources and other support were forthcoming.

With regard to assessing the impact of technical cooperation in the framework of the SPOs, Dr. Perdomo pointed out several methodological difficulties that hindered evaluation of impact in general and evaluation of the impact of technical cooperation in particular—notably, the fact that PAHO was not the only organization providing technical cooperation in the countries, which made it difficult to pinpoint precisely the effects of its activities. He concluded by describing the approach to be taken in preparing the final evaluation to be presented to the Executive Committee in June and to the 26<sup>th</sup> Pan American Sanitary Conference in September. That evaluation would show the progress made towards achievement of all 29 regional goals, using 1998 as a baseline, both for the region as a whole and at the level of each Member State and the fulfillment of the 17 programmatic orientations. The evaluation would also extract lessons learned in relation to the process of defining regional goals, setting priorities, adopting objectives and strategies, and monitoring and evaluation. That information was expected to be extremely useful for future strategic planning.

The Subcommittee agreed that evaluation of the SPOs for 1999–2002 was of crucial importance not only to determine what had been achieved during the quadrennium but to guide planning for 2003–2007. While the Subcommittee encouraged the Secretariat to keep the final evaluation as simple and straightforward as possible, there was consensus that the document to be presented to the Conference should contain more detailed information, particularly in relation to the regional goals and how they would be met by the end of 2002. Several delegates noted that the regional goals were quite ambitious and that, given the limited progress towards some goals thus far, it might not be possible to achieve them by the end of the quadrennium. That being the case, one objective of the final evaluation should be to identify goals that would be carried over into the period 2003–2007.

The Subcommittee also felt that the final evaluation should examine the extent to which the SPOs had influenced health programming and policy-making in the countries, recognizing that priorities in some subregions and countries might sometimes deviate from the SPOs because they had differing health problems and needs. In addition, it was suggested that the evaluation should examine the extent to which health systems and services in the countries were carrying out actions to improve quality of life for the population from the standpoint of primary health care and disease prevention and health promotion. It was considered important to look at different groups within countries, because national data did not necessarily reflect the situation of certain groups and regions within countries. Several delegates pointed out that an analysis of the effect of the SPOs at the national level might also yield useful information for assessing the impact of PAHO's technical cooperation and its effectiveness in addressing the countries' needs.

Various participants commented that, while the Secretariat could hold itself responsible for some of the regional goals, others depended on action at the national level, which in turn often depended on the availability of development resources from other agencies besides PAHO. It was suggested that future strategic and programmatic orientations should differentiate between goals which were truly manageable by the Secretariat and goals which the Secretariat would monitor but would not be primarily responsible for achieving. In that connection, one delegate proposed that the Governing Bodies should perhaps reconsider the policy shift that had occurred in 1994, when the SPOs were deemed to be the exclusive responsibility of the Secretariat, not the Organization as a whole.

The Subcommittee expressed concern about the information gaps identified by the mid-term evaluation. It was suggested that, in selecting future regional goals, the Organization should take into account the strengths and weaknesses of existing health information systems and their capacity to produce the data needed for monitoring and evaluation. However, it was also pointed out that lack of data to measure some goals was not all bad, since sometimes setting objectives not only inspired action to address important health needs but also spurred efforts to improve data collection to track their achievement. One delegate noted that, while information systems were being upgraded to produce the necessary data, it might be possible to use alternative indicators that could demonstrate progress.

Finally, in view of the lack of information, some delegates suggested that the evaluation period should be extended beyond the end of 2002 in order to allow more time to gather the information needed to determine whether or not the regional goals had been met and also conduct a more in-depth evaluation of the impact of the SPOs at the country level. To that end, one delegate proposed that the Subcommittee recommend to the Executive Committee that it defer consideration of the final evaluation until 2003.

Dr. Perdomo thanked the delegates for their valuable suggestions, which the Secretariat would bear in mind in preparing the final evaluation. He highlighted two points that had emerged from the Subcommittee's discussion: the need to evaluate the extent to which the SPOs had been incorporated into plans and policies at the national level and the crucial change from considering the SPOs the responsibility of the Organization as a whole to considering them the exclusive responsibility of the Secretariat.

The Director agreed that the regional goals had been ambitious, but he believed that it was important to avoid setting goals that could be achieved too easily. On the other hand, the goals should not be so stratospheric that they could never be achieved. It was necessary to strike a balance. He felt that the Governing Bodies had done a good job over



the years of finding such a balance in the strategic and programmatic orientations they had approved.

The mid-term evaluation had raised red flags in relation to some goals. The lack of progress in reducing child mortality and screening for syphilis in blood banks, for example, were cause for serious concern, as was the lack of information sources on issues such as tobacco use. The information gaps revealed by the evaluation indicated the importance of improving data collection. Over the years the Organization had invested a tremendous amount in helping the countries produce quality data, since PAHO was committed to publishing only official information supplied by the Member Governments. The deficiencies exposed by the evaluation underscored the need to redouble efforts to produce the necessary information.

In regard to the fundamental issue of responsibility for the SPOs, when the Pan American Sanitary Conference had considered the strategic and programmatic orientations in 1994, the Member States had emphasized that they wanted a clear statement of what the Secretariat's responsibility would be—i.e., not just what the Secretariat was committed to achieving, but the things that would fall within its purview and responsibility. He believed that it had been a correct decision to hold the Secretariat accountable for certain goals and activities. Nevertheless, he agreed with the Subcommittee's suggestion that the evaluation should attempt to determine how the SPOs had informed policies and programs in Member States.

As for the suggestion that it might be preferable to present the final evaluation to the Governing Bodies in 2003, he agreed that extending the deadline would enable the Secretariat to carry out a more comprehensive analysis and provide a more complete picture of the quadrennial. However, the resolution adopted by the Governing Bodies in 1998 called for the evaluation to be presented at the end of the four-year period. Moreover, in September it would be necessary for the 26th Pan American Sanitary Conference to adopt a new strategic plan for the next period. He therefore proposed that the evaluation be presented to the Governing Bodies later in 2002 as planned, but with the understanding that the Secretariat would continue working to refine it as additional data became available in 2003.

The Subcommittee did not recommend that the Executive Committee defer consideration of the final evaluation of the SPOs until 2003.

### ***Strategic Plan for the Pan American Sanitary Bureau, 2003–2007***

Dr. Karen Sealey (Chief, Office of Analysis and Strategic Planning, PAHO) presented the Strategic Plan for the period 2003–2007, emphasizing that the Plan's formulation had been guided by the principles of equity and Pan Americanism, ideals to

which PAHO had been committed throughout its 100-year history. Like the Strategic and Programmatic Orientations for 1999–2002, the proposed Strategic Plan focused on what the Pan American Sanitary Bureau (PASB), as the PAHO secretariat, would do to support the goals of the Member States of the Organization.

She began by summarizing the key features of the planning process, which had sought not only to clarify what the Secretariat would do in the next five years and set regional priorities for technical cooperation and resource allocation, but also to describe how it would do so and identify strategic approaches and ways of improving the Secretariat's performance. The process had also sought to incorporate a monitoring and evaluation framework that would make it possible to evaluate achievement of both the technical priorities and the organizational development initiatives which the Secretariat hoped to undertake. She then reviewed the values that would guide the work of the Bureau (equity, excellence, solidarity, respect, integrity) and its vision, mission, and functions, stressing that PASB's primary aim was to help the countries of the Americas help themselves and one another to improve health and related conditions and systems.

The plan being presented to the Subcommittee was the outcome of an extensive process of analysis and consultation with staff at all levels of the Organization, Member States, and external stakeholders. The external analysis had identified three major forces of change that were key to health development in the Region: globalization, environmental change, and science and technology. Differing demographic and epidemiological patterns and trends in health determinants across the Region would also shape the Secretariat's approaches to technical cooperation with the countries. As for the internal analysis, a survey of managers' perceptions of the Bureau's strengths and weaknesses and a rapid organizational assessment diagnosis had yielded a better understanding of its performance and provided a baseline for monitoring progress in organizational development. The plan set out in Document SPP36/4 described PASB's response to the situation revealed by the internal and external analyses. It identified three major areas for action: special population groups (low-income or poor populations, ethnic and racial groups, and women); key countries (highly indebted poor countries and/or countries which, because of their relatively low level of health development, needed to be the focus of the collective interest of the PAHO Member States, in particular Bolivia, Guyana, Haiti, Honduras, and Nicaragua); and technical priority areas.

The overarching goal of PASB's technical cooperation would be to reduce excess mortality, morbidity, and disability throughout the lifecycle, especially among the poor and other groups that were experiencing inequities in health. The plan identified eight priority areas for technical cooperation aimed at achieving that goal and six indicators of its achievement. For each of the technical cooperation areas, it also summarized the principal issues and challenges to be addressed, PASB's strengths and weaknesses and opportunities for action, the objectives of technical cooperation, and the strategies to be

employed in meeting those objectives. Dr. Sealey pointed out that a number of the objectives were clearly beyond the manageable interest of the Secretariat and their achievement would therefore require joint action with other agencies as well as a commitment from the countries. She concluded by highlighting the organization-wide issues that the Secretariat would endeavor to address during the period 2003–2007 in order to add value and increase the effectiveness and efficiency of its technical cooperation.

The Subcommittee commended the Secretariat, and Dr. Sealey in particular, for the quality of the document, which presented a comprehensive vision of the issues confronting the countries of the Region and reflected the principles of equity and Pan Americanism. Several delegates opined that the proposed strategic plan represented a substantial improvement over previous strategic and programmatic frameworks. The Subcommittee also welcomed the inclusion of specific organizational objectives relating to organizational development and performance and applauded the Secretariat for its candor in recognizing that improvements could be made in staffing and managerial processes, as well as in planning, programming, and evaluation. All the delegates praised the Secretariat's efforts to involve as many stakeholders as possible—both internal and external—in the process of identifying the priorities and formulating the plan. In that regard, it was suggested that it might be useful for Member States to have access to the background analyses conducted in preparation for the plan's development.

Some concern was expressed about the large number and range of priorities and potential areas of activity identified in the plan, especially in view of the likelihood that the Organization would continue to face budgetary pressures in the future. In relation to budgetary matters, it was also pointed out that the proposed Strategic Plan could not really find expression in the Organization's budget until 2004, since the biennial program budget for 2002-2003 reflected the Strategic and Programmatic Orientations for 1999-2002. Several questions were asked regarding the linkage between the priorities in the Strategic Plan and those contained in the WHO General Program of Work for 2002-2005. In light of the development cooperation challenges highlighted in the document and the poorer countries' dependence on external assistance, it was also suggested that there should perhaps be a greater attempt to link PAHO's priorities with those of other agencies in the development sector. In addition, it was suggested that, in developing the framework for implementation of the plan, the Secretariat should endeavor to stratify interventions to help countries with fewer means decide which lines of action they would undertake.

As in the foregoing discussion of the SPOs for 1999-2002, some delegates maintained that the objectives must be viewed as the joint responsibility of the Secretariat and the Member States. One delegate felt that the Strategic Plan should be redrafted to better reflect that joint commitment. For that purpose, he proposed that the Executive

Committee name an ad hoc group, composed of representatives of Member States designated by the Committee and the Director, to draw up the new document.

Members made a number of specific suggestions for enhancing the plan and several also submitted additional comments in writing. In relation to the description of the context and environment for development and execution of the Strategic Plan, it was suggested that the inclusion of charts or graphs might help illustrate the information more clearly. One delegate noted that the section on globalization seemed to present a rather negative view and suggested that the Secretariat reexamine that section with an eye to presenting a more balanced assessment of the effects of globalization on health. Another delegate recommended that the vision statement, which said that PASB would be the major catalyst for ensuring that all peoples of the Americas enjoy optimal health, be changed to read “a major catalyst,” since numerous other national and international agencies were also working to improve health in the Americas.

Several delegates emphasized the need for greater emphasis on promotion of health and healthy lifestyles. It was pointed out that all the indicators for monitoring achievement of the overarching goal for PASB technical cooperation had to do with reduction of morbidity and mortality. While the difficulty of developing indicators to measure health promotion and improvements in quality of life was recognized, the Secretariat was encouraged to try to incorporate such indicators. Several delegates also signaled the need to mention children and indigenous peoples explicitly among the special population groups to be targeted under the plan and to include specific priorities relating to them. Other suggestions included the incorporation of specific objectives relating to the HIV/AIDS, tuberculosis, reduction of antimicrobial resistance, hypertension, and improvement of public health laboratories as an essential public health function. In addition, several delegates pointed out that bioterrorism and other forms of terrorism posed a grave threat to the health and well-being of the peoples of the Americas and that addressing that threat should be a priority for all countries and for PAHO, which had long been a leader in emergency preparedness and disaster mitigation in the Region.

Dr. Sealey thanked the delegates for their detailed comments, which the Secretariat would bear in mind in revising the document for the Executive Committee. She noted that the Subcommittee had suggested the inclusion of several additional priorities, but, unfortunately, the Members had not provided much guidance regarding which priorities should be cut to make room for those new priorities. Still, it was clear that the Secretariat needed to continue working to refine the process of priority-setting, based on the information it had at its disposal and bearing in mind that it was necessary to reflect the priorities of the Region as a whole. Obviously, some issues had higher priority for some countries and not all national priorities could be included. With respect to the suggestions regarding indigenous groups and children, she pointed out that indigenous peoples had been included under the broader heading of “racial and ethnic groups.” The

aim was to identify groups which, because of race or ethnicity or other reasons, were experiencing health inequalities. However, the Secretariat would look again at the idea of targeting both indigenous peoples and children as specific groups.

Responding to the recommendation that the Secretariat provide the Member States with the background information used in developing the plan, she said that the key analytical documents would be made available on the Organization's website. As for the suggestions concerning the indicators for measuring achievement of the overall goal of technical cooperation, the Secretariat had been struggling to find indicators that would reflect not only morbidity and mortality but also achievements in health promotion and improvement of quality of life. She agreed that the plan should include such indicators, even though the nature of the data currently available in the countries might make it difficult to actually measure progress in those areas. As for the stratification of interventions, she agreed that, rather than suggesting blanket strategies for all countries, it would be preferable to make suggestions about which kinds of strategies and activities might be most useful for certain categories of countries, with the understanding that the countries would make the final choice in accordance with their needs and means.

In regard to the comments concerning the linkage between the Strategic Plan and the Organization's budget, she assured the Subcommittee that that linkage had not been overlooked. Members would recall that the SPP had discussed regional budget policy in 2000, and it had been agreed that after the strategic plan had been developed the issue of budgeting would be reexamined to ensure that the plan was driving resource allocation. It was true that the strategic plan, if approved, would not be fully reflected in the biennial program budget (BPB) until 2004. Nevertheless, the programming process was flexible enough to accommodate the new plan. At the mid-term evaluation of the 2002-2003 BPB, the various technical units would be asked to adjust their current programs to reflect the plan approved by the Governing Bodies. As for linkage of the priorities identified under the strategic plan with the priorities of WHO, she assured the Subcommittee that the Secretariat had carefully compared the two sets of priorities and found them to be fully congruent. If some WHO priorities were not contained explicitly in the Strategic Plan, it was because they were not considered priorities for the Region of the Americas as a whole.

The Director observed that he had taken part in a number of strategic planning exercises and he had rarely witnessed a more participatory or iterative process. The thinking behind the plan had been discussed by the Governing Bodies on several occasions. Various iterations of the document had been circulated to the countries and they had been invited to comment repeatedly. Of course, it had not been possible to incorporate all the comments received, but he believed that the process had been genuinely participatory and he was confident that the proposed Plan fairly reflected the priorities that the countries wished the Secretariat to pursue. The Subcommittee's

suggestions, which clearly reflected the Members' careful and detailed review of the document, would enable the Secretariat to continue enhancing the plan prior to the meeting of the Executive Committee in June.

Concerning the issue of the responsibilities of the Secretariat versus those of the Organization as a whole, he believed that the Governing Bodies had taken a major step forward in 1994 when they had agreed that it was necessary for the Secretariat to state clearly what it intended to do. That was a fundamental aspect of good management in organizations such as PAHO, since the Secretariat was the custodian of the resources allotted by the Member States. It was very important to make that distinction and hold the Secretariat accountable. Moreover, PAHO was not a supragovernmental organization that sought to impose actions on the countries, and the Secretariat would therefore never say that Member States must accept the priorities it identified. Technical cooperation projects at the national level are related to the priorities established by individual countries. But he believed there was consensus among the countries of the Americas about certain priorities that should guide technical cooperation at the regional level.

As for the vision statement, he felt it was important to preserve the current wording. Certainly, there were other agencies working to improve health in the Americas, but PASB truly aspired to be the best among them. In regard to the linkage of PAHO's priorities with those of other sectors and organizations, for the past several years the Secretariat had been working towards closer coordination with international financing institutions. The Shared Agenda for Health in the Americas, signed by PAHO, the World Bank, and the Inter-American Development Bank in 2000, was one expression of that effort. The Strategic Plan, if approved by the Governing Bodies, would provide a basis for further dialogue with partners in the financial and other sectors.

In response to the suggestion that an ad hoc group be appointed to revise the document prior to the Executive Committee meeting in June, he pointed out that it would be extremely difficult to organize a meeting of such a group and produce a new document prior to the Committee's meeting in June. He therefore urged the Subcommittee not to recommend that course of action. Nevertheless, the Secretariat would welcome continued input from the countries as it worked to refine the Plan in preparation for its submission to the Executive Committee.

The Subcommittee did not recommend the creation of an ad hoc group to redraft the strategic plan.

### ***Integrated Management of Childhood Illness (Document SPP36/5)***

Dr. Yehuda Benguigui (Regional Advisor on Integrated Management of Childhood Illness, PAHO) outlined the progress made in applying the strategy of

integrated management of childhood illness (IMCI) in the Region and highlighted the main obstacles to expanding the strategy's implementation and extending its benefits to every child in the Americas. The IMCI strategy, developed jointly by WHO and the United Nations Children's Fund (UNICEF) in 1992, had been recognized as one of the most cost-effective interventions for reducing mortality and morbidity and improving care and nutrition for children during the first five years of life. The Directing Council of PAHO had adopted a resolution in 1999 urging the Member States to adopt and expand implementation of the strategy and asking the Director to actively support the process. The same year, PAHO had launched the "Healthy Children: Goal 2002" initiative, which sought to prevent 100,000 deaths of under-5 children during the period 1999–2002 and ensure access to the strategy, especially for the most vulnerable groups.

By late 2001, 17 of the Region's countries had adopted the strategy and all had espoused "Healthy Children: Goal 2002". The results had been highly positive. Evaluations revealed significant improvements in various indicators of quality of care and substantial reductions in deaths from diarrheal diseases and acute respiratory infections, which accounted for the largest proportion of mortality from all the child health problems targeted by the IMCI strategy. Nevertheless, the strategy's obvious benefits in preventing disease and promoting health had yet to reach many children in the Hemisphere. Document SPP36/5 summarized the principal challenges for expanding the use of the IMCI strategy and proposed several actions for addressing those challenges. The Subcommittee was asked to comment on the proposed actions and suggest approaches for increasing access to IMCI, incorporating IMCI training into the education of health workers, adding new components to the strategy to make it better suited to the differing epidemiological profiles of the countries, encouraging use of the 16 key family practices identified by PAHO/WHO and UNICEF for ensuring healthy growth and development of children, and mobilizing resources for expanding the application of IMCI.

The Subcommittee expressed unanimous support for the IMCI strategy and welcomed the progress made in improving child health in those countries that were applying the strategy. Although some delegates said that their governments had not adopted IMCI as an official strategy within their national health programs, they pointed out that similar approaches were being applied in their countries to good effect. The Subcommittee also underscored the importance of monitoring and evaluation to identify best practices and avoid "reinventing the wheel." Dissemination of information on both successful and unsuccessful experiences with IMCI was therefore a crucial role for PAHO, as was assistance in improving data collection to enable countries to measure the impact of the Strategy. Several countries offered to share their experience with other countries in the Region.

Some delegates felt that no additional components should be added to the IMCI strategy until it had been fully implemented across the Region. The need to reach indigenous children and other vulnerable groups was emphasized. However, other delegates affirmed that the strategy should be adapted to the epidemiological profile and specific needs of individual countries and local communities. Those delegates called attention to the need to address problems such as malaria, HIV/AIDS, violence, accidents, and child abuse, which were prevalent in some countries and had a tremendous impact on children's health.

The importance of the strategy's educational component was stressed. Education of families—and especially of mothers—was deemed critical to the strategy's effectiveness. Several delegates pointed out that child health went hand in hand with maternal health and emphasized the need for good prenatal care in order to ensure healthy babies who would survive and grow into healthy children and healthy adults. Mass communication and community education were also seen as crucial. In relation to education of health professionals, it was necessary to increase knowledge and use of IMCI among current practitioners as well as students. To that end, it was suggested that possibilities for training in the field and incentive-type programs should be explored.

Delegates made a number of specific suggestions for enhancing the document, including the incorporation of more detailed information on which groups of vulnerable children were not currently being reached by the IMCI strategy and comparisons of data on drug use in countries that had adopted IMCI with data from countries that were not applying IMCI approaches. One delegate suggested that, in order to better reflect the strategy's focus on the child and promotion of child health, the Organization might consider renaming it "integrated management of child health."

Dr. Benguigui noted that the document on this item had been intended to provide a very brief overview of progress in implementing the IMCI strategy in the region, and it had therefore not provided much detail on matters such as community and family education, training of human resources, and monitoring and evaluation. More explicit information would be included in the document to be prepared for the Executive Committee. Many of the issues raised by the delegates were, in fact, being addressed. Education of the family, especially the mother, was a keystone of the IMCI strategy, though the document did not describe all the approaches and instruments being employed for that purpose. He was pleased to announce that a communications specialist would soon join the staff of the regional IMCI unit, which would boost the unit's capacity to assist the countries in the area of communication and information relating to IMCI. Monitoring and evaluation were key aspects of the strategy as well. WHO, with support from the Gates Foundation, was currently conducting an analytical review of implementation of IMCI throughout the world. PAHO was participating actively in that review, which would analyze indicators of both process and impact. Prenatal care was



also of paramount importance. Both the global and regional programs were working to improve prenatal health, although PAHO had chosen to emphasize neonatal health under the IMCI Program in order to avoid duplication of efforts and resources.

In relation to the incorporation of new components into the IMCI strategy, he pointed out that many countries of the Region were undergoing an epidemiological transition, in which problems such as diarrheal diseases and acute respiratory infections coexisted with chronic diseases such as asthma and with high rates of violence and accidents, which were also significant contributors to child morbidity and mortality and had an enormous impact on children's quality of life. In some countries, malaria and HIV-infection were also serious problems. It was therefore considered essential to adapt the strategy to the epidemiological profile and specific needs of individual countries and communities.

The Director added that the idea was to adapt the strategy to the prevalent problems for which such an integrated management approach could be effective. In that regard, he wondered whether the document was not too purist in identifying the countries that had adopted the strategy, since it was obvious that many other countries were applying integrated management approaches to child health, although they might call them something other than IMCI. With respect to evaluating the impact of IMCI approaches, he had come to believe that general under-5 mortality might be a better indicator than disease-specific mortality. Similarly, in hindsight, he thought it might have been better to make reducing the gap between the countries or population groups with the highest and lowest child mortality rates the goal of the Healthy Children initiative rather than setting the goal of preventing a certain number child deaths. Such an objective would have been more in keeping with the Organization's focus on increasing equity in health.

Regarding the communication and information aspect of IMCI, he noted that much of what the IMCI Program was doing fell under the heading of "social communication," even though there had not been a staff member with that specific function. Disseminating information to show that the strategy worked was essential in order to persuade ministries of health and others in the health sector to embrace it as a means of reducing child mortality. As the Subcommittee had pointed out, one of the best ways of doing that was to share successful experiences from countries that had implemented IMCI.

***Extension of Social Protection in Health: Joint Initiative of the Pan American Health Organization and the International Labor Organization  
(Document SPP36/6)***

Dr. Daniel López Acuña (Director, Division of Health Systems and Services Development, PAHO) and Mr. Emmanuel Reynaud (Chief, Social Security Policy and Development Branch, ILO) described a joint initiative being undertaken by PAHO and the International Labor Organization (ILO) to promote equitable access to health services in Latin America and the Caribbean, especially for the large proportion of the population that currently lacked adequate health care coverage. The initiative's specific objectives were (1) to enable Member States of the two organizations to extend the coverage of health care systems and develop policies for extending social protection for health care, particularly in the informal sector, in both urban and rural areas and among unprotected groups; and (2) to involve all the major stakeholders in the process of policy design, implementation, monitoring, and evaluation in order to gain public support for health reform policy that would foster inclusion, not lead to greater exclusion, marginalization, and lack of social protection.

"Social protection in health" was defined as society's guarantee, through the different public authorities, that individuals or groups of individuals could meet their health needs through adequate access to health services, whether the national health system or any of the country's existing health subsystems, regardless of their ability to pay. Three conditions must be met to guarantee social protection in health: access to health services, financial security of the family, and dignity in the provision of care. Document SPP36/6 identified factors that led to exclusion in health—notably poverty—and the main obstacles to extending social protection. It also identified several strategies for extending social protection in health, based on interventions that had proven effective in the past in Latin American and Caribbean countries. They included establishment of special social security regimes without beneficiary contribution requirements; voluntary, government-subsidized insurance schemes; limited expansion of the supply of services; community-based systems of social protection; and gradual development of unified health systems, combining public and private subsystems.

The document proposed four lines of action relating to government policy on social protection, financing of social protection, health insurance, and service delivery. A sense of ownership on the part of countries was considered crucial to the initiative's success. It would therefore encourage the development of a participatory process at the national level, involving key stakeholders from the health and other sectors. That process would lead to the formulation of a national strategy and a national plan of action for extending social protection in health. At the regional level, PAHO and the ILO would support the countries through a variety of activities, including technical

cooperation, establishment of a clearinghouse of information on best practices and knowledge, and mobilization of resources.

The Subcommittee welcomed the joint initiative as a strategic partnership which would draw on the respective strengths and expertise of PAHO and the ILO to help countries extend social protection and improve access to health services for vulnerable and marginalized population groups. The initiative was amply justified by the huge numbers of people in the Region who lacked any social protection at all. Moreover, the problem of exclusion was growing as increasing proportions of population turned to the informal economy for their livelihood. The Subcommittee considered a multisectoral approach to the problem essential, given the linkages between health and poverty, income, employment, education, housing, and other factors. For that reason, efforts to combat exclusion and lack of social protection should seek to involve other multilateral and bilateral organizations—including WHO at the global level—as well as governments and the community.

The Subcommittee also stressed that access to basic health services should be viewed as a right of all people which governments had a responsibility to ensure. At the same time, it was recognized that governments often could not shoulder the whole responsibility of providing social protection and that the private sector and nongovernmental organizations also had an important role to play. Each country must assess the magnitude and causes of social exclusion and devise appropriate solutions in keeping with its national reality.

Delegates made a number of suggestions for enhancing the document. One was the incorporation of case studies of programs and initiatives that had been successful in improving delivery of health services to unprotected population groups. Another was clearer definitions of concepts such as “social protection,” “social welfare,” and “social security,” which might be interpreted differently in different national contexts. One delegate asked for clarification of the figures on exclusion from social protection cited in the document and cautioned against the use of indicators that attempted to measure exclusion only in terms of demand for health services, since demand for health services was influenced by multiple factors, including cultural perceptions about health and illness and economic and social issues. Clarification of the respective roles of PAHO and the ILO in the initiative was also requested. Noting the document’s focus on health care for curative purposes, another delegate recommended greater emphasis on access to services for disease prevention and health promotion, which were also essential aspects of social protection in health. Several questions were asked in relation to studies of micro-insurance schemes and other research to be conducted in accordance with the memorandum of understanding signed by the two organizations. In addition, it was pointed out that universal coverage did not necessarily guarantee equitable access to health care, especially in systems with mixed public-private financing, and it was

suggested that the studies of different insurance schemes should include a critical examination of their relative equitability.

Dr. López Acuña agreed that carrying out activities to extend social protection in health must be the task of Member States. It was not something that could be done by PAHO or the ILO, and the initiative did not seek to assign them that role. Countries must take the lead in formulating and implementing policies on the extension of social protection and evaluating the effectiveness of those policies. The PAHO/ILO initiative was intended to support action at the national level and compile information on experiences that would help countries apply best practices and realize economies of scale. As the Subcommittee had pointed out, there could not be a single recipe for extending social protection in health. It was essential for each country to develop a social protection framework suited to its specific needs through a process of national dialogue and consensus-building involving a broad range of stakeholders.

Responding to the questions concerning the memorandum of understanding, he noted that several of the activities mentioned therein had already taken place. For example, in 1999 and early 2000, PAHO and the ILO had conducted a comparative analysis of social protection policies in the countries, an analysis of experiences with micro-insurance in the Americas, an analysis of different methods of measuring exclusion and the differing perspectives that might emerge from those methods, and a study of patterns of out-of-pocket expenditure in the countries of the Region. All those studies had been part of the background documentation for the 1999 Regional Meeting on Extension of Social Protection for Health Care to Unprotected People in Latin America and the Caribbean, which had given rise to the initiative. The document prepared for the Subcommittee was intentionally brief and so did not reflect much detail about the findings of the studies, but the Secretariat would be pleased to provide all the background documentation to Member States.

In regard to the involvement of other organizations, he noted that several bilateral development agencies had recently incorporated the issue of social protection in health into their cooperation agendas and had also expressed interest in supporting joint endeavors of two or more international organizations to build national capacity in this area. PAHO and the ILO would seek to mobilize resources for the joint initiative and for national efforts from those agencies, as well as from the multilateral lending institutions and national sources. As for WHO, the regional initiative would make a valuable contribution to related work it was doing in relation to health care financing policy.

Addressing the questions about the respective roles of PAHO and the ILO, Mr. Reynaud said that, simply put, PAHO/WHO was concerned with the supply side of access to health care, while the ILO was more involved with the demand side, since employers and workers, along with governments, were its main constituents and were key

stakeholders in any discussion of social protection and social security schemes. While that view of the relationship might appear rather simplistic, it was also pragmatic, since experience had shown that efforts to extend health care coverage could not succeed without adequate supply, but there must also be adequate demand to finance the supply.

With respect to the issue of equity, he pointed out that countries faced a difficult dilemma: when a large proportion of the population was excluded, was it better to try to extend the same level and quality of protection to everyone or to design a special scheme or system to cover those who lacked protection? The second option, a two-track system, was more likely to create inequities, but extending the same level of protection was a long and arduous undertaking. Hence, the best solution in the short term might be to put in place some special scheme targeting excluded groups, but do so as the first step in a process aimed ultimately at creating a more equitable system that would provide universal coverage.

The Director noted that the right to health had long been recognized in the Region. In the American Declaration of the Rights and Duties of Man, the countries of the Americas had affirmed that every person had the right to those sanitary and social measures necessary to preserve health. But how could countries provide access to those measures in an equitable way? The joint PAHO/ILO initiative sought to provide answers to that question. No country could ever fully satisfy demand for health care, since that demand was boundless. Moreover, as Mr. Reynaud had pointed out, it was exceedingly difficult to establish and maintain a system that covered everyone. To begin to deal with the problem of exclusion, countries therefore had to focus their efforts on the poor and dispossessed. However, services for the poor were often poor services, which created other types of inequities. In the face of this situation, he believed it was the State's role to ensure that everyone had access to services of acceptable quality—especially those services that had the highest externalities—though the State need not provide all services directly. The role of the two international organizations was to add value to the work undertaken in the countries. By analyzing the experiences of the various countries, PAHO and the ILO could extract lessons and best practices that would assist other countries as they struggled to find the best way of extending social protection and ensuring adequate health care for all their people.

A key aspect of the initiative was its broadened conception of social protection, which went beyond the traditional view of social security as a system of protection for contributors or affiliates only. The social protection envisaged under the initiative would extend to the poor and excluded, helping them to escape from the trap of poverty. As Mr. Reynaud had said, results could not be achieved overnight. Assuring social protection for all the excluded would take many years, but the countries should not let that deter them from getting the process started as soon as possible.

***Health and Aging (Document SPP36/7)***

Dr. Martha Peláez (Regional Advisor on Aging and Health, PAHO) presented an overview of the situation of older adults in the Region and outlined the principal strategies for promoting healthy aging. All countries in the Americas were experiencing population aging. By the year 2025, it was estimated that the population aged 60 and over would number around 200 million, and more than half of that population would reside in Latin America and the Caribbean. Rapid growth in the number and proportion of older adults threatened to create a public health crisis, overwhelming health services and creating intergenerational competition for scarce resources. However, that crisis could be averted by taking action now and investing in the health of older persons to promote active and healthy aging. PAHO's technical cooperation in the area of aging and health was aimed at enabling countries to prepare and respond to the challenges and opportunities created by an aging population and supporting their efforts to implement the international plan of action on aging to be adopted by the Second World Assembly on Aging, which would take place in Madrid in April 2002.

The international plan of action had a strong human rights base and established three priority areas for action: encouraging participation of older persons in development, enhancing the health and well-being of older persons, and ensuring enabling and supportive environments for older persons. Document SPP36/7 proposed several strategies for promoting physical and mental health and improving health care for older persons and ensuring respect for their rights and dignity. The strategies were evidence-based and were consistent with the strategies envisaged at the international level. The Subcommittee was asked to examine the issues relating to aging and health and recommend ways of enhancing regional technical cooperation in this area, especially as it related to implementation of the proposed international plan of action.

The Subcommittee applauded the document, which did an excellent job of summarizing the range of issues that needed to be addressed in relation to the health and well-being of older persons. The document also discussed many of the key issues raised in the draft International Plan of Action on Aging 2002. The Subcommittee expressed strong support for PAHO's health promotion approach. Several delegates pointed out that aging should not be viewed as a disease but as a lifelong process that started at birth. Health status in old age was largely the result of an accumulation of injuries and consequences of disease and good or bad behavioral choices. Health promotion was therefore essential, and it should begin early and continue throughout the life cycle in order to optimize physical and mental health in old age.

The Subcommittee also underscored the importance of community-based approaches to care for older persons. It was pointed out that community-based alternatives to nursing homes were not only cost-effective but could lead to improved

health outcomes, prolonged independence, and improved quality of life. Raising awareness of the contribution that older adults could make to their communities and involving the community in caring for older persons were seen as crucial strategies for promoting healthy aging. Delegates stressed the essential role that older adults played in preserving family unity and maintaining the social fabric. Several delegates also mentioned the impact that migration had had on older persons in their countries. When younger family members migrated in search of work, the elderly were frequently left to fend for themselves, and they often had few resources and little access to social protection. The need to adapt primary health care services and train health personnel to meet the special needs of older persons was also stressed. In relation to training of health workers, it was considered important to train not only doctors and nurses, but also dentists, pharmacists, and other health workers who were likely to have more frequent contact with older persons than physicians.

Several delegates highlighted the issue of human rights of older persons, who were sometimes overlooked in discussions of human rights. The need for regulations and standards of care for older persons was emphasized. PAHO could assist countries in developing those norms. Other important roles for the Organization were dissemination of information and best practices; promotion of research, with application of research findings in programs and policies on health and aging; and development of social marketing and communication strategies for promoting healthy behaviors and reducing health risks. Facilitating technical cooperation and joint initiatives among countries of the Regions was also seen as a valuable role for PAHO. One delegate suggested that the Secretariat might consider convening a workshop after the Madrid conference to draft a regional plan of action and set targets for the implementation of the International Plan of Action on Aging 2002.

It was suggested that the document could be strengthened by including more detailed information about the indicators and measurements used in the multicenter study mentioned therein and by elucidating the links between health of older persons and factors such as gender, socioeconomic status, and, especially, poverty. One delegate found the cost-benefit information in the section on investing in care for older persons especially valuable and recommended that such information be included in documents prepared by other programs, as that kind of data was extremely helpful to governments and policy analysts in designing and enlisting support for health programs and policies.

Dr. Peláez thanked the Subcommittee for its comments, which would help improve the next version of the document. The issue of poverty had been raised by several delegates. It was true that poverty and fear of poverty were among the most significant concerns of older persons. Moreover, social protection for older persons in the Region was often deficient or nonexistent. Although social security programs in some countries had been continuously expanded and future generations could look forward to

greater social protection in old age, many of today's older persons had no social security coverage whatsoever. That problem would be highlighted in the revised document, as would the issue of human rights and the need to foster greater awareness and appreciation of the vital roles that older people played in society. For example, an increasing proportion of older persons were heads of household and had assumed responsibility for caring for grandchildren as a result of the migration or death of their parents from AIDS or other causes. The contributions of older people needed to be documented and linked to the need for society to take better care of its senior members.

The Director pointed out that, not only did older persons play an important role in maintaining the social fabric, but they could be instrumental for countries' prosperity and economic growth. Discussions of health and economic growth tended to focus on reduction of infant mortality and lengthening of life expectancy, overlooking the fact that at the end of that longer life span there would be older populations. Investment in keeping older persons healthy would reduce the amount societies spent on medical care for this age group and enable them to earn better returns on other investments in areas such as education.

Several delegates had mentioned the need to reorient health services to care for older persons. Reorienting primary health care services towards preventing the diseases and disabilities that commonly affected older persons was a fundamental strategy of health promotion. Similarly, involving families and the community in keeping older people healthy and caring for the elderly was one of cornerstones of health promotion. As the Subcommittee had pointed out, social communication strategies were needed to raise awareness and engage the community in promoting the health of older persons. At the same time, it was important to educate older persons on self-care. He agreed wholeheartedly with those delegates who had remarked on the need to promote health throughout the life cycle in order to enjoy good health in old age. Indeed, health promotion must begin before birth, since it had been shown that nutritional deficiencies or unhealthy maternal behaviors in the prenatal period could have a lasting impact on health throughout life. The revised version of the document would make that point more forcefully.

***Regional Strategy for Maternal Mortality and Morbidity Reduction  
(Document SPP36/8, Rev. 1)***

Dr. Virginia Camacho (Regional Advisor, Maternal Mortality Reduction Initiative, PAHO) outlined the regional strategy for preventing maternal deaths, reducing maternal morbidity, and improving care for mothers before, during, and after childbirth. Maternal mortality remained a grave public health problem in the Region of the Americas, especially among adolescent mothers, indigenous mothers, and poor and marginalized mothers. Moreover, the maternal mortality figures for the Region reflected



tremendous inequities between countries and between different population groups within countries. Relatively little progress had been made under the Regional Plan of Action for the Reduction of Maternal Mortality in the Americas, adopted by the PAHO Member States in 1990. At the global level, an evaluation of the Safe Motherhood Initiative in 1997–1998 had found a similar lack of progress. As a result, the issue of maternal mortality was receiving renewed attention on international public health agendas.

A number of valuable lessons had been learned in the 12 years since the Regional Plan of Action was launched. Knowledge of the causes of maternal mortality had increased, and effective, evidence-based interventions for preventing maternal deaths had been identified. The regional strategy for maternal mortality and morbidity reduction was aimed at translating those lessons into action. Accordingly, the strategy sought to promote effective public policies and guidelines on safe motherhood and social protection for women; ensure access to good reproductive health services, especially essential obstetric care and skilled attendance at birth; increase public demand for quality maternal health services by empowering and educating women and their families and communities; build partnerships and coalitions to create a supportive environment for safe motherhood; strengthen maternal morbidity and mortality surveillance systems; and assure adequate financing for reproductive health services within health sector reform. The strategy's objective was to achieve the global goal of reducing maternal mortality by 75% (with respect to 1990 levels) by 2015 and, in the Region, decreasing maternal mortality to under 100 per 100,000 live births in all countries within the next five years and closing the equity gap in the area of maternal mortality and morbidity.

The Subcommittee agreed on the need for decisive action to reduce maternal mortality rates in the Region and considered the proposed strategy a sound approach for saving lives of both mothers and newborns. The Subcommittee also agreed that the disproportionately high maternal mortality rates among poor and underprivileged women represented one of the most egregious manifestations of inequity in health, especially since the vast majority of maternal deaths among those women were preventable. It was pointed out that access to adequate maternal health care was a question of human rights, and that governments had a responsibility to ensure that all mothers, regardless of socioeconomic status or ability to pay, received health services of acceptable quality. The issue of quality of care was considered paramount, and several delegates underscored the need to focus as much on the quality of maternal health care as on the quantity. Nevertheless, the shortage of skilled birth attendants was cited as a critical problem, and increasing the numbers of midwives and other trained attendants, especially in rural areas, was viewed as essential in order to address the most common causes of maternal death. Teaching women to recognize danger signs and educating them on the need for good prenatal care and skilled attendance at birth was equally important. In that regard, one delegate noted that in some developed countries, where professional obstetric care

was widely available, some women were choosing to give birth at home with an unskilled attendant or no attendant at all.

Several delegates stressed the need to improve reporting and surveillance of maternal deaths, since complete and accurate data on the causes of maternal mortality and on the most affected population groups were essential for designing and targeting interventions. The document's emphasis on community involvement and creation of supportive environments was applauded. Educating men in the community, especially expectant fathers, about the importance of good maternal health care was seen as a key strategy for fostering supportive environments and encouraging women to demand and utilize quality services. One delegate pointed out that maternal mortality should be viewed as a social problem that required action on the part of society as a whole. He suggested that one way of driving home that point and mobilizing support for efforts to reduce maternal mortality would be to conduct studies to show the economic costs and negative social impact of maternal deaths and the cost-benefit of improving maternal care. Other delegates suggested that another way of increasing support for maternal health programs would be to link them with other health programs, especially those to combat HIV/AIDS, which was becoming an increasingly important contributor to maternal mortality in some countries.

Concern was expressed about some of the document's contents. One delegate felt that it would be stronger as a technical document if references to political barriers to management of abortion complications and to non-measurable terms, such as "powerlessness of women," were either specifically defined or deleted altogether. Another delegate drew attention to the assertion that "episiotomies are ineffective interventions" and cautioned against overgeneralization. While routine episiotomies should be avoided, the necessity of the procedure should be decided on a case-by-case basis, taking into account past evidence, best practices, and risk assessments for each pregnancy.

Responding to the Subcommittee's comments, Dr. Camacho thanked the delegates for highlighting several issues which she had not dwelt on in her presentation for lack of time. One was the connection between HIV/AIDS and maternal mortality. Many of the direct causes of maternal mortality in the Region were, in fact, linked to HIV infection. She agreed that creative programmatic approaches were needed to make the most effective use of resources in addressing those two related problems and also other indirect causes of maternal mortality, such as malaria and tuberculosis. Undeniably, abortion was also a major cause of maternal mortality and a significant public health problem in the Region. Studies had indicated that abortion-related complications were the leading cause of maternal death in some countries, although it was difficult to determine the magnitude of the problem because abortion was illegal in many places. While efforts should be directed towards preventing abortion, it was also critical to ensure that women

who sought medical assistance for complications of abortion were not refused service. The point which the document had attempted to make was that provision of those services was an integral part of essential obstetric care.

***Women, Health, and Development (Document SPP36/9)***

Dr. Marijke Velzeboer-Salcedo (Coordinator, Program on Women, Health, and Development, PAHO) reported on the work of PAHO's Women, Health, and Development Program (HDW), in particular its efforts to identify and eliminate gender-based inequities that affected women's health and promote the incorporation of a gender perspective in the policies and programs of the Organization and its Member States. Gender inequities were defined as inequalities between men and women that were unnecessary, preventable, and unjust. In the area of health, gender inequities often resulted in worse health status for women, limited their access to health services, and lowered the quality of the health care they received. Gender inequities also existed in the provision of health care. While women made up 80% of the health care workforce, they worked mainly in low-income, low-prestige jobs. Moreover, much of women's contribution to health in their families and communities went unpaid.

Reducing gender inequities in health was one of the Program's central goals. To that end, it had identified five strategic areas for action: (1) including a gender perspective in health situation analysis to target policies and programs more effectively; (2) monitoring the effect of health policies and reform processes related to gender equity in health; (3) developing and implementing models that addressed gender inequities in health in an integrated manner; (4) supporting outreach activities with information, education, and communication strategies and materials for advocacy and training; and (5) mainstreaming the gender perspective in the policies and programs of PAHO and Member States. The document related some of the activities being carried out in those areas. With respect to the third area, Dr. Velzeboer-Salcedo highlighted the integrated model for addressing gender-based violence implemented by HDW in 10 countries of the Region. In the fourth area, she drew attention to the Program's information dissemination and training activities through its GENSALUD website and virtual library. She concluded by pointing out that PAHO's Centennial would afford an excellent opportunity for the Organization and the Member States to renew their commitment to closing the gender-health gap in the Americas. Considerable progress towards that objective could be made by implementing the recommendations made by the PAHO Subcommittee on Women, Health, and Development and the various international conferences and agreements on women and women's rights. The document listed the principle recommendations relating to gender and health.

The Subcommittee voiced firm support for the work of the Program and applauded PAHO's commitment to reducing gender inequities in health. It also praised

the Organization's accomplishments in increasing gender parity within PAHO and its efforts to incorporate a gender perspective in all its health policy and programming. Several delegates reported that their governments had adopted similar cross-cutting approaches and were applying the gender perspective across programs and services, rather than through specific programs on women's health. Delegates also emphasized the need for a strong commitment on the part of civil society and governments in order to reduce the gender inequities that affected women's health and pointed out that that commitment must be manifested through allocation of the necessary resources. The Subcommittee welcomed the Program's recognition of the importance of also addressing the specific health needs of men and involving them in reproductive health issues. In that connection, it was suggested that the name of the Program should be changed to "program on gender, health, and development."

The strategies and activities advocated by the Program to promote greater gender equity were considered appropriate and useful. As an additional activity, it was suggested that HDW should promote the design and development of alternatives for reducing the greater burden of care imposed on women as a result of the epidemiological and demographic transitions under way in the Region. Population aging and rising prevalence of chronic diseases meant that women were increasingly being called on to care for elderly and ill family members in the home, often with little support from the health care system. Health system reform should take account of and address those needs. Several delegates commended the Program for its attempts to quantify women's unpaid contribution to health care and requested more information on possible methodologies for including that unremunerated work in national health accounts. In relation to research promotion, it was pointed out that, in order to reveal gender inequities, health research should focus on diseases that were common to both men and women, since focusing on conditions that occurred exclusively in women would be less likely to reveal gender-based disparities in care. With respect to the incorporation of a gender perspective in health situation analysis, one delegate observed that disaggregation of data by sex was just the first step. Contextual analysis was also necessary to reveal differences that were related to gender.

While the document did a good job of presenting the range of gender-related issues that affected the health of women and their access to care, the Subcommittee felt that it could be strengthened in various ways. Several delegates recommended that the Program should reexamine the definition of inequities as "those inequalities that were unnecessary, preventable, and unjust," as it was difficult to conceive of inequalities that would be necessary or just. Similarly, the terms "gender," "gender inequities," "health inequities," and "gender determinants of health" should be clarified. A statement in the document regarding gender equity in health care was considered particularly problematic because it seemed to suggest that the degree of gender equity in health care was related to the ability to pay for services. That idea appeared to be at variance with the

Organization's initiative to promote social protection in health, which emphasized the need to extend equal access to health services regardless of ability to pay. Moreover, it was well known that health care financing systems tended to discriminate against women because of their greater potential need for reproductive health services. The definition of gender was also considered confusing, as it seemed to imply that the social construct of gender resulted solely from the biological differences between men and women. Some of the data were also regarded as unclear or confusing.

Dr. Velzeboer-Salcedo said that the Program would endeavor to clarify the concepts and other sources of confusion in the document. In particular, the section on gender equity in health care would be reworked to clarify the question of ability to pay. The Program had certainly not meant to imply that access to health services should be contingent on ability to pay. With respect to the definition of inequities, she noted that some inequalities between men and women could indeed be viewed as just, and in some cases lesser inequality was reflective of inequities. One example was the difference in life expectancy between the two sexes. Since women generally lived longer than men, where the difference in life expectancy was minimal there were generally gender-related inequities. She agreed that commitment of resources was critical, but if those resources were to be forthcoming it was necessary to persuade governments of the need to invest in reducing gender inequities. That was why the Program was emphasizing the production of evidence-based information and the inclusion of gender indicators in national health accounts. In regard to the development of methodologies for measuring the value of women's unpaid work in the health sector, the Program was taking the first steps in that direction. A recent meeting in Chile with government officials and staff from other agencies in the United Nations system had examined the issue, and HDW staff would soon begin work with the Cuban government aimed at quantifying the unremunerated contribution of women to health.

The Director pointed out the inherent difficulty of measuring the value of unpaid work. Since such work did not entail any monetary transfers, it was very difficult to account for it in gross national product. If assessing the value of unremunerated work in national accounts was difficult, estimating the value of women's unpaid work in national health accounts was even more so.

Regarding the issue of gender parity within PAHO, he was proud of the progress the Organization had made, but he was not entirely satisfied. Women now occupied 45% of professional posts. The Organization would probably never be able reach and maintain true parity, since the proportions of men and women would always oscillate. Still, he would prefer the proportion of women to oscillate around 50% rather than 45%. Although the female professional staff remained concentrated mainly in the lower-level posts, he contended that that was not necessarily bad. He believed it was a mistake and a disservice to women to promote them to higher-level posts simply because they were women. As

they gained increasing experience, he had no doubt that women in PAHO would rise through the ranks and eventually occupy more senior managerial positions, just as their male counterparts had done.

As for the proposed change of name for the Program, it had been suggested before that “women” should be replaced by “gender,” but he had always resisted the idea because he felt it necessary to continue to focus on discrimination against women. That remained the predominant form of gender-based discrimination. Only when there was “equality of discrimination” against men and women would he be in favor of changing the Program’s name.

One area in which discrimination against women was especially evident was maternal mortality. He had not spoken during the Subcommittee’s earlier discussion of that subject, but he firmly believed that maternal mortality was an expression of gender inequity and that the way many women were treated during childbirth was one of the most flagrant manifestations of gender discrimination. Similarly, the treatment that women received for certain diseases reflected discrimination. It had been shown, for example, that women who suffered from myocardial infarction were treated less aggressively than men. He therefore concurred with those delegates who had pointed out that research should focus on conditions that theoretically affected both sexes equally, because it was those conditions that would reveal the existence of gender inequities in care. Another expressive illustration of discrimination against women was a table in the document which showed use of health services by income quintiles. It was well documented that women suffered more episodes of illness throughout their lifetime and tended to use health services more than men. However, the table showed that women in the upper income quintiles—for whom ability to pay was not a significant barrier—made only slightly more use of the services than men. That was another example of how lesser inequality could be indicative of gender inequities. He agreed that disaggregating data by sex was only the first step towards analyzing gender inequities, but it was a terribly important step. Data such as those on health service use revealed sex differences that enabled analysts to understand when inequalities represented inequities.

### ***Public Health Response to Chronic Diseases (SPP36/10)***

The document on this item was prepared jointly by the Secretariat and the Government of Jamaica. It was presented to the Subcommittee by Dr. Deanna Ashley (Director of Health Promotion and Protection, Ministry of Health, Jamaica) and Dr. Sylvia Robles (Coordinator, Program on Noncommunicable Diseases, PAHO). Dr. Ashley began with a review of the situation of chronic noncommunicable diseases (NCDs) in the Americas. NCDs were major causes of death and disability in most of the countries. Overall, in the population under age 70, NCDs caused 44% of deaths in males and 45% in females. Cardiovascular disease was the leading cause of premature mortality

in the Region. Comorbidity was also a significant problem, as 30%–60% of the population suffered from two or more such diseases. Moreover, risk factors for NCDs, such as obesity, inactivity, elevated cholesterol, and smoking, were on the rise, especially among young people. As the population aged, NCDs would become even more prevalent.

That situation had potentially devastating implications for individuals, families, and economies. For example, recent studies in Jamaica showed that 59% of persons with NCDs were at risk of medical indigence owing to the high cost of treating these diseases and the disability they caused, which rendered people unable to work. Clearly, NCDs were a major public health problem, which called for a comprehensive public health response that sought to promote health and prevent and control NCDs. In the English-speaking Caribbean, the Caribbean Cooperation in Health had developed a plan which emphasized two main strategies: building public policy and building alliances and partnerships, which were crucial aspects of an effective public health approach. The challenge for PAHO was to facilitate the development and implementation of strategies and programs for addressing NCDs in the Region, promote the development of public policy and partnerships, and mobilize and allocate resources to ensure that NCDs received the priority attention they deserved.

Dr. Robles described the public health approach advocated by PAHO, which combined health promotion activities to address the determinants of disease with health care strategies to reduce the economic burden of care for NCDs and improve outcomes. A recent review of successful programs for chronic disease prevention and control had determined that three simultaneous lines of action were required: (1) policy building to lift barriers and facilitate implementation of NCD prevention and control strategies; (2) local community action, especially building coalitions in order to pool resources for the achievement of common goals and enlisting the support of key groups that were working to promote health in the community; and (3) responsive health services that incorporated prevention and long-term care and utilized community resources to support self-management and care by persons with chronic diseases. The document provided a number of examples of how those lines of action had been applied to good effect.

A key component of the regional strategy was Actions for the Multifactorial Reduction of Noncommunicable Diseases, a network of community-based programs, known by its Spanish-language acronym, CARMEN. A related initiative in the Caribbean was the Caribbean Lifestyle Intervention Program (CARLI). CARMEN was one of the six regional networks operating in each of the WHO regions. Those networks offered opportunities for evaluating the effectiveness of interventions, exchanging experiences between countries, and training. Other components of the PAHO strategy were surveillance of risk factors and diseases to guide action, innovative models for delivering care for chronic diseases, and advocacy for policy change. The document also listed some of the activities being carried out in those areas.

Dr. Robles concluded by thanking the Government of Jamaica and other counterparts in the Caribbean who had helped shape the regional response to chronic noncommunicable diseases.

The Subcommittee endorsed the strategies and public health approach outlined in the document. Integrated approaches such as CARMEN that addressed the multiple risk factors and determinants of NCDs were seen as particularly valuable. The Subcommittee also agreed that NCDs had generally not received the attention they deserved, possibly because they were viewed as less “glamorous” than certain communicable diseases and because the magnitude of the problem was not recognized. Information such as that presented in the document on the economic burden of NCDs and the cost-benefit of preventive interventions was considered a valuable tool for raising awareness among policy- and decision-makers of the need for action to stem the rising prevalence of chronic diseases. Similarly, a greater effort was needed to raise awareness among international financing institutions in order to increase the amount of development aid available for NCD prevention and control initiatives. In that regard, it was suggested that the next version of the document might describe what had been done in relation to NCDs under the PAHO–IDB–World Bank Shared Agenda for Health. It was also suggested that the document might be strengthened through the inclusion of specific statistics that would illustrate the urgency of the problem.

Several delegates remarked on the linkages between this item and other matters discussed by the Subcommittee, notably health and aging and the extension of social protection in health. The data in the document on the latter item correlated closely with the data on medical indigence and exclusion from care presented in the document on chronic diseases. It was suggested that, in the next version of the document, that information might be expanded and the relationship between health outcomes and financing of and access to health services might be elucidated. The document should also emphasize the need for standardized measurements and approaches to enable comparisons between countries.

The Subcommittee stressed the need to start preventing NCDs from the earliest stages of life through health promotion activities aimed at preventing children from taking up harmful habits such as smoking and encouraging them to adopt healthy diets and active lifestyles. To that end, it was considered essential to strengthen the capacity of primary health care services for prevention and control of NCDs. Several delegates underscored the need to build the evidence base on both successful and unsuccessful interventions. More research was needed to gain a better understanding of the risk factors for NCDs and the kinds of health promotion activities that were most effective in preventing and controlling them. One delegate proposed that it might be useful to produce a compendium of case studies in order to identify best practices. Information-sharing and technical cooperation among countries were also seen as valuable strategies,



as were community involvement and multisectoral action. The Pan American Hypertension Initiative and the Canadian Heart Health Initiative were cited as good examples of effective intersectoral collaboration and community-based action. It was suggested that special presentations might be made during the Executive Committee meeting in June to share information on successful experiences such as those.

Dr. Robles considered that suggestion an excellent one. The idea of producing a compendium of case studies was also excellent. The material could easily be drawn from the CARMEN initiative, which had already generated considerable information on strategies and interventions for reducing NCDs. Regarding evaluations of the effectiveness of interventions, during the second half of 2002, the Program on Noncommunicable Diseases would take part in a global effort involving CARMEN and the other five regional networks, aimed at developing a framework for evaluation that could be applied in different contexts and that would reflect variations between and within countries. She agreed that standardized measurements were essential. Although details had not been included in the document, the Program had reviewed surveys of risk factors conducted in the Region and had developed some standards for measurement. The results of that exercise had been published in the November 2001 issue of the *Pan American Journal of Public Health*. The aim was to have more consistent methodologies and indicators so as to obtain comparable data and be able to identify trends, which was critical in order to recognize populations at risk. The Program was also working to obtain data from all countries in order to have a more accurate idea of the magnitude of the burden of chronic diseases.

The Director pointed out that the public approach to NCDs would not yield results overnight. Reducing the burden of chronic diseases would be a long and difficult process. It could take years, for example, to put in place public policies that addressed or influenced the prevalence of risk factors or to persuade people to adopt healthy behaviors. Moreover, the impact of policies and health promotion activities would not be immediately apparent. Approaches like CARMEN could be extremely effective, but applying them was no easy task. It was hard enough to take action on a single risk factor, such as obesity; designing interventions to address multiple factors at the same time was a monumental challenge. Measuring the economic burden of NCDs, also, was intrinsically difficult. Cost-of-illness analysis was complex even in the case of communicable diseases, for which the period of illness had a defined beginning and end. Noncommunicable diseases could last a lifetime, which made analyzing their true cost exceedingly difficult. Those obstacles should be recognized, but they should certainly not deter efforts to confront the NCD epidemic in the Region.

Regarding the possibility of presentations by countries of their experiences with NCD initiatives, he agreed that the suggestion was a good one. However, he proposed

that a special session be organized for that purpose outside the normal working hours of the Executive Committee so as to avoid overloading the Committee's agenda.

***Pan American Centers (Document SPP36/11)***

Mr. Roberto Rivero (Office of Analysis and Strategic Planning, PAHO) summarized the document on this item, which was examined by the Subcommittee at the request of the Executive Committee. He began by reviewing the definition of "multinational center" established by the 18<sup>th</sup> Pan American Sanitary Conference in 1979 and clarifying the distinction between Collaborating Centers and Pan American Centers. The primary difference was that Collaborating Centers did not necessarily receive financial support from PAHO or WHO and they were administratively independent of the PAHO Secretariat. Whereas WHO had rejected the idea of creating research institutions under its own auspices, PAHO had opted to establish Pan American Centers as vehicles for delivering technical cooperation, disseminating information, and fostering research and training in developing countries to build local scientific and technical capacity. That decision had been motivated by three main factors: availability of qualified human resources in the Region; a relative lack of strong research, training, and technical cooperation institutions; and existence of strong interest and political support from Member States. Thirteen centers had been established between 1949 and 1991. Of those, eight continued operating today. The document listed and categorized the centers.

Over the years the Pan American Centers had introduced several innovations which distinguished them from other international institutions in the United Nations and inter-American systems. Notably, they utilized both international and national staff and they forged ties with the private sector, in some cases selling their services and products. Financing had long been the Achilles' heel of the Centers, and the Governing Bodies had repeatedly expressed concern about their financial viability. On several occasions, the Governing Bodies had provided guidance on the Centers' functions and operation and had fixed criteria for judging their performance. In 1978 the Pan American Sanitary Conference had established that they were to be considered an integral part of the PAHO program and a means of achieving program objectives. Additional criteria approved in 1989 provided a framework for assessing the Centers' continued effectiveness as a modality of technical cooperation. The document outlined the situation of the existing Pan American Centers in relation to those criteria.

The Subcommittee welcomed the opportunity to discuss the work of the Centers and ponder what their role should be in the future. The value of the Centers' contribution to research and the development of human resources in the Region was underscored. It was pointed out that the Centers played a vital role in helping small countries carry out activities that they lacked the capacity and resources to accomplish on their own. In particular, the critical role of the Caribbean Epidemiology Center (CAREC) in supporting national programs on HIV/AIDS, tuberculosis, and other infectious diseases was stressed.

Nevertheless, the Subcommittee affirmed the need to regularly reexamine the efficacy and viability of the Centers in the light of prevailing political, financial, and technical realities. In the current context of budgetary pressures, a critical analysis of the Centers was considered especially timely and important.

While the delegates found that the document provided a good historical perspective on the Pan American Centers, they noted that it did not contain sufficient information to allow an in-depth examination of many of the issues raised. In relation to financing, for example, it did not provide much hard data that would enable the Governing Bodies to undertake a cost-benefit analysis of each Center's activities or its contributions to research and training of human resources. More specific information on the Centers' products and their budgets would also be desirable. Though the document emphasized that the Centers were an integral part of PAHO's technical cooperation programs, it did not analyze how they fit into the strategies and work plans of the various technical divisions or how the Centers had contributed to the fulfillment of the divisions' objectives. Detailed information of that kind was essential for the Governing Bodies to make informed and equitable decisions about the Centers, and it should be included in the next version of the document if the item was to be forwarded to the Executive Committee.

The 1989 criteria listed in the document were considered valid standards for assessing the continued relevance of the Centers. One delegate pointed out that one of the foremost criteria for priority-setting in relation to the Centers should be the extent to which human health was affected by a particular determinant. Based on that criterion, he wondered whether it was appropriate for the Pan American Foot-and-Mouth Disease Center (PANAFTOSA), which was concerned primarily with animal health, to continue to operate under the aegis of PAHO. Several delegates voiced support for the sale of services as a means of putting the Centers on a more solid financial footing and reducing their reliance on the Organization's regular budget. However, they also emphasized the need for caution and close monitoring to avoid any conflict of interest and ensure that this form of revenue generation did not cause the Centers to deviate from their core mandate to protect and improve human health. Flexibility, creativity, and the capacity to adapt to the changing needs of the countries were considered essential to the Centers' survival. Delegates highlighted the need to explore new options and models for technical cooperation, including the creation of "virtual centers" and the formation of collaborative networks.

Mr. Rivero observed that the issue of the Centers was very political. As noted in the document, in the 1980s there had been an attempt to begin divesting the Organization of the Centers, but little progress had been made in that direction because Member States and other stakeholders had opposed the idea. He believed the Governing Bodies had been extremely wise when they decided to consider the Centers individually, on a case-by-case

basis, rather than moving towards a wholesale elimination of all Centers. Resolution CSP20.R31, adopted in 1978, called for regular evaluations of each Center. Currently, the Pan American Center for Sanitary and Environmental Sciences (CEPIS) was being evaluated in terms of its relevance, efficiency, and effectiveness. The delegates' comments regarding cost-benefit analysis and evaluation of the Centers' impact were valid. However, while impact assessment of the Centers could be done, he cautioned that it would be a lengthy and expensive process. Responding to the question concerning PANAFTOSA, he noted that in late 1970s the Organization had explored the possibility of transferring responsibility for that Center to the Inter-American Institute for Cooperation on Agriculture (IICA) and/or the Food and Agriculture Organization of the United Nations. Nothing had come of that effort, however, because the other organizations had not been willing or able to absorb the cost of operating the Institute.

The Director pointed out that the ministers of both health and agriculture had repeatedly reaffirmed the critical importance of PANAFTOSA's work and that of the Pan American Institute for Food Protection and Zoonoses (INPPAZ), given the undeniable impact of zoonoses and food safety on the economy and on human health.

The Subcommittee's point regarding the need for flexibility was well taken. In fact, the Centers had demonstrated remarkable flexibility and adaptability over the years, modifying their functions and activities in response to changing needs and changing technology. In addition, some Centers had been closed when it was found that their functions were being duplicated or they were no longer needed because countries had developed sufficient expertise at the national level to perform those functions.

He emphasized that the Centers must be viewed as an essential aspect of the Organization's technical cooperation. As had been pointed out in the Subcommittee's discussion, some Centers provided services that were not being provided elsewhere. Eliminating them would cut off those services, which certainly be a disservice to those countries that relied on their technical cooperation. It was true that financing had been a persistent problem for some Centers. However, he maintained that it was a flaw in conception to think that the Centers should be financially self-sufficient. They had never been meant to be self-sufficient, just as the Organization's technical divisions and programs were not self-sufficient. Moreover, the financial situation of several Centers had improved dramatically in recent years as their collection of assessments had increased. He believed the countries valued the work of the Centers and were willing to support them, although their internal financial situations sometimes made that difficult. The Centers were also receiving growing amounts of extrabudgetary funding. Nevertheless, the Secretariat was taking great care to ensure that funding from external sources or sale of services did not cause the Centers to deviate from the orientations of the technical cooperation program approved by the Member States.

He disagreed with the view that the Organization would continue to suffer budgetary constraints. There was growing support for multilateralism, especially in the wake of the terrorist attacks of September 2001. He foresaw increasing reliance on multilateral approaches and therefore increasing support for multilateral institutions such as PAHO.

Regarding the question of whether this item should be forwarded to the Executive Committee, he believed it would be more useful for the Committee to examine a single Center in depth, rather than engaging in a general discussion of all the Centers. The report on the CEPIS evaluation would be complete by the time the Executive Committee met and he therefore proposed that the Committee focus its attention on that Centers.

### **Other Matters**

The President, acting in his capacity as the Delegate of El Salvador, presented the Director with a commemorative plaque in appreciation of the work of the Organization and his personal contribution towards improving the health of the people of El Salvador. Dr. Alleyne said that he had been honored and privileged to have served the countries of the Americas.

The Director announced that a special ceremony and reception will take place during the World Health Assembly in May to mark PAHO's Centennial.

### **Closing of the Session**

The Director expressed his appreciation to the President for the skillful and expedient manner in which he had conducted the session and thanked the delegates for their enthusiastic participation in the discussions and their keen observations on the documents and presentations.

The President said that it had been an honor to preside over the session and thanked everyone who had contributed to its success. He then declared the 36<sup>th</sup> Session closed.

## AGENDA

1. Opening of the Session
2. Election of the President, Vice-President, and Rapporteur
3. Adoption of the Agenda and Program of Meetings
4. Evaluation of the Strategic and Programmatic Orientations 1999-2002
5. Strategic Plan for the Pan American Sanitary Bureau for the Period 2003-2007
6. Integrated Management of Childhood Illness
7. Extension of Social Protection in Health:  
Joint Initiative of the Pan American Health Organization and the International Labor Organization
8. Health and Aging
9. Regional Strategy for Maternal Mortality and Morbidity Reduction
10. Women, Health, and Development
11. Public Health Response to Chronic Diseases
12. Pan American Centers
13. Other Matters

## LIST OF DOCUMENTS

SPP36/1, Rev. 1 SPP36/WP/1	Adoption of the Agenda and Program of Meetings
SPP36/3	Evaluation of the Strategic and Programatic Orientations 1999-2002
SPP36/4	Strategic Plan for the Pan American Sanitary Bureau for the Period 2003-2007
SPP36/5	Integrated Management of Childhood Illness
SPP36/6	Extension of Social Protection in Health: Joint Initiative of the Pan American Health Organization and the International Labor Organization
SPP36/7	Health and Aging
SPP36/8, Rev. 1	Regional Strategy for Maternal Mortality and Morbidity Reduction
SPP36/9	Women, Health, and Development
SPP36/10	Public Health Response to Chronic Diseases
SPP36/11	Pan American Centers

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