



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 132nd SESSION OF THE EXECUTIVE COMMITTEE

*Washington, D.C., USA, 23-27 June 2003*

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*Provisional Agenda Item 3.1*

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29 April 2003

ORIGINAL: ENGLISH

### **REPORT ON THE 37th SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING**

1. The Subcommittee on Planning and Programming held its 37th Session at the Organization's Headquarters in Washington, D.C., from 26 to 28 March 2003.
2. The Session was attended by delegates of the following Subcommittee Members elected by the Executive Committee or designated by the Director: Canada, Cuba, Dominica, El Salvador, Honduras, Peru, United States of America, and Uruguay. Also present were observers from Argentina, Bolivia, France, Guatemala, Mexico, and Panama.
3. Elected as officers were the delegates of Dominica (President), Honduras (Vice President), and United States of America (Rapporteur).
4. During the Session, the Subcommittee discussed the following agenda items:
  - Policy Orientation for the Pan American Health Organization and Reorganization of the Pan American Sanitary Bureau for Implementation of the Strategic Plan, 2003-2007;
  - Proposed Program Budget for the Pan American Health Organization for the Financial Period 2004-2005;
  - Globalization and Health;
  - Family and Health;
  - Monitoring the Reduction of Maternal Morbidity and Mortality;

- Obesity, Diet, and Physical Activity;
  - Influenza Pandemic: Preparation in the Western Hemisphere; and
  - Ethnicity and Health.
5. The final report of the Session is attached.

Annex



PAN AMERICAN HEALTH ORGANIZATION  
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# 37th SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE

*Washington, D.C., USA, 26-28 March 2003*

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CE132/5 (Eng.)  
Annex

SPP37/FR (Eng.)  
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**FINAL REPORT**

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## FINAL REPORT

1. The 37th 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 26–27 March 2003.

2. The meeting was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Canada, Cuba, Dominica, El Salvador, Honduras, Peru, United States of America, and Uruguay. Also present were observers for Argentina, Bolivia, France, Guatemala, Mexico, and Panama.

### Officers

3. The following Member States were elected to serve as officers of the Subcommittee for the 37th Session:

<i>President:</i>	Dominica	(Hon. Herbert Sabaroche)
<i>Vice President:</i>	Honduras	(Dr. Fanny Mejía)
<i>Rapporteur:</i>	United States of America	(Ms. Mary Lou Valdez)

4. Dr. Mirta Roses Periago (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Karen Sealey (Area Manager, Planning, Program Budget, and Project Support) served as Technical Secretary.

### Opening of the Session

5. The Director opened the session and welcomed the participants to Washington, noting that the spring had also arrived to form a pleasant background for their deliberations and that the glorious day seemed yet more glorious with the news that the hemisphere had just completed 18 weeks of freedom from measles. That was something for all to celebrate, as it was significant progress on the way to the target that had been set at the urging of the countries of the Caribbean. Observing that the present meeting was the second Subcommittee meeting she had been privileged to open as Director—after that on Women, Health, and Development the previous day—she hoped that the delegates would assist her by showing patience and goodwill. She looked forward to interesting discussions and encouraged participants to be frank and to contribute their knowledge and experience for the good of all.

6. The President added his welcome and thanked the Members for their vote of confidence in electing Dominica to serve as President of the Subcommittee. He also congratulated Dr. Roses on becoming the first female Director in the 100 years of PAHO's existence.

**Adoption of the Agenda and Program of Meetings (Documents SPP37/1, Rev. 2, and SPP37/WP/1, Rev. 1)**

7. 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**

***Policy Orientation for the Pan American Health Organization and Reorganization of the Pan American Sanitary Bureau for Implementation of the Strategic Plan, 2003–2007 (Document SPP37/3 and Add. I)***

8. The Director described some of the changes that had been introduced in the organizational structure and functions of the Secretariat since she had taken office in February 2003. Those changes had been made in response to Resolution CSP26.R18, in which the 26th Pan American Sanitary Conference had requested the Director to present an analysis of the existing organizational characteristics and those required for the implementation of the Strategic Plan, 2003–2007 and to submit to the next Directing Council a proposal reflecting her views with respect to the Plan and its implementation.

9. She began by describing some of the health and development challenges and the public health objectives that had shaped her vision for PAHO in the 21st century, which, together with the Strategic Plan, had formed the basis for the changes in the organizational structure. Her vision was one of a Region united and committed to working harmoniously and synergistically to attain the highest possible level of health for its inhabitants, of governments exercising leadership and responsibility in enlisting society as a whole in the effort to improve the health of the people, and of individuals, families, communities, and institutions empowered to seek social justice by promoting health and protecting life. PAHO aspired to be a forum in which the countries of the Americas could discuss their health problems; a consensus-builder and creator of partnerships; an advocate for social equity, social protection, and access to effective health services; a defender of an integrated view of public health, emphasizing the linkages between primary care, health promotion, and citizenship and human rights; and a generator, disseminator, and repository of reliable health information.

10. With a view to equipping the Secretariat to realize that vision and carry out the Strategic Plan approved by the Member States the previous year, certain necessary

organizational attributes had been identified and a set of strategic objectives for organizational change had been established. Those objectives were: to make work in and with the countries PAHO's central focus; to ensure that the Organization was in the mainstream of health and health-related policy debates at all levels; to build capacity at the local, subregional, and national levels; to act synergistically with more health development partners; to networking and share knowledge inside the Organization and between the Organization and its environment, especially the countries; to forge closer links in health planning and programming between the various levels, both within the Secretariat and in the countries; to maximize extrabudgetary resources, while ensuring attention to the priorities established by the Governing Bodies; to achieve greater programmatic integration and capacity for strategic planning of the Secretariat's work in order to optimize the use of physical, financial, human, and knowledge and information technology resources; and to increase efficiency, transparency, and productivity.

11. The changes in organizational structure described in Document SPP37/3, Add. 1, were intended, in keeping with those strategic objectives, to strengthen emphasis on country support, assure vertical and horizontal integration of planning within the Secretariat and with the countries, and consolidate information and knowledge management. As part of the transition to the new structure, the Secretariat had realigned projects and budgets in the Biennial Program Budget, 2002–2003, without—she was pleased to report—any disruption of the technical cooperation currently under way. At the same time, it had developed a new program budget proposal for 2004–2005, which the Subcommittee would be examining under a separate agenda item. In addition, drawing on the reform processes under way within WHO and the rest of the United Nations system, as well as the state reform processes in the countries, the Secretariat had sought to introduce new methods of work that would allow for greater flexibility, increased teamwork and staff participation in policy and program formulation, and innovative use of expertise in countries and among partners. The transition process thus far had been marked by extensive consultation and collaboration with staff and with Member States and other stakeholders and partners, with emphasis on communication and feedback and on continuously assessing the impact of the changes in order to make any necessary adjustments.

12. As the transition to the new structure proceeded, the Secretariat would continue to seek stakeholder input and fine-tune as needed. It would also avail itself of the funds available from the United Nations and other sources for organizational reform initiatives. PAHO had never sought such assistance for its own internal restructuring but it would do so now in order to ensure that sufficient resources were available to bring the process of organizational change fully to fruition. Dr. Roses concluded by noting that one of PAHO's strengths had always been its ability to change. It was that ability that had enabled the Organization to anticipate and respond to the Region's changing health needs

for the past 100 years and it was that ability that would enable it to meet the challenges of the 21st century.

13. The Subcommittee agreed that it was essential for PAHO to respond to change and felt that the more streamlined organizational structure would allow it the necessary flexibility to do so effectively. The Subcommittee also applauded the transparency and inclusiveness of the restructuring process and commended the Director for her receptiveness to Member States' comments and suggestions. Delegates welcomed the Director's oral presentation, which had helped elucidate the rationale for the organizational changes outlined in the document. It suggested that, in the interest of greater transparency, the next version of the document should contain more explanation of where and why those changes had been made.

14. Clarification was sought regarding some of the modifications, notably the rather significant shift in the role of the Deputy Director and the separation of the budget and finance units, which had traditionally been together. Some concern was expressed about possible overlap in the functions of the Deputy Director and those of the Director of Program Management with respect to the Governing Bodies. The need for clear lines of authority and delineation of the respective roles and responsibilities of those two offices was emphasized. In addition, it was suggested that some of the senior management positions might be overloaded with functions. Information on the budgetary impact of the organizational changes was also requested.

15. As the uncertainty that inevitably accompanied any change might impair the Organization's ability to respond to urgent problems that arose in the Region, the Secretariat was encouraged to complete the organizational restructuring process as swiftly as possible. It was also urged to develop indicators to monitor the impact of the organizational changes and, especially, of the increased emphasis on horizontal collaboration across programs.

16. The Subcommittee recommended that the document be forwarded for consideration by the Executive Committee in June, at which time the Director was requested to update Member States on the progress of the reorganization process and how it had enhanced the Secretariat's efficiency, responsiveness, and productivity. She was also asked to provide information on how the recommendations of the working groups were being implemented.

17. Dr. Roses noted that the Constitution of PAHO identified only three posts within the Bureau—those of Director, Deputy Director, and Assistant Director—but it did not specify their functions. Moreover, it gave the Director wide latitude to decide how best to organize the Secretariat's institutional, human, and financial resources in order to carry out the mandates entrusted to it by the Governing Bodies. She felt that the “founding



fathers” had shown great wisdom in establishing that legal framework for the Organization, as it had allowed for greater flexibility and made it easier for the Secretariat to adapt to change and remain responsive to the needs and expectations of the Member States.

18. All the structural and functional changes introduced had one fundamental purpose: to enable the Secretariat to serve the countries better. It was for that reason that she was seeking input from the Member States. Through the years, previous Directors had altered the organization of the Secretariat and the functions of its staff—sometimes radically so—but those changes had never been discussed by the Governing Bodies. She believed it was important to involve the countries in the restructuring process in order to ensure that the Organization was truly responding to its Members’ needs.

19. Turning to some of the specific concerns raised by delegates, she emphasized that the changes in the Secretariat had been inspired mainly by the changes that had taken place in the countries and by the major reforms introduced in the United Nations and inter-American systems in recent years. For example, the creation of the Office of the Director of Program Management was an attempt to align PAHO’s structure more closely with that of the rest of the World Health Organization—as similar entities existed at WHO Headquarters and in all the other regional offices—and it reflected the effort within WHO to enhance support to the countries and make the coordination of program management more transparent. With regard to the respective functions and responsibilities of the Director of Program Management and the Deputy Director vis-à-vis the Governing Bodies, she pointed out that the latter had never been entirely responsible for the Governing Bodies. While the Deputy Director would continue to exercise general oversight of matters relating to the Governing Bodies and would also continue to serve as Technical Secretary for their meetings, other direct support functions would be transferred from the area of Administration to the area of Program Management.

20. As for the concern that some of the senior management posts might be overloaded with functions, the Secretariat had undertaken a careful analysis of lines of responsibility, functions, and human and financial resources allocated to each area, and had introduced changes with an eye to correcting some imbalances that had existed in the previous organizational structure. She believed that the new structure was indeed more balanced in terms of distribution of functions. Regarding the separation of the budget and finance units, the budget was viewed as an instrument for carrying out the Organization’s program, and the Secretariat felt that, as such, it should therefore be placed within the area of Program Management, while finance should remain under Administration. However, the Secretariat would be developing indicators to assess the effects of this change on the Organization’s performance and, if it were found that it was not yielding the desired

results, would make the necessary adjustments. The same held true for all the other changes that had been introduced in the organizational structure.

21. Finally, with respect to the budgetary impact of the changes, there had been no costs associated with the restructuring process, except in terms of extra work for the staff. The Secretariat had not retained any outside consulting firms to assist it with the reorganization, though it had sought the advice of some retired staff members. A renewal fund had been created by transferring 2003 budget funds allotted to vacant posts. Thus far, about \$150,000<sup>1</sup> had been expended from that fund, mainly to cover the travel costs of transferred staff and to pay the salaries of the retired staff hired as consultants. The reorganization itself was not expected to have any budgetary impact at all. On the contrary, because it had streamlined the Bureau's structure, it would free up additional resources to support work in the countries.

***Proposed Program Budget for the Pan American Health Organization for the Financial Period 2004–2005 (Document SPP37/4)***

22. Dr. Daniel López Acuña (Director, Program Management, PAHO) presented the program budget proposal for 2004–2005, noting that the document before the Subcommittee was the result of a process of consultation and identification of priorities that had begun several months earlier. That process had involved not just the staff of the Secretariat, but also the PAHO/WHO country representatives and government officials from all Member States. He began by reviewing the planning mandates that had formed the basis for formulation of the budget, notably, the Strategic Plan, 2003–2007, and other mandates of the PAHO and WHO Governing Bodies, the WHO global and PAHO regional policy frameworks, WHO's Corporate Strategy and priorities, and the health-related goals emanating from the United Nations Millennium Summit.

23. In consonance with the new organizational structure, the budget proposal contained several new appropriation sections and a revised classified list of programs, or areas of work, within each of the nine appropriation categories: Executive Direction, Governance and Partnerships, Country Program Support, Intersectoral Action and Sustainable Development, Health Information and Technology, Universal Access to Health Services, Disease Control and Risk Management, Family and Community Health, and Administrative support. The revised program list, which reduced the number of areas of work from 61 to 41, reflected a more integrated, targeted, and concentrated approach to program delivery. It was also more convergent with the WHO program structure. In formulating the budget, the Secretariat had followed a strategy that shifted resources towards priority programs and countries, maintained current-level funding for the five priority countries identified under the Strategic Plan, and maximized economies in the

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<sup>1</sup> Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

areas of management and administrative support. Only essential cost increases had been considered.

24. The proposed PAHO/WHO budget for 2004–2005 was \$264,773,000. That figure was \$3,291,000, or 1.3%, higher than the 2002–2003 figure of \$261,482,000. The increase included \$1,991,000 for post cost increases mandated by the United Nations General Assembly and \$1,300,000 for obligatory increases in PAHO's contribution to the WHO retiree health insurance fund. The WHO share of the budget for 2004–2005 was expected to be \$75,399,000, making the PAHO portion \$264,773,000. However, those figures assumed that the slight proposed increase in the WHO share would be approved by the World Health Assembly in May 2003. If not, the WHO portion would remain at the 2002–2003 level of \$73,293,000, and PAHO would be obliged to cover the difference of \$2,106,000. In any case, it was important to note that, with the application of Resolution WHA51.31, the WHO contribution to the total budget had dropped by some \$9 million since the 1998–1999 biennium. That reduction had severely taxed PAHO's ability to meet its commitments, necessitating increasing effort at the regional level.

25. The PAHO portion would be funded by \$175,874,000 in quota contributions from Member States and \$13.5 million in projected miscellaneous income. Assessments would rise by 3.3%, which was one of the smallest increases in PAHO's history. The amount of miscellaneous income expected was substantially less than the projection for 2002–2003, owing to falling interest rates and a generally unfavorable investment climate. It would therefore be necessary to absorb some reductions in non-post program resources. In fact, since 1986, the regular program budget had contracted 21% in real terms. At the same time, the number of posts had decreased from 1,222 to 835. However, thanks to enormous gains in efficiency and productivity, it had been possible to maintain a high level of program performance despite the diminished human and financial resource base.

26. The Subcommittee welcomed the informative presentation on the proposed budget for 2004–2005. However, several delegates expressed the hope that the budget document submitted to the Executive Committee would contain more detailed information on the program, including results indicators for each program area and a breakdown of resources for the regional and country levels, as well as comparative data that would enable Member States to appreciate how the changes in the organizational structure had affected budgetary allocations to the various areas of work. Delegates also signaled the need for more information on how the budget would contribute to achievement of the Millennium Development Goals, the public health objectives for the Americas identified by the Director in her presentation on the new organizational structure, and other PAHO and WHO planning mandates.

27. The delegations of Canada and the United States of America stated that their governments continued to favor zero nominal growth in the budgets of all agencies in the

United Nations system, although the Delegate of Canada noted that his delegation was cognizant of PAHO's financial situation and would take that into account when it discussed the budget proposal with national authorities. Several delegates voiced concern about the proposed increase in assessments, especially given the difficulty that many Member States were having in meeting even their current obligations. All Member States were urged to pay their 2003 assessments and to settle any arrears they might have, as that would help to ease the Organization's financial situation and enable it, in turn, to fulfill its commitments to the countries.

28. The effort to align PAHO's areas of work more closely with those of WHO was applauded. At the same time, the need for integration and collaboration across those areas was emphasized, especially in relation to the area of family and community health, which was considered to be of crucial importance. The importance of building alliances with other international and national institutions was also underscored. It was pointed out that, among other advantages, such joint effort would significantly augment the impact of the budget resources allocated to each area. The Organization was encouraged to maximize efficiencies and economies and to seek creative solutions to accommodate mandatory increases in personnel costs while still ensuring that the limited funds available were used to address the critical health needs in the Region. Several questions were asked about miscellaneous income and about the amount of extrabudgetary funding that might be available to support PAHO's work in the various program areas.

29. Dr. López Acuña thanked the delegates for their feedback, which would be most helpful in the second stage of the budget presentation process: preparation of the document to be submitted to the Executive Committee in June. He assured the Subcommittee that that document would be greatly expanded and would contain much more detailed information on program activities, expected results, and indicators, as well as data that would enable comparisons between the current biennium and the next one. Several additional documents were distributed which provided more information on the areas of work and some preliminary comparative data.

30. Replying to the comments concerning the need to integrate activities, he emphasized that the various program areas did not function as airtight compartments, but rather as interrelated components that worked together to achieve the public health objectives for the Americas. The management model put in place by Dr. Roses sought to intensify that synergy and interaction in order to enhance the impact of the Organization's work at the country level.

31. Concerning incorporation of the various planning mandates into the budget, he explained that budget formulation was an iterative process that included numerous stages of review and analysis. Input was sought from national health authorities, as well as staff at PAHO Headquarters and in the countries offices and Pan American centers, and the

proposal was continually refined to ensure that it was consistent with the various global and regional mandates and that it responded to national priorities.

32. As for extrabudgetary resources, he pointed out that it was intrinsically difficult to estimate the amount of such funding that would actually materialize. The Secretariat did have some projections, which it would be happy to make available, but delegates should be aware that the reality was always different from the projections, and sometimes drastically so. Another factor in estimating extrabudgetary funding was the extent to which resources mobilized by WHO Headquarters were being channeled to regional and country operations. The issue had been discussed recently by the directors of program management from the various regions, and there was a general sense that too many of those resources were being concentrated within the central structures of WHO and that more should flow to the regions.

33. Mr. Eric Boswell (Director of Administration, PAHO), speaking at the suggestion of Dr. López Acuña, responded to the questions regarding miscellaneous income. He pointed out that, while the Secretariat always based its projections on solid information and analysis, and it believed that the figure for 2004–2005 was fairly accurate, predicting miscellaneous income was an art, not a science. Factors beyond the Organization's control often affected actual outcomes. In 2000–2001, for example, whereas miscellaneous income had exceeded expectations, in the current biennium, though PAHO had budgeted \$16.5 million, the actual figure would probably be closer to \$11.5 million, owing to the sharp decrease in returns on fixed instruments.

34. Echoing Dr. López Acuña's comments, the Director said that the document before the Subcommittee was the first iteration of the budget proposal. The Secretariat had refined the proposal since the document was published and would continue to work on it prior to the Executive Committee Session in June, bearing in mind the comments it had received from Member States, both in formal meetings and in informal consultations.

35. Some of the Subcommittee's comments had related to changes in the organizational structure and how they had affected budgetary allocations. It was important to distinguish between the structure of the Organization and the structure of program budget. In previous budget cycles, the budget structure had corresponded exactly to the organizational structure. However, several evaluations had found that that approach limited flexibility and made it difficult to address issues in an integrated, horizontal manner. The Secretariat believed that the work of the Organization could be enhanced when the budget and organizational structures were complementary but not necessarily identical. The budget structure outlined in the document was intended to facilitate the teamwork and interprogrammatic collaboration that Member States had said they favored.

36. At the same time, the budget structure sought to foster a new conception of the regional programs. In the past, the term “regional program” had been used to designate the structural units of the Secretariat. As a result, those programs had been viewed as the province of the Secretariat, not as a vehicle for collective effort by the Organization as a whole, including both Secretariat and Member States, to address common health problems and achieve common health objectives. The immunization program, which was perhaps the Organization’s flagship program, exemplified the elements required of an effective regional program: it encouraged collective action in the pursuit of a solution to a specific problem, with clearly delineated indicators and strategies and a specific resource allocation, an approach which, in addition, facilitated the mobilization of extrabudgetary resources, not just from countries or agencies outside the Region but, more importantly, from the countries of the Americas themselves.

37. Noting that several delegates had alluded to the format of the WHO budget as one that PAHO should emulate, she pointed out that the Region could take pride in the favorable reception accorded to that budget by the WHO Executive Board in January. Many of the features of that budget model were based on the experience of PAHO, which has been recognized as the Region that had made most headway in budget transparency and accountability.

38. Another consideration in budgeting was the unforeseen needs and demands from the countries that inevitably arose after the budget had been approved. The Organization had always tried to respond to those contingencies, and it would continue to do so. However, the Member States also had a responsibility to avail themselves of the support available through other international forums in which they participated. One example was the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which offered an excellent opportunity for countries to seek additional resources to address those epidemics. However, for PAHO, the emergence of that opportunity had created an additional mandate. It was not a formal mandate from the Governing Bodies, but one that came directly from countries wishing to participate in the Fund, which had requested Organization’s assistance in formulating projects. In response, PAHO had mobilized around \$400,000 by shifting funds within the budget in order to help the countries develop and negotiate funding for their projects. As a result, the countries of the Americas had one of the highest percentages of project approval. That was unquestionably due to the quality of the projects, which, in turn, reflected the level of technical cooperation provided by the Organization.

39. That type of assistance was one of the new roles the Organization was being called on to play in relation to resource mobilization. Another was supporting the ministries of health in their efforts to mobilize resources from both international financial institutions and from other countries and through horizontal cooperation. While PAHO was happy to provide such assistance, it must be recognized that this shift in its roles did

not mean that the Organization could do its work more cheaply. The roles might be different, but PAHO still needed resources in order to perform them effectively. And it needed solidarity from the countries in order to channel more resources to those who needed them the most and to put countries in a position to take advantage of opportunities that arose to obtain additional funding.

40. Another recent and very important focus of work for PAHO was the generation of solid information and evidence to help ministries of health make the case for health with their national budget authorities. It was to be hoped that those national budgets would then reflect the need to provide the Organization with the wherewithal to continue its work.

#### ***Globalization and Health (Document SPP37/5)***

41. This item was discussed in a joint meeting with the Subcommittee on Women, Health, and Development, which held its 20th Session on 25 and 26 March 2003. Dr. César Vieira (Area Manager a.i., Governance and Policy, PAHO) introduced the item, and presentations on various aspects of globalization and health were then given by four external panelists.

42. Dr. Vieira outlined the main points of Document SPP37/5, which examined the repercussions of globalization, with particular attention to its impacts on population health. While many of those impacts were positive—greater access to healthful goods at lower prices, for example—some were negative, such as increased consumption of unhealthy food and higher potential for the spread of disease. Globalization had resulted in increased circulation of products and services, knowledge, behaviors, and consumption patterns between countries. Though until recently health services had not been considered tradable goods, international trade experts now recognized that technological and organizational development in the health sector had made it possible to market such services internationally. The document identified four modes of international trade in health services in the Americas: cross-border delivery, movement of patients, commercial presence of foreign health service providers, and migration of health professionals. Those various modes had positive and negative implications, both for exporting and importing countries.

43. The case of drugs and medical equipment was illustrative of some of the issues surrounding international trade in health goods. One of those issues was the emergence of the concept of “global public goods,” which would be addressed in greater detail by some of the panelists. Among the positive effects of the debate on global public goods was the creation of global funds to facilitate access to drugs and vaccines, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the Global Alliance for Vaccines and Immunization (GAVI).

44. A number of forums and agreements at the global, regional, and subregional levels provided guidance for international cooperation in globalization and health. They included the General Agreement on Trade in Services (GATS), the Agreement on Trade-Related Aspects of International Property Rights (TRIPS), the Free Trade Area of the Americas, and subregional bodies such as the Southern Common Market (MERCOSUR) and the Caribbean Community (CARICOM). Those agreements were described in the document and would also be examined further by the panelists.

45. The proposed areas for PAHO/WHO technical cooperation in relation to globalization and health included impact assessment studies to identify the positive and negative impacts of globalization on health, trade regulation from a health perspective, establishment of tariffs and prices that were sensitive to health needs and realities, creation of databases and dissemination of information on trade in health goods and services, and incorporation of health perspectives in trade negotiations and development strategies discussed in the Region.

#### *Global Public Health Goods and Global Governance*

46. Dr. Ilona Kickbusch (Division of Global Health, Yale University) presented an overview of some of the ways in which globalization was affecting governance and vice versa, and then examined some of the challenges of global governance in health and the role of international health organizations in the new globalized context.

47. One of the allegations in the debate about globalization was that it weakened the nation state, and nation states therefore had increasing difficulty in carrying out the four functions that modern states were called upon to assure for their populations: security, social welfare, the rule of law, and national identity and channels of participation. Globalization had brought about changes in context that necessitated new policy responses. A new mindset was also needed, one which viewed globalization not merely as internationalization but as a shift to a system in which links and networks existed not just between nation states but involved a whole wide range of actors. That change in mindset might have significant implications for international organizations and multilateral systems that were based on the nation state principle.

48. Whereas governance had previously been defined as a responsibility of nation states, it was now being defined as a joint responsibility of the global system, which comprised not only states, but multinational corporations, civil society organizations, and the many international institutions that currently existed. The chief global governance challenges were human security and human rights, fairness in national and global distribution of resources, an international rule of law and a global ethics, and forging a common identity as global citizens. In each of those areas, health played a central and



crucial role. The recently adopted Millennium Development Goals also plainly reflected the joint global governance challenges.

49. One response to the challenges of global governance was the search for “collective intentionality,” i.e., the definition of joint priorities. That effort had given rise to the identification of global public goods, and health was defined as one of those goods. In this new context, health was being debated in new ways. It was no longer viewed as strictly a health and technical issue, but as a security issue, a foreign policy issue, a macroeconomic issue, a human rights issue, and as a global public good to which everyone needed to contribute. That shift had engendered growing attention to health in international forums. It had also given rise to new global governance structures, such as the global funds mentioned by Dr. Vieira, and new alliances and public/private partnerships, in which international organizations were one member but were no longer the driving force.

50. The present period might be described as an interregnum in the search for global governance: a period of transition between one system in global health that was no longer working well and a new system that would provide a means for approaching issues that transcended national frontiers and establishing international “rules of the game” that were defined more by relationships than by institutions. In a sense, global health governance described the role of health organizations at this point in time. They faced two major challenges in carrying out that role. First, health governance was still seen mainly as a responsibility of nation states, but the determinants of health and the means to fulfill them were increasingly global. Second, in the interregnum, there was a feeling that no one was in charge and that the present international health system was subject to failure. That perception was due in part to the fact that health problems were still being defined in terms of national interests and not as a global public good, foreign and domestic policy were still being approached as separate issues, and outdated concepts of foreign aid were being applied. Probably the greatest challenge, however, was to address the systems issues and political determinants that were contributing to the present crises in global health, without which those crises would no doubt continue.

#### *Trade in Health Services in the Western Hemisphere*

51. Prof. David Warner (Lyndon B. Johnson School of Public Affairs, University of Texas) focused his remarks on the four modes of trade in health services and the major issues surrounding each one, identifying possible roles for PAHO in the area of health services trade. In the case of cross-border service delivery, in which services originated in one country but were received in another. This type of service delivery was accomplished mainly by means of telecommunications. Even domestically, telecommunications were increasingly being used to delivery diagnostic and treatment services. Health education and information services could also be delivered by this means. PAHO’s Virtual Health

Library was one example. PAHO might also have a role in helping evaluate and rate websites that provided health-related information. Improving the availability of information in Spanish, the language of most of the Region's non-English-speaking countries, was also another important function for the Organization.

52. The second mode of trade in services was movement of patients. Typically, people crossed borders to receive health services for quality or economic reasons. However, cross-border health insurance might be another reason for crossing borders in the case of people who lived in one country but worked in another or those who lived and worked in one country but their families lived in another. The biggest issue, especially from an economic standpoint, in cross-border coverage was probably portability of retirement health benefits for persons who had worked in one country but wished to retire in their countries of origin. More research was needed into the quality, access, and cost aspects of that issue.

53. In relation to the third mode, commercial presence of foreign service providers, the major issues were probably regulation of private providers and private insurance and whether foreign providers would be subject to the same regulations as domestic ones. The fourth mode was migration of health professionals, which raised many complex issues. In the Americas, the United States was by far the largest importer of health workers. However, it was importing the vast majority of those workers from countries outside the Region. Despite the existence of the North American Free Trade Agreement, virtually no nurses came from Mexico, even though there were eight million Mexicans living in the United States and there was a tremendous need for Spanish-speaking nurses. With regard to physicians, only 2.3% of foreign-trained participants in United States residency programs were from Latin America. Limiting access to advanced medical training programs in that country could have serious consequences for medicine in the Region and could hinder future cooperation in research, delivery of services, and other areas.

54. A key role for PAHO might be to help develop more effective cooperation between training programs. Other potential roles included working to set standards, promoting enhanced capacity of the health sector through the Region, helping the nations of the Region benefit from increased globalization and world trade, and promoting modernization of health systems and services.

#### *Impact of Globalization on Women's Health*

55. Dr. Maitreyi Das (Human Development Network, World Bank) described some of the potential linkages between globalization and women's health, explained some of the problems inherent in identifying and studying those linkages, and suggested some ways in which ministries of health could help ensure that globalization did not impact negatively on women's health.

56. As other speakers had pointed out, globalization meant global integration of world markets. In terms of health, what that meant was foreign direct investment in the health sector, migration of people and services, free flow of goods and services between countries, and global flow of ideas (the “information revolution”). It also meant, however, that infectious diseases that had earlier been concentrated in certain areas now became global problems.

57. The evidence available on the linkages between globalization and women’s health was highly equivocal. The phenomenon was intrinsically difficult to study. One problem was attribution of causality. It was difficult to determine whether changes in women’s health were due only to globalization or whether other factors came into play. Defining and measuring globalization was another obstacle, as was lack of reliable data. The linkages were difficult to pinpoint because they could be direct or indirect, short- or long-term, and positive or negative, sometimes simultaneously. At times, the effects of globalization were contradictory or unintended. For example, in some countries, the huge increase in female employment had meant that women were delaying the age of marriage, which had had effects on fertility and other aspects of women’s health. Inequalities and cultural factors also influenced the linkages between globalization and women’s health. Moreover, health could affect globalization. Current health economics studies were looking at the effect of women’s health on trade or macroeconomic growth, for example, and at other examples of this reverse causality.

58. Globalization could have an impact on women’s health through three main mechanisms: women’s employment, trade agreements, and health sector reform. In all three areas, the effects might be positive or negative. For example, female employment had grown massively in the years since globalization had begun. On the positive side, that had led to increased income, self-esteem, and mobility for women, which had increased their access to health and support structures. However, the rise in women’s employment had also had negative consequences, such as heavier workloads, loss of leisure time, increased stress, and exposure to occupational risks. With respect to trade agreements, positive impacts included greater potential access to drugs, technologies, information, and services. But the cost of those drugs and services might be prohibitive. Another negative consequence might be out-migration of skilled personnel. As for health sector reforms, the principal issue was whether they were creating an equity-efficiency trade-off. While trends such as increased competition and involvement of the private sector could improve efficiency and quality of services, they might also compromise access for the most vulnerable women. Similarly, cost recovery schemes might improve financial sustainability, but they could also deny services to those who needed them most.

59. Ministries of health could help minimize the potentially negative effects of globalization on women’s health by sensitizing ministries of finance and trade and building alliances with ministries of labor, drawing attention to women’s health priorities

in the framework of international trade negotiations and ensuring that analysis of the possible health effects of trade liberalization was done *ex ante* rather than *ex post*, promoting women's needs and issues of equity and access in the debate on health care financing, involving women's health activists and community-based organizations in monitoring and evaluation of health sector reform and macroeconomic policies, and making health sector reform work for women's health and for the most vulnerable women.

### *Global Negotiations on Health and Trade*

60. Dr. Nick Drager (Strategy Unit, Director-General's Office, WHO) outlined the work being undertaken by WHO, a lot of it in partnership with PAHO, to try to inform trade negotiation processes in order to place public health interests higher on the trade agenda, focusing on trade in health services and GATS.

61. WHO sought to take a balanced view of globalization, considering both opportunities and risks. The Subcommittee was well aware of the risks, which included cross-border transmission of disease, marketing of harmful products and unhealthy behaviors, and environmental degradation, to name a few. However, where there were risks, there were also opportunities. Some of the health opportunities associated with globalization included wider dissemination of knowledge, more incentives for research on diseases of the poor, greater availability of resources for effective interventions, and new rules to control cross-border risks. Similarly, there were opportunities and risks associated with the four modes of trade in health services. WHO sought to enable countries to take advantage of the opportunities and mitigate the potential risks.

62. The general objective of WHO's work in relation to health and trade was to enhance capacity in the Organization and in Member States to recognize and address the health implications of multilateral trade agreements. This work had four functions: development of WHO policies and strategic approaches, analysis and research, development of tools and training, and country support. The five trade agreements with which the Organization was concerned were the General Agreement on Tariffs and Trade (GATT), which governed trade in goods; the Agreement on Technical Barriers to Trade (TBT) and the Agreement on Application of Sanitary and Phytosanitary Measures (SPS), TRIPS, and GATS. The three major public health issues addressed under those agreements were food safety, access to drugs, and trade in health services.

63. GATS was one of the most important trade agreements to emerge from the Uruguay Round of trade negotiations, as it provided a multilateral legal framework for trade in services. It also created numerous challenges for people working in public health. GATS had become a subject of significant controversy, especially with respect to whether the agreement represented an opportunity or a risk in relation to public service

delivery. The GATS negotiations encompassed issues relating to both rules and market access. The question of market access in health was one that many countries were already grappling with and others would undoubtedly be called upon to address it in the near future. Because GATS was still being negotiated, the health sector had the opportunity to provide input and exert influence in order to assure adequate attention to the agreement's health implications.

64. Some of WHO's activities in relation to GATS and trade in health services included development of guidelines to assist Member States in carrying out a country analysis to inform policy formulation and negotiations, collaboration with the Organization for Economic Cooperation and Development to develop essential data sets, a legal analysis of GATS from a public health perspective, monitoring and tracking of the GATS negotiations, and publication of a handbook on trade in health services and GATS. In addition, WHO had collaborated with the World Trade Organization (WTO) in producing a book that presented a balanced, evidence-based view of the subject. That book was a good basic resource on trade and health. It was available in English, French, and Spanish, and would be made available to all Member States.

65. The Subcommittee welcomed the document and presentations, noting that they gave a good overview of the issues surrounding globalization and health and would serve well in launching a discussion on how PAHO could best address the health effects of globalization. It was suggested that in the next version of the paper, the concept of globalization should be operationalized, in the sense that the task should not be to define globalization but to identify the specific elements of the subject that should be addressed. For example, while the presentation had focused on international trade agreements, other aspects of globalization were certainly also relevant, such as the greater movement of people across frontiers. That, too, had health implications, such as the risk of disease spread. In that connection, the Delegate of Canada reported that his country had recently declared a health emergency with respect to severe acute respiratory syndrome (SARS).

66. It was suggested that five questions might help to highlight the key elements of globalization on which the Organization should focus from the viewpoint of impacts on health and health systems: What were the key factors of globalization impacting health in the Region? What was known about the impact of those factors? What objectives and strategies should ministries of health adopt to address the impact? How could PAHO build on what WHO had already done? What assistance did PAHO Member States need to deal successfully with globalization? In answering those questions, the Organization should seek to view the issues through a gender lens. PAHO was also encouraged to pursue research into the linkages between health and trade, which would enable it to offer practical ways for health sector representatives to participate in trade policy negotiations or discussions.

67. Maintenance of policy flexibility was seen as a key factor for countries that wished to preserve health care systems in the context of international trade agreements. PAHO Member States needed to be able to set policy, so as to achieve the benefits of globalization while controlling some of its negative aspects. The blend of policy choices would vary from country to country within the Region, but one thing would be common: if policy flexibility were not protected, then the outcomes from globalization would be less than optimal. As the document had pointed out, policy coherence between ministries responsible for trade and those responsible for health was key to achieving beneficial outcomes from globalization. That topic would be one of the themes of a joint WHO/Health Canada workshop to be held in the coming summer.

68. Delegates welcomed the emphasis placed by one of the panelists on health as a fundamental component of development, pointing out that the same view was stressed in the UNDP's Human Development Report. It was suggested that the issues raised by another panelist with regard to mobility of labor and services would make an important addition to the content of the document, which would benefit from an analysis of the structural conditions of the labor market for health professionals and from identification of ways to reduce the economic disparities between countries.

69. Several delegates observed that the presentations had helped broaden the approach taken by the document, since in some places the latter gave the impression that the health dimensions of the issue of globalization basically had to do only with trade in drugs and medical devices, whereas the presentations had shown clearly that there was a need to go further and also consider trade in services. Additionally, the presentations had made it clear that in the specific area of trade in drugs there was a need to think not in national but in regional terms.

70. The Delegate of the United States said that his delegation, too, had found the presentations informative and useful. However, the United States was extremely disappointed with Document SPP37/5. It gave a biased and negative impression of trade and economic interchange and made recommendations for PAHO action that went well beyond the Organization's mandate and competence. The agenda item should not move forward to the Executive Committee without major revisions and a sharper focus on PAHO's specific public health role. The document covered a wide variety of issues, some directly related to health and others marginally related, but many of them were squarely within the remit of the international body responsible for trade issues, the World Trade Organization, not PAHO. PAHO should focus on helping Member States address non-trade issues, such as health infrastructure and education and the acquisition and distribution of needed medicines under liberalized trade rules. Several World Health Assembly resolutions gave direction to WHO in dealing with trade and health issues. When WHO wished to offer technical assistance to Member States in relation to WTO agreements, it was obliged to defer to WTO or the World Intellectual Property

Organization (WIPO) as the technical experts. PAHO as the Regional Office of WHO for the Americas should also defer to the relevant international bodies when asked to provide substantive technical assistance.

71. Dr. Rocío Sáenz (Costa Rica, President of the Subcommittee on Women, Health and Development) remarked that the document and the presentations did not seem to contain much discussion of the specific needs of vulnerable groups, in particular women. The role of PAHO and WHO was not only to raise topics for discussion but also to advocate firmly for particular attitudes that should be taken into account in negotiations. She noted that the Subcommittee on Women, Health and Development had prepared recommendations that related to the topic. Those recommendations would be submitted for consideration by the Executive Committee in June.

72. Responding to the Subcommittee's comments, Dr. Kickbusch returned to the issue of the interface between globalization, gender, and health. It had been pointed out that rapid social change and the change in the role of men led to responses that could have unintended consequences for women, perhaps taking the form of violence. Another aspect of the gender issue was the way in which global restructuring changed the lives of young men in countries with a very high youth population, leaving them with insufficient opportunities for employment and a useful male role. It was very important to consider the positive and negative impacts of globalization, not so much on women or men but rather on the relations between them.

73. Dr. Das pointed out that all that was available at present was an *ex post* idea of the impact that globalization had on women's health and on gender relations. It was true that the empirical evidence was mixed, inadequate, and contradictory, but the links were fairly clear. It was also clear, for example, that men's and women's health needs were different. It was important now to move to an *ex ante* understanding of what happened, which meant involving women's organizations in interaction with ministries of health, in policy formulation, and in trade negotiations. Secondly, the issue of adolescent health was important, particularly in an era of public sector downsizing and huge economic liberalization in which the 15 to 19 year-old segment of the population, both male and female, was likely to be faced with increased unemployment. In particular, attention must be given to the health needs of young women, in terms of their sexual rights and reproductive rights. There were huge political issues involved in that area, but failure to encourage the most vulnerable groups of young girls to access the kind of reproductive health services that they might need could have huge impacts on that age cohort as it grew older.

74. Dr. Warner reiterated that as there was increased migration of labor and capital within the hemisphere, there would also be a need to consider what were the broader implications for the integration of health systems. Dr. Drager said that in the area of

policy coherence, particularly between health and trade, WHO certainly had a role, both at world and at country level. There were regular meetings between the Directors-General of WTO and WHO, and the two organizations worked closely together at the technical level. WHO would expect to continue supporting countries and their ministries of health, in terms of providing the evidence and the analysis allowing for informed inputs to the negotiations between ministries of trade. The idea was not to try to create a huge health and trade program. The group at WHO Headquarters working on the issues was small, and would stay small. The real action was at the country and regional level, which was where WHO hoped to strengthen capacity by collaborating with centers of excellence in the various countries.

75. Dr. Vieira thanked the participants for their comments, especially the critical ones, which were necessary to improve and strengthen the document. The suggestions for operationalizing the concept of globalization and focusing on the specific issues that really mattered for the health sector were very important and would be taken into consideration in the next version of the document. Part of the work that had been done in that area had benefited greatly from experiences in Canada, such as the consultation between Health Canada and civil society on the implications of the health issues arising from trade agreements. Another useful experience had been a joint undertaking in Montevideo involving researchers in the trade area and researchers in the health area, who had discussed some of the same issues broached by the panelists. The encounter had produced some very good ideas in terms of follow-up and further analysis. With reference to the several suggestions on sharing information and experience, he pointed out that PAHO was active in several forums in which such exchanges could take place. One located in the United States also covered the Caribbean and Latin America, while another was within MERCOSUR.

76. The interaction of trade and health issues was a field in which there was very little expertise, particularly within ministries of trade, which were taking the lead in trade negotiations. PAHO's aim was to promote a dialogue between ministries of health and trade in order to ensure that health issues were properly addressed in those discussions. Even within international organizations such as WTO and the United Nations Conference on Trade and Development (UNCTAD), there was a lack of expertise in health and, consequently, the health dimensions of trade agreements were frequently overlooked. Hence, joint effort between agencies was needed to ensure adequate attention to health concerns in the framework of trade negotiations.

77. The Director expressed her gratitude to the panelists for their thoughtful presentations, which had greatly enhanced the Subcommittee's consideration of the topic. The ideas that had emerged from the presentations and the discussion would be very helpful to the Secretariat in improving the document. She reminded the Members of the Subcommittee that PAHO had a long history of involvement in health and trade issues.



Indeed, one of the reasons PAHO had been created 100 years earlier was to facilitate the exchange of information and improve health conditions in order to promote trade between the countries of the Americas and those of Europe. The Organization continued to respond to technical cooperation requests from the countries in areas relating to health and trade. One dramatic example of PAHO's involvement in trade issues had occurred in the 1990s in Uruguay, where the liberalization of trade in salt had threatened to undo the tremendous gains achieved as a result of 70 years of legislation on salt iodization, which had virtually eliminated the terrible problem of mental retardation that had resulted from iodine deficiency. Thankfully, as soon as the warnings had been sounded on the introduction of non-iodized salt, emergency control measures had been introduced. That pointed up the need for *ex ante* analysis, as Dr. Das had said, to identify the potential negative effects of trade decisions before they occurred.

78. In line with the mandate given to PAHO right from the start, the Organization was working to maximize the positive effects and reduce the negative impacts of certain aspects of globalization. For example, PAHO had carried out a highly appreciated project at the request of MERCOSUR, which had subsequently been adopted by FAO at the world level, namely, the organization of databases of regulations on foodstuffs. In Uruguay, that information had been supplied online to facilitate negotiations and accelerate the signing of agreements.

79. PAHO was also working in the difficult area of licensing of health professionals. It had provided technical support for the harmonization of licensing in the Caribbean and was now involved in harmonizing the requirements for licensing and registration of health professionals in MERCOSUR. In that and other areas, and in response to requests from countries, the Organization was trying to encourage dialogue among different sectors within countries. One of its main focuses had been the organization of multisectoral teams within countries to provide support for the national authorities involved in negotiations on the various aspects of globalization. PAHO had carried out that work with existing resources. It had not received any form of extrabudgetary support or diverted any resources from country support. Because the work encompassed a variety of issues and areas, it involved many different units within the Organization.

80. She concluded by reiterating her thanks to the Subcommittee for its comments, which would help the Secretariat to revise and improve the document and enhance PAHO's work in relation to globalization and health.

#### ***Family and Health (Document SPP37/6)***

81. Dr. Ernest Pate (Chief a.i., Women and Maternal Health Unit, PAHO) described PAHO's family and health initiative, which sought to improve health outcomes and enhance quality of life through a family-centered approach. He began by explaining some of the conceptual aspects of family and health. The family was the basic unit of social

organization and it was also the setting in which health behaviors and health decisions were first established. The Organization believed that the family must therefore be considered in all analysis, design, and planning for health.

82. Subtle differences in meaning existed between “health of the family” and “family health,” and those differences were fundamental for the analysis of what constituted health interventions in a family setting. “Health of the family” referred to the family as a unit, whereas “family health” referred to the health of individuals within that family unit. PAHO used the term “family and health” to denote both the health of the family and of its individual members.

83. In the previous 10 years, a number of international summits had addressed issues relating to family and health. Those summits had declared that the family was entitled to receive comprehensive protection and support and had called for the development of policies and laws that would support and contribute to the family and its stability. They had also stressed the role of the family in promoting health and the need to reorient health services with a family focus.

84. Responding to those mandates and to the demographic, social, and economic changes that were placing great stress on families in the Americas, PAHO had formulated its family and health initiative. In so doing, it had drawn on the experience of countries in the Region that had implemented family health models or programs. Those programs had several similarities: they were physician-oriented, they focused on the family in the community, they were State-funded, and they delivered integrated services. Most of the models viewed the family as the setting where health was produced and all used a team approach to health care delivery. In addition, most models put health system resources directly in the community by placing the teams in close proximity to families. PAHO proposed to build on those experiences, using a combination of disease prevention and health promotion strategies.

85. The Organization espoused a life-cycle approach that recognized that the foundations of health were laid in the preconception, early childhood, and adolescent periods. Its interventions would seek to strengthen the health promotion and protection approach, address inequities, serve marginalized groups, and foster respect for and protection of the rights of families. It would also seek to involve families in the development of approaches based on family-centered interventions. Eight priority areas for action had been identified: maternal and child health, child health and development, adolescent health, parenting skills, safe physical and social environments, family caregiving for older persons, mental health and psychosocial development, and violence. The strategies that PAHO would employ for its work in those areas were described in Document SPP37/6.

86. The Subcommittee voiced strong support for PAHO's efforts in the area of family and health. The Organization's increased focus on this area was considered very timely as it coincided with efforts to strengthen the family and improve family health in many countries and with the upcoming 10th anniversary of the International Year of the Family. The observance of that anniversary in 2004 would afford an opportunity to draw international attention to issues relating to family health. Several delegates described family health initiatives under way in their countries and offered to share their experiences with PAHO and with other Member States. The Organization was encouraged to utilize the lessons learned from those experiences in refining its approach to family and health. At the same time, however, it was pointed out that there could not be a single "recipe" for family health. The model applied must be tailored to the characteristics of the family and the health care system in each country. Moreover, in the design of family health interventions, account should also be taken of cultural and religious patterns, which had a great influence on family values and family life and also on health and caregiving behaviors.

87. Several delegates expressed concern about some worrisome trends in their countries that were having a negative impact on the integrity and health of the family. The rise in divorce and separation, adolescent pregnancy, and single-parent families, in combination with other social and economic problems, were weakening the family and, ultimately, threatening the very fabric of society. Any initiative that sought to improve family health must take into account all the factors that were affecting family stability and family life. However, because so many of those factors fell outside the immediate control of the health sector, an integrated, intersectoral approach was essential. It was also imperative to increase the generation of information and knowledge about the myriad variables that contributed to family health.

88. The Subcommittee concurred with the priority areas for action identified in the document, although delegates suggested several additional issues that should be addressed under some of those areas. For example, in relation to maternal and child health and child health and development, delegates felt that there should be explicit reference to other components, such as immunization, prevention of birth defects, promotion of protection factors, prevention of sexually transmitted infections, early childhood education, and healthy use of leisure time. It was pointed out that the HIV/AIDS pandemic was taking a heavy toll on families, and the need to promote healthy choices and lifestyles, targeting adolescents and young people, in particular, was stressed. In the area of mental health, another serious issue that was affecting families was alcohol abuse, which was a growing problem among adults and, even more alarmingly, among adolescents at younger and younger ages. Intrafamily violence was also a grave concern that should be addressed in the framework of the initiative. Several delegates highlighted the need for greater attention to males, both in terms of their specific health needs and their role as parents and caregivers.

89. It was suggested that PAHO might wish to consider a focused or phased-in approach to implementation of the initiative, given the large number of priority areas in which it proposed to work. It was also suggested that the next version of the document should provide more information about how, specifically, PAHO would apply the strategies. In addition, the need for monitoring and evaluation to track the progress of the initiative was underscored.

90. Dr. Pate observed that several common themes had emerged from the discussion. One was the idea of integration. PAHO was well aware of the need for an integrated and intersectoral approach. It recognized that taking a medicalized approach would not yield the desired outcomes. The data available, though limited, clearly showed the need to integrate social and economic interventions with health interventions. He pointed out that “family and health” was not a vertical program; rather, it was an initiative that cut across the various units within the area of Family and Community Health and also involved other units within the Secretariat. Many of the concerns raised by delegates would be addressed in the framework of that joint effort. Immunization and HIV/AIDS, for example, were the focus of other units within the Family and Community Health area.

91. The Secretariat was also cognizant of the wide cultural differences that existed in the Region and of the need to develop models that were flexible and adaptable to the characteristics and requirements of individual countries. That was essential because, as the Subcommittee had correctly pointed out, no single model could be applied in all cases. Monitoring and evaluation to assess the initiative’s impact were also important. The Secretariat planned to build on the experience of countries such as Brazil, Canada, Cuba, and the United States, which had developed indicators to measure the effects of their family health programs.

92. With regard to the role of males in family health, he noted that PAHO was currently collaborating with the German technical cooperation agency (GTZ) on a multicountry study on male involvement in sexual and reproductive health. That project had been under way for two years in the seven countries of Central America, and preliminary results were expected to be available by the end of 2003. The information derived from the study would be used to design models aimed at increasing men’s involvement in sexual and reproductive health care. In addition to health components, those models would address issues relating to communication and behavior change.

93. In conclusion, he thanked the countries that had offered to share their experience and assured them that PAHO would be calling on them for guidance as it continued to develop the family and health initiative.

94. The Director was pleased that the first iteration of the document on family and health had been so well received. The Subcommittee’s comments would help the

Secretariat improve the next version. She felt that the creation of the Family and Community Health area would enable the Secretariat to take an integrated approach to family health. However, it would also be necessary to seek input from other areas. For example, in the area of information and monitoring, a great deal of experience had been accumulated through household surveys. Though “household” and “family” were not necessarily synonymous, there was a close association between the two concepts, and those surveys could be a good source of information on family health, as well as data on economic, social, demographic, and other variables that had a bearing on family health.

95. Use should also be made of the work of the Gender and Health Unit, in particular the project on gender-based violence and its causes. The information from that project could be used to identify protective factors that could be incorporated into health promotion efforts under the family and health initiative. The monitoring and surveillance system associated with the violence project could also be very valuable.

96. The unit concerned with extending social protection in health could also make a valuable contribution to the initiative, particularly in identifying health insurance schemes that provided better coverage for families. In that connection, she noted that delegates to the 20th Session of the Subcommittee on Women, Health, and Development had reported that there were some systems that did not extend protection to the spouses of working women, though male employees were entitled to coverage for their wives and families. The existence of such discriminatory practices pointed up the need for policy and legislation to protect and support families.

97. Policy and legislation were also essential to legitimate the family health models that were eventually developed. In that regard, she cautioned that, in the transformation of health care models, and especially the reduction of hospital care, it was important to avoid transferring caregiving responsibilities to families without providing them with the necessary resources and support, both financial and in terms of the necessary reorganization of the health system. Doing so could overburden families and exacerbate the problem of poverty—as some family members would undoubtedly have to leave their jobs in order to care for other family members. This, in turn, would worsen, not improve, family health and quality of life.

98. Lastly, replying to the comment regarding alcohol abuse and its impact on families, she assured the Subcommittee that PAHO was taking steps to address the issue. The Chief of the Mental Health Unit had long advocated increased attention to alcohol and substance abuse, and a regional advisor had been recruited specifically to work on the problem.

***Monitoring the Reduction of Maternal Morbidity and Mortality (Document SPP37/7)***

99. Dr. Virginia Camacho (Regional Advisor, Maternal Mortality Reduction Initiative, PAHO) summarized the main points of the document, which had been prepared as follow-up to the Member States' approval of the Regional Strategy for Maternal Mortality and Morbidity Reduction at the 26th Pan American Sanitary Conference the previous year. Resolution CSP26.R3 of that Conference had requested the Director to strengthen information and surveillance systems for monitoring progress in the reduction of maternal mortality and morbidity.

100. The aim of the document was to articulate a proposal to assist the Secretariat and the countries, at both the national and local level, in monitoring progress towards the Millennium Summit goal of reducing maternal mortality by 75% between 1999 and 2015. Two indicators had been established for that goal: maternal mortality rate and proportion of births attended by qualified personnel. In addition, the proposal set out in the document aimed to help the Member States meet the commitment they had made in Resolution CSP26.R13 of reducing the gaps in maternal mortality that existed both between and within countries in the Region.

101. The document approached the question of monitoring from three perspectives: how to measure progress in terms of impact indicators (e.g., maternal mortality rates), how to measure the efforts that were being made across the Region to address the problem of maternal mortality (e.g., formulation of policies, plans, and programs), and how the Organization could best support the countries' efforts. In implementing monitoring systems at the regional, national, and local levels, PAHO proposed to build on existing systems and make optimum use of good practices and lessons learned in the countries of the Region. Improving capacity for monitoring at the local level was considered crucial, as it was that level that generated the information that went into monitoring systems and it was at that level that the affected population lived.

102. Based on the Regional Strategy, the document identified key components of a maternal mortality and morbidity monitoring system, together with related indicators and questions to be answered under each one. Those components were: creation and implementation of policies, plans, and programs for the reduction of maternal mortality and morbidity; allocation of public investment resources for that purpose; availability and use of essential obstetric care (basic and comprehensive) and skilled attendance at birth; strategies to empower women, families, and communities, which research had shown could have a great impact in reducing maternal mortality and improving maternal health; vital statistics, surveillance systems, and use of information for action; and forging partnerships, another element that had a great impact, not only on the development of public policies, but in ongoing review of the implementation of plans and programs and of the participation of civil society in the process.

103. The Subcommittee was asked to provide feedback on the relevance of those components and how PAHO technical cooperation could best support the countries in implementing systems for monitoring maternal morbidity and mortality. In addition, the Subcommittee was invited to express its views on how to elicit the active participation of stakeholders, especially women's groups, and to comment on how to identify which of the many available indicators were consistent with international mandates, national and local plans, and the objectives of stakeholders.

104. The Subcommittee found the document well-written and well-organized and welcomed the Organization's proposal for monitoring maternal mortality and morbidity. Reducing maternal mortality was considered a high priority for all countries, even those whose rates were relatively low, and implementing an effective monitoring system was considered a crucial step in determining where and why maternal deaths continued to occur. Monitoring would also help identify the causes of maternal morbidity. In that connection, the importance of ensuring good prenatal care throughout pregnancy, as well as skilled attendance at birth, was underscored. Improving sexual and reproductive health services and providing timely and free access to family planning methods was seen as another key strategy for improving maternal health.

105. Delegates agreed with the basic components of the proposal and felt that it would serve as a good framework for the development of monitoring plans at the national and local levels. The proposal's focus on the poor and disadvantaged was applauded, as was its emphasis on encouraging local participation and targeting of areas where it was known that maternal deaths were being underreported. It was pointed out that maternal health was closely linked to overall family health, and the need to involve families and communities in the effort to reduce maternal morbidity and mortality was underscored.

106. Firm support was expressed for the Organization's efforts to avoid duplication of labor, expand on existing information systems, and forge alliances with other organizations that were working to address the causes of maternal morbidity and mortality. Several delegates noted that agencies in their countries had developed tools and methodologies for that purpose and offered to share their experiences with PAHO. Some delegates also indicated that they would submit additional suggestions and comments on the document in writing.

107. Dr. Camacho looked forward to receiving those written contributions. She agreed fully with those delegates who had emphasized the need to focus on reducing maternal morbidity and well as maternal mortality. Though the document did not dwell as extensively on that aspect of the Organization's work, it was an important component of PAHO technical cooperation in the area of maternal and child health, especially among countries that already had low maternal mortality rates. Reducing morbidity during pregnancy would not only prevent maternal deaths but would help mothers avoid possible

health problems later in life. Countries with low maternal death rates that continued to identify maternal mortality as a priority in their public policies were setting an important example—one that acknowledged that even one maternal death was too many. Just as the Region had set the goal of eliminating measles, so should it strive to eliminate maternal mortality.

108. The Director felt that it was important to take a stratified approach to the problem of maternal mortality. While in the case of countries with intermediate or low rates, monitoring was critical in order to reduce rates even further and, especially, identify the causes of maternal morbidity, in countries with high maternal death rates, the priority should be on action. The causes were already known and proven interventions existed to address them; what was needed was to ensure that those interventions were applied, targeting in particular the geographic areas and population groups that were at highest risk.

109. At the same time, it was important to involve organized women's groups in the effort to reduce maternal mortality because it was those groups that often called attention to difficult issues that needed to be addressed. For example, in some countries women had become convinced that delivery by cesarean section was better for them and better for their babies, a view that was fomented by the medical profession. As a result, some women were dying from complications of unnecessary cesareans. When such problems came to light, it was necessary to tackle them head-on. Otherwise, the Region's maternal death rates would remain unacceptably high.

***Obesity, Diet, and Physical Activity (Document SPP37/8)***

110. Dr. Enrique Jacoby (Regional Advisor, Nutrition Unit, PAHO) described the proposed strategy for combating the growing problem of obesity in the Region. That strategy emphasized prevention and sought to identify the factors that discouraged people from making healthy choices with regard to diet and physical activity. He began by presenting statistics on the rising prevalence of overweight and obesity in countries of the Americas. That increase had brought about a corresponding increase in high cholesterol, hypertension, and other diet-related health conditions. The problem was increasing in all countries, not just those with high incomes. Nevertheless, income did influence rates of obesity. In both rich and poor countries, up to a certain point, rising income was associated with an increase in obesity, but beyond that point, among the highest-income segments of the population, obesity rates were lower.

111. Most overweight and obesity could be prevented through changes in diet and level of physical activity, which were lifestyle choices. However, those choices were influenced by environmental factors. For example, the design of many cities encouraged reliance on motorized transportation and discouraged walking and other forms of physical activity. Similarly, the tremendous growth in the availability of energy- and fat-



rich processed foods had changed consumption patterns, increasing the number of calories consumed per day, while also reducing intake of fruits and vegetables. The challenge for the public health sector, then, was how to make it easier for people to make healthier choices, especially among the middle- and low-income brackets, where the problem was most serious.

112. The strategy proposed in Document SPP37/8 was a multipronged approach that emphasized prevention, recognizing that it was far easier and less costly to prevent obesity from occurring in the first place than to treat its consequences later on. Moreover, most countries in the Region simply did not have the resources to address the health problems associated with obesity in an aging population. The strategy called for integration of efforts to prevent obesity and noncommunicable diseases. It also sought to modify the environmental factors that made behavioral change and healthy choices difficult for the segments of the population with the lowest incomes and least education. Because many of those factors fell within the purview of other sectors, building partnerships outside the health sector was also a key component of the strategy. Generating more and better data on the problem was another important aspect.

113. Dr. Jacoby concluded his presentation by stressing that all the elements and activities proposed under the strategy were directed towards one fundamental goal: making healthy choices the easiest choices.

114. The Subcommittee applauded the Organization's involvement in this area. It was pointed out that PAHO's efforts would reinforce the larger WHO effort to develop a global strategy on diet, physical activity, and health. Several delegates commented that the preventive orientation of PAHO's proposed strategy was consistent with current initiatives in their countries which sought to encourage behavioral change and promote healthy lifestyles through an integrated, intersectoral approach involving a wide variety of partners. In that regard, the need to involve the food production industry in addressing the problem of diet and obesity was underscored. One delegate suggested, for example, that the food industry might be a source of funding for research in this area. Another pointed out that it was important for the health sector to collaborate with the food industry to improve the labeling of packaged foods and thus equip consumers with the information they needed to make healthier choices.

115. In general, the Subcommittee found the document a good starting point on which to build an effective strategy, although several delegates suggested additional items that should be incorporated, in particular identification of the components and activities necessary to implement a strategy at country level, recommendations on national policies and regulations, and indicators for monitoring and evaluation. One delegate noted that in many countries increasing numbers of meals were being eaten in restaurants and pointed out that the strategy should take account of that trend. It was also suggested that the

strategy should focus on maintaining a healthy weight—through good diet and sufficient physical activity—rather than on weight loss, and on encouraging individual responsibility for diet and physical activity, rather than excessive reliance on weight loss programs.

116. Several delegates indicated that they would provide further suggestions in writing. The Delegate of the United States said that, in addition, her delegation would provide written feedback on some concerns it had about the document, notably several instances in which assertions were made regarding the impact that advertising had on dietary habits and the link between obesity and consumption of certain types of foods that did not appear to be supported by current evidence. Her delegation was also concerned about a section in the document that seemed to propose that countries should explore regulations, tariffs, and taxes as ways of modifying food preferences and dietary behavior. PAHO appeared to be suggesting that Member States should consider not complying with World Trade Organization agreements. That was an unscientific and simplistic approach to the problem, and it involved matters that clearly fell outside the scope and competency of the Organization. Her delegation therefore requested that the Secretariat revise that section carefully so that it more accurately reflected a public health position.

117. It was pointed out that the recommendation in the document regarding physical activity—30 minutes a day, five days a week—differed from the WHO recommendation of 1 hour a day, five days a week. The Secretariat was asked to comment on that difference and also to clarify the recommendation in the document regarding active participation in the Codex Alimentarius Commission.

118. The importance of promoting changes in behaviors and perceptions about diet and obesity among health workers was stressed. Modifications should be introduced into the curricula and training programs for health professionals to ensure that obesity was recognized as the serious public health problem that it was. Physicians should be encouraged to counsel their patients on the importance of diet and exercise and to refer those who were obese to special programs designed to help them improve their eating habits and increase their level of physical activity.

119. Dr. Jacoby assured the delegates that their comments, both oral and written, would be taken into account in revising the document. He agreed wholeheartedly on the need to involve the food industry in solving the problem of diet and obesity. Improving the supply of foods available on the market was critical, and it was essential to enlist the food industry in the effort to offer consumers a wider array of more healthful food choices.

120. Replying to the concerns expressed by the United States, he said that the intent of the document had certainly not been to promote non-compliance with international trade

agreements. Rather, it had been to point out that action must be taken with regard to the supply of food. That was why PAHO has advocated involving food producers and marketers in the solution of the problem. That was also the reason for the recommendation regarding active participation in the Codex Alimentarius Commission. Many issues that affected the types of foods available to consumers were being discussed in the framework of the Codex and the WTO. As those issues often had a health dimension, it was essential for the health sector to be involved in the discussions. Regarding evidence on the linkages between advertising, consumption of high-fat and high-calorie foods, and obesity, that evidence was available. He would see that the next version of the document included more information on studies that had indicated, for example, that regulating the types of advertising seen by children could have an impact on their consumption of high-fat and high-sugar foods with little nutritional value.

121. As for the recommendation concerning physical activity, given that two-thirds of the Region's population did no exercise at all, PAHO believed that it was much more realistic to recommend 30 minutes of physical activity a day. While it was true that that amount was not sufficient to reduce obesity, 30 minutes was better than none, and it had been proven that even that modest level of activity could yield significant health improvements. Setting the expectation too high would only be an invitation to failure. Moreover, WHO supported the recommendation of 30 minutes per day as a minimum, though it did recommend that, ideally, people should exercise for an hour a day or more, five days a week.

122. The Director agreed on the need to work in partnership with industry. In that respect, the problem of obesity was similar to other consumption problems, such as tobacco use. The whole issue of how to influence consumer decisions was one that the Organization would be looking at more closely in the future. While that was perhaps not a traditional area of activity for public health, in order to design effective public health strategies that would induce consumers to make healthier choices, it was essential to gain a better understanding of what motivated their behavior. That was true not just in relation to diet and obesity, but in many other areas of concern for public health, such as drug and alcohol abuse and utilization of health services and technology. In developing such consumer-oriented approaches, the Organization planned to work in collaboration with organizations of consumers and producers. The latter, especially, could be a valuable source of information as they had done considerable research to identify the factors that drove consumer decision-making.

123. With regard to the Codex Alimentarius, as Dr. Jacoby had explained, PAHO's aim was to increase participation on national Codex Commissions. It was important to involve a variety of sectors, but especially the health sector, in the discussions of those bodies.

124. Finally, she reported that an effort was under way within the Organization to make all the PAHO offices, both in Washington, D.C., and in the countries, healthier settings. Some of the changes being introduced involved offering healthier food choices and promoting physical activity among staff. In that way, the Organization hoped to set an example that would be emulated by its counterparts in the countries.

***Influenza Pandemic: Preparation in the Western Hemisphere (Document SPP37/9)***

125. Dr. Marlo Libel (Regional Advisor, Communicable Diseases Unit, PAHO) introduced the item, noting that it was highly topical in light of the current epidemic of severe acute respiratory syndrome (SARS). While that disease was not influenza, it had served to test the preparedness systems in various countries of the world. Additionally, February 2003 had also seen cases of transmission of avian flu virus to humans in Hong Kong, and the two outbreaks had highlighted the need to focus on preparation for possible pandemics. The aspect of most concern in relation to influenza was the ability of the virus to mutate suddenly and dramatically. Epidemics in the past had resulted in enormous mortality, with huge social consequences. They also often caused grave economic consequences, such as the collapse of poultry production in Asia.

126. The WHO system for dealing with influenza concentrated on two main areas of activity: preparation for pandemics, on the one hand, and reducing the possibilities for spread of the disease, on the other, through early identification of new forms of the virus. The WHO Collaborating Centers and national influenza centers genetically sequenced some 1,000 samples a year with a view to producing vaccines. Currently, some 240 million doses of vaccine were produced worldwide every year, which was insufficient relative to what might be required in the event of a global pandemic.

127. Preparedness for pandemics was inadequate in most countries. While some countries did have detailed response plans, others had little more than basic frameworks. The degree of local preparedness was uncertain, and much work remained to be done on vaccine and antiviral strategies. Production of vaccines was currently limited to nine countries in the world, of which only Canada and the United States were within the Americas.

128. The key elements in preparedness for pandemics were overall coordination, surveillance, availability of vaccines and antivirals, health services planning, emergency response and communications systems. Important aspects of overall coordination were the establishment of a national pandemic committee and chain of command and the creation of a legal framework. Under surveillance—which was important both between and during pandemics—it was essential to identify the onset of a pandemic and to track its arrival and progress in a country; to ensure rapid identification of new strains of the virus and the ability to provide real-time impact data; and to monitor vaccine and

antiviral uptake, efficacy and adverse events, as well as antiviral drug resistance. Virological surveillance was fairly well covered in North America and the Southern Cone, but elsewhere there was a need to widen the population base to obtain more comprehensive findings, as well as to integrate human and animal surveillance and in particular to gain a better understanding of the risks to humans of avian and swine influenza viruses.

129. The principal issue with regard to vaccines and antivirals was difficulty in production (owing in particular to the low number of producers and difficulties in growing the virus in embryonated eggs). The normal influenza vaccine production cycle was eight months, from identification of a virus to availability of the first batches. Normally, it was desirable to develop multivalent vaccines, but in a pandemic it could be necessary to produce monovalent vaccines, specific to the novel form. In such circumstances, certain of the consultative and licensing steps could be omitted, shortening the production time to about five to six months.

130. In the area of health services planning, the major problem encountered with SARS had been transmission to health workers. Infection control was a very serious problem, and plans and procedures were needed to deal with it. Another aspect was community control measures, such as closures of schools and similar installations, which in addition to their technical features also entailed elements of political decision-making. Emergency response required an intersectoral approach in order to maintain critical health and public safety services. The communications segment had two main aspects: communication with the emergency response teams and communication with the population about the risks. All of those areas required preparation: they were not things that could be put in place once the crisis had already started.

131. The actions which were considered essential for countries to take included the establishment of a national pandemic planning task force; preparation of specific contingency plans covering personnel, equipment, and organization; early decisions on vaccination strategy, notably the quantities that would be needed; enhancement of surveillance systems to give the widest possible coverage in the largest possible number of countries; establishment of consensus among the medical and scientific communities on the use of vaccines and antivirals; provision for the supply and logistics of drugs of all kinds; design of a risk communications plan; and improvement of annual vaccination coverage among high-risk groups.

132. The Subcommittee noted that influenza pandemics entailed a need for close international and regional cooperation for the development of sound prevention and control strategies. The time to prepare for the next pandemic was now, and PAHO could play a key role in the facilitation of regional planning activities. It was agreed, as noted in document SPP37/9, that effective communication was a key strategy in pandemic

preparedness and response. However, there was a need for clarification of the role of PAHO in the announcement of the different phases of a pandemic, as proposed in the Annex to the document, and in facilitating communication during a pandemic. PAHO, in collaboration with WHO, should be permanently involved in coordinating and supporting training and laboratory testing and surveillance as well as in studying the burden of disease and the economic impact of influenza.

133. Building local capacity to generate the data required for national immunization program planning should be considered a priority. All countries needed to address an inevitable shortage of vaccines and antivirals in the event of a pandemic. Establishment of national goals and priorities was the necessary first step towards preparedness, and PAHO should collaborate with the countries to assess the regional requirements for vaccines and antivirals. However, the role of PAHO in organizing vaccine distribution during a pandemic in the most equitable manner needed further discussion. Since the capacity for manufacture of influenza vaccines within the Region was currently limited, a high priority activity would be for PAHO to stimulate the interest of regional manufacturers and facilitate discussions among current vaccine producers.

134. Consideration should be given to developing common approaches to plan for and respond to public health emergencies, including influenza pandemics and bioterrorism events such as smallpox. One area in which the Subcommittee felt PAHO could play a critical role was in the provision of information to the media and to medical care providers, enlisting their help in managing public perception and avoiding panic. PAHO could also be of assistance in the regular communication that should be undertaken at the national and regional levels on the importance of planning for the annual epidemics of influenza in the Region. Delegates stressed the necessity of extending the coverage of annual influenza vaccination, especially among the elderly and others at risk. The importance of good surveillance to accurately ascertain the number of deaths attributable to influenza was also highlighted.

135. It was pointed out that the SARS epidemic had revealed a number of weaknesses in preparedness. One was the question of medical evacuation of patients. In Asia in recent weeks, some companies had refused to transport patients who were ill with SARS, greatly hampering efforts to transport patients to facilities with better levels of medical care. As the issue was considered to be primarily one of perception and training, it was suggested that PAHO should be involved in helping to train air crews and companies in proper infection control techniques and perhaps in discussion of contract arrangements that might allow for better and more secure transport of critically ill patients. The second area of weakness was the transport of specimens. There had been great difficulty in many parts of Asia with the dispatch of specimens to WHO Collaborating Center laboratories on a timely basis and without the specimens being compromised in transport.

136. The Subcommittee stressed the importance of multilateral and international interchange of information on successful practices in dealing with influenza and other pandemics. It was also suggested that issues relating to financing and support for the purchase of vaccines should be addressed, notably whether vaccines could be obtained at lower prices than the current ones. One area of concern was the time that would elapse before a vaccine would be available in the various countries in the event of a pandemic involving a new strain. It was important to establish at international level the preventive measures to be taken for the time prior to availability of the vaccine. It was also considered essential to review certain testing methodologies in order to standardize criteria and ensure the reliability of the methods used.

137. Dr. Libel thanked the delegates for their comments and contributions, which would improve the document and also improve PAHO's perspective on how to respond to such health threats. The remarks made in regard to the need for coordinated training and studies of the burden of disease were very valuable. More work was definitely needed in that area. With regard to communication and dissemination of information, information was being disseminated through the PAHO and WHO websites, but there was a need to improve the flow of information, so that it would become real-time communication on the risks facing countries.

138. With regard to vaccine production and distribution, he welcomed the suggestion of involving new laboratories in the Region with a view to trying to speed up production and shorten the time to availability. He thanked the participants for the comments made on costs and the need for funds to develop activities at national and regional levels. The information from the United States that 100 million dollars had been requested for dealing with influenza in 2004 gave an indication of the scale of the resources needed. He encouraged those countries that had finalized their plans to make them available to other countries to help them in the development of their own plans.

139. The transport of specimens was an ongoing problem, which had worsened after the events of 11 September 2001. Through the Laboratory Services Unit of PAHO, officials in every country in the Region, in both national public health laboratories and in the PAHO country offices, had been certified to ship dangerous biological samples. The next and more difficult step would be to establish contracts with a single carrier to transport those samples, rather than having to negotiate each time with individual carriers.

140. With regard to policies on vaccination, the best time of the year to vaccinate was basically a question of when the vaccines were available. For tropical and subtropical countries, there was no particular month that was preferable, as influenza was present throughout the year. A necessary prior step to the centralized purchase of vaccines was that the countries should already have established routine immunization programs. The

resultant guaranteed demand would make it easier for producing laboratories to enter into purchasing contracts and to reduce prices. There had been difficulties in growing the virus in embryonated eggs, but now several of the production laboratories were changing their production methods and preparing instead to cell culture, from which the virus could be developed. That should shorten the time to production. The new approach was currently in an experimental phase, but would be operational in the coming two to three years.

141. At the request of the Director, Dr. Libel gave a brief update on two other viruses, namely SARS and West Nile virus. With regards to SARS, 13 countries had reported cases, on three continents, for a total of 487 cases and 17 deaths. However, only in a few countries had local transmission been confirmed. Those countries were Canada, Hong Kong, Singapore, Taiwan, and the United States, and the transmissions were to health workers or to immediate family members. In other words, SARS was not a virus that appeared to spread widely through the community. People who developed fever and respiratory symptoms such as cough or difficulty in breathing should be considered as potential SARS patients only if they had been in contact with a case or had traveled to the affected countries.

142. Antibiotics had not been effective in treatment, while antivirals appeared to have given better results. The major need had been for intensive respiratory care, with many of the patients requiring assisted respiration. The question of infection control in hospitals had been of major importance.

143. From the standpoint of advice to travelers, WHO was not recommending any restrictions on travel to the affected countries. However, it had also advised that information or training should be given to airline crews so that patients potentially infected with the virus could be detected at the moment of entering the aircraft. PAHO was being notified of cases in the Region, on the basis of the established definitions which had been circulated to all Member States.

144. Cases of West Nile virus in the United States had increased from a few hundred in 2001 to about 4,100 in 2002. The disease was now occurring in 44 states. Migratory birds still comprised the most significant vector, together with mosquitoes. PAHO had already carried out training for veterinary laboratory workers and entomologists in diagnosis and surveillance of this virus. Those workers had been selected from the countries which had laboratories available to work with this type of virus and capable of carrying out on-site surveillance of dead birds. In May 2003, a second training course had been planned, which would cover in particular Central America and Mexico. Elsewhere in the Region, there had been one isolated case in the Cayman Islands in 2001 and one imported case in Mexico, and the virus had been found in birds in the Dominican Republic. Working on both the West Nile and SARS viruses had involved major issues of biosafety.



145. Also speaking at the request of the Director, Dr. Stephen Corber (Area Manager, Disease Prevention and Control) said that the experience with SARS demonstrated the importance of having a plan for controlling the outbreak right at the source. The almost complete success of Hong Kong, Singapore, and Vietnam in containing the outbreak within their borders had made the work of all the other countries much easier. Reemphasizing the importance of communication, he said that while plans and training in specific aspects were important, it was also essential to test out the whole plan by means of simulation exercises. Such exercises revealed the areas where further work was needed, and such areas often involved communication. The SARS outbreak could be seen as a simulation exercise for an influenza pandemic. In that case, communication had truly proved its worth. Both WHO's transmission of information and the countries' reporting of suspect cases to WHO had been crucial in efforts to contain the disease. Daily teleconferences among the countries and WHO had further demonstrated the value of communication. In addition, 11 laboratories in 10 countries were cooperatively examining the specimens collected from patients, which required a major amount of communication and coordination.

146. Dr. Corber also pointed out that what made influenza fundamentally different from other diseases was that the incubation period was so short and that the virus was transmitted through the air. Pandemics could occur very quickly, killing millions. The basic components of pandemic response were detection of new forms of the influenza virus, and having treatment plans in place. Countries tended to train people in specific aspects, such as how to detect a virus, or how to improve reporting, but in addition there was a need to have a view of the plan as a whole.

147. The Director said that the discussion and the comments of the Members of the Subcommittee had indicated that it was considered desirable for PAHO to go further in the area than it had done so far. She agreed with the suggestion that in establishing national committees and drawing up national plans, PAHO should work to bring countries together so that they could share experiences and ideas. She also understood their wish that such plans and committees should be established within existing mechanisms for dealing with emergencies and disasters, for epidemiological surveillance, and for control of immunization practices, rather than any new mechanisms being created. Thus the message to PAHO was clearly that resources had to be combined, not divided up, especially in view of current resources limitations.

148. If resources were not used wisely it would not be possible for PAHO to fulfill the dual mandate being suggested by the Subcommittee, namely supporting the local levels, on the one hand, and responding to the needs for international interchange of information, on the other hand. That made it all the more important to join forces at the national level and to consolidate all countries' efforts for the benefit of all. Some countries had specific mechanisms, in particular since September 11, 2001, designed to deal with bioterrorism,

and those too should be shared. In that way PAHO could assist the ministries which were already working on an intersectoral approach involving, for example, defense, national police, domestic security mechanisms, education, and other sectors.

149. The critical point was that countries should organize their national committees by trying to combine and consolidate existing mechanisms rather than create new structures, which would not be sustainable with present resources. A second major aspect concerned the plans, and the possibility of incorporating simulation exercises within the plans. The plans should be shared and made available at the most local level, particularly in large countries and undergoing a process of decentralization.

150. She noted that a communications strategy, covering both internal and external communication, was critical. There must be a strategy for communication both among countries and within countries. Information had to flow to health workers in the areas for which they were responsible, and also to the public.

151. Some aspects of the work needed could be done through the Southern Cone Network for Emerging Infectious Diseases, which had been in existence for five years now. Additionally, however, it was clear that there was a need for PAHO to negotiate with some actors outside the health sector, such as the airlines involved in the transport of samples or patients.

152. She noted the need to give specific support to the countries of Central America and the Caribbean, not only because in those countries influenza outbreaks were not seasonal, but particularly because of their size and because they were favorite tourism destinations, which meant that they were constantly receiving people from all over the world. The networks of laboratories in those countries needed support, in particular assistance in the definition of the countries' immunization policies.

153. In view of the insufficiency of available resources to address all the influenza preparedness needs in the Region, the Director said that she would be very interested in exploring with governments in the northern hemisphere the possibilities for mobilizing some additional resources, in a spirit of Pan Americanism and in recognition that pandemics did not respect national frontiers. There was a need to organize meetings with private sector actors, notably the airlines, perhaps under the aegis of the International Civil Aviation Organization (ICAO) or the International Air Transport Association (IATA), and PAHO would be grateful for any support from countries, both political and material. Such meetings would provide an opportunity to analyze the obstacles which had to be overcome jointly in order to facilitate the transport of biological samples. A similar dialogue was needed on the subject of transport of patients, with the aim of developing guidelines and recommendations in each country.

154. The discussion on this item had been extremely instructive, and PAHO would endeavor to carry out all the technical cooperation roles the Member States had identified for it. She hoped that countries would be able to contribute some additional resources to enable it to do so.

***Ethnicity and Health (Document SPP7/10)***

155. Dr. Cristina Torres (Chief a.i., Policy and Governance Unit, PAHO) explained that this item arose out of the Strategic Plan for 2003-2007, which stated, *inter alia*, “While inequities are to be reduced throughout the life cycle, the Pan American Sanitary Bureau must work with countries to identify those groups for whom inequalities in health outcome or in related access to services can be addressed with available, cost-effective interventions.” In 2001, a further mandate had emerged from the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, the final document of which had encouraged “WHO and other relevant international organizations to promote and develop activities for the recognition of the impact of racism, racial discrimination, xenophobia and related intolerance as significant social determinants of physical and mental health status.” Additionally, the United Nations Millennium Declaration had called for a strengthening of respect for human rights, including minority rights, and for measures to be taken against acts of racism and xenophobia.

156. There was consensus in the scientific community that differences among human beings had no biological or genetic foundation but, on the contrary, were the result of social, political, and cultural factors. After expanding on the definitions of some of the concepts used in the document, Dr. Torres noted that the demographic reality of the Region of the Americas was complex, with groups of very different origins, and with such groups being of widely varying sizes and accounting for different percentages of the countries’ total populations. Almost all countries of the Region had groups of both indigenous peoples and Afro-descendants. Such groups constituted “minorities” not only because of their relative size but also through their high degree of vulnerability and social exclusion. While, according to figures from the Economic Commission for Latin America and the Caribbean (ECLAC), 43 % of the population of the Region as a whole lived below the poverty line, all studies indicated that ethnic minorities were over-represented among the poor. It was noteworthy, too, that the average income of minorities in the United States was lower than that of the white population, revealing that the disparity was not restricted to the developing countries.

157. Turning to the specific question of health, she said that studies based on the traditional measurements, such as infant mortality, revealed that members of ethnic minorities showed consistently poor results. That could be shown to relate to their degree of social exclusion: for example, a study from Brazil demonstrated that children of women of African descent with eight or more years of schooling had the same mortality rate as children of white women with no schooling at all. Similarly, in 1950, life

expectancy in Brazilian adults of African descent had been seven years lower than that of white Brazilians. By 1990, the life expectancy of both groups had increased, but the seven-year disparity remained. The extent to which people utilized health services, and how soon they did so after onset of a medical problem, also varied sharply by ethnic origin.

158. In searching for features of programs that had potential for successfully reducing such inequities, PAHO had found several common elements. The first was that actions must be based on up-to-date and reliable information. The second was that they needed to include a high degree of social participation. A further important factor was that such programs should be based on alliances among different actors.

159. Accurate statistical and census information was vital. Thirteen countries of the Region had included the ethnicity variable in their 2000 national census (in addition to four countries that had done so earlier), although work still remained to be done on incorporating the ethnicity variable into the health statistics and into the health information systems. Some countries had already made progress, for example by breaking down their mortality statistics by ethnic groupings. Such changes would involve a need for training of the personnel handling the statistics and information. Thirteen countries were implementing special health programs targeting ethnic minorities. The key areas for action in the Region, in order to reduce ethnically-based health inequities, were the development of ethnically sensitive indicators to monitor progress towards meeting the Millennium Development Goals; introduction of the ethnicity variable into national statistics; collection and sharing of successful experiences with regard to information and organization of services; reformulation of health policies, plans and programs to make them more ethnically sensitive; and the introduction of an ethnic perspective in the health plans developed as part of poverty reduction strategies. In addition, it was very important to develop ethnic sensitivity in health programs, notably those to do with the prevention of HIV/AIDS and with reduction of diseases specific to certain ethnic groups.

160. The Subcommittee felt that the document had made a valuable contribution to the overall understanding of the health situation of indigenous people and Afro-descendants. Several members described initiatives and projects in their own countries to attend to the health needs of ethnic minorities. The Subcommittee noted that data could be a powerful tool for policy and program development to address the special needs of ethnic populations. Indeed, the lack of accurate information was itself a barrier to equitable access. PAHO could play a major role in improving the availability and quality of data. Many countries did not routinely disaggregate data by ethnicity, which was the first step to be taken. The challenge was to develop tools and methodologies that would lead to a better understanding of the dynamics of ethnic diversity and how it affected access to health and social services.

161. However, the Subcommittee noted that neither the document nor the presentation had addressed the need to bring the data and information back to the affected populations, which would allow them to play an active part in the design and implementation of solutions that could help improve their health status and health outcomes, rather than simply being passive beneficiaries. With regard to the inclusion of the ethnicity variable in statistics and censuses, PAHO could play an important role in the dissemination of best practices. There was a need to include the ethnic groups themselves in the development of indicators and analysis, and to balance the need to improve information disaggregated by ethnicity on the one hand with people's right to privacy on the other.

162. The Subcommittee also pointed out that the linkage between ethnicity and health was complicated and that the interplay among racial and ethnic elements, socioeconomic factors and educational levels was not well understood or well researched. Consequently there was a need for all countries to work both individually and collectively in that area. There were other subgroups which had special needs, such as migrant populations, refugees, and people displaced because of violence or economic conditions. Such groups could transcend racial lines and have problems unsuspected by outsiders, thus making the situation even more complex. The issue was not simply whether a group was a minority in terms of size, but whether it was being marginalized because of its minority status. It was also pointed out that an additional reason for social exclusion of some groups might simply be geographic, for example if they lived in remote or mountainous areas.

163. While delegates expressed general agreement with the selection of PAHO's five key areas for action, some suggested that the focus should be on the first two, both of which would require major investments of human and financial resources as well as strategic thinking. The Subcommittee noted that in its description of PAHO's programs and activities, the document lacked an impact evaluation. It was suggested that measurable outcomes should be incorporated both into PAHO's current initiatives and into future efforts.

164. A number of delegates noted that their countries, like PAHO, had for years had a focus specifically on indigenous groups, and urged that that special focus not be diluted. Doing so might be detrimental to the health status of indigenous peoples who, as the document indicated, were among the poorest and most disadvantaged groups in the Americas. In that connection, it was suggested that, as the following year marked the end of the International Decade of the World's Indigenous Peoples, documentation should be produced to demonstrate all the progress that PAHO had made in recent years in improving the health status of indigenous peoples. Such documentation could also identify problems and make recommendations for the next step in continuing that important work.

165. It was suggested that PAHO should collaborate with other related organizations, such as ECLAC, in its efforts to fulfill the Millennium Goals related to the topic of ethnicity. PAHO had a role to play in the interchange of successful experiences, since in order for countries to formulate their policies and plans, they needed to know what had been successful elsewhere. In addition, PAHO should provide technical assistance based on those experiences. The information should be shared with other sectors within the countries, in particular those concerned with poverty reduction strategies.

166. Dr. Torres thanked the delegates for their comments and their reports of important recent developments, which should be shared and disseminated throughout the Region. Valuable suggestions had been made which would help the Secretariat to prioritize its work. She noted that all participants had been in agreement that that work should be concentrated on the production of indicators to meet the mandates of the Millennium Summit. Those indicators would also be useful in evaluating the implementation of the Strategic Plan for 2003–2007 and, consequently, the Secretariat intended to develop instruments that would also be useful for the countries.

167. In relation to the need to strengthen systems of health statistics through incorporation of the ethnicity variable, she said that activities had already been undertaken in the context of the Health of Indigenous Peoples Initiative, including a meeting of officials of the census units and statistical institutes together with officials responsible for information systems at the ministries of health. The meeting had served as an exchange of information and had also pointed the way for further activities, notably in the area of trying to harmonize both the statistical questions and the criteria for asking them. It had been pointed out that health had some specific features that were not found in other areas where an attempt had been made to break down information by ethnic grouping. For example, it did not seem appropriate to gather that information on birth certificates or death certificates, since it had been recommended that it should be the respondents themselves who should define their own ethnic grouping. Another excellent suggestion had been that the issue of health inequities relating to displaced persons, migrants and so on should also be addressed, and that was something that would be considered in the context of the Region. As had been pointed out, not all displaced groups were ethnic groups. It had also been suggested that intercultural models should be promoted for interacting with indigenous peoples. Some countries in the Region were already pursuing that approach, and PAHO felt that it was a line of work that should be continued and expanded to other countries and other ethnic groups.

168. In response to the question of whether it was possible to widen the perspective without losing the focus on indigenous peoples that had now been pursued for almost a decade, she said that PAHO felt that a broader approach would ultimately benefit indigenous peoples. PASB's work had always involved close cooperation among units responsible for different aspects of health, and the reorganization currently under way

would enhance that approach, contributing to the mainstreaming of some of issues that should be treated in a cross-cutting manner. Ethnicity was such an issue, as was gender equity.

169. The Director said that the discussion had added a dimension to a topic on which PAHO had been placing great emphasis in recent years, namely the theme of equity. She interpreted the comments from the members of the Subcommittee as indicating to PAHO that a primary emphasis of the work in this field should be the management of information, and the improvement of systems of information disaggregated by ethnicity. That was a topic on which PAHO was already working and the Organization would build on the experience already accumulated.

170. It would perhaps be beneficial for personnel concerned with ethnicity and health to join forces with those who were working in the area of gender equity in an attempt to produce more refined statistics, disaggregated by both sex and by race or ethnic group. In addition, work in the past had taught that an approach based on gender analysis was important since it allowed an enhanced appreciation of the value of diversity and showed that responses and policies should not be homogenized but, rather, made sensitive to diversity. Additionally, that work had made it possible to avoid perpetuating inequities, which sometimes happened when policies were drawn up without a gender perspective.

171. She had taken note of the remarks about minority groups that did not share either the gender variable or the ethnic variable. PAHO was working with some such groups, including street children. That work was very important in the light of the mandate from the Member States that PAHO's work should now focus on two main thrusts, which were complementary: (1) social inclusion and universal access to health services and (2) determining, in the light of the challenges raised by the Millennium Goals, which groups really were being left out or left behind. Certainly, some racial groups had been seriously left behind—some to the point that they were even on the verge of extinction. Those were the groups that should be targeted as top priorities. Otherwise, for them, the Millennium Goals would become absolutely irrelevant.

### **Closing of the Session**

172. The Director expressed her appreciation to the President for the efficient manner in which he had conducted the session and thanked the Subcommittee for its valuable guidance on the work of the Secretariat.

173. The President thanked the delegates for their contributions to the Subcommittee's deliberations and then declared the 37th 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. Policy Orientation for the Pan American Health Organization and Reorganization of the Pan American Sanitary Bureau for Implementation of the Strategic Plan, 2003-2007
5. Proposed Program Budget for the Pan American Health Organization for the Financial Period 2004-2005
6. Globalization and Health
7. Family and Health
8. Monitoring the Reduction of Maternal Morbidity and Mortality
9. Obesity, Diet, and Physical Activity
10. Influenza Pandemic: Preparation in the Western Hemisphere
11. Ethnicity and Health
12. Other Matters
13. Closing of the Session



## LIST OF DOCUMENTS

SPP37/1, Rev. 2 SPP37/WP/1	Adoption of the Agenda and Program of Meetings
SPP37/3 and Add. I	Policy Orientation for the Pan American Health Organization and Reorganization of the Pan American Sanitary Bureau for Implementation of the Strategic Plan, 2003-2007
SPP37/4	Proposed Program Budget for the Pan American Health Organization for the Financial Period 2004-2005
SPP37/5	Globalization and Health
SPP37/6	Family and Health
SPP37/7	Monitoring the Reduction of Maternal Morbidity and Mortality
SPP37/8	Obesity, Diet, and Physical Activity
SPP37/9	Influenza Pandemic: Preparation in the Western Hemisphere
SPP37/10	Ethnicity and Health

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