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FINAL REPORT

Opening of the Session

1. The 132nd Session of the Executive Committee was held at the Headquarters of the Pan American Health Organization (PAHO) on 23-26 June 2003. The session was attended by delegates of the following eight Members of the Executive Committee: Dominica, Dominican Republic, Honduras, Jamaica, Paraguay, Peru, United States of America, and Uruguay. El Salvador, the ninth Member, was not represented. Taking part in an observer capacity were delegates of the following Member and Associate Member States of the Organization: Argentina, Canada, France, Grenada, Mexico, and Puerto Rico. In addition, one intergovernmental organization and five nongovernmental organizations were represented.

2. Dr. Fernando Carbone Campoverde (Peru, President of the Executive Committee) opened the session and welcomed the participants, noting that the Committee was meeting in a context of social unrest and considerable impatience on the part of the peoples of the Americas, especially those most affected by poverty, who were tired of waiting for the benefits of development to reach them. That was true of all areas of development, but it was especially true of health. Many people, himself included, believed that the health sector could lead the way in bringing development to all and in fostering justice and equality of opportunities. At the same time, health ministers throughout the Region had high expectations of PAHO and looked to it for leadership in furthering the development of their countries. The 132nd Session would thus be a very important one, and one in which, he hoped, the Member States would work together to build a stronger Organization that would be better able to serve their populations.

3. Dr. Mirta Roses (Director, Pan American Sanitary Bureau) added her own welcome to the participants. She pointed out that a number of landmark events had taken place in the life of the Organization since she had assumed her post as Director in February 2003. At the global level, the World Health Assembly in May had elected a new Director-General for the World Health Organization (WHO) and had adopted several important new resolutions and policy orientations, including the Framework Convention on Tobacco Control. At the regional level, the Subcommittee on Planning and Programming and the Subcommittee on Women, Health, and Development had met in March and the health and agriculture ministers of the Americas had met in April. On World Health Day, 7 April, the Organization had launched the first Health in the Americas week, and in the first week of June it had carried out the first Vaccination Week of the Americas. Also during the first week of June, 10 Latin American countries, with support from PAHO, had successfully concluded the third round of negotiations for reduced prices on antiretroviral drugs.

4. All those events had been clear demonstrations of the spirit of Pan Americanism that prevailed in the Region and of the countries' enormous capacity for collective action. Nevertheless, though there was much to celebrate, much still remained to be done, as the President had pointed out. She was certain that the Committee would provide much valuable guidance on how the Organization could better fulfill the expectations of the peoples of the Americas.

Procedural Matters

Officers

5. The following Members elected to office at the Committee's 131st Session continued to serve in their respective capacities at the 132nd Session:

President: Peru (Dr. Fernando Carbone Campoverde)

Vice President: Jamaica (Hon. John Junor)

Rapporteur: Dominican Republic (Dr. José Rodríguez Soldevila)

6. The Director served as Secretary ex officio, and Dr. David Brandling-Bennett, Deputy Director of the Pan American Sanitary Bureau (PASB), served as Technical Secretary.

Adoption of the Agenda and Program of Meetings (Documents CE132/1, Rev. 2, and CE132/WP/1, Rev. 1)

7. In accordance with Rule 9 of its Rules of Procedure, the Committee adopted the provisional agenda prepared by the Secretariat. The Committee also adopted a program of meetings (Decision CE132(D1)).

Representation of the Executive Committee at the 44th Directing Council, 55th Session of the Regional Committee of WHO for the Americas (Document CE132/3)

8. In accordance with Rule 54 of its Rules of Procedure, the Executive Committee appointed the delegates of Peru and Jamaica, its President and Vice President, respectively, to represent the Committee at the 44th Directing Council. Honduras and Paraguay were designated as alternate representatives for Peru and Jamaica, respectively (Decision CE132(D2)).

Provisional Agenda of the 44th Directing Council, 55th Session of the Regional Committee of WHO for the Americas (Document CE132/4, Rev. 1)

9. Dr. David Brandling-Bennett (Deputy Director, PASB) presented the provisional agenda prepared by the Director in accordance with Article 14.B of the PAHO Constitution and Rule 7 of the Rules of Procedure of the Directing Council. He noted that Mexico had requested that an item entitled “A PAHO for the 21st Century,” be added to the agenda. Paraguay had requested the inclusion of an item on eradication of rubella and congenital rubella syndrome in the Americas. Inclusion of the latter item was consistent with the resolution adopted by the Executive Committee on sustaining immunization programs (Resolution CE132.R7). Paraguay had also requested that the Directing Council consider a policy for dengue prevention and control. The Secretariat would make the appropriate modifications and present the revised agenda, in accordance with Rules 9 and 10 of the Council’s Rules of Procedure.

10. The Delegate of Mexico said that, in response to a request from the President of the Executive Committee, his government had distributed a document entitled “A PAHO for the 21st Century.” Mexico asked that the document be included as one of the working documents for the Directing Council. The Delegate of Peru, speaking on behalf of her country’s Minister of Health, who had made the request, thanked Mexico for submitting the document, which would help guide the discussion of Member States’ vision for PAHO in the 21st century.

11. The Delegate of Paraguay said that his government had requested the inclusion of an item on dengue because it felt that a policy on prevention and control of the disease was urgently needed. Dengue was a source of enormous concern to countries throughout the Region, and decisive action was needed to control and, if possible, eradicate the disease.

12. The President pointed out that, while all the items on the agenda were unquestionably important, it had to be borne in mind that the Council would have limited time. It might, therefore, be necessary to defer consideration of some items until a later date. The Director said that, in accordance with the Council’s Rules of Procedure, all items proposed by Member States would be included on the revised provisional agenda, which would be circulated prior to the 44th Directing Council. It would then fall to the Member States to set the final agenda at the Council’s first meeting.

13. The Committee adopted Resolution CE132.R10, approving the provisional agenda, as revised.

Committee and Subcommittee Matters

Report of the 37th Session of the Subcommittee on Planning and Programming (Document CE132/5)

14. The report of the Subcommittee on Planning and Programming (SPP) was presented by the Honorable Herbert Sabaroche, in representation of the Government of Dominica, which was elected President of the Subcommittee at the 37th Session. He informed the Committee that the 37th Session had been held at PAHO Headquarters on 26 and 27 March 2003. It had been 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. Observers for Argentina, Bolivia, France, Guatemala, Mexico, and Panama had also been present.

15. The Subcommittee had discussed the following 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.

16. As all those topics were also to be discussed by the Executive Committee at the 132nd Session, he would report on the Subcommittee's comments on each one at the time that it was taken up by the Committee. Summaries of the presentations and discussions on all the above-mentioned items could be found in the final report of the Subcommittee's 37th Session (Document SPP37/FR).

Report of the 20th Session of the Subcommittee on Women, Health, and Development (CE132/6, Rev. 1)

17. The report of the Subcommittee on Women, Health, and Development was given by Ms. Patricia Hoes, in representation of the Government of Canada, which was elected Rapporteur at the Subcommittee's 20th Session. She told the Committee that the session had taken place at PAHO Headquarters on 25 and 26 March 2003. It had been attended by representatives of the following Members of the Subcommittee, elected by the Executive Committee or designated by the Director in accordance with the Subcommittee's Terms of Reference: Canada, Chile, Costa Rica, Dominica, Mexico, Paraguay, and United States of America. Representatives of Bolivia, Cuba, Honduras, and Peru had attended as observers. One intergovernmental organization and one nongovernmental organization had also been represented. In addition to Canada, the

officers elected by the Subcommittee had been Costa Rica (President) and Paraguay (Vice President).

18. The goal of the session had been to review progress in the implementation of gender-based analysis within the Secretariat and in Member States. In its deliberations, the Subcommittee had placed particular emphasis on information-sharing and citizen participation in monitoring health, health policies, and health outcomes. The presentations given during the session had included a report on the activities of PAHO's Gender and Health Unit (formerly the Program on Women, Health, and Development), reports on application of the gender perspective in several PAHO initiatives, and descriptions of country experiences in gender-based monitoring and analysis of healthy policies. The general consensus that had emerged from the Subcommittee's discussions was that, though tremendous progress had been made in Member States, in the Secretariat, and throughout PAHO, more capacity-building was required in the area of gender-based analysis.

19. The Subcommittee had formulated nine recommendations, four for the Member States and five for the Director. Those recommendations were aimed at strengthening gender-based analysis, monitoring, intersectoral approaches, involvement of civil society, and accountability. The Subcommittee's recommendations, together with a full account of its deliberations, appeared in the final report of the 20th Session (Document MSD20/FR).

20. The Executive Committee felt that the Subcommittee had produced a sound set of recommendations which would be helpful to both the Secretariat and the Member States in their efforts to mainstream gender and improve the monitoring and analysis of health policies. The Delegate of Jamaica reported that a gender mainstreaming process had been under way in the Secretariat of the Caribbean Community for the past four or five years and suggested that it might be useful for PAHO to learn more about that initiative. Other delegates highlighted the issue of gender-based violence and expressed the hope that the Gender and Health Unit would continue to support countries in seeking solutions to the problem. The Delegate of Peru noted that his country had incorporated prevention of gender-based violence into the education system, starting at the primary level, as part of a broader effort to promote respect for the rights of men and women and equality of opportunities.

21. The Representative of the Latin American Union Against Sexually Transmitted Diseases (ULACETS) drew attention to the gender dimension of sexually transmitted infections. Though it had been believed that STIs did not discriminate, in fact, they did. They were most likely to strike poor and vulnerable populations, in particular women. In the Americas, women were now more affected by STIs than men. She also announced

that the subject of gender and STIs would be one of the focuses of the World Congress on STI/AIDS, to be held in December 2003, in Punta del Este, Uruguay.

22. Ms. Hoes thanked the Committee for its comments and for its support of the recommendations.

23. Dr. Marijke Velzeboer-Salcedo (Chief, Gender and Health Unit, PAHO) also thanked the Committee for its support and expressed her appreciation to the Subcommittee for its hard work during the 20th Session. The Gender and Health Unit was familiar with the excellent work under way in the Caribbean in the area of gender mainstreaming and gender training, and planned to use that work as a model for its own work in the future. The Unit was also utilizing Peru's model for prevention of gender-based violence to promote school-based prevention efforts in other countries. Peru and Belize were among the first countries to have incorporated violence prevention into their education systems. Peru also had a multisectoral committee that had mobilized to promote policies and legislation on gender-based violence against women. Other countries, notably Mexico, had also made impressive progress in addressing the problem. The Gender and Health Unit would, indeed, continue to support those efforts.

24. With regard to the issue of gender and STIs, she was pleased to report that the Gender and Health Unit and the HIV/AIDS Unit had developed a common issue paper on gender inequities and gender-related behaviors that put women at greater risk for AIDS and other STIs. They had also prepared an information sheet and a PowerPoint presentation in both English and Spanish that could be used for advocacy by counterparts in the countries. In addition, PAHO was part of the United Nations Task Force on Gender and AIDS, which was preparing a set of information sheets that would be ready for distribution in early 2004.

25. The Executive Committee endorsed the recommendations submitted by the 20th Session of the Subcommittee on Women, Health, and Development, thanking Ms. Hoes for her report and expressing its gratitude to the Subcommittee for its work (Decision CE132(D3)).

Report of the Award Committee of the PAHO Award for Administration, 2003 (Documents CE132/7 and CE132/7, Add. I)

26. Dr. Elías Lizardo Zelaya (Honduras) reported that the Award Committee of the PAHO Award for Administration, 2003, had met on Wednesday, 25 June 2003. The Committee had originally consisted of Dominica, El Salvador, and Uruguay; however, Honduras had served in place of El Salvador, which had been unable to send a representative to the Executive Committee's 132nd Session.

27. After examining the documentation on the candidates nominated by the Member States, the Committee had decided to confer the award on Mr. Roy J. Romanow, of Canada, for his outstanding contribution to the development of the health system in his country, particularly through his work in creating the Saskatchewan Human Rights Commission and his leadership of the Commission on the Future of Health Care in Canada.

28. The Delegate of Canada expressed her country's appreciation to the Award Committee for having chosen Mr. Romanow to receive the award. His selection was a great honor, especially given the high caliber of all the other candidates. Through his work on the Commission on the Future of Health Care in Canada, Mr. Romanow had played a pivotal role in ensuring the sustainability of Canada's health care system, and was richly deserving of the award.

29. The Committee adopted Resolution CE132.R8 on this item.

Report of the Standing Committee on Nongovernmental Organizations in Official Relations with PAHO (Documents CE132/8 and CE132/8, Add. I)

30. Dr. Barrington Wint (Jamaica) reported that the Standing Committee on Nongovernmental Organizations, composed of the representatives of Jamaica, Peru, and United States of America, had met on Tuesday, 24 June 2003, to consider a background paper prepared by the Secretariat on two NGOs whose status as organizations in official relations with PAHO was due for review. Those two NGOs were the International Organization of Consumers Unions (CI-ROLAC) and the Latin American Union Against Sexually Transmitted Diseases (ULACETS).

31. After carefully reviewing the background documentation, the Standing Committee had decided to recommend to the Executive Committee that, because the proposed collaborative activities between PAHO and the two NGOs had either not been carried out or had not been completed, official relations with CI-ROLAC and ULACETS be continued for one year, during which those activities were expected to be completed. The Standing Committee would then reexamine relations with the two NGOs when it met in June 2004. The Standing Committee had also seen a need for more precise criteria to guide the reviews of relations with NGOs, and accordingly recommended that the Executive Committee request the Director to develop, for consideration by the Executive Committee at its next session in September 2003, a protocol for evaluating NGO performance.

32. The Committee adopted Resolution CE132.R9, embracing both recommendations of the Standing Committee.

Program Policy Matters

Managerial Strategy for the Work of the Pan American Sanitary Bureau in the Period 2003–2007 (Document CE132/9)

33. The Director outlined the main points of the managerial strategy set out in Document CE132/9, noting that the strategy had been revised since the Subcommittee on Planning and Programming had held its 37th Session in March 2003. The revisions reflected both the comments made by the Subcommittee and the Secretariat's progress in refining the strategy since then. She reminded the Committee that the managerial strategy had been developed in response to Resolution CSP26.R18 of the 26th Pan American Sanitary Conference, which 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. She then referred to priority population groups, countries, and areas for technical cooperation and discussed the importance of achieving the public health objectives for the Americas that had emerged from the analysis of essential public health functions undertaken in the last two years.

34. She went on to describe her vision for the Organization, which was one of a united hemisphere committed to attaining 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. Recent examples of how the vision of a united hemisphere was being realized included the first Vaccination Week of the Americas, during which countries across the Region had mobilized to immunize children, and the first Health in the Americas week, beginning on World Health Day, 7 April, and culminating on the Day of the Americas, 14 April. In furtherance of the second component of the vision, among other activities, PAHO had provided support for the subregional meetings of ministers of health and had assisted countries in negotiating for antiretroviral drugs and in developing effective proposals to be submitted to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. To empower communities, the Organization was seeking, inter alia, to promote community involvement in working towards achievement of the Millennium Development Goals.

35. As she had said on various other occasions, PAHO aspired to be a forum in which all countries of the Americas could find a response to their health concerns; 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, such as the Core Health Data, which constituted an increasingly complete source of information both on individual countries and on subregions.

36. Based on the mission and vision for PAHO approved by the Member States as part of the Strategic Plan, the Secretariat had identified the following strategic objectives for institutional change: to make work in the countries and with the countries PAHO's central focus; to position the Organization in the mainstream of global, regional, and national health policy debates; to build capacity at the local, national, and subregional levels; to develop strategic alliances with other health development partners; to network and share knowledge inside the Organization and between the Organization and its environment; to forge closer links between planning at all levels: national, subregional, regional, and global; to maximize extrabudgetary resources, while ensuring attention to the priorities established by the Governing Bodies; to improve programmatic integration and strategic management of the Secretariat's work; and to increase efficiency, transparency, and productivity.

37. One of the key features of the managerial strategy was a new orientation for regional programs. Whereas in the past, regional programs had been viewed as the domain of the Secretariat, under the new orientation they would be regionwide initiatives that the Member States had agreed to carry out collectively, with support from the Secretariat and other national and international partners, to achieve goals established by consensus among the countries themselves. One example of a public health problem that many ministers of health felt should be the object of such a regionwide effort was congenital syphilis. The Secretariat had therefore commissioned a study to determine the feasibility of launching a regional program aimed at eliminating the disease. The program, would not, however, be a PAHO regional program. It would be a program collectively led by the countries of the Americas, in which the Secretariat and other partners would collaborate in carrying out activities and achieving the desired impact.

38. Another very important aspect of the strategy was its increased country focus, which was in keeping with the WHO Country Focus Initiative. A new Country Support Unit within the Director's Office would oversee the application of a much more strategic and integrated approach to cooperation with countries, including development of medium-term country cooperation strategies (CCS) and establishment of task forces to aid in planning, execution, and monitoring of technical cooperation tailored to the situation and needs of each country. The Secretariat was also adapting the country-focused approach for use at the subregional level. In that regard, she was pleased to announce that the Secretariat was developing a methodology for analyzing the cooperation needs of the countries of the Eastern Caribbean, which would enable it to improve both the support it provided to the Member States in that subregion and its

coordination with the Secretariat of the Organization of Eastern Caribbean States (OECS).

39. Other features of the managerial strategy included a continued commitment to Pan Americanism and technical cooperation among countries; strategic management of resources, including a new streamlined budgeting structure that was consistent with the new organizational structure and linkage of the Secretariat's expected results with the WHO global expected results and with the objectives of the Strategic Plan; and new methods of work, with particular emphasis on teamwork and increased participation of staff and other experts through work groups and task forces. Document CE132/9 described the steps taken thus far and those to be taken in the future to position PAHO to meet the challenges of the 21st century and enable it to function as one team pursuing one goal: improving the health of the Americas.

40. The President of the Subcommittee on Planning and Programming reported that the SPP had discussed the managerial strategy for 2003–2007 the previous March. The Subcommittee had agreed that it was essential for PAHO to respond to changing needs and had felt that the more streamlined organizational structure introduced by the Director would allow it the necessary flexibility to do so effectively. Delegates had also applauded the transparency and inclusiveness of the restructuring process and commended the Director for her receptiveness to Member States' comments and suggestions. The Subcommittee had pointed out that any process of change was inevitably accompanied by uncertainty and had encouraged the Secretariat to complete the organizational restructuring process as swiftly as possible, as that uncertainty might impair the Organization's ability to respond to urgent problems that arose in the Region. The SPP had also urged the Secretariat to develop indicators to monitor the impact of the organizational changes and, especially, of the increased emphasis on programmatic integration and horizontal collaboration across areas of work.

41. The Executive Committee felt that the managerial strategy reflected a sound understanding of the priority issues and challenges faced by the countries. Members expressed strong support for the vision of the Organization as a uniting force and as a health forum in which all countries of the Americas could voice their concerns and participate on an equal footing. They welcomed the strategy's country focus and its emphasis on a team approach and on sharing of knowledge within the Organization and between the Organization and its environment. Its recognition of the linkage between health and other social issues, such as citizenship, human rights, and social justice, was also applauded, as was the importance placed on empowering people to take responsibility for their own health. In that connection, the importance of education in creating a culture of health was underscored.

42. The Committee praised the Secretariat's efforts to focus on a limited number of priorities, achieve greater efficiency and effectiveness, and make optimum use of its human and financial resources. Delegates reiterated the need for indicators to measure the impact of those efforts. It was pointed out that PAHO could set a valuable example—not only for Member States but also for other WHO Regional Offices—by fostering an organizational culture that emphasized transparency, maximized program efficiencies, minimized administrative overhead, streamlined bureaucratic processes, and made the best possible use of technology. Clarification was requested on some aspects of the managerial strategy. In particular, the Director was asked to elucidate the rationale for placing the Program Budget Unit and the Financial Management and Reporting Unit under two different areas of work within the organizational structure. Additional information was also requested on the working group on the regional budget policy, the teamwork approach, and the use of in-house and outside experts, mentioned in the document and in the Director's presentation.

43. The Delegate of Dominica welcomed the Director's announcement regarding subregional cooperation with the countries of the Eastern Caribbean. At a meeting earlier in June, the ministers of health of the OECS had discussed the merits of just such a decentralized approach to technical cooperation and, in fact, had mandated him to issue an invitation to the Director and her team to meet with them in order to see first-hand the challenges they faced and discuss solutions that might be undertaken with PAHO's help. Issues of particular concern to the OECS Member States, which the health ministers hoped would be addressed under a subregional technical cooperation plan, included food safety and environmental health, HIV/AIDS and procurement of antiretroviral drugs, and how to meet the health care needs of the poor and unemployed.

44. Like the SPP, the Executive Committee commended the Director for her transparent management style and her efforts to seek input from and involve Member States in shaping the vision for PAHO in the 21st century. Delegates felt that countries should be active participants in that process, since they were both beneficiaries of and partners in the Organization's activities, and it was they who provided the resources to enable its work. The President, in his capacity as Delegate of Peru, remarked that international organizations seemed to be increasingly concerned that their agendas should reflect the common interests and mandates of Member States and noted that that concern was particularly evident at PAHO. He felt that the countries—with support, as needed, from the Secretariat—should undertake an ongoing process of reflection on the nature, purposes, and short-, medium-, and long-term goals of the Organization. One possible forum for that collective reflection would be the meetings of ministers of health that took place periodically in each subregion. Noting that all the subregions were represented at the 132nd Session, he proposed that the delegates take responsibility for ensuring that time was set aside during their next subregional meetings to discuss the work and the future of PAHO. Representatives of the various subregional groups could then be

designated to report back to the Governing Bodies of PAHO on the outcome of those discussions.

45. The Executive Committee concurred with that proposal. The Delegate of Paraguay suggested that the presidents of the subregional meetings of ministers of health might be invited to attend the next session of the Subcommittee on Planning and Programming to act as spokespersons for their respective subregions. Other delegates felt that time should also be allowed for reflection on this matter during the 44th Directing Council in September. The representatives of several nongovernmental organizations expressed the hope that organizations such as theirs—as partners with the Organization and the countries in the effort to improve health conditions in the Region—could also be involved in the reflection process. It was suggested that one of the topics to be discussed should be the public health challenges associated with globalization—in particular cross-border transmission of diseases such as severe acute respiratory syndrome (SARS)—and the response of the Organization and its Member States to those challenges. It was also pointed out that advantage should be taken of the forthcoming interim Summit of the Americas to highlight public health concerns.

46. The Director felt that it would be very useful to hold a series of subregional consultations on the roles and work of the Organization. As PAHO served as the Secretariat for all the subregional meetings of ministers of health, it could certainly facilitate the process. Many of those gatherings were also attended by representatives of civil society organizations and multi- and bilateral agencies, so it would be possible to obtain a wide range of views. The Secretariat would formulate a proposal within 30 days for incorporating those discussions into the agendas of the various subregional meetings, beginning with the Meeting of the Health Sector of Central America (RESSCA), which would take place in August 2003. The Terms of Reference for the SPP gave the Director a certain latitude in inviting countries to take part in the Subcommittee's sessions, and she could thus ensure that the presidents of all the subregional groupings were present to report on the recommendations emanating from their meetings. The Secretariat would also explore the possibility of organizing panel discussions during the Directing Council to further the process of reflecting on what the Member States envisaged for PAHO in the 21st century.

47. Responding to the Committee's questions, she explained that several approaches were being taken to teamwork. One was to put together task forces to coordinate technical cooperation with individual countries. Those groups sought not only to apply an integrated approach to PAHO technical cooperation with countries but to complement the cooperation being provided by other organizations. In some countries, the teams had included PAHO resources in neighboring countries. For example, in Haiti and Guyana, resources from the Dominican Republic and Suriname, respectively, had been used. Another approach was the formation of groups for specific purposes—such as supporting

the negotiations for antiretroviral drugs—utilizing staff from several areas of work. The aim of the teamwork approach was to take maximum advantage of the expertise that existed across the Organization so as to make optimum use of the available human and financial resources.

48. To further encourage the team approach, the Secretariat was exploring the option of earmarking funds in future budgets specifically for shared activities. The resources would be allocated to several units, which could use them only for joint initiatives. Such an approach would provide an additional incentive for teamwork. That would be one of the topics to be discussed by the working group on budget policy.

49. Regarding that working group, she recalled that the SPP, at its 34th Session, had recommended that the Organization's budget policy be reviewed at the time that new strategic and programmatic orientations were introduced. That review would be carried out during the remaining six months of the year. The group would consist of PAHO staff and budget policy experts from the countries.

50. With respect to the placement of the Budget Unit within the organizational structure, as she had told the SPP, there were different schools of thought about the relationship between budgeting, programming, and financial management. For the last decade, both the budget and finance units had come under the Office of Administration. However, over the years, past directors had applied a variety of approaches. Some had placed the unit responsible for budgeting directly within their offices, so that it was not associated with either programming or administration. She and her executive management team had decided that it was preferable to link the budget more closely to planning and programming, as they viewed the budget as a fundamental program instrument. The Budget Unit had therefore been placed under the Office of Program Management, while the Financial Management and Reporting Unit remained under the Office of Administration. Nevertheless, there continued to be close coordination between the two units. The new arrangement had proved quite successful thus far—preparation of the program budget proposal to be considered by the Committee had gone very smoothly, for example—but the Secretariat would continue to monitor the effect of that change and of all the other changes that had been made in the organizational structure and would make any needed adjustments should problems arise.

51. Responding to the questions about use of experts, she said that one source of expertise would be the Joint Inspection Unit (JIU) of the United Nations system. Expert inspectors from the JIU would conduct a management review, looking especially at the priority issues identified by the Secretariat. The JIU inspectors brought a wealth of experience with different management systems from organizations throughout the United Nations system, and would undoubtedly be very helpful in suggesting ways to improve the management and use of information technology, management of human resources,

and development of more efficient and streamlined work procedures. Moreover, PAHO, in its capacity as a Regional Office of WHO, could take advantage of the JIU's services free of charge. Another source of expertise would be the Member Governments, as in the case of the budget policy working group. A third possibility was the Board of Directors of the Pan American Health and Education Foundation (PAHEF). They have valuable experience to share. Several had already offered to provide expert advisory services on a pro bono basis. Universities and centers of excellence were an additional source of expertise on specific technical and managerial issues.

52. In reply to the Delegate of Dominica, she said that PAHO would definitely be sending an integrated technical mission to meet with the health ministers of the Eastern Caribbean. She also hoped to have the opportunity to meet with them during the Directing Council.

53. Finally, she was pleased to announce that, after consulting with all nine Members of the Executive Committee, she had decided to appoint Dr. Joxel García and Dr. Carissa Etienne to serve as Deputy Director and Assistant Director, respectively. They would take office on 1 August and 3 July 2003, respectively. She wished to convey her gratitude, personally and on behalf of the entire Organization, to Dr. David Brandling-Bennett, who for the past several months had fulfilled the responsibilities of both Deputy Director and Assistant Director. Dr. Brandling-Bennett had held numerous positions during his 14-year career at PAHO, and has done an excellent job in all of them. Perhaps one of his most important and visible roles had been serving as Technical Secretary to the Governing Bodies. The smooth functioning of Governing Body meetings was due largely to his efforts. Although Dr. Brandling-Bennett was leaving PAHO, he would continue to contribute his extensive knowledge and skills to the advancement of public health in his new position with the Bill and Melinda Gates Foundation.

54. The Executive Committee expressed its appreciation to Dr. Brandling-Bennett for his years of service to the Organization and wished him well in his new position.

55. The Committee agreed to foster discussions on the future of PAHO, in the different subregional ministerial meetings as proposed by the Delegate of Peru. Delegates were requested to take the necessary action to ensure that the topic was included on the agendas of the meetings of health ministers in their respective subregions and that a representative was designated to summarize and report on the views put forward at those meetings. The Secretariat was asked to facilitate the consultation process and to arrange for the representatives of the various subregional meetings to participate in the next session of the Subcommittee on Planning and Programming. The President noted that the Minister of Health of Mexico, had informally circulated a paper on PAHO in the 21st century and invited the Delegation of Mexico to share the paper with all participants, as it could be useful for the deliberations on this topic.

Proposed Program Budget of the Pan American Health Organization for the Financial Period 2004–2005 (Official Document 307 and Official Document 307, Add. I)

56. Dr. Daniel López Acuña (Director of Program Management, PAHO) presented the proposed program budget of the Pan American Health Organization for the financial period 2004-2005. He explained that the planning mandates for the preparation of the budget included the mandates of WHO's and PAHO's Governing Bodies, the WHO corporate strategy, WHO global and PAHO regional policy frameworks, the 2003–2007 Strategic Plan for the PASB, the Millennium Development Goals, and the results of the evaluations of PAHO's contribution to the attainment of WHO global expected results and of the 2000–2001 program budget.

57. The new program budget structure was based on conceptual underpinnings relevant to PAHO's work and was also more closely aligned with the WHO program budget structure. It consisted of areas of work, instead of a classified list of programs, grouped in a new set of appropriation categories. The new appropriation categories were: Executive Direction (3.6% of the PAHO/WHO budget); Governance and Partnerships (4.9%); Country Program Support (17.5%); Intersectoral Action and Sustainable Development (13.8%); Health Information and Technology (14.5%); Universal Access to Health Services (13.4%); Disease Control and Risk Management (12.9%); Family and Community Health (8.5%); and Administrative Support (10.9%). The revised areas of work reflected an integrated approach to program delivery and were both more streamlined than the former classified list of programs (their number having been reduced from 61 to 42) and more convergent with WHO's areas of work. Resources had been shifted towards priority programs (HIV/AIDS, control of tobacco, TB and emerging diseases, and emergency humanitarian action), with major importance attached to protecting and maintaining current-level funding for the five priority countries identified in the Strategic Plan (Bolivia, Guyana, Haiti, Honduras and Nicaragua). Those shifts had been possible thanks mainly to an effort to scale down the management structure and reduce administrative costs as much as possible.

58. The initial proposal for the PAHO/WHO 2004-2005 budget had been based on the approved 2002-2003 budget of \$261,482,000, to which had been added only obligatory cost increases for posts and for retirees' health insurance, both mandated by the United Nations General Assembly. Those increases had brought the total initial proposal to \$264,773,000. At the time the initial proposal was presented to the SPP in March, it had been anticipated that the WHO contribution to the PAHO budget would be \$75,399,000, as proposed at the meeting of the WHO Executive Board in January. However, various budget-related resolutions adopted by the 56th World Health Assembly in May had resulted in a net reduction of \$2,169,000 in that amount, making the total WHO contribution \$73,230,000. Hence, the final PAHO/WHO budget proposal for 2004–2005 was \$262,604,000. This represents an increase of 0.4% over the 2002–2003 figure, which

is the smallest in PAHO's history. The Secretariat had deliberately not maintained the originally proposed increase of 1.3% in order to avoid an increasing burden in Member States' quota contributions.

59. Owing to World Health Assembly Resolution WHA51.31, which had changed the distribution of resources among the regions, the level of funding which PAHO received from WHO has been steadily dwindling. That meant that an increasing portion of the budget had to be funded from the quota contributions of PAHO Member States. The topic of the reallocation of resources to the different regions of WHO will be discussed by the Directing Council in September, based on a paper produced by WHO on the reallocation that will evaluate the impact in the different regions.

60. It was also anticipated that there would be a drop of \$3 million in miscellaneous income by comparison with the preceding biennium, owing to the fall in interest rates throughout the world and in North America in particular. The shortfall in miscellaneous income and the need to compensate for the reduction in WHO's contribution would necessitate an increase of 3.3% in Member States' quota contributions. However, that increase was quite modest, especially when compared to the average increases in the 1970s, 1980s, and 1990s, which had ranged from 14% to 24%.

61. Expressed in constant terms, after adjusting for purchasing-power changes and inflation, the program budget had run consistently below the level of zero real growth since 1986. For 2004–2005, it was 21% below that level. The number of posts financed by the Organization's budget had also gone down steadily, from 1,222 in 1980 to the 831 proposed for 2004–2005 (two fewer than in 2002–2003).

62. The President of the Subcommittee on Planning and Programming reported that, when the Subcommittee had discussed the previous version of the budget document in March 2003, several delegates had expressed the hope that the document submitted to the Executive Committee would contain 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 had 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, and other PAHO and WHO planning mandates.

63. The Subcommittee had applauded the effort to align PAHO's areas of work more closely with those of WHO. At the same time, it had emphasized the need for integration and collaboration across those areas, especially in the area of family and community health, which was considered crucial. The importance of building alliances with other international and national institutions had also been underscored. Several delegates had 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 had been urged to pay their 2003 assessments and to settle any arrears they might have, as that would help ease the Organization's financial situation and enable it, in turn, to fulfill its commitments to the countries.

64. The Executive Committee welcomed the document and the supporting presentation, noting that the present budget was the first one designed to reflect the Strategic Plan for 2003–2007 and a number of other relevant mandates of the Organization. The Committee also expressed satisfaction at the changes that had been introduced into the proposal to streamline the classification of programs and make them more convergent with WHO's areas of work. Delegates felt that the format of the budget document and the explanations given facilitated analysis of the various budgetary issues, although it was also suggested that more detail might be useful in some areas, with a breakdown of major expenditure amounts into categories of expenditure.

65. The Delegate of the United States of America expressed the view that the reduction in the amount allocated to PAHO by WHO pointed to hard choices made at the World Health Assembly, which in turn had reflected the global perspective that Member States had agreed was necessary in relation to the WHO budget. Those choices also reflected the economic constraints that countries were facing—constraints which PAHO also needed to consider in relation to the PAHO budget. Her government favored zero nominal growth for the PAHO total budget, and felt that the Organization could maintain existing resource levels by further prioritizing programs, seeking internal cost-savings and efficiencies, and making some hard “belt-tightening” choices, bearing in mind that many countries in the Americas were facing similar choices and were increasingly struggling to pay their quotas. Her delegation hoped that the Secretariat would reconsider the budget level and make a new proposal to the Directing Council in September.

66. A number of other delegates agreed that it would be very hard for their countries to contemplate an increase in quota contributions in the present difficult economic circumstances. It was pointed out that PAHO did not have a mechanism like the one that existed at WHO, under which countries having difficulty in meeting their increased assessments could obtain relief for up to two biennia. That being the case, delegates felt that it would be difficult to persuade financial authorities in their countries to agree to a higher assessment and urged the Secretariat to utilize its creativity to find a way to carry out priority activities without increasing quota contributions.

67. As there had evidently been a significant redistribution of resources from some areas to others, delegates considered it important to know what impact that shifting of funds would have on programs. Clarification was sought with regard to several specific changes in allocations, particularly the increases for the five priority countries, which in some cases were smaller in percentage terms than those for other countries. Additional information was requested about the \$500,000 earmarked for the International Health Regulations and SARS. Dr. Roses was asked to comment on whether there were any preliminary ideas on how the Regional Director's Development Program would be used, and the Secretariat was requested to make periodic reports to the Governing Bodies on its use.

68. Concern was also expressed about the projected figure of \$13.5 million in miscellaneous income for 2004–2005, given that the amount available in the current biennium was a little over \$10 million, which was substantially under the \$16.5 million originally expected. In the present financial climate, it was felt that \$13.5 million might be too optimistic. It was also noted that whereas in the current biennium PAHO had received about \$154 million in extrabudgetary resources, the proposal for 2004–2005 projected an amount of \$55 million, and clarification was sought on how those estimates were calculated. Several delegates thought that it would be useful to set up a mechanism for tracking actual expenditure against the budgeted amounts.

69. Dr. López Acuña assured the Committee that its suggestions for refining the indicators and expected results and for further streamlining the presentations of some of the programs would be incorporated into the document. Changes had been made between the version shown to the SPP and the present one, reflecting the reorganization and reallocation of resources. Additionally, the amount of detail had been increased, as requested by the SPP. While some increases or decreases from one biennium to the next did reflect real changes in programs, others were simply the result of changes in post costs in the duty stations concerned. Replying to a specific question from one of the delegates, he explained that allocations in the past biennium related to public health leadership and infrastructure and health services delivery had now been classified in the area of work of supporting national health development. In the case of all of the priority countries, the existing level of allocation had been maintained, after discounting changes in purchasing power. As far as possible, additional program resources had been allocated to strengthen them and maintain consistency with the priorities. In the process of revising the budget presentation, the Secretariat had taken the utmost care to ensure consistency with those priorities and with the mandates which he had listed at the beginning of his presentation, notably the Millennium Development Goals.

70. The total earmarked allocation for the International Health Regulations and SARS in WHO's global budget was \$10 million. The Region of the Americas was allocated only \$500,000, an allocation rather low relative to the total amount earmarked. With reference to extrabudgetary resources, he clarified that out of a concern for sound and prudent management, only those amounts which the Organization was certain it would receive were included in the budget document. However, the resources that are actually mobilized have been consistently larger than the initial estimate in the budget throughout the last biennium.

71. Finally, he pointed out that the budget total had been reduced by \$2.1 million, reflecting the decrease in the WHO contribution. If that reduction had not been made, then the resultant quota increase would have been 4.8% instead of 3.3%. If the budget were cut any further, the programs which PAHO had committed to deliver would be severely affected.

72. The Director thanked the delegates for their comments, in particular those which had taken note of the major effort towards a total redesign of the budget. That effort had been started before the meeting of the Subcommittee on Planning and Programming, and had continued when the Subcommittee had asked for more detail in the areas of indicators and expected results. She was aware that such a radical change in the structure of the budget, together with the streamlining of the categories from 61 to 42, made it difficult to make historical comparisons or discern exactly where reductions and increases had been made. Some of the shifts in allocations noted by delegates were due simply to relocation of posts from one area to another within the budget structure. Any such relocation produced a transfer of resources amounting to between \$250,000 and \$300,000, which was quite significant in percentage terms relative to the total PAHO budget. However, those changes did not necessarily reflect any change in the non-post part of the budget—i.e., the amounts allocated for actual program delivery.

73. She felt that any calls for zero nominal growth in the PAHO budget had to be seen in the light of the increases in both the budget and country assessments approved at the World Health Assembly in May. Member States had agreed to an increase of almost 2% in the WHO budget, which had resulted in an increase in their quota contributions. However, because the allocation to WHO Headquarters had been protected over the past fifteen years, to the detriment of the amounts going to the regions, none of that 2% increase would reach the Region of the Americas. On the contrary, the Region's share had been reduced. The budget being presented to the Committee represented a sacrifice in terms of absorption of costs and of the effect of devaluations, neither of which would be offset by the proposed increase. Failure to approve that increase, coupled with the reduction in the WHO contribution, would have an enormously negative impact on the availability of resources for PAHO's technical cooperation with the countries.

74. The Organization would continue to pursue greater efficiency, protection of the priority countries, efforts to mobilize extrabudgetary resources and a very prudent management of the budgetary allocations. It would be necessary gradually to change some countries' historical ceiling amounts—a process that had already begun—and to reconfigure PAHO's staffing and presence in various countries in the interests of greater equity and in order to respond more to countries' needs, in particular those that the Member States had identified as priority countries. Any changes in budgetary allocation and personnel distribution among the countries would be made on the basis of a rational analysis of needs, utilizing the best evidence available.

75. Regarding the WHO mechanism for relief from increased quotas, it was a relatively new mechanism that had been created by taking away funds from cooperation programs, which was a matter of considerable concern to many countries. In practice, it had meant a net transfer of resources from the poorest countries to medium-and high-income countries.

76. She clarified that the Regional Director's Development Program, to which approximately \$1.6 million had been allocated for the biennium, was intended to allow a response to unanticipated requests for assistance from countries. One example was the support the Organization had provided for antiretroviral drug negotiations. As for reporting on its use, the financial reports and interim financial reports of the Director always contained information on how Program funds had been employed.

77. Responding to the comments concerning tracking of expenditures and the request for more detail on categories of expenditure, she noted that the Organization's planning, programming, monitoring, and evaluation system, AMPES, was a very modern and sophisticated system—much praised by both internal and external auditors—which enabled it to keep accurate and transparent records of all expenditures. That information would be made available at any time to any Member State that requested it. Among the system's many advantages, it made it possible to maintain strict financial control, while also allowing great flexibility in the use of budgeted resources, the only constraint being that funds allocated to posts could not be used for non-post purposes and vice versa. AMPES had enabled both the Secretariat and the countries to respond to changing health problems and challenges by redirecting resources to where they were needed most. It had also generated confidence among donors, which had greatly enhanced PAHO's capacity to mobilize extrabudgetary resources.

78. In that connection, she emphasized that, in addition to avoiding completely any recourse to internal borrowing, PAHO also refused to speculate on the possibilities for mobilizing resources. In both respects, the situation which prevailed within WHO was different, but resources were entered into the PAHO budget only if it was certain that they would indeed materialize. PAHO had always been successful in mobilizing

extrabudgetary resources, but had been less successful in obtaining a share of the resources gathered by WHO as a whole: in the preceding biennium, WHO had mobilized \$1.8 billion in extrabudgetary funds, of which only 7% had reached the Region of the Americas. Almost 50% remained at Headquarters in Geneva. As in the case of regular budget funds, that disproportion in the distribution of resources was making it increasingly difficult for PAHO to maintain its level of efficiency and support to the countries of the Region.

79. She had discussed PAHO's concerns about resource distribution with the new WHO Director-General, and she was hopeful that as from the 2004-2005 biennium the Region of the Americas would see a more equitable distribution of the resources contributed collectively by all the countries. However, she felt that it was part of her responsibility as Director to point out to the Member States that, ultimately, it was they who controlled how resources were distributed among the regions. She also wished to remind them that WHO Headquarters had been excluded from the reallocation of resources approved under Resolution WHA51.31. Only the regions had been affected. If WHO Headquarters had participated in the reallocation, the amount coming to the Americas would have been greater and the Region would not now find itself in such difficult circumstances. PAHO fully supported the increase that Member States had approved in the WHO budget, but at the same time it expected to see that those resources were distributed fairly, in a manner that would benefit the countries of the Americas, in particular those that had been identified as priorities.

80. In the discussion that followed the Director's remarks, the Delegate of the United States reiterated her hope that the Secretariat would revise the budget proposal prior to the Directing Council, bearing in mind the comments of both the SPP and the Executive Committee. She noted that her delegation had made a number of specific comments on the different program areas and said that she would provide those comments and some further thoughts in writing to assist the Secretariat in revising the document. She also expressed her appreciation to the Secretariat for its willingness to continue to work on the indicators and refine them before the Directing Council.

81. The President pointed out that, under Article 14.C of the PAHO Constitution, it was incumbent on the Executive Committee to submit to the Directing Council the proposed program and budget prepared by the Director, with such recommendations as it deemed advisable. Accordingly, he requested that the Rapporteur prepare a proposed resolution that would reflect the concerns expressed by Member States, but that would also enable the Committee to reach a consensus and fulfill its responsibility to forward a program budget proposal to the Directing Council.

82. The Committee subsequently adopted Resolution CE132.R6, which, the Director noted, had been revised by Members of the Committee, with support from the Secretariat,

on the basis of Member States' comments and an interchange of information concerning the ongoing negotiations with WHO about the proportion of the total budget applicable to the Region of the Americas. In the resolution as revised, the requested increase had been reduced to 0.15% of the overall PAHO/WHO budget, to be funded by an increase of 2.55% in the quota contributions of the Member States. She was pleased with that outcome and hoped that the Member States were equally pleased. The proposal was a very conservative one, which sought to maintain a balance between the various appropriations for the basic programs, took into account all of the efforts under way to increase efficiency in expenditure, and guaranteed that the mandatory cost increases would have the least possible impact on program implementation.

Results Attained in the Strategic and Programmatic Orientations during the Period 1999–2002 (Document CE132/11)

83. This item was introduced by Dr. Germán Perdomo (Senior Policy Advisor, Area of Planning, Program Budget, and Project Support, PAHO), who updated the Committee on the progress made towards meeting the regional goals established under the Strategic and Programmatic Orientations (SPOs) during the period 1999–2002. Those results were outlined in Document CE132/11, which had been prepared pursuant to a request from the 26th Pan American Sanitary Conference in September 2002. The Conference had reviewed a report on the progress made under the SPOs and had asked for a follow-up report that would provide more in-depth information on the achievement of the regional goals.

84. A total of 29 regional goals had been established under the SPOs. Those goals had entailed a joint commitment by the countries and the Secretariat to improve health and environmental conditions for the Region's population, control certain diseases and health impairments, and develop health systems and services. Twenty of the goals had related to health outcomes, two had related to intersectoral actions targeting health determinants, and seven had related to health policies and health systems. The document presented the latest available data on progress towards achieving the goals and examined some of the information-related constraints that had made it difficult or impossible to determine whether some of them had been met.

85. The experience with the SPOs had yielded a number of lessons that would prove useful in establishing future policy orientations to guide the Secretariat's technical cooperation and in evaluating the results obtained from the application of those orientations. In particular, it had been found that the definition of policies to guide technical cooperation should be done with the broadest possible internal and external participation in order to ensure that stakeholders, in particular Member States, were committed to the fulfillment of the policy orientations. A manageable number of goals and objectives for technical cooperation should be established, and those goals and

objectives, while posing a challenge, should be attainable. One of the principal problems identified in the evaluation of the SPOs was that some of the goals were expressed in a way that made it impossible, with existing information systems, to monitor progress towards their achievement. Accordingly, goals and objectives should be formulated in a way that would enable their monitoring and evaluation. The SPO evaluation exercise had also highlighted the importance of continued effort to improve the capacity and quality of national health information systems. In addition, it had pointed up the need for ongoing discussion regarding the implementation of the Strategic Plan for 2003–2007.

86. The Executive Committee thanked the Secretariat for the report and, in particular, the analysis of lessons learned. The report clearly showed that it was a formidable task to set measurable objectives, assess progress, evaluate the results in each country, analyze the factors associated with the achievement of those results, and then apply the lessons learned, and the Committee was grateful to the Secretariat for undertaking that task. Noting that many of the difficulties in assessing progress had been due to lack of information, several delegates underscored the need for countries to put in place information systems to produce data that were timely, reliable, and comparable. The need to develop goals carefully, taking into account the feasibility of monitoring them at the time they were selected, was also emphasized.

87. One delegate commented that, in cases in which data were insufficient to measure change, it might be reasonable to ask whether PAHO was ready to address such a goal in an effective manner. At the same time, however, it was important not to ignore a particular health problem simply because there was a lack of solid baseline data. Another delegate suggested that, as achievement of many of the goals—notably those relating to water and sanitation—was heavily dependent on cross-sectoral collaboration, the extent to which such collaboration had taken place should, itself, be an indicator of progress. A third delegate observed that many of the goals and their indicators had become development indicators, not just health indicators. It was important that they be presented as such, especially to finance ministers, when proposing health budgets. It was also important to ensure that health budgets were set according to technical criteria established by the health sector, not the finance sector.

88. It was pointed out that the Pan American Sanitary Conference had requested that the report presented to the Directing Council in 2003 specify the factors that had been associated with the achievement of the regional goals. However, the document submitted to the Committee offered only an update on progress by countries in achieving some of the established goals. In that connection, delegates signaled the need to analyze what lessons could be learned from those countries that had achieved some regional goals, as that knowledge might help other countries do the same.

89. Dr. Perdomo explained that the report prepared for the Committee had aimed mainly to update the information presented the previous year and to examine some of the factors that had been associated with achievement or non-achievement of some of the goals. Obviously, it was not possible to identify all the factors for all of the goals. Often, as the Committee had noted, factors that fell outside the direct control of the health sector were involved. Moreover, the information available had not always been comparable, making it difficult even to determine to what extent success had been achieved with respect to some regional goals, let alone identify all the factors that had come into play in the results obtained. Nevertheless, for the final report to be submitted to the Directing Council in September, the Secretariat would undertake to present a more in-depth analysis of the factors involved.

90. The Committee's concerns regarding the quality of information and information systems were certainly valid. The Secretariat shared those concerns and had made improvement of data collection and information systems one of the central objectives under the Strategic Plan for the period 2003–2007.

91. The Director agreed that it was important to analyze the factors that had contributed to or hindered achievement of the goals established under the SPOs; however, in her view, rather than dwelling on that analysis, it would be of greater benefit to the countries if the Secretariat concentrated on applying the lessons learned in the period 1999–2002 to the development of indicators and to the implementation of the Strategic Plan for 2003–2007 and the achievement of the Millennium Development Goals. One of the important lessons learned was that the Organization needed to help individual countries establish their own goals, based on regional and global goals. Many of the regional goals had arisen from global mandates emanating from international summits and meetings. Such goals generally needed to be adapted to the specific conditions prevailing in each country. Certainly, that was the case with many of the Millennium Development Goals. In addition, intermediate objectives needed to be established, as it was those objectives that would make it possible to track progress.

92. Another key lesson was that goals needed to be set specifically in relation to strengthening of information systems, since without good information systems it would be impossible to monitor progress and determine whether the other goals were being achieved. Information systems were an essential part of basic public health infrastructure. Although the majority of the countries had made a major effort to develop their health information systems in recent years, in many cases the results had been less than satisfactory. A great deal of money had been invested in sophisticated information technology, but that had not necessarily resulted in the improvement of information systems or in the production of better information. She believed that the time had come for governments to decide once and for all to take the necessary action to upgrade their national health information systems and ensure that they were producing information of

the kind and quality needed for effective decision-making. In the framework of the Summits of the Americas, the governments of the Region had given several health-related mandates to PAHO, the Inter-American Development Bank, and the World Bank. Perhaps they should similarly entrust them with the mandate of collaborating to help countries improve their health information systems.

93. The Executive Committee, recognizing the tremendous effort made by the Secretariat despite the lack of information and data for several of the goals, and bearing in mind that the Pan American Sanitary Conference had requested an updated report did not consider it necessary to adopt a resolution on this item.

Report on the 13th Inter-American Meeting, at the Ministerial Level, on Health and Agriculture (Document CE132/12, Rev. 1)

94. Dr. Albino Belotto (Chief, Veterinary Public Health Unit, PAHO) reported on the 13th Inter-American Meeting, at the Ministerial Level, on Health and Agriculture (RIMSA 13), which was held in Washington, D.C., on 24 and 25 April 2003. He began by explaining the mission of the Veterinary Public Health Unit, which was to support the Member States with priority national programs in the areas of surveillance, prevention, and control of zoonoses of importance to public health; food safety; and eradication of foot-and-mouth disease. The Unit, together with its two associated regional centers, the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) and the Pan American Institute for Food Protection and Zoonoses (INPPAZ), worked in a network with various bodies, including RIMSA. It also had strategic partnerships with a number of other organizations and agencies.

95. RIMSA was the only regional forum for collaboration and coordination between ministers of health and of agriculture on issues related to veterinary public health. It provided an indispensable space for political support, contributing to the success of technical cooperation on questions related to veterinary public health. RIMSA 13 had been attended by representatives of 33 Member States and one Observer State (Spain); representatives of five states outside the Region of the Americas; and representatives of a number of inter-governmental organizations and agencies, including the Economic Commission for Latin America and the Caribbean (ECLAC), the Food and Agriculture Organization of the United Nations (FAO), the Inter-American Development Bank (IDB), the Joint FAO/WHO Codex Alimentarius Commission, the World Health Organization (WHO), and the World Trade Organization (WTO).

96. The inaugural session had been presided over by the Minister of Agriculture of Brazil, who had been the President of RIMSA 12. The Deputy Commissioner of the Food and Drug Administration of the United States, the President of the Republic of Uruguay, and the Director of PAHO had addressed the meeting. The keynote address, given by the

Secretary of Agriculture of the United States, had been on the topic “Towards the Harmonization of Food Safety and Trade in the Americas.” The sessions had included the report on the PAHO Program on Veterinary Public Health and on PANAFTOSA and INPPAZ; panel discussions on the topic “Food Safety: From Production to Consumption,” which had been the overall theme of RIMSA 13; and special presentations on bioterrorism, genetically modified foods, and the Joint FAO/WHO Expert Consultation on Diet, Nutrition, and the Prevention of Chronic Diseases. RIMSA 13 had adopted a total of 10 resolutions, which appeared, together with a full account of all the sessions, in the final report of the meeting (Document RIMSA13/FR, Rev.1).

97. The Executive Committee welcomed the report, and expressed appreciation for the opportunity afforded by the meeting to intensify coordination between ministers of agriculture and health. It was suggested that such coordination might be more effective if ministers of the economy were also involved. With regard to the discussion of bioterrorism and the related resolution, it was noted that many delegates at the meeting had stressed that the measures recommended should not affect trade in products that were safe. The Representative of the Inter-American Institute for Cooperation on Agriculture (IICA) called attention to the emerging problem of agroterrorism and said that his organization looked forward to continued collaboration with PAHO in that and other areas related to public health and agriculture. Other issues on which delegates saw a need for cooperation between ministries of health and agriculture were pesticide poisoning and the impact of pesticide use on human health and the issue of genetically modified foods.

98. Several delegates from countries with economies highly dependent on livestock-raising described vaccination campaigns to control foot-and-mouth disease. It was pointed out that most countries in the region which produced foot-and-mouth vaccine were now considering changing over to production based on cell cultures, and it was suggested that PAHO might be able to assist with the transition. RIMSA was seen as an ideal forum in which to organize multi-country vaccination campaigns against foot-and-mouth disease, particularly in areas near national frontiers. Such campaigns should be intensive, and might take the form of a “vaccination week.” The same approach might be taken to control or eradicate rabies.

99. Dr. Belotto agreed that it was very important to involve ministers of the economy in discussions relating to human and animal health. With regard to the regulations to combat bioterrorism, he said that the participants at RIMSA had been very aware that many countries were highly dependent on the export of agricultural products and had recognized the need for coordination to avoid creating barriers to import and export trade.

100. He welcomed the idea of having a vaccination week, in order to make a major thrust against certain diseases, and noted that part of the value of such a week would be its public-awareness impact. In the case of rabies, for example, since the number of cases

transmitted from dogs to humans had now dwindled to about 25 a year over the whole continent, there was a risk that the public might cease to regard the disease as dangerous.

101. Control of pesticides and of the risks they posed to human health was extremely important, and the topic should, he felt, be placed on the agenda of a future RIMSA in order to examine the issue in depth and explore how the countries might join forces to address it. The area of genetically modified foodstuffs was one in which the health and agriculture sectors tended to have different views. Whereas the health sector was primarily interested in the health impacts of transgenic foods, for the agriculture sector the main concern was trade. The matter could not be looked at in terms of black or white. Transgenic foods had both advantages and disadvantages, which needed to be analyzed in a pragmatic manner on the basis of sound information. The Regional Meeting on Genetically Modified Foods, organized by PAHO/WHO, FAO, and IICA, which had been discussed at RIMSA 13, had made an important contribution towards better understanding of the issues involved.

102. Regarding the foot-and-mouth disease vaccine, he pointed out that producing a cell-culture-derived vaccine would require a large investment in technology. PAHO would be pleased to assist countries in examining technical considerations and in carrying out cost-benefit studies to determine whether switching to that method of production would be worthwhile.

103. The Director observed that the interministerial meeting had elicited a great deal of interest and had yielded a number of important recommendations and decisions. It was encouraging that RIMSA had succeeded in creating a space for interaction which was not only intersectoral but also inter-agency and which allowed for participation by various groups from civil society, including producers, importers, exporters, and consumers. RIMSA not only showed great promise for joint work between the health and agriculture sectors, but it might also point the way towards further collaboration between health and other sectors, notably the environment, education, and labor sectors. She recalled that the health and environment ministers of the Region had held a joint meeting in Ottawa in 2002. That meeting, too, had given rise to some very important recommendations. Similarly, discussions were under way with the International Labor Organization and the International Organization for Migration on the possible inclusion of the topic of health in their forthcoming conferences, as many important health-related issues arose both in the work sphere and in relation to migrant populations. PAHO was also exploring the possibility of incorporating discussion of health issues—such as sustainability of immunization programs—in the agendas of upcoming meetings of the Inter-American Development Bank and the World Bank. In addition, the Organization would seek to take advantage of the various subregional ministerial meetings and other international gatherings to highlight health concerns.

104. She noted that two other important meetings had taken place in the framework of RIMSA 13: that of the Hemispheric Committee for the Eradication of Foot-and-Mouth Disease (COHEFA), under the presidency of the Minister of Agriculture of Paraguay, and that of the Pan American Commission for Food Safety (COPAIA), under the presidency of the Minister of Health of Suriname, to both of whom she expressed thanks. The results of those deliberations had then served as input to the RIMSA meeting.

105. She was pleased to report that PAHO had recently signed a cooperation agreement with IICA. A joint action plan was being drawn up, identifying common areas of work, such as animal health, food security, food safety, and rural development. The latter, obviously, was very closely linked to enhanced agricultural production and animal health. PAHO viewed rural development as crucial. It would be one of the focuses of a new unit that had been created within the area of Sustainable Development and Environmental Health in the new organizational structure. That area would also be concerned with the issue of pesticides and their impact on health.

106. The proposal for a vaccination week was an excellent one, and the Secretariat would begin looking into how best to implement it. One option, at least in the case of rabies vaccination, might be to combine that vaccination campaign with the next Vaccination Week of the Americas.

107. The Committee adopted Resolution CE132.R4, endorsing the recommendations and resolutions of RIMSA 13.

Primary Health Care in the Americas: Lessons Learned over 25 Years and Future Challenges (Document CE132/13)

108. Dr. Pedro Brito (Manager a.i, Area of Strategic Health Development) presented the document on this item, noting that it had been prepared by three areas of work within the Secretariat: Technology and Health Services Delivery, Strategic Health Development, and Governance and Policy. The document reviewed the history of the primary health care (PHC) strategy, examined the impact of and lessons learned from its application in the Americas, and explored some of the challenges that called for a renewal of the vision and commitment to primary health care for the future.

109. The concept of primary health care that had emerged from the Alma-Ata conference in 1978 had brought a new understanding of health and had engendered a new ethos which had shaped the thinking of a whole generation of public health professionals, including many of those present at the Committee's 132nd Session. Primary health care had been defined as the principal strategy for achieving the goal of health for all by the year 2000, established by the World Health Assembly in 1977. In the Region of the Americas, primary health care had become the main platform for health policy in the

hemisphere. Now, 25 years later, it was fitting to reflect on how to adapt the PHC strategy to meet the health challenges of the 21st century.

110. In the Americas, the concept of primary health care had been interpreted and applied in a variety of ways, reflecting different political and public health perspectives. Two main trends could be identified: in some cases, PHC had been adopted as a strategy for reorganizing and restructuring the health system in order to apply the principles and recommendations of Alma-Ata, while in others it had been viewed as an approach to providing care at the most basic level of the health system. In most countries in the Region, the application of PHC had resulted in extension of the coverage of health services to rural and periurban areas and in the development of priority programs, especially at the first level of care. It had led to significant changes in both the education and training of health personnel and in medical and public health practice, and it had also helped encourage community involvement in health development. Although it was not possible to establish a direct cause-effect relationship, in the 25 years since PHC had been introduced, the Region had experienced notable reductions in mortality and gains in life expectancy.

111. The experience with primary health care in the Americas had yielded a number of lessons. PHC had marked a change in the paradigm of public health practice. It had shown for the first time the need for greater integration of models of care, and it had demonstrated that social and community participation and intersectoral coordination were strategic instruments for bringing about change in health. PHC had also contributed to the demedicalization of public health and the prioritization of health promotion. Nevertheless, PHC and the health promotion approach had not been sufficient to change the predominance of curative models of care or achieve effective community participation in all countries. Response capacity at the primary care level remained low, and there was a lack of coordination between different levels of care. In the application of PHC, the impact of the demographic and epidemiological changes that had occurred in the Region had been underestimated. In addition, the PHC strategy had not prioritized the development of interventions aimed explicitly at reducing inequalities and achieving equity in health.

112. PAHO believed that the principles underpinning primary health care and the goal of health for all remained valid and that a renewed commitment to PHC would enable the Region to meet the health and development challenges of the 21st century and achieve the goals established by various recent international summits, in particular the Millennium Development Goals. Renewing the commitment to PHC would entail changes and adjustments in its two major dimensions: as a policy approach, PHC would need to be adapted to promote and support the development of public policies that would favor greater equity in health, while as a level of care, PHC must become the cornerstone for the development of health services and the reorientation of health care models, with

greater emphasis on health promotion and disease prevention. The document outlined the principal actions needed to renew the commitment to PHC and to strengthen the strategy and adapt it to the needs of the years to come.

113. To commemorate the achievements of the previous 25 years and provide opportunities for collective reflection on the future of primary health care, the Secretariat proposed to organize a series of activities and events, to be held at various places throughout the Region over the next year. It also proposed to draft a regional declaration, similar to the Declaration of Alma-Ata, which would set forth regional and national policies and strategies for improving the health situation of the peoples of the Americas and would reaffirm the commitment to primary health care, to health promotion, and to the Millennium Development Goals. The declaration would be formulated in consultation with the Member States and would be submitted for approval by the Directing Council in 2004. The Executive Committee was invited to comment on those proposals and to offer its own suggestions on how to celebrate the 25th anniversary of Alma-Ata and renew the commitment to primary health care in the Americas.

114. The Executive Committee welcomed the document, considering it very timely to take stock of what had been accomplished in the preceding 25 years and think about how best to adapt primary health care to address the new challenges confronting the countries of the Region. The Committee expressed vigorous support for the primary health care strategy and affirmed the continued validity of its basic tenets, in particular health promotion, disease prevention, and community participation and responsibility for health. The value of primary health care as a strategy for enhancing equity, quality of care, and access to services at all levels was underscored. It was pointed out that observance of the 25th anniversary of the advent of primary health care would offer an opportunity to “get back to basics” and focus on what was really needed to improve the health of populations.

115. Delegates highlighted some of the successes achieved in their countries through application of the PHC strategy, including extension of health services to underserved areas, more integrated programs, greater involvement of the community, training of community health agents, improvement of environmental conditions, increased immunization coverage, improved disease control, and reductions in mortality and morbidity. At the same time, it was agreed that a number of challenges remained to be overcome. It was pointed out that, in addition to the demographic and epidemiological changes mentioned in the document, globalization had brought rapid technological change. Harnessing that technology posed a formidable challenge. Another challenge was adapting the PHC strategy and equipping health services to deal with the growing burden of noncommunicable diseases. Attracting and retaining primary health care practitioners was also a challenge. Delegates noted that, whereas the focus in primary health care had originally been on extension of coverage and outreach to the community, now the focus

must be more on quality and on ensuring consistently high-quality care in order to combat the perception that existed in some places that PHC was a “poor package for poor people.” Several delegates also cited the need for research to demonstrate the cost-effectiveness of primary health care, particularly in a context of scarce resources, competing priorities, and increasing demand for costly high-technology interventions.

116. Support was expressed for the lines of action proposed in the document, and PAHO was encouraged to develop a plan of action for implementing them. The need to also develop indicators to track progress was stressed. Delegates thought that indicators were needed in particular to measure progress towards the Millennium Development Goals and link that progress to PHC and public health activities.

117. It was pointed out that the recent World Health Assembly had identified four key needs for renewing the commitment to primary health care: ensuring adequate resources for the development of primary health care, strengthening human resource capability for primary health care, supporting active involvement of local communities in primary health care, and supporting research to identify effective methods for monitoring and strengthening primary health care and linking it to overall improvement of the health system. The Assembly had also called on the Director-General of WHO to convene a meeting of stakeholders to examine the lessons learned in the first 25 years of primary health care and discuss how to move forward. Delegates expressed the view that PAHO and Member States from the Americas could make a valuable contribution to those discussions.

118. The Committee endorsed the idea of a regional declaration and the proposal to organize a year-long program of activities to commemorate the 25th anniversary of the Declaration of Alma-Ata. Members felt that, as 2003 marked the 25th anniversary, the celebration should be launched during the upcoming 44th Directing Council. It was suggested that a series of special midday sessions might be scheduled to begin examining the challenges for the future of primary health care. It was also pointed out that, as community participation was a crucial component of the primary health care strategy, communities should be involved in the celebration and in the process of reflecting on how to adapt the strategy to meet present and future needs.

119. Dr. Brito thanked the Committee for its strong support of the initiative to renew the commitment to primary health care in the Region. He expressed particular appreciation for the comments of the Delegates of Jamaica and the Dominican Republic, both of whom had been present at Alma-Ata in 1978 and could bear witness to the progress that had been achieved since then as a result of application of the primary health care approach. It was clear that there was consensus as to the continued validity and applicability of the principles and strategy of primary health care. It was also clear that primary health care was not at all “a poor package for poor people,” but a means of

achieving equity in access to health services and extending social protection in health to all members of the population.

120. The Committee's discussion had brought to light several important points, which perhaps should have been emphasized more in Document CE132/13. First, it had to be recognized that the implementation of PHC at the local community level had signified a new, more democratic approach to health development and a new form of interaction between communities and health services. It had also meant a change in the approach to health education, with a new emphasis on encouraging the involvement of the community in developing its own health. It had implied, too, greater participation by households and families and new roles for women as fundamental actors in developing health, not just within their families but in their communities. In addition, the implementation of primary health care had fostered new approaches to the delivery of care, bringing health personnel outside health care facilities and directly into the community.

121. The delegates' comments had also pointed up the need for exchanges of experience so that countries could learn from one another's successes and failures. Such exchanges would be especially important as the Member States grappled with all the challenges highlighted in the course of the Committee's discussion. Those challenges also represented a technical cooperation challenge for the Secretariat, and would require it to develop a new agenda and new ways of working. That was one of the aims of the transformation of the Organization envisaged by the Director under the new managerial strategy, to which the entire Secretariat was committed.

122. The Director focused her remarks on the plan for commemorating the 25th anniversary of Alma-Ata and reaffirming the commitment to primary health care in the new health scenario in the Region. She explained that the Secretariat had not developed a more detailed proposal partly because it had been awaiting the outcome of the World Health Assembly discussion on primary health care and partly because it had wished to obtain the Executive Committee's views on the subject. What the Secretariat was proposing to do was to carry out a year-long process of celebration and consultation. The process would be launched at the 44th Directing Council and would involve a broad range of stakeholders from both the governmental and nongovernmental sectors. Countries would be encouraged to plan their own commemorative and consultative activities at the national level, as well. The process would culminate in a declaration of reaffirmed commitment to primary health care that would reflect the concerns and points of view expressed by the various stakeholders consulted.

123. Prior to the Directing Council, the Secretariat would revise the document, incorporating the Committee's comments and outlining the steps in the consultation process. As had been done for the celebration of PAHO's centennial, it might also put together a calendar of the activities planned at the regional and country levels. The

proposed celebration and consultation process would not entail any additional expenditure on the part of the Organization.

124. The Region was privileged to have a number of public health leaders who had played a pivotal role in the development of the primary health care strategy. The Americas had made a great contribution to the original Alma-Ata declaration and would undoubtedly make an equally valuable contribution to the redesign and strengthening of PHC as a strategy for surmounting the new challenges confronting the countries in the 21st century.

125. The Executive Committee adopted Resolution CE132.R5 on this item.

Family and Health (Document CE132/14)

126. Dr. Gina Tambini (Manager a.i., Area of Family and Community Health, PAHO) was pleased to present Document CE132/14 on behalf of the five units that made up the Area of Family and Community Health, all of which had participated in its preparation. She began by explaining that PAHO's work in the area of family and health arose in part from a number of recent international summits, which had called attention to the need for a family-centered approach to health care. Those summits had declared that the family was entitled to receive comprehensive protection and support and had called for recognition of families as key players in health promotion, for the reorientation of health services to include a family focus, for a new social and health agenda for families, and for policies and laws that would support and contribute to the rights, stability, and equality of families.

127. It made sense to focus on the family for a number of reasons. The family was the setting where health behaviors and decisions were first established and where culture, values, and social norms were molded. In addition, family members tended to be exposed to the same health risks (environmental, infectious, behavioral, and vector-borne). Moreover, changes in family structure and in demographic, social, and economic conditions had placed families in the Region under great stress. And though the Region had made tremendous strides in improving health conditions, there was an unfinished agenda of health problems that could best be addressed through an integrated, family-focused approach.

128. A family-focused health approach was one that responded to the health needs of families. It was an approach that provided continuity of care throughout the life cycle and that was comprehensive, incorporating preventive, curative, and rehabilitative care and attention to the biological, psychological, and social dimensions of health. It also took account of the determinants of health. Analysis of the family health models implemented thus far by countries in the Region revealed that they shared several features: they

utilized health care teams comprising physicians, nurses, and other health workers, who provided comprehensive care for family members of all ages; they employed a primary health care approach; and they placed the resources of the health care system directly in the community, in close proximity to families. Most of the models had been introduced in the framework of health sector reform efforts, and most sought to achieve a balance between increased access to health services, enhanced user satisfaction, better quality of care, and containment of operating costs.

129. PAHO viewed the development of a family health approach as a collective task involving all the areas and units within the Secretariat. In building the approach, it would look carefully at country experiences to determine the key components of a family health approach and to identify best practices and lessons learned. Utilizing those elements, it would seek to create a regional framework to guide the development and implementation of a family health approach by countries. It would also undertake to develop indicators to monitor and evaluate the impact of family health models. To that end, a working group would be formed at the regional level to identify, analyze, and evaluate country experiences already under way and to provide guidance to other countries in the Region seeking to develop a family health approach.

130. The President of the Subcommittee on Planning and Programming reported that the SPP had voiced strong support for PAHO's work in the area of family and health. It had considered the Organization's increased attention to this area very timely, as it coincided with efforts to strengthen the family and improve family health in many countries and with the 10th anniversary of the International Year of the Family, to be observed in 2004. Several delegates had described family health initiatives under way in their countries and had offered to share their experiences with PAHO and with other Member States. The Organization had been encouraged to utilize the lessons learned from those experiences in refining its approach to family and health. At the same time, however, it had been 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. The Subcommittee had also noted that the design of family health interventions should take account of cultural and religious patterns, which strongly influenced family values, family life, and family health and caregiving behaviors.

131. The Subcommittee had emphasized that 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, the Subcommittee had also signaled the need for an integrated, intersectoral approach and for increased generation of information and knowledge about the myriad variables that contributed to family health. The Subcommittee had concurred with the priority areas for action identified in the document,

although delegates had suggested several additional issues that should be addressed under some of those areas. In the area of mental health, for example, alcohol abuse had been identified as serious issue that was affecting families. Intrafamily violence had also been viewed as a grave concern which should be addressed in the framework of a family health approach. Several delegates had highlighted the need for greater attention to males, both in terms of their specific health needs and their role as parents and caregivers. The Subcommittee had noted that PAHO might wish to consider a phased-in approach to implementation, given the large number of priority areas in which it was proposing to work. It had also underscored the need for monitoring and evaluation to track progress.

132. Like the Subcommittee, the Executive Committee expressed firm support for the Organization's work in this area and, like the Subcommittee, the Committee felt that it was essential to prioritize, given the broad range of issues to be addressed in relation to family health. It was proposed that the Members should identify three or four priorities on which they wished to see the Organization focus initially. A number of delegates thought that health of adolescents should receive special priority and that there should be a particular focus on identifying the determinants of the behavior-related health problems common among adolescents. Development of parenting skills and attention to the role of fathers were also considered priorities. Many delegates highlighted the linkage between family health and the primary health care strategy and stressed the need to give priority, within a family health approach, to disease prevention and health promotion. Delegates also emphasized the need for monitoring and evaluation to assess the impact of family health interventions, and noted with satisfaction that the revised version of the document clearly recognized that need.

133. The Committee also applauded the life-cycle approach advocated by PAHO. One delegate noted, however, that it would be essential to ensure that the application of that approach did not devolve into vertical programs for different age groups. She suggested that it would be helpful if PAHO would provide practical descriptions of how such an approach might be implemented in Member States. Another delegate suggested that the Organization should produce a manual of best practices that could be used by the PAHO country offices to assist countries in implementing a family health model.

134. Several delegates called attention to the importance of the family—as the basic unit of social organization—in creating a culture of health and fostering individual and collective responsibility for health. However, it was pointed out that, while a focus on the family in health care could be very positive, there was a danger that the needs of individuals who did not belong to a family unit might be overlooked. It was suggested that the document should address that issue and include some consideration of how the application of a family-centered approach might affect access to and quality of care for individuals who were not part of a family unit. It was also suggested that the analysis of the situation of families in the Americas should be expanded to show the implications of

the interactions between changes in the family, in population structure, and in disease patterns.

135. The need for reliable information—both for monitoring and evaluation and for decision- and policy-making in relation to family health—was underscored. Several delegations offered to share research findings and experiences from their countries in the application of family health approaches.

136. The Representative of the InterAmerican Heart Foundation, noting that the Global Youth Tobacco Survey had yielded much valuable information not only on tobacco use among young people, but also on behavioral patterns, requested information on how the findings of the survey were being applied.

137. Dr. Tambini thanked the delegates for their comments and for their offers to share experiences. As she had said, analyzing and disseminating information on country experiences would be a major component of the Organization's technical cooperation in this area. With regard to the prioritization of interventions, she noted that the document contained a section that described the priorities for action, which included most of the concerns and priorities mentioned by the delegates. However, in revising the document for the Directing Council, the Secretariat would undertake to strengthen that section, incorporating the Committee's suggestions. She pointed out that one of the principal challenges that the Organization was seeking to address through the family health approach was how to sustain the health gains achieved in the past while also tackling the unfinished agenda of health problems to which she had alluded in her presentation. PAHO felt that the most effective means of meeting that challenge was through an integrated life-cycle approach that would make it possible to meet the needs of particularly vulnerable groups while ensuring continuity in the delivery of disease prevention and health promotion interventions to all members of the population at all stages of their lives.

138. At Dr. Tambini's request, Dr. Armando Peruga (Regional Advisor on Substance Abuse Prevention and Control, PAHO) replied to the question concerning the Global Youth Tobacco Survey, which was a joint initiative of PAHO/WHO and several partners, including the United States Centers for Disease Control and Prevention (CDC) and the Canadian Public Health Association. He explained that the first round of data collection was being completed, and by year's end data on tobacco use among young people would be available for all countries of the Region. For seven countries, trend data from the second round of the survey were also available. At a workshop scheduled for late November 2003, those trend data would be analyzed with a view to translating them into concrete policy actions.

139. The Director pointed out that for the previous 20 years the Organization had employed a vertical program approach that targeted specific population groups (children, adolescents, mothers, older adults, among others). While those programs had many strengths, they also had weaknesses. What PAHO was proposing now, at the request of the countries and based on their experiences, was an integrated approach which focused on the family as a whole and which addressed the weaknesses of vertical programs while building on their strengths. The family-focused approach reflected the linkage, highlighted in her managerial strategy, between primary health care, health promotion, and citizenship, the family being where future citizens were formed. PAHO viewed the family health approach as an extension of the concept of supportive environments and healthy settings emphasized in the Ottawa Charter for Health Promotion, out of which had grown the healthy cities movement and other initiatives that sought to create environments that were conducive to health. The family was the most basic of environments and the one that had the greatest impact on the health and development of individuals. Nevertheless, PAHO recognized that it was important to promote health in a variety of environments (schools and workplaces, for example), since, as the Committee had noted, not everyone belonged to a family unit. Only by doing so would it be possible to achieve health for all.

140. The Executive Committee did not consider it necessary to adopt a resolution on this item. However, in light of the importance attached to the topic of family health by the Member States and bearing in mind that the subject would be discussed by the World Health Assembly in 2004, the Committee requested that the item be placed on the agenda for the 44th Directing Council.

Globalization and Health (Document CE132/15)

141. Dr. César Vieira (Manager a.i., Area of Governance and Policy, PAHO) summarized the content of Document CE132/15, noting that it incorporated input from colleagues in various units at PAHO. The document also reflected regional and country experiences. It had undergone extensive revision following the March meeting of the Subcommittee on Planning and Programming, which had made a number of helpful suggestions for improvement.

142. The document began by exploring some of the impacts of globalization on population health. Some of those impacts were quite positive—greater access to healthful goods at lower prices, for example. But others—such as increased consumption of unhealthy food, trafficking of illicit drugs, and higher potential for the spread of diseases such as AIDS and SARS—were negative. The Committee had discussed several other examples of the relationship between globalization and population health during the week, notably in relation to RIMSA and to the item on diet, nutrition, and physical activity.

143. The document then examined the effect of globalization on trade in health services, identifying four principal modes of trade: cross-border delivery, movement of patients, commercial presence of foreign health service enterprises, and migration of health professionals. It went on to analyze the special case of drugs and medical equipment, which was illustrative of a number of the issues surrounding international trade in health goods and services. One example was the emergence of the concept of health and health-related goods and services as global public goods. A highly positive outcome of the debate on how to facilitate access to global public goods had been the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Another had been the Doha Declaration on the TRIPS Agreement and Public Health, which affirmed that the World Trade Organization Agreement on Trade-Related Aspects of International Property Rights (TRIPS) should be interpreted and implemented so as to protect public health and promote access to medicines for all. The Doha Declaration constituted a recognition by the international community that public health concerns should be taken into account in discussions of international trade issues.

144. Finally, the document discussed PAHO's technical cooperation in the area of globalization and health. That cooperation was guided by a number of agreements established by countries at the global, regional, and subregional levels. At the global level, the main agreements were TRIPS, the General Agreement on Trade in Services (GATS), the General Agreement on Tariffs and Trade (GATT), and the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS). At the regional level, the most important guidelines were those arising from the negotiations for the Free Trade Area of the Americas (FTAA). The various subregional groups—the Southern Common Market (MERCOSUR), the Caribbean Common Market (CARICOM), and others—were also negotiating agreements on health-related matters. PAHO was providing support for health-sector participation in those subregional negotiations, and the Organization had also lent support for bilateral negotiations—for example between Mexico and the United States—on health and trade issues.

145. Suggested areas for PAHO technical cooperation were impact assessment studies to identify the potential public health implications of trade decisions, facilitating collaboration between the health and trade sectors for the development of trade regulations from a health perspective and for the establishment of health-sensitive tariffs and prices, development of databases on trade in health goods and services, and incorporation of health perspectives in trade negotiations and development strategies. The Executive Committee was asked to comment on how PAHO could best assist Member States in maximizing the positive impacts and minimizing the negative impacts of globalization.

146. The President of the Subcommittee on Planning and Programming reported that the SPP had discussed the item in a joint meeting with the Subcommittee on Women,

Health, and Development in March 2003. Five presentations had been given on various aspects of globalization and its relationship to health. The Subcommittee had felt that the document and the presentations 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. The Delegate of the United States had thought, however, that the document gave a biased and negative impression of trade and economic interchange and that it made recommendations for PAHO action that went well beyond the Organization's mandate and competence. He had urged PAHO to develop a more public-health-oriented approach to its technical cooperation in this area and to focus on helping Member States address non-trade issues, such as acquisition and distribution of needed medicines under liberalized trade rules.

147. Another delegate had suggested that in the next version of the document, 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 from the viewpoint of impacts on health and health systems. It had been emphasized that the Organization should seek to view issues relating to globalization and health through a gender lens. The President of the Subcommittee on Women, Health, and Development had pointed out that the document did not seem to contain much discussion of the specific needs of vulnerable groups, notably women. She had emphasized that the role of PAHO and WHO should be to identify the positive and negative health effects of trade agreements under discussion in the global and regional arenas, with particular attention to their potential impact on the most vulnerable populations.

148. The Subcommittee had encouraged PAHO 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. Policy coherence between ministries responsible for trade and those responsible for health had been seen as essential to achieving beneficial outcomes from globalization. The Subcommittee had considered support for policy development to be another important role for PAHO.

149. In the Executive Committee's discussion of the item, some delegates expressed satisfaction at the modifications that had been made in the document in response to the Subcommittee's suggestions. The Delegate of the United States, however, said that his delegation remained disappointed in the document and believed that it should not be sent forward to the Directing Council without major revisions. As currently written, it lacked evidence to support many of the assertions made, in particular the suggestion that globalization, in and of itself, had led to wider disparities in the access of various groups to health care or that globalization was responsible for income inequality. Assertions such as those ignored 500 years of history in the Region. Income inequality and lack of access to services were by no means new problems in the Americas, and they could not be blamed on developments that had occurred in the last 10 or 20 years. It was true that

those problems might have been brought into sharper focus recently as a result of advances in global communications and transportation, but that could actually be a good thing. The suggestion that globalization was a new phenomenon in the Region was also wrong. The Americas were one of the most globalized regions in the world and had long benefited from interchanges between continents and peoples. The document failed to acknowledge that such interchange could, in fact, have a net positive effect, giving consumers in the various countries greater, not lesser, access to a broader range of health goods and services.

150. In his delegation's opinion, another serious flaw in the document was its contention that PAHO had a particular role in trade negotiations or in monitoring of trade agreements. While the United States believed that PAHO did have a role to play in helping governments to deal with non-trade public-health aspects of globalization, the Organization had no mandate to pronounce on trade issues. If PAHO wished to explore the issue of globalization and health further, his delegation believed it should consult directly with Member States to hear their views. One way to do so might be to convene a small group of government representatives from various sectors.

151. Other delegates found the document significantly improved with respect to the earlier version considered by the SPP and felt that it would serve well in helping to determine how PAHO could best assist Member States in managing the impacts of globalization on the health of their populations. Support was expressed for the proposed lines of work, although it was felt that, before the work could be implemented, there should be a clearer definition of the specific elements of globalization on which the Organization would focus from the standpoint of impact on health and health systems. A plan for operationalizing the lines of action was also needed.

152. It was suggested that one way in which the Organization could be particularly helpful would be to advise countries on how to set standards and strengthen their regulatory systems so as to assure the quality of imported health goods and services. Other areas in which delegates felt PAHO technical cooperation would be appropriate were education and training of health professionals, movement of health professionals between countries, harmonization of scientific and technical standards, and acquisition and distribution of drugs. In relation to the latter, it was pointed out that the document erroneously suggested that the purpose of the Global Fund to Fight AIDS, Tuberculosis, and Malaria was to promote research on and support the availability of drugs to treat neglected diseases. Research had never been part of the purpose of the Global Fund, and while increasing drug availability might be one of the offshoots of the Fund's investments, it was not its whole purpose.

153. Delegates noted that the topic of globalization and health had been discussed at the recent World Health Assembly, which had adopted a carefully negotiated resolution

that set out the scope of work for WHO and its Regional Offices in this area. It was emphasized that PAHO's work should be in consonance with the mandate that the Member States had established for the Organization as a whole on trade questions. The need to avoid functional overlap and duplication of the activities of WHO was also stressed. For example, in relation to health impact assessment—one of the lines of action identified in the document—it was pointed out that WHO had developed a framework for analyzing the way in which globalization impacted on health and identifying appropriate national policy responses. That model could provide a useful foundation upon which PAHO could build its activities, while at the same time avoiding duplication of work already undertaken.

154. The Delegate of Canada noted that many of the issues addressed in the document would be discussed at an upcoming conference in her country. The conference—which would be held from 9 to 11 July 2003 in Ottawa, under the joint sponsorship of WHO and Health Canada—would focus on trade in health services under GATS. One of the themes to be examined would be the need for policy coherence between health and trade ministries, which Canada considered critical to achieving successful health care outcomes in the context of trade agreements.

155. Dr. Vieira thanked the Committee for its comments and suggestions, which would be most helpful in refining PAHO's approach to technical cooperation with regard to globalization and health. Replying to some of the specific comments on the document, he said that the Secretariat had not meant to imply that globalization alone was responsible for the inequities that existed in the Region of the Americas, but there was evidence that, at least at the current stage, the benefits of globalization were not being equitably distributed, especially in Latin America. They were benefiting some groups more than others, and in many cases the equity gaps between groups were widening.

156. He assured the Committee that the Secretariat had every intention of coordinating its activities with WHO Headquarters in order to avoid "reinventing the wheel." PAHO would be using several of the instruments that had been developed either by WHO itself or by the Regional Office for Europe. The impact assessment instrument mentioned by the Committee was just one example.

157. He felt that the idea of convening a working group of government representatives from different sectors had great merit. Doing so would make it possible to promote dialogue between health authorities and their counterparts in the trade sector, which PAHO believed was essential. It would also, as the Delegate of the United States had suggested, help to clarify the Member States' views on the issues raised in the document and in the Committee's discussion.

158. The Director observed that one of globalization's most important effects from a public health standpoint had been that it had heightened awareness of the interdependence of all peoples on the planet. It had become clear that the Earth truly was a global village. Most notably, perhaps, globalization had made people aware of the close relationship between health and the environment, and that, in turn, had raised the visibility of public health on international agendas.

159. She agreed that it would be very useful to hold a consultation with Member States in order to obtain their guidance both on how PAHO should approach the issue of globalization from a public health standpoint and on how it could best operationalize the framework provided by the decisions of the World Health Assembly, adapting it to its work in the Region. In that connection, she noted that the Secretariat had not included the item on globalization and health on the provisional agenda for the Directing Council precisely because it had been awaiting the outcome of the World Health Assembly discussions. The topic would be included in the report presented by the President of the Executive Committee, but it would not be considered by the Council as a separate agenda item.

160. She believed that PAHO could be a valuable partner with the countries in addressing the public health challenges associated with globalization and in maximizing its benefits for the peoples of the Region. The Organization had acquired considerable experience at both the national and subregional levels. At the national level, as Dr. Vieira had said, it had sought, above all, to promote dialogue between ministers of health and ministers of trade, foreign affairs, agriculture, finance, and other sectors involved in trade negotiations. At the subregional level, it had been working for years with the various subregional trade groups to assure that health concerns received the attention they deserved, and PAHO served as secretariat for several of the health-related committees that had been created in the framework of those groups. As she had noted during the March session of the Subcommittee on Planning and Programming, PAHO had also undertaken a project on harmonization of food legislation in the Region, which had provided important input for the global activities of the United Nations Food and Agriculture Organization (FAO) in that area.

161. The Executive Committee did not consider it necessary to adopt a resolution on this item. However, it was agreed that PAHO should continue to support its Member Countries to assess and manage the health impacts of globalization and trade through dialogue, policy coherence and cooperation between ministries of health, trade and other interested sectors. There should be a consultation with Member Countries on specific issues and activities for PAHO action related to globalization and trade at national, sub-regional and regional level, according to decisions of the World Health Assembly and in close coordination with WHO.

Ethnicity and Health (Document CE132/16)

162. Dr. Cristina Torres (Chief a.i., Policy and Governance Unit, PAHO) explained that the item arose out of the Strategic Plan for 2003-2007, which called on the Secretariat to “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, 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 strengthening of respect for human rights, including minority rights, and for measures to be taken against acts of racism and xenophobia.

163. 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. In expanding on the definitions of some of the concepts used in the document, she noted that refugees and displaced persons very often shared ethnic characteristics, and they could therefore be considered an additional category of ethnic group. Dr. Torres noted that the demographic reality of the Region of the Americas was complex. The population included groups with very different origins, which varied widely in size and accounted 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 because of their high degree of vulnerability and social exclusion. While, according to figures from ECLAC, 43% of the population of the Region as a whole lived below the poverty line, all available studies indicated that ethnic minorities—both indigenous peoples and Afro-descendants—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.

164. Turning to the specific question of health, she said that studies based on traditional measures, such as infant mortality, revealed that members of ethnic minorities showed consistently worse health indicators. 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, and the differences could not be explained simply by poverty: the same behavior patterns could be seen even in high-income ethnic minority groups.

165. In searching for features of programs that had potential for successfully reducing such inequities, PAHO had determined that accurate statistical and census information was vital. Twelve countries of the Region had included the ethnicity variable in their 2000 national census, in addition to four countries that had done so earlier, and one more had undertaken to do so when it next conducted a census. However, work still remained to be done on incorporating the ethnicity variable into health statistics and into health information systems. Some countries had already made progress, for example by breaking down their mortality statistics by ethnic groupings. Such changes would necessitate training for the personnel who handled the statistics and information. The key areas for action in the Region—condensed in line with the comments from the Subcommittee on Planning and Programming—were the development of ethnically sensitive indicators to monitor progress towards meeting the Millennium Development Goals; introduction of the ethnicity variable into national statistics; reformulation of health policies, plans, and programs to make them more ethnically sensitive; and strengthening of links with civil society to ensure community-based participation.

166. The President of the Subcommittee on Planning and Programming reported that, in its discussion of the item in March, the Subcommittee had felt that the document made a valuable contribution to the overall understanding of the health situation of indigenous people and Afro-descendants. It had noted that data could be a powerful tool for policy and program development to address the special needs of ethnic populations and that the lack of accurate information was itself a barrier to equitable access. Delegates had 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. They had noted, in addition, that some groups, such as migrants and refugees, might transcend racial lines and could have problems unsuspected by outsiders, thus making the situation even more complex. The Subcommittee had underscored the importance of disaggregating data by ethnicity, as the first step towards a better understanding of the dynamics of ethnic diversity and how it affected access to health and social services. Improving the availability and quality of data on ethnicity and health had been seen as a key role for PAHO.

167. The Subcommittee had also noted that neither the document nor the oral 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. It had been considered essential to include 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.

168. A number of delegates had noted that their countries, like PAHO, had for years had a focus specifically on indigenous groups, and had urged that that special focus not be diluted, as doing so might be detrimental to the health status of indigenous peoples, who were among the poorest and most disadvantaged groups in the Americas. In that connection, it had been suggested that, as the following year marked the end of the International Decade of the World's Indigenous People, 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.

169. The Executive Committee welcomed the revised version of the document, noting that it clearly outlined the key health challenges facing vulnerable populations in the Americas. As it made evident, ethnicity was a cross-cutting factor that could negatively influence socioeconomic conditions, education, opportunities, and health. Only with full information about the health conditions of marginalized populations would it be possible to make the changes necessary to ensure equitable access.

170. The Committee was pleased to see that the document now emphasized the importance of disaggregating national statistics by ethnicity and culture, although it noted that in order to fully meet the monitoring needs of the Millennium Development Goals the data needed also to be disaggregated by gender. The need for precise definitions of ethnic variables and training on how to incorporate those variables into statistical work was noted. Several delegates expressed the view that, of the key areas for action, development of ethnically sensitive indicators to monitor progress towards meeting the Millennium Development Goals and introduction of the ethnicity variable into national statistics were clearly the most important. The need for indicators to assess the impact of PAHO's activities in this area was also underscored.

171. The Delegate of Canada recalled that at the meeting of the Subcommittee on Planning and Programming, her delegation had said that while it supported the increased attention being paid to ethnic and other vulnerable populations, it had stressed that the broader focus on ethnicity should not lessen the emphasis on the need to address the unique and pressing health needs of indigenous peoples in the Americas. However, the revised document did not make a clear distinction between the planned activities related to ethnicity and health and the ongoing work under the Health of Indigenous Peoples Initiative. Canada felt strongly that the importance of information relating to access to needed services for indigenous populations should not be forgotten or understated.

172. The Delegate of Jamaica suggested that PAHO, perhaps because it was an organization dedicated to health, was taking a very antiseptic view of the issue of ethnicity and health. The fact was that minorities had been subjected to a very considerable degree of prejudice and lack of economic opportunity. To discuss health without also addressing those factors would be avoiding the main issue, and the document needed to be strengthened in that regard.

173. Several delegations related information about work being undertaken in their countries to address the health needs of ethnic minorities and to gather information disaggregated by ethnic origin.

174. Dr. Torres thanked the delegates for their comments and suggestions, which she said would be very useful in future work. She added that it would certainly be feasible to incorporate the gender variable in the data collected and in PAHO's activities in this field.

175. In response to the comment from the Delegate of Canada, she explained that the work under the Health of Indigenous Peoples Initiative was targeted specifically towards indigenous populations, whereas the work on ethnic groups would take a more cross-cutting approach. There was thus no contradiction between the two sets of activities.

176. Regarding training for statistics professionals, she said that the PAHO country offices were prepared to provide the necessary support at the national level. In addition, there had been discussions with the Latin American Center for Perinatology and Human Development concerning support at the regional level.

177. With regard to the question on evaluation of impact, she pointed out that ethnicity and health was a relatively new area of work for the Secretariat. Consequently, efforts so far had concentrated on identifying partners and ways of working in a coordinated manner with other institutions, including both United Nations agencies and financial bodies. Those efforts had been fairly successful, leading to coordination with the World Bank, the Inter-American Development Bank, and the Ford Foundation, as well as cooperation with civil society organizations working in the area of ethnicity and health. It would take some time before impact on the health of ethnic populations could be measured. Moreover, measuring impact depended on the production of good statistical information. Assuming that information were available, it might be possible to begin measuring impact within 5 to 10 years.

178. She clarified that the inclusion of migrants, refugees, and displaced persons as ethnic groups had been a suggestion from the Subcommittee on Planning and Programming. Not all migrants or displaced persons formed an ethnic group, but many did, with a shared history, language, and culture.

179. The Director felt that the Committee had given valuable advice on the priorities on which PAHO should focus—in particular, the refinement of information systems and the development of ethnically sensitive indicators. The Organization would continue its work of identifying ethnically based disparities in health, which would make it possible to address the factors, including the discrimination which Jamaica had mentioned, that had led to such disparities.

180. The Executive Committee did not consider it necessary to adopt a resolution on this item. However, it was agreed that PAHO should support its Member States in the ethnic disaggregation of national and health statistics to assess ethnically based health disparities and monitor progress towards the Millennium Development Goals. It should also support the development of ethnically sensitive health policies addressing the discriminatory determinants of such disparities. The adoption of a broader approach to ethnicity and health should benefit from PAHO's experience with the Indigenous Peoples Health Initiative. The achievements of and recommendations about this initiative should be reported next year at the end of the International Decade of the World's Indigenous People.

Sustaining Immunization Programs (Document CE132/17)

181. Dr. Héctor Izurieta (Chief a.i., Immunizations Unit, PAHO) presented Document CE132/17, which outlined the challenges for sustaining and expanding immunization programs and suggested some options for protecting the investments made in immunization. The regional immunization program assisted Member States in reducing morbidity and mortality from vaccine-preventable diseases, enabled countries to be self-sufficient in vaccine purchases, increased regional vaccine production, improved immunization services, and enhanced equity through high coverage (95% or more). It also worked through regional partnerships to monitor progress and to provide additional resources and technical cooperation, and the program was now starting to monitor diseases that would be vaccine-preventable in the future, such as diseases caused by rotavirus.

182. The regional program approach had proved highly positive, as evidenced by the successes achieved in controlling and/or eradicating vaccine-preventable diseases. Since 1991, wild poliovirus had ceased to circulate in the Americas. At present, there were no more than 150 cases of neonatal tetanus in the Region. There had been a dramatic drop in rubella and congenital rubella syndrome (CRS) since accelerated rubella control had started in 1998. Since the end of the measles outbreak in Haiti in September 2001, there had been no transmissions of the D6 measles virus anywhere in the Americas. In September 2001, although a new genotype, the d9 virus, had spread from Venezuela to Colombia, prompt action by the two countries and PAHO had resulted in interruption of

transmission in November 2002. Eradication of measles from the Region was thus considered feasible in the relatively short term.

183. The Immunizations Unit had assisted countries to achieve vaccination coverage for most vaccine-preventable diseases exceeding 90% of children under 1 year of age. That was encouraging, but it was not enough: almost half of the municipalities in the Region had not yet reached 95% coverage, which meant that over 5 million children were not yet protected. June 2003 had seen a new initiative, the Vaccination Week of the Americas, which had been a coordinated effort by 19 countries, with assistance from the PAHO Immunizations Unit and the Area of Public Information. For 2004, it was proposed to extend the Week to all countries in the Americas and to other countries outside the Region, including Spain.

184. The goal was that national programs should achieve immunization equity in all municipalities, with sustainable introduction of new vaccines. However, as a result of the economic crisis, fluctuations in resource allocation for immunization services were jeopardizing programs in some countries, with resources primarily covering the cost of biologicals and syringes, but with only limited investment in supervision, evaluation, and training. Other problems were the impact of uneven management of health reform and decentralization, with immunization programs showing technical, managerial, and financial deficiencies, particularly at the local level; weaknesses in financial and human resource management at all levels; lack of local capacity to obtain quality epidemiological information; weaknesses in local management of immunization delivery and surveillance; and lack of micro-planning, which was imperative at the local level.

185. In order to safeguard the achievements of national immunization programs, there was a need to advocate with ministries of finance to protect the immunization budget; enhance managerial capabilities at local level through training; improve access to immunization services; encourage social participation and increase demand for vaccination services; and strengthen strategic partnerships and alliances. Joint action with the IMF, the World Bank, the IDB, ministries of health and ministries of finance should be explored, in order to establish financing mechanisms within public budgets for immunization programs. Other needs were to ensure that the ongoing implementation of health sector reform and decentralization safeguarded the achievements made in immunization; to support the implementation of an annual regionwide vaccination week, targeting high-risk groups and underserved populations; to keep the Region free of indigenous measles through high vaccination coverage, timely surveillance, and outbreak investigation; to advocate that all Member States maintain uniformly high vaccination coverage at local levels; and to draw up, within one year, national plans of action in support of the elimination of rubella and CRS by 2010.

186. The Executive Committee voiced strong support for PAHO's activities to increase regional vaccination levels and encouraged the Organization to continue to give its flagship regional immunization program the priority and visibility it deserved for its many achievements. It was pointed out that one of the major constraints on the regional program was personnel, particularly at local level, and PAHO was urged to provide the necessary human resources for the proposed actions. The Committee applauded the document's focus on securing the highest-level political commitment in support of national immunization programs and its emphasis on the need to secure the financing of immunization services in every Member State. It was considered essential to make ministries of finance aware of the consequences of interrupting vaccination and of not introducing new vaccines. The value of an annual regionwide vaccination week was underscored, and several countries that had not participated in the 2003 Vaccination Week of the Americas committed to do so the following year.

187. The Committee emphasized that the interruption of measles transmission in the Region was a remarkable achievement and encouraged PAHO to take steps to publicize that achievement and ensure that it was sustained. It was pointed out that the recent resolution on measles morbidity and mortality reduction adopted by the World Health Assembly would provide an impetus to sustain regional efforts. Delegates underscored the need to maintain high-quality laboratory surveillance of acute flaccid paralysis and ensure high levels of population immunity against polio in order to ensure that the Region remained polio-free until eradication of the disease was achieved at the global level.

188. A number of delegates gave information on the vaccination campaigns being undertaken in their countries, describing both the difficulties overcome and the successes achieved. The Delegate of Mexico provided information on the actions being undertaken by his government in response to a recent outbreak of measles in Mexico and thanked PAHO for its collaboration in those efforts.

189. The Delegate of Canada commended PAHO's work over the 25-year existence of the Expanded Program on Immunization, which had clearly shown that immunization was a cost-effective intervention that saved millions of lives annually. Canada felt that promotion of pentavalent vaccines was an important measure for PAHO to encourage in the future. She was pleased to announce that Canada's International Immunization Program had recently committed Can\$ 8.5 million over five years to assist PAHO in increasing immunization coverage in all Member States.

190. Several delegates felt that the Region should make a commitment to eliminate rubella and congenital rubella syndrome by 2010 and called for the Committee to include that goal in the resolution to be forwarded to the 44th Directing Council on this item.

191. Dr. Izurieta thanked the delegates for their positive comments, in particular the reminder that vaccination relied on personnel at the local level. PAHO would consider ways in which it could help countries in that regard. He congratulated Paraguay for its success in achieving 95% coverage, despite the numerous obstacles faced by its immunization program. That was an achievement that showed real commitment to the value of immunization. He congratulated Honduras, too, for including vitamin A and folic acid along with the vaccines administered during its vaccination week. With regard to Mexico, he pointed out that the intensive case investigation work under way was likely to reveal pockets of unvaccinated children, affording the opportunity to protect them not only against the present outbreak but also for the future. He thanked Canada both for the new financial contribution and for its solid support in the past.

192. With regard to the proposal that a commitment to eliminate rubella and congenital rubella syndrome be submitted to the Directing Council, he said that PAHO felt that a goal of elimination was certainly feasible. Indeed, several countries had already achieved it.

193. The Director said that one of the most important issues highlighted in the document was that of sustainability and the importance of pursuing discussions with finance ministries and with sister agencies to ensure continued financial support for immunization activities. It was important to keep before the public the idea that vaccinations were important for disease prevention, a human right and an indicator of child health. The adoption of a resolution on this topic would reinforce PAHO's commitment to discuss with the World Bank, the Inter-American Development Bank, and other institutions the possibilities for ensuring the sustainability of vitally important national immunization programs.

194. The Committee adopted Resolution CE132.R7 on this item, embracing the goal of rubella/CRS elimination by 2010.

Contribution of Integrated Management of Childhood Illness (IMCI) to the Attainment of the Millennium Development Goals (Document CE132/18)

195. Dr. Yehuda Benguigui (Chief a.i., Child and Adolescent Health Unit) introduced this item, noting that it was closely linked to two other topics discussed by the Committee at the 132nd Session: primary health care and family health. He began by pointing out that under-5 child mortality in the Americas had decreased by one-third during the 1990s, mostly as a result of reductions in mortality from acute respiratory infections and diarrheal diseases. The strategies of standard case management and integrated management of childhood illness (IMCI) had contributed greatly to those reductions. Bringing about a further decline to meet the target of reducing under-5 child mortality by

two-thirds between 1990 and 2015, as established in the Millennium Development Goals, would require an approach tailored to the current epidemiological profile in the Region.

196. Overall, infectious diseases accounted for 28% of all deaths of children under 5, and disorders originating in the perinatal period accounted for 40%. However, there were significant differences between and within countries in the proportions of deaths attributable to those causes. In some countries, infectious diseases targeted by the IMCI strategy continued to cause a significant proportion of child mortality, while in others they were responsible for only a small percentage. In the latter group, perinatal causes—and neonatal causes, in particular—now accounted for a larger share of deaths. Hence, to achieve the Millennium Development Goals in relation to child mortality it would be necessary to employ a mixed approach that targeted both infectious diseases and the neonatal causes that were responsible for a growing proportion of under-5 child mortality in the Region. At the same time, it was necessary to improve quality of care for children, both in health services and in their families and communities.

197. PAHO believed that expanding the IMCI strategy to include a neonatal component would make it possible to address the leading causes of death in children under 5 in the Region and thereby attain the target set by the Millennium Summit. An expanded IMCI strategy would also include other components—promotion of healthy child growth and development, for example, as well as prevention and treatment of asthma, child abuse, and other health problems—aimed at improving quality of care and fostering greater equity in health among the Region’s children. In addition to expanding the IMCI strategy, other proposed actions were: epidemiological mapping to identify the most vulnerable groups of children, mobilization of political will and resources, partnerships with NGOs working in the area of child health, empowerment of the population to promote and protect child health, and collaboration with training institutions for health care professionals to ensure training in the expanded IMCI strategy.

198. To implement the proposed actions, approximately \$10 million in extrabudgetary funds would be needed over the next five years to supplement the funding already being provided for IMCI-related activities by the Canadian International Development Agency (CIDA), the United States Agency for International Development (USAID), the United Nations Foundation, and various other governmental and nongovernmental sources. PAHO proposed to mobilize those funds from bilateral agencies, religious organizations, NGOs, charitable foundations, and private partners.

199. In the discussion that ensued, the Executive Committee affirmed the value of IMCI as a strategy for improving child survival and child health, and expressed support for the idea of expanding the strategy to incorporate a neonatal component and address child health problems of particular concern to the countries of the Americas. HIV/AIDS and child abuse were cited as two such concerns. It was pointed out, however, that the

document did not clearly explain what was meant by “expanded IMCI,” and the Secretariat was asked to clarify how the expanded strategy would differ from the IMCI strategy currently in use. It was also pointed out that IMCI was one of a range of strategies and approaches for improving children’s health and that it should not be viewed as the sole strategy for attaining the child health and survival goals set by the Millennium Summit.

200. IMCI was seen as an effective instrument for improving the quality of health care for children and avoiding missed opportunities for disease prevention and health promotion. In that regard, the document’s emphasis on health rather than illness was applauded, as was its recognition of the role of the family in maintaining child health. The educational component of IMCI was considered one of the strategy’s most valuable aspects. Delegates emphasized the importance of educating mothers and others who were responsible for the care of children under 5 in how to promote healthy child growth and development and how to treat illnesses properly when they occurred. The importance of collaborating with the education sector in providing health education for individuals and families was also stressed.

201. Delegates welcomed the approach to targeting vulnerable and high-risk populations described in the document. It was pointed out that, for such an approach to be effective, accurate information was crucial. The need for good surveillance systems to identify the populations to be targeted and to track progress and assess the impact of interventions was underscored. In that connection, one delegate recalled that Resolution CSP26.R10, adopted by the Pan American Sanitary Conference in 2002, had called for strengthening and promotion of effective mechanisms for the collection and analysis of data that would permit monitoring and evaluation of health actions targeting infants and children, and requested an update on progress in that area.

202. The Committee agreed that training health workers to apply the IMCI strategy was important. One delegate cautioned, however, that making training in IMCI a requirement for the certification of physicians and other health professionals, as suggested in the document, could have the effect of limiting countries’ options in the area of child health. She emphasized that a multi-pronged approach, utilizing a variety of strategies and interventions, was needed to address children’s health needs. Another delegate noted that training for auxiliary nurses, rural health technicians, and other non-professional health workers was critical. Training in IMCI was especially important for the technical personnel employed by NGOs, which were the principal suppliers of child health services in many communities.

203. Dr. Benguigui agreed that training for community health agents and NGO personnel was essential, given that there were roughly half a million community agents providing child health care throughout the Region, and in some countries there were more

than 300 NGOs working in the area of child health. PAHO was addressing that need in two ways: it was collaborating with the United Nations Children's Fund (UNICEF) in an initiative aimed at standardizing the child health care services being provided by NGOs at the country level and it was working to strengthen the regulatory capacity of ministries of health to ensure that NGOs were following the criteria and guidelines established by national governments with regard to child health. The Organization was also promoting training in IMCI for nurses, who were chiefly responsible for supervising the activities of auxiliary nurses and community health agents.

204. Responding to the question about Resolution CSP.R10, he said that PAHO was participating in the WHO Multi-Country Evaluation of IMCI Effectiveness, Cost, and Impact. That evaluation, currently under way in several countries in the Americas, was designed to assess the impact and cost-effectiveness of IMCI and determine the best ways of delivering child health interventions.

205. As for the question concerning the definition of "expanded IMCI," he explained that the proposal to expand the IMCI strategy arose from a 1999 resolution of the Directing Council (Resolution CD41.R5), which had asked the Director to take steps to adapt the strategy to the different epidemiological and operational realities of the countries, expanding its components and interventions to enhance its role in promoting the integrated management of childhood illness. The IMCI strategy had originally targeted five conditions which accounted for the vast majority of under-5 child deaths in many parts of the world. However, in the Region of the Americas, neonatal causes were now responsible for 40% of child mortality, and diseases and health problems other than those initially targeted by the strategy had become serious concerns for many countries. Accordingly, the Secretariat was seeking to expand the use of the strategy to address the child health problems that were most prevalent in the Americas and respond to specific needs identified by the countries of the Region. For example, malnutrition was one of the conditions targeted under the original IMCI strategy, but in many parts of the Americas childhood obesity and overweight were far more prevalent than malnutrition, and some countries had sought PAHO's support in adapting the strategy to combat those problems. One of the real advantages of IMCI was its extraordinary flexibility. It was an approach that could easily be expanded and adapted to manage a whole range of child health problems beyond the five conditions it had focused on initially.

206. The Americas had made great strides in improving child health and reducing under-5 child mortality. The majority of Member States had achieved the goals established by the World Summit for Children. However, significant gaps between countries and population groups persisted. In order to close those gaps and meet the Millennium Development Goals in relation to child health and survival, it was necessary to target the most frequent causes of childhood illness and death. The expansion of the IMCI strategy was intended to do just that.

207. The Director said that it was immensely satisfying to see the enthusiasm with which the countries of the Americas had embraced the IMCI strategy and the progress that had been achieved through its application. In bringing this item to the Committee's attention, the Secretariat had wished to call attention to the importance of the IMCI strategy for achieving the Millennium Development Goals and the need to expand the strategy to address new problems identified by the countries. For example, in many countries, as the Committee had noted, HIV/AIDS was a growing cause of illness and death among children under 5. The focus on healthy environments for children—the theme of World Health Day and Health in the Americas Week in 2003—had afforded an opportunity to highlight other factors that had an impact on children's health and to consider how attention to those factors might be incorporated into the IMCI strategy.

208. She pointed out that there was increasing evidence that a number of the chronic diseases that developed later in life were linked to problems that originated in infancy or early childhood. Many of the Organization's NGO partners—the InterAmerican Heart Foundation, for example—were working to identify the causes and reduce the prevalence of those chronic diseases. She appealed to those organizations to support the application of the IMCI strategy by raising awareness of the lifelong impact of measures taken to protect and promote health in childhood.

209. The Executive Committee endorsed the expansion of the IMCI strategy and its use as a means of attaining the Millennium Development Goals for child health, but did not consider it necessary to adopt a resolution on this item.

Monitoring the Reduction of Maternal Morbidity and Mortality (Document CE132/19)

210. Dr. Virginia Camacho (Regional Advisor, Maternal Mortality Reduction Initiative, PAHO) summarized the main points of Document CE132/19, noting that it had been prepared as a 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.R13 of that Conference had requested the Director to strengthen information and surveillance systems for monitoring progress in the reduction of maternal mortality and morbidity.

211. One of the recommendations of the Pan American Sanitary Conference had been to establish a much stricter and faster process for monitoring and tracking progress in reducing maternal morbidity and mortality. The document had been drafted in response to that recommendation and to requests from various countries. It was intended to be a guideline on how maternal morbidity and mortality could best be monitored. In drafting it, PAHO had attempted to include experiences and lessons learned from several countries, to optimize the monitoring tools already available in the region, and to lay

down some basic principles of monitoring. The conceptual framework for the document was the commitment undertaken by all the countries of the Region the previous year to meet the Millennium Development Goal of reducing maternal mortality by 75% of 1990 levels.

212. Monitoring maternal deaths was not simply recording events, but was, more importantly, a process of ascertaining what made women fall ill and die from causes relating to pregnancy and childbirth. Although improving the monitoring of maternal morbidity and mortality would be a major challenge for the Region, a number of assets were already in place to facilitate the task. One was the Organization's general mortality database for 19 countries. Another was the Perinatal Information System of the Latin American Center for Perinatology and Human Development. Other sources of information on maternal morbidity and mortality were the demographic and health surveys (although these had certain methodological problems); process indicators for access to and use and availability of obstetric services; and health indicators and monitoring of health care for safe motherhood.

213. The difficulties to be overcome included insufficient and deficient information in many countries; underrecording and underreporting of maternal deaths; a lack of uniformity in gathering and recording data; inadequate coordination between health and vital records systems; the fact that not all maternal mortality audit committees were operational; exclusive use of data from the services and poor representativeness in the sample; decision-making sometimes not based on sound information; and a low level of participation by women and communities in the monitoring and evaluation process.

214. After examining how monitoring systems could be implemented at local, national, and regional levels, PAHO had concluded that monitoring was effective when processes were integrated and established at different levels; that efforts to improve monitoring systems should build on existing systems rather than creating new ones; that best practices and lessons learned should be shared; and that the value added to the monitoring systems resided in how they strengthened interinstitutional partnerships, set standards, and optimized technical and financial resources. It was also important to break down the data by social and ethnic or geographic group. The key components of effective monitoring systems included creation and implementation of policies, plans, and programs; allocation of public investment resources; availability and use of essential obstetric care and skilled attendance at birth; strategies to empower women, families, and communities; vital statistics, surveillance systems, and use of information for action; and the forging of partnerships.

215. The Executive Committee was asked to comment on what form of PAHO technical cooperation would be most appropriate to assist countries in implementing systems for monitoring maternal morbidity and mortality; how Member States could be motivated to make monitoring a component of their plans to reduce maternal mortality; how to elicit the active participation of stakeholders, particularly women's groups; and how to identify indicators that were consistent with international mandates, national and local plans, and stakeholders' objectives.

216. The President, on behalf of the President of the Subcommittee on Planning and Programming, reported that the Subcommittee had discussed an earlier version of the document at its 37th Session. It had found the document well-written and well-organized and had welcomed the Organization's proposal for monitoring maternal mortality and morbidity. Reducing maternal mortality had been considered a high priority for all countries, even those whose rates were relatively low, and implementing an effective monitoring system had been seen as a crucial step in determining where and why maternal deaths continued to occur. Monitoring had also been considered important to 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, had been underscored. Improving sexual and reproductive health services and providing timely and free access to family planning methods had been seen as another key strategy for improving maternal health.

217. Delegates had agreed with the basic components of the proposal presented in the document and had 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 had been applauded, as had its emphasis on encouraging local participation and targeting of areas where it was known that maternal deaths were being underreported. It had been 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 had been underscored. The Subcommittee had praised 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 mortality and morbidity.

218. The Executive Committee expressed strong support for PAHO's efforts to reduce maternal mortality and morbidity in the Region and highlighted the close linkages between this area and the areas of family health and child health. The Committee agreed that monitoring was essential in order to track progress towards achievement of the goal set by the Millennium Summit in relation to safe motherhood and reduction of maternal deaths. Several delegates recounted personal experiences which had strengthened their resolve to ensure that no woman died from preventable causes related to pregnancy or childbirth. Delegates also described measures taken in their own countries both to reduce

maternal morbidity and mortality and to improve surveillance thereof. It was reported that, in some cases, further investigation of deaths of women of childbearing age had revealed that maternal mortality rates were even higher than previously thought because many deaths that had been attributed to other causes were, in fact, maternal deaths.

219. Like the SPP, the Executive Committee found the document well-written, thorough, and well-organized. It did an excellent job of analyzing monitoring systems and delineating priority areas for action, which would help countries to implement the strategy endorsed the previous year. The Committee felt, however, that one item missing from the document was evaluation of any plans and programs that were implemented.

220. Various specific comments were made in response to Dr. Camacho's request for the Executive Committee's views. It was suggested that death certificates needed to be improved, with details of the pregnancy being included in cases of maternal mortality. Similar information needed to be collected in cases of maternal morbidity, particularly when pregnant women spent long periods in the hospital. One delegate signaled the need for continued discussion on refining specific evidence-based interventions—such as the use of partographs or active management of third-stage labor—that were part of emergency obstetric care and skilled attendance at birth, with indicators being developed for such interventions.

221. The Committee considered it important to establish a national strategy for reducing maternal morbidity and mortality and to ensure that any local plans were consistent with it. Delegates emphasized that national strategies and plans should be based on PAHO's proposed framework. The Committee felt that Member States should be encouraged to include monitoring as a component of maternal mortality reduction plans through a development process that helped them link the information to decision-making. It was also considered important to define the bodies responsible for carrying out the monitoring, identify the specific points in time at which it should be performed, and ensure accountability through annual reporting. In addition, it was suggested that maternal and perinatal monitoring systems should be linked to other disease monitoring systems to ensure that health decision-makers understood the effects of overall health decisions on maternal mortality and morbidity.

222. While the Executive Committee agreed with the document's suggestion of the use of local and national committees for information analysis, it was felt that more emphasis should be placed on the training of such local committees. Several delegates called attention to the important role that local committees could play in encouraging stakeholder participation and in ensuring that pregnant women received antenatal care and gave birth in a health care institution. Delegates also welcomed the importance attached to analyzing data by social, ethnic or geographic categories, and to targeting the poor and disadvantaged. It was deemed crucial to identify vulnerable populations and

address the risk factors that led to mortality and morbidity in those groups. It was pointed out that that approach was in good alignment with PAHO's proposed work on ethnicity. The need for special attention to areas in which there might be underreporting—including rural and isolated regions and indigenous populations—was stressed.

223. It was suggested that PAHO should produce clear, practical, and universal definitions for use in the area of maternal morbidity and mortality. Helping countries to strengthen their surveillance systems, particularly for monitoring of maternal morbidity, was seen as another important technical cooperation role for the Organization, as was facilitating technical cooperation and sharing of expertise between countries. At the same time, PAHO was urged to avoid duplication and coordinate its activities with the United Nations Children's Fund (UNICEF) and the United Nations Development Program (UNDP).

224. Dr. Camacho thanked the delegates for their enthusiastic response to the presentation and the document. Their commitment to reducing maternal mortality and morbidity was an encouragement to her colleagues and herself to continue their work. It was truly gratifying to see how much effort was being expended in so many different countries. She also wished to express her appreciation to the Canadian International Development Agency (CIDA) and the United States International Development Agency (USAID) for their support of PAHO's work in this area.

225. She reported on several of the initiatives that the Organization was working on in the area of maternal health, emphasizing that all the activities under way were closely linked to the Millennium Development Goals. Under the Regional Maternal Mortality Reduction Initiative, PAHO had assigned priority to 12 countries, on which it was focusing its efforts. It was also working to address the problem of maternal morbidity, especially severe morbidity. At the regional level, PAHO was leading an interagency task force involving eight cooperation agencies, including both multilateral and bilateral organizations, which were collaborating to monitor maternal morbidity and mortality in priority countries. Earlier in June, the Organization had taken part in a meeting in Bolivia on skilled attendance at birth, which was one of the indicators for the Millennium Goal on maternal health. The meeting had been attended by representatives of 14 countries and 10 cooperation agencies. Those were just two examples of how PAHO was striving to strengthen interagency collaboration, not only at the regional level but also in individual countries.

226. The Director said that PAHO saw good antenatal care and skilled attendance at childbirth as the keys to reducing maternal mortality. It was committed, in particular, to reducing maternal death rates in the five priority countries identified in the Strategic Plan for 2003–2007. Of those five countries, Haiti had the highest priority because it had the highest maternal mortality in the Americas. She was pleased to announce that the

Organization had entered into an interagency agreement under which maternal mortality would be the main focus in the development of Haiti's health system, in humanitarian aid, and in the strategic development plan for the country.

227. Maternal mortality was, in many respects, the clearest indicator of the quality and responsiveness of the health system and should be the indicator against which the performance of the health sector was measured. As she had pointed out on other occasions, very little was required to render a health system effective in protecting the lives of mothers. The knowledge and techniques needed to overcome the scourge of maternal mortality existed. Doing so was simply a matter of applying them.

228. The Executive Committee noted the report but did not consider it necessary to adopt a resolution on this item.

Influenza Pandemic: Preparation in the Western Hemisphere (Document CE132/20)

229. Dr. Mario Libel (Regional Adviser, Communicable Diseases Unit, PAHO) presented an overview of the state of preparedness in the western hemisphere for a possible influenza pandemic. He noted that the issue was highly topical in light of the recent epidemic of SARS, which had served to test the preparedness systems in various countries of the world.

230. 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 and multisectoral pandemic committee and the creation of a legal framework to handle issues such as compulsory quarantine and closure of schools or workplaces. With respect to 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.

231. As the influenza pandemics of the past had been largely of zoonotic origin, a major aspect of preparedness was surveillance of animal diseases with a view to early detection of their transmission to humans. Equally important was the monitoring for new strains of viruses. 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.

232. The principal difficulty with regard to vaccines and antivirals arose from the low number of producers. Efforts were in hand to increase their number, especially in the developing countries. The normal influenza vaccine production cycle was eight months, from identification of a virus to availability of the first batches, but in a pandemic, certain of the consultative and licensing steps could be omitted, shortening the production time to about five or six months. In the area of health services planning, the major problem was transmission to health workers—a problem which had been encountered frequently during the SARS outbreak. Infection control was a major issue, and plans and procedures were needed to deal with it. It was also essential to put in place alternatives in the event that health establishments had to be closed. As for emergency response, an intersectoral approach was required 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.

233. 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.

234. Virological surveillance was fairly well covered in some parts of the Region, but elsewhere there was a need to amplify capabilities to obtain samples, notably of new strains of the virus. Rapid transportation of samples to the Collaborating Centers had become markedly more difficult since 11 September 2001 and PAHO was seeking to conclude contracts with individual air carriers to resolve the problem. Owing to the animal origin of many influenza strains, it was essential 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.

235. PAHO had defined a series of phases to determine what preparatory activities should be undertaken if a pandemic was approaching. Those phases and the actions needed in each one were outlined in the annex to Document CE132/20. 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 and quantities; enhancement of surveillance systems to give the widest possible coverage; 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 communications plan; and improvement of annual vaccination coverage among high-risk groups. It was not possible to predict an outbreak of influenza, but planning, management of resources, and definition of policies were essential in order to limit as far

as possible the extent of the pandemic and its number of fatalities, while at the same time avoiding adverse effects on other public health priorities.

236. The President of the Subcommittee on Planning and Programming reported that, when the SPP had discussed the item in March, it had emphasized the need to prepare for the next influenza pandemic now, and had noted that PAHO had a key role to play in facilitating regional planning activities. Delegates had agreed that effective communication was a key strategy in pandemic preparedness and response. However, they had seen a need to clarify the role of PAHO in announcing the different phases of a pandemic and in facilitating communication during a pandemic. Delegates had considered that 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 influenza epidemics that occur every year in the Region. The Subcommittee had felt that 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.

237. Building local capacity to generate the data required for national immunization program planning had been considered a priority, and establishment of national goals and priorities had been viewed as the necessary first step towards preparedness and towards addressing the inevitable shortage of vaccines and antivirals in the event of a pandemic. The Subcommittee had encouraged PAHO to collaborate with countries to assess the regional requirements for vaccines and antivirals and to stimulate the interest of regional manufacturers and facilitate discussions among current vaccine producers with a view to boosting the capacity for manufacture of influenza vaccines within the region. Delegates had stressed the necessity of extending the coverage of annual influenza vaccination, especially among older adults and other high-risk groups. The importance of good surveillance to accurately ascertain the number of deaths attributable to influenza had also been highlighted.

238. The Subcommittee had stressed the importance of multilateral and international interchange of information on successful practices in dealing with influenza and other pandemics. In particular, given the time that would elapse before a vaccine became available in the various countries in the event of a pandemic involving a new strain, it had been considered important to establish at the international level the preventive measures to be taken while the countries waited for the arrival of the vaccine.

239. The Executive Committee welcomed the update on influenza preparedness, finding the description of the activities to be undertaken in order to prepare for a pandemic very specific and practical. The Committee felt that PAHO could be a very important resource for countries in the development of national plans and improved surveillance activities, development of recommendations and guidelines for national

policies, and assessment of available vaccines and antivirals in the event of a pandemic. It was pointed out that the recent resolution emanating from the 56th World Health Assembly underscored similar priorities. Several delegates described preparedness efforts in their countries, requesting continued support from the Organization, in particular for the relevant impact studies. Another area in which the Committee suggested that PAHO and Member States could work together was in the provision of information to the media and to health care providers, enlisting their help to manage public perception and avoid panic.

240. Immunization was seen as the most important tool to contain a pandemic. PAHO could work with Member States and the pharmaceutical industry to expand the existing influenza vaccine production capacity and diversify the production base by developing alternative vaccines, for example those derived from cell cultures. Maintaining strong surveillance systems was considered to be of critical importance. The Committee noted that preparing public health infrastructures to identify and respond effectively to a global influenza pandemic would strengthen the very systems that would also be needed to detect and respond to a bioterrorism attack or the emergence of a threatening infectious disease such as SARS.

241. Delegates looked forward to receiving the guidelines on influenza outbreak control, which the document reported that PAHO was preparing. In that connection, further guidance was sought on identifying high-risk groups that should be vaccinated against the disease.

242. Dr. Libel thanked the delegates for their contributions, which would strengthen the document and help to improve preparedness for a future influenza pandemic. He felt that the comments made could be synthesized in two important messages. One was that the various preparatory measures had to be incorporated within the committees and facilities that already existed in the areas of emergency response, immunization, surveillance, and others. It was important not to create new and separate bodies, which would simply use up precious and limited resources. The second message was that it was important to include influenza as one more element in national immunization programs, paying particular attention to the priority groups: older persons, people predisposed to respiratory infections, and health care professionals. However, within those priority groups there existed variations. For example, the population defined as “older persons” varied from country to country. But regardless of how the groups were delineated, increasing coverage for them was crucial.

243. He also announced that preparedness measures were being implemented on a pilot basis in the Southern Cone and would be progressively expanded to the other subregions.

244. The Committee took note of the report but did not consider it necessary to adopt a resolution on this item. However, the Executive Committee strongly supported PAHO's recommendation that all countries establish, under existing national emergency preparedness committees, a national pandemic planning task force responsible for developing strategies to prepare them for the next influenza pandemic. Consideration should be made to develop common approaches for planning and response to public health emergencies in general.

Diet, Nutrition, and Physical Activity (Document CE132/21)

245. Dr. Enrique Jacoby (Regional Advisor, Nutrition Unit, PAHO) outlined the content of the document, noting that it focused in particular on the problem of obesity, which had also been the main focus of the presentation made to the Subcommittee on Planning and Programming in March. He began with some statistics that showed the growing magnitude of the problem. Currently, 20%–30% of women and 8%–20% of men in the Region of the Americas were obese, and one out of every two adults was overweight. Increasing numbers of children were also obese. The problem affected both rich and poor countries and cut across all social strata. Obesity was associated with premature mortality in young adults and with high risk of various noncommunicable diseases, including diabetes, hypertension, cardiovascular disease, and some forms of cancer. It was also associated with high economic costs, both direct and indirect. Clearly, action was needed to reduce the problem and address its root causes.

246. The basic cause of overweight and obesity was an energy imbalance. Weight gain occurred when energy intake exceeded energy expenditure over an extended period of time. In recent years, calorie intake among the Region's population had risen steadily, whereas the amount of energy expended through physical activity had shown a progressive decline. Factors that had contributed to those trends included the increase in sedentary jobs and recreational activities, urban environments that discouraged walking, and the low priority accorded to physical education in schools. Eating habits had also changed significantly, with a marked increase in consumption of foods high in fat, salt, and added sugar, and a simultaneous decline in consumption of fruits, vegetables, and whole grains. Those changes were linked to a number of factors. Personal characteristics (genetic makeup, socioeconomic and education level) certainly played a role, but eating habits were unquestionably also influenced by a series of external factors, including price and availability of foods, production patterns, marketing, advertising, and information.

247. PAHO believed that it was important to address the problem of overweight and obesity through an integrated approach that sought both to bring about personal behavior change and to create an environment that would foster healthy dietary and lifestyle choices. The emphasis of such an approach should not be on weight loss, however, but on the overall health benefits to be derived from eating a better diet and engaging in regular

physical activity. Moreover, in a region such as the Americas, an integrated, family-oriented approach was essential in order to deal effectively with problems such as malnutrition, which persisted alongside the epidemic of obesity. The resources of the health sector in most countries were simply not sufficient to allow separate programs targeting the nutritional needs of different population groups and, indeed, separate programs were not necessary. Ample scientific evidence existed to show that the same varied, high-quality diet that was vital to meet the needs of undernourished children would help adults maintain a healthy weight and prevent chronic diseases.

248. The approach to the problem also had to be intersectoral and had to involve the private sector, in particular the food industry. Without the participation of food producers, it would be impossible to improve the quality of the foods available on the market. At the same time, it was necessary to improve the availability of information on what constituted a healthy diet. Action was also needed in the areas of legislation, regulation, and pricing. Just as those types of actions had proven effective in bringing about other positive public health changes—encouraging the use of automobile seatbelts and discouraging smoking, for example—they could be used to promote healthy eating and exercise habits. Finally, health sector leadership of the multisectoral effort to combat obesity and overweight was essential.

249. Dr. Jacoby concluded his presentation by noting that the Americas was participating actively in the global consultation process that would culminate in the launch of the WHO Global Strategy on Diet, Physical Activity, and Health at the World Health Assembly in 2004. As part of that process, PAHO had held a regional consultation in San José, Costa Rica, in April 2003. The Executive Committee was invited to comment on the results of that consultation.

250. Dr. Elías Lizardo Zelaya (Honduras, Vice President of the Subcommittee on Planning and Programming) reported that when the SPP had discussed the item at its 37th Session it had applauded PAHO's involvement in this area, which the Subcommittee had felt would reinforce the broader WHO effort to develop a global strategy. In general, the Subcommittee had found the document a good starting point from which to build an effective strategy, although several delegates had suggested additional items that should be incorporated. It had been suggested that the strategy should focus on maintaining a healthy weight—through good diet and sufficient physical activity—rather than on weight loss. Some concern had been expressed about the apparent lack of substantiation for some of the assertions made in the document, notably those regarding the impact that advertising had on dietary habits and the link between obesity and consumption of certain types of foods. It had been suggested that the next version of the document should contain more information on the sources for those statements. In addition, one delegate had voiced concern 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. The delegate had cautioned that such trade matters fell outside the competency of the Organization and had encouraged the Secretariat to revise that section so that it reflected more of a public health approach.

251. Additionally, the Subcommittee had stressed the importance of promoting changes in behaviors and perceptions about diet and obesity among health workers. Several delegates had signaled the need to introduce modifications into curricula and training programs for health professionals so as to ensure that obesity was duly recognized as a serious public health problem. Delegates had also underscored the need to encourage physicians to counsel their patients on the importance of diet and physical activity.

252. The Executive Committee expressed appreciation for the revised document, which plainly showed that the Secretariat had taken the comments of the SPP to heart, and for the presentation, which provided a clear enunciation of the policy imperatives that needed to be addressed in dealing with the question of obesity. The Committee welcomed the population-based public health approach laid out in the document. Delegates felt that the activities proposed therein offered governments a range of viable options for sustained action to promote healthier eating and exercise habits. It was pointed out, however, that the document did not provide much guidance on how to implement the proposed actions, and it was suggested that the Secretariat should develop a comprehensive framework for action to assist countries in formulating strategies and plans at the national level.

253. It was emphasized that, while reducing obesity was important, the main objective should be to encourage maintenance of a healthy weight, particularly in the case of children and adolescents. Delegates underscored the importance of a high-quality diet, both to maintain healthy weights and to promote normal development in childhood. In that connection, one delegate reported that studies in his country had shown that rates of obesity and overweight among children who ate a lower-quality, less-varied diet did not necessarily differ from the rates among children whose diets included a wider variety of nutritious foods, but there were clear differences (as much as 5 cm) in height.

254. The Committee agreed that interventions targeting individual behaviors would not be sufficient to solve the problem of obesity, since, as Dr. Jacoby had said, people's behavior was influenced by the environment in which they lived. It would therefore be necessary to adopt strategies designed to promote positive environmental change in order to support regular physical activity and healthy eating and to curb the current obesity trends. It was pointed out, however, that population interventions that led to environmental change were often difficult and contentious. They required healthy public policy at all levels and, often, the introduction of legislation, which in turn required intersectoral action and the cultivation of intersectoral partnerships.

255. One delegate, noting that the document alluded to tobacco control initiatives as an example of how to bring about environmental change, cautioned against drawing any comparison between the food industry and the tobacco industry. The food industry was one of the critical partners whose support the health sector must have in order to tackle the disease burden associated with obesity. In that regard, delegates applauded the Director's decision to include the topic of diet and obesity on the agenda for RIMSA 13, which had afforded an opportunity to involve representatives of the food industry in the discussion. It was hoped that she would seek additional opportunities to bring together a broad range of stakeholders to address this and other public health priorities.

256. The Executive Committee commended PAHO for organizing the regional consultation in Costa Rica. Delegates described the meeting as well-planned and well-executed and felt that it had yielded many useful suggestions on how to increase physical activity and improve diet and nutrition. The Director was encouraged to disseminate the results of the consultation widely among Member States in order to promote broader dialogue on the Global Strategy on Diet, Physical Activity, and Health. Active participation by the Regional Offices in the development of the global strategy was seen as crucial, as it was the regional level that had first-hand knowledge of the priorities and challenges facing countries and their populations. PAHO had made a valuable contribution to the formulation of other global strategies, and it was encouraged to continue to assert its expertise in the development of the strategy on diet, physical activity, and health.

257. Dr. Jacoby thanked the Committee for its support of the Organization's work in this area. Responding to the comments concerning the tobacco industry, he said that the statement in the document had not been meant to suggest that the food industry and the tobacco industry were similar. He had mentioned tobacco control in his presentation because he thought the example of tobacco control campaigns was paradigmatic. The success achieved in reducing tobacco use in the United States, for example, clearly showed how it was possible, through research, information, and legislative and regulatory measures, to build a consensus around an issue and gradually bring about behavior change. He pointed out that it had not been sufficient in the case of tobacco simply to tell people to stop smoking. It had been necessary to educate the public about the dangers of tobacco use and at the same time—through regulations that prohibited smoking in public places and other measures—create an environment that discouraged the practice. The same thing was true of diet and physical activity. It would not be enough to tell people to stop eating high-fat foods or to do more exercise. It was necessary to persuade them to make health a priority and to create an environment that would make it easier for them to make health-enhancing diet and lifestyle choices.

258. With regard to the comment concerning implementation of the proposed actions, he said that in the interest of keeping the document brief, the Secretariat had not included

a great deal of information about programmatic activities. However, a number of activities were under way. For example, the Nutrition Unit was currently developing a regional network for the promotion of healthy eating habits, and it was developing related software to assist health professionals. It was also exploring the possibilities for working with the private sector in several countries to encourage increased consumption of fruits and vegetables. PAHO was also collaborating with several other organizations, including NGOs and private-sector organizations, in a regional network to promote physical activity. The aim of that initiative was to make people aware of simple ways—such as walking or climbing stairs—in which they could incorporate more physical activity into their daily lives.

259. The Executive Committee did not consider it necessary to adopt a resolution on this item. However, it was agreed that PAHO should develop a regional framework to guide the formulation of national strategies and action plans for promoting healthier eating and exercise habits, in order to reduce current levels of obesity and maintain a health weight, particularly among children and adolescents. The framework should take into consideration the Global Strategy on Diet, Physical Activity and Health, as well as the recommendation of the Regional Consultation in Costa Rica. It should involve intersectorial action and partnerships, including with the food industry as recommended by the RIMSA 13.

Impact of Violence on the Health of the Populations in the Americas (Document CE132/22 and CE132/22, Corrig.)

260. Dr. Alberto Concha-Eastman (Regional Advisor, Violence and Injury Prevention, Healthy Settings Unit, Sustainable Development and Environmental Health Area, PAHO) presented Document CE132/22. He began by pointing out that the defining aspect of violence was its intentionality, but that in turn meant that it was a learned behavior which could be unlearned. It also meant that violence was preventable. PAHO's commitment to violence prevention had begun in 1993, when the 37th Directing Council had adopted Resolution CD37.19 on Violence as a Public Health Problem. The following year had seen the Inter-American Conference on Society, Health, and Violence, which had resulted in the first plan of action on violence and health.

261. Significant progress had been made since then. In the area of advocacy, several countries in the Region had approved laws on intra-family violence and violence against women, and various countries or municipalities had prepared or were preparing violence prevention plans. In the area of research and publications, there had been several notable achievements, including the publication by PAHO's Program on Women, Health, and Development (now the Gender and Health Unit) of the findings of a study on the "critical path" followed by women affected by family violence. ACTIVA, a multicenter study coordinated by PAHO, had looked at cultural norms and attitudes towards violence. In

addition, PAHO had played a key role in the publication, in 2002, of the WHO *World Report on Violence and Health*.

262. In the area of information systems, the accomplishments included production and dissemination of guides on setting up and using information systems; testing of patient history forms in hospitals to facilitate decision-making concerning violence-related injuries; and development of information systems and observatories on violence. In the area of networks and coalitions, the number of women's networks now exceeded 170; the Red Andina (Andean Network) served to exchange information and assist with violence prevention in the Andean subregion; and a tripartite initiative of PAHO, Canada, and Mexico was providing assistance to people who had been injured by landmines. In addition, PAHO was collaborating with several national and international organizations in the Inter-American Coalition for Violence Prevention.

263. While progress had been made, further work was needed. The actions currently proposed by PAHO placed emphasis on violence prevention and promotion of peaceful coexistence, which was an approach that had been shown to work. The actions recommended by the Organization included promotion of the adoption by governments of intersectoral plans and programs at the national and/or municipal level; research, situation analysis, and evaluation of interventions; and preparation of national reports. Other necessary actions were improving information systems on violence, strengthening health sector response to victims, networking and building strategic partnerships, strengthening institutional capacity, promoting gender equity, and supporting social development in the areas of education and work. Bearing in mind those needs and the actions proposed in Document CE132/22, the Executive Committee was asked to comment on what elements should be included in a second plan of action on violence and health.

264. The Committee applauded PAHO's approach to violence and expressed satisfaction at the alignment of its work with the WHO *World Report on Violence and Health*. The concept of violence as a public health problem and as "a silent epidemic" was welcomed. Delegates emphasized that reducing violence would require political leadership and an intersectoral and inter-agency approach, involving many stakeholders, most of whom would be from sectors other than health: education, justice, housing, social services, and law enforcement. Community participation in addressing the problem was seen as essential, as was a focus on the family, where many violent behaviors were initially learned. Enlisting the support of civil society organizations and the mass media was also considered important.

265. Delegates felt that the document should place more emphasis on the long-term health and social consequences of exposure to violence early in life. It was pointed out, for example, that children who had been abused or who had witnessed violence were

adversely affected in their social development and were more likely to engage in dangerous behaviors during adolescence, including high-risk sexual practices, which exposed them to sexually transmitted infections, among other health problems. Delegates also suggested that the document should give greater attention to the problem of violence against older persons. The need for primary health care providers to acquire the skills to recognize such violence and intervene was underscored. It was also recommended that the document should reflect more of a population health approach to addressing the factors that affected health and working to reduce the health inequalities within and among populations.

266. It was suggested that the Secretariat should conduct an evaluation of the results of the first plan of action on violence and that the findings of the evaluation should feed into the design of a second plan. Delegates called attention to the need for process and outcome indicators to measure the impact of PAHO's technical cooperation and for surveillance systems to track progress. The importance of reliable data, broken down by sex and age, was stressed, both for planning and monitoring purposes and for advocacy and policy-making. Obtaining data posed challenges to many countries, owing to the limited human and economic resources they were able to devote to the task. Helping countries to improve their data collection and information systems was seen as a key technical cooperation role for PAHO. The importance of involving the private health care system in the effort to strengthen information systems was also noted.

267. A number of delegates highlighted the need for further research to understand the root causes and risk factors for violence in order to design more effective intervention strategies. In particular, it was felt that the social aspects of violence should be studied, for which purpose the health sector should seek the support of social anthropologists and behavioral specialists. More understanding was needed, too, of the interplay between education and violence, between mental health (particularly alcohol and drug abuse) and violence, and between gender and violence. Targeted research was also needed into specific types of violence, including violence in schools, domestic violence, gender-based violence, and violence against children, older persons, and the disabled, as well as violence among aboriginal peoples.

268. With regard to the list of recommended actions in the document, it was proposed that PAHO should, within the broader framework set out in the *World Report on Violence and Health*, develop a regional framework to serve as a basis for national action plans, which would provide the countries of the Americas with general guidelines for action that could then be tailored to their specific circumstances. It was emphasized that national action plans should incorporate a gender perspective. In addition, because the list of recommended actions was rather lengthy, it was suggested that they should be prioritized.

269. Dr. Concha-Eastman said that prioritization had to occur at various levels. One priority was mobilizing the community to address the problem of violence. At the same time, it was imperative to have adequate information that was timely, usable, and credible. However, neither of those things would occur without the political will of governments to act. That was why the primary recommendation of the *World Report* was the preparation of national and local prevention plans. Hence, perhaps the two main priorities were, first, to draw up national and local plans and, second, to ensure the availability of good information that would make it possible to monitor progress.

270. He agreed fully on the need for an intersectoral approach and for research to shed light on the multiple causes of violence. The health sector could not resolve the problem on its own, nor could the police, nor the education sector—it had to be a joint effort. Similarly, violence needed to be viewed from the social, anthropological, sociological, and psychological points of view in order to determine its root causes. He also agreed on the need for incorporation of a gender perspective and for coordination of all activities relating to violence prevention with those relating to family health.

271. Regarding evaluation of the first plan of action, he pointed out that, while it might be possible to evaluate the process, evaluation of impact would be more difficult owing to the lack of reliable baseline indicators from which progress could be measured. The suggestion of creating a framework within which national plans and reports would be drawn up, however, would provide an excellent basis for identifying what issues were to be addressed and assessing how much progress had been made.

272. The Director noted that the Americas had been the first of the WHO regions to look at violence from a public health point of view. That innovative approach had greatly influenced the approach of the other regions and the work of WHO at the global level, which had culminated in the publication of the *World Report*. During the last World Health Assembly, in recognition of the Region's contribution and its pioneering attitude, she had been the one Regional Director called upon to take part in a joint panel on the topic of violence.

273. One of the most important aspects of the Organization's approach had been to bring an epidemiological perspective to the subject of violence, which had made it possible to progressively identify the various factors influencing how, when, and where acts of violence occurred; to classify them in a typology; and to define possible interventions in response. The task now was to evaluate those interventions and select those that had proved most effective.

274. As the *World Report* said, violence was indeed a modifiable phenomenon, and there was a growing consensus that society could develop mechanisms to control and prevent it, promoting a culture of peace and harmony. A major shift had occurred when

the health sector had moved from being a passive agent—an onlooker dealing only with the results of violence—to being the sector that was taking the lead in identifying and shedding light on the factors involved and proposing effective interventions to prevent acts of violence.

275. Noting that the Committee had also called for the development of a regional framework to guide the development of national action plans in the area of diet, nutrition, and physical activity, she said that such an approach was fully in line with the new orientation for action at the regional level under the managerial strategy for the work of the Secretariat in 2003–2007. In accordance with that orientation, two primary instruments were envisaged for promoting joint Pan American work: (1) regional programs, when the countries had agreed to work collectively to address a need, when it was possible to establish concrete goals, and when instruments and strategies for achieving them existed, or (2) regional frameworks for action, when there was still a need to continue assessing the situation, defining strategies, and improving information. In the case of both obesity and violence, the development of a regional framework was the appropriate approach to take.

276. With regard to the prioritization of activities, she pointed out that in a highly decentralized organization such as PAHO, which worked at the regional, subregional, national, and subnational levels, priorities would differ from one level to the next. At the regional level, it was important to prioritize those instruments and elements on which the countries could work together, for example information systems or the systematization and exchange of experiences to identify successful interventions. On the other hand, at the national and subnational level, the priorities would be much more specific and would be determined by the epidemiological situation in each particular case.

277. The Executive Committee did not consider it necessary to adopt a resolution on this item. However, it was agreed that the Secretariat, as requested by the Committee, would develop a regional framework to guide the formulation of national action plans on violence.

Administrative and Financial Matters

Report on the Collection of Quota Contributions (Document CE132/23 and CE130/23, Add. I)

278. Mr. Mark Matthews (Manager, Area of Financial Management and Reporting, PAHO) reported that, as of 31 December 2002, collection of quota assessments had totaled \$90.6 million, of which \$67.6 million represented payment of 2002 assessments and \$23 million pertained to prior years. Detailed information on receipts of quota

payments by Member States and payment dates was included in Annex A of Document CE132/23. On 1 January 2003, total arrears for years prior to 2003 stood at \$49.1 million. Payments received between 1 January and 16 June 2003 had amounted to \$9.4 million, or 19.2% of that total, reducing those arrears to \$39.7 million, as compared to \$30.6 million and \$22.2 million in arrears at the corresponding times in 2002 and 2001, respectively.

279. The collection of contributions for 2003 assessments amounted to \$21.1 million as of 16 June 2003. Eleven Member States had paid their 2003 assessments in full, 3 had made partial payments, and 25 had not made any payments. The collections represented 23% of the current year's assessments; the corresponding figures were 33% in 2002, 32% in 2001, and 27% in 2000. Together, the collection of arrears and current year's assessments during 2003 totaled \$30.5 million, as compared to \$48.3 million in 2002, \$61.5 million in 2001 and \$47 million in 2000. Detailed information on payments received and the application of those payments could be found in Annex B of the document. Since 16 June, PAHO had received additional payments of \$18,591 from Guyana, \$25,000 from Ecuador and \$25,501 from Saint Lucia.

280. Article 6.B of the PAHO Constitution provided for the suspension of voting privileges if a country was in arrears by an amount in excess of two full years' quota payments. The same article also provided the Pan American Sanitary Conference or the Directing Council the option of allowing the Member to vote, if it was satisfied that the failure of the Member to pay was due to conditions beyond its control.

281. The Member States subject to Article 6.B at the present time were Argentina, the Dominican Republic, Suriname and Venezuela. Argentina owed a total of \$24.4 million, of which \$12.1 million related to the years 1997 through 2000. It had submitted a deferred payment plan that had been accepted by the Secretariat in 2000. To retain its right to vote, Argentina would be required to make payments totaling \$11.1 million prior to the opening of the 44th Directing Council. To date, it had made payments totaling \$501,672.

282. The Dominican Republic owed approximately \$515,000, of which \$62,000 was attributable to 2000. The deferred payment plan approved by the Secretariat in 2001 stipulated that the Dominican Republic needed to pay \$197,500 for 2003. In addition, there was a balance of \$560 remaining due for 2002 under the plan. The Dominican Republic had not made any payments during 2003. A minimum payment of \$61,969 would be required to remove the Dominican Republic from Article 6.B status.

283. Suriname owed approximately \$231,000, of which \$55,000 related to 2000. Therefore, it was subject to Article 6.B. No payments had been received from Suriname since 2001. A minimum payment of \$54,884 would be required to remove Suriname from Article 6.B status.

284. Venezuela owed approximately \$8,400,000, of which about \$328,000 was attributable to 2000. No payments had been received from Venezuela since 2000. A minimum payment of \$327,863 was required to remove Venezuela from Article 6.B status.

285. In the discussion that followed the report, it was pointed out that elsewhere in the agenda the Executive Committee would be asked to authorize an increase in the Working Capital Fund. Delegates wondered whether that did not point to a need for more assertive action to motivate Member States to pay their quota contributions on a timely basis. It was also pointed out that PAHO had applied Article 6.B very infrequently, which might indicate to Members that they were in little danger of being sanctioned, and consequently they would tend to pay other commitments before meeting their obligations to PAHO. Other delegates felt that all Member States were aware of the value they obtained in return for their payments to the Organization and had every intention of meeting their obligations, but that it was necessary to be aware of the economic difficulties and conflicting demands that many of them were facing.

286. One delegate wished to know whether the accounts of the Organization genuinely reflected its true financial situation, or whether there might not be some hidden reserves. In particular, he asked whether it was realistic to expect to collect the \$22 million owed by Argentina and the \$8 million owed by Venezuela.

287. Mr. Matthews pointed out that if every country paid its quota in full on the first day of the year, there would be no need for a Working Capital Fund. The need for such a fund was linked to the timing of quota payments, expenditure patterns, and miscellaneous income inflows. He explained that a subcommittee made up of Member States reviewed countries' status under Article 6.B, taking into account their compliance with payment plans. It was that subcommittee that recommended to the Directing Council or the Pan American Sanitary Conference whether or not to apply the provisions of Article 6.B. While it was true that Article 6.B was applied infrequently—only one country had had its voting privileges suspended in the previous eight years—he felt that was evidence that the provisions of Article 6.B did indeed act as an incentive to countries to pay their quota contributions.

288. He assured the Executive Committee that the Organization's accounts as presented in the Director's Financial Report were complete and in full compliance with generally accepted accounting principles; nothing was hidden. The status of the deficient accounts was reflected in that report. He also said that the Organization had never waived receivables from any country, and that it was confident of receiving all of the funds owed to it.

289. The Director noted that while the issues under discussion were delicate, PAHO had always dealt with them in an open and positive manner. Both large and small countries could find themselves in payment difficulties and have to seek a deferment. She considered that one of the healthiest things about the Organization had been the creation—at the proposal of Mexico 20 years before—of the subcommittee charged with examining Article 6.B issues and proposing a way out of difficulties. PAHO had also been the first organization to propose flexible payment plans to Member States that were having difficulties. Usually such plans were complied with, although sometimes they had to be renegotiated. The payment plan approach had later been adopted by WHO, which before that had simply removed the voting privileges of those Member States that were in arrears. That, however, had not proved to be effective in persuading Member States to pay their contributions: some countries had remained in arrears, and without voting rights, for almost 20 years.

290. She emphasized that the Secretariat had been very conscientious in urging governments to pay their outstanding contributions, not only to PAHO but also to WHO. It was in contact with senior budget officials in the Member States, encouraging them to establish specific budget lines for payment of such obligations. The Secretariat had observed that, generally speaking, if a Member State owed money to PAHO, it owed money to all organizations. And when such a country began to pay, the first organization that it paid was PAHO. That was something of which the Organization could be proud, as it indicated the value that countries placed on its work.

291. The Committee adopted Resolution CE132.R2 on this item.

Interim Financial Report of the Director for 2002 (Official Document 311)

292. Mr. Matthews also presented *Official Document 311*, which contained the Director's report on the financial transactions of PAHO for the preceding year and presented the Organization's financial position as of 31 December 2002. He noted that the financial statements continued to adhere to the revised United Nations System Accounting Standards, and that the reports provided an overview of financial status in columnar format, identifying the separate activities of PAHO, WHO, and three Pan American Centers: the Caribbean Epidemiology Center (CAREC), the Caribbean Food and Nutrition Institute (CFNI), and the Institute of Nutrition of Central America and Panama (INCAP).

293. The Statement of Assets, Liabilities and Reserves and Fund Balances as of 31 December 2002 reflected the strong financial position of the Organization. The \$42.0 million increase in cash in banks and investments reflected fund balance increases of \$24.0 million in the Revolving Fund for Vaccine Procurement, \$5.5 million in Advances from Governments and Institutions for Procurement, \$4.3 million in Trust

Funds, \$3.5 million in the Strategic Fund, and \$2.0 million in the Provision for Termination and Repatriation Entitlements Fund.

294. Because income in 2002 had exceeded expenditures, the statement of Income and Expenditure and Changes in Fund Balances reflected an increase of \$658,000 in the balance of the Working Capital Fund. However, it had to be remembered that the Interim Financial Report was shown on a cash basis and did not reflect financial obligations incurred but not yet paid. Thus, the increased balance in the first year of the biennium would be drawn down during the second year as such obligations were paid.

295. In accordance with Article 103.4 of the Financial Rules, any surplus at the end of a biennium was to be used to restore the Fund to its authorized level of \$15.0 million. As of 31 December 2002, the Working Capital Fund had been at its maximum level, but it had been significantly depleted on several occasions during 2003 due to delay in the payment of quota assessments.

296. Total 2002 expenditures of \$359.6 million reflected an increase of \$71.4 million since 2000, the first year of the last biennium. That increase was largely attributable to an increase of \$60.7 million in vaccine purchases for the Revolving Fund for the Expanded Program on Immunization, \$6.2 million for the regular budget, \$4.3 million for the Trust Funds, \$3.5 million for the Strategic Fund, and \$1.4 million for the three centers' expenditures. Those increases had been offset by small decreases in other programs.

297. Miscellaneous income earned during 2002 for the regular budget was approximately \$5.8 million, which included \$4.6 million in interest income, \$689,000 in savings on, or cancellation of, prior periods' obligations, as well as \$59,000 in currency exchange differential and \$514,000 in other miscellaneous income. The total interest earned on the Organization's funds had contributed \$5.4 million to the regular budget and other projects in 2002.

298. Expenditures under the procurement program for governments and institutions had reached \$8.2 million. The fund had ended 2002 with a balance of \$11.4 million. Vaccine purchases placed through the Revolving Fund for Vaccine Procurement had totaled \$144.7 million, as compared to \$130 million in 2001 and \$83.9 million in 2000. The significant factor in this increase was placement of large orders by Argentina, Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, Honduras, and Mexico. The \$4.3 million earned from program support costs for the Revolving Fund in 2002 had increased the Fund's capitalization to \$22.4 million.

299. The three centers (CAREC, CFNI and INCAP) had experienced a combined net excess of income over expenditures of \$3.7 million. In 2002, income received for CAREC's regular budget reached \$2.0 million, while expenditures totaled over

\$1.8 million, a difference of \$184,000. After adjustments, the net income contributed by CAREC's regular budget activities in 2002 had increased its Working Capital Fund from \$737,000 to \$746,000. The Provident Fund, which contained the funds restricted for the retirement investments of CAREC staff members, had reached \$1.6 million. The Statement of Quota Contributions from Members showed balances due as of 31 December 2002 totaling \$4.2 million, slightly lower than at the end of 2001. Full payment of assessed quota contributions by CAREC's member countries would significantly improve its financial condition.

300. The financial statements for CFNI reflected expenditures exceeding income, thus resulting in a deficit of \$77,000 in its 2002 regular budget. The accumulated deficit in CFNI's regular budget and Working Capital Fund had increased to \$421,000 as of 31 December 2002. Delay in the receipt of \$1.2 million in quota assessments was impacting the financial position of CFNI.

301. The Institute of Nutrition of Central America and Panama (INCAP) had received regular budget income of \$932,000 and had experienced similar expenditures in 2002. As a result its Working Capital Fund balance remained at \$1.0 million. The funds restricted for staff members' retirement investments and entitlements amounted to \$2.6 million. Collection of quota contributions had improved significantly during the last five years, with outstanding balances decreasing from \$843,000 in 1997 to \$256,000 in 2002. The significant factor in that improvement had been timely payment of quota assessments by Belize, El Salvador, Guatemala, Honduras, and Panama.

302. Responding to a question from one of the delegates regarding the way that cash and investments were managed, Mr. Matthews clarified that the phrase "cash and term deposits" indicated sums that were invested, but not for the longer term. Every dollar in the Organization was earning a return. PAHO had very capable treasury staff who kept the Organization just liquid enough to meet its cash outflows.

303. The Director said that while the Financial Report illustrated some of the points raised in the preceding agenda item on quota contributions, the picture was in fact more complex. She considered PAHO to be unique among international organizations, owing to the intimate operational links between the Organization and its Members. In many of the countries, PAHO was operating in physical infrastructures provided by the government. In others, it was sharing operating expenses with the government or was working alongside experts provided by the government. That meant that the Organization's pattern of income was intimately linked to all of the non-budgetary resources that the countries were providing, over and above their quota contributions. Every day saw this complex income pattern in movement; every day revealed the immense generosity and solidarity of the countries of the Region.

304. She wished to pay tribute to Mr. Matthews, who was transferring to the WHO Regional Office in Manila, Philippines. His vision, professionalism, and efficiency had been invaluable to PAHO over an often critical eight-year period. His efforts had not only helped to modernize the Organization but had contributed to its prestige, both within the Region and beyond it. He had created a team spirit and had helped to reduce the friction, common in all types of organization, between the technical and the administrative sides.

305. The Committee took note of the report but did not consider it necessary to adopt any resolution on this item.

Review of the Authorized Level of the Working Capital Fund (Document CE132/24)

306. Ms. Sharon Frahler (Chief, Finance Unit, Area of Financial Management and Reporting, PAHO) presented document CE132/24. She explained that it should be read as a complement to document CE130/24, which had proposed an increase in the authorized level of the Working Capital Fund in order to reflect the realities and risks inherent in the current political and economic environment. The Executive Committee's review of the previous proposals had raised some questions regarding prompt payment of assessments, historical analysis of drawdowns, and alternatives available to the Director. The Committee had decided to defer action on the proposal pending further clarification as to the need for an increase, and to reexamine it at the present Session.

307. Since the 130th Session, PAHO had experienced four critical periods in which the unencumbered balance of the Working Capital Fund had been exhausted. Those instances had been directly related to delays in the receipt of quota contributions, and at those times not only had there been a risk of a negative impact on program implementation, but there had also been no buffer available for unforeseeable and extraordinary expenses as provided for in Financial Regulation VII. Without some relief, cash flow deficiencies would reoccur in the future. The economic uncertainties and inflationary pressures which plagued the Region, coupled with the mandatory cost increases of program activities, would continue to place pressure on the Organization's working capital.

308. Currently, the only alternative to increasing the level of the Working Capital Fund would be to authorize internal borrowing. That was a practice followed by many other United Nations agencies, whereby funds administered by an organization were temporarily transferred to its regular operating fund. Such a mechanism not only reflected poor accounting, but it could also impair other critical operations by depriving them of necessary liquidity. It also weakened necessary collection and programming disciplines, and in PAHO's view should occur only as a last resort and with the approval of the Governing Bodies.

309. It was proposed that the authorized level of the Working Capital Fund be increased by \$5 million to a total of \$20 million, or approximately 2.5 months of operating cash for the Organization's regular budget. It was further proposed that the increase should be funded, gradually, from any excess of income over expenditure resulting from the collection of arrears of contributions or efficiencies realized in the implementation of the biennial program budget, beginning with the current biennium.

310. The Delegate of the United States of America said that it was the policy of her government that the working capital funds of international organizations should not exceed 8.3% of the total annual budget, equivalent to about one month's operating expenditures. Such funds were intended only to bridge short-term cash shortfalls due to late payment of quotas. If there was a fundamental problem of non-payment, then it was incumbent on PAHO to adjust the budget to the income that it could reasonably expect to receive. The United States did not support an increase in the Working Capital Fund, which might have the unintended effect of taking pressure off governments that were not paying their contributions.

311. The Delegate of Jamaica, while sharing some of the concerns raised by the United States, expressed the view that there could be no fixed percentage applicable to all organizations within the United Nations system. Rather, the level of working capital funds should be set taking into account the history and experience of particular organizations. He suggested that the proposed increase should be adopted, but that some sort of oversight body should be instituted, to which reference would be made when there was a need to extend the working capital beyond the approved level.

312. Committee Members asked several specific questions regarding the operations of the Fund. One delegate inquired who had discretion over use of the Working Capital Fund and whether it was intended to be used to cover previously budgeted operating expenditures or unplanned expenditures arising from unforeseen circumstances. Another delegate expressed concern as to the way the proposed increase would be funded and whether the resources available for programs would be affected. Ms. Frahler was asked to clarify what was meant by "necessary expansion of PAHO activities" (mentioned in paragraph 7 of Document CE132/24). She was also asked to explain how the proposed increase to \$20 million compared to the Working Capital Fund of WHO, and whether PAHO had a strategy for collecting arrears, so as to minimize use of the Fund, in particular when it was close to being exhausted.

313. Ms. Frahler pointed out that a Working Capital Fund equivalent to 8.3% of the whole PAHO budget, including the WHO portion, would exceed \$20 million. The level had last been increased in 1993, to \$15 million. Since 1993, however, PAHO's share of the regular budget had increased by 24%. Applying that percentage to the current level of \$15 million in order to maintain the same flexibility as in 1993 would raise the Working

Capital Fund to approximately \$18.7 million, but to avoid dealing in fractions of numbers, the Secretariat had rounded the requested increase to \$20 million. Regarding how the increase of \$5 million would be funded, she explained that if the increase were approved at the present time, then at a later date, when some arrears had been paid, any excess of income over expenditure would gradually be paid into the Working Capital Fund until it reached \$20 million.

314. She explained that when there was a shortfall owing to non-receipt of quota payments, PAHO automatically drew on the Working Capital Fund for expenditures under the regular budget. Money from the Working Capital Fund was normally used only to cover regular working expenses: salaries, temporary advisers' fees, programs in the field, and so on. In the case of major extraordinary expenditures not included in the regular budget approved by the Member States, such as the recent renovations of PAHO Headquarters building, the Secretariat was obliged to seek the Executive Committee's approval to utilize the Fund. While on paper it might appear that PAHO had a very high level of cash reserves which could be used to cover shortfalls, those reserves were allocated to specific programs and funds, such as the vaccine program, procurement on behalf of Member States, and terminal entitlements for retiring personnel. The Secretariat had a fiduciary responsibility never to utilize those funds for other purposes.

315. In response to the suggestions about an oversight mechanism, she said that the Secretariat would be happy to provide information on the Organization's financial situation and use of the Working Capital Fund to cover shortfalls at any given point in time. As for the meaning of the phrase "necessary expansion of PAHO activities," it referred to the fact that there was a major financial variable—obligatory increases in salary costs approved by the United Nations—over which neither Member States nor the PAHO Secretariat had any control and which had to be incorporated into the budget.

316. WHO's Working Capital Fund was only \$30 million. However, shortfalls at WHO were mainly financed not from the Working Capital Fund but through internal borrowing. In fact, in the current budgetary period, WHO had resorted to internal borrowing amounting to \$75.5 million. The Secretariat had been reluctant to adopt the practice of internal borrowing because it believed that such a practice would not be in line with the prudent conservative financial management favored by PAHO's Member States. Furthermore, internal borrowing meant taking money allocated to programs and using it to support regular operating expenses. The Secretariat believed it was preferable to utilize the Working Capital Fund to cover such expenses, but, even so, it attempted to minimize use of the Fund. To that end, twice a year a letter was sent to every Member State, indicating the status of its quota payments and asking when the Organization might expect to receive any outstanding payments.

317. The Director emphasized that a distinction must be made between the issue of use of the Working Capital Fund and the issue of funds owed by countries. Use of the Working Capital Fund was a matter of timing of payments and expenditures. For example, if all Member States paid their quota contributions in the last month of the year, they would be in compliance with their obligations, but the Secretariat would still be left with a cash-flow problem and would have to draw from the Working Capital Fund to cover expenses during the other 11 months. Moreover, since the program budget covered two years, if a country paid its contribution in December of the second year, it would not have been possible to use those funds during the biennium, and consequently it would still have been essential to draw on the Working Capital Fund.

318. In recent months, the Secretariat had been discussing with financial authorities in the countries the possibility of making payments on a monthly basis. Monthly payments were much better than annual payments—unless annual payments were made at the start of the year—as they allowed for a regular cash flow and permitted orderly planning of expenditure. Quarterly payment was also helpful, but where large quota amounts were involved, a delay of even a single month in a quarter's payment had an enormously negative impact on the Organization's cash flow.

319. She noted that the mandatory increases in salary and health insurance costs were often approved by the United Nations General Assembly very late in the year and were often retroactive. Although the Secretariat attempted to estimate what those increases might be when preparing the budget, it was impossible to predict their precise level. Additionally, sometimes there were unpredictable external events, such as currency devaluation, which had a severe impact on the Organization's cash position and caused serious problems in ordinary expenditures. There, too, there could be a need to have recourse to the Working Capital Fund.

320. At the suggestion of the Delegate of Jamaica, the President designated a small working group, consisting of Honduras, Jamaica, and the United States, to try to revise the proposed resolution contained in Document CE132/24 and make a recommendation to the Executive Committee concerning the course of action to be taken. Resolution CE132.R3, adopted subsequently by the Committee, reflects the consensus reached by that working group.

PAHO Buildings and Facilities (Document CE132/25)

321. Mr. Edward Harkness (Manager, Area of General Services and Procurement, PAHO) drew attention to Document CE132/25 which reported on the renovation of the PAHO Headquarters building previously approved by the Executive Committee. At its June 2002 meeting, the Committee had approved the use of \$220,000 from the PAHO Building Fund for repairs to the basement and sub-basement garages of the Headquarters

building, which had deteriorated due to wear and water damage. While patch repairs had been made since the building was occupied in 1965, an accumulation of severe damage resulting from water, especially water tainted from salt used on public highways, would require replacement of sizable portions of the floors. An engineering firm had conducted tests and the Organization was awaiting a report detailing the extent of the problem and setting out options and costs for repair work. Once additional details were available, they would be provided to the Executive Committee. So far, \$5,200 had been committed to the initial study of the current conditions. The remaining \$214,800 remained available for the project itself.

322. The Executive Committee took note of the report on the status of the renovation work, but did not consider it necessary to adopt a resolution on this item.

Personnel Matters

Amendments to the PASB Staff Rules (Document CE132/26, Rev. 1)

323. Mr. Philip MacMillan (Manager, Area of Human Resources Management, PAHO) summarized the amendments that had been made to the Staff Rules and Regulations of the Pan American Sanitary Bureau since the Committee's 130th Session in June 2002. The changes had already been approved by the Executive Board of WHO and were being presented to the Executive Committee of PAHO for confirmation.

324. Staff Rule 330.2 amended the salary scale for staff in grades P4 to D2, in accordance with the increases approved by the United Nations General Assembly in December 2002. The change, which had taken effect on 1 January 2003, was being made at PAHO to ensure consistency with the salary scales for professional and higher graded staff in the United Nations common system. As a result of that change, a revision to the salaries for the posts of Deputy Director, Assistant Director, and Director had been required. Using the same 6.3% increase that had been awarded to staff in the D2 grade, the salaries for those three positions had been adjusted accordingly. In conformity with established policy, the Executive Committee was asked to approve the resulting salary changes for the posts of Deputy and Assistant Directors and to recommend to the 44th Directing Council the applicable salary revision for the post of Director.

325. Staff Rules 350.1 and 355 related to the education grant entitlement and had been revised, with effect from 1 January 2003, to reflect an increase in the maximum reimbursable level of the education grant that was provided to eligible staff members. Staff Rule 320.1 had been amended to allow the Organization to grant additional steps on initial appointment in cases in which the staff member's qualifications, skills, and work

experience surpassed the minimum requirements of the post. That change had been made with a view to introducing greater flexibility in the hiring process.

326. In the discussion that followed, the Secretariat was encouraged to seek economies with regard to personnel expenses, wherever feasible, in order to ensure that the Organization maintained the soundest budget position possible. The Executive Committee adopted Resolution CE132.R1, confirming the changes to the Staff Rules and making a recommendation to the Directing Council concerning the salary of the Director.

Statement by the Representative of the PASB Staff Association (Document CE132/27)

327. Mrs. Brenda Simons Gilliam (President, PASB Staff Association) thanked the Committee for the opportunity to present an update on some of the Staff Association's concerns and on some of the strides made in staff-management relations since the Association's last report in June 2002. The past year had been one of the most remarkable in the Organization's 100-year existence, with the election of Dr. Mirta Roses as Director. The Staff Association saluted the Governing Bodies for taking the bold step of electing the first female director in PAHO's history. The Director's theme for the Organization was "One Team, One Goal," and she had taken great care to include the Staff Association as part of that team. The Association looked forward to building on that partnership.

328. The concept of partnership between staff and management would be discussed at the next meeting of the Global Staff Management Committee (GSMC), which included representatives of management and all the WHO staff associations. The PASB Staff Association believed that the concept would benefit both the Organization and the Association, resulting in decision-making based on openness and transparency and strengthening relationships between staff at all levels. The Staff Association looked forward to developing the partnership concept further and, indeed, believed that the process had already begun at PAHO.

329. Turning to the issues of particular importance to the Staff Association, she said that security remained a concern, both for staff at Headquarters—especially since 11 September 2001—and for staff in the field offices. The Staff Association felt that the issue needed to be dealt with on a country-by-country basis in order to address the specific factors that might pose a threat to staff in each duty station.

330. Another concern was the erosion of salaries for field-office staff stationed in countries that were experiencing high rates of inflation and severe devaluation of the local currency. The latter was a concern because devaluation reduced not only current purchasing power but also the value of pension contributions and future pension benefits. The Association hoped that the Organization would put in place some internal

mechanism to ease the strain on the affected staff. The Staff Association had recently learned that the International Civil Service Commission (ICSC) had proposed changes in the methodology for conducting salary surveys at all non-headquarters duty stations, including Washington, D.C., which was not a headquarters duty station within the United Nations common system. The effect of those changes would be to freeze salaries for years to come, which would eventually have a negative impact on the Organization's capacity to recruit and retain staff of the necessary caliber and competence. The Staff Association opposed the implementation of the new methodology.

331. The Staff Association had brought the issue of harassment to the Committee's attention the previous year, and she was pleased to report that a policy was in the drafting stages. The topic of staff career development had also been discussed the previous year. The Staff Association believed that all staff, including General Services staff, should have access to opportunities for career development and that a career development path should be created to ensure that all staff maintained a high level of knowledge and expertise. Doing so would enable PAHO to train future managers from among the ranks of current staff, who were familiar with and understood the Organization, which would, in turn, serve to enhance PAHO's capacity to deliver effective technical cooperation. One vehicle for furthering the training and advancement of staff at all levels might be the Virtual Public Health Campus recently launched by PAHO. Another might be participation in the professional certification programs offered in various fields. Staff rotation from one post to another or between duty stations might be yet another method of career development.

332. In conclusion, she said that the Staff Association acknowledged the positive efforts that had laid the foundation for the current staff-management partnership. The Association faced the future knowing that the issues raised in its report would be given serious consideration. Dr. Roses, both as Assistant Director and as Director, had been very receptive to the Staff Association's concerns, and she was confident that that would continue to be the case in the future.

333. The Director said that she was pleased with the staff-management relations that had prevailed since she had assumed her position. Both formal and informal meetings had been held with the Staff Association to address various personnel issues. With regard to security, as the Committee had acknowledged in the discussion on violence and public health, violence had increased throughout the Region and consequently so had the feeling of insecurity. She assured the Members that PAHO was taking measures to address the problem. The Organization was working with the governments of the Member States and with the rest of the United Nations system to provide staff stationed in all countries with the greatest possible protection. In some duty stations where violence was an especially serious problem, special security officers had been hired to safeguard staff and thereby ensure that the Organization's technical cooperation could continue uninterrupted.

334. She acknowledged the negative effects that currency devaluations and inflation had had on salaries. PAHO had tried to offset those effects through the use of existing mechanisms, although, admittedly, they were insufficient. Nevertheless, it had to be recognized that the Organization's resources were limited and that it had a responsibility to the Member States to manage them prudently. Still, PAHO was mindful of the problem and was continuing to confer with representatives of both the Staff Association and the Member States in an attempt to find the most appropriate solution.

335. Staff had been included in the various working groups established in connection with the restructuring of the Secretariat. She believed that many of the concerns expressed by the Staff Association would be addressed by those groups, in particular those that were examining issues related to healthy working environments and development of human capital. With regard to the latter, the Organization had a long tradition of supporting staff development because it believed that it had an obligation to Member States to provide service of steadily increasing quality. To that end, the Secretariat would soon implement some major changes in the recruitment system, including more objective selection criteria based on assessments of candidates' knowledge, skills, and abilities. In addition, several new personnel policies had been introduced. One was the policy on harassment mentioned by Ms. Simons Gilliam. Others were a code of conduct and a gender policy, based on the gender policy adopted by WHO. A new policy on staff promotion would increase access to senior-level positions within the Organization. In sum, the Secretariat recognized that the Organization's greatest asset was its human capital, and it would therefore continue working to advance the interests and well-being of staff.

336. The Executive Committee took note of the report but did not consider it necessary to adopt a resolution on this item.

General Information Matters

Resolutions and Other Actions of the Fifty-sixth World Health Assembly of Interest to the PAHO Executive Committee (Document CE132/10)

337. Dr. César Vieira (Manager, a.i., Area of Governance and Policy, PAHO) presented Document CE132/10, listing the resolutions and other actions of the Fifty-sixth World Health Assembly of interest to the PAHO Executive Committee. The 56th World Health Assembly had taken place in Geneva, Switzerland, from 19 to 28 May 2003. Delegations from 187 Member States, including 34 countries of the Americas, had participated. Representatives of more than 100 international and nongovernmental organizations had also attended. Dr. Javier Torres Goitia, Minister of Health of Bolivia, had been elected Vice-Chairman of the Assembly, while Dr. J. Larivière, of Canada, had

been appointed Chairman of Committee A, and Mrs. C. Velásquez, of Venezuela, had been appointed Rapporteur of Committee B.

338. The agenda of the Assembly had covered more than 50 items, related to a large variety of policy, managerial, and institutional matters. The Assembly had approved 35 resolutions—10 more than in 2002. Of special importance were Resolutions WHA56.2 and WHA56.4, respectively appointing Dr. Jong-Wook Lee as the new Director-General of WHO for the 2003–2008 period and declaring Dr. Gro Harlem Brundtland as Director-General Emeritus of WHO. Also noteworthy were Resolutions WHA56.1 on the Framework Convention on Tobacco Control and WHA56.32 approving WHO's Program Budget for the 2004–2005 biennium.

339. Twenty of the resolutions of the Assembly were of special relevance both for Member States of the Region of the Americas and for the PAHO Secretariat, 13 of them dealing with health policy matters and the remaining 7 with resources and management matters. Those 20 Resolutions were listed in Tables A and B of the document, respectively.

340. The Executive Committee welcomed the report on the Fifty-sixth World Health Assembly. The Assembly had been an historic one which had adopted resolutions on many key issues, including the Framework Convention on Tobacco Control; the global health-sector strategy for HIV/AIDS, with its commitment to provide assistance to at least 3 million HIV-infected individuals in developing countries by 2005; prevention and control of influenza pandemics and annual epidemics; and SARS.

341. Members pointed out that the long discussion on SARS had reflected the importance which countries attached to coming together to face and overcome a new public health threat. Although that challenge had been met, it had to be recognized that in the early days of the crisis the flow of information had not been handled well or promptly. It was felt that, particularly when there was a danger that other news might supplant public health on the front pages, the Organization had a responsibility to ensure that health information continued to be provided rapidly and correctly.

342. The Delegate of Paraguay noted that Brazil and Paraguay had been the first countries in the Americas to sign, the previous week, the Framework Convention on Tobacco Control. He encouraged the other countries of the Region to follow suit.

343. Delegates considered it unfortunate that, because the Assembly's agenda had been so full, the topic of primary health care and the celebration of the 25th anniversary of the Alma-Ata conference had not received the attention they deserved. For the same reason, delegations had been urged to hand in written statements and forego their chance of addressing the Assembly. That, too, was unfortunate, as the governments expended

considerable time and effort in preparing their position on the issues. Delegates also expressed the view that the ministerial round tables could have been better placed in the flow of the agenda.

344. The President noted that the new Director-General had indicated that he regarded the Region of the Americas as a very important one, to which due attention would be given during his tenure. He also recalled that during the Assembly homage was paid to the former Minister of Health of Colombia, Dr. Juan Luis Londoño, who had died in a plane crash in the course of performing his duties, and to Dr. Carlo Urbani, of WHO, who had been the first to identify SARS and had then died of the disease.

345. Dr. Vieira thanked the delegates for their comments, which would assist the Secretariat in expressing a view on the various resolutions adopted, as well as correcting and amplifying some information that was missing from the initial version of the document, such as the fact that Canada and Ecuador had been elected to the Executive Board.

346. The Director observed that the Region had played an important role in the work of the World Health Assembly. While only two of the Resolutions had needed a vote, reaching consensus had required many hours of work carried out in subgroups. She wished to recognize in particular the efforts of two delegations in the final production of the resolution on intellectual property, namely, Brazil and the United States of America.

347. She concurred with the view that not enough time had been devoted to the topic of primary health care. In the region of the Americas, there was a firm commitment to pursue the commitments of the Alma-Ata conference, as well as those of the Millennium Development Goals. She also agreed with the view that improvement was needed in the organization of round tables and technical sessions. There was a need to achieve a better balance between the technical presentations and the deliberative and administrative sessions.

348. She paid tribute to the Honorable Tommy Thompson, Secretary of Health of the United States, for his support of the Framework Convention on Tobacco Control, and to Ambassador Celso Amorim, of Brazil, for his work as Chairman of the Negotiating Body.

349. During the Assembly, she had taken part in a meeting with all the nongovernmental organizations from the Region to hear their views. She had also attended a discussion meeting with the Missions of the Region located in Geneva, aimed at developing a more efficient process for keeping them informed of the discussions that took place in Washington and ensuring better coordination of activities.

350. She noted that a major topic at the following year's Assembly would be the mid-term evaluation of the impact of Resolution WHA51.31, which, as had been noted in the budget discussion, had changed the regional distribution of WHO resources and caused a significant reduction in the WHO contribution to the PAHO budget. The redistribution been supported by the countries of the Americas in a spirit of solidarity, but it was now time to examine what its real impact had been.

351. The Executive Committee took note of the report but did not consider it necessary to adopt a resolution on this item.

Closure of the Session

352. The Director expressed her appreciation to all the delegations—both Members of the Executive Committee and Observers—as well as to the nongovernmental organizations present, for their active participation. She paid tribute to Mr. Roberto Rivero for his almost twenty years of service and wished him well in his retirement.

353. The President thanked the Director and her staff for all their support during the week. After expressing the good wishes of the Executive Committee to Mr. Rivero, as well as to Mr. Mark Matthews and Dr. David Brandling-Bennett as they moved on to other activities, he declared the 132nd Session closed.

Resolutions and Decisions

354. The following are the resolutions adopted and decisions taken by the Executive Committee at its 132nd Session:

Resolutions

CE132.R1: Amendments to the Pan American Sanitary Bureau Staff Rules

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the amendments to the Staff Rules of the Pan American Sanitary Bureau submitted by the Director in Annex 1 to Document CE132/26;

Taking into account the actions of the Fifty-sixth World Health Assembly relating to the remuneration of the Regional Directors, Senior Advisors, and the Director-General;

Bearing in mind the provisions of Staff Rule 020 and Staff Regulation 3.1 of the Pan American Sanitary Bureau and Resolution CD20.R20 of the 20th Directing Council; and

Recognizing the need for uniformity of conditions of employment of PASB and WHO staff,

RESOLVES:

1. To confirm in accordance with Staff Rule 020 the amendments to Staff Rule 330.2 that have been made by the Director with effect from 1 January 2003, concerning the salary scale applicable to staff in the professional and higher categories.
2. To establish, effective 1 January 2003:
 - (a) The net annual salary of the Deputy Director at US\$ 115,207 at dependency rate and \$104,324 at single rate;
 - (b) The net annual salary of the Assistant Director at \$114,207 at dependency rate and \$103,324 at single rate.
3. To confirm in accordance with Staff Rule 020 the amendments to the Staff Rules that have been made by the Director with effect from 1 January 2003, as follows:
 - (a) to Staff Rule 110.7 regarding standards of conduct;
 - (b) to Staff Rule 320.1 concerning salary determination;
 - (c) to Staff Rules 350.1, 350.2.2, and 355 with effect from the school year in progress on 1 January 2003, in respect of education grant entitlements; and
 - (d) to Staff Rules 410.3.1 and 410.3.2.1 regarding the employment of relatives.
4. To recommend to the 44th Directing Council to:
 - (a) Note the amendments to the Staff Rules made by the Director and confirmed by the Executive Committee at its 132nd Session concerning, *inter alia*, Standards of Conduct, Education Grant Entitlements, Salary Determination, Recruitment Policies, and Paternity Leave;
 - (b) Confirm the annual salary of the Director at \$125,609 at dependency rate and \$113,041 at single rate, effective 1 January 2003.

(Second Meeting, 23 June 2003)

CE132.R2: Collection of Quota Contributions

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the report of the Director on the collection of quota contributions (Document CE132/23 and Add. I), and the report provided on Member States in arrears in the payment of their quota contributions to the extent that they can be subject to the application of Article 6.B of the Constitution of the Pan American Health Organization;

Noting the provisions of Article 6.B of the PAHO Constitution relating to the suspension of voting privileges of Member States that fail to meet their financial obligations and the potential application of these provisions to those Member States that are not in compliance with their approved deferred payment plan; and

Noting with concern that there are 25 Member States that have not made any payments towards their 2003 quota assessments and that the amount collected for 2003 assessments represents only 23% of total current year assessments,

RESOLVES:

1. To take note of the report of the Director on the collection of quota contributions (Document CE132/23 and Add. I).
2. To thank the Member States that have already made payments for 2003 and to urge the other Member States to pay all their outstanding contributions as soon as possible.
3. To recommend to the 44th Directing Council that the voting restrictions contained in Article 6.B of the PAHO Constitution be strictly applied to those Member States that by the opening of that session have not made substantial payments toward their quota commitments and to those that have failed to make the scheduled payments in accordance with their deferred payment plans.
4. To request the Director to continue to inform the Member States of any balances due and to report to the 44th Directing Council on the status of the collection of quota contributions.

(Sixth Meeting, 25 June 2003)

CE132.R3: Review of the Authorized Level of the Working Capital Fund

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the report of the Director on the authorized level of the Working Capital Fund (Document CE132/24);

Noting that the provisions of Financial Regulation 7.1 stipulate that the amount and purposes of the Working Capital Fund will be determined from time to time by the Pan American Sanitary Conference or the Directing Council;

Noting, with concern, the increasing demands placed on the Working Capital Fund as the Organization's activities expand; and

Noting the need to adequately position the Organization to manage the uncertainties of the income and budgeting cycles,

RESOLVES:

To recommend to the 44th Directing Council the adoption of a resolution along the following lines:

THE 44th DIRECTING COUNCIL,

Having considered the recommendation of the Executive Committee, concerning an increase to the authorized level of the Working Capital Fund, and recognizing that increasing demands require additional working capital to ensure that the Organization's program of technical cooperation is carried out in an efficient and orderly manner,

RESOLVES:

1. To approve an increase in the authorized level of the Working Capital Fund from US\$ 15 million to \$20 million.
2. To authorize the Director to finance the increase to the Working Capital Fund from any excess of income over expenditure resulting from the collection of arrears of contributions or efficiencies realized in the implementation of the biennial program budget, beginning with the 2002-2003 biennium.
3. To request that the Secretariat:

- (a) Review the status of the quota payments of all Members States with approved payment plans to strive for compliance with those plans by 31 December 2003 or, in case of Members in noncompliance, to negotiate new payment plans with the goal not to exceed a payment period of five years;
 - (b) Inform the Executive Committee Members as of 1 January 2004 whenever the month-end deficit of the Organization exceeds \$10 million, including the names of the Member States that are not in compliance with their payment plans, and to provide those Member States with copies of the letter notifying the Executive Committee Members;
 - (c) Establish payment plans, with the goal of not exceeding five years, with Member States subject to Article 6.B as of 1 January of each year.
4. To review the status of the Working Capital Fund and the payment plans of the Member States in June 2006.

(Seventh meeting, 26 June 2003)

CE132.R4: 13th Inter-American Meeting, at the Ministerial Level, on Health and Agriculture (RIMSA 13)

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the final report of the 13th Inter-American meeting, at the Ministerial Level, on Health and Agriculture (RIMSA 13) (Document CE132/12, Rev. 1),

RESOLVES:

To recommend that the 44th Directing Council adopt a resolution along the following lines:

THE 44th DIRECTING COUNCIL,

Having considered the final report of the 13th Inter-American Meeting, at the Ministerial Level, in Health and Agriculture (RIMSA 13) (Document CD44/8);

Bearing in mind Resolution CD17.R19, which authorized the Director to convene this meeting and Resolution RIMSA11.R3, ratified by the 41st Directing Council, mandating the Director of PAHO to convene both the ministers of agriculture and health at the RIMSA meetings;

Considering that RIMSA continues to operate as the intersectoral forum at the highest political level to address important health issues related to the health and agriculture sectors; and

Recognizing the broad response to the call by the Director of PAHO to the ministers of agriculture and health of Member States to participate in RIMSA 13,

RESOLVES:

1. To endorse the recommendations and resolutions of RIMSA 13.
2. To urge Member States to continue strengthening the mechanisms for intersectoral coordination between health and agriculture in order to formulate joint and complementary plans and activities, with private sector participation, in relation to zoonoses, foot-and-mouth disease, and food safety.
3. To request the Director of PAHO to support strategies to generate the necessary mobilization of resources from the relevant sectors in support of technical cooperation activities in the areas of zoonoses, foot-and-mouth disease, and food security/safety, to facilitate compliance of RIMSA recommendations and mandates.

(Seventh meeting, 26 June 2003)

CE132.R5: Primary Health Care in the Americas

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having seen Document CE132/13 on primary health care in the Americas;

Bearing in mind the lessons learned in the 25 years since the implementation of primary health care began, as well as the challenges of its renewal for the future in the Region;

Recognizing the validity of primary care as a general strategy for improving the health of the population and human development; and

Taking note, moreover, of Resolution WHA56.6, adopted by the World Health Assembly in May 2003,

RESOLVES:

To recommend that the 44th Directing Council adopt a resolution along the following lines:

THE 44th DIRECTING COUNCIL,

Having seen Document CD44/9 on primary health care in the Americas;

Considering the Declaration of Alma-Ata (1978), as well as Resolutions CD27.R20 and CD27.R21 on the regional strategies to promote health for all by the year 2000 (HFA2000) and CD28.R11 on the plan of action for the implementation of the regional strategies to promote HFA2000; Resolutions CSP21.R12 and CSP21.R20 on the Regional Plan of Action on HFA2000; Resolutions CD31.R27, CD33.R17, and CD35.R19 on the monitoring and evaluation of the HFA2000 strategies; and Resolutions CD39.R4 and CD40.R11 on renewal of the call for HFA and the health for all strategies;

Observing the impact of a changing environment on primary health care in the Americas; and

Acknowledging the efforts of the countries of the Region to put policies and programs on primary care at the center of their health services systems to meet the goal of health for all—efforts in which the State, nongovernmental organizations, and grassroots community organizations have played a role,

RESOLVES:

1. To request the Member States to:
 - (a) ensure that the necessary resources are available for primary care and that its implementation helps to reduce inequalities in health;
 - (b) renew their commitment to ensuring the human resources development required for primary health care in the long term;
 - (c) boost the potential of primary health care to reorient the health services, fostering the adoption of a health promotion approach;
 - (d) promote the maintenance and strengthening of information and surveillance systems in primary health care;
 - (e) support local communities to participate actively in primary health care.
2. To request the Director to:
 - (a) take the principles of primary health care into account in the activities of all technical cooperation programs, especially those related to the attainment of the Millennium Development Goals;

- (b) evaluate the different systems based on primary health care and identify and disseminate information on best practice with a view to improving application of the relevant policies;
- (c) continue assisting the countries to improve training for health workers in the priority activities of primary health care;
- (d) place renewed emphasis on support for locally defined primary health care models that are both flexible and adaptable;
- (e) promote and organize a celebration with activities devoted to underscoring throughout the Region the importance of the 25 years of experience with primary health care in the Americas. This would be a year-long process involving discussions, national commemorations, subregional forums, regional activities, etc.;
- (f) organize a regional consultation for the definition of future strategic and programmatic orientations in primary health care.

(Seventh meeting, 26 June 2003)

CE132.R6: Proposed Program Budget of the Pan American Health Organization for the financial period 2004-2005

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the report of the Subcommittee on Planning and Programming (Document CE132/5);

Having examined the proposed program budget of the Pan American Health Organization for the financial period 2004-2005 contained in *Official Document 307* and Add. I;

Noting the efforts of the Director to propose a program budget that takes into account the climate of continuing fiscal difficulty of Member States;

Noting with concern the significant reduction in regular budget resources for 2004-2005 from WHO to the Region, despite an increase in the total WHO budget and in quota assessments of Member States;

Noting that the share of the mandatory post cost increase for 2004-2005 was not incorporated in the WHO allocation to the Region;

Further recognizing that a disproportionate share of the cost of the WHO Retirees' Health Insurance premium is financed with the PAHO share of the program budget;

Bearing in mind Article 14.C of the Constitution of the Pan American Health Organization and Article III, paragraphs 3.5 and 3.6, of the PAHO Financial Regulations,

RESOLVES:

1. To thank the Subcommittee on Planning and Programming for its preliminary review of and report on the proposed program budget.
2. To express appreciation to the Director for the attention given to cost savings and the strengthening of programs in her development of the program budget.
3. To request the Director to discuss with the Director-General of WHO, in advance of the 44th Directing Council, an increase in the Region's share of the total WHO regular budget approved at WHA.56 that would be used to offset the increase in assessments of PAHO Member States required to finance the proposed program budget.
4. To request the Director to incorporate the comments made by the Members of the Executive Committee in the revised *Official Document 307* that will be brought to the consideration of the 44th Directing Council.
5. To recommend to the 44th Directing Council that it adopt a resolution along the following lines:

THE 44th MEETING OF THE DIRECTING COUNCIL,

RESOLVES:

1. To approve the Program of Work for the Secretariat as outlined in the revised Biennial Program Budget, Proposal for 2004-2005, *Official Document 307*.
2. To appropriate for the financial period 2004-2005 an amount of \$296,598,940, as follows:

<u>SECTION</u>	<u>TITLE</u>	<u>AMOUNT</u>
1	EXECUTIVE DIRECTION	9,407,000
2	GOVERNANCE AND PARTNERSHIPS	12,920,000
3	COUNTRY PROGRAM SUPPORT	45,829,800
4	INTERSECTORAL ACTION AND SUSTAINABLE DEVELOPMENT	35,852,400
5	HEALTH INFORMATION AND TECHNOLOGY	38,168,200
6	UNIVERSAL ACCESS TO HEALTH SERVICES	35,082,000
7	DISEASE CONTROL AND RISK MANAGEMENT	33,672,800
8	FAMILY AND COMMUNITY HEALTH	22,223,800
9	ADMINISTRATIVE SUPPORT	28,729,000
	<u>Effective Working Budget for 2004-2005 (Parts 1-9)</u>	<u>261,885,000</u>
10	STAFF ASSESSMENT (Transfer to Tax Equalization Fund)	34,713,940
	<u>TOTAL – ALL SECTIONS</u>	<u>296,598,940</u>

3. That the appropriation shall be financed from:

(a) Assessments in respect to:

Member Governments, Participating Governments, and Associate Members assessed under the scale adopted by the Organization of American States in accordance with Article 60 of the Pan American Sanitary Code or in accordance with Directing Council and Pan American Sanitary Conference resolutions209,868,940

(b) Miscellaneous Income13,500,000

(c) AMRO share approved with Resolution WHA56.3273,230,000

TOTAL 296,598,940

4. In establishing the contributions of Member Governments, Participating Governments, and Associate Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that credits of those which levy taxes on the emoluments received from the Pan American Sanitary Bureau (PASB) by their nationals and residents shall be reduced by the amounts of such tax reimbursements by PASB.

5. That, in accordance with the Financial Regulations of PAHO, amounts not exceeding the appropriations noted under paragraph 1 shall be available for the payment of obligations incurred during the period 1 January 2004 to 31 December 2005, inclusive. Notwithstanding the provision of this paragraph, obligations during the financial period 2004-2005 shall be limited to the effective working budget, i.e., Sections 1-9.

6. That the Director shall be authorized to transfer credits between sections of the effective working budget, provided that such transfer of credits between sections as are made do not exceed 10% of the section from which the credit is transferred, exclusive of the provision made for transfers from the Director's Development Program in Section 3. Except for the provision made for the Director's Development Program in Section 3, transfers of credits between sections of the budget in excess of 10% of the section from which the credit is transferred may be made with the concurrence of the Executive Committee. The Director is authorized to apply amounts not exceeding the provision for the Director's Development Program to those sections of the effective working budget under which the program obligation will be incurred. All transfers of budget credits shall be reported to the Directing Council or the Pan American Sanitary Conference.

(Eighth meeting, 26 June 2003)

CE132.R7: Sustaining Immunizations Programs

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having analyzed the progress report of the Director on sustaining immunization programs (Document CE132/17),

RESOLVES:

To recommend that the 44th Directing Council adopt a resolution along the following lines:

THE 44th DIRECTING COUNCIL,

Having seen the progress report of the Director on sustaining immunization programs (Document CD44/11);

Recognizing the important breakthroughs in the fight against vaccine-preventable diseases to protect the children of the Region made possible through the close partnership of the Member States and the international development community;

Noting with great pride the sustained collective efforts by the Member States in fulfilling the goal of interruption of indigenous measles transmission in the Western Hemisphere;

Considering the remarkable progress and experience gained by the Member States in the accelerated control of rubella and the prevention of congenital rubella syndrome (CRS) initiatives, which seek to achieve a more rapid decrease of rubella cases and infants born with CRS;

Taking note of the spirit of solidarity and Pan Americanism in the implementation of the first *Vaccination Week* in the Americas that targeted immunization services to high-risk and underserved areas;

Concerned with the fluctuations in the allocation of resources in public budgets to these activities at the national level, mainly due to economic downturns; and

Cognizant of the potential negative impacts of certain health sector reform and decentralization processes on the implementation of national immunization programs, including disease surveillance activities,

RESOLVES:

1. To urge Member States to:
 - (a) Encourage the establishment of a specific line item for immunization in their national budgets and the timely allocation of financial resources towards vaccines, supplies, and operational costs;
 - (b) Inform the finance ministers and senior budgetary decision-makers about the benefits of sustaining immunization programs and the risk resulting from pockets of low immunization coverage;
 - (c) Implement health sector reform and decentralization policies and programs in a manner that safeguards the achievements made in immunization;
 - (d) Support the implementation of an annual hemispheric Vaccination Week, to be held in April, targeting high-risk population groups and underserved areas;
 - (e) Maintain the Region free of indigenous measles through high, routine (>95%) measles vaccination coverage by municipality or district, and follow-up measles vaccination campaigns at least every four years, timely surveillance, and outbreak investigation and control;

- (f) Maintain high ($\geq 95\%$) and homogenous vaccination coverage by municipality or district for all antigens;
 - (g) Eliminate rubella and congenital rubella syndrome (CRS) from their countries by the year 2010; to accomplish this, they are requested to draft the respective national plans of action within one year.
2. To request the Director to:
- (a) Elaborate a regional plan of action and mobilize resources in support of a rubella/CRS elimination goal for 2010;
 - (b) Continue advocating for an active mobilization of national and international resources to sustain and expand the investments made in immunization programs by the Member States;
 - (c) Foster joint action by the International Monetary Fund, the World Bank, and the Inter-American Development Bank and Member States, ministries of health and finance, to establish provision within the public budgets that ensure the uninterrupted allocation of funds to national immunizations programs;
 - (d) Promote the annual hemispheric Vaccination Week to improve equity in immunization.

(Eighth meeting, 26 June 2003)

CE132.R8: Report of the Award Committee of the PAHO Award for Administration, 2003

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having examined the report of the Award Committee of the PAHO Award for Administration, 2003 (Document CE132/7, Add. I); and

Bearing in mind the provisions of the procedures and guidelines for conferring the PAHO Award for Administration, as approved by the 18th Pan American Sanitary Conference (1970) and amended by the 24th Pan American Sanitary Conference (1994) and the 124th Session of the Executive Committee (1999),

RESOLVES:

1. To note the decision of the Award Committee to confer the PAHO Award for Administration, 2003, on Mr. Roy J. Romanow for his outstanding contribution to the development of the Canadian Health System, particularly in the creation of the Saskatchewan Human Rights Commission, and in leading the Commission on the Future of Health Care in Canada. Mr. Romanow is internationally regarded as a leading figure in health policy and administration.
2. To transmit the report of the Award Committee of the PAHO Award for Administration, 2003 (Document CE132/7, Add. I) to the 44th Directing Council.

(Eighth meeting, 26 June 2003)

CE132.R9: Nongovernmental Organizations in official relations with PAHO

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having studied the report of the Standing Subcommittee on Nongovernmental Organizations (Document CE132/8, and Add. I); and

Mindful of the provisions of the *Principles Governing Relations between the Pan American Health Organization and Nongovernmental Organizations* (1995, revised 2000),

RESOLVES:

1. To continue official relations between PAHO and the Latin American Union against Sexually Transmitted Diseases (ULACETS) and with the International Organization of Consumers Unions (CI-ROLAC) for one year, with the understanding that progress in addressing concerns raised will be reviewed at the next meeting of the Standing Committee on NGOs in June of 2004.
2. To request the Director to:
 - (a) advise the respective NGOs of the decisions taken by the Executive Committee;
 - (b) prepare an evaluation protocol which would serve as criteria for the Standing Committee on NGOs when called upon to review PAHO's collaboration with NGOs. This protocol will be reviewed by the Standing Committee on NGOs and submitted to the Executive Committee at the next session in September 2003;

- (c) continue developing dynamic working relations with inter-American NGOs of interest to the Organization in areas which fall within the program priorities that the Governing Bodies have adopted for PAHO;
- (d) assess the relevance of the relationship with inter-American NGOs working officially with PAHO, encouraging more participation and collaboration; and
- (e) continue fostering relationships between Member States and NGOs working in the field of health.

(Eighth meeting, 26 June 2003)

***CE132.R10: Provisional Agenda of the 44th Directing Council of PAHO,
55th Session of the Regional Committee of WHO for the Americas***

THE 132nd SESSION OF THE EXECUTIVE COMMITTEE,

Having examined the provisional agenda (Document CD44/1) prepared by the Director for the 44th Directing Council of PAHO, 55th Session of the Regional Committee of WHO for the Americas, presented as Annex to Document CE132/4, Rev. 1 with the additions requested by Member States, in conformity with Rule 8 of the Rules of Procedure of the Council, and

Bearing in mind the provisions of Article 12.C of the Constitution of the Pan American Health Organization and Rule 7 of the Rules of Procedure of the Council,

RESOLVES:

To approve the provisional agenda (Document CD44/1) prepared by the Director for the 44th Directing Council of PAHO, 55th Session of the Regional Committee of WHO for the Americas, with the modifications proposed by the Member States.

(Eight meeting, 26 June 2003)

Decisions

Decision CE132(D1) Adoption of the Agenda

Pursuant to Rule 9 of the Rules of Procedure of the Executive Committee, the Committee adopted, without modification, the agenda submitted by the Director (Document CE132/1, Rev. 1).

(First meeting, 23 June 2003)

Decision CE132(D2) Representation of the Executive Committee at the 44th Directing Council, 55th Session of the Regional Committee of WHO for the Americas

Pursuant to Rule 54 of its Rules of Procedure, the Executive Committee decided to designate its President (Peru) and Vice President (Jamaica) to represent the Committee at the 44th Directing Council, 55th Session of the Regional Committee of WHO for the Americas. As alternates to those representatives, the Committee designated the delegates of Honduras and Paraguay, respectively.

(First meeting, 23 June 2003)

Decision CE132(D3) Report of the Subcommittee on Women, Health, and Development

The Executive Committee endorsed the recommendations submitted by the 20th Session of the Subcommittee on Women, Health, and Development (Document CE132/6, Rev.1), thanking the Rapporteur for her report and expressing its gratitude to the Subcommittee for its work.

(First meeting, 23 June 2003)

IN WITNESS WHEREOF, the President of the Executive Committee and the Secretary ex officio, Director of the Pan American Sanitary Bureau, sign the present Final Report in the English and Spanish languages, both texts being equally authentic.

DONE in Washington, D.C., United States of America, on this twenty-sixth day of June in the year two thousand three. The Secretary shall deposit the original texts in the archives of the Pan American Sanitary Bureau and shall send copies thereof to the Member States of the Organization.

Fernando Carbone Campoverde
President of the 132nd Session
of the Executive Committee
Delegate of Peru

Mirta Roses Periago
Secretary ex officio of the 132nd Session
of the Executive Committee
Director of the Pan American Sanitary
Bureau

AGENDA

1. OPENING OF THE SESSION

2. PROCEDURAL MATTERS

- 2.1 Adoption of the Agenda and Program of Meetings
- 2.2 Representation of the Executive Committee at the 44th Directing Council of PAHO, 55th Session of the Regional Committee of WHO for the Americas
- 2.3 Provisional Agenda of the 44th Directing Council of PAHO, 55th Session of the Regional Committee of WHO for the Americas

3. COMMITTEE MATTERS

- 3.1 Report on the 37th Session of the Subcommittee on Planning and Programming
- 3.2 Report on the 20th Session of the Subcommittee on Women, Health, and Development
- 3.3 PAHO Award for Administration, 2003
- 3.4 Nongovernmental Organizations in Official Relations with PAHO
 - Periodic Review of Nongovernmental Organization in Official Relations with PAHO
 - Consideration of Applications

4. PROGRAM POLICY MATTERS

- 4.1 Managerial Strategy for the Work of the Pan American Sanitary Bureau in the Period 2003-2007
- 4.2 Proposed Program Budget of the Pan American Health Organization for the Financial Period 2004-2005

4. PROGRAM POLICY MATTERS *(cont.)*

- 4.3 Results Attained in the Strategic and Programmatic Orientations during the Period 1999-2002
- 4.4 Report on the 13th Inter-American Meeting, at the Ministerial Level, on Health and Agriculture
- 4.5 Primary Health Care in the Americas: Lessons Learned over 25 Years and Future Challenges
- 4.6 Family and Health
- 4.7 Globalization and Health
- 4.8 Ethnicity and Health
- 4.9 Sustaining Immunization Programs
- 4.10 Contribution of Integrated Management of Childhood Illnesses (IMCI) to the Attainment of the Millennium Development Goals
- 4.11 Monitoring the Reduction of Maternal Morbidity and Mortality
- 4.12 Influenza Pandemic: Preparation in the Western Hemisphere
- 4.13 Diet, Nutrition, and Physical Activity
- 4.14 Impact of Violence on the Health of the Populations in the Americas

5. ADMINISTRATIVE AND FINANCIAL MATTERS

- 5.1 Report on the Collection of Quota Contributions
- 5.2 Interim Financial Report of the Director for 2002
- 5.3 Review of the Authorized Level of the Working Capital Fund
- 5.4 PAHO Buildings and Facilities

6. PERSONNEL MATTERS

6.1 Amendments to the PASB Staff Rules

6.2 Statement by the Representative of the PASB Staff Association

7. GENERAL INFORMATION MATTERS

7.1 Resolutions and Other Actions of the Fifty-sixth World Health Assembly of Interest to the PAHO Executive Committee

8. OTHER MATTERS

LIST OF DOCUMENTS

Official Documents

- Off. Doc. 307 Proposed Program Budget of the Pan American Health Organization for the Financial Period 2004-2005
- Off. Doc. 311 Interim Financial Report of the Director for 2002

Working Documents

- CE132/1, Rev. 2 and
CE132/WP/1, Rev. 1 Adoption of the Agenda and Program of Meetings
- CE132/3 Representation of the Executive Committee at the 44th Directing Council of PAHO, 55th Session of the Regional Committee of WHO for the Americas
- CE132/4 Provisional Agenda of the 44th Directing Council of PAHO, 55th Session of the Regional Committee of WHO for the Americas
- CE132/5 Report on the 37th Session of the Subcommittee on Planning and Programming
- CE132/6, Rev. 1 Report on the 20th Session of the Subcommittee on Women, Health, and Development
- CE132/7 and Add. I PAHO Award for Administration, 2003
- CE132/8 and Add. I Nongovernmental Organizations in Official Relations with PAHO
- Periodic Review of Nongovernmental Organization in Official Relations with PAHO
 - Consideration of Applications
- CE132/9 Managerial Strategy for the Work of the Pan American Sanitary Bureau in the Period 2003-2007

Working Documents (cont.)

CE132/10	Resolutions and Other Actions of the Fifty-sixth World Health Assembly of Interest to the PAHO Executive Committee
CE132/11	Results Attained in the Strategic and Programmatic Orientations during the Period 1999-2002
CE132/12, Rev. 1	Report on the 13th Inter-American Meeting, at the Ministerial Level, on Health and Agriculture
CE132/13	Primary Health Care in the Americas: Lessons Learned over 25 Years and Future Challenges
CE132/14	Family and Health
CE132/15 and Corrig.	Globalization and Health
CE132/16	Ethnicity and Health
CE132/17	Sustaining Immunization Programs
CE132/18	Contribution of Integrated Management of Childhood Illnesses (IMCI) to the Attainment of the Millennium Development Goals
CE132/19	Monitoring the Reduction of Maternal Morbidity and Mortality
CE132/20	Influenza Pandemic: Preparation in the Western Hemisphere
CE132/21, Rev. 1	Diet, Nutrition, and Physical Activity
CE132/22 and Corrig.	Impact of Violence on the Health of the Populations in the Americas
CE132/23 and Add. I	Report on the Collection of Quota Contributions
CE132/24	Review of the Authorized Level of the Working Capital Fund

Working Documents (cont.)

CE132/25	PAHO Buildings and Facilities
CE132/26, Rev. 1	Amendments to the PASB Staff Rules
CE132/27	Statement by the Representative of the PASB Staff Association

Information Documents

CE132/INF/1	Statistics on PASB/WHO Personnel
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