



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 134th SESSION OF THE EXECUTIVE COMMITTEE

*Washington, D.C., USA, 21-25 June 2004*

---

*Provisional Agenda Item 3.1*

CE134/5 (Eng.)

7 May 2004

ORIGINAL: ENGLISH

### **REPORT ON THE 38th SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING**

1. The Subcommittee on Planning and Programming held its 38th Session at the Organization's Headquarters in Washington, D.C., from 24 to 26 March 2004.
2. The Session was attended by delegates of the following Subcommittee Members elected by the Executive Committee or designated by the Director: Argentina, Barbados, Brazil, Canada, Guatemala, Honduras, Peru, and United States of America. Also present were observers from Mexico.
3. Elected as officers were the delegates of Barbados (President), Argentina (Vice President), and Brazil (Rapporteur).
4. During the Session, the Subcommittee discussed the following agenda items:
  - Millennium Development Goals and Health Targets,
  - Observatory of Human Resources in Health,
  - Access to Medicines,
  - Scaling Up Health Systems for an Integrated Response to HIV/AIDS,
  - International Health Regulations: Perspectives from the Region of the Americas,
  - Ten-year Evaluation of the Regional Core Data in Health Initiative,
  - Progress Report of the Working Group on Regional Budget Policy,

- Strategy for Increasing the Rate of Collection of Quota Assessments, and
  - WHO's 11th General Program of Work.
5. Under 'Other Matters' the following topics were also discussed: the Report of the Working Group on PAHO in the 21st Century; Update by the Secretariat on Recent Events and Other Matters of Interest to the Subcommittee—the Hemispheric Conference on the Eradication of Foot-and-Mouth Disease, the status of the three PAHO Centers, and the status of the Framework Convention on Tobacco Control; and Other Matters Raised by Member States.
6. The final report of the Session is attached.

Annex



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



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

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

---

CE134/5 (Eng.)  
Annex

SPP38/FR (Eng.)  
26 March 2004  
ORIGINAL: ENGLISH

**FINAL REPORT**

## CONTENTS

	<i>Page</i>
<b>Officers</b> .....	3
<b>Opening of the Session</b> .....	3
<b>Adoption of the Agenda and Program of Meetings</b> .....	4
<b>Presentation and Discussion of the Items</b> .....	4
Millennium Development Goals and Health Targets .....	4
Observatory of Human Resources in Health .....	12
Access to Medicines .....	18
Scaling Up Health Systems for an Integrated Response to HIV/AIDS .....	23
International Health Regulations: Perspectives from the Region of the Americas .....	30
Ten-year Evaluation of the Regional Core Data in Health Initiative .....	36
Progress Report of the Working Group on Regional Budget Policy .....	41
Strategy for Increasing the Rate of Collection of Quota Assessments .....	46
WHO's 11th General Program of Work .....	47
<b>Other Matters</b> .....	51
Report of the Working Group on PAHO in the 21st Century.....	51
Update by the Secretariat on Recent Events and Other Matters of Interest to the Subcommittee .....	53
Other matters raised by Member States .....	56
<b>Closing of the Session</b> .....	57
 Annex A: Agenda	
Annex B: List of Documents	
Annex C: List of Participants	

## FINAL REPORT

1. The 38th Session of the Subcommittee on Planning and Programming (SPP) of the Executive Committee of the Pan American Health Organization (PAHO) was held at the Organization's Headquarters in Washington, D.C., from 24 to 26 March 2004.

2. The meeting was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Argentina, Barbados, Brazil, Canada, Guatemala, Honduras, Peru, and United States of America. Representatives of Mexico also attended in an observer capacity.

### Officers

3. The following Member States were elected to serve as officers of the Subcommittee for the 38th Session:

<i>President:</i>	Barbados	(Hon. Jerome X. Walcott)
<i>Vice President:</i>	Argentina	(Dr. Carlos Vizzotti)
<i>Rapporteur:</i>	Brazil	(Dr. Jorge Antonio Zepeda Bermudez)

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

### Opening of the Session

5. The Director opened the session and welcomed the participants, extending a special welcome to the observers. As Members were aware, the SPP was the body concerned with matters of planning and programming, and as such it provided invaluable guidance on the activities of the Organization. The atmosphere of the Subcommittee's sessions was characterized by seriousness of purpose but also by slightly less formality than sessions of the Governing Bodies. It thus provided an ideal forum for friendly and productive dialogue between Member States and the Secretariat on fundamental aspects of the Organization's work. She was certain that discussions during the 38th Session would prove just as rich and fruitful as had those of previous Subcommittee sessions.

6. During the session, in addition to considering the matters on the Subcommittee's formal agenda, Member States would have the opportunity to hear updates on several current and future activities, including preparations for the second Annual Vaccination Week in the Americas and the observance of World Health Day. In addition, there would be a briefing on the situation in Haiti and PAHO's efforts to assist the country. The Subcommittee would also be hearing a progress report from the Working Group on PAHO in the 21st Century.

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

**Adoption of the Agenda and Program of Meetings (Documents SPP 38/1, Rev. 1, and SPP 38/WP/1, Rev. 1)**

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

**Presentation and Discussion of the Items**

***Millennium Development Goals and Health Targets (Documents SPP38/4 and SPP38/4, Corrig.)***

9. Dr. Ilona Kickbusch (Senior Advisor for Millennium Development Goals and Health Targets, PAHO) outlined the principal components of PAHO's strategy for strengthening commitment to and supporting the achievement of the Millennium Development Goals (MDGs) in the countries of the Americas. She began by pointing out that the approach to the MDGs described in the document reflected a new form of technical cooperation and a new way of working between programs within the Organization. She also noted that the document did not contain many examples from countries of the Region. A survey of progress with respect to the MDGs was under way, and more country-specific information would be included in the paper to be presented to the Executive Committee.

10. It was important to bear in mind that the MDGs were part of the Millennium Development Compact between developed and developing countries, through which the international community had committed to work together to help all countries achieve the goals. That was one of the innovations of the MDGs: they were not goals of one specific sector, they were goals of the international community as a whole and of governments as a whole. While many of the goals had been long-standing concerns of the health sector,

the adoption of the Millennium Declaration had made them concerns for all sectors of government and for nongovernmental organizations (NGOs) and the private sector, as well. The MDGs had thus brought investment in people's health to the center of the global development agenda.

11. Nevertheless, a high-level forum convened recently by the World Health Organization (WHO) and the World Bank had found that progress thus far on the health-related MDGs had been too slow, particularly in low-income countries. Accordingly, the Director of PASB had decided that the work of the Organization in relation to the MDGs should focus in particular on meeting the goals in the five priority countries identified in the Strategic Plan for the Pan American Sanitary Bureau for 2003–2007 (Bolivia, Guyana, Haiti, Honduras, and Nicaragua). Because it was felt that the MDGs were not as well known in Region as they should be, several important events had been organized to raise the visibility of the goals and increase commitment to them among a wide range of sectors and stakeholders.

12. One such event was a conference held in Brasilia, Brazil, in November 2003, which had brought together political leaders and representatives of regional organizations. The Brasilia Declaration, adopted at that gathering, had underscored the importance of achieving political consensus around the implementation of the MDGs in the Americas. The Declaration provided good guidance on what different parts of society should contribute in order to move forward towards attaining the goals. A crucial aspect of the Declaration was the call to parliamentarians and also to the private sector to support the MDGs.

13. PAHO viewed the MDGs as an indivisible package, within which the individual goals and targets could be looked at in terms of health determinants, including classic social determinants, such as poverty, gender discrimination, and education; environmental determinants, such as water and sanitation; and new global determinants, such as trade-related issues and debt relief. Such a view made it possible to see the synergy between development and health and between the non-health targets and the health targets as a contribution to development, poverty reduction, and enhanced quality of life. The focus on the unfinished health agenda as expressed in the health MDGs also helped highlight equity issues, both between and within countries.

14. Four basic principles guided PAHO's approach to support for the countries in achieving the MDGs: (1) country ownership, (2) accountable governance and targeted development, (3) costing for investment to reach the poorest population groups, and (4) policy, not charity. The Organization's strategic goals to support the countries were to increase awareness of and investment in health priorities; intensify action on national health development to support progress on the MDGs; integrate the work on MDGs with the initiatives on health goals and targets and outcome-oriented health policies in the

Americas; increase health literacy and empowerment of communities; improve measurement of progress through high-quality disaggregated health data at regional, subregional, and country levels; initiate research to strengthen the evidence base and generate new knowledge; integrate the strategic dimensions of the work on MDGs with other strategic efforts; and engage and increase cooperation with other partners—particularly at country level—to obtain results.

15. A key aspect of PAHO's approach was to mainstream the work on the MDGs into all its current activities, rather than making the goals the focus of separate initiatives or programs. As part of that effort, the Organization had begun conversations with the World Bank and the Inter-American Development Bank with a view to reflecting a greater commitment to the MDGs in the Shared Agenda for Health in the Americas, and it was also seeking to integrate the MDGs into its collaboration with other partners at country level. Finally, an aspect of the MDGs that was considered especially important was their strong linkage with the development of democracy, particularly through the participation of communities in their own health and through promotion of debate in society as to human rights, equity, and access to the most basic services that people, particularly the most vulnerable populations, should have in relation to their health.

16. The Subcommittee applauded PAHO's commitment to helping all countries of the Region achieve the goals and targets set out in the Millennium Declaration and voiced general support for the technical cooperation approaches and activities outlined in the document. Particular support was expressed for PAHO's efforts to integrate its MDG-related work into existing programs and activities and its emphasis on addressing country-specific contexts and promoting country ownership of both the work undertaken to attain the goals and the gains made as a result of that work.

17. Delegates underscored the need to focus on what was required at country level to translate the MDGs into concrete action, and several delegates described measures already being taken in their respective countries with a view to achieving the goals. Political will and parliamentary support were seen as crucial; however, it was pointed out that political support on the part of a single government administration would not be sufficient, since meeting the goals would require a sustained commitment over time. The Delegate of Guatemala observed that some sort of "political armor" was needed to protect work related to the MDGs and ensure that it would continue uninterrupted, despite changes in political leadership. Another delegate noted that, in many cases, the countries that could most benefit from the actions included under the MDGs were the countries that had not yet fully incorporated the goals as an integral part of their national policies or accorded them the priority that they deserved. That was partly because the MDGs were still being seen as a distinct, separate initiative, not as a general policy framework that could encompass many initiatives. More work was therefore needed to show the close

relationship between the MDGs and various other global and regional health and development initiatives, including, in particular, the Action Plan of the Summit of the Americas. In addition, there was a need to convert the MDGs into national, subnational and local plans, with disaggregated goals and means of monitoring to show where actions needed to be strengthened in order to ensure that work on the goals was serving to reduce inequities and inequalities.

18. Resource allocation and mobilization were also seen as critical to countries' success in attaining the MDGs. In that connection, the Delegate of Honduras pointed out that countries needed help, first, in calculating how much would need to be invested over the next 10 to 15 years in order for governments to be able to plan for both their own budgeting and their requests for external cooperation. The Delegate of Peru drew attention to the problem of countries like his, which had recently been classified as a middle-income country and had consequently seen its ability to obtain resources from international development and lending agencies seriously curtailed. At the same time, however, it lacked sufficient resources of its own to finance the incremental costs of achieving the MDGs. That situation, which was by no means unique to Peru, should be borne in mind in the discussions with donors mentioned in paragraph 35 of the document.

19. It was suggested that another way in which PAHO could support countries was by assisting them in programming their existing aid more efficiently and effectively and in harmonizing and integrating the efforts of all international cooperation partners. In that regard, one delegate pointed out that the various cooperation agencies all had their own methodologies and their own ways of measuring results, which did not necessarily coincide with those of the country, and emphasized that, in order to ensure country ownership, the focus must be on working towards the common purpose of helping countries to achieve the MDGs. Another delegate stressed the need for interministerial integration and called on PAHO to assist countries in facilitating partnerships and joint effort between the various ministries that had to be involved in achieving the MDGs. Country-to-country cooperation was also seen as a key strategy for mobilizing the necessary technical and financial resources, and PAHO was encouraged to help countries forge such bilateral partnerships.

20. On the topic of resources, the Delegate of Canada recalled that several years earlier Canada had suggested that all working documents prepared for the Governing Bodies should contain information on the costs associated with the activities in question and on the amount of the PAHO budget being devoted to them. Such information would give Member States a better understanding of the budgeting and financial realities of the Organization. Canada would therefore encourage the Secretariat to include in all future working documents information on budget and resources, including both financial and human resources. His delegation also recommended that all documents include

information on the expected impact of the Organization's activities on vulnerable populations, in particular children, women, older adults, and indigenous groups.

21. While the Subcommittee found that the proposals put forward in paragraph 38 of the document constituted a good starting point for PAHO's work in relation to the MDGs, several concerns were raised and a number of suggestions were made for enhancing both the Organization's approach to the goals and the next iteration of the document. Some delegates also submitted additional comments and suggestions in writing.

22. The Delegate of the United States said that her delegation found the view of globalization presented in the document—in particular the premise that it was the root cause of poverty and inequity—biased and overly generalized. The United States felt that PAHO lacked the competency and mandate to undertake, as proposed, systematic analysis of the impact on health of larger contextual and policy determinants such as trade agreements, immigration policies, and economic policies. She stressed that PAHO should focus on its technical mandate, including working with countries to build the necessary capacity to use data more effectively for national policy development and to monitor and evaluate progress towards attainment of the goals.

23. With respect to paragraph 14, it was pointed out that the term “public good” was not clearly defined, nor was it clear how access to such goods could be guaranteed without charge. Moreover, there did not appear to be any justification for the reorientation in policy and strategy proposed in that paragraph. It was felt that several other terms used in the document also needed to be elucidated, as they lent themselves to multiple interpretations. Examples included “multidimensional governance” and “new poverty.” In addition, the document needed to distinguish between the Millennium Development Goals and the goals and targets agreed to by Member States in the Millennium Declaration adopted in 2000. The term “Millennium Development Goals” referred to the goals formulated subsequently by the United Nations, the World Bank, the International Monetary Fund, and other organizations, and while there was a great deal of overlap between the Millennium Declaration and the MDGs, the latter had not necessarily been formally agreed to by Member States.

24. Concerning paragraph 23, which called on countries to reinforce their commitment to the principle that citizens should not be excluded from access to health services, independently of their ability to pay, it was suggested that the last part of that sentence should be expanded to read “independently of their age, ethnicity, sex, income, or place of residence.” In relation to paragraph 25, which pointed out that gender discrimination was a classic social determinant of health, PAHO was encouraged to emphasize the importance of sexual and reproductive health in the attainment of a number of the MDG targets, including maternal health, reduced child mortality,

combating of HIV/AIDS, and eradication of extreme poverty and hunger. The Organization was also encouraged to weave the ideas on the integrative approach described in paragraphs 32–34 throughout the document, as the integration of the goals and targets into existing programs was central to the new approach that PAHO was proposing. In addition, it was suggested that the document should more clearly identify the approaches that PAHO would use to assist countries in adapting the broadly defined goals and targets to country-specific contexts.

25. Regarding paragraph 37, the Secretariat was asked to elaborate on whether the efforts to align PAHO's programming with the MDGs would mean a restructuring of the Bureau and on how the five priority countries would be directly assisted in meeting the goals through PAHO's efforts. It was felt that the "Next Steps" section at the end of the document should be further developed, with more detail and proposed dates for reporting on the work of the MDG team. Regarding the proposal for the creation of a high-level intellectual forum/policy advisory group, it was suggested that the work of that group should be aligned with the recommendations of the High-Level Forum on the Health MDGs, convened in Geneva in January 2004.

26. Finally, the Subcommittee emphasized the need for ongoing monitoring to track progress towards the MDGs. It was hoped that existing routine data collection systems would be used for that purpose. Delegates welcomed PAHO's collaboration in the Health Metrics Network and affirmed their support for a system of regular progress reporting by regions and countries.

27. Dr. Kickbusch thanked the Subcommittee for its very helpful comments, which would be taken into account in revising the document. In particular, the Secretariat would endeavor to clarify some of the concepts and terminology highlighted by delegates. It would also clarify the relationship between the MDGs and the Millennium Declaration and explain how the MDGs had evolved since the Millennium Summit in 2000, and it would also try to show the relationship between the MDGs and other regional and global commitments. She noted that several developments had occurred since the first version of the document was produced. For example, the MDG strategy team had been set up within PAHO, and the process of mainstreaming the MDGs throughout the various programs and areas of work had begun in earnest. The next version of the paper would contain more information on recent developments, both within the Secretariat and in Member States. In addition, the Secretariat would establish an Intranet to keep PAHO staff at Headquarters and in the countries informed of what was happening. That Intranet might also eventually be used as a reporting instrument for keeping Member States apprised of activities under way and of progress towards the goals.

28. One of PAHO's key concerns was determining what toolbox it could offer to help countries with the "how" of achieving the MDGs. To that end, the MDG team was in close contact with colleagues at the United Nations Development Program (UNDP), who were also working on such a toolbox. One of the team's first goals was to develop a toolbox in collaboration with the healthy municipalities network for use at the local level. The team was also looking at the "how" of partnership-building. Conversations with staff in the PAHO/WHO country offices had indicated that the MDGs were obliging them to work with new partners, but that they needed support to develop the necessary skills, and the Secretariat was exploring how best to take advantage of that opportunity.

29. She wished to highlight three points in particular which had been raised during the discussion. First, regarding the high-level forum in Geneva, the regions had not been invited to participate, nor had they been consulted as to who from each region should be represented at the forum. Consequently, the Region of the Americas had not been represented sufficiently or at a high enough level. The Secretariat had discussed the matter with colleagues at WHO and the World Bank and was trying to resolve the issue of regional participation, particularly in light of the proposal to hold regional fora. She assured the Subcommittee that the MDG team was looking at how PAHO could best contribute to the recommendations that had come out of the high-level forum.

30. Second, in relation to the interministerial linkages that had been mentioned, the Secretariat had begun discussions with the Organization of American States (OAS) as to how health and education ministries might work together, especially towards the health literacy goal, and what brokering role PAHO might play in facilitating that collaboration. PAHO saw the link between health and education as crucial to the MDG process because increased health literacy would contribute to the attainment of virtually all the health goals. Third, the Secretariat was working on a communications strategy in relation to the MDGs. As a first step, it was looking into documenting some of the experiences under way in a special issue of the Organization's magazine *Perspectives in Health*. In addition, the Secretariat hoped to utilize the following year's World Health Day, the theme of which would be maternal and child health, as a communications vehicle for the MDGs.

31. In conclusion, she emphasized that the Secretariat's aim was to develop a matrix approach to the MDGs that would fulfill one of the Director's chief objectives: to ensure that PAHO worked in a more integrated manner. The goals were not viewed as an "add-on" but as something that would help strengthen work already under way in various areas and programs. Hence, there were no plans to undertake any major restructuring or reorganization.

32. The Director said that for PAHO, and for her personally, there was a sense of urgency surrounding the MDGs, given that almost one third of the period for their

attainment had already elapsed but the necessary action to ensure that the goals could be realized had not yet been taken. For that reason, PAHO viewed the MDGs as a call to action, and its approach was infused with that sense of urgency. The Organization understood that if it was to demonstrate leadership where the MDGs were concerned, they could not be treated as a separate project for which resources had to be mobilized over a period of time. Rather, it was essential to reorganize and adapt existing resources in order to achieve the goals by the target date.

33. Unfortunately, from the start there had been a perception that the MDGs were not applicable to the Region of the Americas, as the majority of the countries had already achieved or were close to achieving the goals. However, the Americas were known to be the most inequitable region in the world, and the fundamental value enshrined in the MDGs was equity. Through the Core Data in Health Initiative, PAHO had 10 years of experience in assessing basic indicators and measuring the inequities, and the evidence accumulated during that period demonstrated that the Region faced two main challenges in relation to the MDGs: (1) some countries in the Region—in particular the five priority countries—were in a truly disadvantaged situation vis-à-vis other countries in the Region and needed the assistance of their sister countries in order to achieve the levels of health and development envisaged in the MDGs; and (2) internally, all countries in the Americas had inequities, and several of them ranked among the most inequitable countries in the world. For the heavily indebted poor countries and the other priority countries in the Region, PAHO believed that the international community had a critical responsibility to provide support and show solidarity. But for the other countries, there was a critical national responsibility to reallocate resources and formulate more equitable policies within countries. Hence, the Region did have a great deal of work to do with respect to the MDGs.

34. Dispelling the notion that the MDGs did not apply to, or were not a concern for, the Americas had thus been the first step for PAHO. Then, the Organization had had to decide how to approach its work with regard to the goals. As Dr. Kickbusch had said, PAHO did not view the MDGs as a new initiative or project that would necessitate any restructuring or reorganization, except in a functional sense. Like Health for All, they were an integrating mandate and a lens through which the Secretariat should look at everything it did, the ultimate aim being to ensure that by the year 2015 the Americas were no longer the most inequitable region in the world.

35. Strengthening existing networks—of municipalities, of religious institutions, of women, of youth, of health-promoting schools, and others—and persuading them also to embrace the MDGs was an important component of the Organization's work, as was integrating initiatives already under way, such as the maternal mortality initiative, into the whole MDG effort. Similarly, the Organization's work in the area of indicators needed to

be revised with a view to accelerating the identification of population groups, geographic areas, and sectors in the countries that were truly in need or were truly lagging behind with regard to the various concepts reflected in the MDGs.

36. For PAHO, a real success in the coming year would be to put a human face on the MDGs by identifying, for example, the persons and the communities for whom the goals remained just an unimaginable dream and for whom it was inconceivable that the living conditions envisaged in the goals were something to which they were entitled as a human right. That was the Organization's real objective with regard to the MDGs: to make visible those who were living in such situations and to make the goals a motor for bringing about change in their communities.

***Observatory of Human Resources in Health (Document SPP38/5)***

37. Dr. Charles Godue (Unit Chief, Human Resources Development, PAHO) updated the Subcommittee on the progress of the Observatory of Human Resources initiative, which had been launched in 1999 and endorsed by the Directing Council in 2001, through Resolution CD43.R6, which urged Member States to "actively participate in the Observatory of Human Resources initiative, facilitating the creation of intersectoral and interinstitutional groups in each country to analyze the situation, generate essential information, and formulate proposals on human resources policy, regulation, and management." He recalled that PAHO had taken on an important leadership role in the area of human resources in the Region during the sectoral reforms of the 1990s. Notably, in 1997 it had organized a regional meeting in Costa Rica on the topic "Human Resources: A Critical Factor of Health Sector Reform." Before that time, there had been almost no discussion of the topic of human resources in the reform processes, other than from the purely utilitarian point of view of how human resources could be matched to the aims and objectives of health systems.

38. The issue of human resources in the Region was a dynamic and evolving one. There were new, emerging problems, but there were also old problems associated with 30 years of imbalance in the health workforce. That imbalance was partly a matter of geography, with very uneven distribution of health personnel as compared to the distribution of overall populations, and partly a matter of the skill mix, notably in the preponderance of physicians relative to other health care professionals. There were also gender-related and rights-related problems within health services.

39. Those problems had taken on new dimensions in the course of the processes of reform and decentralization, with their implications for the capacity of central government to define policies and regulations for human resources management. Globalization had brought new challenges or intensified old ones, including problems

relating to migration of health personnel and harmonization of qualifications in integration processes. Some of the problems had the potential to become structural obstacles to the fulfillment of health policies and the development of health systems oriented towards equity, efficiency, and universal access.

40. Fundamentally, the Observatory was a conceptual and methodological framework directed toward formulation of human resources policies in support of health sector policies. It was founded on three main principles. First, the initiative was country-based; second, it brought together all relevant actors to work together in making decisions and developing policies in the human resources arena; and, third, it sought to enhance the availability of information and to increase access to and use of the available evidence to support the formulation of policies in the sector.

41. A total of 21 countries were currently involved in the initiative, some of them having several observatories. The dynamics, the entry points, the priorities, and the lines of work varied from country to country, but all had in common that the purpose of the Observatory was to provide a forum for interinstitutional and intersectoral discussion for the formulation of policies in the areas of planning, regulation, and education and training as they related to human resources in health.

42. Participants in the Observatory initiative included ministries of health, academic institutions, and labor and professional organizations, and there was also very active participation by the PAHO/WHO country offices. Their contribution of the latter included the financing of workshops and seminars, creation of information banks, development of observatory websites, and financing of research, case studies, and publication. Centrally, PAHO participated by providing technical assistance for the development of observatories. The initiative also received significant funding from the Norwegian Agency for Development Cooperation (NORAD), whose contribution was much appreciated.

43. There were four main aspects to the future development of the initiative. First was a renewed commitment by the Governments of the Region to the priority issue of human resources development and particularly to the Observatory initiative. Second was a focus on the five priority countries, where there was the double challenge of responding immediately to urgent human resource problems, while at the same time working to put in place the necessary mechanisms and institutional bases to develop a medium-term approach to human resources development. Third was intensification of work in the area of training for human resources professionals, an area in which there were currently very few training programs in the Region. Finally, the fourth was the major challenge of strengthening the capacity for operations research in the area of human resources, in line with countries' concerns or priorities.

44. PAHO was convinced that the issue of human resources in the current decade was of central strategic importance for the achievement of health objectives and the creation of health policies oriented towards universal access, equity, a focus on primary health care, and the capacity to match the changes in populations' demographic, epidemiological, and social profiles. If the necessary priority was not given to the issue, it had the potential to turn into a bottleneck hampering the achievement of wider objectives, such as the health-related MDGs and the WHO target of "3 by 5" (provision of antiretroviral treatment to 3 million persons living with HIV/AIDS in developing countries by the end of 2005). It was therefore essential to examine how the problems in human resources and the imbalances in the distribution and skill mix of the health workforce could be resolved in order to meet those ambitious goals.

45. The topic of human resources was a very complex one, and one which inevitably implied taking a medium-term view, as there were no immediate solutions. What was needed was a fundamental commitment by the various actors and strong leadership from the ministries of health, coupled with sustained investment over time in capacity-building in the areas of human resources planning, regulation, management, and education.

46. The Subcommittee welcomed the help that the Observatory initiative could give countries in their development of human resource policies. Several delegates gave information on the human resources situation in their countries and the efforts that were being made to recruit additional health professionals, including initiatives in training and education. The Delegate of Barbados, noting with regret that his country was not yet involved in the Observatory, reported that it was now working on a human resources development plan and hoped to join the initiative soon. He urged PAHO to accelerate its program for the involvement of countries in the Caribbean Community (CARICOM) and Caribbean Forum (CARIFORUM) areas, at the same time calling on Caribbean countries to participate actively.

47. It was pointed out that the causes of the health human resource shortages confronting many countries were complex, had their roots in history, and were largely not confined by borders. Meeting the growing and changing demand for health care services with a workforce of qualified, healthy, and motivated care providers was a daunting task. All countries were having difficulty in recruiting and retaining health professionals at all levels, at a time when health systems were growing increasingly complex and national and international environments were converging in terms of priorities and challenges, which called for a range of different skill sets.

48. Delegates' recommendations for the future work of the Observatory included: that it should focus on development of valid and reliable core data sets that would allow comparisons across jurisdictions and across countries; that it should be not simply an

academic research structure but a responsive, current, and relevant resource for policy- and decision-makers; that it should integrate its work with the work under way in parallel structures, including WHO and the Organization for Economic Cooperation and Development (OECD), in order to avoid duplication of effort; that it should continue to position health human resources not just as “important to the health system” but as the very foundation of the system; that it needed to address changing population demographics, including migration both into and out of the countries of the Region; and that PAHO could offer a valuable and forward-looking service by hosting regular health policy fora that brought together its Member States to discuss issues of interest to the hemisphere such as migration and accreditation of health professionals.

49. It was suggested that human resources priorities should include forecasting countries’ needs in terms both of numbers and of workforce composition at all levels, including not just physicians, but also nurses, dentists, pharmacists, and other health professionals. It was also considered important to identify both the medical and the non-medical skills needed and to develop curricula and design learning delivery systems to ensure that those skills would be available. Additionally, personnel had to be given incentives to provide quality care, and they had to possess the management and leadership skills necessary to ensure that such care was provided.

50. With regard to the document, while it was recognized that expanded mobility of health human resources throughout the Region and the world was creating new challenges, it was regretted that the document made no mention of the positive aspects of globalization, such as increased opportunities for technical cooperation, technology as a window to increased knowledge at all levels of society, and improved educational opportunities, including exchanges and distance learning. It was felt, too, that the Observatory initiative, as described in the document, did not have a defined evaluation strategy. Such initiatives were more accountable if measurable objectives were included so that progress could be tracked and weaknesses identified and addressed early. In addition, it was suggested that information on the PAHO human and financial resources that had been invested in the initiative, relative to the outcomes achieved, should be incorporated into the document.

51. It was pointed out that there was a growing understanding that a wide range of sectors, going well beyond the traditional health sector, had a role to play in health matters. Health was also impacted by communications, ethics, the education system, and other fields. The education sector, in particular, had a crucial role that would largely determine the quantity and quality of human resources in public health.

52. Dr. Godue thanked the participants for their very useful and stimulating comments. He concurred on the need for a solid core data set, observing that ideally such

data should allow comparisons between countries. That would be highly beneficial, but there were major challenges in implementing such a system. He also agreed both that participation by educational institutions was important and simultaneously that the Observatory must not become a purely academic ivory tower. On the contrary, it had to be a mechanism to support decision-making and policy development. To that end, working with other organizations was of paramount importance. The Observatory had a close relationship with the human resources departments at WHO and with the International Labor Organization.

53. With regard to the advantages of globalization for information-sharing and education, he noted that PAHO was thinking of an array of training modalities including on-line virtual courses. The intention was to generate a community of ideas, one where best practices could be shared. In relation to the remarks about needs forecasting, he said that one of the aims of the Observatory initiative was to involve educational institutions in the actual processes of human resources planning for the future, in terms both of skills and of demographics. Recalling that he had described the Observatory initiative as country-based, he emphasized that it was for each country to decide its own particular priorities with regard to human resources. It was interesting to see the different triggers for the agenda of the Observatory in the different countries. It might be a conflict with a labor union, or a staffing problem in a hospital, or any one of a number of occurrences that generated a whole discussion of wider issues.

54. He welcomed the impending participation of Barbados in the Observatory, and thanked the delegate for the interesting suggestion regarding CARICOM and CARIFORUM. Noting that shortage of nurses was a particular problem in the Caribbean, he pointed out that the current initiative with regard to migration of nurses in that subregion was also a source of learning about migration and about what kind of policies might address the issue, not necessarily with the aim of impeding the mobility of nurses but perhaps leading to policy alternatives such as an agreement on compensation between the destination country and the country that had paid for the education and training of the nurses.

55. The Director wished to stress three principal points in relation to the topic of human resources. The first was the important issue of workforce migration and its relationship to trade agreements and to the relaxation of many requirements that in the past had constrained the movement of human resources between countries. That loosening of the restrictions did not always necessarily go hand-in-hand with protection of the interests of the population, particularly in the case of human resources in health. She drew attention to various interesting approaches to the question in the international sphere. For example, the Commonwealth had a code of ethical behavior (to which PAHO

had contributed) that had to be followed when a country hired medical personnel from a different country.

56. Clearly, health could not be approached simply from the standpoint of market rules. Policies were needed to guarantee the protection of the population's health, especially in countries that were "exporters" of health professionals. In the Region there were cases in which new health facilities, such as maternity clinics, were built or upgraded but then no personnel could be found to staff them because they had all emigrated to other countries offering better working conditions and remuneration. Some countries did not plan in advance for the profiles of health personnel that they would need, and when they found they had a shortage they simply took the shortcut of offering higher remuneration. Here, there was clearly a need for policies which went beyond national frontiers. In that connection, the coming months would see an international conference on two interrelated issues: the migration of health professionals and the health of migrants, to be organized by the International Labor Organization and the International Organization for Migration, with participation by PAHO.

57. Secondly, a case could be made for introducing the topic of the Observatory initiative not only at national but also at subregional level, as Barbados had suggested in the case of CARICOM. The present was a propitious moment to take a broader Caribbean-wide view of accreditation, profiles, and reciprocal recognition of qualifications. This topic had been broached, too, in Central America, in the Andean region and in MERCOSUR, and some preliminary analysis had been undertaken of the impact of more open frontiers on the accreditation process and the freedom to practice medical professions.

58. Her third point related to expansion of the Observatory's scope to other topics which were not currently covered, such as training in cultural sensitivity, which was needed especially in the Central America and Andean countries. In such countries, it was important for health professionals to know at least one of the indigenous languages of the population they were serving. There was a similar need for gender sensitivity. Those were expressions of the equity-based approach to health matters advocated by PAHO. Other issues that might bear examining were training of health technicians—given that a number of technical colleges seemed to be closing their doors—and the invisible volunteer work of women in health. In relation to the latter, the Observatory could help determine the impact of volunteer work on women's reduced opportunities to play an active part in the development of their countries.

*Access to Medicines (Document SPP38/6)*

59. Dr. James Fitzgerald (Regional Advisor, Health Supplies Management Systems, PAHO) explained that the concept of essential public health supplies was an extension of that of essential medicines, and related specifically to those pharmaceutical products and medical supplies that were required to achieve the goals set out in priority public health programs, the rational use of which had direct impact on disease prevention and control. Several countries in the Region had established specific ministry of health departments promoting regulation of and equitable access to essential public health supplies. These were responsible for the establishment and review of basic lists of essential medicines and other critical supplies that were required by priority public health programs and services.

60. The ongoing debate on access to essential public health supplies continued at all levels of society throughout the Americas, driven by the question of how to achieve equitable access to essential public goods that were required to save and improve lives, particularly those of the poor and the marginalized. In addressing that question, PAHO was guided by Millennium Development Goals 4 (reduce child mortality), 6 (combat HIV/AIDS, malaria, and other diseases), and 8 (in particular Target 17: provide access to affordable essential drugs in developing countries).

61. The conceptual framework for presenting the determinants of access could be viewed in several ways, but regardless of the model chosen, access to essential public health supplies would depend on choices made in the selection process, price and factors affecting pricing, commodity supply management, the availability of adequate financing, and the financing system involved. However, those were not the only factors: very often the options available and decisions to be made in those areas were guided and directed by options and decisions elsewhere, such as in policy development, sector regulation, quality standards, and the rational use of products. Account had also to be taken of the impact of global, regional, and national economies, which influenced the amount of resources that could be brought to bear on the issue of inequitable access to public health supplies, and of market conditions, which could affect the supply of available products on a given market.

62. The strategic lines presented in the WHO medicines policy for 2004–2007 comprised four principal areas: policy, quality and safety, access, and rational use. Adapting elements of the proposed WHO policy to the regional context, Document SPP38/6 proposed that four principal lines of work should be developed: promotion of coherent generic drug policy as a means to increase the availability and use of quality essential medicines; development of cost-containment strategies for essential public

health supplies, focusing on the two areas of pricing and intellectual property; strengthening public health commodity supply systems to ensure continuity and availability; and development of regional pooled procurement mechanisms as a viable option for supplying low-cost essential public health supplies.

63. The strategy proposed would build on the principal advantage of generic medicines, namely their cost-effectiveness in the delivery of health care. However, the development of coherent generic medicines policy was not without challenges. A consensus had to be reached on what was meant by “generic,” and that definition had to be encompassed in appropriate legislation and regulations. In addition, effective quality assurance systems would have to be put in place to ensure that standards conformed with the requirements laid down in national legislation and that national authorities had appropriate tools for assessing product quality. It would also be necessary to ensure that manufacturers observed good manufacturing practices and that wholesalers guaranteed that the quality of products was not undermined within the supply chain.

64. Public acceptance of generic medicines, which remained key to the success of the policy, could only be achieved through partnerships between the public and the private sectors. For example, governments could develop a framework of economic incentives for the manufacture, registration, prescription, and rational use of generic medicines. In its support to countries through the Pan American Network for Drug Regulatory Harmonization (PANDHR), PAHO was well-placed to advise them on regulation of generic medicines. The work being carried out through the Network could be complemented by exchanges between countries and the development and implementation of policy with a focus on acceptance and incentives to promote rational use.

65. The term “cost containment” was a relatively new one and was generally applied to well-established processes. Numerous studies had shown that the most effective way of reducing the cost of medicines and public health supplies was to increase the number of source options available. It was important that those involved in the regulation and procurement of products had adequate information on factors governing competition and an understanding of factors that affected price.

66. In regard to the third line of action proposed, little information was extant on the characteristics, strengths, and weaknesses of current supply management systems in countries of the Region. There was a need to map and assess those systems and examine the lessons that had been learned in the development of centralized or decentralized systems. That need had become all the more apparent given the increased emphasis being placed on commodity supply management by financing sources such as the Global Fund to fight AIDS, Tuberculosis, and Malaria. Within supply management systems, procurement mechanisms for essential public health supplies were an area of particular

importance. With multiple actors bringing resources to bear in the Region, it was essential to maintain a country focus, prioritizing the needs of the country rather than the obligations of the financing agency. Principles of prequalification of suppliers should be promoted to facilitate product procurement and registration.

67. In examining options for pooled procurement, it would be important to review the experience with the PAHO Revolving Fund for Vaccine Procurement, applying lessons from that to the development of other procurement mechanisms. The Revolving Fund had initially, in 1979, been capitalized at \$1 million,<sup>1</sup> with 19 countries participating, for the purchase of five vaccines. The corresponding figures now were \$24 million, 35 countries, and 12 vaccines, and the Fund had contributed significantly to the achievement of priority objectives in immunization in the Americas by supporting countries in commodity procurement, supply, and use. Another option for pooled procurement was the PAHO Strategic Fund, which had been established to help countries in the procurement of HIV/AIDS, TB, and malaria products. Although 11 countries had signed participation agreements with the Fund, it had been used in only a few countries to date. The Fund could become an effective instrument for ensuring continuous supply of public health products and building capacity in supply management, but in order for that to happen it would be necessary to reaffirm political commitment, redirect the technical cooperation package supporting the Fund, review the administrative procedures governing operation, and develop lines of communication with countries.

68. The strategic lines set forth in the document were proposed as key areas for future work which were intended to complement existing programs. Being interprogrammatic in nature, the work would utilize resources existing in various parts of the Secretariat, particularly the units working on HIV/AIDS, TB, and malaria. Additional support would be drawn from the knowledge and experience of countries, as well as the capacity and experience of the collaborating centers in the region. The proposed action lines would be further discussed and refined by a working group, which would probably meet at PAHO Headquarters in Washington in May 2004, with input from PAHO/WHO country offices as well as other key external partners.

69. The Subcommittee thanked the Secretariat for the report and voiced solid support for the four main lines of action proposed. With regard to generic drugs, it was agreed that there was a need to pursue the conceptual debate, seeking a consensus among countries' views of what constituted generic medicines and their differing thoughts on how best to promote access to them. Attention needed to be paid, too, to the impact of multilateral and bilateral trade agreements on access to medicines, particularly new ones such as antiretrovirals. Another issue that merited consideration was whether the development of generics might impact the development of new drugs. It was felt that the

---

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

issue of drug quality was very important, and that the topic needed to be developed further. Given that government regulation of generic drugs was essential to provide reassurance to the public on their use, the Subcommittee was pleased to see PAHO willing to provide assistance to countries in establishing the ground rules that would lead to public acceptance.

70. In the area of cost containment strategies, PAHO was urged to give its advice in an unbiased and data-driven way, and to take account of ongoing research and various models. It was pointed out that WHO had recently initiated a study on drug pricing, and it was hoped that PAHO would build on that work. One delegation suggested that rigid price controls were not appropriate, as they often had the unintended effect that customers paid more for generics than they needed to. Another issue raised in this regard was the need for regulation of pharmacies in order to ensure that cost savings that might be achieved by governments at the wholesale level were not eaten away at the retail level. PAHO was encouraged to provide technical advice and support to aid countries in addressing that problem.

71. The Subcommittee noted that many countries needed to enhance their procurement processes. That was a task for central government, as procurements of goods and services were a matter not only for ministries of health but also for other areas, but PAHO could provide valuable support. In the area of strengthening commodity supply and distribution systems, it was suggested that storage and transport conditions and physical plant status should be added to the items making up the review of the supply management chain. Countries also needed assistance in forecasting their needs, for both drugs and non-pharmaceutical supplies, of which there were sometimes critical shortages in the Americas.

72. The Subcommittee expressed appreciation for the work of the Revolving Fund for Vaccine Procurement, but suggested that before contemplating the creation of another regional fund, it was essential to understand the cost and the methods of operating the existing two and to determine the resource commitment of the Secretariat involved in running them.

73. Various members of the Subcommittee gave information on problems concerning access to medicines in their countries and on the initiatives being undertaken either to promote the use of generic medicines or to improve access to them. Some also gave details of the regulatory systems governing the supply of generic drugs to their countries' markets, and offered to make that knowledge available to the Secretariat and to other Member States.

74. Dr. Fitzgerald thanked the delegates for their comments, assuring them that the interesting issues raised would be taken into account by the working group as it endeavored to fine-tune PAHO's approach to technical cooperation in this area. In particular, he thanked the various countries that had offered to make their experience available. He agreed that procurement of supplies was a critical issue, noting that the several countries involved in Global Fund proposals could benefit from technical support in that area. Combining the needs of several countries would result in significant economies of scale. He clarified that it was not proposed to create a new procurement fund, but to reinvigorate the Strategic Fund, reexamining its dynamic, redirecting the technical cooperation package, addressing certain administrative issues, and learning from the experience with the Vaccines Fund. The intention was to create a technical cooperation tool that would help countries in developing procurement plans for their Global Fund proposals and in building national capacity for supply management.

75. Agreeing that the approach to cost containment should be evidence-based, he explained that work was in hand to determine just what evidence was available in relation to particular resource settings or particular classes of drugs, and to ascertain whether differing approaches would be called for in differing situations. With regard to generic drugs, he felt that generics and patented drugs were not mutually exclusive. Research and development were extremely important in the treatment and prevention of disease, and it was possible to move forward both in the development of new patented drugs and in the manufacture of generics. Finally, he confirmed that assistance in the regulation of pharmacies would be an important element of PAHO's work in the area of supply chain management, the aim being to help countries ensure that any cost-savings realized earlier on in the process were not lost at the end point.

76. The Director confirmed that it was not the intention to develop a new procurement system. Indeed, PAHO already had three procurement systems: the General Procurement System, the Revolving Fund for Vaccine Procurement, and the Revolving Fund for Strategic Public Health Supplies, also known as the Strategic Fund. In addition, other procurement mechanisms were available at the global level to support countries in negotiations for and procurement of drugs.

77. In the approach that PAHO was proposing to improve access to medicines, an absolutely key concept was transparency, which was crucial in order to gain public trust and acceptance. She had found in her visits to countries in the Region, for example, that the press and the public were very suspicious of generic medicines. In vain she would point out that 30% of the market for drugs in the United States of America was accounted for by generics, or that in Switzerland 100% of drugs procured by the public sector were generics (except where there was no generic drug for a particular condition), but the suspicion persisted that generic drugs were second-rate medicines being fobbed off on

poor countries. Often, those suspicions were linked to lack of transparency in public procurement.

78. Hence, there was a great need for transparency, so that the public could see what its government was buying, and why. There was just as high a need for transparency in the prescribing process and in provider-patient relationships, so that everyone involved had sufficient information to make rational use of products. People's lack of knowledge about medicines also fostered counterfeiting and other undesirable phenomena. In that connection, she agreed that in some cases within the Region, pharmacies were the weakest links in the supply chain, with some of them even selling counterfeit drugs. Such issues were being addressed by the Pan American Network for Drug Regulatory Harmonization, of which PAHO was the Secretariat.

79. She was very pleased that the Subcommittee had endorsed the approach proposed by the Secretariat and that it agreed that the focus should be on increasing access to medicines. Concerning the working group referred to by Dr. Fitzgerald, she clarified that it was an internal group, not a regional consultation body. It would be assessing the current situation in the Region and seeking to identify PAHO's strengths and weaknesses in this area, including the availability of human resources, in order to enable the Organization to better support the countries in increasing access to medicines and other public health supplies.

***Scaling Up Health Systems for an Integrated Response to HIV/AIDS (Document SPP38/7)***

80. Dr. Carol Vlassoff (HIV/AIDS Unit Chief, PAHO) reported to the Subcommittee on PAHO's efforts to accelerate and enhance the response to the HIV/AIDS epidemic in the Region. She began by presenting statistics on the magnitude and trend of the epidemic in Latin America and the Caribbean, noting that the latter subregion had the second highest prevalence in the world and that prevalence rates had also been raising steadily in some parts of Latin America, in particular Central America. Despite the challenges faced by the Region, however, there were many opportunities for an improved, clear, and focused response. Demonstrated successful interventions against HIV/AIDS now existed, both in the fields of prevention and treatment, and the increased availability of antiretroviral (ARV) therapy and the lower prices negotiated in the Region in 2003 made universal treatment a realizable goal.

81. The establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the two special sessions of the United Nations General Assembly devoted to HIV/AIDS, and the adoption of the Millennium Development Goals had all helped to galvanize increased political and financial commitment at the global level. At the regional level, in

June 2003 PAHO had spearheaded increased cooperation among the regional cosponsors of the Joint United Nations Program on HIV/AIDS (UNAIDS), initiating regular meetings of the regional directors of those agencies. The 3 x 5 Initiative, launched by the WHO Director-General and endorsed by PAHO, provided an additional opportunity for scaling up the response to HIV/AIDS in the Region. Worldwide, it aimed to provide ARV therapy to 3 million persons living with HIV/AIDS (PLWHAs) in the developing world by the end of 2005. In the Region, the goal embraced by the heads of state and government at the recent Special Summit of the Americas, held in Monterrey, Mexico, was to facilitate treatment for at least 600,000 individuals by 2005.

82. PAHO had taken several actions to advance the 3 by 5 Initiative in the Region. It had formed an internal core group and a task force comprising the core group, other PAHO staff, and representatives from countries and from NGOs. The 3 by 5 Task Force had met in Washington in January 2004 and had agreed on the following goal for PAHO: To work in partnership with the Member States to enable the greatest possible contribution towards improved survival and quality of life for PLWHAs in the Region, while advancing toward the ultimate goal of universal access to antiretrovirals for those in need, as a human right, as an effective prevention method, and as a measure against discrimination for those living with HIV and AIDS. The Task Force had also defined strategic orientations, actions, and indicators, which could be accessed on the PAHO website. The Secretariat was currently in the process of translating those strategies into actions in the priority subregions and countries, and the Biennial Program Budget (BPB) had been adjusted and realigned accordingly. Responsibility for implementation of the strategic orientations would be shared by the HIV/AIDS Unit at Headquarters and other PAHO units, both in Washington and in the countries. The budget had also been adjusted to allow for joint missions and activities.

83. The estimated treatment gap in Latin America and the Caribbean was 174,000 people, but that estimate was being updated in order to complete a more recent situation analysis, which would provide baseline data for monitoring the Initiative in the Region. Countries had been prioritized by HIV prevalence and ARV therapy coverage. Countries with high prevalence and low coverage were the highest priority, as they clearly required urgent attention to bridge the treatment gap, but those with low prevalence and low coverage were also a priority because they offered the potential for a comprehensive prevention and treatment approach, thus averting high burdens of infection in the future. The Caribbean and Central America were the highest-priority subregions.

84. Fortunately, resources for ARV therapy were now increasingly available in most of the priority countries, and PAHO could play an important role in coordinating efforts to maximize those resources. Given the increase in resources, the 3 by 5 Initiative was the engine that powered the train, which was the health system. There were clear gaps that

PAHO could help fill in order to strengthen health systems, including laboratory services, procurement and quality monitoring of medicines and commodities, capacity-building in voluntary testing and counseling, prevention of mother-to-child transmission, provision of care and treatment for sexually transmitted infections (STIs) and AIDS, and the provision of strategic information, monitoring, and evaluation.

85. Regarding the financing available within PAHO and externally for HIV/AIDS-related activities, regular budget funds for the HIV/AIDS Unit had risen 44% under the BPB for 2004–2005 as compared to the BPB for 2002–2003, but extrabudgetary funding was down 31%, reducing the total amount of funding currently available from \$2,771,783 to \$2,192,379. Extrabudgetary funds were expected to increase later in the period, however. Fund-raising for the 3 by 5 Initiative at the regional level was a priority, and several proposals were under development. Resources from WHO had been limited, but funding had just been made available for a 3 by 5 coordinator post at the regional level and for a coordinator for Haiti. Additional resources for Guyana were foreseen for the second wave of countries, but it must be recognized that WHO support for the Region was unlikely to be sufficient to enable it to reach its goals. Human resources at the regional level were also limited, with only four professionals, one of whom was a joint PAHO-UNAIDS appointee. To compensate for the small staff, the Unit was relying on the contributions of the other core team members and was collaborating with other partners, both at the regional level and in countries. In addition, the appointment of the 3 by 5 coordinator would fill a major gap in the Unit.

86. The impact of the 3 by 5 Initiative activities on vulnerable groups was expected to be substantial. For example, women and children would be helped through prevention of mother-to-child transmission, through training in gender- and youth-sensitive counseling and testing as part of a collaborative effort between the HIV/AIDS Unit and the Child and Adolescent Health Unit, and through a nutrition project for children affected by HIV/AIDS, to be carried out jointly by the HIV/AIDS Unit and the Nutrition Unit. Additionally, discussions were under way with pharmaceutical companies to provide free ARV therapy to the most disadvantaged populations in the countries of the Region.

87. The Subcommittee was invited to provide feedback on the proposed strategy and to make suggestions regarding PAHO's role in strengthening health systems for an integrated response to HIV/AIDS.

88. The Subcommittee commended PAHO on its efforts to scale up the response to HIV/AIDS through the 3 by 5 Initiative and endorsed the strategies presented in the document. Delegates expressed support, in particular, for the Organization's focus on implementing the 3 by 5 Initiative as part of a broader effort to strengthen health systems; its promotion of an integrated and comprehensive response that included prevention,

treatment, and care; and its incorporation of a human rights perspective and its attention to the problem of stigma and discrimination against persons living with HIV/AIDS.

89. While the Subcommittee agreed with the strategies proposed, several delegates felt that there should be more emphasis on prevention and avoidance of risk behaviors. While meeting the goal of providing treatment to 600,000 PLWHAs by 2005 was considered extremely important, it was pointed out that prevention remained a crucial strategy in the fight against HIV/AIDS. It was also noted that the greater availability of ARV therapy might cause people to become more lax about prevention and risk avoidance, and it was therefore deemed vital to continue promoting behavior change and encouraging healthy behaviors, such as sexual abstinence for young people, fidelity for married people and those in committed relationships, and correct and consistent condom use for high-risk groups. The importance of targeting young people with prevention efforts was stressed. In that connection, it was pointed out that the education and mass communications sectors had enormous potential to reach young people, but were not being sufficiently used in HIV/AIDS prevention efforts. PAHO was encouraged to utilize its prestige and influence in the Region in order to involve those sectors to a greater extent.

90. It was pointed out that a great challenge with regard to health system strengthening was enhancing the capacity of systems to identify and reach persons who needed ARV drugs. In some countries, although resources from the Global Fund and elsewhere had made it possible to offer treatment to significantly more PLWHAs, the system was not capable of seeking out all the people who were currently being excluded from treatment. Another challenge was that pressure to meet the demand for HIV/AIDS services was straining the capacity of health systems to respond to other, equally important, health problems.

91. The Subcommittee stressed the importance of collaboration between countries, and various Members offered to share their technical expertise and resources with others in the Region. The Delegate of Brazil noted that her country was collaborating with Bolivia, Ecuador, and Peru in a very effective HIV/AIDS prevention project for which PAHO had provided support. The country was also collaborating, within the horizontal technical cooperation group of Latin America and the Caribbean, on an ARV drug price database, which was an important tool in reducing drug prices. The group requested PAHO's support for that initiative, as well. The Delegate of Barbados, affirming his country's desire to share its facilities and knowledge with other countries and to learn from their experiences, expressed surprise that Barbados' outstanding example in HIV/AIDS prevention, care, and treatment had not been mentioned in the document. From the outset of the epidemic, there had been strong political support for HIV/AIDS prevention and control in Barbados, as evidenced by the creation of an HIV/AIDS

commission under the direct management and leadership of the Prime Minister. Since July 2002, the response to the disease had been scaled up, with outstanding results, including significant declines in morbidity and mortality and fewer HIV/AIDS-related hospital admissions and hospital days.

92. Delegates also underscored the need for collaboration between countries in order to strengthen HIV/AIDS prevention and control in border areas. Relatedly, the Observer for Mexico reported that in the framework of the Plan Puebla-Panamá her country, along with Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, would soon be submitting for funding from the Global Fund a project on HIV/AIDS among mobile populations.

93. PAHO was urged to continue helping countries develop proposals for submission to the Global Fund and to continue using its influence to bring down the price of ARV drugs, which were still unaffordable for many in the Region. Concerning the Global Fund, delegates lamented that, under the current eligibility criteria, many middle- and upper-middle-income countries were unable to avail themselves of the Fund's assistance. The Delegate of the United States noted that his country had been working, and would continue to work, to change the eligibility criteria in order to make all Latin American and Caribbean countries eligible for assistance from the Global Fund. He thanked the Secretariat for its support in that effort.

94. The United States also appreciated PAHO's work to promote simplified treatment regimens, standardized tools, protocols for counseling and testing, and the use of safe and effective fixed-dose combination drugs of high quality to deliver therapy more efficiently and foster patient adherence. In that regard, the Delegate announced that the United States, together with WHO, UNAIDS, and the Southern African Development Community, would be sponsoring a technical conference, to be held in Botswana the following week, on fixed-dose combination drugs for AIDS, tuberculosis, and malaria. He was pleased that a number of countries from the Americas would be participating in that event.

95. Responding to the Subcommittee's comments, Dr. Vlassoff clarified that the budget figures she had presented earlier included only the amounts allocated to the HIV/AIDS Unit; they did not reflect all the resources that were being devoted to HIV/AIDS-related activities across the Organization. She acknowledged that Barbados offered an outstanding example that could be of benefit to other countries and said that information on that country's experience would be included in the next revision of the document. The drug price database mentioned by Brazil had also been extremely useful, and although PAHO felt that it was the role of countries to negotiate their own prices, the

Organization could certainly help by facilitating access to information on the prices that had been obtained by other countries.

96. Concerning prevention, certainly PAHO recognized its importance, but the HIV/AIDS Unit was a small unit faced with many demands. The Unit saw its role in prevention as one of helping to strengthen and expand the capacity for prevention that currently existed within health services. Because it was small, the Unit felt that it had to focus its work and that the 3 by 5 Initiative gave it a focus. However, that focus certainly did not exclude prevention. For example, one of the delegates had mentioned the importance of working with schools on HIV/AIDS prevention, which was something that PAHO was seeking to encourage through its UNAIDS cosponsors. The Organization was also seeking to improve its collaboration with the International Labor Organization, which had an excellent model for achieving better social protection for people living with HIV and AIDS in the workplace.

97. With regard to youth, a project on child and adolescent health which had been ongoing for several years was now being expanded to incorporate a peer counseling approach, with a heavy involvement of youth. As for communication and the role of the media in HIV/AIDS prevention programs, the unit had played a major part in capacity-building in that area.

98. She had not said much in her presentation about the problem of stigma, but in fact it was probably the most important factor in making the 3 by 5 Initiative work. As the Subcommittee had noted, stigma made it extremely difficult to reach the populations that needed treatment, and ministries of health had said repeatedly that it was the most important obstacle they faced in delivering antiretrovirals. PAHO was well aware of the problem and was working to find ways of helping health services interface better with PLWHAs.

99. Finally, the project mentioned by Mexico was very timely. It was known that mobile populations were a highly vulnerable group, but they were also a difficult group to reach and influence with regard to behavior change. She wished the group of countries involved every success with their Global Fund proposal.

100. The Director observed that although the document had been titled "Scaling Up Health Systems for an Integrated Response to HIV/AIDS," little had actually been said about strengthening health systems. Instead, both the presentation and the discussion had centered mainly around how to implement the 3 by 5 Initiative in the Americas and around what PAHO should do to support the countries. As she had commented earlier to the President of the Subcommittee, this was an area in which the Organization needed a great deal of guidance from Member States in order to know how it could meet the

myriad demands for support and assistance when its resources were so limited. PAHO was doing everything possible to respond to countries' requests for help, but those requests only seemed to increase, while the amount of resources available to the Organization did not.

101. When, for example, Member States had asked for PAHO's assistance in drawing up proposals to be submitted to the Global Fund, the Organization had responded. No specific resources had been allocated in PAHO's budget for that purpose, but by shifting resources from other areas and suspending activities in others, the Secretariat had managed to mobilize the equivalent of \$1.5 million in 2002–2003 to support countries of the Region in developing proposals. And although it had been predicted that countries of the Americas could not expect to receive much from the Global Fund, a record number of those requests had been approved, which said a lot about the quality of the proposals that countries had formulated with PAHO's support.

102. Similarly, in the area of drug negotiations, although initially the global position on the part of UNAIDS, WHO, and the pharmaceutical industry had been that no multicountry negotiations would be accepted, at the request of Member States in the Americas, the PAHO Secretariat had insisted on joint negotiations, and it had succeeded in making them a reality, again without any resources having been allocated specifically for that purpose. Now the countries were asking the Organization for additional support in this area, but it simply did not have the wherewithal to provide such support.

103. In the area of horizontal cooperation, as well, PAHO had done everything it could to support countries. But there, too, its resources were limited, and the Organization had received extrabudgetary funds only from the Government of the United Kingdom, which had enabled it to support the collaboration between Brazil and the Andean countries.

104. The Secretariat had, as Member States had requested, structured the BPB for 2004–2005 so as to increase regular budget funding for HIV/AIDS-related activities. It had also created a core group and mainstreamed HIV/AIDS across the Organization, such that all programs were collaborating and sharing their resources to support the integrated response to AIDS. At the same time, it had done its utmost to enhance the regional response through closer coordination with the other UNAIDS cosponsors in their respective areas of work—education, discrimination and stigma, care for AIDS orphans, HIV/AIDS programs in the workplace, etc.—but still there were so many needs and so many requests for cooperation in so many areas which were going unmet. PAHO could not hope to respond to all those requests with its current level of resources.

105. She therefore appealed to Member States to provide guidance as to how the Organization could provide the response that they were asking of it and how Member States could assist the Organization in order to mount a truly integrated regional response to the problem of HIV/AIDS in the Americas.

106. The Delegate of Canada said that he had been impressed but a little perplexed at the Director's comments, which he interpreted as a request to countries to assist with additional financial resources and input on the issue of HIV/AIDS. He had found that request perplexing because he believed that countries came to PAHO thinking that there were adequate resources to deal with HIV/AIDS. Indeed, it was hard to think of another substantive health issue that was receiving as much money as HIV/AIDS, yet the Secretariat seemed to feel that the Organization's resources were not sufficient. He would therefore challenge the Director to prepare a business case—expanding on the financial information that had been provided in the presentation and showing in detail how the budget was currently being allocated within the Organization, identifying areas of extra need, specifying the amount of additional resources needed for those areas, and indicating how the Organization proposed to spend the resources—and then to submit that business case to the countries for consideration and discussion, either at the Executive Committee or the Directing Council, or in another forum.

107. The President thanked the Delegate of Canada for his proposal, which he thought was an excellent one. He looked forward to continued discussion of the matter during the Executive Committee.

***International Health Regulations: Perspectives from the Region of the Americas  
(Document SPP38/8)***

108. Dr. Marlo Libel (Regional Advisor, Communicable Diseases, PAHO) said that his presentation on the International Health Regulations (IHRs) would touch on three main points: the key aspects of the IHR revision process currently under way, PAHO's technical cooperation activities in this area, and the next steps needed in order to conclude the revision and begin implementing the Regulations.

109. Revision of the IHRs had become necessary as a result of the increase in international travel and trade and the emergence or reemergence in the past 20 years of more than 30 pathogens that represented an international threat. The key changes being proposed in the revision process were: (1) expansion of the scope of reporting to include any public health emergency of international concern, rather than notification of only three specific diseases, as required under the current IHRs; (2) designation by national governments of national focal points to serve as points of contact and communication links with WHO; (3) definition of core surveillance and response capacities required at the national level, including specific surveillance and response capacities at points of

entry; (4) recommended measures for dealing with public health emergencies of international concern and with ongoing public health risks; and (5) establishment of two WHO advisory bodies: the Emergency Committee, whose function would be to advise the Director-General on whether an event constituted a public health emergency of international concern and on the issuance of emergency recommendations, and the Review Committee, which would review, monitor, and advise on the application of the Regulations and on standing recommendations and would consider disputes concerning the interpretation or application of the Regulations.

110. The process that had resulted in the draft version of the revised IHRs currently before Member States for consideration and comment had begun with an extensive process of technical consultation during 2002, which had yielded specific recommendations on surveillance and control measures. In 2003, following the outbreak of severe acute respiratory syndrome (SARS), which had provided an opportunity to test some of the proposed revisions, changes had been introduced in two main areas: use of unofficial sources to obtain information on communicable disease outbreaks and WHO participation in the investigation of outbreaks. The next step would be subregional consultations, which would be followed by a meeting in November 2004 of an intergovernmental working group. That group would draw up the final draft to be submitted to the World Health Assembly in May 2005.

111. PAHO's principal technical cooperation activities in relation to the IHRs had been directed towards keeping Member States informed and facilitating their participation in the revision process, both through consultation meetings and through ongoing exchange of information. In addition, the Organization had supported the establishment of subregional networks for the surveillance of emerging infectious diseases (EIDs) to complement national surveillance mechanisms and enable countries to work together in controlling the potential spread of infectious disease across national borders. An important component of those subregional networks was strengthening of laboratory capacity and establishment of reference laboratories for specific pathogens. The Southern Common Market (MERCOSUR) had taken a particularly active role in the IHR review process, both at the subregional level and within individual member countries. However, workshops and other activities relating to the IHRs had also been carried out, at subregional and country level, in the Andean, Central American, and English-speaking Caribbean subregions.

112. The next step in the revision process would be regional and, in the case of the Americas, subregional meetings to hear Member States' views and concerns regarding the content of the revised IHRs and their implementation at country level. Countries would be encouraged to involve a variety of sectors in addition to the health sector in the

consultation process, including all sectors that had to do with the movement of people and goods, and to include in their delegations both political decision-makers and technical personnel. Four subregional meetings would be held between April and June. The outcome of those consultations would be the contribution of the Region of the Americas to the intergovernmental working group, which would consolidate the feedback received from all the regions and produce the final draft version of the revised Regulations.

113. Looking to the future, once the Regulations were approved, PAHO planned to assist countries in implementing them through technical cooperation in the following strategic areas: continued support for the subregional EID surveillance and laboratory networks, improvement of operational mechanisms for alert and response at both regional and country levels, strengthening of laboratory capacity and laboratory networks in the countries of Latin America and the Caribbean, and capacity-building to strengthen countries' capacity for both emergency response and sustained control of communicable diseases.

114. The Subcommittee expressed strong support for the IHR revision process and applauded PAHO's efforts to ensure that the views of governments in the Americas were taken into account. Delegates commended PAHO for organizing consultations at the subregional level and looked forward to participating in those gatherings. Members also praised the quality of the document, which provided solid background on the IHRs and on the need for their revision and outlined the procedure for that revision, although it was suggested that future iterations should focus more on the WHO and PAHO activities currently under way and slightly less on the work undertaken by PAHO in the past, as the period leading up to May 2005 would be extremely important in determining the wording and concepts that would be included in the final version of the revised Regulations.

115. It was emphasized that the revised IHRs must be flexible yet clarify the authority and conditions under which it would be appropriate for Member States to restrict the movement of humans, animals, or cargo to contain the spread of disease. There was need for a careful balance among disease containment efforts, infringement of individual liberties, and a nation's right to engage in international trade, business, and migration. The importance of collaboration between countries and regions in early detection and response to disease outbreaks was also stressed. The crucial role of international and regional entities, such as the WHO Global Outbreak Alert and Response Network (GOARN) and the Caribbean Epidemiology Center (CAREC), in facilitating such collaboration was highlighted. In addition, technical cooperation between countries was viewed as essential to assist countries that might lack the expertise or human resources needed to detect and respond to disease outbreaks.

116. The Delegate of Canada, noting that the document indicated that several countries were beginning to reorganize their surveillance systems to prepare for future disease outbreaks, said that his country should be added to that list. In the wake of the SARS outbreak of the previous year, Health Canada had commissioned an analysis of how the situation had been handled. The report on that analysis had revealed the need for a new public health agency, which the country was in the process of planning and designing. It looked forward to learning more about the experiences of other countries that were engaged in similar efforts to revamp their systems.

117. The Delegate of the United States said that, while his country had found the draft version of the Regulations issued in January 2004 a good initial effort, it had a number of concerns, which were detailed in the written comments it had submitted to WHO. Those comments had also been distributed to the Subcommittee, and it was hoped that they would be a useful contribution to the discussions that would take place during the subregional meetings. In particular, the United States strongly disagreed with WHO's proposal regarding use of an algorithm as the sole means for determining reportable events and it believed that PAHO's apparent endorsement of that method as the only approach (in paragraphs 8–10 of Document SPP38/8) was premature, as WHO had not yet heard the views of all Member States. His country supported the use of an algorithm to determine whether certain events constituted "public health emergencies of international concern," providing that the term was carefully defined, but the United States believed that the revised IHRs should also require reporting of a specific list of diseases that were known to be serious communicable diseases with a potential for creating international public health emergencies. A suggested list of those diseases was included in his government's written comments.

118. The Delegate of Barbados pointed out that for small island states in the Caribbean which depended heavily on tourism for their economic survival, early and good surveillance and a quick response to any imported diseases was vital. In the case of her country, which served as a transit point for tourists travelling to smaller islands in the Caribbean, such information was even more crucial, since other countries depended on it to carry out surveillance functions and serve as an information clearinghouse.

119. Dr. Libel said that, before responding to the Subcommittee's comments, he wished to acknowledge the financial and technical support that WHO had provided for the consultation meetings to be held in the Region. He also wished to thank the Government of the United States, which, along with the Government of Brazil, had been one of the most active participants in the IHR revision process in terms of its contributions of technical expertise and feedback on the proposed changes.

120. With regard to Canada's wish to learn more about the experiences of Argentina, Bolivia, Brazil, and other countries which were revamping their surveillance systems, he said that those countries had shown an extraordinary commitment, allocating loan resources obtained for health service development specifically to reorganize and strengthen their surveillance and response systems, not only at the central level but also at the level of local health services. In addition, in several cases, biosafety level-3 laboratories had been established. PAHO considered such strengthening of laboratory capacity essential in order to enhance the diagnostic capabilities of countries in the southern hemisphere and thus avoid the need for international transport of biological specimens that might pose a risk of disease transmission.

121. Several of the aforementioned activities were taking place in the framework of another initiative being supported by PAHO, which related directly to the comment by the Delegate of Barbados: country assessments of national capacity for detection of, confirmation of, and response to infectious disease outbreaks. That initiative sought to assist countries in identifying gaps in their systems. Recognizing that a variety of other agencies might collaborate with the ministry of health in surveillance and response, PAHO's approach to the assessment sought to bring together all the agencies involved.

122. He thanked the Delegate of the United States for having provided PAHO with his country's detailed response to the first draft of the IHRs several weeks before the Subcommittee session. The Secretariat had thus been able to share those comments with the other countries and obtain their input as to the degree to which the concerns expressed by the United States were relevant to them. That was important because a balance must be struck in the IHR revision process between the collective interests of all countries and the national interests of individual countries and their capacity to fulfill the commitments that they would be making when they approved the Regulations.

123. Regarding the document before the Subcommittee, he clarified that its sole purpose had been to inform Member States of the proposals currently on the table for consideration. The forum for discussion of specific issues would be the subregional consultations, and it was at those meetings that the concerns raised by the United States would be addressed. Accordingly, he would not comment at length on those issues; however, he did wish to point out that the decision to use the concept of "international emergencies of public health concern" had come from the experience with the current IHRs, which did include a list of diseases. Under that approach, countries had not generally paid sufficient attention to outbreaks of infectious disease that did not have a specific diagnosis. That was one justification for the new approach being proposed. Another was that, as occurred in national surveillance systems, when there was a list of diseases, the focus of the system tended to be exclusively on that list. If an event did not meet the case definition to be classified as one of those diseases, it was not viewed as an

international threat on which action should be taken. Nevertheless, it would be up to the Member States to decide whether a complementary list of diseases should be included in the revised Regulations.

124. Concerning the comments on the balance between disease containment and the rights of countries and individuals, that would be another important point to be discussed during the subregional meetings. In order to make those gatherings as productive as possible, he urged all Member States to take the time to review the draft Regulations carefully and to come to the meetings with concrete suggestions.

125. The Director observed that, as the Regulations were a treaty and therefore a binding legal instrument, it was appropriate that they should be subjected to in-depth scrutiny by governments. In supporting the revision effort, PAHO had focused on the subregional level because within the various integration groupings, countries had already put in place certain mechanisms and made certain commitments with regard to information exchange, border issues, customs, transportation, and other matters directly related to the IHRs.

126. As Dr. Libel had said, preparation at the national level would be crucial to ensure the success of the subregional consultations. Part of that preparation, in the Secretariat's view, should be to involve and gather input from other sectors, not just at the national government level but also at subnational and local levels. There were now so many paths for population movement, both legal and illegal, and therefore so many routes for the transmission of disease across borders, that the involvement of authorities at all levels was essential. It was also important to seek the perspectives of other sectors—trade and defense, for example—that had an interest in the issues addressed by the Regulations. The IHR revision process was similar to the process by which the Codex Alimentarius and other international regulations had been developed and, like those processes, it required the perspectives of many different sectors.

127. The Secretariat would, of course, bear in mind the Subcommittee's comments about the document; however, as Dr. Libel had pointed out, the purpose of any documents produced on the IHRs would be to keep countries abreast of what was being discussed. PAHO did not have a position on the Regulations. Its role was to facilitate the exchange of information so that countries could understand one another's positions and then negotiate and come to a common agreement. Accordingly, PAHO sought to clarify the issues and identify both the critical points that were most likely to be controversial and the points on which there was likely to be consensus, in order to move the process forward as expeditiously as possible.

***Ten-Year Evaluation of the Regional Core Data in Health Initiative (Document SPP38/10)***

128. Dr. Carlos Castillo-Salgado (Area Manager, Health Analysis and Information Systems, PAHO) recalled that work on the Regional Core Data in Health Initiative (RCDI) had been launched in 1995 to monitor the attainment of health goals and compliance with the mandates adopted by the Member States and to ensure a basic set of data that would make it possible to characterize and monitor the health situation in the Americas. Almost 10 years later, a survey had been sent to all the countries of the Region to seek their input on how to improve the Initiative and set its future directions.

129. The Initiative covered the minimum set of information required to plan and evaluate countries' public health programs, comprising essential indicators which provided fundamental information on public health management for ministries and other health agencies. Over the 10 years, the Initiative had provided guidance for countries' efforts and strategic directions, had facilitated the identification of priorities and unmet needs of various national groups, and had made it possible to review health trends in the countries.

130. Of the 37 countries surveyed, 21 had indicated that they had used the Initiative to identify needs and priorities for care and service to critical populations, while 16 respondents had indicated that they had used it for specific measurement of inequalities in health in their countries and to evaluate the public health programs intended to deal with them. Other functions and activities were mentioned by 22 countries.

131. The countries had also been asked whether the Initiative was contributing usefully to their monitoring of the achievement of the Millennium Development Goals. Seventeen had replied that there was indeed a positive linkage, while 13 had said that they had not yet started that monitoring effort. The Core Data already included 12 of the 19 health-related indicators of the Millennium Development Goals. One more was shortly to be added, and PAHO was engaged in specific discussions with countries on the best way to implement four more. The final ones would require a special data-collection effort.

132. One of the findings from the countries' responses was that there were still obstacles to the implementation and maintenance of the Initiative at national level, owing to human resources shortages, constraints on access to information, and limited financing and political backing. However, the responses had also indicated that it was essential to continue improving the flow of information between the countries and PAHO and WHO, drawing special attention to the need for actions designed to avoid duplication of countries' efforts.

133. The survey had also asked about specific products at national level. In 1995, only five countries in the Region had published pamphlets on health indicators. Ten years later, 24 countries were systematically publishing such information, disaggregated at subnational level. The production of such information had had a great impact within health ministries, in academia, and in bilateral and multilateral negotiations relating to technical cooperation. A total of 14 countries had made their information directly accessible through the Internet. That was a great achievement, placing their critical information within reach of the public at large.

134. In particular, Brazil and Argentina had made a tremendous effort to bring their national core data systems up to date, and to publish their core data updates regularly every year. That had proved enormously beneficial to public health activities in those countries. Brazil had set up the RIPSAs network, which was the first interagency health information network in the Region and which had made it possible to systematically harmonize all health indicators for the whole country. The achievement of that level of harmonization was enormously significant, particularly since at the beginning of the Initiative, much of the data published by countries had been no more than approximate estimates, including optimistic versions and pessimistic versions, with no indication as to which were more likely to be accurate. Moreover, there had been wide variations in the figures for the same indicator from agency to agency, with all estimates being classified as equally official. An investment of a million dollars, together with a fundamental change in approach to information management, had made it possible for Brazil to obtain coordinated and harmonized data from all relevant agencies.

135. The Initiative had given rise to several outputs produced at subregional level, which had required a major effort of coordination. The first core data pamphlet for the Caribbean had been produced in 1996, followed by one covering all of Central America and providing data at subnational level. In 2003, a collaborative effort of the United States and Mexico had produced the first core data pamphlet covering a border area. The work on the United States-Mexico border area could serve as an example for other countries with shared frontiers.

136. One of the important outputs of the Initiative was the publication every September of the regional brochure "Health Situation in the Americas: Basic Indicators," which was the most important instrument for strategic use of health information in the Region. The Initiative had also generated a coordinated system of health information, and together with the United Nations Statistics Division and the United Nations Statistical Commission, PAHO had striven towards total harmonization of the indicators, an undertaking which had included the production of a glossary and specific technical notes for each indicator.

137. A further output of the Initiative was the Atlas of Basic Indicators, which many countries used in their negotiations for technical cooperation. The Atlas had made it possible for the first time to display indicators not only at country level but at the level of the political subdivisions within them. Only in the Region of the Americas was this information available at such a level of detail. The national core data initiatives had thus made it possible to have an insight into the complex epidemiological mosaic of the Region.

138. Also available on the Internet were the widely praised multidimensional table generator—which had the capacity to provide detailed and dynamic information by indicator, by country, by group of countries, or by year—and the country health profile system, which was updated annually and provided health and demographic information on every country in the Region. After PAHO's systems had been presented to the wider World Health Organization in 2003, other regions had begun to publish their core data, following the same model. In addition, PAHO had supplied the web-based systems to SEARO at no cost, and was currently reviewing with WHO the possibilities for doing the same for other regions.

139. The Subcommittee commended PAHO for its considerable efforts to promote the routine collection of standard health data across the Region, which in conjunction with the efforts of Member States had brought about an increase in the use of data for health planning and better monitoring of health programs. Several delegates provided information on their countries' systems and mechanisms for collecting and publishing core data. The Delegate of Brazil thanked the presenter for his positive comments on the work of RIPSAs and gave some further information on how the system functioned. The Delegate of Canada drew attention to work that had been undertaken in that country over the past 10 years to produce annual health indicator reports as well as the annual report "How Healthy Are Canadians?"

140. The Subcommittee emphasized the desirability of even further disaggregation of the data by specific population groups, especially marginalized populations such as older adults, indigenous peoples, and children. It also drew attention to the importance of gender analysis in the study of social inequities. Sex-disaggregated data were very important, as were data which took into consideration the impact of gender as a social construct resulting from political, social, legal, and other structures and forms of power. Delegates sought information on how resource-poor countries could be assisted to improve their capacity to collect core data for the Initiative and to analyze it, once collected. Additionally, more information was requested on how the Initiative was proving useful to Member States—for example, the extent to which it contributed to health ministries' planning and policy-setting.

141. It was suggested that in order to fully evaluate the regional core data program, it would be helpful to see a list of the indicators recommended to Member States. Equally important would be the technical documentation underlying PAHO's development of the indicator set. It was felt that the document would benefit from a more detailed presentation of the availability of RCDI data across the countries and the Region, together with a discussion of individual countries' levels of participation in the Initiative, as the recommendation at the conclusion of the document that more human resources should be allocated to promote access to information and its analysis and dissemination did not make clear whether those extra resources should be drawn from PAHO internally, from the Member States, or both. It was also suggested that a more detailed analysis of existing human and financial resources, together with a projection of needs, be added.

142. Delegates pointed out that a formidable amount of information was available which could be used to analyze trends and behaviors and predict possible deteriorations or advances which were not evolving as predicted. An additional effort should be made to obtain disaggregated information at supranational level, making it possible for countries to receive early warnings on areas where interventions needed to be concentrated. This data collection effort should be enhanced over future years.

143. Dr. Castillo-Salgado thanked the participants for the comments and suggestions, in particular from those delegates who had provided information on their respective countries, noting that both Argentina and Brazil had adopted the practice of publishing information each year on a specific subject, such as infant mortality or gender aspects, over and above the core data provided. He noted that Canada was a pioneer country in the strategic management of information. PAHO recognized the major efforts that Canada had made to create and structure core data series, and the design of the Initiative had built on Canada's achievements.

144. PAHO recognized the importance of disaggregating data by sex, but in many countries the regular data collection systems did not include that variable. The Organization was working with the countries towards improvements in that area. Agreeing on the importance of information on indigenous populations, he explained that PAHO was preparing a specific pamphlet of health data concerning indigenous peoples throughout the Region, with publication expected during the course of 2004.

145. Turning to the question on the impact of the Initiative at national level, he recalled some of the results of the survey that PAHO had carried out in 37 countries. Thirty countries had replied and, of those, 21 had indicated that they were using the Initiative to determine health priorities and specific needs at subnational level. Sixteen countries were using it to measure inequities in health care and twelve to evaluate the impact of their public health programs.

146. With regard to the question as to additional human resources, he clarified that the recommendations in the document were those made by the countries to PAHO. The three major problems identified by the countries in the survey were lack of sufficient resources, limited access to data from countries' most marginal areas, and, in some cases, non-existence of an electronic network. Despite these difficulties, countries were making a valiant effort to produce the data. For example even Haiti, despite its extremely difficult situation, had produced two core data pamphlets. With regard to the request for the addition of more information about the indicators, he clarified that documents detailing that information were already on the Internet. They included the glossary, explanations on how the indicators were constructed, information on harmonization, and so on.

147. He agreed that the issue of training in data collection and analysis was one of the major bottlenecks, jeopardizing the Initiative's mission of providing valid and reliable information to facilitate analysis of health situations. Together with the World Bank, PAHO was working on the provision of online courses in analysis of health situations. The first course would be available in about two months, and the cost to countries would be minimal. He also gave information on the launching in 2004 of the first Health Metrics Network, intended to make governments and agencies aware of the crucial strategic relevance of routine health statistics at national, regional, and global level. The Network had been created with assistance from the governments of Mexico and South Africa, USAID, the Bill and Melinda Gates Foundation, and many other partners.

148. The Director clarified that while the presentation had focused largely on indicators, the Regional Core Health Data Initiative had many other aspects, including the assistance that PAHO was giving in training of human resources in data production, strengthening of countries' capacity for analysis, and more. She concurred with the view expressed by several delegates that the essential point was to know what use was being made of the core data collected, and noted that, in some cases, countries were utilizing the data for purposes which went beyond the original scope of the Initiative, such as the preparation of technical publication series on specific topics, including women's health, the health of indigenous peoples and migrants, and children's health.

149. Another important aspect of the Organization's work in this area was the revival of the Regional Advisory Committee on Health Statistics (CRAES), a joint effort between PAHO and several other agencies. That group was working to improve the quality and consistency of both health statistics and vital statistics, although in her view vital statistics were not really the responsibility of the health sector. The sector was a major user of vital statistics, but it was not responsible for compiling them. Nevertheless, improving vital statistics was important, since a good system of vital statistics was essential to the exercise of representative democracy and to the exercise of certain fundamental rights in democratic societies, notably the right to identity, but also the right

to vote, the right to own property, and others. Unfortunately, some countries in the Region still lacked a vital statistics system, and other countries' systems had deteriorated over the past 30 or 40 years, owing to lack of the investment needed to maintain them.

150. Vital statistics were of concern to PAHO, too, because they were an equity issue. The groups that suffered the greatest inequity, the groups with the fewest resources and the least power, were often completely left out of a country's vital statistics. Frequently, that was because births simply were not registered. In some cases, that was a result of obsolete legislation which required payment of a fine if births were not registered by a certain date. In other cases, it was due to manipulative or extortionate practices on the part of private entities that managed vital statistics registries without adequate government control.

151. PAHO was therefore working, in particular through the CRAES, to highlight the need to strengthen vital statistics systems and to encourage Member States to make the necessary investment to upgrade and maintain their systems.

***Progress Report of the Working Group on Regional Budget Policy (Documents SPP38/3 and SPP38/3, Add. I)***

152. Dr. Karen Sealey (Area Manager, Planning, Program Budget and Project Support, PAHO) reported to the Subcommittee on the progress made in reviewing and revising the Organization's program budget policy. She began by reviewing the history of the development of program budget policies in PAHO. The current program budget policy dated from 1985, when the WHO Executive Board had asked the regions to develop regional program budget policies to support the work towards the goal of Health for All; however, PAHO had begun the task of formulating a policy in the late 1970s. In 1998, when World Health Assembly Resolution WHA51.31 reduced the allocation to AMR, effective in the 2000–2001 biennium, PAHO had recognized the need to review its regional program budget policy, given that the reduction would lower the WHO allocation to the Region by some \$9 million. A working group consisting of members of the Executive Committee had been established in 1999 to undertake that task in collaboration the Secretariat. The group had submitted a report to the SPP in 2000. That report assessed the experience with the current policy and identified some principles and criteria for the revision. The SPP at the time, while endorsing the principles identified, requested that further work on the budget policy be deferred until the work on the Strategic Plan for 2003–2007 had been completed.

153. As the Subcommittee knew, the Strategic Plan had been adopted in 2002 and it had given priority to five key countries. Subsequently, two other things had happened which were directly relevant to the discussion of the budget policy: the Director-General of WHO had decided in 2003 to decentralize WHO's operations to the regions and

countries and had begun to shift resources in support of that country-focus approach, and, also in 2003, the Directing Council of PAHO had signaled the urgent need to update the criteria for resource allocation among countries based on need.

154. She then outlined the steps that had been taken or were planned in the budget policy review process, the aim of which was to make the budget a strategic instrument of policy. The Director of Program Management had established a consultative group of experts in planning and budgeting to work with the Secretariat in the process of developing criteria for the revision of the budget policy. To that end, he had asked the group first to review and assess the criteria for the current policy, and also to review trends in budget policies of other international agencies and identify relevant practices, and then to recommend principles and criteria to further guide the development of the budget policy. The Consultative Group on PAHO Regional Program Budget Policy had held its first meeting on 4 and 5 March 2004, with the participation of experts from Canada, Guatemala, and Trinidad and Tobago. Representatives from four other countries and two international development agencies had been unable to attend, but they continued to be part of the group. The report of that meeting (Document SPP38/, Add. I) had been distributed to the Subcommittee. Building on the work of the Consultative Group, the Secretariat would develop a draft proposal for the policy during April, which would be discussed with the Consultative Group in early May. The comments of the group members and of other countries would then be incorporated into the proposal to be submitted to the Executive Committee in June.

155. Turning to the report of the Consultative Group, she noted that Document SPP38/3 identified some of the principal issues that the Secretariat believed should be taken into account in updating the program budget policy. Those issues had been discussed by the Consultative Group at its March meeting, and the group had concluded, *inter alia*, that there was a need for balance between predictability and flexibility in the intercountry distribution of the budget, such that countries could rely on a certain level of support from PAHO, but at the same time there would be sufficient flexibility to accommodate changes that might occur in individual countries or across the Region. The Group, after much discussion, had recommended a two-part approach to country allocations: a core part, which would be needs-based, and a variable part, which would allow the Secretariat and the Member States to identify the criteria or priorities that needed to be focused on in a particular biennium—the MDGs, for example.

156. With regard to the criteria for determining need, the Consultative Group had recognized that while traditional indicators such as infant mortality remained valid, new or modified indicators were required in order to better target the Organization's work to identify countries of need and areas of need within countries. Concerning the country presence of PAHO, the Group had noted that countries were at different levels of health development and had different needs, and a methodology was therefore required that took

account of those differences and identified the particular needs for particular countries. Some countries might not require a physical presence, while others definitely would. In such cases, it also had to be determined how the costs of maintaining that presence would be covered. Finally, the Group had recognized that, for any proposal that went forward, the implementation method should result in as little disruption as possible of the technical cooperation currently under way with countries.

157. The Subcommittee was asked to comment on the revision process and on the appropriateness of the approach being taken and to identify and comment on principles and issues that should be taken into consideration in the revision of the regional program budget policy.

158. The Subcommittee welcomed the progress report on the work of the Consultative Group and voiced firm support for the revision of the regional budget policy to reflect the current greater emphasis, by both WHO and PAHO, on country-level programs and activities. The Consultative Group was encouraged to look carefully at how the budget policy might be used to improve health for marginalized populations in the countries, including women, children, older adults, and indigenous groups, and at how the budget might be structured to be more effective at the country level. In that connection, it was suggested that the Consultative Group might wish to consider the recommendations of the Working Group on PAHO in the 21st Century.

159. It was pointed out that the changing nature of PAHO's relationship with countries needed to be fully reflected not only in the budget policy but also in strategic planning and technical cooperation. In that regard, delegates emphasized the need to examine how resources for technical cooperation among countries (TCC) could be used more effectively for countries in need. Delegates also stressed that the increase in resources at country level should be coupled with thorough oversight of the use of those resources, through monitoring, evaluation, and financial accountability. Closely related to that, one delegate expressed the view that program performance and results should inform all future PAHO budgets. Such an approach was in line with the objective of making the budget a flexible and strategic policy instrument.

160. Recalling that at the previous year's Directing Council several Member States had expressed their willingness to shift resources allocated to their country programs to countries in greater need, delegates were pleased to note that that redistribution was already occurring. With regard to the criteria for allocation of funds, the Consultative Group was urged to continue drawing on the work already done by other agencies of the United Nations with respect to indicators. It was felt that the Human Development Index could be a useful means of weighting allocations between countries in the Region as it provided a good analysis at the macro level through a comprehensive matrix of indicators which included health, economic, and a variety of other indicators.

161. One delegate proposed that, in addition to examining the criteria for allocation and use of resources, the Consultative Group should perhaps look at possible mechanisms and strategies for mobilizing additional budgetary resources to enable the Organization to respond to the new demands being placed on it. That seemed particularly important in the light of the Director's earlier comments on the insufficiency of resources for scaling up the response to HIV/AIDS. Another delegate, noting that the Consultative Group should also consider how the revised budget policy would be aligned with the Millennium Development Goals, the Summit of the Americas goals, and PAHO's Strategic Plan for 2003–2007, suggested that it might be useful for the Secretariat to prepare a composite chart showing all the various goals listed side by side, with a comparison of how they related to one another and to the budget policy.

162. Dr. Sealey thanked the Subcommittee for its comments, which she said she would convey to both the Consultative Group and the internal working group that would be drafting the budget policy proposal. The suggestion regarding preparation of a chart showing the various goals and mandates was, she thought, an excellent one, as it would enable the group to identify clearly what the goals were and to what extent they were being covered. She also agreed that it would be important for the Consultative Group to have input from the Working Group on PAHO in the 21st Century; although, since the work of the latter group was still in the very early stages, that input would not be available immediately.

163. Concerning the comments on TCC, she noted that the Consultative Group, though it had just begun discussing the topic, had signaled the need for TCC to become more of a norm rather than a project within the Organization. With regard to the comments on the HDI, as the report of the Consultative Group indicated, there were some drawbacks to its use—for example, the fact that the ranking of the countries tended to change frequently and sometimes significantly. However, as she had said, she would transmit that suggestion and the suggestion regarding mobilization of additional resources to the Consultative Group. She and the other members of the Secretariat involved in the budget policy revision process looked forward to continuing to work with Member States on this initiative.

164. Echoing Dr. Sealey's comment, the Director encouraged more countries to become involved in the budget policy revision. The participation of the countries invited to form part of the Consultative Group had been very fruitful, but broader participation was desirable, not only in order to complete the work in the briefest time possible, but

also in order to take advantage of the experience of budget experts from other PAHO Member States.

165. She pointed out that the country focus envisaged in the discussions regarding the new budget policy was not new for PAHO. As Members would recall, in the budget approved the previous year, the combined allocation to countries—including both country programs and regional centers, which were located in the countries—had amounted to 60%. And although the current budget policy mandated an allocation of at least 35% of the total budget to country programs, in fact a significantly larger percentage than that had been allocated for years. Moreover, the budget for regional programs included funding for many regional posts which were actually located in countries, not at PAHO Headquarters, because PAHO, unlike WHO, had been decentralized for more than 20 years.

166. She felt that the new regional budget policy could serve as a model for the rest of the World Health Organization, as had so many other PAHO initiatives and activities, both in technical areas and in administration, finance and accounting, planning and programming, and monitoring and evaluation. For that reason, she hoped that Member States would share their budgeting expertise in order to produce a regional budget policy that would not only enhance the work of PAHO in the Region but would also provide an impetus for other regions and for WHO as a whole.

167. Regarding the criteria for allocation of budget resources, one of the considerations that should be borne in mind was that, as the 2002 edition of *Health in the Americas* had shown, health results were better when countries were equitable, regardless of whether they were rich or poor. Hence, a poor country that was equitable could have better results than a rich one that was inequitable, but it would still need sustained support to maintain its achievements. It was therefore important, when choosing indicators, not to penalize poor but equitable countries for their efforts and successes in regard to health, and it was equally important to protect the gains made in the past.

168. As concerned TCC, the Secretariat would be happy to prepare a special presentation on the experience of the past 20 years for the Executive Committee. A document entitled “Technical Cooperation Among Countries: Pan Americanism in the Twenty-first Century” (Document CSP25/9) had established a set of principles, values, and methodologies for horizontal cooperation in the Region, which had been endorsed by the Member States in 1998. The document continued to be used by governments across the Region as a guide for horizontal cooperation. The fund for TCC had grown each biennium and now amounted to almost \$4 million, and it had produced excellent results. One notable example was the horizontal cooperation between Brazil and the Andean countries which had been mentioned during the earlier discussion on HIV/AIDS.

***Strategy for Increasing the Rate of Collection of Quota Assessments (Document SPP38/11)***

169. Ms. Sharon Frahler (Area Manager, Financial Management and Reporting, PAHO) gave a brief overview of the initiatives currently being implemented by the Director in response to concerns expressed by Member States at the 44th Directing Council in 2003. Overall quota collections for the 2002–2003 financial period totaled \$172 million, exceeding the amounts collected in each of the preceding biennia, for which the figures had been: \$168.2 million for 2000–2001, \$169.1 million for 1998–1999, and \$160 million for 1996–1997. Quota receipts as of 24 March 2004 were \$8.9 million, including a payment of \$5.7 million from the Government of Venezuela.

170. PAHO was committed to improving the rate of collection, to which end the Director had instituted several strategies. The most visible was the inclusion of the report “Quota Contributions Due From Member States” both on PAHO’s Internet site and on its Intranet, which meant that any concerned individual could review the status of amounts due and address any arrearages in a timely manner. As a further initiative, pursuant to recommendations from PAHO/WHO representatives and PAHO regional center directors, the Director would be submitting to the next session of the Executive Committee a proposed amendment to the Financial Regulations which would allow payment of assessed contributions in local currency. That would facilitate timely payment by many Member States whose particular circumstances made payment in United States dollars difficult.

171. Other initiatives were to encourage installment payments throughout the financial period for those Member States who had difficulty in meeting their assessed quota in a single payment, and to encourage quota discussions at every level and opportunity. Many more initiatives were under way to meet the expectations of Member States, and the Director’s message to all PAHO staff had been that ensuring the prompt and full payment of Member States’ assessed contributions constituted an integral part of the responsibility of senior managers throughout the Organization.

172. The Subcommittee welcomed the update on the efforts being made to increase the rate of quota collection. It was pointed out that some countries had fiscal years that did not correspond to the calendar year. Several of those fiscal years started in April, which might explain why the current figures, taken in March, showed such a low amount collected for 2004. Further information was requested on countries’ difficulties in making their payments, the reasons for allowing payment in local currency, and the steps envisaged to guard against foreign exchange risk.

173. Ms. Frahler acknowledged that some countries did have fiscal years that differed from the calendar year, including, for example, Canada and the United States. PAHO knew that it could count on those two countries' quotas arriving at the appropriate time in the year, and was grateful when they did. The rationale for allowing payments in local currency arose out of a problem occurring in some countries between the ministry of health and the ministry responsible for the treasury. In many cases, the PAHO quota was encompassed in the ministry of health budget, and ministries were able to set aside the amounts needed to pay those quotas, but a bottleneck occurred when they requested the treasury ministry to purchase the necessary United States dollars, owing to the treasury ministry's need to balance its inflows and outflows of foreign currency. As the ministries of health had explained to her, if they were authorized to meet their assessed quotas in local currency, they would be able to do so in installments throughout the year.

174. With regard to the exchange rate risk, she explained that two safeguards would be put in place. Firstly, a country wishing to pay in local currency would be expected to confirm with PAHO whether payment in that currency was, in fact, acceptable. Secondly, the requisite amount of local currency would be held at the local PAHO office for 30 days, as it could be assumed that the exchange rate would stay reasonably stable for that length of time. After that, the payment would be transferred to PAHO's account in Washington, and the country would be credited with the dollar amount actually received in the account. She said that the two safeguards would be explained in greater detail at the forthcoming Executive Committee meeting.

175. The Director commented that the topic of increasing the rate of collection had been discussed several times by the Governing Bodies, and had been the subject of two resolutions. In response to the question on the reasons for Member States' payment difficulties, she reported that a questionnaire had been sent out to determine what those difficulties were. She noted, too, that almost all bodies of the United Nations system, including WHO, accepted payment in local currency. PAHO was the exception, although the Organization did accept local currency for payments other than assessed quotas—for example those to the Revolving Fund for Vaccine Procurement. Of course it was essential to protect the Organization against exchange rate risk, but she felt confident that cautious and prudent financial management and dedicated vigilance on the part of the Secretariat's finance staff would enable it to do so.

***WHO's 11th General Program of Work (Document SPP38/9)***

176. Dr. Daniel López-Acuña (Director of Program Management, PAHO) pointed out that the SPP session provided an early opportunity to make the Member States aware of the progress in developing WHO's 11th General Program of Work (GWP) and to obtain their feedback in its early stages. Instead of the usual five years, the 11th General Program of Work would cover the period between 2006 and 2015. Another innovation

was the decision to make the preparation of the Program a very inclusive process, with many consultative iterations. In consequence, rather than being developed hastily in time for approval in 2005, it was intended that the 11th General Program of Work would be submitted to the World Health Assembly in 2006.

177. Mrs. Namita Pradham (Director, Planning, Resource Coordination, and Performance Monitoring, WHO) observed that the Subcommittee was one of the first official regional bodies to be considering the development of the 11th General Program of Work. Such farsightedness was worthy of congratulation. She stressed that the information she was presenting on the Program represented the initial thinking on it and was very much subject to change. Many issues were still open for discussion, and WHO was looking for input from the regional committees. Recalling that the Constitution of WHO stipulated that there should be a General Program of Work but did not specify a duration for it, she said that it had seemed logical to make the 11th GPW longer than usual, so that its conclusion in 2015 would coincide with the target date for attainment of the health-related Millennium Development Goals.

178. She explained that the Program would take a strategic look at the world, with a broader than usual perspective on the place of health within it, reflecting the linkage between health and development, health and national security, health and foreign policy, and so on. Since it could not be predicted how the world would be in 10 years, the program would examine different scenarios. It was thus intended to be a road map of various routes to health, not a grandiose new vision for WHO. It would raise questions, but it might not give all the answers. The General Program of Work was to be developed in two distinct phases: the first could be described as the divergent stage—a stage of gathering information and collecting inputs from the countries and the regions—which would last until about the end of 2004. The second stage would be a convergent process of using those inputs for workshops and focus groups, out of which the final version of the General Program of Work would emerge. A preliminary outline version (Document SPP38/, Annex) had been distributed, although further work had already been undertaken on it since then.

179. After an explanatory introduction, Part I of the GPW would examine the current global status and position of health. It would look at health as important in its own right, but at the same time it would examine the synergies and impacts between health and the broader development agenda. Topics for detailed examination included, for example, the way in which HIV/AIDS was impacting development across societies; human security and the need for health across borders; and challenging the positioning of health within the development agenda. The Program would also examine the past and present

determinants of health, and would then go on, in Part II, to examine possible future scenarios.

180. The ideas for Part II, she stressed, were at a very preliminary stage, with WHO seeking and welcoming comments and input from the Regions. First, Part II would examine a stable scenario, with the current planning track and current trends being maintained. It would then go on to examine less certain futures, characterized by greater variation than normally anticipated and by changing environments and new technologies that would present different and novel challenges and would require new ways of doing business. Finally, it would look at possible scenarios subsequent to truly radical changes, whether negative (collapsing economies or new wars, for example) or positive (such as the discovery of a vaccine for HIV/AIDS or rapid economic growth). In each of those scenarios, the questions to be answered would relate to how the changes impacted health and to WHO'S leadership role, the role of the countries, WHO's relationship with governments, and so on. There would also be a chapter on international commitments and responses. As WHO was currently involved in around 70 partnerships, there was a need to map out how those partnerships could operate most effectively, what WHO's contribution to each of them was, and what was to be brought by the other partners.

181. In summary, the intention was, first, to gather data and, second, to determine how best to use those data for future planning, positioning, and development of WHO. The process would serve to highlight the questions, even while acknowledging that many had no answers. WHO could not predict the course of the next 10 years, but it could be prepared to change course and anticipate requirements. The Program gave it the framework for doing so.

182. The Subcommittee welcomed the presentation on the General Program of Work and, in particular, WHO's intention to make the process of developing it an inclusive one. It also praised the division of the Program's development into the divergent and convergent phases, which would ensure that the regions, having been given the opportunity to provide input, would regard the General Program of Work not only as WHO's program, but also as their own. It was emphasized that the lessons learned from previous Programs of Work should be applied in planning the 11th GPW and that the Program as a whole should be evidence-based and data-driven.

183. Acknowledging that the preparation of the GPW represented a unique opportunity to assess health trends and identify future health challenges, the Subcommittee found it beneficial that the Program would examine the linkages among health, poverty, and development, as well as the impact of trade on health and the possible negative health impacts of globalization. It was noted that while Part I of the draft outline placed the emphasis on the global health environment and on key health challenges and priorities for international action, there was less coverage of WHO's actual priorities, strategic

directions, and goals, and no clear delineation of WHO's role, opportunities, and comparative advantage. It was suggested that the "Key Challenges" part of the document, rather than focusing on the problems and negatives, should pay more attention to key opportunities and to areas where WHO could take the lead in making a difference. It was also suggested that the same section should place greater emphasis on intersectoral cooperation. In addition, clarification was sought concerning the key role of WHO in partnerships.

184. Noting that the draft outline spoke of a possible need to reshape WHO's core functions, the Subcommittee urged caution, given that a very comprehensive reexamination of the Organization's core functions had taken place as recently as 1999. The Subcommittee was strongly in favor of both measurable goals and a monitoring and evaluation function, but sought clarification on how the latter would be integrated into the actual discussion as the General Program of Work was developed. In addition, more information was sought on the timetable for the convergent and the divergent stages.

185. Mrs. Pradham said that WHO had every intention of learning from the lessons of past successes and failures, including the extent of progress made down the path towards health for all. The Organization was very aware that there had been many targets over the years, and that it was important to examine which ones had and had not been met and what were the reasons for the failures. That examination would fall within the analytical part of the Program. On the question of evaluation and measurable goals, she said that there might well be a need for a review after, perhaps, five years of the Program, to look at how well the adopted strategies were working. With regard to WHO's role in partnerships, she noted that further reflection was needed on that question and suggested that that might be a topic for one of the workshops to be held in the regions.

186. Responding to the question concerning the timetable, she explained that it was intended to produce by May 2004 a somewhat more elaborate paper than the present draft, outlining the process for development of the GPW, along with a brief outline. That would be submitted to the 114th session of the WHO Executive Board. In June 2004 a short paper would be circulated to the Regional Committees, so that comments could be obtained from them by September, and then the paper would go to the Assistant Directors-General, the Directors of Program Management, and the Regional Directors for a fresh iteration. A new outline would be submitted to the 115th session of the Executive Board. The first full draft of the Program would be prepared around April 2005 and would be circulated to the Regional Committees in September. It would then be submitted to the Executive Board in January 2006 and to the Assembly in May 2006.

187. The Director considered it very important for the Region to have an opportunity to be involved as early as possible in the preparation of the Program of Work. It was an important topic, and one that was certain to be on the agenda of the Subcommittee again in 2005 and 2006. Additionally, the Members of the Subcommittee had an opportunity to make their views known not only at the World Health Assembly but also—in the case of certain countries—as members of the Executive Board. Members would thus have ample opportunity to contribute their thoughts and opinions.

188. The Millennium Development Goals gave a strong mandate for WHO to work in a longer cycle than usual and also provided a guideline to orient both PAHO's and WHO's work. As the Subcommittee would note when it turned its attention to the budget for 2006–2007, that work was being pursued in very close alignment, yielding valuable synergies in terms of health outcomes.

## **Other Matters**

### ***Report of the Working Group on PAHO in the 21st Century***

189. Hon. Jerome Walcott (Barbados, President of the Working Group on PAHO in the 21st Century) reported on the progress of the Working Group created pursuant to Resolution CD44.R.14 of the Directing Council to review the situation of PAHO in the 21st century. The Working Group had held its first meeting in Roseau, Dominica, on 26 and 27 February 2004. In addition to Argentina, Barbados, Costa Rica, and Peru, the four Member States designated by the Executive Committee as members of the Working Group, the following Member States were represented: Antigua and Barbuda, Bahamas, Chile, Dominica, France, Mexico, United States of America and Uruguay. The World Health Organization and the Latin American and Caribbean Association for Public Health Education had also been represented.

190. In accordance with Resolution CD44.R14, the Working Group had agreed on its own terms of reference, based on a proposal developed by the President of the Executive Committee. Those terms of reference identified six major topics to be examined by the Working Group: (1) challenges in public health in the Americas for the coming years; (2) evolving nature of partnerships and alliances in international development in health pertinent to PAHO's role; (3) regional and global public health goods in the 21st century and their relationship with PAHO's mandate; (4) modalities of technical cooperation in health; (5) governance of PAHO; and (6) resources for health. Under each of the six topics, the Working Group had identified various subpoints to be considered.

191. The Working Group had also developed a draft work plan at the first meeting, with the understanding that it would be finalized at the second meeting, held on 23 March 2004. According to the plan agreed at the latter meeting, between March and the end of May 2004, each of the four member countries of the Working Group designated by the Executive Committee would prepare a preliminary analysis for one of the terms of reference: the evolving nature of partnerships and alliances in international development in health pertinent to PAHO's role would be analyzed by Peru; regional and global public health goods in the 21st century and their relationship with PAHO's mandate, by Argentina; modalities of technical cooperation in health, by Costa Rica; and governance of PAHO, by Barbados. Those four Member States would lead the process, but they would seek support from the PAHO Secretariat and the PAHO/WHO representatives in their countries and from other sources as they deemed appropriate. At the Working Group's first meeting, the PAHO Secretariat had been asked to draft the preliminary analysis on the topic of challenges in public health in the Americas for the coming years. The preliminary analysis on resources for health would include two components, one relating to PAHO financial resources and the other to resources for health in countries. The Consultative Group on Regional Budget Policy would be asked to take the lead responsibility for that analysis and, as had been suggested earlier in the week, to liaise with the Working Group in that area.

192. The six preliminary analyses would be sent to all Member States for comment, and the feedback received would be incorporated into the progress report to be presented to the Executive Committee in June 2004. A budget for the Working Group, to be prepared by the Secretariat, would also be presented at that time. The Working Group would hold its next meeting during the World Health Assembly in Geneva in May 2004. The PAHO Secretariat would make arrangements for the meeting and would inform Member States of the exact place and time.

193. The Subcommittee welcomed the report of the Working Group and looked forward to the opportunity to comment on the six preliminary analyses. In response to a question from one of the delegates, the President clarified that the analyses would be circulated and comments would be received electronically, although hard copies of all documents would also be available. The Secretariat would inform Members of how to access them and how to submit their comments.

194. The Director extended thanks to the Government of Dominica for hosting the meeting. She noted that a number of countries had been represented at the Working Group's first meeting by their ministers of health, which was an indication of the interest that Member States had in the future of the Organization. She and her staff were grateful to all those who had attended for taking time out of their busy schedules to contribute to

the Group's work. She assured the Subcommittee that the Secretariat would continue to provide any support or services requested by the Working Group.

195. The President commended the Secretariat for its interest in and support for the Working Group process, which he felt would yield important input not only for the future work of PAHO but also for the 11th General Program of Work of WHO.

***Update by the Secretariat on Recent Events and Other Matters of Interest to the Subcommittee***

196. The Director updated the Subcommittee on the outcome of a recent conference on foot-and-mouth disease and on the status of three regional centers: the Pan American Institute for Food Protection and Zoonoses (INPPAZ), the Caribbean Epidemiology Center (CAREC), and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA).

197. Regarding INPPAZ, she reported that, owing to the present financial crisis, the Government of Argentina, the host country for the Institute, had been unable to keep up its financial commitment as stipulated under the terms of the agreement establishing INPPAZ. The Secretariat had been exercising its prerogative to advance the resources necessary for the Institute's basic operations, but the accumulated debt now amounted to almost \$1.5 million. Consequently, on 5 February 2004 she had sent a letter to the Ministry of Health and the Ministry of Agriculture, which were jointly responsible for INPPAZ, informing them that if the Government of Argentina could not assure prompt payment of at least the minimum biannual payments necessary to cover operating expenses, the Organization would be obliged to close the Institute. At a meeting on 16 March with officials from the Secretariat and the Director of INPPAZ, the Argentine authorities had expressed their desire to maintain the Institute and had committed to pay, by 30 May, the \$250,000 needed for the second half of the year. They had also agreed to formulate a plan or proposal for liquidating the remainder of the debt by the end of 2004. However, the agreement between the Secretariat and the Government of Argentina provided that biannual payments for operating expenses were to be made in advance of each six-month period, and if those payments were not received it would be necessary for the Organization to take steps to close the Institute.

198. With respect to CAREC, she noted that the Center had been established in 1964 under a multilateral agreement between PAHO and the governments of the Caribbean subregion, which had been renewed periodically through the years. The current agreement would expire at the end of 2005. The Directing Council of CAREC, which was formed by the member countries of the Center, would be discussing the renewal of the agreement when it met in April 2004. However, during a visit to the Secretariat of CARICOM in February 2004, she had been informed by the Secretary-General that

CARICOM intended to start discussions with the governments of the Caribbean on the possibility of a new relationship between CAREC and PAHO, leading to autonomy for the Center. The matter was to be raised during the 15th Inter-Sessional Meeting of the Conference of Heads of Government of CARICOM in late March and at the session of the CARICOM Council for Human and Social Development in April 2005. She had written to the Secretary General to inform him that under the multilateral agreement between Member Governments of CAREC and the Organization, to which neither CARICOM nor the Secretariat of CARICOM were parties, any changes in the status of the Center would have to be brought before the Governing Bodies of PAHO.

199. In addition, CARICOM intended to carry out an evaluation of the status of various regional centers in the health area, including CAREC and the Caribbean Food and Nutrition Center (CFNI). PAHO was represented on the steering committee for the evaluation by Dr. Karen Sealey. At the same time, as part of the review of the five-year multilateral agreement, she had decided that the Organization should undertake an evaluation of the current organizational and managerial situation and governance of CAREC, as well as its relations with donors and with its strategic allies and partners. That evaluation, which would also look at the financial situation and performance of the Center, would serve as input for renewal of the multilateral agreement and would be presented to the Directing Council of CAREC in early April.

200. She wished to emphasize that, as she had told the Secretary General of CARICOM, PAHO had exercised fiduciary, supervisory, and administrative responsibility for CAREC over the previous 28 years with the aim of making its structure and management optimum to meet the needs of the Caribbean subregion. She, as Director of PAHO and as a former staff member of CAREC, was highly committed to ensuring that the Center, regardless of any changes made in its institutional framework, would continue to respond appropriately to the needs of its members.

201. Concerning PANAFTOSA, that institution was also facing a critical financial situation, owing to lack of prompt payment by the Ministry of Agriculture of Brazil, which was responsible for covering local support costs for the Center's operations. She had written to inform the Government of Brazil that unless the Organization began receiving payment in advance for each half-year's operating expenses, she would have to start proceedings to close the Center.

202. Turning to the Hemispheric Conference on the Eradication of Foot-and-Mouth Disease (FMD), she reported that the event, which had taken place in Houston, Texas, from 2 to 4 March 2004, had been attended by 174 participants from 21 countries of the Americas and other regions. The conference had been organized jointly by PAHO and the United States Department of Agriculture, pursuant to a resolution of the Hemispheric Committee for the Eradication of Foot-and-Mouth Disease (COHEFA), which had been

endorsed by the Directing Council in 2003. She expressed her gratitude to the Government of the United States for hosting the conference, the main goal of which had been to increase awareness and build a hemispheric alliance with all stakeholders, both private and public, involved in the livestock production chain in order to join forces and eradicate FMD from the Region.

203. The main outcome of the Conference was the Houston Declaration, which recognized that the countries of the Americas have an historic window of opportunity to rid the Region once and for all of foot-and-mouth disease. The Declaration established an interinstitutional regional working group within COHEFA, with public and private sector participation, which would be responsible for preparing, supervising, and executing the Regional Project for the Final Phase of the Eradication of Foot-and-Mouth Disease from the Americas. She was pleased to report that the working group's activities were moving along quickly.

204. Finally, she wished to bring to the Subcommittee's attention the status of the Framework Convention on Tobacco Control, adopted by Member States at the World Health Assembly in May 2003. To date, only 17 countries in the Region had signed the Convention and none had ratified it. She encouraged the countries not to lose momentum after having committed to such an important process.

205. The Subcommittee thanked the Director for the updates on the financial situation of the three centers and requested that she present a fuller report to the Executive Committee in June, including, specifically, the results of the evaluation of CAREC and the other Caribbean center and the outcome of any conversations that might lead to a change in the multilateral agreement. It was suggested that it might be appropriate and timely for the Governing Bodies to undertake an in-depth examination of all the regional Pan American centers, looking not only at their financial situation but also at their roles and mandates. As conditions in the Region had changed considerably since many of the centers were established, it might be time to reassess the reasons for their existence and contemplate whether such centers remained the best modality for delivering technical cooperation in the current context.

206. The Delegate of Argentina assured the Director and the Subcommittee of his Government's intention to meet its financial obligations to the Organization, including not only its financial commitment to INPPAZ but also its quota assessment to PAHO. With regard to CAREC, Members emphasized the important role that the Center had played in the past and expressed support for its continued existence and sustainable development in the future.

207. Concerning the Framework Convention on Tobacco Control, the Delegate of Canada noted that his country had been a leader in international tobacco control efforts and was a strong supporter of the Convention. Canada urged Member States in the Americas to take action to ratify the Convention as soon as possible.

*Other matters raised by Member States*

208. The Delegates of Canada and the United States noted that the documents for the session had been distributed very late and urged the Secretariat to ensure that documents for future Governing Body sessions were made available well in advance in order to allow sufficient time for Member States to circulate them for comment and feedback among various agencies within their governments. The Delegate of Canada reiterated his request that all documents should include budgetary information, including information on both the financial and human resources being devoted to specific programs and activities.

209. The Delegate of Canada also inquired whether the Secretariat was planning to add any substantive items—apart from those examined by the Subcommittee—to the agenda for the Executive Committee. He requested that updates be presented on two specific matters: the PAHO/IDB/World Bank Shared Agenda for Health in the Americas and the Action Plan of the Summit of the Americas. Regarding the Shared Agenda, Member States had not heard much about what collaboration had taken place in the four priority areas identified under the agreement. Canada viewed the Shared Agenda as an important modality for collaboration and cooperation in the hemisphere and would appreciate an update on progress, particularly with respect to action in the area of health and the environment. As for the Action Plan of the Summit of the Americas, Canada wished to make certain that PAHO continued to play a leadership role in the Summit process by highlighting the need for countries to live up to the commitments they had made and by reporting on the status of activities in the four priority areas related to health identified in the Plan of Action adopted at the third Summit of the Americas, held in Quebec City in 2001.

210. The Delegate of the United States expressed appreciation to the Director for her leadership role in bringing health issues to the forefront in the Region through the planned celebrations for World Health Day and, especially, Health Week in the Americas.

211. The Director said that, except for a formal progress report by the Working Group on PAHO in the 21st Century, the Secretariat had not planned on adding any other substantive items to the Executive Committee agenda, although that agenda would include the various committee reports and administrative and financial matters normally

considered by the Committee. In addition, the Secretariat would provide the updates on the regional centers and other matters requested by the Subcommittee.

212. Responding at the request of the Director to the comments concerning the Shared Agenda and the Action Plan of the Summit of the Americas, Dr. Daniel López-Acuña (Director of Program Management, PAHO) recalled that during the previous year's Executive Committee session in June, the Secretariat had offered a briefing session on various summits, including the Summit of the Americas. A similar session would be offered in June 2004, and the Secretariat would present detailed information on follow-up of the action plans of the various summits, including an update on progress with regard to the resolutions adopted at the Special Summit of the Americas held in Monterrey, Mexico, in January 2004, in particular the goal of providing antiretroviral therapy to at least 600,000 HIV-infected individuals in the Americas by 2005.

213. As for the Shared Agenda, he assured the Subcommittee that it was very much alive. PAHO had recently held three brainstorming sessions with representatives of the World Bank and the IDB aimed at finding common ground for work towards the attainment of the Millennium Development Goals relating to health and poverty reduction. Those exchanges were leading to an enlargement of the scope of the Shared Agenda as the three agencies sought to better align their technical and financial cooperation in order to support countries as effectively as possible in achieving the MDGs. The upcoming EUROLAC Forum on improving health systems performance, to be held on 14–16 April 2004 in Recife, Brazil, was also part of the Shared Agenda. At the same time, work in the four areas identified initially under the Shared Agenda had continued. The work group on national health accounts, for example, had been very active. The Secretariat would include information on the progress of the work groups and other recent Shared Agenda activities in the aforementioned briefing during the Executive Committee session in June.

### **Closing of the Session**

214. The President said that he felt the meeting had been useful, informative, and successful. He thanked the Secretariat staff for the well-researched and enlightening documents and presentations, and commended the delegates for their keen participation, constructive criticisms, and thoughtful comments and recommendations. After expressing gratitude to his fellow officers and to the Director and the Technical Secretary, he declared the 38th Session of the Subcommittee officially closed.

## **AGENDA**

1. Opening of the Session
2. Election of the President, Vice President, and Rapporteur
3. Adoption of the Agenda and Program of Meetings
4. Progress Report of the Working Group on Regional Budget Policy
5. Millennium Development Goals and Health Targets
6. Observatory of Human Resources in Health
7. Access to Medicines
8. Scaling Up Health Systems for an Integrated Response to HIV/AIDS
9. International Health Regulations: Perspectives from the Region of the Americas
10. WHO's 11th General Program of Work
11. Ten-year Evaluation of the Regional Core Data in Health Initiative
12. Strategy for Increasing the Rate of Collection of Quota Assessments
13. Other Matters
14. Closing of the Session

## LIST OF DOCUMENTS

SPP38/1 and SPP38/WP/1	Adoption of the Agenda and Program of Meetings
SPP38/3	Progress Report of the Working Group on Regional Budget Policy
SPP38/4	Millennium Development Goals and Health Targets
SPP38/5	Observatory of Human Resources in Health
SPP38/6	Access to Medicines
SPP38/7	Scaling Up Health Systems for an Integrated Response to HIV/AIDS
SPP38/8	International Health Regulations: Perspectives from the Region of the Americas
SPP38/9	WHO's 11th General Program of Work
SPP38/10	Ten-year Evaluation of the Regional Core Data in Health Initiative
SPP38/11	Strategy for Increasing the Rate of Collection of Quota Assessments

**LIST OF PARTICIPANTS  
LISTA DE PARTICIPANTES**

**Members of the Subcommittee  
Miembros del Subcomité**

***Argentina***

Dr. Carlos Vizzotti  
Subsecretario de Relaciones Sanitarias e  
Investigación en Salud  
Ministerio de Salud  
Buenos Aires

***Barbados***

Hon. Jerome X. Walcott  
Minister of Health  
Ministry of Health  
St. Michael

Mr. Lionel Weekes  
Permanent Secretary  
Ministry of Health  
St. Michael

Dr. Elizabeth Ferdinand  
Senior Medical Officer of Health  
Ministry of Health  
St. Michael

***Brazil***

***Brasil***

Dr. Jorge Antonio Zepeda Bermudez  
Diretor da Escola Nacional de Saúde Pública  
Fundação Osvaldo Cruz  
Rio de Janeiro

**Members of the Subcommittee (cont.)**  
**Miembros del Subcomité (cont.)**

***Brazil (cont.)***

***Brasil (cont.)***

Dr. Verônica Ferreira Machado  
Assessora Técnica do Programa Nacional de DST/AIDS  
Ministério da Saúde  
Brasília

***Canada***

***Canadá***

Mr. Nick Previsich  
Director  
International Affairs Directorate  
Health Canada  
Ottawa, Ontario

Ms. Melissa Follen  
Senior Policy Advisor  
International Affairs Directorate  
Health Canada  
Ottawa, Ontario

***Guatemala***

Dr. Carlos Fernando Andrade  
Director de la Unidad de Planificación Estratégica  
Ministerio de Salud Pública y Asistencia Social  
Ciudad de Guatemala

***Honduras***

Dra. Fanny Mejía  
Subsecretaria de Riesgos Poblacionales  
Secretaría de Estado en el Despacho de Salud  
Tegucigalpa

**Members of the Subcommittee** (*cont.*)  
**Miembros del Subcomité** (*cont.*)

***Peru***  
***Perú***

Dr. Oscar Castillo Velásquez  
Director General  
Oficina General de Cooperación Internacional  
Ministerio de Salud  
Lima

***United States of America***  
***Estados Unidos de América***

Dr. William Steiger  
Director  
Office of Global Affairs  
Department of Health and Human Services  
Rockville, Maryland

Ms. Ann S. Blackwood  
Director of Health Programs  
Bureau of International Organizations Affairs  
Department of State  
Washington, D.C.

Ms. Jane Cowley  
Foreign Affairs Office  
Bureau of International Organizations Affairs  
Department of State  
Washington, D.C.

Ms. Ruth Fisher  
Population, Health, and Nutrition Team Leader  
Office for Regional Sustainable Development  
Bureau for Latin America and the Caribbean  
Washington, D.C.

**Members of the Subcommittee** (*cont.*)  
**Miembros del Subcomité** (*cont.*)

***United States of America*** (*cont.*)  
***Estados Unidos de América*** (*cont.*)

Ms. Ginny Gidi  
International Health Officer for the Americas  
Office of Global Health Affairs  
Department of Health and Human Services  
Rockville, Maryland

Ms. Lisa E. Jacobson  
Program Analyst  
Office of the United Nations System Administration  
Bureau of International Organizations Affairs  
Department of State  
Washington, D.C.

Ms. Peg Marshall  
Senior Advisor in Maternal and Child Health  
and Infectious Diseases  
Office for Regional Sustainable Development  
Bureau of Latin America and the Caribbean  
Agency for International Development  
Washington, D.C.

Dr. Stuart L. Nightingale  
Senior Medical Advisor to the Director  
Office of Global Health Affairs  
Department of Health and Human Services  
Rockville, Maryland

Ms. Mary Lou Valdez  
Deputy Director for Policy  
Office of Global Affairs  
Department of Health and Human Services  
Rockville, Maryland

**Members of the Subcommittee** (*cont.*)  
**Miembros del Subcomité** (*cont.*)

**Mexico**  
**México**

Dr. Roberto Tapia  
Subsecretario de Prevención y Protección de la Salud  
Secretaría de Salud  
México, D.F.

Sr. Miguel Ruiz Cabañas  
Embajador  
Representante Permanente de México ante la  
Organización de los Estados Americanos  
Washington, D.C.

Lic. Hilda Dávila  
Directora General de Relaciones Internacionales, a.i.  
Secretaría de Salud  
México, D.F.

Sr. Ernesto Campos  
Ministro  
Representante Alterno de México ante la  
Organización de los Estados Americanos  
Washington, D.C.

Lic. Manuel Herrera Rábago  
Representante Alterno de México ante la  
Organización de los Estados Americanos  
Washington, D.C.

**PAN AMERICAN HEALTH ORGANIZATION  
ORGANIZACIÓN PANAMERICANA DE LA SALUD**

**Director and Secretary ex officio of the Subcommittee  
Directora y Secretaria ex officio del Subcomité**

Dr. Mirta Roses Periago  
Director  
Directora

**Advisers to the Director  
Asesores del Director**

Dr. Joxel García  
Deputy Director/Director Adjunto

Dr. Carissa Etienne  
Assistant Director/Subdirectora

Ms. Dianne Arnold  
Director of Administration, a.i.  
Director de Administración, a.i.

Dr. Daniel López Acuña  
Director of Program Management  
Director de Gestión de Programas