



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



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### REVIEW OF THE PAN AMERICAN CENTERS

A continuously evolving technological, political, and economic environment demands an in-depth review of many of the technical cooperation approaches of PAHO. The Pan American Centers of PAHO have been an important cooperation mode for almost 60 years. During six decades, PAHO has created or managed as many as 13 Centers and has disestablished six. These institutions have been the subject of intense debate and discussion by the Governing Bodies at least as far back as the 1960s.

This document was requested by the 46th Session of the Directing Council in response to the standing mandate of the Governing Bodies to undertake regular reviews and evaluations of the Pan American Centers. It provides an update on the resolution on the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) and the Latin American and Caribbean Center on Health Sciences Information (BIREME) along with a proposal to align the Caribbean Epidemiology Center (CAREC), the Caribbean Food and Nutrition Institute (CFNI) and the Institute of Nutrition of Central America and Panama (INCAP) with the subregional allocation criteria set in the new Regional Program Budget Policy.

The Executive Committee is requested to review the document and provide comments to guide the Bureau in terms of the process of realignment.

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## **Introduction**

1. In September 2005, PAHO Directing Council adopted Resolution CD46.R6 which requested the Director submit to the 138th Session of the Executive Committee the following:

- A review of the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) and the Latin American and Caribbean Center on Health Sciences Information (BIREME)
- A proposal to align the Caribbean Epidemiology Center (CAREC), the Caribbean Food and Nutrition Institute (CFNI), and the Institute of Nutrition of Central America and Panama (INCAP) with the subregional allocation criteria set in the new Regional Program Budget Policy in consultation with the respective institutions.

2. The Pan American Centers as a whole have been discussed many times by the Governing Bodies, starting in the 1960s. By the late 1970s, the Pan American Sanitary Conference was calling for “regular evaluations of each Center” (Resolution CSP20R31, 1978) to ensure that, with the continuously evolving political, technological, and economic environment, the Centers continue to be an appropriate and efficient mode for the delivery of PAHO’s technical cooperation. The Governing Bodies have also encouraged the Director to transfer the Centers to the host governments or groups of governments in the event that the national institutions are capable of maintaining the availability of quality technical cooperation services to other Member States of PAHO.

3. It cannot be sufficiently emphasized that each Center has a very different origin, history and functions. Each Center is a very different instance of PAHO’s technical cooperation. The Centers vary significantly in the legal framework under which they operate, in their governance structures, and in their ownership and partnership arrangements.

4. However, as the Pan American Sanitary Conference considered in 1978, a PAHO Center must be an integral part of the PAHO program for that Center to be considered as a valid and worthwhile unit of PAHO. Basically, a Center is just another PAHO programmatic modality with its own legal, managerial, and programmatic characteristics. There is no justification for PAHO to have a Center, unless it is a way for achieving PAHO’s stated program objectives. The key question has remained the same for the last quarter of a century: what is the most relevant, efficient and effective way to accomplish the objectives of a particular PAHO program, approved by the Governing Bodies, above and beyond the historical, technical, administrative, political and stakeholder issues surrounding a particular Center.

5. This question has attained a pressing urgency since the beginning of the new century in the light of budgetary and financial constraints, the Internet/World Wide Web technological revolution, and the increased level of technical, managerial and research capacities in many PAHO Member States. There is no doubt that for more than half a century, in spite of serious, recurrent financial difficulties, the PAHO Center as a mode of technical cooperation proved to be scientifically successful and politically resilient. Yet there is also no question that change is increasingly catching up with this technical cooperation approach.

6. New structures, agreements, governance, and sources of funds are being explored to allow the remaining Pan American and Subregional Centers to address more efficiently and effectively ongoing public health concerns in their areas of expertise. The Bureau is working intensely on various fronts to bring these Centers in alignment with the regional policies of the Governing Bodies, including the subregional allocation criteria. Whether this medium- and long-term process of development of a new Center paradigm for the Region and subregion takes place within the PAHO organizational structures and budget, outside them, or some place in between is too early to say at the present time. Yet the process has been started in earnest in response to the mandates of the Governing Bodies, and the Director wants to keep Member States fully apprised about it.

7. The focus of this document therefore is to inform all Member States on the evolving relationship between PAHO and five of the Centers. PAHO would like to ensure that the current legal, governance, ownership and partnership aspects of the eventual relationships optimize PAHO's technical cooperation to the Region.

8. The PAHO Centers concern each and every one of the PAHO Member States, without exception. Given the the planned and, quite frequently, unanticipated impact that the Centers have upon the PAHO/WHO regular budget in the Americas, all 38 Members should follow very closely developments concerning this issue.

#### **Pan American Foot-and-Mouth Disease Center (PANAFTOSA)**

9. PANAFTOSA, a PAHO Center located in the Brazilian state of Rio de Janeiro, was created in 1951 as a technical cooperation program of the Organization of American States (OAS) and administered by PAHO. In 1968 it became a regular program of PAHO. In 1998, reference, research, and technical cooperation activities for zoonoses were transferred from INPPAZ to PANAFTOSA. Following the closing of INPPAZ in 2005, the technical team on food safety was transferred to available space on the premises of PANAFTOSA.

10. PANAFTOSA has three main functions:

- *Researching new vaccines and diagnostic procedures:* PANAFTOSA is one of the World Organization for Animal Health (OIE) regional reference laboratories for the diagnosis of FMD and vesicular stomatitis and for the control of the FMD vaccine. Most research activities are carried out in collaboration with the South American veterinary laboratory network, coordinated by PANAFTOSA.
- *Serving as a catalyst for technology transfer to PAHO Member States:* For example, in a May 2003 meeting in Chile, the South American Foot-and-Mouth Disease Control Commission (COSALFA) called on PANAFTOSA to begin supplying diagnostic kits for FMD surveillance, while seeking an outside partner capable of longer-term, larger-scale production.
- *Development and administration of the regional surveillance system for selected animal diseases:* In the early 1970s, PANAFTOSA developed a proposal for a continental surveillance system for vesicular diseases, which was approved by the agriculture ministers at the Hemispheric meeting on foot-and-mouth disease and zoonoses (RICAZ). Since then PANAFTOSA has collaborated with each country in the implementation of the system to receive, analyze, and distribute a weekly report of vesicular diseases, including training government and private-sector workers throughout the Americas to set up and operate systems for animal disease surveillance and control. The reports from each country consist of the grid location for any suspicious outbreak of vesicular disease.

### ***Governance of PANAFTOSA***

11. PANAFTOSA is a PAHO Center and a part of the Veterinary Public Health Unit within the Area of Disease Prevention and Control. The Director of PAHO names the Director of PANAFTOSA who is then a PAHO staff member. The Director of PANAFTOSA prepares a planned budget and program of work for PANAFTOSA which the Director of PAHO reviews and submits to the Governing Bodies for their final approval.

12. Based on Resolution CD12.19 of the 1968 Directing Council, the Director of PAHO was authorized to convene an annual meeting of the Ministers of Agriculture in order to review the program and budget of the Center. In 2000, with the inclusion of the participation by those countries' Ministers of Health, the meeting changed its name to RIMSA (Inter-American Meeting at the Ministerial Level on Health and Agriculture). RIMSA is convened every two years and, along with other hemispheric meetings, provides advice on the development of PANAFTOSA's programs.

### ***Financial and Human Resources of PANAFTOSA***

13. PANAFTOSA's host government, Brazil, contributes in cash and by making facilities available to the Center through its Ministry of Agriculture. The other Member States contribute through the regular budget. PAHO provides personnel and funds for the maintenance of the Center and for its technical cooperation activities. As PANAFTOSA is a part of PAHO, PAHO is responsible for its administration and its financial and technical operation. As a result, PAHO may be obligated to make up any budget shortfalls if the above revenue streams do not actualize, or to take other appropriate measures, as needed. Further financial and human resource information is found in Annexes A and B.

### ***Current Situation of PANAFTOSA***

14. Following the 1987 Resolution RIMSAS.5.R13 of the 5th RIMSAS meeting, PANAFTOSA developed a proposal for FMD eradication by 2009. The Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA) has been implemented. Closely related to PHEFA is the Inter-American Group for FMD Eradication (GIEFA), the result of a Houston, Texas, Hemispheric meeting on FMD. PANAFTOSA is the technical Secretariat of GIEFA. It is expected that through GIEFA and PHEFA substantial amounts of private and public resources will be channeled over a period of five years in an effort to eradicate FMD. Full eradication will require the continued use of the continental surveillance system, technical expertise, political will, and international cooperation—along with the involvement of all the Region's farmers, down to the smallest farm.

15. In 2005, the 14th RIMSAS meeting endorsed the conclusions and recommendations of the 10th Meeting of Directors of National Rabies Control Programs of Latin America (REDIPRA10), especially their request that the Director prepare a plan of action for 2005-2009 which aimed at eliminating dog-transmitted rabies and diminishing the risk of rabies transmitted through other species.

16. PANAFTOSA, in conjunction with PAHO's healthy municipalities strategy, has been promoting work at the intersection of the health, agriculture, and other related sectors. PANAFTOSA looks at areas of mutual interest such as small livestock producers near urban and suburban areas, where zoonoses are a major health problem.

17. In response to the Directing Council Resolution CD46.R6 (2005) the Veterinary Public Health Unit convened a high-level External Advisory Group (EAG) to conduct a review of veterinary public health in the Region. The EAG submitted its preliminary report in May 2006. The EAG considered the following three aspects:

- (a) Needs Assessments: A thorough analysis of the current needs of veterinary public health in Latin America was undertaken.
- (b) Future vision: The EAG also looked ahead to see what the future needs would be, what the upcoming challenges are, and what the rapid changes in the operating environment will bring.
- (c) Current Assessments of the organization's capacities: The EAG also evaluated the assets PAHO has in terms of human resources, institutions, and linkages and the success of PAHO's technical cooperation in this area.

18. With the convergence of animal and human health, the EAG saw an increasing need for PAHO to have a leadership role in the area of zoonoses, veterinary health (including Foot-and-Mouth disease), and food safety. PAHO has a convening role on the regional, subregional, national, and subnational levels. Thus, PANAFTOSA should be a Center for Veterinary Public Health with expertise in all these areas.

19. The next challenge for PAHO is to determine, based on the strategic analysis of the EAG, the best governance and administrative mechanisms to maximize the potential of PANAFTOSA.

### **Latin American and Caribbean Health Sciences Information Center (BIREME)**

20. The Latin American and Caribbean Health Sciences Information Center, originally named the Regional Library of Medicine (*Biblioteca Regional de Medicina*) was founded in 1967 through the collaboration of PAHO, the Paulista School of Medicine (*Escola Paulista de Medicina*), located in São Paulo, Brazil, the Health Secretariat of the State of São Paulo, and the Brazilian Ministry of Health and Ministry of Education.

21. BIREME's primary purpose is to promote and strengthen access to scientific and health care information and to facilitate the dissemination and application of health science research in Latin American and the Caribbean by establishing a regional information center. BIREME serves all Latin America & Caribbean countries through its Virtual Health Library (VHL) and complementary networks. BIREME functions in collaboration with the Paulista School of Medicine in São Paulo and serves as its library. BIREME also serves the medical community of São Paulo and supplements the collections of the School of Medical Sciences of the University of São Paulo.

### ***Governance of BIREME***

22. BIREME is part of the Area of Information and Knowledge Management. Its relations with the host country, Brazil, are determined by a “Basic Agreement,” known as the Maintenance and Development Agreement. PAHO is responsible for the administration of BIREME and the designation of its Director. In 2004, PAHO and the other signatories extended BIREME’s agreement to continue providing scientific and technical information until 2009. A National Advisory Committee composed of representatives of the signatories to BIREME should meet at least twice a year to follow up and approve its program, evaluate the Center, and fix the annual quota contributions.

### ***Financial and Human Resources of BIREME***

23. PAHO provides personnel and funds for the maintenance of the Center and for its technical cooperation activities. Since BIREME is a part of PAHO, PAHO is responsible for the financial and technical operation of the Center. Thus, PAHO may be obligated to make up any budget shortfalls if revenue streams do not actualize, or to take other appropriate measures, as needed.

24. In addition, the Brazilian Ministry of Education is responsible for funding the journal subscriptions and for maintaining access to the core collection of international journals. The Federal University of São Paulo is responsible for providing personnel, physical facilities, and basic services. The Brazilian Ministry of Health and the Secretary of Health of the State of São Paulo provide funds for the maintenance and operation of BIREME.

25. BIREME also sells products, services, and consultancies, and receives grants, mostly from Brazilian public institutions and funding agencies of developed countries. Currently, sales of products, services, and consultancies represent the largest source of income for BIREME. Further financial and human resource information is found in Annexes A and B.

### ***Current Situation of BIREME***

26. PAHO has created Terms of Reference for a review of BIREME, including the legal, fiduciary, management and governance relationship between PAHO and BIREME. These Terms of Reference are currently being discussed with Brazil. The evolving paradigm that is being sought must balance devolving autonomy to BIREME while ensuring that PAHO’s future involvement is in line with the programmatic and budgetary priorities approved by the Governing Bodies.



## **Subregional Centers (INCAP, CFNI, and CAREC)**

### ***Governance of the Subregional Centers***

27. CFNI, and CAREC are both subregional centers for the Caribbean. INCAP is a subregional center for Central America. For these three subregional Centers, PAHO entered into agreements with the relevant PAHO Member States and other institutions to manage the Centers on their behalf. The subregional Centers have their own governing bodies which meet on a yearly basis and advise the Director of PAHO on policy matters. These subregional Centers also have technical advisory committees which report to the respective Center directors. Some of the staff members of these Centers are PAHO employees and the rest are contracted under several employment arrangements. All employees, however, are under the managerial authority of the Center director, who is a PAHO international civil servant reporting to a regional Area Manager.

28. One of the impacts of this complex governance structure is that the core mandates and priorities constantly are under conflicting pressure due to the input of so many parties.

### ***Financial and Human Resources of the Subregional Centers***

29. PAHO makes annual allocations to these Centers through its regular budget and provides extra financial support through its regular technical cooperation work. Member States of each Center contribute to their financial upkeep through quota contributions. The host governments also contribute in cash and by making facilities available to the Centers. The budgets for CAREC and CFNI are reviewed by the Council for Human and Social Development (COHSOD), which is responsible for the health policies of the Caribbean Community (CARICOM) while the budget of INCAP is reviewed by INCAP's Directing Council.

30. Extrabudgetary (nonregular) funds and, increasingly, the sale of goods and technical services make up an important part of the Center income. Concerns have been expressed over the large proportion of some of the Center's core work that is now dependent on donor partners or neglected. Further financial information can be found in Appendix A and B.

31. Oftentimes substantial budget shortfalls in the subregional centers have occurred due to revenue streams not materializing. Historically, PAHO, as it has had a long-term management relationship with these Centers, has provided the missing funds out of its own regular budget account. However, if budget shortfalls persist PAHO may be obligated to take other appropriate measures, as needed..

### **Caribbean Epidemiology Center (CAREC)**

32. The Caribbean Epidemiology Center, based in Trinidad and Tobago, was formally established in 1974 as a partnership among Caribbean countries and PAHO/WHO.

33. The work of the Center falls under four major headings: epidemiologic surveillance, which includes notification of diseases to CAREC and prompt information to the countries of the area; training activities, of which approximately half are held at CAREC and half at other centers; laboratory services, with extensive back up of reference work at CAREC plus advisory service to the various Governments on improving their own laboratories; and research.

### ***Governance of CAREC***

34. The Multilateral Agreement for the operation of CAREC, among other things, defines CAREC's functions, programmes, organization and structure, and confirms CAREC's status as an international organization with immunities and privileges in its own right. This agreement is supplemented by a Bilateral Agreement between the Government of Trinidad and Tobago and PAHO. Thus, CAREC is administered by PAHO and subject to its financial rules and regulations and Manual for Field Operations, but it has its own Staff Rules, which are established by PAHO on recommendations of the CAREC Council. The original Multilateral Agreement was signed in 1974 and has subsequently been amended and extended several times. The last agreement was in effect from January 2001 to December 2005. It was recently extended for two years, at which time governance issues are to be resolved.

35. CAREC's governing body, known as the Council, meets on a yearly basis to advise and make recommendations to the Director of PAHO. The Council reviews the annual report, the proposed program and budget, the proposed quota contributions, and proposed policies concerning CAREC and submits recommendations to the Director of PAHO. The Council is composed of the Minister of Health of Trinidad and Tobago, five representatives designated by COHSOD from other member governments of CARICOM, a representative from the University of the West Indies, a representative from the Caribbean Health Research Council, a representative from the CARICOM Secretariat (CCS), a representative from PAHO, and the Chairman of the Scientific Advisory Committee.

36. CAREC has a Scientific Advisory Committee which advises the Director of PAHO through the Council on the scientific program of CAREC. The program responds to the priorities articulated in the CARICOM health agenda, called the Caribbean

Cooperation in Health (CCH). CAREC also contributes to the PAHO Caribbean subregional program and is guided by the Organization's Areas of Work.

### **Caribbean Food and Nutrition Institute (CFNI)**

37. The Caribbean Food and Nutrition Institute, headquartered on the Mona Campus, University of the West Indies (UWI), Jamaica, with a subcenter at the St. Augustine Campus, UWI, Trinidad and Tobago, was established as a regional health institution in 1967. Unlike CAREC's multilateral agreement, CFNI's does not need to be renewed every five years.

38. CFNI's member states saw a need for a regional institution for food and nutrition as the national institutions in the Caribbean subregion do not usually have the capacity to deal with all aspects of nutrition due to the relatively small and scattered population of the subregion. Also, as these services place a substantial burden on health services budgets and as the countries have many common food and nutrition issues, it was seen as more effective and economic to handle the issues at a subregional level.

39. The Institute aims to attain food security and achieve optimal nutritional health for all peoples of the Caribbean through collaboration with the Caribbean countries to enhance, describe, manage, and prevent the key nutritional problems and to increase their capacity in providing effective nutritional services. As obesity has emerged in the Caribbean as a critical issue, CFNI has evolved to consider this issue as well.

### **Governance of CFNI**

40. CFNI is part of the program of PAHO's Family and Community Health. Since CFNI is a part of PAHO, PAHO is responsible for the administration of CFNI and the designation of its Director who is also PAHO international staff member. CFNI uses the same financial and personnel processes as PAHO.

41. CFNI has a Policy Advisory Committee (PAC) and a Scientific Advisory Committee (SAC) that meet every other year. The SAC, composed of members designated by the Ministers of Health and Ministers of Agriculture of CFNI Member States, the University of West Indies, the University of Guyana, CARICOM, PAHO, and other relevant technical experts, makes technical recommendations to the PAC. The PAC has a similar but more policy oriented composition comprising of Ministries of Health and Agriculture, the CARICOM secretariat, the University of the West Indies, the University of Guyana, and PAHO. The PAC reviews the technical recommendations of the SAC and makes recommendations on the proposed program and budget and quota contributions to the Director of PAHO. The last meetings of the PAC and SAC were in 2005.

42. Although the Food and Agriculture Organization (FAO) was a founding signatory of CFNI, they are not currently active with this Center. PAHO has been

looking into CFNI's Basic Agreement to determine if it should be modified to reflect this and other changes.

**Process for Alignment of the Caribbean Subregional Centers (CAREC and CFNI)**

43. There were five areas regarding CAREC and CFNI that need further clarification:

- (a) Core function definition
- (b) Structure (defined as a result of the core function)
- (c) Financing
- (d) Administration
- (e) Governance

44. Since 1984, PAHO has worked closely with the CCS to develop the Caribbean Cooperation in Health Initiative (CCH). The CCH is a mechanism through which Member States of the Caribbean Community:

- collectively focus action and resources over a given period towards the achievement of agreed-upon objectives in priority health areas of common concern;
- identify the approaches and activities for joint action and/or technical cooperation among countries (TCC) in support of capacity building for the achievement of the objectives.

45. In July 2001, the CARICOM Secretariat made the Nassau Declaration on Health which mandated:

- (a) The evaluation of CCH II and the preparation of CCH III to be submitted to the Council of Human and Social Development (COHSOD): In pursuit of this mandate, CCS, with the support of PAHO, conducted an assessment of CCH II and an analysis of the new emerging health issues. The reports were considered by an inter-disciplinary team comprising of chief medical officers, directors of regional health institutions and PAHO. The reports recommended eight CCH III priorities: HIV/AIDS, chronic non-communicable diseases, mental health, food and nutrition, environmental health and family health, and human resource development and strengthening of health systems. PAHO also supported and participated in a meeting of CCS and health officials to develop the goals and

indicators for each of these priority areas. On the basis of these studies and analyses, COHSOD approved the recommendations emanating from the Meeting of the Chief Medical Officers held in April 2006 and requested that the final draft CCH III Program be presented at the Caucus of Ministers of Health in September 2006.

- (b) The review of the regional health institutions: CCS mobilized resources to conduct a management review of the regional health institutions (RHIs), namely the Caribbean Epidemiology Center, the Caribbean Environmental Health Institute (CEHI), the Caribbean Food and Nutrition Institute, the Caribbean Health Research Council (CHRC), and the Caribbean Regional Drug Testing Laboratory (CRDTL). The purpose of the review was to provide information to the Heads of Governments of CARICOM States on the efficiency and effectiveness of the RHIs, and to guide decisions on how to restructure and strengthen these institutions to better serve the health needs of the Caribbean region. CCS hired the consulting firm Universalialia from Canada to review the RHIs. PAHO was involved in this process as a member of the Steering Committee for the review. Universalialia submitted its report in March 2005 and COHSOD considered it in June of 2005. Some of the major findings of this study include:

- The core mandates of these institutions needed to be “reviewed and balanced in light of core funding available to support them”
- There are “uncertain understandings of what constitutes core mandate areas”
- “The core mandates should be assessed for their fit with the health needs of the Caribbean”
- “Most RHI governance systems need to be strengthened to improve the engagement of senior decision-makers (ministers) and accountability”
- COHSOD mandated CCS to look again at the governance structure and to determine some sustainable financing for the RHIs.

46. Simultaneous to this process, PAHO, in light of its subregional budget policy, initiated a study on the Caribbean subregional priorities for health to assess the strengthening of its technical cooperation in, and with, the subregion. This included a review of the Office of the Caribbean Program Coordinator (OCPC), CAREC and CFNI. As PAHO was doing this work, CCS accepted PAHO’s offer to include the review of the core mandates of CAREC and CFNI in their study. In September 2005, PAHO submitted a preliminary report to the Caucus of CARICOM Ministers of Health.

47. The CARICOM Ministers, upon receiving the report, asked PAHO to expand its scope to review, jointly with CCS, all the RHIs (except CRDTL) and to look at the framework, priorities, and management structure for CCH III. This resulted in the 30

December 2005 report entitled “Report on the Development of Priorities and Process for the Caribbean Cooperation in Health (CCH III) and Review of the Core Mandates of the CARICOM Regional Health Institutions.” At the time of the completion of this report, PAHO agreed to a request from the CARICOM ministers of health to support an exercise to determine the optional governance structure of the RHI and its cost; to cost the management structure for CCH III and make recommendations for mobilizing resources to support it; and to identify a system of sustainable financing for the RHI.

48. On 27 and 28 April 2006, COHSOD met and the directors of the five RHIs presented a proposal to enhance the governance structure. The proposal focused on the strengthening of governance systems, the engagement of senior government officials, accountability, and reduced cost of the governance system. COHSOD accepted their proposal for implementation and requested that a final document be prepared and submitted to the Caucus of Ministers of Health in September 2006, detailing the management structure and the cost implications.

#### **Institute of Nutrition of Central America and Panama (INCAP)**

49. The Institute of Nutrition of Central America and Panama, a PAHO Center which focuses on food security and nutrition was founded in 1946 with the cooperation of PAHO and the W. K. Kellogg Foundation. It is currently headquartered in Guatemala. The Central American States and PAHO proposed the original framework for INCAP in February 1946, modified it and extended it in December 1949, and adopted a Basic Agreement for INCAP in 1953 with a proposal to make it a permanent institution. This Basic Agreement was modified again in 1998 and the changes came into force in 2003. INCAP currently is a part of the PAHO’s Sustainable Development and Environmental Health Area.

#### ***Governance of INCAP***

50. INCAP is an international organization with immunities and privileges in its own right. As such, INCAP has its own financial and personnel processes. The Directing Council of INCAP oversees the functioning of INCAP within the framework of the Center’s mission, vision, and political institutional arrangements. Thus, INCAP’s Directing Council reviews the plans, programs, and projects of INCAP; the biennial budget; and the statutes, norms, and regulations of INCAP. Representatives of the ministers of health of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, and the Director of PAHO are members of INCAP’s Directing Council.

51. INCAP’s Consulting Council provides technical input to INCAP’s Directing Council and monitors the Center’s program and activities. It is comprised of one delegate from each Member State and one delegate from PAHO.

52. INCAP's External Advisory Committee is comprised of one representative from each Member State, one representative from PAHO, and four international experts named by INCAP's Director. The External Advisory Committee makes recommendations regarding the planning, administration, execution, and review of INCAP programs; suggests new projects; and helps identify resource mobilization opportunities.

53. PAHO is both a member of INCAP and responsible for the administration of the Center. While the Basic Agreement for INCAP is a permanent agreement, the arrangement for PAHO to administer the Center is renewed every five years.

### ***Process for Aligning the Roles of INCAP***

54. In the context of the changes in PAHO's regional priorities and the increasing efforts toward the integration of the Central American Member States, a team was formed in 2004 to review INCAP's technical cooperation. The team produced a report that proposed a plan of action to INCAP's Directing Council in September 2004. In August of 2005, INCAP's Directing Council met and reviewed the report and made recommendations directed at the enhancement, among other things, of INCAP's capacity for resource mobilization and partnership creation and to ask the Director of PAHO to increase the delegation of authority regarding INCAP and its Director.

55. PAHO is now in the process of reviewing and analyzing internally the legal and governance options for the future of INCAP, in an attempt to align its involvement in INCAP with the mandates of its Governing Bodies and with the new technical, financial, and political realities and trends in Central America.

### **Action by the Executive Committee**

56. The Executive Committee is requested to review this document, and to provide comments to guide the Secretariat concerning the process of realignment.

Annexes

**Annex A**  
**FINANCIAL RESOURCES OF PAHO REGIONAL CENTERS**  
**2004-2005 Biennial Budget**

NATURE OF FUNDING	PANAFTOSA	BIREME	CAREC	CFNI	INCAP	INPPAZ	TOTAL
Regular Budget (PAHO and WHO)	5,871,862	1,217,154	1,162,155	2,548,158	2,475,285	2,076,320	20,844,707
Quota Contributions from member states	0	0	4,197,128	581,328	899,645	0	5,678,101
Extrabudgetary funds –net of host country contribution-	200,582	2,279,009	7,928,870	1,535,035	0	218,464	13,784,969
Host country contributions	2,061,166	2,845,088	0	0	0	270,000	5,610,087
Sale of Products and Services	1,511,798	3,590,488	1,115,780	97,117	0	4,867	7,440,602
<b>TOTAL</b>	<b>9,645,408</b>	<b>9,931,739</b>	<b>14,403,933</b>	<b>4,761,638</b>	<b>3,374,930</b>	<b>2,569,651</b>	<b>53,358,466</b>

Figures considered for 30 December 2005 analysis are actual expenditures in each category.

Not included in the above figures:

CAREC Provident Fund	381,535
CAREC Capital Equipment Fund	68,912
CAREC – Provision for Terminal Entitlements	9,590
CAREC Building Fund	33,104

**Source: PAHO Program Budget and Project Support**



**Annex B**  
**Human Resource Analysis of PAHO Regional Centers**  
**As of February 2006**

<b>Center</b>	<b>Posts</b>	<b>Vacant</b>	<b>International (PRFP, PRFN)</b>	<b>Local (NAP, NOP, NATP, NATN)</b>	<b>Ministry (MIN)</b>	<b>GS (GSP)</b>
PANAFTOSA	97	5	12	61	0	17
BIREME	65	1	5	2	58	0
INCAP <sup>1</sup>	2	0	2	0	0	0
CFNI	33	2	6	15	0	12
CAREC	43	0	7	36	0	0
<b>Total</b>	<b>238</b>	<b>7</b>	<b>34</b>	<b>116</b>	<b>58</b>	<b>31</b>

<sup>1</sup>INCAP local staff is not accounted for in the PAHO systems.

**Source: PAHO Human Resource Management**

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