PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

25th PAN AMERICAN SANITARY CONFERENCE

50th SESSION OF THE REGIONAL COMMITTEE

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PROVISIONAL SUMMARY RECORD OF THE SECOND MEETING
ACTA RESUMIDA PROVISIONAL DE LA SEGUNDA REUNIÓN

Monday, 21 September 1998, at 2:30 p.m.
Lunes, 21 de septiembre de 1998, a las 2.30 p.m.

President:
Presidente: *Dr. Alberto Mazza* *Argentina*

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Note: This record is only provisional. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted. Delegates are requested to notify Conference Document Center (Room 215), in writing, of any changes they wish to have made in the text. Alternatively, they may forward them to the Chief, Conference Services, Pan American Health Organization, 525 - 23rd Street, N.W., Washington, D.C., 20037, USA, by 31 October 1998. The final text will be published in the *Proceedings* of the Conference.

Nota: Esta acta es solamente provisional. Las intervenciones resumidas no han sido aún aprobadas por los oradores y el texto no debe citarse. Se ruega a los Delegados tengan a bien comunicar al Centro de Documentación de Conferencias (Oficina 215), por escrito, las modificaciones que deseen ver introducidas en el texto. Como alternativa, pueden enviarlas al Jefe del Servicio de Conferencias, Organización Panamericana de la Salud, 525 - 23rd Street, N. W., Washington, D.C., 20037, EUA, antes del 31 de octubre de 1998. El texto definitivo se publicará en las *Actas* de la Conferencia.

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NOTE: In relation to Item 3.2 all country reports submitted in writing will be included in the Proceedings of the Conference.
NOTA: En relación con el punto 3.2 todas los informes de país presentados por escrito se incluirán en las Actas de la Conferencia.

The meeting was called to order at 2:35 p.m.
Se abre la reunión a las 2.35 p.m.

FIRST REPORT OF THE GENERAL COMMITTEE
PRIMER INFORME DE LA COMISIÓN GENERAL

El Dr. MAZZA (Presidente de la Comisión General) informa que, bajo la dirección del Presidente de la Conferencia Sanitaria Panamericana y con la participación de los dos Vicepresidentes, el Relator y los delegados del Brasil, Cuba y los Estados Unidos de América, la Comisión celebró su primera reunión el lunes, 21 de septiembre de 1998, a las 12.30 p.m.

Como resultado del debate, la Comisión General acordó lo siguiente: las horas de trabajo de la Conferencia serán de 9.00 a.m. a 12.30 p.m., y de 2.30 p.m. a 6.00 p.m.; los idiomas oficiales de trabajo de la Conferencia serán español, francés, inglés y portugués; se decidió el orden de la consideración de los temas, y que se distribuirá en el documento titulado *Programa de reuniones* (CSP25/WP/1); la Comisión General tendrá su próxima reunión el miércoles, 23 de septiembre de 1998, inmediatamente después de la reunión matutina.

La Comisión General tomó nota de las elecciones para los distintos comités, que se llevará a cabo la mañana del miércoles. Se decidió sugerir que cuando hubiera más candidaturas que puestos vacantes, como era el caso del Comité Ejecutivo, y a fin de agilizar la elección, los candidatos consideraran la posibilidad de llegar a un acuerdo antes de que se iniciara el proceso de elección. Asimismo, a fin de agilizar el proceso electoral,

cuando las candidaturas se hubieran anunciado con anterioridad, no habría necesidad de pasar por el proceso de presentación de candidatos, y los nombres de éstos se anunciarían por el Secretario. El Presidente procedería entonces a preguntar si había otros candidatos o si se deseaba retirar alguna candidatura.

Decision: The first report of the General Committee was approved.
Decisión: Se aprueba el primer informe de la Comisión General.

ITEM 3.2: ANNUAL REPORT, 1997, AND QUADRENNIAL REPORT, 1994-1997, OF THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU (*continued*)
PUNTO 3.2: INFORME ANNUAL, 1997, E INFORME CUADRIENAL, 1994-1997, DEL DIRECTOR DE LA OFICINA SANITARIA PANAMERICANA (*continuación*)

Dr. YUNES (Brasil), diz que a Delegação do Brasil gostaria de felicitar o Diretor da Organização Pan-Americana de Saúde por seu informe e expressar sua satisfação com a forma pela qual o Dr. Alleyne vem conduzindo a gestão atual da Organização Pan-Americana da Saúde. Na nossa avaliação, o Dr. Alleyne tem sabido reformular e atualizar a Organização com muito equilíbrio e eficiência, de modo a enfrentar os novos desafios que se têm apresentado à Saúde Pública nos dias atuais na Região das Américas. Sua persistência em atingir metas ambiciosas, como a promoção da eqüidade, entre outras, na tentativa de reduzir as desigualdades em saúde, que ainda se observam na região, bem como a adoção de iniciativas corajosas e inovadoras para ajustar o trabalho da Organização as atuais demandas dos países merece nosso reconhecimento e apreço, e

justificam nosso desejo de que o atual esforço de direcionamento que vem sendo imprimido às atividades continuem nos próximos anos. Um dos aspectos que nos parece central no trabalho do Dr. Alleyne é a diretriz de descentralizar as ações, fortalecendo os países e os centros colaboradores da Organização Mundial da Saúde, por entendermos que se trata de uma estratégia apropriada, que valoriza as capacidades nacionais e estimula a formação de redes de cooperação entre países que compartilham problemas semelhantes. Para assegurarmo-nos de que este trabalho possa avançar com sucesso, apoiamos, com confiança e entusiasmo, a reeleição do atual diretor. Estamos certos de que a Região das Américas como um todo só terá a ganhar com a liderança de um novo mandato do Dr. Alleyne. No caso específico do Brasil, a cooperação que vem sendo concedida pela Organização Pan-Americana de Saúde é condizente com as políticas e programas em andamento no país e um instrumento que consideramos extremamente valioso para completar o esforço nacional destinado a aprimorar continuamente a atenção prestada à população brasileira pelo setor saúde. O conteúdo e as modalidades de cooperação são, efetivamente, compatíveis com as necessidades que identificamos no país e nos têm ajudado substancialmente. Essa colaboração vem, inclusive, se expandindo nos últimos anos e a tendência é que continue a crescer, não só pelo apoio altamente qualificado que a OPAS oferece, mas também pelo interesse da Organização em buscar novos caminhos para ampliar o alcance de ações conjuntas mutuamente vantajosas. A utilização do fundo rotatório para aquisição de vacinas e a necessidade de criação de um mecanismo similar para compra de insumos estratégicos nas ações de saúde pública servem para ilustrar essas

novas possibilidades. Por todas as razões apontadas, aproveitamos para reafirmar o apoio da Delegação brasileira à recondução do Dr. Alleyne ao cargo de Diretor da OPAS, no qual, ratificamos, tem-se destacado pelo seu desempenho, e que certamente resultará em beneficios concretos importantes para toda a região.

El Dr. DOTRES (Cuba) felicita al Director por el informe presentado y encomia los esfuerzos desplegados por la OPS bajo el espíritu del panamericanismo. Subraya, sin embargo, que el problema predominante en la Región es la inequidad, la cual se expresa por el deterioro de algunos indicadores de salud. A título de ejemplo, menciona que el incremento de las tasas de mortalidad infantil significa que cada año mueren en el continente 350.000 niños antes de cumplir un año de edad. En consecuencia, la OPS debería hallar fórmulas para resolver los problemas de la pobreza y la inequidad en los países. En este contexto, critica las corrientes privatizadoras exageradas surgidas al amparo de un neoliberalismo desenfrenado, que a veces llevan a los Estados a transferir su autoridad y responsabilidad en materia de sanidad a entidades que se rigen por criterios reduccionistas y mercantilistas. Por último, destaca la importancia decisiva de la cooperación técnica en el ámbito de la salud y señala que ésta debe adoptar una forma innovadora, ágil, oportuna y bien dirigida, en conformidad con los tiempos actuales.

Hon. Dr. AYMER (Antigua and Barbuda) noted that his Delegation had submitted to the Secretariat a brief written report on advances and failures of Antigua and Barbuda in the field of health over the 1994-1997 quadrennium. Any successes the country had

achieved were due in no small measure to the assistance and technical cooperation it had received from PAHO in the framework of a relationship that could truly be described as a partnership. His Delegation congratulated the Director for an excellent quadrennial report. The report reflected a keen understanding of the history and development of health in the Region, an awareness of the economic, social, and political dynamics in the Member States, and a recognition of the impact of globalization. At the same time, it reflected a pluralism that took account of ethnic, economic, and cultural differences and of the multidimensional nature of the issues PAHO was called on to address. The report also clearly defined the role of health in the current randomized, turbulent environment, and it addressed the managerial, structural, and functional issues that provided an enabling environment for the Organization's work. Finally, the report provided hope for the future under PAHO's continued leadership in moving the Region in the right direction into the new millenium.

Dr. JUNOR (Jamaica) added his Delegation's congratulations to the Director and the staff of the Organization for the leadership provided by PAHO during the quadrennium and for the vision that had guided its work. That vision had made it possible to weld together a disparate group of countries and had enabled them to work together to solve common problems. Jamaica had benefited especially from the Organization's programs in the areas of health promotion, healthy environment, and health reform. Despite the notable progress of the previous four years, however, many challenges remain. Poverty

was still the biggest sickness in the world, and PAHO's continued efforts to call attention to that fact would be critical in addressing the issue. Jamaica also congratulated Dr. Brundtland for the direction in which she was steering WHO and pledged its continued support for the work of both WHO and PAHO.

El Dr. GALVIS (Colombia) felicita al Director por su extraordinaria presentación del informe cuadrienal, reconoce la ausencia anterior de su país por voluntad del pasado Gobierno, y manifiesta que la PAHO es una Organización necesaria para integrar voluntades y resolver a los problemas de los países de las Américas. Por ello, quiere solicitar el apoyo de todos para Colombia, un país convulsionado por una lucha fratricida, en donde se han generado emigraciones hacia las grandes ciudades, en cuyos cinturones marginales las necesidades están en casi un 35% insatisfechas, es decir, que viven en extrema pobreza. Ello genera el peor fermento, que es la violencia. El problema no es el alcohol, ni el tabaco, ni el juego, sino el cambio de hábitos y los estilos de vida. Hay que generar educación, vivienda, salud y trabajo, como prioridades importantes, a fin de lograr unos municipios saludables y de vivir en paz y tranquilidad.

El Dr. FIGUEROA (Chile) felicita a la Dra. Bruntland por su reciente elección como Directora General de la OMS y celebra que en ella se reconozca la gran contribución de las mujeres en la esfera de la salud. Felicita al Director por el informe presentado y por la manera sobria y profesional con que ha dirigido la Organización, así como por el interés que ha puesto en lograr la equidad. A fin de que todos los habitantes

del continente americano tengan un acceso digno y oportuno a servicios sanitarios de calidad. En el informe presentado se puede apreciar la capacidad del Director para armonizar propuestas diversas y formular políticas sanitarias bien acogidas por los Estados Miembros. Hay que destacar también el gran apoyo que el personal, cuya dedicación y profesionalismo son conocidos, ha prestado al Director en su labor.

Un tema importante abordado en el informe es el de la cooperación técnica, indispensable para seguir avanzando en el mejoramiento de las condiciones de salud de los pueblos americanos. En consonancia con la Declaración de Santiago y la intervención del Presidente de Chile, Sr. Eduardo Frei, con ocasión de la reciente Cumbre Iberoamericana, su país desea que el tema de la salud ocupe un lugar destacado en el orden del día de la próxima Cumbre de las Américas, que se celebrará en el Canadá a comienzos del tercer milenio.

Manifiesta su preocupación por que los problemas económicos que se han producido en Asia repercutan en el continente americano y desencadenen otra crisis que ponga en riesgo la prestación de los servicios básicos de salud, cuya demanda no cesa de aumentar. Por ello, exhorta a todos los países a adoptar medidas para proteger los servicios sociales básicos ante esa eventualidad. Por último, dice que su país también está a favor de que el Dr. George Alleyne sea reelegido para un nuevo período como Director de la Organización.

Hon. Dr. THOMPSON (Barbados) added her Delegation's congratulations to Dr. Alleyne for his quadrennial report, which was excellent in both appearance and content. Barbados was pleased that the Director had succeeded in thoroughly reforming and transforming the Organization without changing its essential nature. Under his leadership, PAHO had become even more responsive to the needs of the countries. Barbados was also pleased with the institutional reforms that had been introduced, in particular the recruitment or promotion of large numbers of women to high-level posts. Dr. Alleyne had stressed the idea of partnerships, and PAHO had indeed been a wonderful partner with the Caribbean, helping the countries to deliver the kinds of programs and services that they wanted to offer and that their people demanded. At the same time, however, the Organization had allowed the countries to take full ownership of their programs and health systems.

Her Delegation welcomed PAHO's recognition of the power and influence of the church and its incorporation of the church as a partner in promoting health. The Organization had also made very effective use of information as a tool for planning and development of health policy, and the benefits of its activities in that area had extended to the country level. PAHO's efforts to highlight the nexus between health and the environment were of particular relevance to the Caribbean island nations given their economic dependence on tourism, which in turn depended on the preservation of a healthy environment.

Over the years there had been increasing cooperation among the countries of the Caribbean and among countries throughout the Region. Barbados was encouraged to find that the countries were increasingly relying on each other for guidance and technical expertise rather than continuing to look to the North for the resolution of their problems. Such partnerships were being actively promoted in the context of the Caribbean Cooperation in Health. As the countries moved forward toward the achievement of health for all, they would be faced with many challenges: new diseases, old diseases that were re-emerging, and chronic diseases that were increasing, compounded by economic difficulties resulting from the international financial situation. Nevertheless, they could look to the future with confidence that the partnerships that had been forged and the accomplishments that had been made would prepare them to confront the challenges that lay ahead.

Finally, the Barbadian Delegation wished to welcome the Director-General of WHO to the Region, and looked forward to continued collaboration with both Dr. Brundtland and with the distinguished Director of PAHO.

La Sra. HERNÁNDEZ DE HUNG (Venezuela) felicita al Director por la labor realizada durante los últimos cuatro años, durante los cuales se han emprendido actividades innovadoras que han ofrecido opciones para transformar los sistemas de salud de los países de la Región. Dichas actividades se han fundamentado en una sólida base técnica que ha permitido aumentar la eficiencia en el campo de la cooperación en salud. No obstante, es preciso garantizar que el trabajo que se lleva a cabo esté respaldado por

una voluntad política sólida, el diálogo fecundo y la sensibilidad intelectual necesaria, requisitos vitales para diseñar proyectos de salud y desarrollo integrales basados en la participación activa.

Uno de los principales retos que afrontan los países de la Región es la equidad y, para alcanzarla, es necesario canalizar todos los esfuerzos a través de la cooperación técnica en salud. En los cuatro años precedentes, la Organización ha demostrado seguir la dirección acertada y ejercer el control que precisa la consecución de los objetivos marcados.

El Dr. LECHTIG (Observador, UNICEF) felicita al Director por los avances realizados y a la Dra. Brundlant por sus acertadas observaciones. Considera fundamental mantener la integridad del tejido social: los niños, la familia, la mujer y la comunidad y, en este sentido, señala que la pregunta que ha de formularse es cómo pueden participar la familia y la comunidad en los servicios de salud o, en otras palabras, cómo conseguir que dicho tejido social se convierta en el sustento de los servicios de salud entendidos como el elemento clave de su proceso de desarrollo.

La ausencia de los servicios de salud necesarios, la guerra y la pobreza violan los derechos de todas las personas y, especialmente, los de las mujeres y los niños. Estos últimos son los seres más vulnerables, como se constata, por ejemplo, en períodos de ajuste económico o durante desastres climáticos.

La Organización ha logrado situar a los niños en un lugar central, tanto de la formulación de políticas nacionales como de políticas de cooperación internacional en salud, lo cual se ha traducido en diversas líneas de acción. Entre ellas cabe destacar las metas de la Cumbre Mundial de la Infancia para el año 2000 y los planes a corto plazo que se diseñarán en la Conferencia Ministerial sobre Política Social e Infancia, que se celebrará en Lima del 25 al 27 de noviembre de 1998, con objeto de acelerar la consecución de los objetivos pendientes.

La Dra. RIVAS (Uruguay) señala que, como se indica en el Informe Cuadrienal del Director, al prestar cooperación en salud es sumamente importante preservar las pautas y los valores culturales de los países. Por otra parte, se debe analizar si las políticas de salud de cada uno de los países han de contemplarse de forma global o si es preferible proceder de forma diferente. Por último, destaca el papel decisivo que ha desempeñado la Organización en la resolución de algunos problemas de INCOSUR y en facilitar algunas actividades de MERCOSUR.

The DIRECTOR thanked the delegates for their comments and words of encouragement. He was pleased that the report had been so well received, but at the same time he was encouraged by the delegates´ recognition that many problems remained to be addressed and their sense that the work that PAHO had accomplished in the preceding four years would help in the solution of those problems. On behalf of the staff, he pledged

the Organization´s continued support for the health programs that the countries were putting in place.

ITEM 3.1: ANNUAL REPORT OF THE PRESIDENT OF THE EXECUTIVE COMMITTEE
PUNTO 3.1: INFORME ANNUAL DEL PRESIDENTE DEL COMITÉ EJECUTIVO

El Dr. FIGUEROA (Presidente del Comité Ejecutivo) presenta el informe sobre las actividades del Comité Ejecutivo y sus diversos subcomités entre septiembre de 1997 y septiembre de 1998. Durante ese período, se celebraron la 121.ª y la 122.ª sesiones del Comité, y el Subcomité de Planificación y Programación celebró su 9.ª y 30.ª sesiones. A continuación informará únicamente sobre los puntos examinados por el Comité no incluidos en el orden del día de la Conferencia Sanitaria Panamericana, y presentará el informe sobre los otros puntos cuando sean considerados por la Conferencia. Los delegados podrán encontrar información más detallada en los informes finales de la 121.ª y la 122.ª sesiones del Comité y en los informes respectivos de los subcomités. La 121.ª sesión del Comité Ejecutivo se celebró en la sede de la Organización Panamericana de la Salud el 26 de septiembre de 1997. La sesión contó con la asistencia de los delegados de los nueve Miembros del Comité Ejecutivo, a saber: Antigua y Barbuda, Bahamas, Chile, Colombia, Costa Rica, Ecuador, México, Panamá y Paraguay. También estuvieron presentes observadores de Argentina, Canadá, Estados Unidos de América y Venezuela.

Se eligió a Chile para ocupar la presidencia de la 121.ª y la 122.ª sesiones. Para la vicepresidencia se eligió a Bahamas, y para la relatoría al Paraguay. Se eligió al Ecuador para formar parte del Subcomité de Planificación y Programación, por haber llegado a su término el mandato de El Salvador en el Comité Ejecutivo, y se eligió a Antigua y Barbuda para formar parte del Comité Permanente de No Gubernamentales por haber llegado a su término el mandato de Saint Kitts y Nevis en el Comité Ejecutivo.

Como es costumbre, el Comité efectuó un análisis completo del proceso y contenido del 40.º Consejo Directivo y examinó las resoluciones aprobadas por éste que tenían particular interés para el Comité Ejecutivo. En general, el Comité estimó que la sesión del Consejo Directivo había sido muy productiva y eficaz. Sin embargo, se sugirió que, en el futuro, debería tratarse de que se siguiera más estrictamente el horario y el programa de reuniones aprobados. El Comité hizo varias recomendaciones para acrecentar la eficiencia de las sesiones futuras del Consejo Directivo; en particular, recomendó que, al elaborar el orden del día de las sesiones del Subcomité de Planificación y Programación y del Comité Ejecutivo, se tuviera presente la necesidad de limitar el número de puntos incluidos en el orden del día del Consejo y de procurar que el Comité Ejecutivo le enviara menos puntos.

Además, el Comité fijó las fechas y los temas propuestos para la 29.ª y la 30.ª sesiones del Subcomité de Planificación y Programación, la 122.ª sesión del Comité Ejecutivo y la 25.ª Conferencia Sanitaria Panamericana. El Comité adoptó seis decisiones,

las cuales se reflejan, junto con una síntesis de las deliberaciones, en el informe final de la 121.ª sesión.

La 122.ª sesión del Comité Ejecutivo se celebró en la sede de la Organización, en Washington, D.C., del 22 al 25 de junio de 1998. Contó con la asistencia de los delegados de los nueve Miembros del Comité Ejecutivo, a saber: Antigua y Barbuda, Bahamas, Chile, Colombia, Costa Rica, Ecuador, México, Panamá y Paraguay. En calidad de observadores estuvieron presentes representantes de los siguientes Estados Miembros y Estados Observadores: Bolivia, Canadá, Cuba, Estados Unidos de América, Francia, Jamaica, Uruguay, Venezuela y España. Además, estuvieron representadas cinco organizaciones intergubernamentales y cuatro organizaciones no gubernamentales.

El Comité Ejecutivo nombró a los delegados de Chile y de Bahamas para que lo representaran en la 25.ª Conferencia Sanitaria Panamericana, y seleccionó a los delegados de México para suplir a Chile y a los de Barbuda para suplir a Bahamas. También aprobó el programa provisional de temas de la 25.ª Conferencia Sanitaria Panamericana.

Se presentaron al Comité informes del Subcomité de Planificación y Programación y del Jurado para la Adjudicación del Premio OPS en Administración.

Con relación al Subcomité de Planificación y Programación, la Dra. Merceline Dahl-Regis, quien presidió la 30.ª sesión del Subcomité en representación de Bahamas, informó sobre la 29.ª y la 30.ª sesiones del Subcomité de Planificación y Programación. En las dos sesiones el Subcomité trató nueve puntos que posteriormente se incluyeron en el orden del día del Comité Ejecutivo, a saber: prevención y control del consumo de

tabaco; salud de las personas de edad; hantavirus; orientaciones estratégicas y programáticas para la Oficina Sanitaria Panamericana, 1999-2002; la cooperación técnica entre países: panamericanismo en el siglo XXI; cambio climático y enfermedades infecciosas: consecuencias del fenómeno El Niño; población y salud reproductiva; programa de publicaciones de la OPS; y anteproyecto de presupuesto por programas de la Organización Mundial de la Salud para la Región de las Américas para el ejercicio 2000-2001. Casi todos esos puntos serán examinados también por la presente Conferencia Sanitaria Panamericana.

El Subcomité consideró asimismo los siguientes puntos que no se transmitieron al Comité Ejecutivo para su consideración: vigilancia y prevención de enfermedades transmitidas por los alimentos; comunicación y salud; salud y turismo; mitigación de desastres en los establecimientos de salud; y bioética. En los informes finales de la 29.ª y la 30.ª sesiones del Subcomité pueden consultarse los resúmenes de las ponencias y los debates sobre los temas antedichos (documentos SPP29/FR y SPP30/FR).

Se presentó al Comité Ejecutivo una ponencia sobre hantavirus. El Dr. Gabriel Schmunis, Coordinador del Programa Enfermedades Transmisibles de la OPS, describió algunas de las actividades emprendidas por la Organización para ayudar a los países a combatir el síndrome pulmonar por hantavirus, que se había presentado en forma de brotes epidémicos en el sudoeste de los Estados Unidos de América en 1993, en el Canadá en 1994, y en Argentina, Brasil, Chile, Paraguay y Uruguay entre 1995 y 1998. Para marzo de 1998, se habían confirmado en la Región más de 400 casos.

En vista de la gravedad de la situación, el 40.º aprobó una resolución en septiembre de 1997 por la cual exhortó a los Estados Miembros a que fortalecieran los esfuerzos de cooperación y promovieran — por medio de actividades de información, educación y comunicación — la adopción de buenas prácticas de saneamiento ambiental. La resolución también solicita al Director de la OPS que la creación de un grupo de estudio para formular recomendaciones sobre vigilancia, diagnóstico, tratamiento y prevención de a infección por hantavirus. El grupo de estudio se reunió en marzo de 1998.

La OPS ha proporcionado ayuda técnica a diversos países en respuesta a los brotes y ha patrocinado investigaciones para caracterizar el virus e identificar el reservorio. Además, ha apoyado proyectos de cooperación técnica entre países en áreas como el diagnóstico, vigilancia, estudio de los roedores, producción de reactivos y capacitación para el diagnóstico. Asimismo, la Organización ha proporcionado apoyo a la producción y distribución de guías técnicas sobre el hantavirus.

Para seguir respondiendo a las necesidades de los países, la Organización continuará fortaleciendo los mecanismos de vigilancia cooperativa entre los países, promoviendo actividades de información, educación y comunicación, y apoyando la transferencia de tecnología y la capacitación para el diagnóstico y tratamiento del síndrome pulmonar por hantavirus. También proporcionará apoyo para la producción regional de los antígenos necesarios para el diagnóstico de las infecciones por hantavirus y para investigaciones específicas en las esferas definidas por el grupo de estudio.

En el debate acerca de este punto del orden del día, el Comité destacó el hincapié que se había hecho en la cooperación regional, dada la naturaleza continental del problema. Se recalcó que la vigilancia constante, la atención a la prevención y el saneamiento ambiental, la educación sanitaria y la información eran claves para evitar problemas de salud pública como la infección por el hantavirus.

El Comité Ejecutivo consideró asimismo diversos asuntos administrativos y financieros, entre ellos los informes sobre el Fondo de la OPS para bienes inmuebles y mantenimiento y reparación de los edificios propiedad de la OPS, así como edificios de las oficinas de campo de la OPS. El Sr. Eric Boswell, Jefe de Administración de la OPS, informó al Comité sobre el estado de un proyecto en tres etapas para mantenimiento y reparación del edificio de la OPS en Brasilia, así como las obras para reemplazar el calafateo de los ventanales de vidrio de la pared exterior y reparar el techo de la sala de máquinas del edificio de la sede de la OPS en Washington, D.C., a fin de remediar un problema persistente de filtración de agua. Finalmente, el Sr. Boswell informó al Comité de que el Director había decidido asignar US$1,4 millones de los ingresos extrapresupuestarios para cubrir el costo de instalar calderas y compresores nuevos en el edificio de la Sede.

Por medio de la Resolución CE122.R14, el Comité aprobó que la suma de $550.000 del Fondo de la OPS para bienes inmuebles se empleará para costear la fase final del proyecto del Brasil y las reparaciones del edificio de la sede de la OPS.

En otros asuntos administrativos, la Dra. Diana LaVertu, Jefa de Personal, describió varios cambios del Reglamento del Personal de la Oficina Sanitaria Panamericana cuya introducción se proponía, y que eran congruentes con las modificaciones adoptadas por el Consejo Ejecutivo de la OMS y se consideraban necesarios de conformidad con las decisiones adoptadas por la Asamblea General de las Naciones Unidas, basadas a su vez en las recomendaciones de la Comisión de Administración Pública Internacional. Las modificaciones fueron aprobadas por el Comité mediante la resolución CE122.R8.

Como es habitual, habló ante el Comité Ejecutivo un representante de la Asociación de Personal de la OPS/OMS. La Presidenta de la Asociación, Sra. Luz María Esparza, declaró que el Director había decidido crear el puesto de mediador en la OPS y que, en opinión de la Asociación de Personal, ello tendría consecuencias positivas en la vida de la Organización. El Comité Ejecutivo reconoció la inestimable aportación del personal a la labor de la OPS. Sin embargo, reiteró el punto de vista que había expresado en su 120.ª sesión del año precedente, en el sentido de que no era adecuado que el Comité Ejecutivo interviniera directamente o pretendiera influir en las decisiones relativas a la dirección interna del personal; de ello no obstante, se debía mantener informado al Comité. El Director manifestó que colaboraría con la Asociación de Personal para determinar como proceder en cuanto a la decisión de crear el cargo de mediador. También respondió a las inquietudes planteadas por la Asociación con respecto a la existencia de diferentes sistemas de contratación y el nuevo sistema de evaluación del desempeño de la

Organización. En el informe final de la 122.ª sesión puede consultarse un relato más detallado del debate en torno de la intervención de la representante de la Asociación de Personal.

The meeting was suspended at 3:45 p.m. and resumed at 4:15 p.m.
Se suspende la reunión a las 3.45 p.m. y se reanuda a las 4.15 p.m.

ITEM 5.1: REPORT ON THE COLLECTION OF QUOTA CONTRIBUTIONS
PUNTO 5.1: INFORME SOBRE LA RECAUDACIÓN DE LAS CUOTAS

Dr. DAHL-REGIS (Representative of the Executive Committee) summarized the report that had been presented by Mr. Mark Matthews, Chief of the Department of Budget and Finance, at the 122nd Meeting of the Executive Committee. Of the $124 million in total contributions that had been due on 1 January 1997, $72 million had been received during 1997, resulting in a balance due of $52 million as of 31 December 1997. Payments on those arrears received from 1 January to 12 June 1998 had amounted to $34 million, or 65%. Mr. Matthews had also reported that additional payments totaling more than $1.37 million had been received since 12 June 1998.

As of June 1998, six Member States had paid their 1998 assessments in full; eight Member States had made partial payments for 1998; and 25 Member States had not made any payment toward the current year assessments. Together, the collection of arrears and current year assessments during 1998 totaled $54 million, an increase of $10 million over 1997.

At the time of the Executive Committee's June session, seven countries — Bolivia, Cuba, Dominican Republic, Ecuador, Grenada, Nicaragua, and Peru — had been potentially subject to the application of Article 6.B of the PAHO Constitution.

The Executive Committee had adopted Resolution CE122.R1, thanking those Member States that had already made payments for 1998 and urging the other Member States to pay their outstanding contributions as soon as possible.

Mr. MATTHEWS (PAHO) thanked the Member States for their efforts to pay their quota assessments in a timely manner, as the extent to which the Member States met their commitments determined the degree to which the Organization would be able to carry out its mandate.

The most recent data on assessments and payments could be found in Document CSP25/19, Add. 1. As shown in Annex A of Add. 1, on 1 January 1998 the total arrears of contributions for years prior to 1998 had amounted to $52.1 million. Payments on those arrears received from 1 January to 14 September 1998 had equaled $36.9 million, or 71%, which had reduced the arrears to $15.2 million, as compared to $8.0 million in 1997, $16.3 million in 1996, and $11.9 million in 1995 at the corresponding time of year.

As of 14 September 1998, the collection of contributions for 1998 assessments had stood at $38.5 million, an increase of $3.7 million over the amount in 1997 ($34.8 million). Nine Member States had paid their 1998 assessments in full, 11 had made partial payments, and 19 had not made any payments toward the 1998 assessments. Those

collections represented 47% of current year assessments, as compared to 42% in 1997 and 48% in 1996.

Together, the collection of arrears and current year assessments during 1998 totaled $75.4 million, an increase of 9% compared to 1997. All payments received from Member States by 14 September 1998 were shown in Annex A. Since that date, $60,000 had been received from Cuba, $4,909 from the Bahamas, $4,412 from Guyana, and $333 from Guatemala.

According to Article 6.B of the Constitution, if a Government failed to meet its financial obligations to the Organization by the opening date of the Pan American Sanitary Conference or the Directing Council by being in arrears in an amount exceeding the sum of its annual assessments for two full years, the voting privileges of that Government would be suspended, unless the Conference or Directing Council considered that the failure to pay was due to conditions beyond its control. As of the opening of the current Conference, there were three Member States who were subject to the provisions of Article 6.B. the status of those quota payments had been reviewed by the Article 6.B Working Party, whose chairman would report on its conclusions.

Hon. Dr. AYMER (Antigua and Barbuda), Chairman of the Article 6.B Working Party consisting of the delegates of Antigua and Barbuda, Mexico, and Uruguay, reported that Cuba, the Dominican Republic, and Grenada currently had payment arrears in excess of two full years.

Cuba owed $2.5 million, of which $244,541 related to 1994 and $557,880 related to 1995. The payment plan approved by the Secretariat in 1996 had stipulated that a payment of $600,000 was due in 1996 and that payments would increase by $50,000 in each subsequent year until the arrears were liquidated. In 1996 and 1997, the Organization had received payments from Cuba totaling $600,000 and $650,000, respectively, and $540,000 had been received so far in 1998. Therefore, Cuba was in compliance with the terms of its deferred payment plan.

The Dominican Republic owed $560,824 in quota assessments, of which $137,431 related to 1995. No payments had been received from that Government in 1998, but the Organization had been advised that a check for $137,431 had been prepared and was awaiting a second signature before being forwarded to the Organization. The Working Party therefore determined that the Dominican Republic had evidenced a good faith effort to meet its obligation.

Grenada owed $90,712 in quota assessments, of which $20,148 related to 1995. No payments had been received from Grenada during 1998. The Organization had been informed of a wire transfer of $23,522 from Grenada to the Organization on 16 September 1998. Although that payment had not yet been received, the Working Party determined that Grenada had evidenced a good faith effort to meet its obligation.

The Working Party, bearing in mind the provisions contained in Resolution CE122.R1 and the official reports and resolutions of past sessions of the Directing Council, and giving due regard to the current economic situations in the Member States,

recommended that the Conference restore Cuba's voting privileges as it had met its commitment to the Organization according to the terms of its deferred payment plan. Furthermore, in the spirit of Panamericanism, the Working Party voted to restore the voting privileges of the Dominican Republic and Grenada because of their good faith efforts.

The Working Party complimented those Member States that had made special efforts to meet their quota commitments as early as possible during the calendar year and especially recognized those countries experiencing difficult economic conditions. The members of the Working Party unanimously agreed that deferred payment plans should be considered firm commitments and as such should not be subject to modification except to accelerate the liquidation of arrears.

The Working Party proposed the following resolution for consideration by the Conference:

THE 25th PAN AMERICAN SANITARY CONFERENCE,

Having considered the report of the Director on the collection of quota contributions (Document CSP25/19 and Adds. 1 and 2) and the concern expressed by the 122nd Session of the Executive Committee with respect to the status of the collection of quota contributions;

Noting that Cuba is in compliance with its deferred payment plan; and

Further noting that the Dominican Republic and Grenada have made "good faith" efforts to pay their 1995 arrearages,

RESOLVES:

1. To take note of the report of the Director on the collection of quota contributions (Document CSP25/19 and Add.1).

2. To express appreciation to those Member States that have already made payments in 1998, and to urge all Member States in arrears to meet their financial obligations to the organization in an expeditious manner.

3. To congratulate the States which have fully met their quota obligations through 1998.

4. To compliment the States which have made payment efforts to reduce quota arrears for prior years.

5. To request the Director to notify Cuba, the Dominican Republic, and Grenada that their voting privileges have been restored at this 25th Pan American Sanitary Conference.

6. To request the Director:

(a) to continue to monitor the implementation of special payment agreements made by Member states in arrears in the payment of prior years' quota assessments;

(b) to advise the Executive Committee of Member States' compliance with their quota payment commitments;

(c) to report to the 41st Directing Council on the status of the collection of quota contributions for 1999 and prior years.

LA 25.ª CONFERENCIA SANITARIA PANAMERICANA,

Habiendo considerado el informe del Director sobre la recaudación de las cuotas (documento CSP25/19 y Add. 1) y la inquietud expresada por la 122.ª sesión del Comité Ejecutivo con respecto a la situación de la recaudación de las cuotas;

Tomando nota de que Cuba ha cumplido con lo estipulado en su plan de pagos diferidos y

Tomando nota además de que Granada y la República Dominicana han hecho esfuerzos de "buena fe" para pagar sus cuotas atrasadas de 1995,

RESUELVE:

1. Tomar nota del informe del Director relativo a la recaudación de las cuotas (documento CSP25/19 y Adds. 1).

2. Expresar su reconocimiento a los Estados Miembros que ya han efectuado pagos correspondientes a 1998 e instar a los demás Estados Miembros atrasados en el pago de sus cuotas a que cumplan con sus compromisos financieros con la Organización lo más pronto posible.

3. Felicitar a los Estados Miembros que yan han cumplido con todos sus compromisos relativos a las cuotas correspondientes a 1998.

4. Agradecer a los Estados Miembros que han hecho esfuerzos de pagos para reducir el monto de sus cuotas atrasadas de años anteriores.

5. Solicitar al Director que informe a Cuba, Granada y la República Dominicana que sus privilegios de voto han sido restablecidos en esta 25.ª Conferencia Sanitaria Panamericana.

6. Pedir al Director que:

a) continúe vigilando el cumplimiento de los arreglos especiales de pago hechos por Estados Miembros atrasados en el pago de sus cuotas de años anteriores,

b) mantenga informado al Comité Ejecutivo acerca del cumplimiento por los Estados Miembros de sus compromisos de pago de las cuotas.

c) Informe al 41.ª Consejo Directivo sobre el estado de la recaudación de las cuotas para 1999 y años anteriores.

The DIRECTOR pointed out that Cuba merited special recognition for having faithfully complied with its deferred payment plan for the past three years, despite grave economic circumstances. Perhaps future resolutions on the application of Article 6.B

should contain language that more clearly compliments countries that had made such tremendous efforts to meet their payment obligations.

Decision: The proposed resolution was adopted.
Decisión: Se aprueba el proyecto de resolución.

ITEM 5.2: FINANCIAL REPORT OF THE DIRECTOR AND REPORT OF THE EXTERNAL AUDITOR FOR 1996-1997
PUNTO 5.2: INFORME FINANCIERO DEL DIRECTOR E INFORME DEL AUDITOR EXTERNO SOBRE 1996-1997

Dr. DAHL-REGIS (Representative of the Executive Committee), calling attention to the Financial Report of the Director and Report of the External Auditor for 1996-1997 (*Official Document 286)*, reported that Mr. Mark Matthews, Chief of the Department of Budget and Finance, had outlined its content at the 122nd Session of the Executive Committee in June. Mr. Matthews had noted that the report reflected careful financial management and progress in strengthening the Organization's financial position in 1997. Income for 1997 had exceeded expenditures by $8.5 million in the regular budget, which had increased the working capital fund balance to $8.6 million. Cash in banks and investments had increased 55% between 31 December 1995 and 31 December 1997 to $139.6 million. Total 1996-1997 expenditures had decreased $24.2 million with respect to the 1994-1995 biennium. However, only 69% of current quota assessments had been collected during 1996-1997, a lower percentage than in the three previous biennia (73%,

80%, and 71%, respectively). With regard to extrabudgetary funds, $103.2 million had been received on behalf of trust fund projects during the 1996-1997 biennium.

The report also contained financial statements for three Pan American centers: the Caribbean Epidemiology Center (CAREC), the Caribbean Food and Nutrition Institute (CFNI), and the Institute of Nutrition of Central America and Panama (INCAP). In 1996-1997, CAREC's regular budget income had exceeded expenditures by $658,000, and the Center had ended 1997 with a budget surplus of $314,000. CFNI's income had exceeded expenditures by $74,000, and its accumulated deficit decreased to $142,000 as of 31 December 1997. INCAP's regular income had fallen from $1.6 million to $1.1 million, creating a $175,000 shortfall on regular budget operations, which had been covered by the working capital fund. However, INCAP's financial position appeared sound overall, and its working capital fund balance had been $1 million as of 31 December 1997.

Mr. Richard Maggs had reported to the Executive Committee on behalf of the External Auditor, Sir John Bourn. Based on his examination, the External Auditor had issued an unqualified opinion as to the accuracy, completeness, and validity of the financial statements of the Organization for the financial period ended 31 December 1997. He had emphasized the strengthened financial position of the Organization as a whole, including the Pan American centers, which he had attributed mainly to PAHO's success in collecting additional income and its efforts to contain and, in some cases, reduce key administrative expenditures. The Organization had been commended for the excellent support provided to the External Auditor during the preparation of his report and for having effectively

addressed issues raised in his previous report, particularly recommendations concerning compliance with the United Nations Common Accounting Standards, resolution of certain problems with the Organization's financial management system (FAMIS), and improvement of asset control in local offices.

In its subsequent discussion, Members of the Executive Committee had requested clarification of a number of details included in the report. An account of those questions and of the Secretariat's responses could be found in the final report of the 122nd Session, which was attached as an annex to Document CSP25/4.

With respect to the substantial increase in extrabudgetary funds during the 1996-1997 biennium, it had been pointed out that allowing extrabudgetary resources to play too large a role in financing PAHO programs could distort the PAHO regular budget, raising the prospect of competition among PAHO programs for outside funding and a shift away from the Organization's strategic and programmatic priorities. Several other concerns had been broached in the Executive Committee's discussion, including the persistence of problems with the FAMIS software and the year 2000 computer problem. The use of regular budget financing to support the Pan American centers had also been questioned. One delegate had noted that at the meeting of the Caribbean Community (CARICOM) in April 1998 a decision had been made to undertake an independent review of all the centers in the Region and that, as a result, some of the trends noted by the External Auditor might be reversed, particularly at CFNI.

Mr. Matthews had reported that, on the whole, the FAMIS system was now functioning well, although some upgrades were needed. With regard to the issue of year 2000 compliance, the Secretariat was well aware of the problem and all computer systems within the Organization would be fixed on time. In relation to the funding of the Pan American centers, both Mr. Matthews and the Director had stressed that the centers were an integral part of PAHO's technical cooperation program and that it had never been envisioned that they should become financially self sufficient or programmatically separate from the Organization.

The Executive Committee had adopted Resolution CE122.R2, in which it transmitted the financial report to the 25th Pan American Sanitary Conference, noted that the financial statements for 1996-1997 were presented in accordance with the United Nations System Accounting Standards, acknowledged the Organization's efforts to strengthen the financial situation of the Pan American centers, and congratulated the Director on his successful efforts to maintain a sound financial position for the Organization.

Mr. BOYER (United States of America) noted that although PAHO's financial condition appeared to be better than in previous years and significant amounts of arrearages had been collected, the payment of annual assessments was still falling about 30% short of the total required to fund PAHO's regular budget each year—evidence, he believed, of the need to ensure that assessments did not exceed the capacity of the

Member States to pay. He hoped that the Organization would continue to review the idea of using miscellaneous income to finance the regular budget, perhaps allowing assessments to be reduced.

With regard to extrabudgetary contributions by governments, his Delegation agreed that although voluntary contributions might play an important role in funding new PAHO projects, those contributions had the potential to distort priorities if they were not allocated to the identified priorities of the Organization. He was pleased that the Director had pledged not to allow that to happen and that the Director General of WHO was proposing new policies to ensure that the use of extrabudgetary funds remained in conformity with WHO priorities, so that programs would not compete with each other in trying to raise money. PAHO and WHO should work in concert in that area. In addition, since extrabudgetary contributions were usually considered to be net additions to health resources, money channeled through PAHO by countries for programs in those same countries should not be recorded as extrabudgetary contributions, and he urged PAHO to review that method of recording them.

Noting that his country had been trying to strengthen the internal audit function throughout the United Nations system, he recommended that PAHO consider including an oversight function in the role of the internal auditor. He reiterated his concern that PAHO and all other international organizations act to solve the year 2000 computer problem in a timely manner. In relation to the use of regular budget funds in support of the PAHO centers, he called attention to the recommendation of the External Auditor that the

financial situation of those centers be reviewed. It would be useful for the Director to prepare a report for the Governing Bodies summarizing the work of the centers, the intended financial support, the use of regular budget funds to keep them operational, and appropriate solutions, if necessary, for phasing out such support.

The PRESIDENT noted that there was no need to adopt a resolution on this item.

ITEM 4.1: PROVISIONAL DRAFT OF THE PROGRAM BUDGET OF THE WORLD HEALTH ORGANIZATION FOR THE REGION OF THE AMERICAS FOR 2000-2001

PUNTO 4.1: ANTEPROYECTO DE PRESUPUESTO POR PROGRAMAS DE LA ORGANIZACIÓN MUNDIAL DE LA SALUD PARA LA REGIÓN DE LAS AMÉRICAS PARA 2000-2001

Dr. DAHL-REGIS (Representative of the Executive Committee) reported that the Executive Committee had discussed the provisional draft of the WHO program budget at its 122nd session. Mr. Michael Usnick, Chief of Budget, PAHO, had presented the document prepared by the Secretariat, which contained only the WHO portion of the combined PAHO/WHO regular program budget for the Region of the Americas 2000-2001. The combined budget would be presented to the Governing Bodies in 1999. Mr. Usnick had explained that the instructions from the Director-General of WHO provided for no overall program growth and called for regional budget proposals to be submitted without any cost increases with respect to the 1998-1999 program budget. Hence, the amount being requested for the Americas was $82,686,000.

Mr. Usnick had also noted that in May 1998 the World Health Assembly, after intense discussion and negotiation, had voted to adopt a new model for determining the budget allocations to the six Regions of the World Health Organization. The new model was designed to establish allocations on the basis of more objective, need-based criteria. Its practical effect would be to drastically reduce the allocations to some Regions while substantially increasing those of others. However, to help mitigate the impact on Regions whose allocations would be reduced, the World Health Assembly had voted to limit the reductions to 3% annually over a period of six years, or three biennia. The model would then be reviewed at the Fifty-seventh World Health Assembly, to be held in May 2004.

Although, at the time of the Executive Committee session, WHO had not finalized the reallocations for the 2000-2001 biennium, Mr. Usnick had said that PAHO expected the Region's allocation to be reduced by approximately $3.7 million from the 1998-1999 level of $82,686,000. The reductions for the following two bienniums (2002-2003 and 2004-2005) would be approximately $8.4 million and $12.7 million, respectively.

The Director had noted that most countries of the Region had expressed considerable opposition to the proposed reallocation scheme, although they had endorsed the concept of allocations based on more objective and equitable criteria. However, the World Health Assembly had ultimately adopted the proposed model without any modification. The countries of the Region had shown a great deal of solidarity in accepting the reduction because it was deemed to be in the best interests of the World Health

Organization as a whole. Nevertheless, application of the new model would result in an overall reduction of 20% in the WHO allocation to the Americas.

In its discussion, the Executive Committee had pointed out that the reallocation model appeared to penalize Regions that had made the most progress in improving health conditions and implementing sound financial management. The Committee had emphasized that all WHO Regions—but especially those that would be receiving an increase in their allocations—should be expected to utilize their resources efficiently and manage them transparently.

The Executive Committee had adopted Resolution CE122.R3, in which it recommended that the 25th Pan American Sanitary Conference approve the proposal for $82,686,000, without cost increases, for the Region of the Americas in the 2000-2001 biennium.

Mr. MATTHEWS (Chief, Department of Budget and Finance, PAHO), referring to Document CSP25/7, stated that the Pan American Sanitary Conference, in its role as Regional Committee of WHO for the Americas, was required to make recommendations to the Director-General of WHO concerning the 2000-2001 WHO Regular Budget proposal for the Region of the Americas, which constituted approximately 33% of PAHO's regular budget. The final decision on the WHO budget would be made by the World Health Assembly in May 1999, following further review by the WHO Executive Board in January 1999.

The Director-General had instructed that the budget remain at the same level as the 1998-1999 budget, which itself was only slightly higher than the 1996-1997 budget. In particular, the Conference should note that World Health Assembly Resolution WHA51.31, entitled “Regular Budget Allocations to Regions”, would actually reduce the WHO portion of PAHO’s budget, as well as its allocations to the Southeast Asia, Eastern Mediterranean, and Western Pacific Regions. Beginning in the 2000-2001 biennium, those reductions would be reallocated to the African and European Regions.

The changes called for in Resolution WHA51.31 were based in large part on the recognition that the resources allocated to the Regions had not changed proportionately since the inception of WHO despite major socioeconomic and political changes in Africa and Europe. In response, a group of experts established by the WHO Secretariat at the request of the Executive Board had developed a model of resource allocation using objective, need-based criteria. The model drew heavily upon the United Nations Development Program’s Human Development Index, adjusted for immunization coverage and large population disparities. The accepted methodology was outlined in Document EB101/7, dated 14 November 1997. Under the model, the allocation for the Americas would be reduced by 15.4%.

After intense discussion, the World Health Assembly in May 1998 upheld the use of the model to develop future program budgets but approved a resolution that would limit the reductions faced by the four Regions to 3% annually over a period of six years, or

three biennia. The model will be reviewed again by the Fifty-seventh World Health Assembly in 2004.

At the time of the 122nd Session of the Executive Committee, WHO had not finalized the reallocations for the 2000-2001 Program Budget; thus, the Committee had approved the original proposal of $82,686,000. Subsequently, the Director-General had formally notified PAHO that the allocation for the Region of the Americas would be $77,725,000, a reduction of $4,961,000. The resolution proposed by the Executive Committee for consideration by the Conference would need to be modified to reflect that revised figure.

Mr. BOYER (United States of America) recalled that the 1998-1999 biennial budgets of both WHO and PAHO had called for zero nominal growth reflecting increasing concern on the part of many Member States about the growth of budgets of international organizations. For the biennium 2000-2001, his Government would again pursue the reduction of the budgets of WHO and other specialized agencies. His country was committed to living up to its obligations to international organizations, but at the same time it was committed to strictly controlling and limiting those obligations, since the US Congress had shown itself to be extremely reluctant to approve increases in funding.

Although the instruction from WHO had called for no program growth, the document indicated that WHO intended to permit cost increases to be added at a later

stage. Therefore, the 2000-2001 WHO Regular Budget might actually be higher than the budget for 1998-1999. That would not be acceptable to the United States of America.

His country and, he believed, many other countries, wished to have the WHO budget focus increasingly on the programs that were the highest priorities of the Member States and decrease allocations to lower priority programs, while seeking other ways to address the Member States' needs in those areas. PAHO should contribute to that definition of priorities and seek to influence positively the outline of the overall WHO budget in that regard.

His country strongly supported the gradual reallocation of resources among the six WHO Regional Offices that had been approved by the World Health Assembly in May. That decision provided a powerful demonstration to all UN agencies that reform was possible when Member States and Secretariats were committed to achieving it. The Director was to be praised for his constructive approach to implementing that decision without negative impact on the level of the allocations to the countries.

Mr. AISTON (Canada) commented that while his country had consistently called for PAHO to live within its means—a goal that had been achieved during the last two years—it did not believe that circumstances would permit any reduction in the PAHO budget. A stable budget that focused on the needs of the countries was needed. He urged those countries in arrears on their quota assessments, especially the large contributors, to pay them promptly.

With regard to extrabudgetary funds, a mechanism was needed to discriminate funds channeled through the Organization for use in the donor country from truly extrabudgetary funds. The Director should seek every means to increase extrabudgetary funds and to ensure that they are applied to priority programs.

He did not share the enthusiasm of the Delegate of the United States for the decision to reallocate WHO resources among the Regions. That decision would need to be revisited in the future. Nevertheless, the Director deserved praise for the way he had responded to the decision and for his wise preliminary solutions for dealing with the resulting reductions.

The DIRECTOR thanked all the delegates for their comments regarding the budget. He was pleased that Mr. Boyer had made a distinction between the WHO and PAHO budgets in his comments concerning reduction of the budget. He also welcomed Mr. Boyer's observation that some countries were in arrears in the payment of their quota obligations, and might therefore wish to see a reduction in assessments. However, as the United States was not in arrears, it would seem logical that there would be no suggestion from that country about quota reductions.

He also gratified to see that the delegates had noted PAHO's efforts to keep country programs intact and align the budget with the priorities established by the Member States. PAHO had also succeeded—despite the reduced allocation to the Region—in maintaining the priorities established by the WHO Executive Board and incorporating

them among PAHO's own strategic and programmatic orientations. Still, no organization wished for that kind of belt-tightening to go on indefinitely.

He assured the delegates that the Secretariat would not allow extrabudgetary funds to distort the program that the countries had agreed to.

El PRESIDENTE pide al Relator que dé lectura a la versión definitiva del proyecto de resolución.

El RELATOR dice que en el proyecto de resolución presentado por el Comité Ejecutivo solo se han modificado las sumas señaladas en el preámbulo y la parte dispositiva. Tales modificaciones se introdujeron tras el examen del documento CSP25/7.

THE 25th PAN AMERICAN SANITARY CONFERENCE,

Having considered Document CSP25/7 and the tentative request of the World Health Organization for US$ 77,725,000 without cost increases for the Region of the Americas for 2000-2001; and

Noting the recommendation of the 122nd Session of the Executive Committee,

RESOLVES:

To request the Director to transmit to the Director-General of WHO the request for $77,725,000 without cost increases for the Region of the Americas for 2000-2001, for consideration by the WHO Executive Board and the World Health Assembly in 1999.

LA 25.ª CONFERENCIA SANITARIA PANAMERICANA,

Habiendo considerado el documento CSP25/7 y la solicitud tentativa a la Organización Mundial de la Salud de un monto de US$ 77,725,000 sin aumento de costos para la Región de las Américas para el ejercicio económico 2000-2001, y

Tomando nota de la recomendación de la 122.ª sesión del Comité Ejecutivo,

RESUELVE:

Solicitar el Director que transmita al Director General de la OMS la solicitud de un monto de US$ 77,725,000 sin aumento de costos para la Región de las Américas para el ejercicio económico 2000-2001, a objeto de que sea sometida a la consideración del Consejo Ejecutivo de la OMS y de la Asamblea Mundial de la Salud en 1999.

El PRESIDENTE dice que de no haber objeciones dará por aprobado el proyecto de resolución.

Decision: The proposed resolution was adopted.
Decisión: Se aprueba el proyecto de resolución.

The meeting was suspended at 5:20 p.m. and resumed at 5:35 p.m.
Se suspende la reunión a las 5.20 p.m. y se reanuda a las 5.35 p.m.

ITEM 8.1: FIFTIETH ANNIVERSARY OF THE WORLD HEALTH ORGANIZATION
PUNTO 8.1: CINCUENTENARIO DE LA ORGANIZACIÓN MUNDIAL DE LA SALUD

El PRESIDENTE dice que en primer lugar se escuchará la intervención de la Dra. Gro Harlem Brundtland, Directora General de la OMS. La Dra. Bruntland recibió su título de médico de la Universidad de Oslo, Noruega y la maestría en salud pública de la Universidad de Harvard. Ha desempeñado cargos públicos durante más de 20 años, incluido el de Primera Ministra de Noruega. Por invitación del Secretario General de las Naciones Unidas creó y presidió la Comisión Mundial sobre Medio Ambiente y Desarrollo, conocida como “Comisión Brundtland", que culminó en la Cumbre para la

Tierra celebrada en Rio de Janeiro en 1992. En julio de 1998 asumió el cargo de Directora General de la Organización Mundial de la Salud.

Address of Dr. Gro Harlem Brundtland
Palabras de la Dra. Gro Harlem Brundtland

Dr. BRUNDTLAND (Director General, WHO):

"I would like to thank Dr. Alleyne for convening us to this gathering to commemorate the fiftieth anniversary of the World Health Organization. In fact, fifty years is no age to celebrate when we gather here in Washington. Forty-six years before WHO was created, wise and forward-looking people understood that countries needed to unite for health and human development. The creation of the International Sanitary Bureau in 1902 was an event of historic proportions. Before WHO was born, the foundations were being laid here in this country and in this Region. The world as a whole, not just the people of the Americas, has reason to be profoundly grateful and WHO can be proud to count the Region of the Americas as one of the most vibrant parts of its Organization.

As we celebrate a fiftieth anniversary, let us also look ahead to the centenary for the cause of health which we will celebrate in only four years time. People who are old enough to remember the world fifty years ago, can barely recognize it today. The scars of the Second World War had barely began to heal. The world, particularly Europe and Japan, was beginning painfully to recover and rebuild. The colonial era was coming to an end. Many countries were in the process of liberation. Added to the huge numbers of people killed or disabled during the war, millions were dying from preventable diseases. Most of the world population was still living in extreme poverty suffering from chronic malnutrition, communicable diseases and parasitic infections. Much of the existing health services across Europe, North Africa and Asia had been severely disrupted. Structured health services were in any case rare. Where they did exist, huge segments of the population, usually the most vulnerable, who could not pay, were excluded. The imperative need was recognized for a new world body capable of gathering resources for health, setting health goals and providing a forum for the exchange of health information and experiences. Improving the health of humanity emerged as a common good, as a common bond between us. Let us not forget that it is still our common bond today. WHO's Constitution puts a main emphasis on equity: the objective of the World Health Organization shall be the attainment by all peoples of the highest possible level of health. It is clear, it is comprehensive, stating health as a fundamental human right.

How timely it is that our fiftieth anniversary should coincide with that of the Universal Declaration of Human Rights. Today globalization is in every headline, but the concept of globalization is far from new. The founding fathers and mothers of WHO, like the grandfathers and grandmothers who founded PAHO, knew it perfectly well. There are no health sanctuaries. The suffering of the many must be a common concern in an interdependent world. In his famous play *The Enemy of the People*, Henrik Ibsen's main character cries out in solitude: "The thing is, you see, that the strongest man in the world is the man who stands most alone". Dr. Stockman ended his life in tragedy. It was the very notion of being stronger by not standing alone that led to the creation of WHO. That was the attitude that prevailed in 1902 and in 1948 and that has to be the attitude that underpins and inspires our work today. Even the strongest among nations will stand to lose from isolationism. Health is the most striking reminder of our interdependence.

The evidence is there: some of the biggest human advances during these fifty years have been in the field of health. There has been steady and sometimes spectacular progress in the control and prevention of disease. Take immunization. WHO's global campaign to eradicate smallpox began in 1967 with a systematic vaccination of entire populations in over 30 endemic countries. Global eradication was achieved in 1980. Thanks largely to WHO's expanded program launched in 1974, over 80% of the world's children are now immunized against diphtheria, tetanus, whooping cough, poliomyelitis, measles, and tuberculosis. There have been other success stories; our goal as a norm- and standard-setting agency has been guiding public health workers around the globe.

Some achievements are less obviously connected with the health sector itself. Social and economic development, greater access to education, expanded access to safe water and sanitation have led to remarkable improvements in standards of living that would have been unimaginable half a century ago. For the most part, people are living longer and healthier lives and enjoying benefits stretched across the human life span. Of course this is not the whole picture, but from many points of view mankind has never been in better health than it is today. The progress, however, has been unevenly and unjustly distributed. We are left with unacceptable inequities in the balance sheet of our century; inequality remains one of the largest social debts. The immediate challenge for WHO is how to help achieve better health for all, not just for some. The truth is that vast numbers of people have noticed little if any improvement at all. Many gaps in health between rich and poor are at least as wide as they were half a century ago, and some are still widening between nations and within nations.

While people in most countries live longer, life expectancy is decreasing in some others. Between 1975 and 1995, 16 countries with a combined population of 300 million experienced such a decrease. Many of them were African countries and, recently, even

European countries experienced this. As much of the world steps confidently into the future, it cannot, it must not ignore the plight of those in danger of being left behind. More than one billion people live in extreme poverty, a condition of life characterized by malnutrition, illiteracy, and ill-health, a condition of the life beneath any reasonable definition of human decency. There are many hundreds of millions of men, women, and children who are still chained to the past by grim poverty. Their future is not only their own: in one way or another we all have to share it. Indira Gandhi once observed that poverty is the greatest polluter. We can carry on. Poverty is the biggest source of ill-health and the vicious circle goes on as ill-health, in turn breeds poverty.

The future is owned and shared by the many, not by the fortunate few. So it must be for the poor, most of all, that WHO pledges itself to make a difference. But WHO cannot do it alone, no one can do it alone. We are, in one way or another, in it together. Together we can make a difference by reaching out to each other in the UN family; by uniting our resources and our knowledge; by engaging more closely with countries in their elaboration of sustainable policies and paths of progress; by building consensus that no country can achieve lasting growth if their people do not enjoy access to primary health care; by reaching out to the private sector and by engaging the immense, creative potential of innovation to get new drugs, more affordable drugs, new technologies to safeguard our environment and allow future generations to inherit at least the same opportunities as we did.

We can learn from the past. The first World Health Assembly, in June 1948, listed its top priorities in the following order: malaria, maternal and child health, tuberculosis, sexually-transmitted diseases, nutrition, and environmental sanitation. Looking at it today, we see that they are all critical issues we have to deal with. Malaria is hitting back again, killing 3,000 children every day, especially in Africa. In defining the Roll Back Malaria project of WHO, we will do all we can to learn from the successes and failures of the past and mount a realistic combat to significantly reduce mortality from malaria. Tuberculosis is on the offensive and we must and can strike back, by securing treatment but also by making new advances in drugs. Child health is equally critical; investing in child health yields lifelong results. Nutrition also remains vital. New knowledge gives us new opportunities at least to ensure that children get the right start in life. When they defined sexually-transmitted diseases as a key area in 1948, little did they know of the HIV/AIDS pandemic. We have to mobilize in the struggle against the pandemic—as a co-sponsor of UNAIDS—but also as WHO, by integrating HIV/AIDS into many of our programs and by making our own contribution in the area of safe blood.

Times are changing. Aging, mental health, injuries, violence, the broad spectrum of environmental interdependence—we must give our response. To make the perspective complete, we need to place health sector development at the core of our work. Many of

the nations' self-systems were created at the same time as WHO saw the day. Today they are undergoing profound change, and we must be on the side of those countries and support them in building sustainable health systems that can make enduring progress in the struggle against inequity and we must be ready to learn from experience and improve the way we work.

Take the critical area of immunization. Immunization remains a vital tool. WHO will put renewed emphasis on its efforts to promote immunization and to enter into broader partnerships with other agencies and the private sector, to stimulate new research towards breakthroughs which may not belong to a distant future. In recent years some have questioned WHO's leadership in this field; some have even argued for the creation of a new body to coordinate vaccination efforts. I believe that would be a mistake. My attitude is simple: an organization has to earn its leadership; that is what we are ready to do. WHO, the lead agency in health, with first-hand knowledge of the anatomy and of the world's communicable diseases. We will lead not by saying that we will do all but by forging a new working relationship with our partners, providing our strength and drawing upon the strength of others. I pledge to demonstrate that WHO can make a real difference in this area.

The health agenda is compelling and there is plenty of evidence to make a compelling case for efficient multilateralism. But there is also reason to be concerned. The rich countries are paying less; development aid is on a slippery slope, running far behind the agreed goal of targeting 0.7% of GDP. The average among industrialized countries runs closer to .0.2% and that figure is declining. We need to improve our ability to show the interdependence of a modern world and to illustrate that he who stands alone is by no means the strongest. We will need the United Nations. I often make this reflection when I see people put the blame on the UN for much of what is wrong in this world. Why not ask a completely different question: Where would we have been without the United Nations, its agencies, and its thousands and thousands of dedicated people in the field? Who would have been there to monitor the cease-fire? Who would have been there to guide the vaccine campaign? Who would have been there to secure clean water? Who would have spread the word effectively of the new emerging disease threatening to spread across borders? Without the UN, we would not have been entirely empty-handed, but our hand would have been terribly weak. We have every reason to celebrate fifty years of WHO work, but it is not characteristic of health workers to rest on their laurels. We have to move forward every day, every week There is so much to do, there is so much we can do. I invite you all to join in a renewed effort to make a real difference for world health."

El PRESIDENTE dice que la segunda exposición la hará Dr. Plutarco Naranjo, quien se graduó de médico en la Universidad Central del Ecuador, donde ha sido profesor y miembro del cuerpo docente durante muchos años. Fue Ministro de Salud del Ecuador de 1988 a 1992 y presidió la Asamblea Mundial de la Salud en 1992. En calidad de Embajador, representó su país en la Alemania Oriental, Polonia y Unión Soviética. Es autor de numerosos artículos y libros y ha recibido muchos premios, incluido el Premio Abraham Horwitz en Salud Interamericana correspondiente a 1993.

Address of Dr. Plutarco Naranjo
Palabras del Dr. Plutarco Naranjo

El Dr. NARANJO:

"Las epidemias del siglo pasado, tanto en Europa como en el continente americano, llevaron a algunas naciones al convencimiento de que solo los esfuerzos mancomunados de los países, como ha recalcado la Directora General de la Organización Mundial de la Salud, podían detener esos azotes que tantos miles y millones de vidas habían costado. En Europa, tras la epidemia del cólera, se reunió la primera Conferencia Sanitaria Internacional en 1851, en París. Asimismo, en el continente americano, después de la epidemia de fiebre amarilla, que solo en Buenos Aires cegó más de 15.000 vidas, en 1881, en Washington, se celebró la Primera Conferencia Internacional que, entre otras medidas, adoptó la de crear la Oficina Sanitaria Panamericana. Terminada la Segunda Guerra Mundial, se reunió en San Francisco un grupo numeroso de delegaciones gubernamentales, con el propósito de sentar las bases de una paz justa, universal y duradera. Con ese objetivo crearon las Naciones Unidas al considerar que sin salud no hay verdadera paz. La naciente institución internacional creó en 1948, entre sus organismos especializados, la Organización Mundial de la Salud y ésta a su vez, sobre la base de la Oficina Sanitaria Panamericana, constituyó el mismo año la Organización Panamericana de la Salud, con más amplios horizontes que la antigua Oficina.

Es pertinente recordar por lo menos tres de los principios básicos que figuran en la Constitución de la OMS, que aspira a contribuir a la felicidad, a las relaciones armoniosas y a la seguridad de todos los pueblos en la inteligencia de que el goce del grado máximo

de salud que se pueda lograr es uno de los derechos fundamentales de todo ser humano, sin distinción de raza, religión, ideología política o condición económica o social. La desigualdad de los diversos países en lo relativo al fomento de la salud y control de las enfermedades, sobre todo las transmisibles, constituye un peligro común. El desarrollo saludable del niño es de importancia fundamental y la capacidad de vivir en armonía en un mundo que cambia constantemente es indispensable para este desarrollo. La OMS se convirtió así en el máximo organismo mundial encargado de luchar por los altruistas objetivos de la salud y el bienestar humanos y los logros obtenidos por ella a lo largo de sus cincuenta años son inumerables. Quizá el primero sea haber despertado la conciencia de los gobiernos y las comunidades sobre la importancia de la salud, haber superado el viejo concepto de simple tratamiento de enfermos y haber proclamado el revolucioario principio de que la salud es el estado de bienestar físico, mental y social.

En el campo de la lucha contra las epidemias y las enfermedades infecciosas transmisibles, la OMS ha alcanzado los más trascendentales éxitos, entre los cuales cabe citar la erradicación de la viruela. A modo de ejemplo que revela la importancia de la erradicación de esta enfermedad, cabe mencionar lo sucedido en el nuevo mundo. Poco después del segundo viaje se Colón de desataron terribles epidemias de viruela y sarampión que acabaron con cerca del 90% de la población aborigen, lo que llevó a los conquistadores a importar negros del Africa y convertirlos en esclavos, que trajeron sus propias enfermedades de Africa. La erradicación de la poliomielitis es otro eslabón de esa cadena de victorias. En las Américas se erradicó ya en 1991 y en el resto del mundo está a punto de culminar la campaña. La inmunización de los niños ha salvado millones de vidas. En la actualidad, más del 90% de los niños del mundo están ya protegidos contra varias enfermedades infecciosas. No menos importante ha sido y sigue siendo la lucha de la OMS contra el paludismo, el SIDA, la tuberculosis, la lepra, el pián, el cólera, las enfermedades venérias, la oncocercosis, la ceguera de los ríos, el tabaquismo, el cáncer y las enfermedades cardiovasculares.

Reflejo de la complejidad de acciones de salud es el incremento de la esperanza de vida al nacer. El promedio de 46 años hace medio siglo cuando se creó la OMS subió a 65 años en 1995. Con todo, los promedios son engañosos, el aumento de la esperanza de vida es notoriamente más alto entre las minorías de alto nivel económico mientras que entre las mayorías pobres es muy escaso. Otros campos de lucha infatigable de la OMS, en los que por desgracia ha obtenido resultados limitados son el del saneamiento básico, la dotación de agua segura y la eliminicación de la desnutrición. En términos de las mayorías ciudadanas, el Tercer Mundo se ha empobrecido durantes los últimos años. Hay que considerar que no puede haber salud donde hay pobreza e indigencia. No puede haber salud donde la desnutrición afecta, como ocurre en el Tercer Mundo, a aproximadamente

la mitad de los niños menores de cinco años. No puede haber salud donde el 30% de las madres embarazadas sufre de anemia y desnutrición. No puede haber salud donde no hay ni saneamiento básico ni agua segura.

Es cierto de que algo han hecho los diferentes países, pero no en la medida necesaria ni siguiendo toda la estrategia de la atención primaria de salud. Es cierto también que algunos índices vitales han mejorado. La mortalidad infantil ha disminuido a cifras que varían entre 20 y 40 por 1.000 en el Tercer Mundo, pero este hecho ha de considerarse primariamente como resultado de acciones médicas y de los antibióticos, pero bajar de esos niveles al de los países desarrollados ya no es asunto solo médico, sino un gran problema social, económico y político. La responsabilidad no descansa únicamente sobre los servicios de salud. Entre otras medidas indispensables están las de crear puestos de trabajo, disminuir el desempleo, mejorar la capacidad adquisitiva del pueblo y mejorar las condiciones sanitarias del país, así como la calidad y cobertura de la educación. Todo esto requiere grandes decisiones políticas, continuidad en las acciones y priorización de los gastos de los gobiernos. La OMS y la OPS han colaborado activamente con los gobiernos, pero estos organismos intergubernamentales, por sí mismos, no pueden realizar acciones que corresponden a los gobiernos, ni tampoco cambiar la estructura social y económica de los países.

La estructura social y política de las naciones de la Región permite que se atente contra las futuras generaciones en forma inhumana e irresponsable. No otra cosa significa permitir que ahonde la desnutrición. Ahora se sabe que el feto y el infante requieren proporcionalmente un gran aporte energético que la madre desnutrida no puede proporcionarle. El desarrollo del cerebro en el feto requiere alrededor del 80% de la energía total a disposición del nuevo ser. La desnutrición de la madre determina un menor y más lento desarrollo del feto. Los niños nacen con peso bajo, es decir menos de 2.500 gramos. Hasta los cuatros años de edad el cerebro del niño alcanza casi el tamaño del cerebro del adulto. Hasta los dos años se multiplican las neuronas y hasta los cuatros años se proyectan en infinitas redes las fibras nerviosas del cerebro. El niño nace pues con la máxima potencialidad cerebral, pero esto no es completamente cierto para el niño desnutrido. Es alentador saber que ha disminuido la mortalidad. Sin embargo, cabe preguntarse qué clase de ciudadanos habrá si en la niñez, en el período más crítico del crecimiento y desarrollo mental y físico, han estado desnutridos. Este futuro ciudadano, verdadero héroe biológico, vencedor de la diarrea y la bronquitis, que ha adaptado a la desnutrición, quizá no vea disminuidas sus dimensiones somáticas, pero es posible que no ocurra lo mismo con las capacidades intelectuales indispensables para aprovechar la educación y las oportunidades de trabajo. Una prueba de esta tragedia es que un porcentaje apreciable de niños, sobre todo rurales no logra rebasar el segundo o tercer grado de la escuela y engrosa las filas de analfabetismo. Si los organismos internacionales han sido capaces de organizar una gran campaña contra las epidemias virales, cuán

deseable sería ahora que organizaran la más amplia y efectiva campaña contra la peor epidemia de los siglos XX y XXI: la desnutrición. Se necesita un nuevo humanismo que haga realidad los derechos humanos y, en particular, los derechos de los niños.

El desarrollo tecnológico crea infinitas posibilidades de mejorar la calidad de la vida. Se producen nuevos y variados aparatos a los que las clases pobres tienen poco o ningún acceso, pero se crean así nuevas necesidades que quedan insatisfechas. No todo es positivo, y también el progreso tecnológico contribuye en ese sentido a ahondar las diferencias. ¿Cuán importante sería canalizar el indetenible progreso tecnológico para que los beneficios fueran para todos y no solo para los sectores privilegiados? ¿De qué le sirve la Internet, por lo demás tan importante, a un pobre indio andino y a uno de los Chiapas, si ni siquiera posee electricidad y los equipos correspondientes? He mencionado algunos de los dolorosos aspectos de la salud como médico del Tercer Mundo para subrayar que, frente a los indiscutibles éxitos del pasado, están los retos del futuro. La OMS, sin duda, ha conducido al mundo entero por varios caminos de triunfos y ha alcanzado muchas metas trascendentales. En 50 años, el mundo ha cambiado. Algunos de los problemas de salud mencionados se han ahondado o no han sido superados y quizá haya llegado la hora de establecer nuevas prioridades, nuevas metas, y de concienciar a los gobiernos, sobre todo del Tercer Mundo, sobre sus propias responsabilidades frente al futuro de sus pueblos. Ante este breve pero realista balance hay que abrige la esperanza de que en el próximo medio siglo, la OMS, con un valeroso espíritu de renovación y basándose en los 50 años de experiencia que hoy se conmemoran, haga realidad algún día ese maravilloso propósito de salud para todos".

El PRESIDENTE dice que el orador siguiente es el Dr. William Foege, Profesor en Salud Internacional, quien se graduó de médico en la Universidad de Washington. Obtuvo su maestría en salud pública en la Universidad de Harvard. Luego de dirigir la exitosa campaña para erradicar la viruela en Africa en 1977, fue nombrado Director del Centro para el Control de Enfermedades de los Estados Unidos y en 1986 asumió el cargo de Director Ejecutivo del Carter Center, donde además participó como experto y Director Ejecutivo del Grupo de Trabajo para la Supervivencia y el Desarrollo del Niño. Entre

1985 y 1986 fue Presidente de la Asociación Estadounidense de Salud Pública y actualmente es Profesor eminente de Salud Internacional en la Universidad Emory.

Address of Dr. William Foege
Palabras del Dr. William Foege

Dr. FOEGE:

"Thank you, Mr. President, for this wonderful opportunity to pause and mark a passage. My wife has taught four-year-olds for many years, and the first day of school is always marked by giving them instructions and new rules. One year the final rule was: if you want to use the bathroom, raise your hand. And a very perplexed four-year-old boy asked, "But how does that help?" And so we ask today: How has it helped to have a World Health Organization for 50 years?

Mrs. Clinton wrote a book about it taking a village to raise a child. Many years ago, while I was immunizing children in Nigeria, I found myself thinking about the chain of actions that actually brought one dose of measles vaccine to a child in Nigeria, and by the time you calculate the research chain that allowed the vaccine to be developed, the steps in manufacturing the vaccine, providing needles and syringes, glass, caps and cardboard shipping containers, the many steps in shipment, the building of airplanes, the land rovers for distribution, a health infrastructure for health education, vaccinators and a school system to have trained every person in the entire complex, it takes millions of people and a system where everything goes right. It literally takes the whole world to raise a child today…and WHO has made that possible. It has made it possible for the whole world to collectively plan a rational health future.

What was happening when WHO was getting its start in 1948? Dr. Brundtland talked of the great changes at that time

The global community was reforming. Israel was established, as was the Republic of Korea, the Berlin airlift began, Gandhi was assassinated, the Marshall plan was implemented, and the Olympics were resumed after 22 years. If that seems like an impossibly long time ago we can remember that one current US Senator, Strom Thurmond, actually ran for president that year!

The first jets flew the Atlantic that year and we remember that, having lost a former WHO employee, Jonathan Mann, on an Atlantic jet a few weeks ago.

Medicine was flourishing with the introduction of cortisone, aueromycin, chloromycin, and dramamine. Vitamin B12 was isolated.

Richard Feynman, the great physicist, developed the quantum theory of electrodynamics and WHO was formed with the US accepting membership on June 14th.

But we look back, in order to look forward. Stephen Smith helped start APHA in 1872 at the age of 49. At the fiftieth anniversary he was asked to give the keynote address and so, at the age of 99, he went to the lectern and began talking about "The Future of Public Health." Today we honor 50 years of WHO by asking how that will impact on the future.

There are many lessons of the past 50 years for our use in the future. Allow me to mention only 10.

1. The accomplishments are real: life expectancy, infant mortality, specific diseases such as smallpox, polio, guinea worm, and measles. The lessons allow us anticipation of more successes with tobacco, malaria, and chronic diseases. It has been 50 years of astounding successes, but we haven't seen anything yet.

2. We have learned that not one of us is as smart as all of us. And that is why there have been such accomplishments. The combining of efforts so that, in the words of E. O. Wilson, "the single mind can travel swiftly and surely from one part of the communal mind to the other."

Using the lessons of the renaissance, the enlightenment and all of the social experiments of history, WHO has sought an orderly world—an orderly health future. But the future never just happens. It is created. Therefore the future of WHO will be as creator.

3. Fifty years is a very short period of time. We don't even know what the best way of organizing will turn out to be. We do know, after 50 years, that there is no substitute for WHO. Now we must make it the best it can be, tenacious, with a distant vision. As Bartlett Giamatti reminded us "We cannot escape epic's long view: that rest will come by never resting."

4. Leadership as an active verb is key—people look to WHO for leadership and will follow even with a bad plan. The first malaria plan had flaws, but people followed. Now we get a second chance. Leadership has been thrust on WHO—a heavy burden, but a great opportunity.

5. We have learned that the organizations of today and the organizations of tomorrow are built on partnerships. People joined together around a shared goal or outcome.

In no field is it easier to get people to share goals than in health. As trust develops the ripples extend beyond health to other shared goals. The rapid spread of democracy may, in part, be due to the experiences of practicing participatory government at World Health Assemblies. The role of the smallpox eradication program during the cold war may have played some small part in peace, as people from various cultures shared a goal. As we learn to work on health we build skills to work together on other things deathless things. Will Durant defined immortality as the absorption of one's soul in deathless things. We have worked together on deathless things.

6. Setting of objectives. It is one of the secrets of successful organizations, and WHO has learned to set objectives on smallpox eradication, guinea worm eradication, polio eradication, disease control, primary health care. It has learned to join UNICEF in setting health goals at the Summit for Children in 1990. The last two months have seen an exciting explosion of new objectives. The health world has been energized.

7. WHO has set examples—and I think especially of the examples set by PAHO. Sometimes an almost impossible example as with polio. And now with measles. You have provided the gold standard for the rest of the world.

8. Perspective: The good news is very good and must be emphasized. But it must always be presented on the backdrop of what has yet to be done. To provide perspective. To never rest.

To link ethics with science—science with the humanities. To link the needs of the poor with the fears of the rich. To seek balance.

To provide the good news and, at the same time, in this strange world where half are starving and a third are dieting, to highlight, the disparities, the desperate, the disadvantaged, the absolutely miserable and let them know that WHO exists also for them.

9. Hope: The outcomes may be spectacular in terms of suffering and death- but the greatest of these is hope. Indeed the most important product of WHO is hope. Showing that it is possible to harness the knowledge, the resources, the goodwill of this world for a better future. Which leads me to the final lesson that I will mention.

10. Optimism: It is a gift that public health workers give the world and it is warranted.

A man was told by a fortune teller that he would be very poor and very unhappy until he was 45. Grasping at that straw he asked what would happen when he was 45. The fortune teller said, "You will get used to it." Our job is to never let the world get used to unnecessary suffering, early death, or compromised quality.

The opportunity has been granted us to benefit from those 50 years of experience and ask how to do even better. Dr. Brundtland suggested we ask a new question. Richard Feynmann looked in a mirror and asked, if the usual explanation was true about why left and right are reversed, why is top and bottom not reversed? This new question led to new answers. With a new Director General we have the chance to take a new look and to ask new questions about global health.

In 1932, Lincoln Steffens said, "What is true of business and politics is gloriously true of the professions, the arts and crafts, the sciences—the best picture has not yet been painted, the greatest poem is still unsung, the mightiest novel remains to be written." And we echo today that the most spectacular contributions of public health are still unimagined this day, the finest solutions are still before us. What we do know is that WHO and PAHO will be part of those solutions.

Abraham Lincoln died 133 years ago. He has left no DNA in the germ pool. All of his descendants are dead. But not a day goes by that we don't know that life is better because he lived. Why? Because he left the social equivalent of DNA. To the workers of WHO and PAHO, and those who work with them, these 50 years have united you in deathless acts. Your social DNA has made you immortal. For that we say, with all of our hearts, thank you."

Address of Sir George A.O. Alleyne
Palabras de Sir George A. O. Alleyne

Dr. ALLEYNE (Director):

"Let me first thank Dr. Brundtland, Dr. Naranjo, and Dr. Foege for their remarks. How thrilling it is to hear them address with such fervor and eloquence the reasons why we should celebrate the fiftieth anniversary of the World Health Organization!

When I have spoken on several occasions this year, I have remarked that 1948 was a vintage year for organizations and movements that to this day have left and are leaving their imprint upon what we do and how we do it. It was also a year of significant scientific achievement. It was the year that Enders, Robbins and Weller developed their

techniques for growing viruses in living cells, and the children of the world are everlastingly grateful. It is less well known that that was the year that Margaret Mead, in her seminal work *Male and Female, A Study of the Sexes in a Changing World*, laid down some of the groundwork for the appreciation of what is meant by gender identity. The men and women of this world should be and will be grateful to her. This was the year of the discovery of the transistor that was the beginning of the shrinking of distances that has changed our lives forever. And let me be chauvinistic and say that it was the year that my own University was founded in the West Indies and its motto, oriens ex occidented lux—a light arising from the West—has served as a guide for persons like myself and thousands others.

However, I will not argue that perhaps the two most significant events of that year were the Universal Declaration of Human Rights and the foundation of the World Health Organization. The former has assumed the character of one of the great documents of all time and the opening sentence has been repeated perhaps millions of times because of its scope and import:

Whereas recognition of the inherent dignity and of the equal and inalienable rights of the members of the human family is the foundation of freedom, justice, and peace in the world.

It would go on to describe those rights pertaining to health that the newly created World Health Organization would seek to uphold and promote, and how well it has done so. I claim a double reason for offering my congratulations and joining in this celebration. As Regional Director of WHO for the Americas, I glory in the achievements of WHO and the role it has played in health in the Americas. As Director of the Pan American Sanitary Bureau, I salute WHO and take great pleasure in detailing what we have done together and the extent to which we in the Americas have been pleased, proud, and rather humbled at our contributions made to global health. We here cannot forget that it was the delegate from Brazil who, along with his Chinese colleague at the San Francisco conference that founded the United Nations, called for establishing a World Health Organization.

I know only too well that the survival of any Organization for this length of time has meant that it has been of palpable benefit to the world and moreover has remained conscious of the need to be of benefit. It is not for me to chronicle here those achievements of which WHO can be justly proud—achievements in the field of disease prevention and control, the environment, health services. This has been done brilliantly by the three speakers before me. But as Dr. Brundtland remarked, it is chastening to note that the first World Health Assembly established four priorities for attention—malaria, tuberculosis, venereal diseases, and the need to improve maternal and child health. Who could have imagined that 50 years later we are again calling for priority attention to

malaria, and tuberculosis and the venereal diseases have found a new captain in HIV/AIDS? Why is this so? Did we become arrogant and drunk in our success in the field of disease elimination? Did we glory too much in the development of new antibiotics and new magic bullets in the invention of new technologies from the laboratories of developed countries? My thesis is that we went astray and we forgot the dictum of Rudolph Verchov that medicine is a social science. Perhaps we are so influenced by the marked advances in the physical sciences that we became too reductionist in approach. But I believe we have changed and we are focusing on more interdisciplinary and systemic approaches, because we now see that WHO has taken on roles that go beyond calling for direct care, and perhaps the greatest of them all has been to sound the call of health for all, surprising and delighting the world that a health organization should enter the lists on the side of social justice.

But today, as we celebrate the past, we have to look at what remains to be done—what is the unfinished business. Clearly WHO must recommit itself to be the organization for the health of the world and the health organization of the world, and that is not a semantic difference. It will have to address those global problems which you know so well that cannot be addressed by any single country or agency. The interconnectedness of the world and its people makes the presence of aconnecting body imperative. In that sense it will be the organization that addresses the health of the world. But even within this grand and global scope it will not forget that the world is peopled by many individuals whose health condition can and will be the concern of WHO.

WHO will, I am sure, seek by force of moral and technical leadership to fold into its skits those actors that stake claim to concern for the health of the world's peoples or groups of them. This does not mean establishing a hegemony, but earning by performance the ability and capacity to win others over. It is in this context that we take pride in its being the premier health organization of the world.

I have absolutely no doubt that the auguries are excellent for the start of another 50 years and those of us who are here and those who come after us will be only too pleased to follow the global leadership.

Mr. President, it is fitting at moments like these when we celebrate the achievements of institutions and the leadership they have exercised, that we not forget the men and women who made the institutions great—the heroes of WHO. Most of these heroes will never be known to the vast majority of us. Some have given all that they possessed intellectually, spiritually, and physically. Some have paid the ultimate sacrifice in discharge of their duties as WHO staff.

Let us not forget them. As Benjamin Disraeli said: *The legacy of heroes is the memory of a great name and the inheritance of a great example.*

We have inherited a great example of an organization that is great in more that name—let us resolve to keep it so!"

The meeting rose at 6:40 p.m.
Se levanta la reunión a las 6.40 p.m.