



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 126th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., 26-30 June 2000

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*Provisional Agenda Item 3.1*

CE126/5 (Eng.)

11 May 2000

ORIGINAL: SPANISH

### SUBCOMMITTEE ON PLANNING AND PROGRAMMING

The Subcommittee on Planning and Programming (SPP) held two sessions during the period since the last session of the Executive Committee: 33rd Session, 2-3 December 1999; and 34th Session, on 29-30 March 2000.

The 33rd Session was attended by delegates of the following Subcommittee Members elected by the Executive Committee or designated by the Director: Bolivia, Canada, Cuba, Ecuador, Guyana, Mexico, and the United States of America. Also present were observers for Brazil and Honduras.

The 34th Session was attended by delegates of the following Members of the Subcommittee, elected by the Executive Committee or designated by the Director: Bolivia, Canada, Costa Rica, Cuba, the Dominican Republic, Ecuador, Guyana, Mexico, and the United States of America. Also present were observers for Antigua and Barbuda, Honduras, Panama, and Uruguay. Representatives of the Asociación Latinoamericana de Industrias Farmacéuticas (ALIFAR), Emergency Care Research Institute (ECRI), Federación Latinoamericana de la Industria Farmacéutica (FIFARMA), and United States Pharmacopeia (USP) attended the session.

Elected as officers for both sessions were the delegates of Ecuador (President), Cuba (Vice President), and Bolivia (Rapporteur).

During the sessions the following agenda items were discussed:

- Virtual Health Library
- Food Protection
- Cardiovascular Diseases, with emphasis on Hypertension

- Participation of the Pan American Health Organization in the United Nations Reform in Member States
- Operations of the Subcommittee on Planning and Programming (SPP)
- Maternal Health
- Repairs to the PAHO Headquarters Building
- Program Budget Policy of the Pan American Health Organization programs
- Prospects for the Pan American Health Organization Collaboration with Nongovernmental Organizations
- Information Technology in the Pan American Health Organization
- Pan-Americanism: What it Means for the Pan American Health Organization
- Medical Devices
- Child Health
- Pharmaceutical Regulatory Harmonization in the Americas

With respect to the operation of the SPP, various Member States gave an account of its operations from 1979 through 1998, including the degree and frequency of participation in its sessions. A description of the current context of Subcommittee operations was also provided. Finally, Subcommittee Members were asked to debate the extent to which the SPP should participate in strategic planning and evaluation of technical cooperation at the national and regional levels; appropriate topics for SPP action; the extent to which the aforementioned topics should concern long-term planning versus planning for the immediate future; and the operational procedures and frequency of SPP sessions.

The delegates agreed that the SPP could concentrate more on improving long-term planning processes as well as on the evaluation of results of these processes. In addition, the value of the procedure, whereby the Subcommittee reports to the Executive Committee regarding programming issues, was recognized. Moreover, it was reiterated that the Subcommittee, in its capacity as an advisory body to the Executive Committee, is responsible for examining any matter referred to it by the Committee.

With respect to the form and frequency of SPP sessions, the suggestion was made that only one session be held each year, and that consideration be given to holding the session in the field. It was proposed that there be less formality and more dialogue in sessions, and that the composition of the Subcommittee might be modified to include less Executive Committee Members, but appoint them for a longer term. This would allow a wider participation of Member States, particularly those that have seldom or never participated in SPP sessions. It was also recommended that outside technical experts, from both the public and private sector, be invited to participate in both the drafting of Subcommittee documents and in its debates.

With respect to documents prepared for consideration by the Subcommittee, especially those involving programmatic matters, it was emphasized that these documents should always include an analysis of the degree to which the foreseen activities contribute to greater equity, as well as information on the financial implications of programming matters.

The final reports of the two Sessions are annexed.

Annexes



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## **33rd SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE**

*Washington, D.C., 2-3 December 1999*

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CE126/5 (Eng.)  
Annex A

SPP33/FR (Eng.)  
3 December 1999  
ORIGINAL: SPANISH

# **FINAL REPORT**

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## FINAL REPORT

The 33rd Session of the Subcommittee on Planning and Programming of the Executive Committee of the Pan American Health Organization (PAHO) was held at the Organization's Headquarters in Washington, D.C., on 2 and 3 December 1999.

The session was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Bolivia, Canada, Cuba, Ecuador, Guyana, Mexico, and United States of America. Also present were observers for Brazil and Honduras.

### Officers

The Subcommittee elected the following officers to serve for the 33rd and 34th Sessions:

<i>President:</i>	Ecuador	(Dr. César Hermida)
<i>Vice President:</i>	Cuba	(Dr. Antonio González Fernández)
<i>Rapporteur:</i>	Bolivia	(Dr. Fernando Cisneros del Carpio)

Sir George Alleyne (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Karen Sealey (Chief, Office of Analysis and Strategic Planning) served as Technical Secretary.

### Opening of the Session

The President opened the session and welcomed the participants. The Director added his welcome, noting that the Subcommittee was meeting on 2 December, the anniversary of the founding of PAHO. He was certain that the session would be very productive and the same spirit of open dialogue would characterize it as in past sessions. He looked forward especially to the discussion on the functions of the Subcommittee, which would undoubtedly prove beneficial to the work of the Organization as a whole.

## **Adoption of the Agenda and Program of Meetings (Documents SPP33/1 and SPP33/WP/1, Rev. 1)**

In accordance with Rule 2 of its Rules of Procedure, the Subcommittee adopted the provisional agenda, with the addition, at the suggestion of the Director, of an item on repairs to the PAHO Headquarters Building. The Subcommittee also adopted a program of meetings.

### **Presentation and Discussion of the Items**

#### ***Virtual Health Library (Document SPP33/6)***

Mr. Abel Packer (Director, Latin American and Caribbean Center on Health Sciences Information - BIREME) described the Virtual Health Library (VHL) project, which was launched within BIREME in 1998 as part of the Organization's technical cooperation in the area of scientific and technical information. The aim of the project was to ensure broad and equitable access to scientific and technical health information, as a prerequisite for the full development of health in the Region. The VHL was a network of health information resources on the Internet. Its development and operation were decentralized and were carried out by institutions distributed throughout the Americas—in particular, the national networks of libraries and documentation centers that made up the Latin American and Caribbean health sciences information network, coordinated by BIREME, which had been a major component of PAHO technical cooperation over the last decade. The VHL was expected to become a valuable source of reliable and readily accessible information for health professionals, educators, and decision-makers, as well as the general public.

Implementation of the project would take place in three stages: (1) 1999-2000, the launching period; (2) 2001-2003, the stage in which the VHL would gain momentum and new institutions and information sources would be incorporated into the network; and (3) 2003 and beyond, when the VHL would be fully operational and would serve as a major point of reference for health information products and services in the Region. The document contained information on progress in implementing the VHL thus far and on the results expected by the end of 2000.

The following principles were guiding the implementation process: adoption of the new paradigm represented by the Internet, in which information users interacted directly with networks of sources and with other users; promotion of alliances and consortia of producers, intermediaries, and users of information in order to increase access to information at lower cost; decentralized development and operation, as a means

of spurring the development of expertise in new information and communication technologies at the national and local levels and making the VHL more accessible, equitable, and sustainable; equity in development and operation, ensuring that all countries and all institutions within countries had equal opportunity to participate; attention to local conditions and needs and use of appropriate information technologies, so that participation in the VHL did not entail excessive expense for the countries or become a resource reserved for an elite few; and integrated evaluation and quality control in order to disseminate reliable information that met users' needs.

Continued development and strengthening of the VHL would require the political backing of the Member States. The inclusion of this topic on the Subcommittee's agenda was aimed at eliciting that support within the Governing Bodies.

The Subcommittee expressed decided support for the development of the Virtual Health Library, although it was pointed out that political support must be accompanied by concrete action at the country level in order to develop the technologies and expertise needed to successfully implement the VHL. It was emphasized that the VHL would provide more equitable access to the scientific and technical information needed to advance health development and achieve health for all. Its value as a source of information for human resource training and education was also underscored. Several delegates noted that the library would help overcome traditional barriers to access of information. For example, it would essentially eliminate geographic barriers and make it possible for health personnel and the general public in the countries to access a large volume of health information from all over the world. It would also increase the availability of information from a broader range of sources, including scientific production from Latin America and the Caribbean that has not been readily accessible before now. The Subcommittee also felt that the VHL would help enhance information-sharing and technical cooperation between countries and that it would also be an excellent source of up-to-date information for decision-making and priority setting.

It was pointed out that choices regarding the kind of information that would be made available and the way in which it would be delivered would determine, in large measure, who would receive the information. It was also pointed out that the development of the VHL would require technologies that were relatively costly and complex and that it might thus widen the gap between those who had those resources and those who did not. On the other hand, several delegates observed that, even in the poorest and most remote areas, most health institutions had telephone service and at least one computer and that access to the Internet was expanding rapidly in the Region. In that connection, it was suggested that the PAHO/WHO Representative Offices might play a role in facilitating access for areas and institutions that lacked it. It was also emphasized

that availability of appropriate equipment and technologies was not sufficient to ensure the viability and sustainability of the VHL; it was essential to train and motivate human resources to access and make the best use of the information.

The Secretariat was asked to clarify or elaborate on several issues, including the following:

- Plans for expanding the VHL, which now appeared to be geared mainly toward Spanish-speakers in Latin America, to better serve other parts of the Region, notably the English-speaking Caribbean, and integrate the immense volume of health and scientific information available from the United States and Canada.
- Projected resource requirements for continued development of the VHL, both in monetary and human resource terms.
- Quality control measures to guarantee accuracy and timeliness of the information, and standards to ensure compatibility and integration of data.
- Intellectual property issues in relation to the VHL.
- Criteria for identifying the thematic areas to be developed in the VHL.
- The strategy for training information and health professionals and other potential users of the VHL.

Responding to the Subcommittee's comments, Mr. Packer pointed out that one of aims of the VHL was to help the countries of Latin America and the Caribbean become full participants in the inexorable process of globalization of information. An important aspect of that effort was making the scientific production of the Region available through the VHL so that it could be accessed by other Latin American and Caribbean countries, as well as by users in the United States and Canada and the rest of the world. In regard to the English-speaking Caribbean, it had been an integral part of BIREME since its founding in 1982. The MedCarib database available through BIREME provided access to articles published in medical journals and other sources from the English-speaking Caribbean. During the year 2000, BIREME intended to prioritize the participation of the English-speaking Caribbean countries in the virtual health library. However, an indispensable criterion for including information from those countries in the VHL was that it be published electronically.

In regard to integrating information from outside Latin America and the Caribbean, BIREME has been a partner of the United States National Library of Medicine

(NLM) since its inception. Advances in technology had greatly facilitated interchange with the NLM, providing faster access to information from the United States, but also accelerating the availability of information from Latin America and the Caribbean through the NLM. For example, of the 44 Latin American journals that were indexed on the NLM's Medline database, 8 were now available in electronic format; as a result, they could be accessed internationally within 24 hours of publication. Before the advent of the Internet, it might have taken as long as nine months for an article from one of those journals to be made available internationally.

As concerned international compatibility of data, one of the main strengths of BIREME was its use of "common languages" for organizing and retrieving information. With respect to training, in the pre-implementation phase, training was being approached as an activity external to the VHL. However, the idea was that, once it had been fully implemented, the VHL itself would serve as a vehicle for training. In regard to the issue of quality control, peer review would be the principal mechanism used. BIREME's policy was that if an article or other item of information was not authored by a school of medicine, a recognized research institution, a ministry of health, or another reputable source, it must undergo peer review or it would not be included in the VHL.

The Director pointed out that the Organization had no control over the nature or the quality of the information that was placed on the Internet. The best it could do was to ensure that the information included in the VHL came from reputable and reliable sources with a history and tradition of publishing quality articles related to PAHO's areas of concern. The quality of statistical data on the countries was a different issue. PAHO published only data from official sources. Hence, it could be assumed that national authorities had validated any statistics on the countries available from the Organization through the VHL.

The issue of intellectual property and protection of information published on the Internet was a source of concern for PAHO. The Organization was looking into what rights it could and should claim as to ownership of information. In the meantime, he could state categorically that PAHO would never allow its name to be used as a source of any personal health information or advice for individuals disseminated via the Internet.

With regard to the resources required for the project, while there would be certain costs and human resource requirements for the countries that participated in the VHL, it would not really entail new expenditures for PAHO, since the Organization was simply building on an infrastructure already in place. BIREME had not been expanded and no new staff had been added to implement the VHL. The VHL was the result of the natural progression of a system that already existed. Originally, BIREME had been a traditional library. Then it had progressed to a network, with connections by telephone, fax, and

modem. The Internet had enabled even greater interconnectedness through the creation of “networks of networks,” which would not necessarily increase the amount of information available, but would make it available to many more users.

As for the thematic areas under development, mainly they were topics that had “suggested themselves” because they were areas in which the Organization was active and/or in which a large volume of information already existed, such as adolescent health and environmental health.

### ***Food Protection (Document SPP33/5)***

Dr. Jaime Estupiñán (Director, Pan American Institute for Food Protection and Zoonoses) – (INPPAZ) presented a brief overview of the problem of foodborne disease (FBD) in the Americas and described PAHO’s response through the Regional Program for Technical Cooperation in Food Protection. FBD outbreaks in the past decade had given a new dimension to food protection programs in the countries. The frequency of outbreaks—especially those caused by emerging pathogens such as *Escherichia coli* O157:H7—coupled with the need to ensure the safety of food supplies in the face of enormous growth of international trade in food products, had prompted an effort to review and enhance national programs.

To strengthen food protection in the Region, in 1986 PAHO had launched the Regional Program for Technical Cooperation in Food Protection, which was consolidated with the creation of INPPAZ in 1991 to implement the program. The program had two main objectives: (1) to achieve a food supply that was safe, wholesome, nourishing, pleasing, and inexpensive, and (2) to reduce human morbidity and mortality caused by FBDs. The plan of action for technical cooperation under the program included five components: organization of national food safety programs, strengthening of laboratory capabilities, surveillance of FBDs, strengthening of food inspection services, and community involvement in food protection.

Major accomplishments in recent years included the adoption by almost 60% of the countries of integrated food protection programs; development of a regional electronic system to provide information on food legislation; strengthening of national Codex Alimentarius committees in the countries; formation of the Inter-American Network of Food Analysis laboratories; strengthening of laboratory capacity to test for pesticide residues and other chemical contaminants; training of laboratory personnel in methods for rapid detection of emerging pathogens; strengthening of inspection services, especially through training in good manufacturing practices (GMP), sanitation standard operating procedures (SSOP), and the hazard analysis and critical control points (HACCP) methodology; strengthening of national FBD surveillance systems and coordination of the

Regional Information System for Epidemiological Surveillance of FBDs; and joint sponsorship of a seminar on protection of foods sold by street vendors and a workshop on integrating consumer interests into food production and protection activities.

The document contained information on additional achievements under the five components, as well as the strategies, objectives, and goals for the program in the short, medium, and long terms. In the next biennium (2000-2001), technical cooperation would continue to be provided under the same five components, with emphasis on new regulatory, technological, and strategic developments for food protection programs.

The Subcommittee voiced unanimous support for the objectives and strategies set out in the document, although there was some concern that the objectives of the Regional program might be overly ambitious, given the relatively short timeframe proposed. It was pointed out, in that connection, that full implementation of the plan of action would require considerable infrastructure, resources, and commitment on the part of all countries of the Region. Support was also expressed for the work of INPPAZ and for the Secretariat's decision, taken several years earlier, to transfer responsibility for prevention and control of zoonoses from INPPAZ to the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) and make food protection the dominant role of the Institute. Various delegates commented that INPPAZ's progress in strengthening food safety programs and enhancing surveillance of foodborne pathogens and diseases in the Region had confirmed the wisdom of that decision.

It was pointed out that the orientations of PAHO's food protection program were entirely consistent with the emerging global food safety priorities of WHO arising from the recommendations of the United Nations Food and Agriculture Organization (FAO) Conference on International Food Trade Beyond 2000, held in Melbourne, Australia, in October 1999. Several delegates also noted that PAHO was in a position to play a leadership role in the global efforts, as food safety activities were generally more advanced in the Americas than in other WHO regions.

Clarification or additional information was requested on the following matters:

- PAHO's role with respect to that of the other agencies operating in the area of food safety, including FAO, especially in light of the proposal that PAHO become the principal technical cooperation agency and the main source of information and training in food protection in the hemisphere.
- Actual flows of food trade and the safety implications thereof, given the increase in food trade within the Region and its importance for consumers and for the economies of most countries.

- Means of rating the different methodologies for assessing food safety so that governments can be properly advised as to what are workable options in their particular socioeconomic situations, taking into account that the most sophisticated methodologies may not be appropriate or necessary in all contexts.
- Coordination between officials at the local level with respect to responsibilities for food safety and inspection of agricultural produce and practices at the local level.

The Subcommittee also identified several valuable roles for PAHO, in addition to those described in the document. One was providing accurate information on the issue of genetically modified foods and the potential risks they might pose, so that governments, producers, and consumers had a sound basis for decision-making. Another role was facilitating countries' participation in relevant Codex meetings and their understanding of their rights and obligations under World Trade Organization (WTO) agreements such as the Agreement on the Application of Sanitary and Phytosanitary Measures.

Dr. Estupiñán agreed that it was very important to define PAHO's role vis-à-vis FAO and other agencies. The Organization had communicated with all the agencies involved in food safety for that purpose. PAHO's orientation was shaped by the fact that it was a public health entity and food safety was a public health priority. Accordingly, the Organization's efforts focused largely on ensuring the safety of food for national consumption. Still, because PAHO was aware that the economies of many countries depended on the export of food products, an important component of its strategic plan of action was harmonization of food safety standards and legislation in the countries, including compliance with the agreements on Sanitary and Phytosanitary Standards and Technical Barriers to Trade. Moreover, WHO as a whole had been asked in various international trade forums, including the Melbourne conference, to step up its activities in the area of food safety in response to growing concern for consumer health protection.

Though the plan might appear to be somewhat overly ambitious, it should be understood that, to carry out the plan, the Organization would coordinate its efforts with those of other agencies and it would utilize resources and infrastructure that were already in place. For example, it would not be necessary for PAHO to develop any food safety and quality standards, as that work was already being done by the joint FAO/WHO Food Standards Program. Hence, PAHO's role would be to disseminate that body of standards and facilitate its application in the countries. Moreover, the countries themselves had built up considerable infrastructure and expertise in food safety over the years, and the Organization would seek to form alliances and consortia to take advantage of that experience. One of long-term objectives of the plan of action was the establishment of a regional commission on food protection to serve as an advisory body and as an agency for evaluating national programs. PAHO's experience with such bodies—notably the

Hemispheric Commission for the Eradication of Foot-and-Mouth Disease—showed that they were a very effective vehicle for spurring action at the national level and facilitating joint effort at the regional level.

The concern regarding the suitability of inspection methods such as the HACCP methodology in some contexts was valid. Certainly, introduction of the HACCP system required significant investment and a fairly high level of technological development. In some countries, a more appropriate course of action might be to start with the introduction of good manufacturing and production practices. Experience had shown that improving workers' knowledge of food protection principles could lead to marked reductions in contamination problems. For that reason, PAHO was emphasizing the communication and information component of the plan of action.

As for the issue of inspection at the local level, in most countries, the agriculture sector had taken the lead in inspection of local agricultural produce. However, PAHO advocated a coordinated approach through the creation of intersectoral committees or commissions involving both the health and agriculture sectors. The Organization's role was to facilitate such meetings of health and agricultural officials so they could define the role of each sector and coordinate their activities.

The Director said that he had been pleased that the recommendations of the Melbourne conference had called on WHO to take a more aggressive role in relation to food protection. Clearly, assuring food safety was a critical public health function, and organizations devoted to public health must therefore play a leading role in that area. As several delegates had noted, the WHO Executive Board would be discussing the subject in January 2000. In preparation for that discussion, the Secretariat would be happy to provide Executive Board Members from the Americas with additional information on PAHO's activities in the Americas or on the issues raised in the Executive Board document. In regard to additional information on the food safety problems associated with international trade, the Secretariat did not currently have much data on the flow of foods in international commerce and the problems that had arisen, but it would make every effort to compile some information and make it available to delegates prior to the Executive Board session.

He was also pleased that the Subcommittee was satisfied with the work of INPPAZ, although he felt that the Institute had the potential to do much more. Resource constraints had limited the scope of its activities in recent years; however, the Ministry of Agriculture of Argentina, the host country for INPPAZ, had committed itself to contribute a larger share of the financing for the Institute. He was therefore hopeful that INPPAZ would soon have the resources necessary to strengthen its capacity to respond in some of the areas identified by the Subcommittee. As for the decision to shift INPPAZ's focus

toward food protection and away from zoonoses, he pointed out that it had come about as a direct result of recommendations made by the Subcommittee in earlier sessions. He agreed that it had been a wise decision, given the magnitude of the problem of foodborne illness.

In regard to the creation of a hemispheric commission on food protection, he was happy to report that considerable interest had been expressed among high-level officials in the countries.

***Cardiovascular Disease, with Emphasis on Hypertension (Document SPP33/8)***

This item was introduced by Dr. Sylvia Robles (Coordinator, Program on Noncommunicable Diseases), who presented data illustrating the magnitude of the problem of cardiovascular disease in the Region. The two most important cardiovascular diseases, in terms of premature mortality, were ischemic heart disease and cerebrovascular disease. Hypertension was a key risk factor for both diseases and for other cardiovascular diseases. Studies had shown that preventing and controlling hypertension could bring about significant reductions in deaths from cardiovascular causes. Accordingly, the PAHO Program on Noncommunicable Diseases was working to strengthen programs for the prevention and control of hypertension, given their potential impact in the medium and long terms.

Dr. Armando Peruga (Regional Advisor, Noncommunicable Diseases) then provided more specific information on the problem of hypertension, the status of national control programs, PAHO's efforts in this area, and some recommended strategies for closing the gap between present levels of control and the level possible with current scientific knowledge. Studies in the Americas indicated that the prevalence of hypertension was between 8% and 31%, although the data were not always comparable owing to differences in the methodologies and definitions used. While most of the countries had national programs in place, few of those programs were comprehensive, encompassing prevention, control, and management of hypertension. Moreover, although three fourths of the countries had national guidelines for the detection, treatment, and management of hypertension, they were systematically applied and regularly revised in only one third. As a result, a high proportion of hypertension cases went undetected and fewer than two thirds of those detected were being treated. Of those being treated, only 30%-50% were adequately controlled.

Improving hypertension control programs meant detecting and treating more hypertensives, enhancing the quality of care, and improving patient education. While treating hypertension entailed higher expenditure, in most cases the reduction in the costs associated with cardiovascular disease would compensate for that expenditure. In

addition, there was increasing consensus among experts that it was possible to treat hypertension without raising the cost of care, provided that the complexity of care was limited and the lower-cost drugs of proven effectiveness recommended by WHO were utilized.

The PAHO Noncommunicable Diseases Program had developed an approach that integrated health promotion and primary prevention with control of noncommunicable diseases, including hypertension, under the rationale that since many health problems shared the same risk factors, the same strategies could be used to address them. With a view to promoting a concerted effort on hypertension, PAHO had joined with the U.S. National Heart, Lung, and Blood Institute and several other organizations to create the Pan American Hypertension Initiative. The objectives were to increase the detection of individuals with high blood pressure in all health services and to improve patient acceptance of and adherence to treatment. The Organization recommended the following strategies for achieving that objective: development of the surveillance of noncommunicable diseases and their risk factors, including hypertension; promotion of greater community awareness of the problem; implementation of guidelines for cost-effective care; and patient education. The Subcommittee was asked to comment on those strategies and suggest others for strengthening the prevention and control of hypertension in the Region.

The Subcommittee endorsed the overall strategy of preventing and controlling hypertension as a means of reducing rates of cardiovascular disease, as well as the more specific strategies for strengthening hypertension prevention and control programs. It was felt that the activities proposed in the document would contribute to PAHO's efforts to promote health, prevent and control disease, strengthen health systems and services, and forge linkages between health and human development throughout the Americas. Several delegates commented that there was strong justification for PAHO's increased emphasis on cardiovascular diseases, given their growing importance in both developing and developed countries. At the same time, it was pointed out that the health care infrastructure and economic and professional resources in some countries might be insufficient to deal with the new challenges presented by chronic and noncommunicable diseases, such as cardiovascular disease, while simultaneously contending with infectious and parasitic diseases and problems related to malnutrition. It was emphasized that meeting those challenges would require expanded collaboration and partnership between the Organization and the Member States and among the Member States themselves to maximize collective resources.

Members of the Subcommittee suggested that the following points should be added to or emphasized in the document and in the proposed agenda for action:

- The approach to hypertension as a public health problem can contribute valuable strategies for both clinical management and public health approaches to other noncommunicable diseases linked to lifestyle, including diabetes, liver cirrhosis, and some forms of cancer. Integrated approaches that address common risk factors for hypertension (obesity, inactivity, high sodium intake and low potassium intake, excessive alcohol consumption, and others) will also help to lower the risk for other noncommunicable diseases.
- While hypertension is generally regarded as a health problem of older adults, it should be recognized that it can also be a significant cause of maternal mortality among young women, especially when associated with eclampsia. The primary health care approach proposed in the document should therefore incorporate prevention of hypertension during pregnancy.
- Hypertension prevention and control programs should be seen as a high priority from both a public health and an economic perspective. Notwithstanding the cost of pharmaceuticals, controlling hypertension is extremely cost-effective, given the huge economic losses caused by cardiovascular diseases. Moreover, a primary health care approach that emphasizes health promotion, prevention of risk factors, and, where appropriate, nonpharmacologic approaches to treatment, can be highly effective at relatively low cost.
- Research and evaluation of the quality of care provided to patients are needed to determine why a larger percentage of diagnosed hypertensives are not being adequately controlled and identify the failures in current therapeutic approaches, with particular attention to the use of technologies that are costly but may not be particularly effective in controlling the problem.
- Under- and nonutilization of health services should be recognized as one factor in the low levels of detection of hypertension. Community-based programs are needed to raise awareness of the problem and encourage and facilitate the use of services in order to detect more cases of hypertension. Improved quality of care and increased use of nonpharmacologic therapies will also help expand the use of services.
- The document could be enhanced through stronger emphasis on professional and, especially, public education. Much greater effort is needed to educate patients and the general public on how they can better protect their own health.

- The document could also be enhanced through incorporation of the statement that emanated from the March 1999 meeting on the Pan American Hypertension Initiative, or elements from that statement.

Dr. Robles pointed out that several of the delegates had underscored the importance of cardiovascular diseases in developing countries, which represented a change from past. Traditionally, those diseases had been seen as problems mainly of developed countries, but there was now incontrovertible evidence that the developing countries were being equally affected. Indeed, PAHO's information indicated that cardiovascular diseases were the leading cause of premature death in the countries of Latin America and the Caribbean. Primary prevention and control of hypertension was a strategic response that would address not only the risk factors for cardiovascular diseases but for many other noncommunicable diseases, as various delegates had noted. The Organization was working on several integrated, community-based approaches to prevent risk factors for noncommunicable diseases, notably the CARMEN<sup>1</sup> project. Technical cooperation activities under the Pan American Hypertension Initiative and the CARMEN project would complement one another.

***Participation of the Pan American Health Organization in the United Nations Reform in Member States (Document SPP33/4)***

Dr. Irene Klinger (Chief, Office of External Relations) reviewed the main objectives, features, and status of the process of United Nations reform and its impact on PAHO's work at the country level. She began by noting that the document and presentation on this item represented a collaborative effort by the Office of External Relations and the Office of the Assistant Director, who was responsible for overseeing the Organization's technical cooperation at the national level.

United Nations Secretary-General Kofi Annan had initiated a wide-ranging reform program in 1997 aimed at making the United Nations system work more efficiently and strengthening it as a force for sustainable, people-centered development. The objectives of the reform program were greater unity of purpose, increased cost-effectiveness, and coherence of efforts and agility in responding to the needs of Member States. At United Nations Headquarters, one of the key elements in the reform process had been the formation of the United Nations Development Group (UNDG) to enhance the effectiveness and impact of United Nations development operations through facilitation

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<sup>1</sup> CARMEN is the Spanish acronym for "Actions for the Multifactorial Reduction of Noncommunicable Diseases."

of joint policy formation and decision-making at the central level. The group was composed of the various United Nations agencies engaged in development activities, including WHO.

At the country level, the Secretary-General had asked the participating funds and programs to establish corresponding consultative and collaborative arrangements and to seek to integrate their country-level assistance into a United Nations Development Assistance Framework (UNDAF). United Nations country teams, under the leadership of the United Nations Resident Coordinator, would work closely with governments in preparing the frameworks, permitting a new strategic approach to national development priorities. The first step in formulating the UNDAF would be to conduct a Common Country Assessment (CCA), a comprehensive, multisectoral analysis of the country's situation and development needs. As an additional means of reducing costs and enhancing efficiency, the Secretary-General had proposed that the field operations of all United Nations agencies be placed together in a single United Nations office, or "UN House," under the Resident Coordinator.

PAHO, as the Regional Office of WHO, was called on to play an active role in all aspects of the reform process. In some instances, PAHO would lead the process at the country level, since the PAHO/WHO Representative served as the UN Resident Coordinator in some countries of the Americas and as Deputy Resident Coordinator in others. The United Nations reform process created both challenges and opportunities for the work of PAHO and its efforts to further health development in its Member States. On the one hand, PAHO's leadership role—whether as UN Resident Coordination or as the lead agency in the various interagency task forces or thematic groups that existed at country level—represented a considerable demand on the time of the PAHO/WHO Representative and on PAHO resources in the country. In some cases, PAHO field staff were devoting as much as 25% of their time to the reform process.

On the other hand, the Organization's participation in the CCA and UNDAF formulation process could afford an opportunity to call attention to health issues, promote greater leadership by the ministries of health in establishing national development priorities and strategies, and mobilize additional resources and intersectoral collaboration to address the determinants of health. A more unified United Nations system thus could lead to better and more equitable health outcomes. Nevertheless, PAHO considered that each agency should maintain its programming and budgeting independence and utilize it to contribute to achieving the goals stated in the UNDAF.

The Subcommittee was invited to comment on how the United Nations reform process was being perceived by national authorities, how the ministries of health could

better use the reform process to promote health priorities in development discussions, and how PAHO could better perform its technical cooperation functions in the context of reform.

In the Subcommittee's discussion of this item, support was expressed for the ideals behind the reform process—i.e., enhanced coordination of United Nations cooperation processes at the country level, increased efficiency, and cost-savings. However, a number of concerns were raised as to the concrete impact of the process on the health sector and on PAHO's work in the countries. The main ones are summarized below:

- The priorities established by the UN Resident Coordinator may not coincide with those that the country has established for cooperation in certain sectors or with certain agencies, especially in cases in which the Resident Coordinator is an agency other than PAHO. The Organization has always worked closely with countries to establish priorities and plan cooperation based on needs identified by national authorities, but the same is not true of all agencies. Strategic plans in some countries are developed not on the basis of national consultation and dialogue, but through an internal process among the agencies, generally overseen by the UNDP. Social issues, including health issues, may not receive adequate attention in such strategic plans.
- Coordination among United Nations agencies must be complemented by adequate national coordination in establishing priorities. This is a concern especially in relation to the national focal point for the United Nations reform process. There is a risk that the social sector in general, and the health sector in particular, might not receive sufficient attention if a single national focal point is designated to represent national interests in the reform process, especially if that focal point is the ministry of finance or the ministry of foreign affairs.
- While many health issues are intersectoral in nature, and intersectoral coordination to address them is generally desirable, some issues are specific to the health sector and must be discussed and resolved within the health sector alone. How will those issues be handled within a unified United Nations framework at country level?
- The idea that a single framework for United Nations funds and programs will maximize the mobilization of resources should be approached with caution. In fact, it could lead to increased conditionality and a narrowing of priorities, which ultimately could reduce the volume of resources received by the countries.

- In view of PAHO's recommendation that all the agencies should maintain separate programming and budgeting, what would be the function of the UN House?
- PAHO is in a unique position with respect to the other agencies involved in United Nations reform at the country level. PAHO is older than the other agencies. It has established a strong presence in the countries and has a long history of collaboration with national health authorities. While PAHO, as the Regional Office of WHO, has a responsibility to participate in United Nations reform, it should take care to ensure that its involvement in the process does not detract from its traditional leadership in health in the Americas.

The Subcommittee encouraged PAHO to utilize its unique strengths to exercise leadership in the United Nations reform process at the country level and ensure a prominent place for health on national development agendas. It was emphasized that the real test of the success of reform would be how well it resulted in improved performance and ability by the agencies to deliver cooperation to their clients—the countries. The importance of continuous monitoring and evaluation of the relevance of the UNDAF to country needs and priorities was also underscored.

Dr. Mirta Roses (Assistant Director, PAHO) assured the Subcommittee that PAHO was keenly aware of the need to be mindful of the wishes and priorities of the Member States, which had provided the impetus for United Nations reform and should be the prime beneficiaries of the reform process. She pointed out that the direction that reform processes would take at country level would depend, to a large degree, on the leadership of the overall process of external cooperation within the country. Strong government leadership of the external cooperation process would translate into a strong government presence in the UN reform process at the national level. Without that presence, the process would tend to become an end in itself, rather than a process that would lead to achievement of the stated objectives of more consistent, coherent, cost-effective cooperation that responded to the countries' needs. As the Subcommittee had noted, PAHO had a long tradition of consulting with national authorities to establish its cooperation priorities in each country. The Organization would continue to rely on the governments, and in particular the ministers of health, for guidance on how and to what extent it should contribute to United Nations reform at the country level.

Dr. Klinger stressed the need to use the CCA as a means of incorporating the national vision of the country's development problems into the formulation of the UNDAF and ensuring that it would respond to national needs and priorities. Replying to the comments concerning the drawbacks of establishing a common framework for cooperation and the risk that it might limit the possibilities for mobilizing resources to

address health priorities, she pointed out that health authorities would need to remain vigilant and insist that health was accorded the importance it deserved. Just as they often had to compete with other sectors in negotiations for bilateral and multilateral financing, health authorities would have to be strong advocates for health in the United Nations reform process, both in their dealings with the UN Resident Coordinator and with the national focal point for the reform process. With regard to the role of the UN House, the idea was that costs could be reduced if agencies shared facilities and services. PAHO's decision on whether or not to move its Representative Office to the UN House would depend on the situation in each country and on factors such as whether the Organization already owned or leased its own building.

As for the issue of independence in programming and funding, PAHO's position was that each agency should retain control over those processes, but their programming should respond to the CCA and the UNDAF. As the delegates had pointed out, because of PAHO's history, it enjoyed a rather unique position in the countries and could essentially "wear two hats." It had a responsibility to support the process of United Nations reform and respond to the Secretary-General's requests; however, if it saw that the reform was not responding to the health needs and priorities of its Member States, it might opt to "wear the other hat."

The Director was pleased with the level of interest expressed by the Subcommittee in the topic of United Nations reform, which was of crucial importance to the Organization as a whole. He explained that this item had been included on the Subcommittee's agenda because the Secretariat considered it important to make the Governing Bodies aware of the implications of United Nations reform in terms of PAHO's time, its relationships with its partners, and its independence of thought and action. One of the aspects that most troubled him about the process was the concept of a common development framework. His view was that there could be no single development program, since human development called for action in such a wide range of areas. It must be recognized that health was a vital component of development and that the health sector was an equal partner in the development process. From that standpoint, PAHO was as much a development agency as any other agency, and it would not relinquish its right to speak about what constituted development or allow another agency to assume the responsibility of speaking in its name before the governments of Member States, as had happened in some countries with the UNDP representatives. Representations that were made to governments should be made commonly, cooperatively, and in a collaborative spirit.

He was similarly troubled by the implications of the World Bank's parallel development of a separate framework—the Comprehensive Development Framework

(CDF). There was no evidence that the CDF would be consistent or compatible with the UNDAF, and the existence of two frameworks was unlikely to enhance coordination between the World Bank Group and the United Nations system.

With regard to the issue of focal points in the countries, the concept of a single development framework was based on the precept that there was some single point in the countries where decisions about development were made, but that was not true. In a cabinet system, each minister sought to protect the interests of his/her sector and decisions were made collectively. As Dr. Roses had pointed out, the extent to which the effort at coordination among the agencies would function well would depend on the extent to which the government agreed that there would be pluralism in terms of focal points and that there would be some consensus in terms of where the various areas would come together. In any case, the focal point for PAHO's action at the country level would remain the ministry of health. Ministers of health had told him repeatedly that, regardless of how PAHO participated in the reform process or in the common development framework, they would not want to see a reduction in the dialogue and direct interaction between PAHO and the ministries of health.

As for the UN houses, PAHO would participate in them only if it was to the Organization's advantage to do so. Functional cooperation and mutual self-interest—not physical space—would be the primary considerations in the decision. If participation in the UN House would be detrimental in any way to its relationship, proximity, or ability to communicate with the ministries of health, PAHO would not participate.

The experience with UNAIDS had demonstrated that the Subcommittee's concern over the impact of a common development framework on funding for the countries was quite valid. In essence, coordination and collaboration in the framework of UNAIDS had resulted in a reduction of the funding going to countries. Furthermore, in some countries, a significant amount of money was being put into the coordination effort itself, and the use of funds for coordination at the country level meant a reduction in the funds available for technical cooperation.

It was true that PAHO, with the experience gained over its 97-year history, had a lot to contribute to the reform process at the country level, particularly in terms of relationships with governments and knowledge of the countries. In almost every country, PAHO was the strongest presence numerically, and it was usually the best-developed in terms of programming. Another valuable contribution was the development of indicators for the country assessments. In some countries, the Organization was already working with other agencies to develop indicators within a common framework. Moreover, in most countries, PAHO had more data available than other agencies.

It was the Organization's responsibility—not so much to the United Nations system, but to the countries—to contribute its knowledge and expertise to the reform process at the country level. All of the PAHO/WHO representatives were participating in the CCA and in formulating the UNDAF in their respective countries. Nevertheless, the Director felt strongly that the Organization's participation in United Nations reform in no way should be inimical to its responsibility to its primary clients: its Member States, and in particular the ministries of health. If PAHO had to choose between participating in the coordination mechanism or leading a thematic group at country level and serving its primary clients, it would always give priority to its primary clients. As the Subcommittee had noted, the primary purpose and the foremost consideration in coordination and reform efforts should be improvement in the countries.

***Operations of the Subcommittee on Planning and Programming (Document SPP33/3)***

Dr. Karen Sealey (Chief, Office of Analysis and Strategic Planning) introduced this item, which had been included on the Subcommittee's agenda at the request of the Executive Committee at its 125th Session, held in October 1999. The Executive Committee's proposal to reexamine the operations of the Subcommittee on Planning and Programming (SPP) had coincided with an internal process aimed at strengthening the strategic planning process within the Secretariat. The aim of the Subcommittee's discussion of this topic was to determine whether the current operations of the SPP were appropriate, given the need for effective planning and programming in the challenging regional and global environment. Dr. Sealey began by reviewing the evolution of the SPP since its creation by the Executive Committee in 1979. She then presented highlights of its operations from 1979 through 1998—including the extent and frequency of participation by the various Member States in Subcommittee meetings—and she described the current context in which the Subcommittee was operating. Finally, she suggested several possible issues for discussion by the Subcommittee.

Initially, the SPP had been known as the Subcommittee on Long-term Planning and Programming. It had been conceived of as a "think tank" whose principle function was to identify strategic issues and advise the Executive Committee and the Director on matters pertaining to long-range planning and programming. One of its chief concerns had been implementation and monitoring of the recently adopted regional plan of action for achieving health for all by the year 2000. The Subcommittee had worked in collaboration with the Headquarters Program Committee. That committee had become defunct around 1981, and in 1984 the Executive Committee had formalized the role of the Subcommittee in planning and programming, assigning it a defined set of functions and changing its name to Subcommittee on Planning and Programming.

The functions established by the Executive Committee in 1984 had been modified slightly in 1996, when the Subcommittee's terms of reference and rules of procedure were updated. Its current functions were those adopted in 1996, namely: to advise the Executive Committee on matters relating to general and specific orientations proposed for the Organization and the corresponding monitoring and evaluation reports; the process and methodology of planning; the process of technical cooperation with the countries, including monitoring and evaluation of progress toward the goal of health for all; receipt of the reports from monitoring of health conditions in the Americas and of the economic and social factors that affect health conditions and the health sector; review of special programs, with an emphasis on the formulation and evaluation of those programs; and any other functions assigned to it by the Executive Committee.

One of the underlying objectives of the Executive Committee in creating the SPP had been to increase participation by Member States in the Governing Bodies of the Organization. The document contained statistics on membership and participation by the countries in the 32 Subcommittee sessions held between 1979 and March 1999. A total of 225 delegations had attended those sessions, representing most of the countries of the Region; however, seven Members had participated only once and nine countries had never participated in a Subcommittee session. The delegations had been composed mainly of public health officials from the ministries of health. Thirty-eight ministers of health had attended sessions.

In the early years of its existence, the SPP had focused primarily on topics related to the organization and work of the Secretariat. Gradually the focus had shifted to specific issues of technical cooperation. In recent years, the majority of the topics examined by the SPP had been referred to the Executive Committee for further consideration, which reflected a change in the function of the Subcommittee: whereas in the early years, it had tended to work more as a think tank, between 1994 and 1998 it had become almost a screening body for the Executive Committee. The Subcommittee was asked to consider whether its current functions and operations remained appropriate in the context of rapid global and regional change and in light of the need to strengthen institutional development, long-term planning, and evaluation in order to anticipate and facilitate the Organization's response to change.

In particular, the Subcommittee was asked to contemplate the following questions: To what degree should the SPP be involved in strategic planning and evaluation of regional cooperation? What kind of topics should be discussed by the SPP and to what extent should those topics be related to planning for the long term, rather than planning for the immediate future? What should be the role of the SPP in the evaluation of technical cooperation at country level? What should be the Subcommittee's modality of work in its sessions and what type of documents would be needed to support any

change in the current modality? How often should the Subcommittee meet and might it be possible to utilize telecommunications to continue its work between sessions? How might the differing functions of the SPP and the Executive Committee be better reflected in the modality of work, the matters discussed, and the membership of each body so that the SPP can contribute more effectively to the overall planning and evaluation process for the Organization?

The delegates agreed that it would be desirable for the Subcommittee to return to its long-range planning orientation and for it to function more as a think tank, as it had done originally. It was pointed out that, increasingly, the documents discussed by the Executive Committee and the Directing Council were essentially the same as those that had been examined initially by the Subcommittee and that, as a result, the tenor of the discussion in all three bodies tended to be the same. It was felt that the Subcommittee could contribute more constructively to the work of the Organization if it focused less on current program matters and concentrated instead on enhancing long-term planning processes and on evaluating the outcomes of those processes. At the same time, however, the value of the Subcommittee's role in screening documents and advising the Executive Committee on programmatic matters was recognized. It was pointed out that Executive Committee sessions might well be longer if the Subcommittee ceased to fulfill that screening function. It was also emphasized that, as an advisory body of the Executive Committee, the Subcommittee was not at liberty to set its own agenda but had a responsibility to examine whatever matters were referred to it by the Committee.

In regard to the format and frequency of SPP sessions and participation therein, a number of concrete suggestions were made, including the following:

- Eliminate the fall session and hold only one session each year, which would allow the Secretariat staff more time to prepare and distribute the documents and would afford the delegations more time to circulate them among the appropriate agencies within their respective governments.
- Continue to hold two sessions per year, but make the fall session more of a brainstorming session on a single topic, which could be decided during the spring session, thus providing ample time to prepare the necessary documentation.
- Encourage greater informality and more dialogue in Subcommittee sessions.
- Continue and expand the practice of including discussion questions in the documents and presentations prepared for the Subcommittee as a means of stimulating greater exchange and dialogue.

- Distribute documents at least four weeks—but preferably six weeks—before Subcommittee sessions to give participants the opportunity to thoroughly familiarize themselves with the matters to be discussed and thereby enable them to participate more actively in the sessions.
- Ensure that all slides, overheads, and other visual aids used in Subcommittee sessions are bilingual (English/Spanish) in order to facilitate communication and discussion among the participants.
- Modify the composition of the Subcommittee to include fewer Executive Committee Members in order to avoid repetition of the same topics and comments in the sessions of the other Governing Bodies.
- Seek to ensure broader participation by the Member States, in particular by those that have rarely or never taken part in Subcommittee sessions.
- Lengthen the term of Subcommittee Members in order to foster greater continuity and build a body of experience and expertise that would better enable the SPP to contribute to long-range planning.
- Consider inviting outside technical experts from both the private and public sectors to participate in the drafting of documents and take part in the discussions of the Subcommittee.

The consensus that emerged was that it would be desirable to hold a single session per year, probably in February or March. In order to allow ample time for discussion, it was felt that the session should be three days long, rather than two days, as had been the practice in recent years. The need to circulate the documents well in advance of sessions was underscored.

As for the Subcommittee's participation in the evaluation of PAHO technical cooperation at country level, it was agreed that the SPP should play a role in the evaluation process, although there were differing views on the extent and nature of that role. One delegate proposed that SPP sessions might occasionally be held in countries in which evaluations were being conducted in order to engage the Subcommittee more directly in the process—either at the outset, so that the Subcommittee could provide input on the content of the evaluation, or at the conclusion, so that the Subcommittee could comment and make recommendations relative to the findings of the evaluation. Another delegate suggested that it might be more useful to submit the written evaluations of technical cooperation to SPP Members throughout the year for information and feedback. The Secretariat could then use that feedback to identify shared challenges at country

level, especially those that might impact regional initiatives or improve PAHO's interventions across countries. The evaluative discussions would thus be more issue-specific and less focused on national environments. In any case, the Director was encouraged to carefully weigh the benefits of holding sessions outside PAHO Headquarters against the costs that such a move would entail.

With respect to the topics that should be discussed by the Subcommittee, it was emphasized that they should include practical issues of common interest to the countries, such as how to extend health care coverage to underserved populations. In this connection, the Delegate of Ecuador expressly requested that the subject of universal health insurance be discussed by the Subcommittee during 2000 in order to provide an opportunity for countries that had developed, or were planning to develop, such insurance plans to compare and learn from one another's experiences. It was emphasized that the documents prepared for discussion by the Subcommittee, especially those on programming matters, should always include an analysis of the extent to which the activities envisaged would contribute to greater equity. In addition, it was emphasized that the SPP should seek to ensure linkage between the planning and budgeting processes, as the budget was the visible manifestation of planning. To that end, it was considered essential for the documents to include information on the financial implications of programming matters.

Dr. Sealey said that the Secretariat would make every effort to see that future documents and presentations on programming matters included a discussion of costs and financial implications, as well as an analysis of the degree to which the principle of equity was being incorporated into the Organization's programs and activities. The Secretariat would also ensure that all future visual presentations contained text in both English and Spanish and that documents were distributed at least a month prior to Subcommittee sessions. In response to a comment from one of the delegates, she acknowledged that the document on this item had not explicitly addressed the functional relationship of the SPP to the other Governing Bodies. However, she felt that it was clear from the discussion that the delegates considered it an important function of the SPP to assist the Executive Committee in its role of analyzing issues that were to be sent on to the Directing Council for action.

The Director said that he saw both negative and positive aspects of this overlap of functions. He pointed out that the efficient manner in which the Directing Council generally dispatched its work was often a result of the fact that the issues had been so well "digested" previously by the delegations to the Subcommittee and the Executive Committee sessions. In the case of difficult or contentious matters, it had proved beneficial to have the initial discussion within the SPP, as it had helped build consensus. Nevertheless, the repetition that sometimes characterized discussions in the Governing

Bodies should be avoided to the extent possible. That could be accomplished if the Executive Committee would identify certain specific matters within broader topics on which it wished to receive advice or recommendations from the Subcommittee.

In regard to the membership of the Subcommittee, he agreed that an effort should be made to achieve better balance in Member States' participation in the work of the SPP; however, because the Subcommittee was a subsidiary body of the Executive Committee, he felt that its core membership should be composed of Executive Committee Members. It might be possible to achieve greater continuity, as had been suggested, by designating some permanent or longer-term Members to the Subcommittee in order to build up institutional memory. It was also feasible to enrich the presentations made to the SPP with support from experts in various areas, including experts from Member States and from outside the Organization.

He was enthusiastic about the idea of holding only one session a year; however, the Secretariat would need to consider how best to structure that session so that it would yield the greatest benefit for both the Member States and the staff of the Organization. If it was agreed that the primary function of the Subcommittee should be long-term planning, programming, and the generation of new ideas, longer preparation time would be required. It would probably also be advisable to hold a longer session in order to allow sufficient time to explore topics in depth, as the delegates had proposed. The Secretariat would also look for ways to make the SPP more of a think tank and foster more informal dialogue among participants.

The idea of holding meetings outside PAHO Headquarters was appealing for several reasons. In particular, it would allow Members to see and take part in the process of planning and programming "live" at country level and to appreciate the practical effects of Subcommittee recommendations in the countries. Certainly, it would be more costly to hold sessions outside Headquarters, but if doing so would enhance the functioning of the Organization, he considered the idea worth examining. Moreover, holding the session at country level would in no way preclude discussion of matters relating to the overall planning and programming of the Organization, managerial and policy issues, or current topics of regional and/or global interest, such as the one suggested by the Delegate of Ecuador.

He agreed that it was essential to link any discussion of planning and programming to the budget, whether that was done prospectively or after the budget was approved. Similarly, it was important to examine the financial implications of proposed actions. The Secretariat would strive to ensure that documents presented to the Subcommittee included such financial information.

Finally, he expressed his gratitude to the delegates for the cooperative and nonconfrontational spirit in which they had approached the discussion. It was clear that everyone had the best interests of the Organization as a whole at heart.

***Maternal Health (Document SPP33/7)***

Ms. Carol Collado (Coordinator, Program on Family Health and Population) presented some general considerations in relation to maternal health and examined the lessons suggested by PAHO's work in this area over the years. She began by pointing out that the understanding of what constituted maternal health had changed. For a long time in the history of public health, "maternal health" had been taken to mean the health of women during pregnancy or the perinatal period. However, maternal health was now seen as an outcome of complex interactions that took place at both the individual and societal levels throughout a woman's lifetime, in combination with the characteristics and functioning of health systems and services. At the individual level, maternal health was influenced by numerous factors, including nutritional status, knowledge base, educational level, belief system, inherited tendencies, and specific environmental determinants. At the societal level, cultural and ethnic influences and changing roles for women had an impact on maternal health, as did poverty, economic instability, and the growing gap in the distribution of wealth and possibilities for accessing education, nutrition, and health services.

Despite this reality, health services for women continued to be mainly episodic and reactive, with little attention to cultural and contextual factors that influenced women's health. That deficiency had repercussions not only for the women concerned, but for those whose lives they touched, since there was ample evidence that maternal health affected not only the health of women themselves, but that of their children, their families, the wider community and, ultimately, the entire national development process.

After a century and a half of work in maternal health in the Americas and globally, a number of lessons had been learned. The principal ones were that maternal health must be considered a lifelong process and that attention to women's health must begin long before and continue long after their childbearing years; that quality of care and capacity-building for human relationships were crucial, as it had been demonstrated that women would not use services if they were treated badly; that policy and legislation on women's health must be accompanied by monitoring, evaluation, and enforcement mechanisms; that health authorities must be involved in the development of policy in education, commerce, labor, and other sectors in order to raise awareness of the health impacts of policy-making in those areas; and that health literacy and social participation

were key to changing attitudes and behaviors in relation to maternal health, but that efforts to transmit knowledge and bring about behavioral change must take account of cultural diversity.

Based on those lessons, PAHO advocated a gender-sensitive, lifecycle approach to maternal health that emphasized prevention and health promotion and recognized the myriad factors involved in achieving health. The Organization saw its role in promoting maternal health as one of continuing to support the countries in developing a framework for care that incorporated available knowledge and technology and that recognized the long-lasting intergenerational implications of maternal health; examining existing normative frameworks to assure adequate attention to monitoring, evaluation, and enforcement mechanisms; reviewing and restructuring existing programs to include activities aimed at addressing underlying conditions and determinants that lead to poor outcomes in maternal health; and evaluating health services and the training, distribution, and utilization of the different categories of human resources in the delivery of maternal health care.

The shift to a more holistic approach to maternal health was expected to yield the following outcomes: a change in the vision of maternal health as strictly a women's health issue to a vision that recognized maternal health as a family and community, public health, equity, human rights, and development issue; a policy framework that prioritized maternal health as a means of righting inequities; synergy among partners towards common maternal health goals; action plans and resource distribution oriented toward quality and health promotion; and more women able to exercise their rights and decide freely on matters related to their sexuality and reproductive health free of coercion, discrimination, and violence.

The Subcommittee welcomed the holistic and integrated view of maternal health advocated in the document, which took account of factors such as gender discrimination, domestic violence, and reproductive rights that had a profound impact on maternal health. The Subcommittee also endorsed the view of maternal health as a family and community development issue and applauded the document's recognition of the intergenerational nature of maternal health. The emphasis on improving the health, nutrition, and education of girls in order to improve maternal health outcomes in the long term was considered especially important. The Secretariat was encouraged to consider developing a plan or framework for action in the Region based on the conclusions in the document. PAHO was also encouraged to continue calling attention to socially and politically sensitive issues such as gender-based violence and abortion, which were leading causes of maternal morbidity and mortality. It was suggested that the Organization might want to investigate the possibilities for collaboration on the issue of family violence with the Inter-American Children's Institute, which had a related initiative.

Several delegates described ways in which some of the document's recommendations were being incorporated successfully into maternal health programs in their countries. It was reported that Bolivia and Ecuador, for example, had recently introduced free maternal and child health care programs that addressed the principal causes of high maternal and infant mortality, as well as problems such as low birthweight and child growth and development problems associated with poor maternal health. Equally important, those programs recognized the responsibility of the State and society to promote and protect maternal health.

The importance of intersectoral action to address maternal health issues was underscored. It was pointed out that ministries of health should seek to engage ministries of health, education, labor, finance, and planning in dialogue with a view to highlighting the socioeconomic and development repercussions of maternal death and poor maternal health. The need to develop indicators for monitoring and evaluating efforts to address the multiple determinants of women's health was also emphasized. Several delegates commented on the relationship between maternal health and health sector reform, and the value of maternal health outcomes as a marker of progress in health reform was highlighted. In that connection, it was also pointed out that decisions about how health services were to be provided—especially decisions about private vs. public funding of services—would have a direct impact on women's access to services and therefore on maternal health. Strong support was expressed for the idea that maternal health should be a collective responsibility of society.

A number of suggestions were made regarding additional concerns and recommendations that might be incorporated into a framework or plan of action for maternal health, including the following:

- All policies on maternal health should take into account cultural features in each country; only if cultural traditions and practices are respected will women be willing to come to health services, and only then will it be possible to extend coverage, improve maternal health, and reduce maternal mortality.
- Community outreach programs that identify and support every pregnant woman in the community—regardless of whether or not they use the formal health system—should be promoted.
- Development of local-level maternal health committees should be encouraged; these committees would be responsible for reporting and investigating every maternal death, and input from the committees would feed into existing surveillance systems.

- Maternal health services should include at least four comprehensive obstetric health care facilities and 20 basic obstetric health care facilities per half million population, in accordance with WHO guidelines.
- Professional midwifery programs should be established, subject to a situational analysis in each country that would scrutinize the demand for such services.
- Strategies should be developed for counseling women to make them aware of the importance of good nutrition and healthy lifestyles before they become pregnant.
- Any comprehensive framework for maternal health should take account of the impact on maternal health of changes in women's roles and lifestyles. For example, in some countries, increasing numbers of women are delaying pregnancy to pursue higher education and enter professions. The maternal health issues faced by these women (higher risks associated with later pregnancy, infertility) are different than those faced by younger women.

Ms. Collado noted that, in producing the document, the Family Health and Population Program had consulted extensively with other divisions and programs of the Organization, with a view to incorporating all the determinants and factors that influenced maternal health. Unquestionably, the Subcommittee's comments would help the Program to continue to develop and refine the proposed framework.

### ***Repairs to the PAHO Headquarters Building***

Dr. Richard Marks (Chief, Department of General Services) recalled that the Secretariat had informed the 124th Session of the Executive Committee in June 1999 that some serious problems had been detected in components of the heating and air-conditioning systems at the PAHO Headquarters building. At that time, an engineering consultant had been assessing the situation. The situation assessment had since been completed, and the Secretariat was now in a position to present more complete information on the problems encountered and the recommended course of action for addressing them.

While the building's boilers and chillers were being replaced in 1999, major problems had been discovered in the joints of pipes that supplied the heated and chilled water used to heat and cool the building. On two occasions, pipe joints had broken due to rust and corrosion, causing major damage to ceilings and extensive flooding inside the building. It had been extremely difficult to repair the damage because the water shut-off valves were inaccessible and because the ceilings contained asbestos, which posed a

health threat to workers unless asbestos abatement procedures were performed prior to repair. Sampling in nine sites indicated that the corrosion was generalized, which meant that similar incidents of breakage and flooding were likely.

The engineering consultant had found the pipes to be in extremely poor condition and had estimated that the building's air induction units had, at most, a three-year life span remaining. He had recommended immediate replacement of both pipes and induction units. The work would have three major components: replacement of the shut-off valves to permit independent control of water in 26 vertical zones; asbestos abatement and replacement of all pipe risers and run-outs; and replacement of the induction units and enclosures. The Secretariat estimated the total cost of the work, including costs associated with temporary relocation of staff, at approximately US\$ 7.5 million.

The Members of the Subcommittee pointed out that the Executive Committee, not the SPP, was authorized to make decisions regarding repairs to PAHO buildings; nevertheless, they expressed concern about the impact of waiting to consult the Executive Committee, given the urgent need to remedy the situation and the potential for increased cost if the repairs were delayed. Several questions were asked about the source of funding for the repairs.

Mr. Eric Boswell (Chief of Administration) explained that the matter had been brought to the attention of the SPP because immediate action was needed. The Executive Committee would also be informed about the problem in June 2000, but in the meantime the Secretariat was seeking from the Subcommittee Members—all of whom were also Members of the Executive Committee—a “nod of approval” to proceed with the necessary repairs. To cover the costs, the Secretariat proposed a one-time increase of \$7.5 million in the ceiling of the PAHO Building Fund. The Fund was currently capped at \$500,000.

The Director said that he appreciated the Subcommittee's understanding of the gravity of the situation. He agreed that it was necessary to consult the Executive Committee; however, seven of the nine Members of the Committee were present at the Subcommittee's session. If those Members would agree to the one-time increase in the Building Fund, he would communicate immediately with the two Committee Members who were not present to inform them of the Subcommittee's recommendation and seek their approval.

The Members of the Executive Committee present at the SPP session agreed to authorize the Director to take the necessary action and requested that he communicate formally in writing with Members of the Executive Committee to apprise them of the situation, the action to be taken, and the budgetary implications of that action.

## **Other Matters**

The Delegate of Cuba presented a brief account of the outcomes of the Ninth Ibero-American Summit of Heads of State and Government, in which PAHO had played a leading role and which had yielded several outcomes of interest for the Organization and its Member States. Cuba had served as the host country for the Summit, which had taken place in Havana on 15 and 16 November 1999. The theme of the meeting had been “Ibero-America and the international situation in a globalized economy.” The first event of the Summit had been the inauguration of the Latin American School of Medical Sciences, which had been hailed as a symbol of what the countries could accomplish when they worked together. Although the idea for the school had been conceived less than a year earlier, it had already enrolled 1,929 students, representing 18 countries and 27 ethnic groups, who would return to serve their countries as physicians in geographic areas in which there had previously been no doctors.

A strong tradition of cooperation among the Ibero-American countries had developed since the first Summit, held in Guadalajara (Mexico), in 1991. The heads of state and government had decided to structure and formalize the cooperation process at the fourth Summit, and the Ibero-American Cooperation Agreement had been signed at the fifth Summit. The seventh Summit had decided that it was necessary to further institutionalize the process through the creation of a permanent secretariat. The ninth Summit had approved the establishment of the secretariat in Madrid. At its next session, the Executive Committee might wish to consider the possibilities that the recently created Ibero-American Cooperation Secretariat offered for increased cooperation among the countries in the area of health.

The ninth Summit had adopted the Declaration of Havana, which reaffirmed the value of the summits in promoting unity and collaboration among the Ibero-American countries. At the closing session, the President of Panama had announced that the theme of the tenth Summit, which will be hosted by Panama, would be “Childhood and Adolescence.” In view of the signal importance of that issue for health, the Cuban delegation recommended that it be discussed by the Executive Committee in June 2000, with a view to helping the Organization and the Member States prepare for their participation in the Summit.

The Subcommittee welcomed the creation of the Latin American School of Medical Sciences, which would unquestionably redound to the benefit of traditionally underserved populations in the Region. Several delegates expressed their appreciation to the Government of Cuba for affording students from their countries the opportunity to

prepare for medical careers. Support was also voiced for the idea of discussing within the Executive Committee the role of PAHO in political forums such as the Ibero-American summits.

Dr. Klinger, speaking at the invitation of the Director, said that PAHO viewed its participation in regional summit processes (the Ibero-American summits and the summits of the Americas) as an opportunity to raise the prominence of health issues on political and development agendas. The discussion of equitable access to health services at the 1994 Summit of the Americas in Miami had been a reflection of discussions of the topic of health equity by the ministers of health within the Governing Bodies of the Organization. A number of initiatives and opportunities for resource mobilization had resulted from those discussions, including the integrated management of childhood illness (IMCI) initiative, the health sector reform monitoring initiative, the reduction of maternal mortality initiative, and the measles elimination initiative. The Organization, in collaboration with the Member States had succeeded in mobilizing some \$30-\$35 million to follow up on those efforts. Hence, PAHO considered the collective mandates that emerged from the summits a very important means for advancing health priorities in the Region.

Certainly, the creation of the new Ibero-American Cooperation Secretariat would provide the Organization additional opportunities to advocate for the inclusion of health topics on political and development agendas and mobilize support to implement the plans of action that had come out of the summits. In relation to the tenth Ibero-American Summit, the Secretariat had already begun to discuss with the Government of Panama and the other Member States how the Organization could participate most effectively in that gathering. The Secretariat was also exploring how to utilize the joint plan of action that PAHO had established with the Government of Spain to further the implementation of the collective mandates of the summits.

The Director thanked the Delegate of Cuba for his report on the Ninth Ibero-American Summit and affirmed that the Organization would respond as aggressively as possible to ensure that the issue of health remained high on the agenda at the next summit. In addition, the Secretariat would seek the advice of the Executive Committee as to how PAHO should position itself within the hemispheric political movement which the summits represented. He also expressed the Organization's thanks to the Government of Cuba for hosting the celebration of the 75th anniversary of the signing of the Pan American Sanitary Code.

In regard to the next session of the Subcommittee, the current rules of procedure called for the Subcommittee to hold two regular sessions a year, unless the Executive Committee decided otherwise. The first of the two sessions was to take place after the

Directing Council and prior to the meeting of the WHO Executive Board. The other session was to take place after the WHO Executive Board meeting and before the meeting of the PAHO Executive Committee. He would communicate with the Members of the Subcommittee regarding the dates and agenda for the next session, bearing in mind those rules and the comments made during the discussion of the operations of the SPP. He reiterated his gratitude to the delegates for the cooperative spirit in which they had approached that discussion.

### **Closing of the Session**

The President thanked the delegates for their active and thoughtful participation during the session, which had been very productive. He expressed the Subcommittee's appreciation to the staff of the Secretariat for their efficient assistance and then declared the 33rd Session closed.

## **AGENDA**

1. Opening of the Session
2. Adoption of the Agenda and Program of Meetings
3. Operations of the Subcommittee on Planning and Programming
4. Participation of the Pan American Health Organization in the United Nations Reform in Member States
5. Food Protection
6. Virtual Health Library
7. Maternal Health
8. Cardiovascular Disease, with Emphasis on Hypertension
9. Repairs to the PAHO Headquarters Building
10. Other Matters

## LIST OF DOCUMENTS

<i>Document No.</i>	<i>Title</i>
SPP33/1, Rev. 2	Agenda
SPP33/2, Rev. 2	List of Participants
SPP33/3	Operations of the Subcommittee on Planning and Programming
SPP33/4	Participation of the Pan American Health Organization in the United Nations Reform in Member States
SPP33/5	Food Protection
SPP33/6	Virtual Health Library
SPP33/7	Maternal Health
SPP33/8	Cardiovascular Disease, with Emphasis on Hypertension

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PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## **34th SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE**

*Washington, D.C., 29-31 March 2000*

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CE126/5 (Eng.)  
Annex B

SPP34/FR (Eng.)  
30 March 2000  
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# **FINAL REPORT**

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## FINAL REPORT

The 34th Session of the Subcommittee on Planning and Programming (SPP) of the Executive Committee of the Pan American Health Organization (PAHO) was held at the Organization's Headquarters in Washington, D.C., on 29 and 30 March 1999.

The meeting was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Bolivia, Canada, Costa Rica, Cuba, Dominican Republic, Ecuador, Guyana, Mexico, and United States of America. Also present were observers for Antigua and Barbuda, Honduras, Panama, and Uruguay, as well as representatives of four nongovernmental organizations.

### Officers

The following Members, elected as officers by the Subcommittee at its 33rd Session in December 1999, continued to serve in their respective positions.

<i>President:</i>	Ecuador	(Dr. Bayardo García)
<i>Vice President:</i>	Cuba	(Dr. Antonio González Fernández)
<i>Rapporteur:</i>	Bolivia	(Ms. Edy Carmen Jiménez Bullaín)

Sir George Alleyne (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Karen Sealey (Chief, Office of Analysis and Strategic Planning) served as Technical Secretary.

### Opening of the Session

The President opened the session and welcomed the participants, noting that the session had brought the delegates together with the common goal of enhancing the work of the Organization and contributing to the betterment of health and well-being for all the peoples of the Americas.

The Director added his welcome to the participants. He pointed out that several changes were being introduced at the Subcommittee's 34th Session in response to suggestions made during the previous session's discussion of SPP operations. For example, as a means of engaging Members more actively in the sessions, two Member Governments—Canada and United States of America—had been invited to prepare

documents and make presentations on two of the agenda items. In addition, in response to the suggestion that a broader range of actors from outside the Organization be involved in the Subcommittee's deliberations, representatives of several nongovernmental organizations had been invited to take part. He was certain that the changes would help stimulate a lively and productive debate.

### **Adoption of the Agenda and Program of Meetings (Documents SPP34/1, Rev. 1, and SPP34/WP/1, Rev. 1)**

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

### **Presentation and Discussion of the Items**

#### ***Program Budget Policy of the Pan American Health Organization (Document SPP34/3)***

Dr. Sealey presented the document on this item, which reviewed the development and application of the current PAHO program budget policy, adopted by the Directing Council in 1985, and outlined the parameters and principles that were guiding the revision process. The current policy provided guidelines for the development of the program budget and the allocation of resources between regional and country programs, as well as criteria for the distribution of country and regional program funds among the countries, based on their fulfillment of collective mandates adopted by the Governing Bodies, indicators such as infant mortality and population size, and previous levels of technical cooperation.

The policy established support for country programs as a fundamental priority of the Organization, calling for not less than 35% of the total regular budget to be allocated to those programs. Funds were to be allocated to regional programs to provide direct support to country program objectives and priorities and to fulfill regional and collective mandates. The policy also contained provisions regarding mobilization and use of extrabudgetary funds, support for technical cooperation among countries (TCC), and promotion of flexible and innovative administrative mechanisms to maximize resources.

Because the policy set out few measurable objectives or specific indicators, quantitative assessment of its impact was difficult. Nevertheless, a review of the program budgets for the period 1982-2001 showed that one measurable objective—allocation of at least 35% of the total regular budget to the countries—had not only been met but had been far exceeded. As for qualitative assessment of the policy's impact, planning, programming, and budgeting had followed the guidelines of the current policy almost to

the letter. In keeping with the policy, PAHO's nature as a technical cooperation organization—as distinct from a financial cooperation institution—had been continually stressed, as had flexibility in programming and budgeting and responsiveness to the countries' needs. The amount budgeted for support of TCC had increased 122% between 1988-1989 and 1998-1999. The Organization had also had great success in mobilizing extrabudgetary funding, which currently represented around 40% of the total budget.

Various recent developments made it necessary to revise the 1985 budget policy. Most notably, in May 1998 the World Health Assembly had approved Resolution WHA51.31, which changed the methodology for distribution of funds to the WHO regions. As a result, the allocation to the Region of the Americas would be reduced by \$10 million<sup>1</sup> over three biennia, beginning with the current one. Other trends in the external and internal environments also had an impact on the Organization's work and therefore influenced its programming and budgeting. Among the most significant external trends were demographic and epidemiological changes, natural disasters, globalization, steady decline in Official Development Aid (ODA) and a shift toward channeling funds through nongovernmental organizations (NGOs), the United Nations reform process, and increasing demand for zero nominal growth in the budgets of all international organizations. Internally, PAHO's program budget was guided by the policy orientations approved by the Governing Bodies, especially the strategic and programmatic orientations; the Organization's core values of Pan-Americanism and equity; and a managerial philosophy that emphasized transparency, efficiency, and accountability.

The Director had established a working group—consisting of representatives of various PAHO offices and two Members of the SPP—to assist the Office of Analysis and Strategic Planning (DAP) in developing a proposal for a revised budget policy. The working group had identified some basic principles that should guide the policy development process. Those principles, which were described in greater detail in the document, included the following:

- Flexibility and responsiveness to changing needs;
- Explicit statement of any mathematical formula(s) used, recognizing that no single formula will allow sufficient flexibility;
- Development of a budget policy that will support a culture of prioritization within the Organization;

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

- Recognition that the Organization comprises different levels with different functions, with a distribution of funds that will allow for different weighting of the functions that need to take place at any given time; although support for the countries should remain paramount, the importance of the work being undertaken at other levels of the Organization should be recognized and sufficient funding should be provided for that work;
- Building on PAHO's comparative advantage of having a country presence in all of the countries;
- Rationalization of the budget structure to facilitate results-based management and reporting.

The Subcommittee was asked to comment on the adequacy and relevance of the principles, as well as the relevance and timing of the overall budget policy revision process. It was also asked to consider whether contextual factors other than those identified in the document should be taken into account in revising the policy and how frequently the Organization's budget policy should be revised.

The Subcommittee found the document a sound basis for initiating a review of the Organization's program budget policy and endorsed the principles identified by the working group. The principles of flexibility, solidarity, and equity were considered particularly important. It was emphasized, however, that any revision of the budget policy should build on the current policy, not start from scratch. Strong support was expressed for the idea of a "culture of prioritization," which recognized that PAHO could not respond to all demands for assistance and that its limited resources must be utilized where they would produce the greatest impact. Various delegates emphasized the need for flexibility in the face of changing needs, especially in the context of the health sector reform processes under way in the majority of countries. At the same time, it was pointed out that too much flexibility might tend to dilute efforts aimed at achieving common regional goals.

The Subcommittee agreed that there could be no single formula that would allow sufficient flexibility or take account of countries' differing needs and vulnerabilities. In the case of small states such as those in the Caribbean, for example, it was pointed out that, while they had relatively good health indicators, their internal capacity and resources were limited by their small size; moreover, they were frequently subject to devastating natural disasters, and so they continued to require assistance from PAHO. Several delegates cautioned against giving too much weight to health indicators in calculating country allocations. They noted that the use of indicators for that purpose would tend to penalize the countries that had made the greatest gains in health and suggested that more

weight should be given to another criterion identified in the document: the commitment shown by countries in complying with mandates adopted by their collective decisions at the regional and global levels and in their application of national resources in response to those mandates.

As for the frequency with which the budget policy should be revised, the Subcommittee felt that it would be appropriate to reexamine the policy at the time that the Organization's quadrennial strategic and programmatic orientations were discussed. However, it would probably not be necessary or advisable to completely overhaul the policy every four years; rather, the policy could be adjusted to reflect any change in the regional orientations and in global policies and priorities.

The Subcommittee considered that PAHO's program budget policy should reflect the global priorities established by WHO. However, it was also pointed out that the distinction between the policy role of WHO and PAHO's role in the delivery of technical cooperation should be recognized. Though the priorities and policies set by WHO should be taken into consideration, they should not necessarily define PAHO's policy or its actions because its role was qualitatively different in many respects. It was emphasized that the budget policy should clearly reflect PAHO's role as a catalyst and facilitator of technical cooperation, expertise, and capacity-building in the countries.

The importance of evaluation to determine the best use of resources in program budgeting was highlighted. It was emphasized that evaluation should be undertaken systematically to assess program impact and determine whether programs should continue to be funded based on their relevance and effectiveness. Several delegates stressed that the Organization's budget policy should take account of the importance of extrabudgetary funding in the Organization's total budget and should acknowledge the growing role of NGOs in health activities in the Region. It should also continue to reflect PAHO's commitment to the promotion of technical cooperation among countries. It was also pointed out that, while it was true that the budget had suffered as a result of the policy of zero nominal growth advocated by some Member States, PAHO had received an increase in assessed contributions for the current biennium, and that fact should be acknowledged.

Several delegates related experiences from their countries that might be useful in the Organization's budget policy review. The Delegate of Mexico shared the formula that her country had devised for allocating resources to each state in order to extend health care coverage, increase equity, and better meet the needs of marginalized population groups. The Delegate of Costa Rica reported that the Ministry of Health in her country had identified certain cross-cutting themes, based on national priorities, that were emphasized in the formulation of all program budgets.

Dr. Sealey said that it was clear from the Subcommittee's discussion that the principles of solidarity, flexibility, and prioritization were considered crucial. She thanked the delegates for their useful comments and suggestions, which would certainly enhance the document and help guide the overall policy revision process. She also thanked those delegates who had shared their experiences at the national level, noting that, like PAHO, countries had to make decisions about the distribution of resources at various levels and among various programs. The idea of identifying cross-cutting themes in addition to thematic priorities was worth exploring. PAHO might apply a similar approach in order to ensure that its priorities, especially Pan-Americanism and equity, were reflected in budgetary allocations. She agreed on the importance of evaluation and pointed out that for the past six months the Secretariat had been engaged in an effort to improve the quality of program definition to enable it to better assess program impact at the end of the biennium. As for the incorporation of extrabudgetary funds into the budgeting process, when budget proposals were developed, it was standard practice to estimate not only the amount of extrabudgetary funding expected but to indicate the programs for which that funding was anticipated. However, the Secretariat was always careful to ensure that extrabudgetary resources supported the strategic orientations approved by the Governing Bodies, rather than allowing the availability of extrabudgetary funding to influence the direction of the Organization's activities.

The Director stressed that the presentation of this item to the Subcommittee represented only the first step toward developing a budget policy. The next step would be to formulate a draft policy, taking into consideration the input from Member States, the working group, and the Organization's technical staff. The draft version would undoubtedly undergo several more revisions before a final policy was approved. As the Subcommittee had pointed out, the aim of the process was to revise and enhance the current policy, building on the experience gained over the years, and not to formulate an entirely new policy.

He was pleased that the Subcommittee's discussion had focused on the program budget policy and not on the amount of the Organization's budget. The delegates had obviously recognized that that program budget was an instrument for achieving the objectives set by the Member States. He was also gratified by the Subcommittee's emphasis on flexibility and solidarity. Flexibility in budgeting was essential to enable the Organization to respond to changing needs and unexpected occurrences. The concept of solidarity was also crucial and PAHO should seek to operationalize that concept by maintaining a presence, including a budget presence, in all countries. No Member State should be excluded from the Organization's technical cooperation.

He agreed that it was important to distinguish between the roles of WHO and PAHO and also to distinguish between the functions of the regional programs and those

of the country programs within PAHO. Identification of the different functions and responsibilities of various levels was a fundamental management principle for any organization, and that principle would certainly be reflected in PAHO's program budget policy. With regard to the new methodology for allocating WHO funds to the Regions, as he had said on other occasions, that methodology—especially its use of the Human Development Index as a basis for budgeting—was conceptually flawed. The process of formulating the methodology had also been flawed because it had dealt only with allocations to the Regions, whereas it should have reexamined WHO's overall program budget, including the allocation to WHO Headquarters.

As Dr. Sealey had said, the Secretariat made every attempt to anticipate the availability of extrabudgetary funds and signal the areas in which it would seek such funding, but it was impossible to know for sure how much would be received during a biennium. Programming of extrabudgetary funds was therefore impossible. While he was extremely sensitive to the national situations that had led to the policy of zero nominal growth in some countries, he hoped that the countries would be willing to show the same flexibility in applying that policy that they asked of the Organization in its budget policy. He maintained that not all organizations should be subject to a zero-nominal-growth policy. In the case of PAHO, its application had tended to reduce the Organization's efficiency and effectiveness.

***Pan-Americanism: What it Means for the Pan American Health Organization (Document SPP34/6)***

The Director introduced this item, noting that Pan-Americanism and equity were the two main principles that guided the Organization's technical cooperation. He began by tracing the historical development of the concept of Pan-Americanism and then cited several examples of Pan-Americanism in action.

Simón Bolívar had first begun to promote the idea of Pan-American unity in the early 1800s, though his efforts had met with limited success. Joseph Lockey's "Essays in Pan-Americanism," published in 1939, traced the development of the concept. The term "Pan-Americanism" had originated some 100 years earlier and had been a constant in political discourse since then, particularly in the context of the International Conferences of American States, which had given rise to the Organization of American States (OAS) and the entire inter-American system. Enthusiasm for the idea had been rekindled in recent years with the Summits of the Americas and the Ibero-American summits. Lockey had identified a set of principles which defined the meaning of Pan-Americanism. The principles included independence, representative government, territorial integrity, law rather than force, non-intervention, equality of all countries within the councils of the Americas, and cooperation.

Those principles continued to shape relations among the countries of the Americas, which were linked together through the organs of the inter-American system, including PAHO. Indeed, the establishment of PAHO could be regarded as an affirmation of the spirit of Pan-Americanism. Through concerted action, the countries of the Region had made tremendous gains in health, which had benefited all of them. Moreover, it had been demonstrated that joint action on health could lead to joint action on other, more thorny issues. A notable example was the initiative “Health: A Bridge for Peace” in Central America. It had been suggested that such subregional initiatives might be inimical to Pan-Americanism, but the Secretariat felt that, on the contrary, they complemented and enhanced regionalism. Pan-Americanism did not imply that all 38 Member States would be involved in every activity. The critical issue was that the countries should “buy into” the concept of sharing and providing mutual assistance and support.

The document examined three areas of the Organization’s work in which the spirit of Pan-Americanism was especially evident: disaster relief, communicable disease surveillance and control, and immunization and vaccine procurement. The Director described some of the activities under way in the first two areas and then invited Dr. Ciro de Quadros (Director, Division of Vaccines and Immunization, PAHO) to make a presentation on the PAHO Revolving Fund for Vaccine Procurement.

In the area of disaster relief, the countries had joined forces not only in responding to disasters, but in preventing, preparing for, and reducing vulnerability to disasters. PAHO had put in place a very effective system for coordinating and channeling the generous outpouring of resources and supplies that the countries of the Americas unflinchingly shared with each other in the aftermath of a disaster. A recent resolution of the Organization of American States had proposed the creation of a formal inter-American disaster response system, which would further strengthen cooperation among the countries in this area. PAHO would have a key role in coordinating the health aspects of the system.

In regard to communicable disease surveillance and control, the need for joint action was obvious, since infectious diseases did not respect national boundaries. Because success in controlling communicable diseases hinged on the availability of accurate information from the countries, the Secretariat had devoted considerable effort to strengthening surveillance systems and laboratory networks in the various subregions. The experience in the first two years of operation of the networks had validated that approach. The ultimate aim was to create a “network of networks” in order to achieve regionwide coverage. A striking example of the effectiveness of Pan-Americanism in this area was the joint initiative of the Southern Cone countries to control Chagas’ disease.

Several of the countries were now free of vectorial transmission of the disease, and transmission had been reduced to extremely low levels in the other countries of that subregion.

As for vaccine procurement, Dr. de Quadros pointed out that the Revolving Fund contributed to Pan-Americanism by providing a mechanism through which the countries could receive regular supplies of high-quality vaccines at affordable prices, thus strengthening national immunization programs and helping to control vaccine-preventable diseases throughout the Region. In many countries, the Fund had also facilitated the introduction of new vaccines into routine immunization programs. The Fund had been established in 1977, pursuant to a resolution of the Directing Council. It operated on an annual cycle. Countries established their yearly vaccine requirements and submitted them to PAHO, which consolidated them and then invited vaccine suppliers to bid on contracts. Once the suppliers and prices were established, PAHO placed quarterly orders for the countries. Hence, PAHO did not sell vaccines to the countries but rather established annual vaccine contracts on their behalf. The Fund's sustainability was therefore not dependent on profit. In addition to the clear economic benefits of the Fund, it had provided a means of delivering technical cooperation in relation to cold chains, calculation of vaccine needs, vaccination strategies, and other aspects of immunization programs.

The Director concluded the presentation on this item by noting that the most important way in which PAHO could strengthen Pan-Americanism was through the provision and analysis of information and the identification of issues that would lend themselves to joint action. Successful collaboration in one area would stimulate collaboration in other areas. The Subcommittee was invited to comment on future prospects for Pan-Americanism and on how the Pan-American approach might be promoted in the Region.

The Subcommittee voiced strong support for Pan-Americanism, which was seen as an expression of the concepts of solidarity and equity. It was pointed out that Pan-Americanism had formed the foundation for many of the great public health achievements in the hemisphere during the 20th century and would continue to underpin the countries' efforts to address ongoing shared problems, such as the HIV/AIDS pandemic. The recently created revolving fund for strategic public health supplies, modeled after the vaccine procurement fund, would enable more countries to afford the costly pharmaceuticals needed for the treatment of HIV infection and AIDS. The spirit of Pan-Americanism was also evident in several of the initiatives discussed by the Subcommittee, including child health and harmonization of regulations on drugs and medical devices. Health sector reform was identified as one of the areas in which Pan-American cooperation could prove most beneficial, since by sharing information and

experiences, countries could help one another to avoid the pitfalls and negative consequences of reform processes. It was pointed out that one of the ways in which PAHO could best further Pan-Americanism was through the maintenance of databases and directories of professionals and specialists in order to facilitate the exchange of information and expertise between countries. PAHO could also contribute to Pan-Americanism through translation and dissemination of health materials and publications produced in the countries.

Support was also expressed for subregional initiatives as a way of strengthening Pan-Americanism. Collaboration between neighboring countries on shared border health issues was seen as particularly valuable, and PAHO was encouraged to support such joint efforts. It was emphasized that, in order to achieve true Pan-Americanism, it was important to cultivate ties and promote cooperation not only between governments but between the peoples of the countries. At the same time, it was pointed out that there could not be joint action on every issue and that the Pan-American approach should be applied for specific purposes that would yield clear benefits for the countries involved. The need to find a balance between Pan-Americanism and the global health agenda was also highlighted. One delegate noted that the Region had a great deal to contribute to the global agenda and that the successes achieved through a Pan-American approach could serve as a model for the world.

The Subcommittee suggested several other ways in which PAHO could promote Pan-Americanism, including exchanges of visits and staff between ministries of health, promotion of internships and similar programs for young people at international agencies or in the countries, increased diversity and intensity of TCC projects, and greater use of common resources such as the WHO Collaborating Centers. In addition, PAHO was encouraged to continue its efforts to ensure that health occupied a prominent place on the agendas of regional political summits, especially the next Summit of the Americas in 2001. The Organization was also urged to take a leadership role in addressing health issues that were arising in the context of globalization and growing international trade.

At the Director's request, Dr. Daniel López Acuña (Director, Division of Health Systems and Service Development, PAHO) described how Pan-Americanism was guiding PAHO's efforts to support the countries in health sector reform through the health sector reform clearinghouse, which was a collaborative regional initiative between the Organization and the Government of the United States. The electronic clearinghouse (<http://www.americas.health-sector-reform.org>) included information on health reform activities under way in numerous countries, as well as a database with information on more than 300 people working in that area throughout the Region. A common methodology for monitoring and evaluating health sector reform had also been developed as part of the initiative.

Also at the Director's request, Dr. Mirta Roses (Assistant Director, PAHO) elaborated on the Organization's recent efforts to promote technical cooperation among countries. A specific fund to promote TCC had been established in 1998, and during 1999 a special effort had been made to support cooperation between countries. The amount devoted to the execution of TCC projects rose to \$1.7 million, and all Member States participated in the fund. For the 2000-2001 biennium, the amount allocated to the fund was \$3.6 million. Two additional modalities existed for promoting TCC: a fund managed by the Assistant Director's Office for the support of integration initiatives in Central America, the Andean Area, and the Southern Cone, and another fund for integration activities in the Caribbean, which was managed by the Caribbean Program Coordination. Projects between neighboring countries made up approximately one third of the TCC projects currently being supported by the Organization. Another third were projects involving countries within the same subregional integration grouping. However, PAHO was receiving a growing number of proposals for horizontal cooperation between countries in different subregions—projects for the development of common statistical methodologies or projects on the regulation of health professions between countries of the Caribbean and Central America, for example. The future for Pan-Americanism through TCC thus appeared very promising.

In reply to a question from one of the delegates regarding the greatest impediments to increased TCC, Dr. Roses said that lack of knowledge about this modality of cooperation was a significant obstacle. The Organization was endeavoring to address that obstacle through dissemination of information. Another impediment was the fact that proposals for TCC in the health sector were not always fully articulated with the countries' broader foreign policy and priorities for horizontal cooperation. PAHO was seeking to stimulate discussion within the countries between the health ministries and the foreign affairs ministries with a view to promoting harmonization of interests and objectives.

The Director underscored the need to actively promote the idea of TCC and Pan-Americanism and provide information that would enable the countries to identify opportunities for cooperation between themselves. However, it must also be recognized that, for various political, social, and practical reasons, the Pan-American approach was not suitable to all areas. Collaboration between countries should be undertaken only in areas where there was mutual interest.

With regard to the fund for strategic public health supplies which had been mentioned by several delegates, as he had reported to the Governing Bodies in 1999, a trial experience was under way with Brazil. Establishing such a fund was an extremely complex undertaking. If that experience with Brazil proved successful, the fund would eventually be expanded to encompass other countries. Several delegates had also

mentioned that PAHO might assist in translating materials produced at the country level, which the Organization was fully prepared to do. PAHO had a machine translation system which, while not the answer to all translation needs, could facilitate the process.

As for PAHO's role in the summit processes, the Organization would continue striving to ensure that specific health proposals were brought to the summits, and it would carry out any follow-up functions assigned to it. Finally, he stressed that Pan-Americanism was in no way inimical to a global approach to or the Region's participation in global efforts. As had rightly been pointed out, the Americas had a great deal to contribute to the global good.

### ***Child Health (Document SPP34/8)***

Ms. Carol Collado (Coordinator, Program on Family Health and Population, PAHO) presented a general description of the health situation of the Region's children and outlined some of the strategies and lines of action proposed by PAHO for achieving integral child health and development. In Latin America and the Caribbean, the child health situation was characterized by widening equity gaps, with increasing numbers of vulnerable children at risk for unhealthy development; urbanization and migration patterns that had left many children and families without traditional social support systems; changes in the State's role in health service delivery, with an expansion of the actors involved; health services that were reactive to demand (usually for curative services), with limited capacity for adequate response, referral, or the incorporation of health-promoting activities; and the emergence of new challenges, such as AIDS and certain environmental problems associated with modern life, alongside older, still unresolved issues, such as nutritional deficiencies, communicable diseases, and the risks associated with poverty and underdevelopment.

Although major challenges remained, significant progress had been achieved toward improving child health since the 1990 World Summit for Children, especially with regard to infectious disease control, immunization coverage, improvement in nutritional status, increases in prenatal coverage, and strengthening of health services. A number of valuable lessons had been learned from the experience of the past decade, notably that there were critical moments for promoting health behaviors, that early intervention yielded results through the life cycle and that investment in the health of young children was therefore amply justified, that approaches must be adapted to local realities, and that consistency and continuity were key to success.

Drawing on those lessons, PAHO proposed to move forward with a model for integral child development, with health as the centerpiece. Such a model would incorporate action to promote healthy biopsychosocial development through multiple

entry points and at various levels: individual, family, community, population, and health systems and services. The strategies and lines of action for operationalizing the concept of integral child health and development were detailed in the document. The preliminary estimate of the budget necessary to provide the personnel and activities needed for the development and first-stage implementation of the regional plan was \$1,000,000.

Dr. José Antonio Solís (Director, Division of Health Promotion and Protection, PAHO) explained that the proposal on child health, like the proposal on maternal health presented at the Subcommittee's preceding session, coincided with the end of a decade of work aimed at achieving the maternal and child health goals of the World Summit for Children. The issues surrounding maternal and child health would be further examined at the Fifth Ministerial Meeting on Children and Social Policy, which would take place in Jamaica in October 2000, and at the tenth Ibero-American Summit of Heads of State and Government, to be held in Panama in November 2000, the theme of which would be "childhood and adolescence." Topics relating to the health of adolescents would also be discussed at an upcoming meeting of the Region's First Ladies in Peru. All these events would culminate, in 2001, in a special session of the United Nations General Assembly for follow-up to the World Summit for Children, at which a proposal for revised goals for the next decade would be presented. It was therefore an opportune moment for the countries and the Organization to take stock of the progress achieved in the past decade and develop a vision and an agenda to guide work through the year 2010.

The Subcommittee supported the proposal to develop a regional plan of action on child health and endorsed the model for integral child health and development presented in the document. The holistic approach and the emphasis on prevention, behavioral change, and attention to preschool children, in particular, were applauded. It was pointed out that implementing the plan would require interprogrammatic collaboration within the Organization and intersectoral action in the countries. Joint effort with the education sector was considered particularly important. One delegate noted that in her country there were a great many government institutions and NGOs that dealt with some aspect of child health and development, but their efforts were not necessarily coordinated. She suggested that PAHO might play an important role in facilitating communication and coordination between the entities engaged in child health activities at the national level. The Subcommittee considered promotion of child health at the various international forums mentioned by Dr. Solís another key role for the Organization.

A number of suggestions were made for enhancing the document and the proposed strategies and lines of action. For example, it was suggested that the document should place greater emphasis on the human rights of children, since it was impossible for children to achieve optimum growth and development if their basic rights were not being respected. The issue of child labor also merited greater attention. The Organization was

encouraged to work with other inter-American agencies on these issues, in particular the Inter-American Children's Institute, which was also concerned with children's rights. It was suggested that the document should also give more attention to two population groups: pregnant women, in view of the long-term implications of maternal health for child health, and children aged 5-12, which was the period during which children made decisions and adopted habits that would shape the rest of their lives. It was pointed out that the health sector needed to target children in that age range with its messages of prevention and health promotion, just as advertisers targeted them with commercial messages. The role of the media should be taken into account in the development of any strategy for child health and development.

Several delegates noted that the document failed to mention the "Healthy Children" initiative launched by PAHO in December 1999 following the Directing Council's decision to pursue the goal of reducing under-5 child mortality by 100,000 by the year 2002 (Resolution CD41.R5). The same delegates also felt that the related strategy of Integrated Management of Childhood Illness (IMCI) should figure more prominently in the document and in the proposed plan of action, especially considering that the communicable diseases targeted by the strategy continued to be significant causes of infant and child mortality in many countries. Various delegates called attention to the need to address the increasingly serious public health problems of violence among children, child abuse, and street kids. Several delegates also requested clarification regarding the proposed budget, the source of funding, the potential for extrabudgetary funding, and the distinction between the budget for child health and that allocated for IMCI. In addition, the Delegate of Mexico offered to provide information to complement and update the information on the nutritional situation of children in her country in the document.

Given the intersectoral and interprogrammatic nature of the issue of child health, one delegate requested that Drs. Juan Antonio Casas (Director, Division of Health and Human Development, PAHO) and Mauricio Pardón (Director, Division of Health and Environment) share with the Subcommittee how child health figured into the work of their divisions. Dr. Casas observed that the document did a good job of incorporating a human development perspective. It was increasingly being recognized that focusing resources on early child development could have a significant impact on overall human development, poverty alleviation, and the reduction of inequity, which were the primary concerns of his division. Hence, there was a great deal of overlap between the area of child health and the activities of the Division of Health and Human Development.

Dr. Pardón said that the Division of Health and Environment was currently developing a project on the impact of pollution on child health. Pollution had serious implications for children's health owing to their smaller body size. The project would

address specific problems, such as the effects of leaded gasoline on children and the exposure of child workers to various contaminants, as well as broader issues related to basic sanitation, without which it was impossible to achieve child health goals. The project's lines of action were fully in line with the strategy proposed in Document SPP34/9.

Ms. Collado apologized for the omission of any reference to the Healthy Children initiative and the year 2002 goal. They had been mentioned in an earlier version of the document; however, it had undergone several revisions and had been worked on by staff in various programs, which probably accounted for that omission. The Secretariat would correct that omission and would also incorporate the Subcommittee's suggestions for improvement in the next version of the document.

Replying to the questions on the budget, she said that the proposed budget was intended to "jump-start" the process of working with the countries to move towards a paradigm that emphasized not only prevention and treatment but the promotion of overall health and development in the child. Owing to the divisional structure of the Organization's budget, support for child health activities currently came from various areas, including the funds allocated for IMCI, immunization, environmental health, and other programs. The budget proposed in the document for the first stage of the child health plan would be additional to existing funding and would be used specifically to support the countries in developing and implementing the regional plan. With regard to possible partners, the Organization had already approached several potential donors, and it appeared that the idea was definitely "sellable." PAHO was also exploring with the Director of the Inter-American Children's Institute how the two agencies could work together.

It had been decided that the plan should target children aged 0-10 because the Governing Bodies had recently approved various child and adolescent health initiatives that focused on that age range. Particular attention was being given to preschool children because children between the ages of 1 and 5 often had very little formal contact with health services. Certainly, there had been no conscious attempt to de-emphasize the health of schoolchildren, but it had been tacitly recognized that children in that age group tended to have at least some contact with health services through schools. However, the delegates had raised some valid concerns regarding the health and development of older children, and the Secretariat would try to ensure that they were reflected in the plan.

The Director said that the Organization's prime concern in relation to the rights of children was to ensure that each child had the right to the "social and sanitary measures" to enable him or her to enjoy health, as stated in the American Declaration of the Rights and Duties of Man. That meant closing the equity gap that translated into 10 times higher

infant mortality in poorer countries compared to richer countries. The Organization had recently analyzed data that indicated that the gap had changed very little over the previous 40 years. PAHO believed that it was every bit as important to take action to narrow the equity gap and ensure that all children had access to the social benefits as it was to reduce absolute mortality rates. The plan was aimed precisely at addressing inequalities in access to those benefits. The bedrock of any such program was the availability of good data in order to identify inequities and inequalities, and the Organization was therefore engaged in a concurrent effort to improve the registration of vital statistics in the countries of the Region.

The point raised by one delegate about the role of the media was an excellent one. There was growing realization that the health sector must take a more aggressive approach to mass communication and marketing. For that reason, the Organization had gradually been incorporating additional staff to work in that area.

***Prospects for Pan American Health Organization Collaboration with Nongovernmental Organizations (Document SPP34/4)***

Dr. Irene Klinger (Chief, Office of External Relations, PAHO) summarized the experience of PAHO and other international organizations in collaborating with NGOs to date and examined the prospects for future collaboration. NGOs were clearly a force to be reckoned with, as had been demonstrated by the protests mounted during the recent World Trade Organization conference in Seattle. A similar campaign (“Fifty Years is Enough”) had been organized by NGOs at the 1994 World Bank meetings,<sup>2</sup> as a result of which the World Bank now sought to actively engage NGOs in many of its activities. As a group, NGOs currently delivered more aid than the entire United Nations system, and they constituted the second largest source of development assistance. Fifteen percent of all ODA and 22% of ODA for health was channeled through NGOs. As of 1998, some 1,500 NGOs had been granted “consultative status” by the United Nations Economic and Social Council (ECOSOC). The Joint United Nations Program on AIDS (UNAIDS) was the first program of the United Nations to include NGO representatives as full participants on its governing board.

Until 1990, PAHO had worked mainly with NGOs engaged in technical assistance, training, and research activities. Since 1991, the Organization had entered into partnerships with a broader range of NGOs, notably in areas relating to health sector reform and in the planning and delivery of health services and programs, such as those for cholera control and polio eradication. Involving NGOs in technical support and health sector reform had been accomplished mainly through trilateral relationships between

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<sup>2</sup> As this report was being prepared, NGOs were mobilizing for a new campaign to protest certain policies and practices of the World Bank and the International Monetary Fund during their April 2000 meetings.

governments, NGOs, and PAHO. Technical discussions on the subject at PAHO in 1996 had yielded a set of general conclusions and recommendations for strengthening the process of NGO-government collaboration for health and development. Those recommendations had called for the Organization to play a more active role in building government-NGO-PAHO alliances, increased outreach to NGOs, NGO capacity-building, improved practices in NGO-government collaboration, documentation of experiences, and increased involvement of NGOs in the Organization's internal biennial planning cycle. Currently, PAHO had official relations with 13 NGOs, but it collaborated with a number of other organizations working in health and human development in Latin America and the Caribbean.

PAHO believed that future collaboration with NGOs should be directed toward achieving objectives that could better be achieved through joint action than separately. To that end, and in keeping with the recommendations of the 1996 technical discussions, the Organization would seek to increase outreach to NGOs involved in public health activities. Once potential NGO partners had been identified, they might be engaged more actively in PAHO's agenda by establishing a consultative council of NGOs that would meet in parallel to meetings of the Governing Bodies, or ministries of health might be encouraged to include NGOs as part of their national delegations to those meetings.

In light of the need to involve more components of civil society in multilateral policy development and decision-making, the Subcommittee was asked to consider what the nature of future relations between PAHO and NGOs should be. Should PAHO continue to emphasize trilateral arrangements or should it focus mainly on PAHO-NGO interaction? What role should NGOs play in meetings of the Governing Bodies, and should multilateral organizations such as PAHO devote resources specifically to cultivating relationships with NGOs?

The Subcommittee agreed that NGOs were making many valuable contributions to the advancement of health in the Region and affirmed that PAHO should continue to work with NGOs, both bilaterally and in trilateral relationships with governments. Several delegates described how NGOs in their countries had been involved not only in health program and service delivery but also in policy dialogue and formulation at the national level. It was reported that in one Member State, the Dominican Republic, NGOs even received a portion of the official health budget, which they managed independently. Nevertheless, several delegates pointed out that NGOs tended to be viewed with suspicion by some in official circles because at times they seemed to want to usurp the role of governments. Moreover, while some NGOs managed their finances and activities responsibly and transparently, others were less conscientious. It was suggested that one way in which PAHO could assist the countries in optimizing their relations with NGOs would be the development of a methodology for screening, accrediting, and evaluating

the performance of NGOs. The Organization might also organize forums to facilitate dialogue between representatives of governments and NGOs to promote greater mutual trust and understanding. Another role for PAHO might be to serve as a broker to bring together NGOs to work toward common objectives. It was also suggested that PAHO might need to revise the criteria by which it selected the organizations with which it worked, as the number of organizations in official relations with PAHO was very small.

With regard to the role that NGOs should play in the Governing Bodies of PAHO, some support was expressed for the idea of creating a separate NGO advisory body similar to those that existed within the Organization for Economic Cooperation and Development. However, some delegates felt that it would be preferable to invite specific NGOs to participate when topics on which they had special expertise were being discussed by the Governing Bodies. It was stressed that, regardless of the mechanism through which they participated, NGOs should have consultative status, and the fact that they had resources to offer should not be allowed to influence the Organization's decisions or priorities. As for the advisability of allocating resources specifically for activities with NGOs, some delegates felt that the idea warranted consideration, given NGOs' comparative advantage and ability to leverage resources in some areas. However, it was pointed out that, before any support was provided, it would be essential to screen NGOs carefully to ensure that their interests were aligned with those of the Organization and that the collaboration would truly benefit people in the Member States. The need to periodically review the performance of NGOs was also underscored.

Dr. Klinger noted that there had been several recurring themes in the Subcommittee's discussion, in particular the ideas of transparency and accountability and the need to be selective in working with NGOs. Clearly, an important role for PAHO would be to facilitate relations between governments and NGOs. While governments tended to want to establish standards and impose certain controls on the activities of NGOs, the latter saw their greater flexibility and lack of formality as one of their main advantages and tended to resist any attempts to limit their activities. PAHO could help to find the middle ground between too much control and too little in order to ensure transparency in the management of resources and enhance NGOs' contribution to health development processes. With regard to the relatively small number of NGOs in official relations with PAHO, the Organization had traditionally established official relations only with regional NGOs that met certain legal and technical criteria and that had established a joint plan of action with PAHO's technical programs. Undoubtedly that number would grow if the Organization engaged in greater outreach and proactively sought to work with more NGOs.

The publication *Achieving Effective Collaboration between Governments and NGOs for Health and Health Sector Reform: PAHO's Experiences and Future Strategies*

provided more detailed information on PAHO's approaches to working with NGOs at the country level and its criteria for selecting the NGOs with which it would work. Those criteria included: institutional sustainability and transparency, technical excellence, territorial presence, appropriate thematic experiences, and willingness to work with government ministries. The publication, which was distributed to the Subcommittee, also provided examples of best practices in PAHO-NGO-government collaboration in the area of health sector reform.

The Director said that the Organization was well aware of the need to be selective and work only with NGOs that were legitimately trying to assist, not undermine, the activities of its Member Governments. With regard to the organizations in official relations with PAHO, they were inter-American NGOs; however, in reality, most of the Organization's activities with NGOs involved groups that worked at the national level. The regulations currently in place called for the Executive Committee to review the Organization's relations with NGOs every six years, but those reviews might be conducted more frequently—perhaps every three years as was the practice in WHO.

The issue of how to involve NGOs in the governance of international organizations was a difficult one. None of the multilateral agencies had yet found the perfect solution. The matter was problematic both for the organizations and the NGOs themselves. From the standpoint of the multilateral organizations, the problem was how to choose which NGOs would participate and how to ensure the legitimacy of those chosen. As the experience of UNAIDS had demonstrated, regardless of which NGOs were chosen, there would inevitably be dissatisfaction among other NGOs that felt that their views were not being represented. PAHO would continue to watch other organizations to see how they grappled with the issue, with a view to identifying a solution that would be in the best interests of the Member States and the Organization as a whole.

The representatives of the Emergency Care Research Institute (ECRI) and the U.S. Pharmacopoeia, two of the NGOs invited to take part in the Subcommittee session, affirmed that their relationship with PAHO had been very productive. The Organization had facilitated their access to and interaction with government officials in the countries. Both representatives felt that their organizations would not have achieved the same degree of progress without the involvement and support of PAHO. They also agreed that NGOs must be transparent and responsible in their financial dealings in order to maintain their legitimacy and gain the trust of governments.

*Medical Devices (Document SPP34/7)*

Dr. Beth Pieteron (Medical Devices Bureau, Health Canada) summarized the document prepared by the Government of Canada on the subject of medical device regulation and harmonization of regulatory requirements. She began with a description of where medical device regulation fit within the “big picture” of health technology management. She then briefly reviewed PAHO’s initiatives to date in the area of medical devices and outlined the recommendations proposed in the document.

The purpose of medical device regulation was to ensure that medical devices sold in a country were safe, effective, and of high quality. Regulations helped accomplish that by setting standards for the manufacture and performance of products and by establishing the government’s legal authority to prevent the sale of products that did not meet the standards and take action against manufacturers that sold substandard products. Medical device regulation was an integral part of the overall process of medical equipment planning, procurement, and management.

Countries had increasingly been requesting PAHO technical cooperation in the area of medical device regulation. In 1995, Canada had presented to PAHO an overview of the Canadian approach to regulation, and in 1996, PAHO had begun fostering harmonization of regulatory requirements in various Member States through the provision of technical information, advice, and expertise. The Organization had also sponsored presentations of the Canadian model in several national and international seminars. In fall 1999, PAHO held a consultative meeting on medical devices, which recommended, inter alia, that the ministries of health assign priority to the regulation of medical devices as part of their leadership role in health sector reform and that WHO and PAHO should step up their technical cooperation in this area and promote technical cooperation between countries, including the development of specific projects. The consultation had also recommended that the Latin American and Caribbean countries should be represented at meetings of the Global Harmonization Task Force (GHTF), a voluntary international consortium that promoted harmonization of medical device regulations in developed and developing countries throughout the world. The document outlined a proposed plan of action based on those recommendations, to be coordinated by PAHO with the support of WHO. It also contained guidelines developed jointly by PAHO and the Government of Canada for the establishment of regulatory programs in developing countries.

The recommendations of the 1999 consultation also formed the basis for the recommendations to the Subcommittee set out in the document. The three main recommendations could be summarized as follows:

- PAHO should encourage harmonization of medical device regulation among Member States.
- For that purpose, PAHO should make maximum use of the resources currently available, especially existing international standards and the documentation produced by the GHTF.
- A more formalized structure should be established within PAHO to foster the development of medical device regulations in Member States. Among other things, PAHO should establish a steering committee on medical devices, composed of representatives from regulatory authorities of Member States, representatives from WHO Collaborating Centers, industry associations, and other important actors identified by the Committee. The Committee's role would be to enable progress between workshops by coordinating, promoting, facilitating, and monitoring harmonization processes in the Americas. In addition, the Organization should host workshops every two years to promote the development of harmonized regulations.

Mr. Antonio Hernández (Regional Advisor, Health Services Engineering and Maintenance, PAHO) presented additional information on PAHO's role with respect to medical device regulation, which was a priority area related to the Organization's activities in health sector reform and strengthening of the leadership role and regulatory function of ministries of health. Regulation was essential, given the increased number of high-technology devices available, the globalization of markets for medical devices, growth in the market for used and refurbished equipment and in donations of medical equipment, a trend toward re-use of single-use devices, increased use of medical devices in the home, a more informed population, weak after-sale service support, and the need for tracking of adverse events and recalls of medical devices.

The objective of the Organization's technical cooperation in this area was to collaborate with the countries in the development and strengthening of medical device regulation in order to guarantee the safety, quality, and efficacy of the devices used. To that end, it planned to undertake the following activities, which were in keeping with the recommendations emanating from the 1999 consultative meeting:

- Preparation of a regional profile and country status report on medical devices regulation;
- Organization of five subregional workshops on medical devices;

- Promotion of participation by Latin American and Caribbean countries in GHTF meetings;
- Identification of areas for PAHO/WHO technical cooperation in coordination with the Collaborating Centers and the regulatory authorities in the countries;
- Promotion of the use of communication technologies to encourage information-sharing between countries and agencies, for example the “Med-Devices” electronic discussion group coordinated by PAHO;
- Facilitation of access to technical information, such as the two documents cited in Document SPP34/7;
- Provision of technical expertise to countries for the organization and strengthening of medical device regulation.

The estimated budget for the aforementioned activities during the period 2001-2002 would be \$300,000.

Mr. Jonathan Gaev (Representative of the Emergency Care Research Institute) said that as an NGO involved in the area of health care technology, his organization was grateful for the opportunity to contribute to the Organization’s work on regulation of medical devices. The Emergency Care Research Institute (ECRI) was a non-profit health service agency and a PAHO/WHO Collaborating Center. ECRI was in a position to support PAHO’s efforts through its information products and services, including its medical device nomenclature, problem-reporting system, databases on medical device programs, international directory of manufacturers, and directory of over 40,000 standards related to health care technology.

The Subcommittee expressed strong support for PAHO’s activities with regard to medical device regulation and endorsed the recommendations contained in the document, although some doubt was expressed as to the advisability of establishing a formal steering committee, in light of resource limitations. It was suggested that it might be preferable to create an ad hoc group to identify mechanisms within existing structures for achieving mutual objectives in the regulation of medical equipment and the harmonization of regulations.

The importance of being responsive to the differing needs of Member States was underscored. In this connection, it was pointed out that many countries had a critical need for training of human resources in the evaluation, regulation, and use of medical devices and equipment. Various delegates emphasized that personnel training should be an

integral component of PAHO's technical cooperation in this area. It was suggested that such training might be incorporated into the periodic workshops proposed in the document. It was also suggested that the Organization's cooperation should be delivered in stages corresponding to the status of regulatory development in the countries. In the early stages that cooperation might be directed toward providing guidance to countries in the acquisition of equipment, while in later stages the focus would be implementation of the equipment and training of personnel.

More specific information was requested on the proposed plan of action and the funding for its implementation. One delegate inquired whether the medical devices industry might be a potential source of funding. Several questions were asked regarding the workings of the "Med-Devices" discussion group and the activities of WHO and the WHO Collaborating Centers in relation to medical device regulation. The Delegate of Cuba provided information to supplement the information in the document on the status of regulatory systems in Latin American and Caribbean countries.<sup>3</sup>

Dr. Pieterse agreed on the need for incremental development of regulatory systems. Such systems certainly lent themselves to implementation in stages, and she recommended such an approach. Assessment of the needs and the technological expertise existing in a country was an essential first step in the development of any regulatory system in order to tailor the process to the country's requirements.

Mr. Hernández pointed out that the countries of Latin America and the Caribbean fell into two distinct groups: one group had fairly well-developed regulatory systems, while in the other group those systems were incipient. The Organization was working with the first group to strengthen and enhance their regulatory capacity. Those countries were also in a position to share their experience in order to assist other countries in organizing regulatory programs. With the second group of countries, which constituted the majority, PAHO was orienting its efforts toward developing regulatory systems and supporting the countries in technology management, which included planning, negotiation, acquisition, installation, use, maintenance, and renovation of medical devices and equipment, as well as evaluation of health technologies.

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<sup>3</sup> The Cuban Delegation requested that the paragraph on Cuba in Section 7 of the document be modified to read as follows: "In 1991, in keeping with its public health strategies, the Cuban Government identified the establishment of a medical devices registry within its Medical Equipment Regulatory Program as an indispensable requirement. In 1992, regulations for the evaluation and registration of medical equipment were implemented under Public Health Law 41, which also created a national regulatory authority within the Ministry of Public Health—the Center for Regulation of Medical Devices. Cuba's program includes risk classification; manufacturer registration; pre-marketing evaluation, with safety requirements; and demonstration of efficacy through pre-clinical, technical, and clinical trials, depending on the risks associated with the medical equipment."

With regard to the Collaborating Centers, in addition to ECRI, the Organization was working with the Medical Devices Bureau of Canada and the Food and Drug Administration of the United States. It had also formed strategic alliances with the regulatory agencies of countries such as Argentina, Brazil, and Cuba, which were not formally recognized as Collaborating Centers but had provided considerable support for PAHO's activities. As for the "Med-Devices" electronic discussion group, it was one of several such groups that PAHO had established to facilitate the exchange of information, experiences, queries, and documentation on specific topics. The group was open to regulatory authorities from all the Member States, but it was intended to benefit small countries, in particular, as they did not have the means to put in place an extensive system to manage all aspects of regulation. By working in a network, they could utilize the capacity, experience, and information available from countries that already had well-developed systems.

Mr. Gaev pointed out that, while it was important to adapt information to local needs, it was equally important to utilize the large body of information that already existed. ECRI would be pleased to collaborate in the information-sharing process.

Replying to the questions regarding sources of funding for the proposed plan of action, the Director said that PAHO would certainly seek extrabudgetary funding. A great deal of support for the plan's implementation would probably take the form of in-kind contributions. As for internal funding, it would be necessary to reexamine the budget carefully, since any moneys the Organization allocated for this area would have to be taken from another area. Regarding the possibility of approaching the medical devices industry for funding, PAHO generally did not solicit funds from industry. He would be particularly hesitant to do so in this case because some of the recommendations that the Organization would make to the countries might well run counter to industry recommendations.

### ***Harmonization of Drug Regulations (Document SPP34/8)***

Dr. Justina Molzon (Food and Drug Administration, United States of America) presented the document prepared by the Government of the United States on this item. She began with a brief overview of the issues involved and the current situation of drug regulatory harmonization and then described PAHO's activities in this area. She concluded her presentation with some recommendations for proposed action.

International harmonization of the technical requirements for development and registration of pharmaceuticals (drugs and biologicals) would reduce unnecessary and duplicative requirements, which would expedite the availability of pharmaceutical products and reduce the cost of their development, while also ensuring that

pharmaceutical products sold in the Region met standards of safety, efficacy, and quality. Harmonization was thus in the interest of consumers and public health. Harmonization efforts were under way globally and in various regions of the world. At the global level, WHO had formed various Expert Technical Committees to carry out its constitutional mandate to develop, establish, and promote international standards for pharmaceuticals. In addition, every two years since 1980 the Organization had convened the International Conference of Drug Regulatory Authorities (ICDRA) to promote harmonization, exchange of information, and the development of collaborative approaches to problems of concern to drug regulatory authorities worldwide. The International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), a project launched in 1990, brought together the regulatory authorities of Europe, Japan, and the United States to seek ways of improving, through harmonization, the efficiency of the process of developing and registering medicinal products in the three regions.

At the regional level, the European Union had developed a structure and system for harmonizing the laws and regulations of its members countries. The European Agency for the Evaluation of Medicinal Products (EMA) was established to oversee, coordinate, and facilitate European harmonization of pharmaceutical requirements. In the Region of the Americas, harmonization efforts were taking place mainly in the framework of the various subregional integration groupings. The document outlined the progress that had been made in each subregion. To support drug regulatory harmonization in the Americas, PAHO had convened two conferences between 1997 and 1999. The first conference had recommended that a hemispheric forum be established, with PAHO as its Secretariat, to facilitate communication on drug regulation among the different subregional blocs. It had also recommended the creation of a Steering Committee on which each subregional group would be represented. The most recent conference, held in November 1999, had acted on those recommendations, creating the Pan American Network for Drug Regulatory Harmonization, which was to hold a conference every two years, and forming the Steering Committee to enable continued progress toward regional harmonization in the interim between conferences. The first meeting of the Network was scheduled for the first week of April 2000.

The budget for the activities of the Network and Steering Committee in the first two years was estimated at \$300,000. Financing would be sought from governments, trade and professional associations, NGOs, and other sources, as well as PAHO. Given the Organization's resource constraints, it was recommended that any financial support from PAHO be supplied through extrabudgetary sources.

The following actions were recommended to advance the process of drug regulatory harmonization in the Region:

- PAHO and the countries should make every effort to endorse and assure the success of the Network.
- The countries of the Region should officially endorse the Steering Committee.
- PAHO should provide administrative support.
- PAHO should work with the countries of the Region to strengthen the capacity of regulatory authorities involved in the harmonization process.
- Regional harmonization goals and timetables for achieving them should be established.

Ms. Rosario D'Alessio (Regional Advisor, Pharmaceutical Services, PAHO) presented additional information on the harmonization processes under way in the Americas and PAHO's work in this area. To a greater or lesser extent, each subregional grouping was dealing with the issue of harmonization. Generally speaking, the harmonization discussions taking place within each subregion were aimed at the eventual adoption of common requirements, standards, and procedures for drug registration. The most structured efforts were taking place within the Southern Common Market (Mercosur)—comprising Argentina, Brazil, Uruguay, and Paraguay—which had a special subgroup on drug regulatory harmonization. In the Andean Group, Bolivia, Colombia, Ecuador, Peru, and Venezuela had been discussing issues such as the establishment of a common drug registry and drug policy for a number of years. A drug advisory commission created in the framework of the Hipólito Unanue Agreement—which included the five Andean countries plus Chile—had made considerable progress toward harmonization. Bilateral accords between countries had also been established.

The Central American Integration System (SICA), composed of Costa Rica, El Salvador, Guatemala, Honduras, and Nicaragua, did not have any internal structure for the discussion of harmonization issues; however, several projects related to drug regulation and strengthening of regulatory authorities had been carried out under the initiative "Health: A Bridge for Peace." Panama and the Dominican Republic had also participated in some harmonization activities with the SICA countries. North America and the Caribbean were the subregions in which the least headway had been made with regard to drug regulatory harmonization. Among the parties to the North American Free Trade Agreement (NAFTA)—Canada, Mexico, and the United States—there had been an exchange of information on drug registration but no formal steps had been taken toward harmonization. The Secretariat of the Caribbean Community (CARICOM) had initiated activities related to harmonization in 1999 with support from PAHO.

PAHO's mandate in the area of drug harmonization was provided by the WHO Constitution. The Organization's efforts were directed toward supporting harmonization in the priority areas identified by the second Pan American Conference on Drug Regulatory Harmonization, namely: bioequivalence and bioavailability standards, classification of products, counterfeit drugs, good clinical practice, good manufacturing practice, good pharmacy practice, harmonization of pharmacopoeias, and development of a study to determine the feasibility of creating a regional entity for drug registration.

Mr. Miguel Angel Maito (Representative of the Asociación Latinoamericana de Industrias Farmacéuticas – ALIFAR) expressed his organization's unequivocal support for the drug regulatory harmonization process in the Region. ALIFAR looked forward to collaborating in that process and participating in the upcoming meeting of the Pan American Network for Drug Regulatory Harmonization. The Association was also grateful for the opportunity to participate in the Subcommittee session.

Mr. José Manuel Cousiño (Representative of the Federación Latinoamericana de la Industria Farmacéutica – FIFARMA) underscored the benefits of drug regulatory harmonization for the people of the Region. Harmonization would lead to increased access to safe, effective, high-quality drugs. In FIFARMA's view, good manufacturing practices (GMP) and studies of bioequivalence were essential aspects of drug registration and quality assurance, and they were therefore essential aspects of drug regulatory harmonization. The position of WHO had always been that drug manufacturers should guarantee the quality, safety, and efficacy of their products, and both the medical profession and people in the countries demanded high-quality drugs. Nevertheless, in Latin America there continued to be tremendous variability in compliance with good manufacturing practices and the performance of bioequivalence studies, with little standardization or harmonization of regulations. The Organization's efforts at harmonization therefore had FIFARMA's full support. The Federation had been involved from the outset in the conferences on drug regulatory harmonization and would continue to provide financial and technical support for the Pan American Network until the objective of harmonization had been realized.

Mr. Jerome Halperin (Representative of the U.S. Pharmacopoeia – USP) agreed that the aim of harmonization was to ensure the availability of drugs of high quality, safety, and efficacy throughout the hemisphere. His organization was mainly concerned with the quality of drugs. For almost 100 years, the USP had been promoting the harmonization of quality in the hemisphere through various activities. With the collaboration of Professor José Guillermo Díaz, of the University of Havana, Cuba, it had published the first Spanish translation of the U.S. Pharmacopoeia in 1908. The U.S. Pharmacopoeia and National Formulary continued to be published in Spanish and were widely used in Latin America, as was a Spanish translation of the U.S. Pharmacopoeia

Dispensing Information, a compendium of pharmaceutical information. The latter had also been translated into Portuguese. The USP had enhanced its presence in the Region through its sponsorship, with PAHO, of scientific meetings and forums on drug quality and information in Central and South America. It had also established a dialogue with the other pharmacopoeias in the Region aimed at establishing a basis for harmonization. To further that process, Dr. Enrique Fefer, former Coordinator of the PAHO Program on Essential Drugs and Technology, would be joining the USP as Director of its International Affairs Office in August 2000.

Mr. Halperin concluded his intervention by noting that on 16 April 2000 he would retire from his post as Chief Executive of the USP. His successor would be Dr. Roger Williams, who brought considerable experience in the area of drug regulatory harmonization, including having served as Chair of the International Conference on Harmonization.

Dr. Williams said that the USP was strongly committed to the success of the Pan American Network and congratulated the countries of the Region and PAHO for embarking on the harmonization initiative, which was creating a model for the world. He also commended the Organization for including other stakeholders from the drug industry, whose participation would be critical to the initiative's success. The USP would continue to support the harmonization effort in all areas related to drug quality.

The Subcommittee expressed support for the creation of the Pan American Network and endorsed the recommendations contained in the document. It was pointed out that, though PAHO could provide technical and administrative assistance, it could not take sole responsibility for maintaining the Network and moving the harmonization initiative forward. The countries must be committed and actively involved in the process. It was also pointed out that harmonization might be viewed negatively by some because of its association with globalization. The Network would have to be sensitive and responsive to the needs of individual countries and subregions to ensure that no one felt disadvantaged or excluded from the harmonization process. Ms. D'Alessio was asked to elaborate on the impediments that had hindered progress toward harmonization in some subregions. In regard to the proposed budget for the initiative, it was suggested that funding could be obtained from the pharmaceuticals industry without compromising the Organization's neutrality. However, another delegate cautioned that great care would have to be taken to see that no conditions were placed on any funding received from the industry.

Ms. D'Alessio thanked the representatives of ALIFAR, FIFARMA, and the USP for their valuable contributions to the discussion and to the harmonization effort. Responding to the question regarding impediments, she noted that reaching agreement on

issues such as bioavailability/bioequivalence was not easy. Moreover, even when agreements were reached among technical experts, often there was little political support for their implementation. Frequent changes of political authorities created yet another obstacle, since agreements reached by one set of authorities might not be recognized by their successors. As a result, sometimes it was necessary to repeat the whole negotiating process. Presentation of the issues to the Governing Bodies would help to sensitize political authorities to the importance of harmonization and gain their support. As for the possibility of financing from the pharmaceutical industry, she assured the Subcommittee that any funds received from the industry or from trade associations would come with no strings attached. She also pointed out that, in the end, all stakeholders, including the industry, would benefit from harmonization.

Speaking at the Director's request, Dr. López Acuña noted that the efforts at harmonization of regulatory practices for both drugs and medical devices were clearly an expression of Pan-Americanism that required the active engagement of the countries, in addition to PAHO's efforts. The resources needed for the drug regulatory harmonization initiative would far exceed any amount that the Organization could allocate or mobilize from extrabudgetary sources in the short term. Hence, it would be crucial to have the support of countries through in-kind contributions, participation in the Network, and resource mobilization. The creation of the Network and the Steering Committee was an example of a modality of technical cooperation that allowed for multiple stakeholders from both the private and public sectors to work together to devise realistic approaches for achieving common public health goals.

The Director said PAHO was endeavoring to provide a forum in which stakeholders could come together, exchange views, and reach positions that would be acceptable to all concerned. However, harmonization did not necessarily mean that every aspect of drug regulation had to be the same in all countries. He was pleased with the progress achieved thus far, which demonstrated that where there was commonality of interests, it was relatively easy for the public sector, the private sector, and civil society to work together. He was also gratified by the keen interest the countries had shown in the Network and the overall harmonization process. Hopefully the Network would help to stimulate the political support necessary to keep the process moving forward.

With regard to the issue of bioequivalence, one of the findings that had emerged from the Organization's work in this area was that many different mechanisms for ensuring bioequivalence existed. Some countries had the capacity to carry out studies internally, while others had to rely on external agencies or universities. In the spirit of technical cooperation among countries, the Organization proposed to facilitate exchanges so that countries that lacked capacity could learn from those that had expertise in bioequivalence testing.

***Information Technology in the Pan American Health Organization (Document SPP34/5)***

Ms. Diane Arnold (Chief, Department of Management and Information Support, PAHO) said that this item had been included on the Subcommittee's agenda in order to make the Subcommittee aware of certain issues relating to the Organization's ability to effectively fulfill its information functions, in particular the factors influencing information technology, the level of investment required to maintain PAHO's information technology infrastructure and possible sources of funding for that purpose, and key initiatives for 2000-2001.

PAHO, like all other organizations in the world today, was heavily dependent on information technology (IT). The Organization's IT infrastructure at Headquarters and in the field offices comprised a mainframe computer, around 2,500 desktop computers, and numerous laptops, printers, and other equipment, as well as some 100 software products. As of February 2000, the total replacement value of that infrastructure was estimated at \$25 million. Protecting the Organization's investment required policies and procedures to ensure the physical security of the equipment and safeguard the data, standards for software and hardware purchases, maintenance and periodic updating of equipment and software applications, and prudent planning for investment to meet future needs in the face of rapid change in the IT industry.

Planning was influenced by numerous factors, including past and projected increases in the numbers of users, the demand for services, and the availability of resources for IT—both monetary and human. In the swiftly changing IT environment, it was imperative to plan for periodic hardware and software upgrades. PAHO's policy was to retain a certain level of obsolescence and replace costly equipment and software only as needed. However, the Secretariat's ability to plan was hindered by the need to fit technological decisions into the biennial budget cycles, which meant that decisions as to when to upgrade or replace hardware and software often were governed by the availability of funding and not necessarily by technological feasibility or opportuneness. As a result, PAHO sometimes incurred higher costs because products were not purchased when it was most appropriate to do so from a technological and organizational standpoint. In addition, there were periodic large "peaks" in spending on IT infrastructure.

In order to make the most cost-effective use of PAHO's limited resources and avoid "peaks and valleys" in spending, alternative methods of funding, not tied to the biennial budgeting cycle, were needed. To that end, the Secretariat proposed to use the Capital Equipment Fund, established by the Executive Committee in 1993, to cover the cost of replacing or updating electronic and computer equipment and for major software purchases. Meeting the challenges of the future would also require sound strategic

planning and clearly defined organizational priorities for IT in order to ensure coordination of IT initiatives, avoid duplication of effort, and make the wisest use of resources.

The document described the major IT initiatives planned for the 2000-2001 biennium. They included replacement of the mortality and population database, as the present system, which was 15 years old, did not support the Tenth Revision of the International Classification of Diseases (ICD-10); completion of a project to update the software used in the Organization's planning, programming, and evaluation system (AMPES) and the Office Management Information System (OMIS) used in the field offices; implementation of a "data warehouse," which would merge data from many software applications into a single database to facilitate management and decision-making; and cost-benefit analysis to determine when to replace various corporate information systems, several of which were well over 10 years old. In addition, the Secretariat was studying the options available to protect the Organization's data from viruses and unauthorized access or corruption by hackers.

The Subcommittee underscored the importance of effective information management, both for the Organization itself and for the Member States, which relied on the information produced by PAHO. The Members also welcomed the move toward more user-friendly software packages, which would facilitate the countries' communication with the Organization, and they applauded the Secretariat's decision to develop a strategic plan, which would help save money and regulate spending, thus smoothing out the "peaks and valleys." Investment in IT, though expensive, was considered wise because, in the long-term, it improved efficiency and reduced costs.

Several specific questions were raised in relation to PAHO's future plans in the area of information technology. With regard to the replacement of the mortality database to accommodate the use of the ICD-10, it was pointed out that many of the countries were still using systems that did not support the ICD-10 and that it was important to plan for the introduction of new software applications not only at PAHO Headquarters and in the field offices, but also in the countries in order to ensure compatibility of systems and data. One delegate asked about the possibility of PAHO's donating used equipment or providing support to countries to enable them to strengthen their IT capabilities. Noting that there had been some problems with compatibility between the Organization's e-mail system and the systems used in some countries, another delegate inquired about future plans for e-mail communications. Several delegates asked for clarification regarding the use of the Capital Expenditure Fund and the cost and source of funding for the IT initiatives described in the document; it was pointed out that the cost of the proposed initiatives—combined with other, routine expenditures, such as software licensing fees—would probably far exceed the \$5.6 million cap on the Fund. One delegate asked whether

WHO had any special fund or cost-sharing mechanism to assist the Regions in covering IT expenses, given that WHO relied on data provided by them to fulfill its statistical reporting functions. The same delegate observed that PAHO appeared to be utilizing an unusually large number of software products and asked whether there was any mechanism in place to standardize the use of software across the Organization.

Replying to the question regarding e-mail systems, Ms. Arnold said that it was difficult to ensure 100% compatibility between programs. PAHO had chosen to use Microsoft products because they were widely available around the world and were used by the largest number of individuals and organizations; however, the Organization would continue to monitor competing products that were emerging on the market and examine compatibility issues with a view to minimizing problems. As for the feasibility of donating equipment, it was Organization's practice to make equipment available to ministries of health and other partners whenever it upgraded. In regard to the large number of software products in use on PAHO's computers, it was important to note that they included not just the word- and data-processing applications typically used by staff, but also all the underlying operating systems and connection and communication programs that enabled each personal computer to function as part of a network. PAHO did have an oversight committee that reviewed not only standardization policies for the Organization as a whole (including the field offices), but also issues relating to the advisability, timing, and funding of large IT initiatives. With respect to the questions on financing and the Capital Equipment Fund, around \$400,000 of the Fund had been used thus far. Although the strategic plan had not yet been fully developed, it was estimated that the annual cost for carrying out the initiatives described in the document, as well as anticipated future initiatives, would be approximately \$5 million.

Mr. Eric Boswell (Chief of Administration) added that, while the Fund had been established in 1993 with a ceiling of \$5.6 million, it had never been funded at anywhere near that level. Currently, there were around \$2 million in the Fund, which had been used only for relatively small projects. If, budget permitting, the Fund could be fully capitalized, the Secretariat's intention was to use it to provide a steady source of financing for IT initiatives in order to avoid the peaks and valleys to which Ms. Arnold had alluded. As for the possibility of funding from WHO, there was no provision for financial assistance to the Regions for information technology.

The Director reiterated that this item had been presented primarily in order to make the Subcommittee aware of the amount of money the Organization had had to invest and the challenges it faced in maintaining the technology needed for the production and dissemination of information, which was a constitutional responsibility. While it was true that technology enabled an organization to work more efficiently, PAHO had not found that it necessarily reduced costs because the technology itself was so expensive and

because its use had not led to dramatic reductions in staff, although staff functions had changed somewhat with the introduction of the technology. The Organization was indeed willing to donate equipment, although it would never wish to donate equipment that, while still functional, was so old that it had outlived its usefulness. As for the Capital Equipment Fund, it was essential to find an alternative source of financing for IT expenditures, and the Fund was considered the best option. For the moment, the Secretariat did not believe it necessary to seek an increase in the Fund's ceiling, but it might do so in the next biennium.

### **Other Matters**

The Delegate of the United States of America said that his delegation had found the experience of working with the Secretariat to write a paper for presentation to the Subcommittee a very enlightening experience. It now had a greater appreciation of the complexities of preparing the documents for meetings of the Governing Bodies. Initially, the personnel responsible for drafting the paper had been confused about whether the aim was to present the position of the United States or to serve as expert facilitators in the process of preparing a document that presented a more global view; ultimately, they had opted for the latter approach. In future, if the practice of asking Member Governments to prepare documents was to be continued, his delegation would recommend that the respective roles of the governments and the Secretariat should be clarified. In addition, the process should begin earlier in order to allow sufficient time for all the work involved; ideally, the Executive Committee, when it met immediately following the Directing Council each year, would decide whether there were any topics on which it wished to request a Member's collaboration in preparing a document.

The Delegate of Canada said that his delegation had also found the process a challenge and endorsed the recommendations of the United States. Recalling that it had been suggested at the previous session that the Subcommittee should meet only once a year, he inquired whether the practice of holding two sessions per year was to be discontinued. His delegation also wished to thank the Secretariat for providing information on the budget implications of the various proposed initiatives and for the increased attention given in the documents to the special needs of marginalized populations, especially women and aboriginal groups.

The Director thanked the Delegations of Canada and the United States for their efforts in preparing the documents on harmonization of regulations on medical devices and drugs. Their understanding of the approach to be taken was indeed correct: the exercise was intended to be a joint effort, in which Member States worked with PAHO staff, sharing their expertise in a particular area. He felt that the end products had been superb and hoped that the experience could be repeated with other Members at future

Subcommittee sessions. He also believed that the presence and active participation of several NGOs had enhanced the session.

With regard to the number of SPP sessions to be held each year, the final decision as to any changes in the functions of the Subcommittee and/or the frequency of its sessions would have to be made by the Executive Committee in June 2000. In any case, a session would have to be held in spring 2001 to discuss the proposed budget for the 2002-2003 biennium before the proposal went to the Executive Committee in June 2001. If he felt that there was need to also hold a session of the Subcommittee in late 2000, he would so recommend to the Executive Committee.

Finally, he announced that WHO Director-General Dr. Gro Harlem Brundtland and all the WHO Regional Directors would gather at PAHO Headquarters on 11-13 April 2000 for a meeting of the Global Cabinet.

### **Closing of the Session**

The Director expressed his gratitude to the President for the skillful and efficient manner in which he had conducted the session and thanked the participants for their insightful comments.

The President felt that the session had afforded a valuable opportunity for the delegates to exchange views under the banner of Pan-Americanism. He thanked the participants for their contributions to that exchange and then declared the 34th Session closed.

## **AGENDA**

1. Opening of the Session
2. Adoption of the Agenda and Program of Meetings
3. Program Budget Policy of the Pan American Health Organization
4. Nongovernmental Organizations
5. Information Technology in the Pan American Health Organization
6. Pan-Americanism: What it Means for the Pan American Health Organization
7. Medical Devices
8. Harmonization of Drug Regulations
9. Child Health
10. Other Matters

## LIST OF DOCUMENTS

<i>Document No.</i>	<i>Title</i>
SPP34/1, Rev. 1	Agenda
SPP34/WP/1	Program of Meetings
SPP34/2, Rev. 2	List of Participants
SPP34/3	Program Budget Policy of the Pan American Health Organization
SPP34/4	Nongovernmental Organizations
SPP34/5	Information Technology in the Pan American Health Organization
SPP34/6	Pan-Americanism: What it Means for the Pan American Health Organization
SPP34/7	Medical Devices
SPP34/8	Harmonization of Drug Regulations
SPP34/9	Child Health

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**Pan American Sanitary Bureau (cont.)**  
**Oficina Sanitaria Panamericana (cont.)**

*Advisers to the Director (cont.)*

*Asesores del Director (cont.)*

Dr. Mauricio Pardón  
Director, Division of Health and Environment  
Director, División de Salud y Ambiente

Dr. José Antonio Solís  
Director, Division of Health Promotion and Protection  
Director, División de Promoción y Protección de la Salud

Dr. Irene Klinger  
Chief, Office of External Relations  
Jefa, Oficina de Relaciones Externas

Dr. Diana La Vertu  
Chief, Department of Personnel  
Jefa, Departamento de Personal

Dr. Karen Sealey (*Technical Secretary/Secretaria Técnica*)  
Chief, Office of Analysis and Strategic Planning  
Jefa, Oficina de Análisis y Planificación Estratégica

*Office of Analysis and Strategic Planning*  
*Oficina de Análisis y Planificación Estratégica*

Dr. Germán Perdomo  
Senior Policy Adviser  
Asesor Principal de Políticas

*Legal Counsel*  
*Asesora Jurídica*

Dr. Heidi V. Jiménez

**Pan American Sanitary Bureau (cont.)**  
**Oficina Sanitaria Panamericana (cont.)**

*Advisers to the Director (cont.)*

*Asesores del Director (cont.)*

*Chief, Department of General Services*

*Jefe, Departamento de Servicios Generales*

Dr. Richard P. Marks

*Chief, Conference and Secretariat Services*

*Jefe, Servicios de Conferencias y Secretaría*

Ms. Janice A. Barahona