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STRATEGY FOR THE FUTURE OF THE PAN AMERICAN CENTERS

The Pan American Centers are an important modality of PAHO technical cooperation, and as such have been the object of study and debate by the Governing Bodies for decades.

Each Center has its own particular origin, history, and functions. The Centers' technical cooperation is a key component of the regional and subregional programs, combining the dissemination of information, the development of methodologies and instruments, training, and research with support for the formulation of plans and projects and direct technical cooperation to the member countries in priority areas and issues in health in which national capacity has been insufficiently developed.

From the outset, the Pan American Centers were conceived as a temporary modality of technical cooperation and were established only in the absence of appropriate national institutions.

In recent decades, the Member States have made significant progress in health, both in terms of indicators and the development of national institutions to address local sanitary problems, with infrastructure constituting important public capital. During this period, the Pan American Centers have helped in various degrees to make these sanitary improvements at the national level. Furthermore, they have promoted and supported the structuring and operation of horizontal collaboration networks among national institutions of recognized prestige and over time have become important vectors for PAHO technical cooperation.

The Region of the Americas currently has 204 WHO Collaborating Centers and a significant group of technical reference centers involved in areas relevant to the work of the Pan American Centers.

There are 312 staff members of different categories at the 8 Pan American Centers, 39 of them international professionals.

In the biennium 2004-2005, as of 31 March 2005, a total of US$49,371,666 in regular and extrabudgetary funds had been allocated to the Pan American Centers.

The new regional program budget policy adopted by the 45th Directing Council in 2004 increases allocations to the countries and subregional lines of action, reducing the resources allocated to regional activities.

Financial sustainability has long been the greatest challenge for the Centers.

This document provides an update on several technical, managerial, and administrative aspects pertaining to the operations of the Pan American Centers, in the general context of the technical cooperation needs identified by the countries, the available national institutional capacity, and the urgent need to make the best possible use of the resources allocated to the Organization.

The document also details the operations of CEPIS and CLAP and proposals for their reorganization in light of the further decentralization of regional technical cooperation, and it brings to the attention of the Executive Committee the urgent need to review the current institutional structure and value of INPPAZ. Its proposals will make it possible to rationalize and make better use of the available human and financial resources.

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The Role of the Pan American Centers in the Technical Cooperation of PAHO

Introduction

1. The present document draws together and updates various technical, managerial, and administrative elements related to the operation of the Pan American Centers, analyzing their role as a PAHO technical cooperation modality. This updating takes three main areas into consideration: the technical cooperation needs identified by the countries; the available national institutional capacity, and the urgent need to make the best possible use of the resources allocated to the Organization.

2. The new regional program budget policy adopted in 2004, Managerial Strategy for the work of the Pan American Sanitary Bureau in the Period 2003-2007, and the discussions of the Working Group on PAHO in the 21st Century make it necessary to review current institutional arrangements to guarantee sustained technical cooperation that is effective, viable, and most responsive to the current needs of the Member States

3. Within this context and in keeping with the mandates and resolutions adopted by the Governing Bodies of PAHO, this document presents general information on the operations of the Pan American Centers. More specifically, it describes the current situation of the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) and the Latin American Center for Perinatology and Human Development (CLAP) and the steps taken by the Secretariat to ensure that the two Centers carry out their mission effectively and efficiently. It also brings to the attention of the Executive Committee the urgent need to review the current institutional structure and value of the Pan American Institute for Food Protection and Zoonoses (INPPAZ) to more adequately address technical cooperation needs in food hygiene and security.

Frame of Reference and Conceptual Development

4. Since the creation of the Institute of Nutrition of Central America and Panama (INCAP) in 1949, the Pan American Centers have been an important element of PAHO technical cooperation, and, as such, have been the object of study and debate by the Governing Bodies for several decades.

5. Each Center has its own particular origin, history, and functions and maintains a different relationship with its host country, the countries of a given subregion, and the Region of the Americas as a whole. For a little over five decades, the Centers have contributed to the development of the countries' technical and scientific capacity, generally exhibiting the necessary flexibility and continuing capacity to adapt to various emerging needs both in their areas of technical expertise and in the management, administration, and financing of technical cooperation.

6. The Centers' technical cooperation function is considered an key component of the regional and subregional programs and combines the formulation of plans and policies with information dissemination, the development of methodologies and instruments, training, research, and direct technical cooperation with the Member States in priority areas and issues for health in which national capacity has been insufficiently developed.

7. Over the course of a little more than five decades, the Governing Bodies of PAHO approved the creation of 12 Pan American Centers and the elimination of 4 of them. Furthermore, the Pan American Zoonosis Center (CEPANZO) was eliminated in 1991, and the Pan American Institute for Food Protection and Zoonoses (INPPAZ) was created that same year to replace it.

8. PAHO currently has eight Pan American Centers in seven countries.[1] Three of the Centers are subregional in nature (INCAP, CFNI, and CAREC), and five are regional (PANAFTOSA, BIREME, CEPIS, CLAP, INPPAZ). The host countries and the Centers' place in the PASB organizational structure are presented below:

Center	Host Country	Place in the PASB organizational structure
BIREME	Brazil	Area of Information and Knowledge Management
CAREC	Trinidad and Tobago	Office of the Assistant Director
CEPIS	Peru	Area of Sustainable Development and Environmental Health
CFNI	Jamaica	Area of Family and Community Health
CLAP	Uruguay	Area of Family and Community Health
INCAP	Guatemala	Area of Sustainable Development and Environmental Health
INPPAZ	Argentina	Veterinary Public Health Unit
PANAFTOSA	Brazil	Veterinary Public Health Unit

[1] Annex A contains a table on the signatory countries to the constitutive agreements currently in force in the Pan American Centers.

Mandates of the Governing Bodies concerning the Pan American Centers

9. From the outset, the Pan American Centers were conceived as a temporary modality of technical cooperation. In resolution CSP18.R33, recognizing the usefulness of the multinational centers in addressing health problems of mutual interest to various countries, the 18th Pan American Sanitary Conference, held in 1970, resolved that:

> "The establishment and operation of multinational centers shall be based on the priorities arising out of the planning of the PAHO/WHO program."

10. That resolution further states:

> "Where there are no suitable national institutions to deal with problems of common interest, multinational centers will be planned and developed in consultation with the Governments in order to make maximum use of PAHO/WHO assistance."
>
> "In view of the fact that multinational centers are institutions and are created only when there are no adequate national institutions, international financial assistance is regarded as a long-term obligation. Nevertheless, each multinational center should be reviewed regularly in planning the program and in the light of its importance in relation to the needs of the participating countries."
>
> "Proposals for multinational centers shall continue to be submitted as part of the PAHO/WHO program and budget to the Executive Committee and to the Directing Council or the Conference for consideration and approval."

11. In 1978, the Pan American Sanitary Conference approved document CSP20/3 on the Pan American Centers. This report makes explicit reference to the enormous potential for cooperation at the international level that the Associated National Centers could assume, pointing out that "in effect, such a center extends the Pan American Center concept with far less burden on the program and budget of PAHO." The cited document proposes a series of recommendations on the (a) standards and conditions and (b) procedural steps for designating Associated National Centers.

12. That same conference adopted resolution CSP20.R31 on the Pan American Centers, resolving:

> "To direct that any proposal for the establishment, disestablishment, or transfer of any Pan American Center be routinely submitted to the Executive Committee and the Directing Council and be accompanied by a complete study."

13. Subsequently, during the 95th session of the Executive Committee of 1985 it was mentioned in document CE95/11 that:

> "An examination of the past resolutions and discussions by the PAHO Governing Bodies indicates that the Pan American Centers were established to provide solutions to health problems of common interest to countries where no suitable national institutions existed. It was not intended that these Centers would become permanent activities of the Organization but should operate as Pan American Centers until such time as the countries and national institutions acquired the technical and institutional capacity for carrying out the corresponding functions. Pan American Centers are justified for fulfilling specific activities when national institutions are not capable of performing them."

14. As per the 31st Directing Council held in 1985, Resolution CD31.R24 resolved to:

1. "Ask the Director to continue to take measures adequate to improve the relation of cost-effectiveness and the efficiency of the Centers in the utilization of the available resources, including the establishment of administrative systems and of personnel new in the Pan American Centers

2. Confirm the long-term goal of the Organization to act in favor of the transfer of the administration of the Centers to the host Governments in the event that the national institutions are capable of maintaining the quality and quantity of the provided services to the Member Countries with the current administration."

Relevance of Technical Cooperation

15. In recent decades, the Member States have made significant progress in health, both in terms of indicators and the development of national institutions to address local sanitary problems, building important public capital. The Pan American Centers have helped in various degrees to make these sanitary improvements at the national level. Furthermore, they have promoted and supported the structuring and operation of horizontal collaboration networks among national institutions of recognized prestige and over time have become important vectors for PAHO technical cooperation.

16. It is important to point out that, despite the progress made in health indicators and the growing strength of national institutions, there continue to be marked health inequities within and among the countries. The pace urgently needs to be accelerated to meet the Development Goals of the Millennium Declaration (MDGs). In this context, investments in people's health and in environmental health are the linchpin and true

challenge in the fight against poverty and for human development in the 21st century. The 2003 Directing Council approved document CD44/5: Managerial Strategy for the Work of the Pan American Sanitary Bureau in the Period 2003-2007. This document includes the criteria and operational principles that guide the work of the Organization. One of the internal objectives of Institutional change is the "Creation of networks, inside and outside the secretariat, as well as the exchange of experience and knowledge," promoting, moreover, greater decentralization of resources toward the countries and ensuring that "priorities will be addressed through innovative approaches to technical cooperation and the strategic management of the Secretariat's resources."

17. The Region of the Americas currently has 204 WHO Collaborating Centers and an important group of technical reference centers specializing in areas related to the work of the Pan American Centers. These centers constitute a powerful group of institutions that in one way or another are or could assume greater responsibilities and functions in support of international technical cooperation.

Governance

18. The regional Pan American Centers have an organic relationship more directly integrated with the technical area programs and are governed by the administrative and managerial regulations of the Bureau. The Governing Bodies of the Organization approve their priorities and budgets. The majority have technical, advisory, or scientific committees that operate differently. There are other forums whose mandates also direct the work of some of the Centers, as is the case of PANAFTOSA and INPPAZ, through the Inter-American Meeting, at Ministerial Level, on Health and Agriculture (RIMSA).

19. Some of the Pan American Centers have consultative committees or units that deal exclusively with cooperation between the Center and the host country.

20. Governance of the Pan American Centers requires and demands a special ability to develop a shared vision among different interest groups, including the Governing Bodies of the Organization and the Centers, as well as relationships with the host country, with other countries in the subregion and region, as the case may be, with donors, with staff members from the Centers themselves, and with other PAHO colleagues.

Relations with Host Countries

21. A basic principle of the Pan American Centers is signing a collaborative agreement with the host country, which commits to providing the sites, basic services, equipment, and essential support services for the maintenance and operation of the center. This commitment requires a substantial investment on the part of the country,

which is partially compensated by both the programming and economic advantages of having a Pan American Center under national jurisdiction.

Human Resources

22. In 1985, the 35th Directing Council adopted resolution CD35.R24 on policy guidelines regarding Pan American Centers and authorized the establishment of new administrative and personnel systems in the Pan American Centers. Accordingly, the hiring schemes were diversified, seeking greater flexibility and lower costs, facilitating the transfer of the centers' administration to the host countries.

23. At present, there are 312 staff members of different categories at the eight Pan American Centers. 39 of them are international professionals. Each center is considered an integral part of various areas and units in the Organization and, in a decentralized manner, account for 68% of the total staff corresponding to these technical areas and units at Headquarters (SDE, DPC, FCH, IKM).

Financial Resources

24. As indicated in document SPP36/11 of 2002, the Pan American Centers have essentially five sources of income:

a) PAHO regular funds. These have been reliable, but are decreasing in real terms;

b) Direct country quota contributions. These are applicable to the three subregional Centers only, and it is theoretically the most important part of the budgets of these Centers;

c) Grants (non-regular or extrabudgetary funds). These funds are increasing in several centers, while others have not appropriately prepared to take advantage of the possibilities in this field;

d) Sale of products and services. This element represents possibly one of the greatest potentials for the centers' growth but entails serious political and regulatory concerns;

e) Contributions from Host Countries. These are the funds the host country contributes to the center's maintenance or operations. The respective arrangements vary from center to center. There are problems in connection with the timeliness with which these funds are received.

25. In the biennium 2004-2005, as of 31 March 2005, a total of US$49.371.666in regular and extraordinary funds had been allocated to the Pan American Centers.[2]

Regular Funds

26. The combined regular budget of PAHO and WHO for the Region was $ 259,530,000 for the biennium 2004-2005. Of this, the Pan American Centers received $22,366,300, or 8.6% of the regular budget. This figure represents a 20.3% reduction with respect to the biennium 2002-2003, when the amount allocated was $28,047,700.

Direct Quota Contributions from the Countries

27. For the biennium 2004-2005, the Member States had approved quotas totaling $6,053,970 for the three subregional centers (CAREC, CFNI, and INCAP). As of 31 March 2005, payments in the amount of $6,053,970 had been received.

Extrabudgetary Funds

28. As of 31 March 2005, the Pan American Centers as a whole had mobilized $11.268.557, or 22% of the Centers' total budget. These funds weigh heavily in the budgets of CAREC (46%) and INCAP (28.9%).

Sale of Products and Services

29. As of 31 March 2005, the cumulative available total generated by the sale of products and services was $5,724,202. This figure included laboratory services, information, training, and diagnostic kits for the most part. This source of income is especially important for BIREME, representing 39% of its financial resources.

30. As indicated in document SPP36/11, income from the sale of services and from other modalities can be an ingredient that contributes to the financial viability of the centers. However this matter needs to be discussed in greater depth to ensure that the identity of the Pan American Centers and adherence to the mandates issued for the centers do not become distorted.

[2] Annex B includes a table with the distribution of funds allocated to the Pan American Centers for the biennium 2004-2005 up to 31 March 2005.

Contribution of Host Countries

31. As of 31 January 2005, the host countries had contributed $3,958,637 toward the maintenance of the following Centers: CEPIS (Peru: $806,912), PANAFTOSA (Brazil: $1,125,994), BIREME (Brazil: $1,880,731), and INPPAZ (Argentina: $145,000).

32. In the case of CLAP, the Government of Uruguay makes a contribution in kind by assuming part of the cost for the installations housing the center.

33. Financial sustainability has long been the greatest challenge for the centers, as can be seen in the financial reports of the Director and the External Auditor.

Status of Selected Centers

34. The steps taken in regard to a number of selected Centers are presented below. The Director intends to periodically present the situation of a group of Centers for the consideration of the Governing Bodies.

Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS)

35. The agreement establishing the Pan American Center for Sanitary Engineering was signed in 1971 between PAHO and the Government of Peru and is still in force. The name of CEPIS was later changed to Pan American Center for Sanitary Engineering and Environmental Sciences, without changing its original acronym.

Evaluation of CEPIS

36. The last evaluation of CEPIS was conducted in 2002, with the participation of consultants from the Pan American Sanitary Bureau, the National Audit Office of the United Kingdom, and the private sector.

37. The findings of the CEPIS evaluation (CSP26/17) were presented to the Pan American Sanitary Conference in 2002 in a document stating that “the evaluation concluded that CEPIS is a valuable source of technical cooperation and a broker of knowledge. It would be too much of a loss to abolish it and take too much effort to try to re-create an international agency to fulfill its role. However, CEPIS should adapt its present role and functions in terms of being more proactive, and working more through networks of institutions to achieve a multiplier effect on its technical cooperation.” That Conference resolved to request the Director of PAHO to:

- "Implement the pertinent recommendations of the evaluation team to ensure the evolution of a strengthened CEPIS, able to serve better the current and emerging needs of Member States in the field of health and environment;"

- "Promote the development of networks of cooperation among CEPIS, the Collaborating Centers, and institutions linked with health and the environment in the countries."

Basic Sanitation—the Unfinished Agenda

38. At the beginning of the 21st Century, drinking water supply and sanitation coverage in Latin America and the Caribbean were 84.6% and 79.2%, respectively. When the absolute numbers are considered, the situation is disquieting: 77 million people are without access to safe drinking water and 105 million lack facilities for sanitation and the elimination of wastewater and other waste. Of these, 37 million live in urban areas and 68 million in rural areas. Clearly, the Region suffers from serious inequalities in terms of access to water that are generally associated with income level and place of residence. The situation is most critical in peri-urban areas, where roughly 128 million people live in substandard dwellings. As a consequence of these cumulative deficiencies, diarrheal diseases continue to be a major factor in the disease burden. Other diseases associated with the environment, such as vector-borne diseases (especially dengue and malaria) are major public health problems. According to data from WHO, an estimated 43% of the environmental burden of disease impacts children under 5, even though this group accounts for only 12% of the population.

39. Although solid waste collection coverage in urban areas exceeds 80%, only 35% is disposed of properly. Hospital waste remains a serious problem in Latin American and Caribbean countries. Hospitals produce from 1 to 6 kg of waste per bed. Of this, 10%-40% is hazardous, consisting of infectious material, chemicals, or sharps.

40. Improving basic sanitation depends to a great extent on investment in infrastructure. This demands better coordination among stakeholders, including the different levels of government; national and international financial institutions, NGOs, academia, and communities, in the formulation of sectoral plans. In that context, CEPIS has a fundamental and critical role to play. The decentralization of public management down to the local levels and the need to strengthen municipal governments both provide new opportunities for CEPIS technical cooperation.

41. CEPIS' objectives and technical cooperation strategy are directly linked with the MDGs. They include a direct commitment to Target 10 on increasing safe drinking water and basic sanitation coverage. PAHO considers the MDGs an indissoluble commitment

to public health, poverty reduction, and inclusion, creating more favorable conditions for human security and sustainable development.

Centers of Reference, Networks, and Strategic Partners

42. CEPIS has effectively promoted several collaborative networks in which diverse institutions and experts from the different countries of the Region participate. The most significant of these that remain active include the following:

- Pan American Information Network on Environmental Health (REPIDISCA)
- Program for Final Disposal of Wastewater in Coastal Cities
- Coastal Waters for Recreation
- Safe Drinking Water in Indigenous Communities
- Latin American and Caribbean Network of Environmental Laboratories (RELAC)
- Inter-American Healthy Housing Network (REDVIVSALUD)

43. Similarly, CEPIS supports subregional integration initiatives, among them the Andean Community (CAN); maintains working relations with international cooperation agencies, among them the Water Sanitation Program/World Bank (WSP/WB) and the IRC International Water and Sanitation Center, and other civil society and private sector organizations, such as the Inter-American Association of Sanitary Engineering (AIDIS) and universities and academic institutions in Peru and other countries of the Region.

Redefining the Role of CEPIS

44. As a result of the 2002 CEPIS evaluation and based on the managerial Strategy for the Work of the Pan American Sanitary Bureau in the Period 2003-2007, the Area of Sustainable Development and Environmental Health (SDE) is in the process of restructuring to decentralize regional technical cooperation related to drinking water and sewerage services, and refuse and solid waste management of municipalities to CEPIS headquarters, taking an integrated approach to health, with special emphasis on the priority countries of the Region so that they can move toward the attainment of the respective Development Goals of the Millennium Declaration .

45. The management of these programming lines from CEPIS will facilitate the concentration of human and financial resources to boost the efficiency and effectiveness of PAHO technical cooperation in the areas indicated, with CEPIS retaining its identity as a Pan American Center, pursuant to the terms agreed to with the Government of Peru in its Constitutive Agreement.

Latin American Center for Perinatology and Human Development (CLAP)

46. CLAP was created in 1970. The last Basic Agreement between the Ministry of Health and the University of the Republic of the Ministry of Education of the Government of Uruguay and PAHO was renewed on 1 March 2001 and will remain in force until 28 February 2006.

Technical Cooperation Needs in Women's Health and Maternal and Perinatal Health

47. The situation analysis for the Region of the Americas reveals that maternal and perinatal mortality and morbidity indicators in Latin America and the Caribbean are still a matter of concern. The latest available data (Basic Indicators. PAHO 2004) show that the median regional maternal mortality rate remains at approximately 87/100,000 live births, with abysmal disparities between Haiti, with a rate of 523, and Uruguay and Canada, with rates of 11.1 and 7.8, respectively.

48. As to perinatal mortality, the quality of the recordkeeping remains poor, especially with respect to fetal mortality. CLAP estimates the number of perinatal deaths in Latin America and the Caribbean in 1995 at 483,000.

49. There is a clear and inseverable connection between health outcomes for women and newborns and the quality of sexual and reproductive health services in the Region and access to them. Inadequate maternal care implies higher maternal and child morbidity and mortality and a lower quality of life for both.

50. The situation analysis has also revealed the low levels of male participation in the Region's sexual and reproductive health services. Greater male involvement in this area has had a positive impact, resulting in a reduction in domestic violence, greater co-participation in household decision-making, and better communication in the family, which ultimately leads to an improvement in couples' sexual and reproductive health.

Millennium Development Goals

51. The fourth (MDG) is to reduce by two-thirds the mortality rate in children under 5 by 2015. The fifth is to reduce the maternal mortality rate by three-quarters over 1990 figures by 2015. The sixth addresses the need to reverse the spread of HIV/AIDS. These goals guide the present and future work of CLAP, especially in matters and programs to monitor and reduce reproductive and perinatal risk, including vertical transmission of HIV/AIDS and congenital syphilis, with emphasis on the priority countries of the Region.

52. These lines of action will in turn make it possible to accelerate implementation of the plan of action of the International Conference on Population and Development (ICPD), held in Cairo (1994) in the area of reproductive health, and fulfillment of the commitments assumed at the IV World Conference on Women, held in Beijing, China, in 1995. In 2004, the 57th World Health Assembly adopted a resolution promoting strategies to speed up compliance with the agreements of these conferences

Centers of Reference, Networks, and Strategic Partners

53. CLAP's main cooperation strategy is its Network of Associated Centers (CLAP/PAHO), whose purpose is to ensure more streamlined and efficient technical cooperation among countries in the Region of the Americas. The Network currently consists of 16 health institutions in nine countries of the Region.

54. This Network works at promoting the implementation and use of the Perinatal Information System (PIS); improving the quality of maternal and neonatal services, chiefly through the dissemination and application of scientifically sound clinical practices and clinical research, mainly operations research.

55. The Network's main sources of financing are the Spanish International Cooperation Agency (AECI), PAHO regular funds, and funds from national institutions such as COLCIENCIAS in Colombia. In 2004, WHO granted funds to the centers of Nicaragua, Honduras, and El Salvador, which can be renewed for the next five years.

Institutional Reorganization of CLAP

56. With a view to optimizing the available resources, the Area of Family and Community Health (FCH) is in the process of restructuring to decentralize to CLAP headquarters the regional technical cooperation aimed at boosting capacity to improve national epidemiological surveillance systems, reduce reproductive risks and maternal perinatal mortality. The management of these programming lines from CLAP will permit the concentration of human and financial resources to improve the efficiency and effecitiveness of PAHO technical cooperation in the areas indicated. CLAP will retain its identity as a Pan American Center, pursuant to the terms agreed to with the Government of Uruguay and the University of the Republic.

Pan American Institute for Food Protection and Zoonoses (INPPAZ)

Background

57. INPPAZ and PANAFTOSA are two Pan American Centers assigned to the Veterinary Public Health Unit of PAHO

58. On 15 November 1991, an agreement was signed in Washington, D.C. between the Pan American Sanitary Bureau, the administrative organ of the Pan American Health Organization/Regional Office of the World Health Organization, and the Government of the Argentine Republic, for the creation of the Pan American Institute for Food Protection and Zoonoses (INPPAZ) to serve as the executor of PAHO's Regional Program for Technical Cooperation in Food Safety. Execution of the agreement is monitored by the International Coordinating Committee (ICC), in which are represented the Minister of Health of Argentina, the President of the National Animal Health Service (SENASA), two members designated by the Administration of PAHO, three representatives of governments designated by the Directing Council of PAHO, and representatives of organizations that maintain cooperation agreements with INPPAZ. The Program Committee for Argentina monitors specific areas of the Agreement related to Argentina.

59. INPPAZ is the only WHO Center specializing in food safety. WHO has been working with the member countries of PAHO in building a new vision and developing activities to improve food safety, based on a shift from traditional inspection services to a holistic approach that covers the entire food production chain, from the farm to the table.

60. Food safety is currently a vital global issue that demands ongoing examination for the development of national programs.

Financial Situation

61. From the outset, INPPAZ has had a small operating budget, which has been shrinking since 2001. Since its creation it has had difficulty obtaining the counterpart funds from the host country in a timely manner to finance operating expenses.

Mandates

62. PAHO's technical cooperation in food safety as a structured program was a response to the recommendations of the Inter-American Conference on Food Protection, held in Washington, D.C. in 1985, which led to the adoption of the Plan of Action 1986-1990 during the 22nd Pan American Sanitary Conference in September 1986. An evaluation of this Plan of Action in 1991 served as the basis for a new Plan of Action

1991-1995 in late 1991, aimed at reformulating the goals and lines of action for the delivery of technical cooperation in food safety. This Plan of Action was evaluated in 1996 and, based on the findings, the Strategic Plan of the Regional Program for PAHO/WHO Technical Cooperation was drawn up; it was approved by the 42nd Directing Council of PAHO/Regional Committee of WHO for the Americas, in 2000.

63. The Pan American Commission for Food Safety (COPAIA), which serves as an advisory organ of the Inter-American Meeting, at the Ministerial Level, on Health and Agriculture (RIMSA), was created in 2000. COPAIA has representatives from the official health and agriculture sector, producers, and consumers. Four meetings have been held to date, which have confirmed the importance of PAHO's technical cooperation in food safety. INPPAZ acts as the Secretariat *ex officio* of COPAIA.

Technical Cooperation—Challenges and Opportunities

64. Foodborne diseases (FBD) are a growing public health problem. Many countries have reported a substantial increase in the incidence of diseases caused by microorganisms transmitted mainly by food. Chemical contaminants, including toxins and environmental contaminants, continue to be a major cause of foodborne disease.

65. Food safety has important implications for the international food trade. In Latin America, agricultural exports place an important role, with Central America, the Southern Cone, and the Andean Region contributing 48%, 34%, and 23%, respectively, of all exports. The countries must have effective food safety programs in place to operate in the new environment for the international food trade created by the Agreements on Sanitary and Phytosanitary Measures (AMSF) and Technical Barriers to Trade (TBT) of the World Trade Organization (WTO). Likewise, the countries must adapt their systems to participate in regional and subregional integration blocs such as MERCOSUR, the Andean Community (CAN), the Caribbean Single Market Economy (CSME), the recent South American Community initiative, and bilateral treaties such as the free trade agreement with the United States (NAFTA) and the agreements being reached with Asian countries.

66. Food safety is one of the requirements for sustainable tourism. Tourism is one of the fastest-growing industries in the Region. The number of tourists visiting the countries of the Region rose from 92.9 million in 1990 to 128.4 million in 2000, for a cumulative growth of 5%. Anything that interferes with quality and competitiveness is highly relevant.

Networks and Strategic Alliances and Partnerships

67. Technical cooperation in food safety through INPPAZ is buttressed by a series of global and regional networks that deal with a variety of issues connected with food safety. These networks include:

- WHO Global Salm-Surv (GSS): A Global Salmonella Surveillance Network
- Latin American Molecular Subtyping Network for Foodborne Disease (PulseNet)
- Codex Committee for Latin America and the Caribbean (CCLAC).
- Inter-American Network of Food Analysis Laboratories (INFAL).
- National laboratories as reference centers of excellence for countries of the Region.
- Pan American Network on Fish Inspection and Quality Control.
- Regional Surveillance System for Foodborne Diseases.
- Modern Food Inspection and Quality Control Systems.
- International Food Safety Authorities Network (INFOSAN).

Institutional Reorganization

68. The strategic importance of food safety and its impact on health and the economy has been reflected in the conclusions and recommendations of COPAIA and in the PAHO/WHO Plan of Action for Technical Cooperation in Food Safety 2006–2007. The countries have noted the urgent need to make the best possible use of the available human, institutional, and financial resources in the Region. It is therefore proposed that the Executive Committee consider:

(a) Discontinuing INPPAZ as a Pan American Center

(b) Creating a network of associated national centers, coordinated by the Veterinary Public Health Unit, that would serve as referents in the priority components of the Plan of Action, taking advantage of the institutional strengths of the countries of the Region. This work strategy would enable PAHO to maintain and strengthen timely, fluid, and effective technical cooperation with the full participation of the countries.

(c) Merging the team for technical cooperation in food safety with the team working on zoonoses and foot-and-mouth disease, taking advantage of the current PANAFTOSA infrastructure in Rio de Janeiro, Brazil. There would be multiple

advantages to this decision. It would permit: (a) better use of the available administrative infrastructure (b) the integration of common activities such as training, epidemiological surveillance, risk analysis, laboratory quality assurance and (c) strengthening of the work on the concept of the production chain.

(d) Mobilizing additional resources to strengthen technical cooperation in the different subregions.

69. This proposal envisages the generation of a multilateral and multisectoral project with the Government of Argentina to buttress the national food safety system with the capacity to provide international technical cooperation in this field.

Budget Implications

70. The regional program budget policy adopted by the 45th Directing Council in 2004 creates the level of subregional action and increases the proportion assigned to countries and reduce the proportion assigned to activities. As the regional Centers operate in this latter dimension of the program budget, it has been necessary to introduce some changes. It is hope to obtain the budgetary efficiencies necessary to respond to the mandate while preserving effectiveness in the lines of cooperation established within the priorities.

71. The discontinuation of INPPAZ and the alignment of CEPIS and CLAP, granting them decentralized lines of regional technical cooperation, is to attain to optimization of the resources allocated and a net savings of US$ 1.5 million which is reflected in the proposed BPB 2006-2007, which is being presented to this Committee.

72. In June 2006 proposals for changes in PANAFTOSA and BIREME will be presented to the Executive Committee, together with others for the alignment of the subregional centers of CAREC, CFNI, and INCAP, based on the subregional allocation criteria set by the new regional policy.

Action by the Executive Committee

73. The Executive Committee is requested to issue its comments and recommendations on the strategy proposed in this document, express its opinion about the proposal for the institutional reorganization of some of the Centers and discontinuation of INPPAZ as a Pan American Center, and recommend a resolution on this matter to the Directing Council.

Annexes

SIGNATORIES TO THE CURRENT CONSTITUTIVE AGREEMENTS ON THE CENTERS

CENTER	AGREEMENT	SIGNATORY COUNTRIES	OTHER SIGNATORIES	FOUNDATION AND END DATES	LATEST MODIFICATION
BIREME	Agreement between Brazil, through the Ministries of Health and of Education, the State of São Paulo, the Federal University of São Paulo, and PAHO, through BIREME, for the maintenance and development of BIREME	Brazil	State of São Paulo Federal University of São Paulo	Founded: 1999 Ends: December 2009	For the maintenance and development of the Center, signed 2 December 2002
CEPIS	Agreement for the establishment of a Pan-American Center of Sanitary Engineering on Environmental Science.	Peru		Founded: 1971 Currently in force	
CLAP	Agreement for the Establishment of a Latin American Center for Perinatology and Human Development in the Eastern Republic of Uruguay, between the Government of the Eastern Republic of Uruguay, represented by the Ministry of Public Health; the University of the Republic, through the Medical School; and PAHO.	Uruguay	University of the Republic	Founded: 1970 Ends: February 2006	Extended to date
INPPAZ	Agreement between the Argentine Republic and PAHO for the Establishment of a Pan American Institute for Food Protection and Zoonoses	Argentina		Founded: 1991 Currently in force	

SIGNATORIES TO THE CURRENT CONSTITUTIVE AGREEMENTS ON THE CENTERS *(cont.)*

CENTER	AGREEMENT	SIGNATORY COUNTRIES	OTHER SIGNATORIES	FOUNDATION AND END DATES	LATEST MODIFICATION
CAREC	Multilateral Agreement for the Operation of CAREC	Antigua and Barbuda Bahamas Barbados Belize Dominica Grenada Guyana Jamaica Netherlands Antilles Aruba St. Kitts and Nevis St. Lucia St. Vincent and the Grenadines Suriname Trinidad and Tobago United Kingdom and the Caribbean Overseas Territories		Founded: 1975 Ends: December 2005	Latest multilateral and bilateral agreements went into effect on 1 January 2001
	Bilateral Agreement between PAHO and Trinidad and Tobago for the Operation of CAREC	Trinidad and Tobago			

SIGNATORIES TO THE CURRENT CONSTITUTIVE AGREEMENTS ON THE CENTERS *(cont.)*

CENTER	AGREEMENT	SIGNATORY COUNTRIES	OTHER SIGNATORIES	FOUNDATION AND END DATES	LATEST MODIFICATION
INCAP	Basic Agreement on INCAP between PAHO and countries of Central America and Panama	Belize Costa Rica El Salvador Guatemala Honduras Nicaragua Panama		Founded: 1946 Indefinitely in force	New agreement superseding earlier agreements signed on 27 August 1998
PANAFTOSA	Agreement between Brazil and PAHO for the Organization and Operation of the Pan American Foot-and-Mouth Disease Center in Brazil	Brazil		Founded: 1951 Currently in force	
CFNI	Agreement for the Operation of CFNI	Antigua Bahamas Barbados Bermuda Belize British Virgin Islands Cayman Islands Dominica Guyana Grenada Jamaica Montserrat St. Kitts–Nevis–Anguilla St. Lucia St. Vincent Trinidad and Tobago Turks and Caicos	University of West Indies FAO	Founded: 1968 Currently in force	Agreement replacing the constitutive agreement signed on 14 November 1973

REGULAR BUDGET APPROVED AND EXTRABUDGETARY FUNDS ALLOCATED BY CENTER BIENNIUM 2004-2005 AS OF 31 MARCH 2005

CENTER	PAHO/WHO APPROVED REGULAR BUDGET	ASSESSED CONTRIBUTIONS MEMBER STATES	GRANTS AND OTHER CONTRIBUTIONS [4]	INCOME FROM PRODUCTS AND SERVICES	HOST GOVERNMENT CONTRIBUTIONS	TOTAL
BIREME	**1,137,600**		1,105,891	2,631,630	1,880,731	**6,755,852**
CAREC	**1,539,200**	4,308,851 [1]	5,555,092	647,632		**12,050,775**
CEPIS	**4,452,800**		1,062,175	971,807	806,912	**7,293,694**
CFNI	**2,522,800**	582,134 [2]	1,116,671	119,915		**4,341,520**
CLAP	**1,567,500**		424,397	7,735		**1,999,632**
INCAP	**2,698,400**	1,162,985 [3]	1,570,676			**5,432,061**
INPPAZ	**2,762,400**		144,300	11,329	145,000	**3,063,029**
PANAFTOSA	**5,685,600**		289,355	1,334,154	1,125,994	**8,435,103**
TOTAL	**22,366,300**	**6,053,970**	**11,268,557**	**5,724,202**	**3,958,637**	**49,371,666**

SOURCE: PPS/PB

(1) Actual quota contributions received CAREC members as of 31 March 2005 is $3,540,711

(2) Actual quota contributions received from CFNI members as of 31 March 2005 is $380,743

(3) Actual quota contributions received from INCAP members as of 31 March 2005 is $673,972

(4) Includes voluntary contributions received from donors and Program Support Costs assigned by the Director