PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

51st DIRECTING COUNCIL

63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

CD51/FR (Eng.)
30 September 2011
ORIGINAL: ENGLISH

FINAL REPORT

CONTENTS

Page

CONTENTS *(cont.)*

Page

CONTENTS *(cont.)*

Page

CONTENTS *(cont.)*

Page

FINAL REPORT

Opening of the Session

1. The 51st Directing Council of the Pan American Health Organization (PAHO), 63rd Session of the Regional Committee of the World Health Organization (WHO) for the Americas, was held at the Headquarters of the Pan American Health Organization in Washington, D.C., from 26 to 30 September 2011. The Council adopted 15 resolutions and 4 decisions, which appear at the end of this report. The agenda and list of participants are attached as Annexes A and C, respectively.

2. Hon. Salomón Chertorivsky Woldenberg (Mexico, outgoing President) opened the session and welcomed the participants. Opening remarks were made by Dr. Mirta Roses (Director, Pan American Sanitary Bureau [PASB]), Ms. Kei Kawabata (Social Sector Manager, Inter-American Development Bank), Ambassador Albert R. Ramdin (Assistant Secretary General, Organization of American States), Hon. Kathleen Sebelius (Secretary of Health and Human Services, United States of America, Host Country), Dr. Margaret Chan (Director-General, World Health Organization), and Mr. Chertorivksy Woldenberg. The text of their remarks may be found on the website of the 51st Directing Council.[1]

Procedural Matters

Appointment of the Committee on Credentials

3. Pursuant to Rule 31 of the Rules of Procedure of the Directing Council, the Council appointed Antigua and Barbuda, Canada, and Honduras as members of the Committee on Credentials (Decision CD51[D1]).

Election of the President, Two Vice Presidents, and the Rapporteur

4. Pursuant to Rule 16 of its Rules of Procedure, the Council elected the following officers (Decision CD51[D2]):

President:	Panama	(Dr. Franklin Vergara Jaén)
Vice President:	Bahamas	(Hon. Dr. Hubert Alexander Minnis)
Vice President:	Uruguay	(Dr. Jorge Venegas)
Rapporteur:	Bolivia	(Dr. Nila Heredia)

[1] See website of 51st Directing Council: http://new.paho.org/hq/index.php?option=com_content&task=view&id=5723&Itemid=4139&lang=en.

5. As the Delegate of Bolivia was obliged to return to her country shortly after the opening of the session, Argentina (represented by Mr. Sebastián Tobar) was appointed to serve as Rapporteur pro tempore for the remainder of the session.

6. Dr. Mirta Roses (Director, PASB) served as Secretary ex officio, and Dr. Jon Kim Andrus (Deputy Director, PASB) as Technical Secretary.

Establishment of a Working Party to Study the Application of Article 6.B of the PAHO Constitution

7. The President announced that it would not be necessary to establish a working party, as no Member State was currently subject to the voting restrictions provided for under Article 6.B of the PAHO Constitution (see Report on Quota Contributions, paragraphs 140 to 146 below).

Establishment of the General Committee

8. Pursuant to Rule 32 of the Rules of Procedure, the Council appointed Cuba, Guatemala, and United States of America to join the President of the Council, the two Vice Presidents, and the Rapporteur as members of the General Committee (Decision CD51[D3]).

Adoption of the Agenda (Document CD51/1, Rev. 1)

9. The Council adopted the provisional agenda contained in Document CD51/1, Rev. 1, with one change: Item 8.1, "WHO Medium-term Strategic Plan 2008-2013 and Proposed Program Budget 2012-2013," was deleted since those documents had already been approved by the World Health Assembly in May 2011 (Decision CD51[D4]). The Council also adopted a program of meetings (Document CD51/WP/1, Rev.1).

Constitutional Matters

Annual Report of the President of the Executive Committee (Document CD51/2)

10. Dr. St. Clair Thomas (Saint Vincent and the Grenadines, President of the Executive Committee) reported on the activities carried out by the Executive Committee and its Subcommittee on Program, Budget, and Administration between September 2010 and September 2011, highlighting the items that had been discussed by the Committee but not sent forward for consideration by the 51st Directing Council and noting that he would report on other items as they were taken up by the Council. The items not sent forward included Nongovernmental Organizations in Official Relations with PAHO, Annual Report of the Ethics Office, Report of the Office of Internal Oversight and Evaluation Services, Report of the PAHO Audit Committee, Status of Projects Funded from the

Holding Account, Amendments to the PASB Staff Rules, and a statement by a representative of the PAHO/WHO Staff Association. Details of the discussions and the action taken on those items may be found in the final report of the Executive Committee's 148th Session (Document CE148/FR).

11. The Council thanked the Members of the Committee for their work and took note of the report.

Annual Report of the Director of the Pan American Sanitary Bureau (Document CD51/3)

12. Following the projection of a video that provided an overview of the Organization's work during the previous year, the Director presented her Annual Report, the theme of which was "Health and the Millennium Development Goals: From Commitment to Action," highlighting some of the ways in which PAHO's technical cooperation had supported countries' efforts to achieve the Goals. She noted that while the Region as a whole was on track to achieve most of the health-related Millennium Development Goals (MDGs), including those on hunger, child mortality, and water and sanitation, progress had been uneven across and within countries, and in nearly all countries there were vulnerable populations that had not benefited fully from national progress on the Goals. The need to focus on those populations had been a central tenet of PAHO's technical cooperation. The Organization's "Faces, Voices, and Places" initiative had sought to make the MDGs a reality in the daily lives of such populations.

13. PAHO's cooperation with regard to the MDG-1 targets for hunger had included strengthening of surveillance, detection, and treatment of malnutrition; promotion of breastfeeding; support for micronutrient supplementation and food fortification; and inter-agency cooperation on evidence-based, multisector interventions to tackle the causes of malnutrition. Work aimed at contributing to the achievement of MDG-4 (Reduce child mortality) had been carried out in the framework of the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care, adopted by the 48th Directing Council in 2008. Immunization had been a key factor in the Region's success in reducing child mortality. PAHO's Revolving Fund for Vaccine Procurement had expended nearly $723 million[2] for the purchase of vaccines and immunization supplies on behalf of countries and territories of the Region, many of which had introduced new childhood vaccines into their immunization programs during 2010-2011, with support from PAHO and the GAVI Alliance. A total of 41 million people had been immunized during Vaccination Week in the Americas.

14. Technical cooperation to reduce maternal mortality (MDG-5) had ranged from protocols and training on obstetric care to support for surveillance, health services

[2] Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

reorganization, and advocacy on the rights of health service users to comprehensive, high-quality sexual and reproductive health care. PAHO had also supported efforts to reduce maternal mortality among indigenous women. With regard to MDG-6 (Combat HIV/AIDS, malaria, and other diseases), critical support for expanding antiretroviral treatment coverage had been provided by PAHO's Regional Revolving Fund for Strategic Public Health Supplies (the "Strategic Fund") between June 2010 and June 2011, as a result of which countries had acquired sufficient medications to treat some 30,000 HIV-infected individuals. Efforts carried out under the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis had included support for prevention and control interventions, improvements in health services, increased collaboration with other agencies and sectors and with the community, and support for improved data collection and analysis.

15. The Organization had continued to partner with the United States Agency for International Development (USAID) to fight malaria through the Amazon Network for the Surveillance of Antimalarial Drug Resistance and the Amazon Malaria Initiative, as a result of which malaria cases and deaths had declined by 52% and 69%, respectively, since 2000. To fight tuberculosis, PAHO had supported laboratory strengthening and interventions designed to address the social determinants of the disease.

16. Work in respect of MDG-7 (Ensure environmental sustainability) had sought to expand access to drinking water and sanitation and to reduce the access gaps between urban and rural areas. Much of that work had focused on water safety and on the development of evidence-based standards for regulatory purposes, the design of plans and programs for surveillance and monitoring of water quality, and capacity-building in epidemiological surveillance of water-borne diseases. The Organization had also provided technical cooperation in the area of climate change and health.

17. As for MDG-8 (Develop a global partnership for development), PAHO was participating in a number of regional partnerships aimed at accelerating progress on the MDGs, including the Pan American Alliance for Nutrition and Development, the Latin American and Caribbean Newborn Health Alliance, and the Regional Interagency Task Force for Maternal Mortality Reduction. It was also working with other United Nations agencies, with bilateral development agencies, and with nongovernmental partners.

18. The Director invited Member States to examine Chapter 3 of her report, which provided an in-depth discussion of the lessons learned over the previous decade of work on the MDGs and explored the challenges remaining in the years before 2015 and beyond. Those lessons included the need to adapt targets and indicators to make them more meaningful in the regional context, the urgency of building human capital at the local level, and the importance of a second generation of MDGs that would address new issues such as chronic noncommunicable diseases and neglected tropical diseases, public safety,

justice, and human rights. She stressed the importance of applying the lessons learned to help consolidate the gains made thus far and to ensure they were sustained beyond 2015. Above all, the Region must ensure that the MDG vision remained alive, inspiring new effort to extend the benefits of health and development to everyone in the Americas.

19. The Directing Council thanked the Director for her comprehensive report and welcomed the progress made towards the health-related MDGs. At the same time, the Council acknowledged that considerable work remained to be done in order to ensure that the Goals were met in all geographic areas and in all population groups, and underscored the need for sustained commitment and concerted effort to that end. PAHO was urged to continue its work to help Member States to strengthen their health information and communications systems in order to identify areas in which progress had been limited and to reduce inequities in health status. In that connection, the proposed Strategy and Plan of Action on *eHealth* (see paragraphs 107 to 116 below) was welcomed. Continued effort to strengthen health systems and to reinforce primary health care services was also urged. The need to improve access to health services and to make those services more responsive to the needs of vulnerable, remote, and underserved populations was emphasized. Several delegates highlighted the link between poverty and malnutrition—including both undernutrition and obesity—and underscored the need for policies and programs aimed at ensuring food and nutrition security. PAHO was encouraged to step up its efforts to promote exclusive breastfeeding up to the age of six months.

20. Numerous delegates stressed the need for multidisciplinary and intersectoral action in order to address the social and economic determinants that were standing in the way of full achievement of the MDGs. The importance of regional and global solidarity, cooperation and sharing of experiences between countries, and multilateralism were also underlined. Delegates affirmed their support for the work of PAHO, and expressed gratitude for the Organization's support for their countries' efforts to achieve the health-related MDGs. The contribution of the Revolving Fund for Vaccine Procurement to strengthening national immunization programs and helping countries to prevent vaccine-preventable diseases was highlighted in particular.

21. The need for intensified action to improve maternal health and reduce maternal mortality was emphasized, and strong support was expressed for the proposed Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity (see paragraphs 90 to 106 below). It was pointed out that most maternal deaths could be prevented by ensuring women's access to high-quality health services and emergency obstetric care and by making obstetric care available free of charge. It was also noted that many infant and child deaths were avoidable, and the need for increased attention to accident prevention and problems such as sudden infant death syndrome was noted. Immunization was seen as one of most effective ways of preventing child deaths, and Member States were encouraged to incorporate new vaccines such as the pneumococcal

and rotavirus vaccines into their immunization schedules. It was reported that in one country the introduction of the latter vaccine had led to a 41% drop in child deaths from diarrheal diseases. Member States were also encouraged to support the implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health in order to monitor and evaluate progress in improving health outcomes for women and children.

22. Prevention and control of chronic noncommunicable diseases was identified as an area requiring concerted action, both in the immediate future and beyond 2015. Delegates emphasized the need to maintain the momentum generated by the recent high-level meeting of the United Nations General Assembly on the issue (see paragraphs 200 to 212 below). PAHO's leadership in preparing for that meeting was commended.

23. Several delegates underscored the importance of the WHO reform process currently under way. The Delegate of Paraguay, seconded by the Delegate of Brazil, made a statement on the issue on behalf of the member countries of the Union of South American Nations (UNASUR). (The content of that statement is reflected in the summary of the Council's deliberations on WHO reform, paragraphs 180 to 194 below.) The Delegate of Brazil invited all Member States to participate in the World Conference on Social Determinants of Health, to be held in Rio de Janeiro from 19 to 21 October 2011.

24. The Council thanked the Director and took note of the report.

Election of Three Member States to the Executive Committee (Document CD51/4)

25. The Council elected Brazil, Chile, and El Salvador to the Executive Committee, replacing Argentina, Guatemala, and Haiti, whose periods of office on the Committee had expired.

26. The Council adopted Resolution CD51.R1, declaring Brazil, Chile, and El Salvador elected to membership on the Executive Committee for a period of three years and thanking Argentina, Guatemala, and Haiti for their service.

Program Policy Matters

PAHO Program and Budget 2012-2013 (Official Document 338 and Add. I; Add II, Rev. 1; Add. III; and Add. IV)

27. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had discussed the proposed program and budget extensively during its 148th Session and subsequently in a virtual meeting. The initial budget proposal examined by the Committee had called for no increase in the overall budget, which would have remained at its 2010-2011 level of $642.9 million. The Committee had considered

three funding scenarios: scenario A, which called for a 10.5% increase in assessed contributions to cover inflationary and statutory costs already incurred during 2010-2011; scenario B, which called for a 6.7% rise in assessed contributions; and scenario C, which called for zero nominal growth in assessed contributions. In all scenarios, a significant decline in voluntary contributions and miscellaneous income was expected.

28. Scenario A had been considered unrealistic in the current economic climate. Some delegations had supported scenario C. They had pointed out that their countries were grappling with severe financial constraints, which would make it difficult, if not impossible, to obtain approval at national level for an increase in their governments' assessed contributions to PAHO. Other delegations had supported scenario B, pointing out that scenario C would result in a drastic reduction of the Organization's technical cooperation budget and render it unable to achieve many of the strategic objectives established in the Strategic Plan 2008-2013. In view of the lack of consensus as to which scenario should be recommended to the Directing Council, the Committee had asked the Bureau to formulate an alternative scenario, one that would not require a 6.7% rise in Member States' assessments, but that would not entail the severe cuts to the non-post budget that would result from a zero-nominal-growth scenario.

29. The Bureau had subsequently presented scenario D, which originally called for a 4.5% increase in Member States' assessments and a 28.25% reduction in the non-post portion of the budget—versus a reduction of 23.7% under scenario B and 37.8% under scenario C. The total regular budget under scenario D would be $290.5 million—versus $294.5 million under scenario B and $282.1 million under scenario C. The post portion would total $222.5 million under all three scenarios, while the non-post portion would be $67 million under scenario B, $54.6 million under scenario C, and $63 million under scenario D. Several delegates had supported scenario D, considering it a good compromise between scenario B and zero nominal growth. The delegates that had supported scenario C in the earlier discussion remained in favor of zero nominal growth in assessed contributions. It had been pointed out that in all four scenarios, any increase in assessed contributions would be allocated to the post portion of the budget, which would increase by 14.5% in all scenarios, while the budget for technical cooperation activities would decline. The Committee had urged the Bureau to explore ways of redistributing funds between the two components, and had asked it to draw up alternatives to scenarios B, C, and D that would call for a smaller increase in the post component.

30. Those alternative scenarios had been discussed several weeks later in a virtual meeting. The Bureau had revised scenarios C and D, which were still under discussion, whereas scenarios A and B were not, and had drawn up a revised budget proposal based on scenario D (contained in *Official Document 338* and Add. I). The total budget under revised scenario D would be $626.7 million, a reduction of 2.5%, or $16.2 million, with respect to the 2010-2011 budget. The fixed-term post component would account for 40%

and the non-post component for 60%. The regular budget would remain unchanged at $287.1 million. In order to maintain the regular budget at that level, however, a 4.3% rise in Member States' assessed contributions would be needed in order to offset an expected $8 million decline in miscellaneous income.

31. After considerable discussion, the Committee had agreed to adopt Resolution CE148.R16, recommending that the Directing Council approve the proposed program and budget based on revised scenario D, which had been supported by a majority of Committee members. However, at the request of one of its members, the Committee had also decided to ask the Bureau to draw up another scenario for discussion during the Directing Council, one in which the proposed increase in assessed contributions would be 2.15%; i.e., half the increase of 4.3% proposed in revised scenario D. The Bureau had therefore drawn up scenario E (contained in Document OD338, Add. II, Rev. 1). The Committee had also adopted Resolution CE148.R17, recommending that the Directing Council establish the assessed contributions of Member States, Participating States, and Associate Members on the basis of revised scenario D. Additional details of the Committee's discussions on the budget could be found in the final report of its 148th Session (Document CE148/FR).

32. The Directing Council thanked the Executive Committee for its careful consideration of the budget proposal and expressed gratitude to the Bureau for its hard work in preparing the various scenarios. Delegates commended the detail and the transparency evident in the budget proposal and praised the Bureau's efforts to contain costs and enhance efficiency and productivity. They also acknowledged the financial challenges that PAHO faced as a result of rising post costs and anticipated reductions in voluntary contributions and miscellaneous income, and recognized that scenarios C, D, and E would all entail significant cuts to the non-post portion of the budget, diminishing the Organization's technical cooperation capacity and compromising its ability to achieve the strategic objectives established under the Strategic Plan 2008-2013.

33. Nevertheless, while affirming their strong support for PAHO's work and acknowledging the validity of the Bureau's justification of the requested increase in assessments, numerous delegates said that their governments would be unable to accept a 4.3% rise in their quota contributions to the Organization, as envisaged in scenario D. Many noted that, like PAHO, their countries were contending with severe financial constraints and had been obliged to impose austerity measures, including downscaling or elimination of programs, spending cuts and freezing of salaries in the public sector. Several pointed out that their assessed contributions had risen for two consecutive bienniums, and in some cases they would increase again in the next biennium, even in a zero-nominal-growth scenario, as a result of the most recent revision of the scale of assessments of the Organization of American States (OAS), on which PAHO's scale was based.

34. Among the Member and Participating States that opposed scenario D, four favored scenario C and five supported scenario E. The latter group considered scenario E a fair compromise between scenarios C and D one in which the Secretariat and Member States would share responsibility for covering the shortfall in miscellaneous income and one which would strike an equitable balance between the financial constraints facing many Member States and the impact that the reduced funding would have on PAHO's programs and activities. Several delegates highlighted the need for increased cooperation among countries to offset the reduction in PAHO's technical cooperation capacity. The importance of ensuring that the Region received its full allocation of regular and voluntary funds from WHO was also underlined.

35. All the countries of the Caribbean Community (CARICOM) and eight other Member States supported scenario D. A number of delegates noted that a 4.3% increase in assessed contributions would represent a burden for their governments, but in a spirit of solidarity and Pan Americanism they were willing to make that sacrifice. The Delegate of Barbados appealed to the Council to give due consideration to the impact that a reduction in PAHO's technical cooperation capacity would have on small countries with vulnerable economies in the Caribbean region.

36. In view of the lack of agreement as to which scenario should be supported, the Council decided to form a working group consisting of Argentina, Brazil, Colombia, Dominica on behalf of CARICOM, Mexico, Panama, and the United States of America in order to reach consensus.

37. Dr. David Johnson (Dominica) subsequently reported that Paraguay had also joined the working group, which had held three meetings. The group had first considered scenarios D and E, but had been unable to come to consensus on either of the two. A proposal had then been made to consider a middle ground between the two scenarios, and the working group had asked the Bureau to draw up a possible scenario F, calling for a 3.2% increase in assessed contributions. After further discussion and consultation with their respective governments, the members of the working group had agreed unanimously to recommend that the Council adopt a revised budget proposal based on scenario F. Under scenario F, the total budget would be $613.4 million (a 4.6% reduction with respect to 2010-2011), the regular budget would total $285.1 million (a 0.7% reduction), and 12% of the targets under the Strategic Plan would not be met. The working group had emphasized that the approval of a rise in Member States' assessed contributions did not represent a blank check for PAHO and that the Bureau needed to identify areas in which administrative costs could be further reduced so that more of the Strategic Plan objectives could be met.

38. The Council accepted the recommendation of the working group without further comment and adopted Resolutions CD51.R10 and CD51.R11, Rev.1, approving the

program of work for the Bureau as outlined in *Official Document 338* and Add. IV, and establishing the assessed contributions of Member States, Participating States, and Associate Members on the basis of scenario F.

39. The Director thanked Member States for the confidence they had placed in the staff of the Organization and for their commitment to reaching consensus in a true spirit of collaboration and solidarity. She assured the Council that the staff valued the trust and the responsibility bestowed upon them and would do their utmost to ensure that the hard-won funds were put to use for the maximum benefit of the health of all peoples in the Americas.

Strategy and Plan of Action on Urban Health (Document CD51/5)

40. Dr. St. Clair Thomas (Representative of the Executive Committee) recalled that the proposed strategy and plan of action on urban health had been prepared in response to a request by ministers of health participating in the roundtable on urban health held during the 50th Directing Council in 2010 and had been submitted for consideration by the Executive Committee at its 148th Session. The Committee had welcomed the strategy and plan of action, underscoring the importance of the issue and acknowledging that current patterns of urbanization often discouraged healthy behaviors and contributed to public health problems and to higher rates of communicable and noncommunicable diseases among urban populations. The need for interprogrammatic and intersectoral action to address determinants of urban health had also been stressed. The Committee had proposed several revisions aimed at enhancing the clarity of the strategy and plan of action (details may be found in the final report of the Committee's 148th Session, Document CE148/FR), and had subsequently adopted Resolution CE148.R10, recommending that the Directing Council endorse the strategy and approve the plan of action following their revision by the Bureau in the light of the Committee's suggestions.

41. The Council welcomed the strategy and plan of action. It was pointed out that urbanization had often outpaced the ability of governments to plan, build, and maintain infrastructure, transportation systems, and other aspects of urban development. Moreover, inadequate planning and lack of essential infrastructure had led to unhealthy living conditions such as poor quality housing, environmental pollution, violence and injury, high rates of both communicable and noncommunicable diseases, and road accidents. It was considered that the strategy and plan of action would help to address those problems, thus also helping to address the growing epidemic of chronic noncommunicable diseases.

42. Delegates expressed appreciation for the revisions made to the strategy and plan of action in response to the Executive Committee's suggestions. Several further improvements were proposed. In particular, it was suggested that the strategy and plan of action should be revised to take account of the outcome of the recent United Nations high-level meeting on noncommunicable diseases (see paragraphs 200 to 212 below). In

addition, it was felt that some of the language in the document needed clarification, including the reference to "territorial management of social determinants" under activity 1.1 and the phrase "protective factors of urban populations" under activity 2.3. It was also suggested that the phrase "in synergy with the efforts by the WHO Centre for Health Development," should be moved to the beginning of the paragraph on activity 5.2 in order to more clearly convey the idea that the regional mechanisms envisaged under that activity would work in concert with the WHO center. The need for coordination and synergy among all the various agencies of the United Nation system engaged in addressing urban health issues was underscored.

43. It was also suggested that the plan of action should include activities aimed at preventing the harmful use of alcohol and drugs in urban settings, should be linked to the strategy on road safety, and should make some mention of the need to improve health systems so as to permit access for all citizens. It should also draw attention to the need for a multicultural approach in order to respond appropriately to the flows of migrants from various backgrounds into cities. It was pointed out that urban sprawl and population migration away from city centers to suburban areas were growing trends in some countries and that measures aimed at revitalizing city centers were therefore needed.

44. The strategy's emphasis on health impact assessment, a whole-of-society approach, and enhanced surveillance were welcomed, and PAHO technical assistance in developing those areas was requested. Delegates stressed that community-level participation would be essential in order to ensure that the people directly affected by the strategy and plan of action had a stake in its success. It was suggested that it would be beneficial to develop strategies for communication and awareness-raising directed towards town managers, mayors, and governors, so as to place urban health at the top of the local political agenda.

45. It was emphasized that surveillance systems should include a broad range of determinants and indicators related to urban health, including socioeconomic status, migration conditions, race, ethnicity, indigenous populations, and homelessness and housing conditions. It was also suggested that the proposed resolution on this item should urge Member States to promote health promotion and sustainable development projects in vulnerable communities and to encourage social participation and intersectoral action.

46. Several delegates described activities being carried out in their countries with a view to improving health conditions in urban areas. Such activities included the development and upkeep of green spaces and pedestrian zones in urban areas, which, as well as providing safe places for the population to engage in physical activity, also enhanced the aesthetics of cities, yielding benefits for the country's tourism industry. Other activities included measures aimed at enhancing personal safety in urban areas, improvements to the public transit system, programs to encourage healthy lifestyles and

discourage tobacco use and alcohol misuse, road safety initiatives, and maintenance of rigorous food safety, environmental, sanitation, and vector control standards.

47. It was pointed out that some of the reporting requirements in the plan of action would need to be implemented flexibly in order to allow countries with a federal or decentralized structure to comply with them. It was also pointed out that implementation of the activities envisaged under this plan of action and others considered by the Council would be affected by resource availability.

48. Dr. Luiz Augusto Galvão (Area Manager, Sustainable Development and Environmental Health, PASB) said that he had taken careful note of the Council's suggestions for improvement of the strategy and plan of action, which he agreed were closely related to those dealing with the harmful use of alcohol, road safety, and other issues, and therefore an integrated interprogrammatic approach should be taken in implementing them. However, the specific problems that needed to be addressed in the various areas differed, as did the stakeholders involved, and it was therefore considered advisable to have separate strategies and plans of action for each one. He also concurred that working to improve urban health would certainly have an impact on the control of noncommunicable diseases, and said that the document would be revised to incorporate the conclusions of the United Nations high-level meeting.

49. The Council adopted Resolution CD51.R4, endorsing the strategy and approving the plan of action as revised in the light of Member States' suggestions.

Strategy and Plan of Action on Climate Change (Document CD51/6, Rev. 1)

50. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had supported the strategy and plan of action on climate change, but had suggested several areas in which they could be strengthened. The Committee had recommended, inter alia, that greater emphasis should be placed on pursuing work within existing partnerships rather than creating new ones and had suggested that some of the actions envisaged within the plan of action should be expanded, while others should be more narrowly focused. Additionally, the Committee had recommended that the linkages between the strategy and plan of action and the Organization's work in the areas of urban health and sustainable development should be made more explicit. It had also been suggested that the strategy and plan of action were not properly balanced between the two important concepts of adaptation and mitigation, and it had been pointed out that a further important aspect of the climate change discussion—that of "common but differentiated responsibilities"—had not been addressed at all. The Executive Committee had adopted Resolution CE148.R2, recommending that the Directing Council endorse the strategy and approve the plan of action, following their revision to incorporate the Committee's suggested changes and additions.

51. The Council welcomed the strategy and plan of action. Delegates stressed that adaptation to and mitigation of climate change, and dealing with its health aspects, would require a multisectoral approach involving not only the ministry of health but also the ministries of environment, education, agriculture, and others, as well as civil society and the private sector. It was pointed out, however, that discussions on climate change had thus far often failed to take adequate account of health concerns, and it was suggested that the health sector needed to invest greater effort in making stakeholders aware of those concerns. It was also emphasized that the response to the health effects of climate change would depend on individual countries' circumstances and might involve a range of measures, including developing an early warning system for climate-induced health risks through monitoring of meteorological data and air and water quality, training of health sector personnel for temporal and spatial targeting of vector control interventions in response to early warning indications, or implementing community-based public health education campaigns on vector control.

52. It was pointed out that, as the health effects of climate change would differ by age, sex, socioeconomic level, and other factors, mitigation and adaptation action plans would need to be tailored to particular circumstances, taking account of local needs and priorities. It was also considered important to link work in the area of climate change with work on urban health and sustainable development.

53. Several delegates described the measures being taken by their governments to combat the health effects of climate change and expressed their willingness to exchange information and best practices with other countries. While it was noted that climate change phenomena varied from country to country, their impacts were seen as universally negative. In some countries, the effects of climate change were causing population displacements, with the adverse health consequences that such migration entailed; in others they were causing damage to hospitals and other health facilities. It was reported that in some countries climate change effects were also causing reduced agricultural production, leading to hunger and exacerbating health problems. A number of delegates noted that climate change could lead to increased incidence of vector-borne diseases such as dengue, yellow fever, and malaria.

54. The Council expressed appreciation for the changes made to the strategy and plan of action following their review by the Executive Committee. At the same time, it was noted that there was room for further improvement: in particular, it was considered that references to human rights aspects of climate change in paragraph 11 of Document CD51/6 were not appropriate, since PAHO was not a human rights body and the relationship between human rights and climate change were being addressed in more appropriate forums, such as the United Nations Human Rights Council.

55. With regard to the proposed resolution on this item, a delegate suggested that in several places climate change should be described as a "potential" threat to health, since, while climate change itself was unquestionably a real phenomenon, the impact it would have on health was still unknown. Other delegates disagreed, emphasizing that climate change was an existing threat to health, not a potential one. After further discussion by a working group consisting of Brazil, Colombia, Mexico, the United States of America and the officers of the Council, it was agreed to replace "potential" with "current and projected."

56. Dr. Luiz Augusto Galvão (Area Manager, Sustainable Development and Environmental Health, PASB) thanked delegates for their comments and suggestions, which would help to enrich not only the strategy and plan of action but also the input that the Bureau would be providing, together with ECLAC, for the Rio + 20 United Nations Conference on Sustainable Development in 2012.

57. The Council adopted Resolution CD51.R15, as amended by the working group, endorsing the strategy and approving the plan of action.

Plan of Action on Road Safety (Document CD51/7, Rev. 1)

58. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had strongly supported the proposed plan of action on road safety, stressing that the health sector must work in cooperation with other sectors in order to reduce traffic accidents and their health consequences, and highlighting the linkages between alcohol and drug use and traffic accidents. It had been pointed out that while some of the proposals in the plan of action relating to national regulatory agencies might be inappropriate in some circumstances, such as in federally structured countries, at the same time a national agency would be required in order to establish multisectoral partnerships in support of road safety decision-making. It had been suggested that some of the proposed activities dealing with mass transit, highway safety audits, and vehicle inspection might be outside the purview of the health sector, and that those activities should be reshaped to focus on encouraging national health authorities to participate in or promote intersectoral collaboration for their implementation. (Further details may be found in the final report of the Committee's 148th Session, Document CE148/FR.) The Committee had adopted Resolution CE148.R11, recommending that the Directing Council adopt the plan of action following its revision to reflect the Committee's suggestions.

59. The Council welcomed the plan of action, noting that road accidents were one of the leading causes of death in the Region and highlighting the need for multisectoral action to address the problem. It was pointed out that road accidents caused not only death and suffering, but also entailed huge economic costs, estimated in one country at 2% of gross domestic product. As a result, financial resources allocated to other public health purposes had to be diverted to provide care for the victims of traffic accidents. It was also

pointed out that, while people who contracted a disease could not be blamed, those injured in road accidents in some cases brought the misfortune on themselves because they failed to comply with traffic and safety regulations, and it was suggested that if those who caused accidents were required to help cover their costs, including medical care for victims, more resources would be freed up to deal with other public health problems.

60. Several delegates described the actions being undertaken by their governments to enhance road safety at the national level. In many cases, countries had formulated 10-year national action plans to run concurrently with the Decade of Action for Road Safety 2011-2020, some of them based on the five pillars contained in the Global Plan for the Decade of Action. Such action plans included reviews of road traffic legislation; establishment of multisectoral road safety councils; overhaul of road systems, with improvements in safety features such as crash barriers, as well as the creation of safe areas for pedestrians and cyclists; creation of monitoring mechanisms to identify and investigate "hot spots" where repeated accidents occurred; and campaigns to encourage seatbelt use, the wearing of helmets, and the observance of speed limits and vehicle load limits.

61. Other steps taken involved reducing the permitted blood alcohol levels for drivers. In that connection, it was suggested that activity 2.5 of the proposed plan of action should be modified to recommend a zero limit for young drivers. Several delegates reported that breweries and other producers of alcoholic beverages in their countries were supporting stricter laws on drinking and driving.

62. It was recommended that the plan of action should include an indicator or objective relating to improvement of road infrastructure, including lighting and road surfaces, and an indicator on assistance to offenders through, for example, rehabilitative services, driving school, or substance abuse treatment programs. It was suggested that the advisory committee or lead agency referred to in activity 1.1 should also have the responsibility of promoting the establishment of multisectoral partnerships at regional level and that it should also be responsible for creating or advancing the operation of road safety observatories to provide accurate, timely, and clear information to assist in decision-making and priority-setting.

63. Dr. Luiz Augusto Galvão (Area Manager, Sustainable Development and Environmental Health, PASB) welcomed the various suggestions for enhancements to the plan of action. He thanked those countries that had contributed expertise to the process of developing the plan. Their experience and best practice would doubtless prove beneficial to other countries. He assured the Council that the Bureau recognized that the issue of road safety was closely related to those of urban health, noncommunicable diseases, and the harmful use of alcohol and that it planned to take an integrated approach to the implementation of the plans of action in those areas.

64. The Council adopted Resolution CD51.R6, endorsing the plan of action. The term "traffic accident" in the resolution was replaced with "road traffic injuries" in order to bring the language of the resolution into line with that of the plan of action and of the various resolutions of WHO and the United Nations on the subject.

Plan of Action to Reduce the Harmful Use of Alcohol (Document CD51/8, Rev. 1)

65. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had welcomed the Plan of Action to Reduce the Harmful Use of Alcohol, which was intended to facilitate implementation at the regional level of the Global Strategy to Reduce the Harmful Use of Alcohol, adopted by the World Health Assembly in 2010 (Resolution WHA63.13). The Committee had expressed particular appreciation for the plan's emphasis on technical support and capacity-building and had encouraged the Bureau to assist Member States in developing sufficient public health infrastructure to carry out the plan and in setting priorities for the implementation of activities. Several modifications to the plan had been recommended, particularly in relation to the activities proposed under its objective 3 (details may be found in the final report of the Committee's 148th Session, Document CE148/FR). The Committee had adopted Resolution CE148.R8, recommending that the Directing Council adopt a resolution calling on Member States to implement the Global Strategy through the regional plan of action.

66. The Directing Council commended PAHO's efforts to assist Member States in implementing the global strategy and expressed support for the proposed plan of action, noting the linkages between it and the plans of action on road safety and psychoactive substance use. Numerous delegates reported that their countries were already taking action to implement the global strategy, including the development of national plans of action, measures aimed at preventing the sale and marketing of alcohol to minors, regulations restricting the availability of alcohol, stiffening of penalties for driving while intoxicated, school-based prevention programs to discourage alcohol consumption among young people, and expansion of the availability of treatment options for persons with alcohol-use disorders. Delegates also provided data on alcohol consumption in their countries, with several noting that excessive drinking among women and young people was a growing problem.

67. The Council welcomed the revisions made to the plan in response to the Executive Committee's recommendations and suggested several additional modifications to both the plan and the proposed resolution on this item. Attention was drawn to the need for intersectoral action and for the involvement of the private sector in raising awareness about and preventing harmful alcohol use, and it was suggested that a reference to the private sector and to civil society organizations should be included in activity 1.1, which called for the involvement of other sectors in awareness-raising.

68. The need to tailor the activities envisaged under the plan to the socioeconomic and cultural context of each country was underscored, and it was suggested that "in the national context" should be added to paragraph 4(c) of the operative part of the proposed resolution. It was emphasized that the aim of the plan of action was to prevent the harmful use of alcohol, not alcohol use per se, and it was therefore suggested the word "harmful" should be inserted before "alcohol use" in several paragraphs of the plan. It was pointed out that the language of paragraph 5 of the proposed plan of action was inconsistent with the language of paragraphs 2 and 3 of the global strategy and it was recommended that the reference to a "beneficial impact" of alcohol be removed. It was also suggested that a recommendation aimed at promoting abstinence among pregnant women should be included in the plan. A request made during the 148th Session of the Executive Committee that activity 4.3 should be removed from the plan was reiterated. That activity dealt with trade-related issues, which were considered to fall outside the mandate and sphere of competence of PAHO.

69. Dr. Luiz Augusto Galvão (Area Manager, Sustainable Development and Environmental Health, PASB) said that that the plan of action would be revised in keeping with the Council's suggestions and that the language would be brought into consistency with that of the global strategy.

70. The Council adopted Resolution CD51.R14, approving the plan of action, as revised.

Plan of Action on Psychoactive Substance Use and Public Health (Document CD51/9)

71. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had welcomed the proposed Plan of Action on Psychoactive Substance Use and Public Health, which was intended to facilitate implementation of the regional public health strategy to address the health problems associated with the use of psychoactive substances, adopted by the Directing Council in 2010 (Document CD50/18, Rev. 1). The Committee had recommended that the Directing Council endorse the plan, which had been revised in the light of several changes suggested by Committee members. (Details may be found in the final report of the Committee's 148th Session, Document CE148/FR.) The Committee had also stressed the need to work closely with other partners, such as the Inter-American Drug Abuse Control Commission (CICAD) and the United Nations Office on Drugs and Crime, and had emphasized that the proposed activities would need to be tailored to the specific conditions and context of each country. The Committee had adopted Resolution CE148.R9, recommending that the Directing Council approve the Plan of Action.

72. The Directing Council reaffirmed support for the regional strategy and its public health approach to substance abuse prevention, treatment, and recovery and voiced solid support for the plan of action. It was felt that the plan of action provided clear guidelines

for implementing the strategy and embodied a balanced approach to reduction of both supply of and demand for psychoactive substances. The Council also welcomed the revisions made to the plan of action in response to the Executive Committee's suggestions. Like the Committee, the Council underscored the importance of coordination with CICAD and other partners. In particular, PAHO was encouraged to work closely with CICAD to ensure that follow-up of the plan of action was appropriately coordinated with the CICAD multilateral evaluation mechanism and that resources were shared in order to avoid duplication of work and reduce reporting requirements for Member States. A delegate requested clarification of the reference to unpaid health care providers in the indicator under objective 3.3 of the plan; specifically, he wondered how remuneration, or lack thereof, was relevant to the training of providers. The linkages between this strategy and plan of action and the Organization's work on harmful use of alcohol, tobacco control, road safety, and primary health care were highlighted.

73. A number of delegates noted that the strategy and plan of action were in line with their countries' approaches to the problem of psychoactive substance abuse and described initiatives under way at national level. Several delegates reported that their countries were seeing rising rates of substance use among children and young people, with some noting that studies had shown that children as young as 11 were using psychoactive drugs. The need to involve families in combating the problem was underscored, as was the need to approach substance abuse first and foremost as a mental health problem, seeking to reduce social stigmatization and respecting the human rights of affected individuals. The importance of community-based and primary health care approaches was also emphasized. Numerous delegates affirmed the need for intersectoral action to address the health and social problems associated with substance abuse and for international collaboration to combat drug trafficking.

74. Dr. Luiz Augusto Galvão (Area Manager, Sustainable Development and Environmental Health, PASB), responding to the question about unpaid health care providers, explained that the aim was to ensure training not just for health care professionals but also for family caregivers, members of charitable or religious organizations, and others who provided care and services for persons with substance use problems.

75. The Council adopted Resolution CD51.R7, endorsing the plan of action.

Strategy and Plan of Action on Epilepsy (Document CD51/10, Rev. 1)

76. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had welcomed the proposed strategy and plan of action on epilepsy and commended PAHO's efforts to draw attention to the gap between the number of people with epilepsy and the number receiving adequate care and to the need to combat stigma and discrimination against people with epilepsy. However, the Committee

suggested several ways in which the strategy and plan of action might be improved, for example by placing more emphasis on the issue of psychiatric comorbidity in persons with epilepsy and on epilepsy self-management strategies and by bringing the information on etiology into line with the classification scheme of the International League Against Epilepsy. The Committee had adopted Resolution CE148.R3, recommending that the Directing Council endorse the proposed strategy and plan of action, following their revision by the Bureau and the incorporation of the Committee's suggestions for improvement.

77. The Directing Council strongly supported the proposed strategy and plan of action, which would help to guide action at country level and enhance the availability and quality of treatment and services for persons with epilepsy and other neurological disorders. The activities and objectives envisaged under the plan of action were seen as ambitious but feasible. Delegates reported that their countries were already carrying out many of the proposed activities, including establishment of national epilepsy programs, training for health professionals and development of treatment standards and guidelines, procurement of diagnostic equipment, and initiatives aimed at improving the quality of life of persons with epilepsy. It was reported that the Dominican Republic, Guatemala, and Panama were collaborating in a joint technical cooperation project on integrated management of epilepsy.

78. The Council also welcomed the modifications made to the strategy and plan in response to the Executive Committee's suggestions. In particular, delegates applauded the greater emphasis on comorbidity of epilepsy and psychiatric disorders such as depression and psychosis, on the need to train primary health care workers to recognize such comorbidity, on a life-course approach to epilepsy prevention and treatment, on self-management strategies, and on integrated care involving all levels of the health system. It was stressed that persons with epilepsy should be managed mainly at the primary care level, but at the same time it was suggested that hospital seizure intervention units should be set up to provide urgent care for persons suffering epileptic seizures and that links should be established between such units and primary health care services in order to ensure continuity of care and follow-up of patients.

79. Several delegates observed that the stigma associated with the disease limited educational and employment opportunities for persons with epilepsy and had negative economic and social consequences for them and their families. They therefore applauded the emphasis in the strategy and plan of action on education and awareness-raising to reduce stigma and discrimination. Research was seen as necessary to assess the public health burden of epilepsy and provide necessary information with regard to prevention, early detection, treatment, education, and service needs and to promote effective care and support programs for people with epilepsy. In order to ensure consistency of definitions and methods and comparability of research findings, it was recommended that the

standard methods for epidemiologic studies and surveillance accepted by the International League Against Epilepsy[3] should be followed and that reference to those standards should be made under strategic area 4 of the strategy and plan of action. Some editorial improvements were also suggested.

80. Representatives of the International League Against Epilepsy and the International Bureau for Epilepsy drew attention to the high prevalence and the preventability of epilepsy in countries of the Region and commended PAHO's efforts to narrow the treatment gap for persons with the disease. Both expressed firm support for the strategy and plan of action and affirmed their organizations' commitment to collaborate in implementing them.

81. Dr. Luiz Augusto Galvão (Area Manager, Sustainable Development and Environmental Health, PASB) welcomed the expressions of support for the strategy and plan of action and said that Member States' suggestions would be incorporated into the document.

82. The Council adopted Resolution CD51.R8, endorsing the strategy and approving the plan of action as revised in the light of Member States' suggestions.

Strategy and Plan of Action on Malaria (Document CD51/11)

83. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had endorsed the proposed strategy and plan of action on malaria, which built on the Regional Strategic Plan for Malaria in the Americas 2006-2010, adopted by the 46th Directing Council in 2005 (Resolution CD46.R13). PAHO had been encouraged to coordinate its malaria prevention and control efforts with existing undertakings, such as the Amazon Malaria Initiative. It had been suggested that the thrust of the Organization's work should be to provide guidance to countries' malaria programs and assist them in setting appropriate goals for control, pre-elimination, or elimination of malaria. Several delegates had stressed the need for increased production of anti-malarial drugs, especially in malaria-endemic countries, in order to remedy the shortage of such drugs in the Region. The need to encourage pharmaceutical companies to supply antimalarials and other drugs at affordable prices through PAHO's procurement funds had also been emphasized. The Committee had adopted Resolution CE148.R5, recommending that the Directing Council endorse the strategy and approve the plan of action.

84. The Council applauded the enormous progress that had been made in reducing the malaria burden in the Americas under the Regional Strategic Plan 2006-2010, paid tribute

[3] Thurman, DJ et al. Standards for epidemiologic studies and surveillance of epilepsy. *Epilepsia* 2011 Sep;52 suppl s7:1-26.

to the legions of health care workers who had contributed to that success, and welcomed the new strategy and plan of action aimed at furthering progress towards the ultimate goal of eliminating malaria in the Region. Delegates reported significant progress in reducing malaria transmission in their countries in recent years, with several noting that they were on the road towards achieving or regaining malaria-free status. The need to remain vigilant in order to prevent the importation of cases or the resumption of transmission was stressed, as was the need to strengthen surveillance in order to detect and respond to malaria threats promptly and monitor malaria drug resistance.

85. It was also emphasized that malaria was an international problem and that cooperation between countries was therefore essential in order to prevent its spread across national borders. The Amazon Malaria Initiative and a project of the Andean Health Organization for malaria control in border areas were cited as excellent models for international collaboration. Attention was drawn to the need for a special focus on the Dominican Republic, Haiti, and Venezuela, without which it would be impossible to achieve the regional goals proposed in the strategy and plan of action. The Delegate of the Dominican Republic appealed for international support to complete the implementation his country's binational plan with Haiti aimed at eliminating malaria from the island of Hispaniola.

86. It was pointed out that while the strategy and plan of action recognized the importance of malaria diagnosis and the management of febrile illness cases, more emphasis on the importance of quality control and quality assurance for rapid malaria diagnostic tests, and on training for health care workers in their use, was needed. The importance of maintaining malaria diagnostic expertise in areas currently free of transmission was underlined. PAHO was urged to provide support for integrated vector control for the management of both malaria and dengue and to supply countries with more effective tools in support of vector control programs. In that connection, it was suggested that the plan of action should incorporate indicators relating to monitoring of the use and impact of insecticide-treated nets and indoor residual spraying, including support for periodic surveys to track ownership and use of nets and to measure their durability. The Organization was also encouraged to ensure that a gender perspective was incorporated in the development, monitoring, and evaluation of malaria policies and programs and in research and training activities, and countries were encouraged to pursue malaria control strategies that would ensure that vulnerable populations, including young children and pregnant women, were protected.

87. Delegates shared a number of lessons learned from their national malaria prevention and control efforts, including the importance of addressing gaps that could allow for a resurgence of the disease; maintaining surveillance capacity and formulating and updating strategic plans for malaria prevention and control, even in areas of low endemicity and areas in which malaria had been eliminated; engaging other sectors in the

fight against malaria; integrating malaria control into other, related environmental programs; mounting intense public education programs early on in the event of an outbreak; and treating cases and contacts promptly. The importance of epidemiological risk stratification, improved risk and ecological niche factor analysis, and community participation in vector control was also highlighted, as was the need to move from vertical approaches to decentralized, community-based ones. A primary health care approach to malaria was also seen as essential.

88. Dr. Marcos Espinal (Area Manager, Health Surveillance and Disease Prevention and Control, PASB) said that the Bureau intended to prepare a more detailed plan of action than the one contained in Document CD51/11 and would incorporate the various suggestions made by Member States, including those relating to the need for transborder cooperation and technical cooperation among countries, which was indeed imperative. With regard to the situation in the Dominican Republic, Haiti, and Venezuela, he noted that only in Haiti were malaria rates continuing to rise; the other two countries had shown a downward trend since 2005. Nevertheless, all three countries remained priorities. PAHO had placed staff in Haiti specifically to support malaria control efforts on Hispaniola.

89. The Council adopted Resolution CD51.R9, endorsing the strategy and approving the plan of action as revised in the light of Member States' suggestions.

Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity (Document CD51/12)

90. Hon. Beverley H. Oda (Minister of International Cooperation, Canada) introduced the plan of action, noting that she was speaking on behalf of Hon. Stephen Harper, Prime Minister of Canada and Co-Chair of the Commission on Information and Accountability for Women's and Children's Health. She observed that PAHO was playing an important role in moving the health agenda forward in the Americas. The thought and solid research behind PAHO's plan of action were to be highly commended. It was a plan that addressed known gaps and was results-focused while being well aligned with global commitments and strategies. It also went beyond the official Millennium Development Goals targets to address the major disparities concealed by national averages.

91. The past several months had seen a number of extremely significant events for maternal, newborn, and child health, including the Muskoka Initiative on Maternal, Newborn, and Child Health and the establishment of the Commission on Accountability and Information for Women's and Children's Health. Through those initiatives, the international community had pledged unprecedented resources to improving the health of women and children through better access to vital medicines, increased disease research, and enhanced training for community-level health workers. Making commitments was only a first step, however. In the end, what counted were results: How many lives were being saved? How many mothers were giving birth with a skilled attendant present? How

many newborns had made it through their first year? When countries could answer those questions and show progress, then they would know that they were truly making a difference.

92. The Commission on Information and Accountability for Women and Children's Health had brought together leaders from different countries and organizations to create a report which set out 10 action-oriented recommendations for specific actions to better match results achieved with resources committed, based on a cycle of monitoring, action, and review, intended to encourage greater transparency by all partners and to ensure that resources were spent wisely. Recommendations for countries included tracking a core set of 11 indicators, particularly for those Millennium Development Goals where performance was lagging most seriously; the creation of new systems to track whether donors were living up to their pledges, and the establishment of an independent Expert Review Group. Every country in the Americas and every country that worked with the Americas should be encouraged to look at the report and commit to adopting its recommendations, with a resolute focus on turning commitments into real action to deliver measurable results and outcomes.

93. She was pleased to announce that Canada was supporting a new three-year initiative with PAHO to strengthen basic primary health care systems and service delivery in Latin America and the Caribbean. The project would focus on three of the six components of a well functioning health system as identified by WHO, namely governance, health services delivery, and health information systems. Under the project, PAHO would work to establish coherence among national strategies, policies, legislation, and financing mechanisms, and would collaborate with national and local health care institutions to deliver services and to improve the collection of health information. Canada was committed to doing its part to meet the Millennium Development Goals by 2015, and as a neighbor in the hemisphere was proud to support PAHO in its work to improve the health of the peoples of the Americas.

94. Dr. Margaret Chan (Director-General, WHO) said that WHO was proud to be working with the Government of Canada to promote the importance of the health-related Millennium Development Goals, in particular Goal 5. It was important at the country level that results that actually improved the life of women were being demonstrated. There was no reason why women should continue to die while giving birth when the health professions knew how to prevent such deaths. But political leaders had to "walk their talk." Changes must be brought about in the social status and political participation of women. Violence against women must be stopped, as must child marriage. Those were issues that the international community must tackle, working in concert. The relative lack of progress on Millennium Development Goal 5 was a reflection of the huge inequity that women suffered. It was also a reflection of failures by many stakeholders: donors did not always keep their promises, for whatever reason, but at the same time those who were

receiving donated funds also sometimes failed to deliver on what they had committed to do.

95. There was no room for delay: every minute women were dying and all involved must never lose the sense of urgency. WHO, PAHO, and other United Nations agencies would all do their part, but they needed financial support from countries and organizations. By the same token, countries and organizations that received support must deliver on the results they had promised. Without such dual commitment and solidarity, it would not be possible to improve the health of women and children.

96. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had examined an earlier version of the proposed plan of action. As several members of the Committee had considered that the plan of action suffered from serious weaknesses, and also because it had been made available only one week before the session, it had been suggested that a group of technical experts should be established to improve it prior to its submission to the Directing Council. It had also been recommended that the plan of action's proposed budget of $30 million should be reviewed with an eye to its feasibility. Attention had been drawn to a number of specific shortcomings in the document, and also to some broad policy issues that seemed insufficiently developed. (Further details may be found in the final report of the Committee's 148th Session, Document CE148/FR.) The Committee had decided to adopt Resolution CE148.R14 recommending that the Directing Council endorse the plan of action, with the understanding that it would be revised in the light of Member States' comments and suggestions. Electronic consultations for that purpose had been held during the month of July.

97. The Council welcomed and supported the revised plan of action, which delegates felt would make a valuable contribution towards ensuring that all countries in the Region met Millennium Development Goal 5 and would also chart a course for continued action to improve maternal health after the MDG deadline of 2015 had come and gone. The plan's alignment with the Global Strategy for Women's and Children's Health and with the recommendations of the Commission on Information and Accountability for Women and Children's Health was also welcomed. Support was expressed for the plan's emphasis on ensuring the availability of high-quality health services for women, irrespective of their ability to pay, and on reducing the financial, social, and geographic inequalities that hindered women's access to such care. Some delegates expressed appreciation that changes they had called for during the Executive Committee session had been incorporated, while others drew attention to some requested changes that had been overlooked. In particular, it was reiterated that the plan should highlight the need for access to services to prevent HIV infection and treat HIV-positive pregnant woman. Given that the Organization's approved budget for 2012-2013 (see paragraphs 27 to 39 above) was lower than the figure presented to the Executive Committee, it was again suggested

that the feasibility of raising the sum envisaged for the plan's implementation should be reassessed.

98. Attention was drawn to the link between noncommunicable diseases and maternal health, and it was suggested that the plan of action should incorporate activities and interventions aimed at addressing risk factors such as diabetes, hypertension, and obesity, as well as genetic disorders such as sickle-cell disease, that could cause complications during pregnancy. It was also pointed out that the economic recession had obliged many women to continue working throughout their pregnancies, often neglecting their antenatal care. Several delegates noted a link between pregnancy—particularly unplanned pregnancy—and higher rates of domestic violence. The importance of raising awareness among and educating men about their role in improving maternal health was emphasized, as was the need to make society as a whole aware that, while natural and to be welcomed, pregnancy and childbirth had the potential for severe morbidity if not managed well.

99. Delegates described activities in their countries to reduce maternal mortality. Several of them reported that their governments had national plans of action in line with the proposed regional plan. Important features of those national plans included enhancing information-gathering, in some cases through the creation of an observatory, to improve policy-making and the assignment of resources and personnel, and mechanisms for immediate reporting of maternal deaths to enable causes to be determined and lessons to be learned quickly. It was reported that one country had established a system of radio communication and emergency transport for rapid reaction to obstetric emergencies, while another had established a countrywide system of maternal care facilities so that when complications developed women could be referred rapidly to the location with the required expertise.

100. In some countries, stress was being laid on increased training and capacity-building for health workers, including traditional birth attendants. In that connection, the human resources shortages created by emigration of reproductive health workers was highlighted. It was also suggested that more medical personnel should be available in health care facilities in the evenings and at night, when a higher proportion of maternal deaths tended to occur, precisely because of lack of highly trained staff during those periods.

101. A representative of the International Federation of Medical Students' Associations also spoke in support of the plan of action, underlining the importance of culturally sensitive methods of delivering reproductive health care.

102. Dr. Gina Tambini (Area Manager, Family and Community Health, PASB) thanked the delegates for their comments, which were an encouragement to the Bureau to continue working on the topic. She also took note of suggested changes to the proposed resolution, as well as of the request to reexamine the feasibility of the proposed budget for

implementation of the plan of action. She appreciated the comments on the linkages drawn between pregnancy and noncommunicable diseases. She also expressed appreciation to the many individuals and organizations who were active in promoting maternal health and in particular reducing unsafe abortions. As Dr. Bachelet had pointed out, there was ample knowledge of what needed to be done to reduce maternal mortality. Now it was necessary to disseminate that knowledge and to share best practices. To that end, PAHO was planning a symposium in conjunction with International Women's Day.

103. The Director said that reducing maternal mortality would require not only a whole-of-government approach but also, on the part of PAHO, a whole-of-Organization one. She called on all Member States in the Region to set the goal of zero maternal mortality, because, as numerous speakers had pointed out, with the current state of knowledge it was not acceptable that women continued to die in childbirth.

104. During the Council's discussion of the proposed resolution on this item (contained in Document CD51/12), it was suggested that the goal of providing maternal health services free of charge to the most vulnerable populations might be too much of a burden for some economies, and that the idea should be removed from the resolution. However other delegates felt that it should be kept, as an aspiration to strive for. Some delegates suggested that a phrasing such as "to the extent possible" might be useful. The Director suggested that the English version might read "and to also consider providing these services free of charge for the most vulnerable populations." It was also suggested that some mention should be made of the involvement of men in improving the health of women.

105. After examining a new version of the proposed resolution incorporating amendments proposed by various Member States, the Council adopted Resolution CD51.R12, endorsing the plan of action.

106. The Council also expressed gratitude to the members of the Panel on Safe Motherhood and Universal Access to Sexual and Reproductive Health (see paragraphs 117 to 130 below, which took place in conjunction with this item, and welcomed the opportunity to hear the panelists' informative and inspiring ideas on how to improve women's health and end the scourge of maternal mortality.

Strategy and Plan of Action on eHealth (Document CD51/13)

107. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had welcomed PAHO's efforts to promote the use of health information technology as a means of broadening access to health services, and had voiced support for the proposed Strategy and Plan of Action on *eHealth*. The Committee had also endorsed the proposal to establish a forum of experts to promote the use of information and communications technologies for public health applications. The

strategy's recognition of the intersectoral nature of *eHealth* had been applauded, and the importance of support and collaboration between different sectors on issues of infrastructure, financing, education, innovation, and interoperability had been highlighted. At the same time, however, it had been stressed that the development of *eHealth* must be led and overseen by ministries of health, not by the information technology industry or other parties with commercial interests. The Committee had underscored the need to work within existing partnerships and initiatives rather than creating new ones and had recommended that some of the proposed indicators for the plan of action be refined and clarified (details may be found in the final report of the Committee's 148th Session, Document CE148/FR). The Committee had adopted Resolution CE148.R4, recommending that the Directing Council endorse the strategy and approve the plan of action.

108. A video illustrating the development and benefits of *eHealth* was then projected. In the ensuing discussion, Member States welcomed PAHO's efforts to promote and strengthen the use of information and communications technologies in order to expand access to health services and improve the quality of those services, and voiced firm support for the proposed strategy and plan of action, while also noting that they would need to be adapted to the situation and needs of each country. Numerous delegates remarked that the use of telemedicine and other communications technologies could help to extend health services to remote populations, thus reducing inequities in access to health care. The value of such technologies for archipelagic countries such as those in the Caribbean was also noted. The linkage between the strategy and plan of action on *eHealth* and larger efforts to strengthen health information systems was highlighted.

109. Delegates reported on their countries' *eHealth* initiatives, noting that their national activities were fully in line with the strategic areas and objectives proposed under the regional strategy and plan of action. The activities being pursued included the formulation of national policies and strategies for the use of information and communications technology in the health sector, the development of health legislation databases, digitization of medical records, the establishment of virtual health libraries and distance-learning campuses, and the use of social networks and mobile telephony to transmit health information ("*mHealth*"), including information on disease outbreaks. It was pointed out that mobile devices were one of the most promising *eHealth* technologies, since mobile phone service was widely available in most countries of the Region, even those with limited Internet connectivity and even in remote areas. Many delegates stressed the importance of interoperability and the need for seamless integration and transfer of patient information between health care providers in order to improve patient care and prevent medical errors and duplication of services. The need to be able to capture health information from private health care providers was highlighted, as was the need to develop protocols and regulatory frameworks for the exchange of patient data between

countries, since in some parts of the Region it was common for patients to travel to neighboring countries to receive medical care.

110. Like the Executive Committee, the Council underscored the need to work within existing *eHealth* initiatives, such as a telemedicine program of the Amazon Cooperation Treaty Organization, and urged PAHO to support such initiatives in order to avoid duplication and fragmentation of efforts and waste of resources. The Council also emphasized the importance of sharing experience and best practice and called on PAHO to support such exchanges. The Delegate of Mexico said that her country had a national center of excellence in health technology (Centro Nacional de Excelencia Tecnológica en Salud) that had developed courses and workshops on telemedicine and telehealth, which it would be pleased make available to other countries electronically through PAHO.

111. It was pointed out that the functions of the regional laboratory proposed under objective 1.4 appeared to overlap with those of the technical advisory committee proposed under objective 1.2, since both mechanisms would monitor and evaluate *eHealth* policies in the Region, and it was felt that there could be stronger linkages between the two, as well as linkages with the virtual health libraries proposed under objective 4.2.

112. The capacity-building component of the strategy was seen as very important, and support from PAHO was sought in that and other areas. In particular, Member States requested assistance in strengthening their health information and communications infrastructure, enhancing the technological skills and expertise of health sector personnel, evaluating health information technologies, and establishing standards for health information technology and for ensuring privacy and maintaining the confidentiality of patient information. One delegate suggested that guidelines for health information governance should be drawn up in the framework of PAHO's *eHealth* initiative. The same delegate sought advice on experiences with the use of open-source alternatives versus proprietary software, in particular their pitfalls and advantages for developing countries.

113. Mr. Marcelo D'Agostino (Area Manager, Knowledge Management and Communication, PASB) observed that one of the ideas inherent in the concept of *eHealth* and in the broader concept of the "information society" was that of living without borders, an idea that had been alluded to by several delegates, as had the related idea of interoperability. He also noted that many delegates had stressed the importance of training, and pointed out that training must be provided not only for health professionals, but also for patients. For that reason, PAHO was placing great emphasis on digital literacy training. He thanked Member States for their comments and suggestions, which would be incorporated into the strategy and plan of action, and assured the Council that the Organization would continue to support Member States in assessing health information and communications technologies and strengthening their technological infrastructure and would also continue to support existing *eHealth* initiatives in the Region.

114. Dr. Najeeb Al-Shorbaji (Director, Department of Knowledge Management and Sharing, WHO) welcomed the various *eHealth* initiatives described by delegates and affirmed that WHO would do its utmost to support the implementation of the regional strategy and plan of action. He said that WHO viewed *eHealth* as means of improving equity and universal access to health services and health information, as well as a way of enhancing the efficiency and quality of health services and reducing their cost, all points that had emerged from the Council's discussion. WHO was supporting the efforts of the regional offices mainly by building an evidence base for *eHealth*, the aim of which was to demonstrate the impact of *eHealth* interventions on health outcomes so that decision-makers and potential donors would be convinced that investment in *eHealth* projects was worthwhile. The Organization's Global Observatory for eHealth provided a means of sharing knowledge, information, and lessons learned among Member States. WHO was also supporting the development and implementation of interoperability standards for *eHealth*.

115. The Director, noting the Council's calls for PAHO to coordinate its *eHealth* activities with those of other organizations, said that one of the Organization's main objectives in developing the strategy and plan of action had been to ensure that the views and needs of the health sector were reflected in the *eGovernment* initiatives of the United Nations Economic Commission for Latin America and the Caribbean, the World Bank, the Inter-American Development Bank, and other institutions, as well as those of the various regional integration groups. In particular, PAHO wished to ensure that the needs of health ministries in countries with limited economic and technological capacity were taken into account.

116. The Council adopted Resolution CD51.R5, endorsing the strategy and approving the plan of action on *eHealth* as revised in the light of Member States' suggestions.

Panel on Safe Motherhood and Universal Access to Sexual and Reproductive Health (Document CD51/14, Rev. 1)

117. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had heard a report in June on the objectives of and proposed program for the Panel on Safe Motherhood and Universal Access to Sexual and Reproductive Health, and had made several suggestions regarding topics that should be addressed by it. One was the issue of therapeutic abortion and the misconceptions and biases surrounding it, which might stand in the way of medical interventions that could save many lives. Another was the need for more flexible sexual and reproductive health indicators that would reveal disparities and inequities, both between countries at the national level and within them at the subnational level, and that would take account of the specific circumstances of different countries.

118. The President introduced the panelists: HRH Infanta Cristina of Spain (Director, International Cooperation Area, La Caixa Foundation and President, Instituto de Salud Global, Barcelona (ISGlobal)); Dr. Michelle Bachelet (Under-Secretary-General and Executive Director, UN-Women); Dr. Laura Laski (Chief, Sexual and Reproductive Health Branch, United Nations Population Fund (UNFPA)); Dr. Aníbal Faúndes (Chair, Working Group for the Prevention of Unsafe Abortion, Latin American Federation of Obstetrics and Gynecology Societies); Dr. Margaret Chan (Director-General, WHO); and Dr. Mirta Roses (Director, PASB).

119. The Director noted that over the past 20 years maternal mortality had been reduced by around 30% for the Region as a whole, but the decrease had been uneven across countries and within countries and insufficient to achieve Millennium Development Goal 5 in the Americas by 2015. Approximately 95% of maternal mortality in Latin America and the Caribbean was due to causes that were preventable with existing knowledge. Many maternal deaths were related to unwanted pregnancy, to which a frequent contributing factor was limited access to contraception. Restrictive legislation on abortion was another contributing factor, as many women resorted to unsafe abortion. Essential obstetric services were not available to all women and were often expensive, of poor quality, or not culturally acceptable to women, in part because appropriately trained staff were lacking.

120. One year earlier, PAHO, in conjunction with the Regional Working Group for the Reduction of Maternal Mortality, the La Caixa Foundation, and other organizations, had called on the countries of the Region, within the framework of the Safe Motherhood Initiative, to redouble efforts to meet the targets for MDG 5. Together, those institutions were supporting efforts to ensure access to free and comprehensive sexual and reproductive health services; to improve the quality of prenatal, delivery, and postpartum care; to reduce unsafe abortion; and to address gender violence.

121. HRH Infanta Cristina of Spain said that the La Caixa Foundation was pleased to have been able to participate in and support the Safe Motherhood Initiative with a view to reducing maternal mortality, which, despite the progress made, remained unacceptably high. She gave an overview of the work of the La Caixa Foundation aimed at improving maternal and child health, noting that much of that work focused on social mobilization, education, and awareness-raising and underscoring the need to promote the idea that investment in safe motherhood was an investment not only in women's health but also that of their families and communities. She highlighted the creation of the Instituto de Salud Global (ISGlobal), an initiative of the La Caixa Foundation, which among other lines of work was active in reproductive and neonatal health. The institute was committed to the United Nations Secretary-General's Global Strategy for Women's and Children's Health and was promoting coordination of research in that area among European academic bodies. She welcomed events such as the panel discussion, which were

important for strengthening regional and national commitments to improve the health of the most vulnerable, and to demonstrate leadership in pointing the way forward.

122. Dr. Bachelet saw reason to be optimistic about the prospects for improving the health situation of women in the Region. Trends with regard to contraceptive use and antenatal care coverage, for example, were encouraging, and the Safe Motherhood Initiative was serving as an excellent platform for shared work, with partnerships growing up among governments, communities, civil society, and the private sector. Moreover, the ways to avoid maternal deaths were now well known, making the reduction of maternal mortality no longer a matter of technical knowledge or discovery, but of political will. Nevertheless, much remained to be done in order to ensure access to contraceptives and to antenatal care and skilled attendance at birth.

123. She pointed out that most of the statistics on maternal mortality were averages, which masked profound inequities within the Region, which in the case of women were compounded by the inequity that they already suffered in some countries just by being female. Women needed to be empowered in the sense of gaining opportunities and rights and becoming a force to be considered when decisions were being made. To that end, economic empowerment was central: women who had their own income could hold their own in political debate and could devote more to the health, education, and food security of their families, thus advancing the interests of their families and their communities as well as their own. Hence, there was a need to link the fight against maternal mortality with the fight to ensure the rights and empowerment of women.

124. Dr. Laski, noting that she was speaking on behalf of Marcela Suazo, Director of the UNFPA Regional Office for Latin America and Caribbean, stressed that family planning was one of the most cost-effective interventions for reducing maternal mortality and morbidity, and that it also contributed to improving the situation of poverty in families and to empowering women, as well as playing a major role in preventing unsafe abortions. She pointed out that, although the Region was making progress with regard to family planning, it was primarily measuring data relating to women who were married or in a relationship, and overlooking the situation of sexually active adolescents in the Region, the majority of whom commenced contraceptive use after the birth of their first child. Nevertheless, the Region's adolescent fertility rate remained very high, second only to sub-Saharan Africa, with marked variations among between countries. Traditionally, education had played an important role in preventing unwanted pregnancy and its consequences, as evidenced by the fact that girls with higher levels of education tended to experience fewer unintended pregnancies; however, statistics were now showing that the beneficial effect of education seemed to be lessening. To tackle those inequities and gaps, it was necessary to focus on specific disadvantaged groups in promoting contraceptive use. It was also essential to ensure access to comprehensive sexual education, especially for adolescents.

125. Dr. Faúndes noted that while mortality from abortion had gone down sharply, the Region still had one of the highest rates of unsafe abortion in the world (10 times that of the European Region and second only to sub-Saharan Africa). He cited statistics showing that the rate of abortions performed was 6 to 8 times higher in countries where abortion was illegal than in countries where it was not only legal but readily accessible. The difference arose from the fact that the countries that had legalized abortion were also those that provided sexual and reproductive health counseling and access to modern contraceptive methods.

126. The first step towards lowering the number of unsafe abortions was prevention of unplanned and unwanted pregnancy, which would require comprehensive family planning programs. He cited the example of Chile, which had seen a downward trend in abortion when contraceptives were made available through its national health service. A second area of action was ensuring that abortions that were legal were also safe. In some countries of the Region, even where abortion was permitted under certain circumstances, women were often prevented from terminating a pregnancy. There was a fear in those countries that facilitating abortions, or making legal changes to permit them, would lead to the use of abortion as an alternative to contraception. But experience had shown that, although there was generally a slight rise in abortions immediately after they became legal, the numbers then began to drop steadily. That apparent paradox could be explained by the fact that once abortion was being perform by legitimate health care providers, women who received abortions were also being provided with family planning counseling and contraceptive services.

127. The third area of action was preventing deaths and severe morbidity from unsafe abortion by ensuring that women who sought medical care for complications following an abortion did indeed receive the care they needed. That would mean changing discriminatory attitudes on the part of health care providers. The fourth area of action involved post-abortion counseling and provision of information on family planning with a view to preventing further unintended pregnancies and thus preventing repeat abortions.

128. Dr. Chan said that the discussion had been a frank and realistic exchange with no illusions, and yet had offered some good reasons for optimism. The speakers had pointed out what needed to be done and identified the range of barriers to be overcome. Striving for universal access to the full range of sexual and reproductive health and safe motherhood services meant addressing inequities in access to care and understanding that the barriers to better health for women and girls were not primarily medical and technical, but social, cultural, and political.

129. For far too long, safe motherhood had been an issue talked about with great emotion and rhetorical passion but with few or very limited results. Decades had passed with hardly a dent in that monstrous figure of half a million maternal deaths. Finally, the

numbers had begun to decline, particularly in the Region of the Americas. However, much of the work under way was proceeding on the basis of inadequate information: too many countries did not have reliable cause of death statistics, leaving health programs to base their strategies on crude estimates. Implementation of the Global Strategy for Women's and Children's Health would help to address that problem. Financial pledges for the Strategy had continued to build on the initial commitment of about $40 billion, which was an astonishing figure against the present backdrop of financial austerity. Transparency and accountability in the use of the funds donated would be a key factor in garnering support for the major effort needed to improve the health of women and children, reduce inequities by addressing social determinants of health, and strengthen the various important components of health systems and services.

130. Following the panel presentations, the Council considered the Regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity (see paragraphs 90 to 106 above).

Roundtable on Antimicrobial Resistance (Document CD51/15, Rev. 1 and Add. I)

131. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had welcomed the selection of antimicrobial resistance as the topic for the Council's roundtable, and had suggested several issues that should be considered by the discussion groups, including: current and future availability of antibiotics; quality control and rational use of antibiotics; strengthening of hospital pharmacy services and national laboratory networks; enhancement of surveillance, prevention, and control of hospital-acquired infections; and improvement of drug dispensing practices.

132. A keynote address introducing the roundtable topic was given by Dr. Patrick W. Kelley, Director of the Board on African Science Academy Development of the Institute of Medicine at the United States National Academies. Dr. Kelley observed that misuse of antimicrobials promoted drug resistance and degraded public health. Self-medication without prescriptions was common in many places in the Region, but unfettered use of antibiotics was a recipe for poor individual and global health. The remedy lay in education and awareness-raising, to enable those who misused and overused antibiotics to understand the dangers. There was a persistent assumption that the pharmaceutical industry would come to the rescue, constantly producing new antibiotics to replace those that had developed resistance. However, there was increasing difficulty in providing such new and more powerful antibiotics. Drug development was extremely expensive, which meant that if a company had the opportunity to develop drugs for chronic noncommunicable diseases that could be taken every day for decades, it had much less incentive to develop antibiotics that might be taken only for a week or two.

133. Additionally, substantial quantities of counterfeit antimicrobials could penetrate the borders of even the most vigilant countries. A substandard antibiotic that fell short in potency would promote the emergence of resistant organisms wherever the global supply chain took it, as well as causing more difficult clinical courses for patients, or even death. A further complication was the issue of intellectual property rights. Most problems to do with falsified medicines were public health issues unrelated to trademark infringement, but the intellectual property issues had dominated the international negotiations to improve access to safe and effective drugs, leading to deadlock. Contributing to the problem was the use of antibiotics as growth promoters in food animals, resulting in the presence of resistant bacteria in foods in both European and American supermarkets.

134. In Europe, drug-resistant bacteria caused about 400,000 infections and over 25,000 deaths every year, at a cost, in terms of days spent in the hospital, of at least 1.5 billion euros. The figures for the Americas would undoubtedly be similar. And as elderly populations grew in size worldwide, spending more time in the hospital receiving care for noncommunicable diseases, the economic burden of drug-resistant hospital-acquired infections would rise. A sustainable and effective response demanded a whole-of-government approach, involving ministries of health, agriculture, education, and finance, with the public health community taking a lead role in advancing hospital infection control programs based on solid surveillance, epidemiologic analysis, clinical policy, hygiene, and education.

135. The PAHO Antimicrobial Resistance Technical Advisory Group had reviewed laboratory performance and had found uneven results, which had highlighted the importance of investing in improved diagnostics, data systems, quality assurance systems, laboratory and epidemiological training, and periodic external accreditation. Without good laboratory work, much money would be wasted, owing to weak surveillance and trial-and-error selection of drugs. It was also important to ensure that clinicians adhered to evidence-based guidelines. Institutionalized quality-of-care peer review should be considered in every hospital.

136. Fortunately, the excellent work of PAHO had clearly defined the issues to be addressed across the health spectrum, and the Region was now well-positioned to develop and implement national strategic plans for quality-assured surveillance and control of antimicrobial resistance. The next steps would take some courage and mutual encouragement. States would need to consider some potentially unpopular interventions to better control access to antibiotics, as well as popular education on antibiotic use, in order not only to achieve quality patient care, but also to preserve for as long as possible the miracle of antibiotics that had been foundational to global health for the past 70 years.

137. Following Dr. Kelley’s remarks, the Council broke into three groups, concentrating, respectively, on the social and economic impact of antimicrobial resistance,

epidemiological information and its potential use, and a multifaceted approach to contain antimicrobial resistance.

138. Dr. Marcos Espinal (Area Manger, Health Surveillance and Disease Prevention and Control, PASB) presented the report of the findings of the different discussion groups, described in Document CD51/15, Rev. 1, Add. I. He noted that the groups had observed that antimicrobial resistance posed a threat to health that entailed a high social and economic cost and demanded a multisectoral response. Strengthening governments' steering function had therefore been seen as key to success. In practice, that response began with a legal, political, and regulatory framework that encompassed all aspects of the antimicrobial use cycle, laboratory surveillance of resistance, and the control of health care-related infections. Implementation of that framework should involve the sharing of successful experiences and best practices and cooperation among Member States.

139. The Council requested the Bureau to prepare a regional strategy and plan of action for the containment of antimicrobial resistance that would serve as a guide for national policies and operating plans and would be presented at the next meeting of the Governing Bodies.

Administrative and Financial Matters

Report on the Collection of Quota Contributions (Documents CD51/16 and Add. I)

140. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had been informed that as of 20 June 2011 the combined collection of arrears and current-year assessments had totaled $54.7 million, as compared to $49.3 million in 2010 and $38 million in 2009. Collection of current-year assessments had amounted to $31 million, or 32% of the total amount due for 2011. The Committee had also been informed that two Member States had been potentially subject to the voting restrictions envisaged under Article 6.B of the PAHO Constitution, and that the Bureau had encouraged those Member States to take the necessary steps in order to retain their right to vote during the Directing Council.

141. Ms. Linda Kintzios (Treasurer and Senior Advisor, Financial Services and Systems, PASB) thanked Member States for their continuing efforts to pay their assessed contributions in a timely manner, thereby ensuring a predictable cash flow to the Organization. She explained that Document CD51/16 reflected receipts as of 31 July 2011, and that its Addendum I contained updated data on payments received up to 16 September 2011. Since that date, PAHO had received an additional payment of $1,348,981 from the Government of Mexico, which had thereby paid its 2011 assessment in full.

142. Total assessed contributions received by 16 September 2011 amounted to $85 million, as compared to $81 million in 2010, $69 million in 2009, and $53 million in 2008. As of 16 September 2011, collection of contributions for current year assessments amounted to $57.3 million, which represented only 58% of the $98.3 million total assessment for 2011. A total of 20 Member States had paid their 2011 assessments in full, five had made partial payments, and 14 Member States had not yet made any payments toward their current year assessments.

143. As of 1 January 2011 the total arrears of assessed contributions for the years prior to 2011 had equaled $29.7 million, with 90% of that amount relating to 2010. Payments received on those arrears by 16 September 2011 amounted to $27.7 million, or 93% of total arrears, with the outstanding balance amounting to only $2 million. As of the opening of the Council, no Member State was subject to the voting restrictions envisaged under article 6.B of the PAHO Constitution.

144. In the discussion that followed Ms. Kintzios' remarks, it was noted that Member States' payment of their quota contributions reflected the major commitment that they felt to public health issues, which motivated them to keep up with their payments even at a time of financial austerity. In turn, the Council recognized the efforts being made by the Director and staff of the Bureau to make the optimum use of the resources contributed.

145. The Director expressed her gratitude to Member States for continuing to pay their contributions at a time of serious financial constraint.

146. The Council took note of the report on the collection of quota contributions.

Financial Report of the Director and Report of the External Auditor for 2010 **(Official Document 340)**

147. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had heard presentations on the Financial Report of the Director by Ms. Sharon Frahler, Manager of the Area of Financial Resources Management, and Ms. Helen Freetenby, representing the External Auditor. Ms. Frahler had summarized the content of the Financial Report, noting that the Organization's total financial resources continued to show significant growth, reaching an accrued total of $932.6 million in 2010, as compared with cash receipts of $731 million in 2009. Expenditures for the year had totaled $927.3 million, and the Organization had thus ended 2010 with a net excess of revenue over expenditure of $5.3 million.

148. Accrued quota contributions for 2010 had totaled $98.3 million and accrued miscellaneous income, $5.2 million. In addition, the Organization had received and implemented a total of $200 million in trust funds under multi-year agreements for public health programs, including $82.8 million received from governments for externally

funded projects, $106.8 million for internally funded projects, and almost $10 million for emergency response efforts in Chile and Haiti.

149. Ms. Freetenby had informed the Committee that the External Auditor had found no weaknesses or errors considered material to the accuracy or completeness of the Organization's accounts and had therefore issued an unqualified audit opinion. She had congratulated the Organization on its successful implementation of the International Public Sector Accounting Standards (IPSAS), while noting that doing so had made the timetable for completing the audit very tight. She had also drawn attention to the need to upgrade or replace some key financial accounting and management information systems so that the Organization could derive full benefit from the IPSAS, and had noted the need for a solid risk management framework.

150. The Executive Committee had welcomed the information on the Organization's strong financial position, and its receipt of an unqualified audit opinion. The high quality of the Organization's accounts, and the greater transparency provided by the IPSAS, had been viewed as particularly important in light of the continuing growth in the resources managed by the Organization. The Committee had encouraged the Bureau to give close attention to the issues raised by the External Auditor and to its 12 recommendations, which could be found in Official Document 340. Attention had been drawn to the recommendations on frequent updating of project data to be sure that management information was current, and on developing an approach to deal with the underfunded liabilities relating to staff benefits. Noting that the External Auditor had expressed concern about some possibly inappropriate procurement activities, the Committee had suggested that the rules should be tightened.

151. The Directing Council commended the Organization on its success in preparing IPSAS-compliant financial statements and in securing an unqualified audit opinion on them. It noted that, in line with the External Auditor's recommendation, the Bureau still needed to address certain information technology risks in order to ensure that essential business and reporting needs were met, and to continue monitoring the implications for the Organization of the staff health insurance plan that it shared with WHO.

152. Concern was also expressed concerning a small number of questionable procurement contracts, to which attention had been drawn in the External Auditor's report, and the Bureau was urged to implement the External Auditor's recommendation that it carry out a formal risk assessment for high-value procurement contracts and contracts in new areas of activity. The External Auditor's comments on the updating of the PASB Management Information System were noted, and the Bureau was asked to provide reports confirming that the implementation of the new system had addressed the risks highlighted. The External Auditor's concerns regarding the underfunded liabilities for Bureau staff's retirement entitlements and after-service health care were also noted. It

was also recalled that the wish had been expressed at the Executive Committee meeting to have a document detailing the different remits of the various oversight and audit functions covering the Organization.

153. Ms. Sharon Frahler (Area Manager, Financial Resources Management, PASB) expressed appreciation for the Council's acknowledgement of the work that had been necessary to implement the IPSAS fully and on time, pointing out that as an early implementer, the Bureau had become a source of information to which other bodies in the United Nations system turned for guidance and help with their own IPSAS implementation processes. Turning to the issue of the staff health insurance plan, she said that as the plan had been shared with WHO for years, it was proving difficult to divide up the assets that the two organizations had contributed. One factor was that while PAHO had implemented the IPSAS in 2010, WHO would not do so until 2012, and consequently had not felt the same urgency to resolve the issue. The two organizations were working towards a mutually acceptable solution, and the issue was not expected to cause any difficulty in closing the current year's accounts.

154. While the External Auditor had expressed misgivings about two specific procurement operations, the Bureau had been able to provide reassurance that the procurements had indeed been carried out within the Organization's mission. The incident had reminded the Bureau of the importance of ensuring that every part of the decentralized Organization was aware of the rules on procurement, and from now on, if a procurement request was received that appeared not to adhere to those rules, it would be immediately rejected.

155. On the matter of risk assessment, the Bureau was moving forward, and hoped to have a robust solution ready for presentation to the Subcommittee on Program, Budget, and Administration in March 2012. A paper would also be prepared for the Subcommittee on the issue of the underfunded liabilities for staff entitlements.

156. The Director concurred that the previous financial period had been a critical one, as the first time that the Organization's financial statements had been prepared in accordance with the new accounting standards. She was grateful for the work contributed by all to achieve that success and noted that in a decentralized organization such as PAHO, efforts had to be made in the country offices and other locations, in the ministries of health supplying the data, as well as at Headquarters.

157. The Council took note of the report.

Appointment of the External Auditor of PAHO for 2012-2013 and 2014-2015 (Document CD51/17)

158. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had been informed in June that three nominations had been received for the position of External Auditor: the Government of Bolivia had nominated the Controller and Auditor General of India; the Government of Panama had nominated the Spanish Court of Audit; and the Government of Peru had nominated the Supreme Audit Institution of Germany. An additional nomination had been received from the Government of Jamaica, but as it had arrived after the deadline it had not been eligible for consideration.

159. Ms. Linda Kintzios (Treasure and Senior Advisor, Financial Services and Systems, PASB) added that in accordance with Regulation 14.1 of the Financial Regulations, the Pan American Sanitary Conference or Directing Council was to appoint an External Auditor of international repute to audit the accounts of the Organization. The duration of the appointment was at the discretion of the Conference or Council, but previous practice had been to appoint the External Auditor for two bienniums. She added that the External Auditor must be experienced in the provision of professional auditing services under the International Public Sector Accounting Standards, and must have experience of working in a multicultural environment, with the ability to provide appropriately qualified staff having both Spanish and English language capabilities.

160. A note verbale had been sent to all Member States in October 2010, describing in detail the process to be followed in nominating an External Auditor. The deadline for the receipt of nominations had been 30 April 2011, subsequently extended by the Director to 1 June 2011. Member States had been encouraged to review the bodies auditing other United Nations agencies, funds, and programs, as well as other supreme audit institutions, taking note that the External Auditor of PAHO did not have to be from the Region of the Americas. Additionally, since PAHO was not specifically required to appoint a national audit entity as its External Auditor, Member States had been encouraged also to consider the possibility of nominating a private-sector firm.

161. She confirmed that three nominations had been received, as described by the Representative of the Executive Committee, but noted that the submission concerning the Controller and Auditor General of India had been incomplete, which had rendered it ineligible for consideration by the Council, leaving only two candidates: the Supreme Audit Institution of Germany and the Spanish Court of Audit.

162. Mr. Michael Schrenk, representing the Supreme Audit Institution of Germany, gave a presentation on his institution's offer of service, and quoted an annual audit fee of $277,000. Mr. Ciriaco de Vicente, representing the Spanish Court of Audit, also gave a presentation on his institution's offer of service, quoting an annual audit fee of $240,000.

163. Questions were asked regarding the Spanish Court of Audit's approach to Information Technology auditing, about its approach to and experience with IPSAS, and about its plans for allocating person-months to the PAHO audit. Mr. de Vicente said that his institution concentrated on computer system security, accessibility, reliability, and internal consistency and that the Court had experience with the IPSAS, as well as with other sets of standards.

164. A vote was taken by secret ballot. The representatives of Puerto Rico and Brazil were appointed to act as tellers. The results of the voting were as follows: 33 valid votes were cast, 23 in favor of the Spanish Court of Audit and 10 in favor of the Supreme Audit Institution of Germany.

165. The Council adopted Resolution CD51.R3, declaring the Spanish Court of Audit appointed as the External Auditor of the Pan American Health Organization for the period 2012 to 2015.

Salary of the Director of the Pan American Sanitary Bureau (CD51/18)

166. Dr. St. Clair Thomas (Representative of the Executive Committee) said that as he had reported earlier, the Executive Committee had confirmed several amendments to the Staff Rules during its session in June. The Committee had also established the salaries of the Deputy Director and the Assistant Director, effective 1 January 2011, and had recommended that the Directing Council establish the gross annual salary of the Director at $204,391, also with effect from 1 January. Those decisions were reflected in Resolution CE148.R12, which was attached as an annex to Document CD51/18

167. The Directing Council adopted Resolution CD51.R13, setting the gross annual salary of the Director at $204,391 with effect from 1 January 2011.

Election of Member States to Boards and Committees

Election of Two Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME) (Document CD51/19)

168. The Council selected Bolivia and Suriname as members of the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME) (Resolution CD51.R2).

Awards

PAHO Award for Administration, 2011 (Document CD51/20)

169. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Award Committee of the PAHO Award for Administration, 2011, consisting of the representatives of Saint Vincent and the Grenadines, the United States of America, and the Bolivarian Republic of Venezuela, had met during the Executive Committee's 148th Session. After reviewing the information on the award candidates nominated by Member States, the Award Committee had decided to confer the PAHO Award for Administration 2011 on Dr. John Edward Greene of Guyana, for his contribution to the development of the health sector and human resources in the Caribbean Community, and for his mobilization of political commitment to achieve meaningful outcomes on a broad range of priority public health issues. The Award Committee had noted that making a selection among the candidates, all of whom had highly impressive qualifications, had been very difficult, and had suggested that the process might be facilitated, and any possible subjectivity avoided, if a checklist were drawn up of weighted objective criteria to be considered in making the selection of the award winner.

170. The Executive Committee had extended congratulations to Dr. Greene and adopted Resolution CE148.R13, noting the decision of the Award Committee and transmitting the report to the 51st Directing Council.

171. The President and the Director presented the PAHO Award for Administration 2011 to Dr. John Edward Greene of Guyana, whose acceptance speech may be found on the webpage of the 51st Directing Council.

Abraham Horwitz Award for Excellence in Leadership in Inter-American Health, 2011

172. Dr. Fernando Mendoza (Secretary of the Board of Trustees, Pan American Health and Education Foundation) recalled that for 43 years the Foundation had partnered with PAHO to advance the common goal of protecting life and improving health in the Americas. As part of that partnership, several awards for excellence in inter-American public health were presented each year, including the Abraham Horwitz Award for Leadership in Inter-American Health, established to honor Dr. Abraham Horwitz, former Director of PAHO and later President of PAHEF. The award recognized leadership that had changed lives and improved the health of the people of the Americas.

173. Dr. Mendoza, the President, and the Director presented the Abraham Horwitz Award for Leadership in Inter-American Health 2011 to Dr. Peter J. Hotez, Dean of the National School of Tropical Medicine, Professor in the department of Pediatrics and Molecular Virology and Microbiology at Baylor College of Medicine in Houston, Texas, and holder of the Texas Children's Hospital Endowed Chair in Tropical Pediatrics, for his

work on neglected tropical diseases. Dr. Hotez' acceptance speech may be found on the website of the 51st Directing Council.

Manuel Velasco Suárez Award for Excellence in Bioethics, 2011

174. Dr. Mendoza said that the Manuel Velasco Suárez Award for Excellence in Bioethics had been created in 2002 to recognize groundbreaking thinking in the field of bioethics. It honored Dr. Manuel Velasco Suárez, a Mexican national and a physician, researcher, and scholar who had dedicated more than 50 years of his life to public health and had been one of the founders of the Mexican Academy of Bioethics.

175. Dr. Mendoza, the President, and the Director presented the Manuel Velasco Suárez Award for Excellence in Bioethics 2011 to Dr. Laura Adriana Albarellos, Professor at the University of the Americas in Puebla, and special adviser on health policy to the government of Mexico, for her proposal "Creating and using a system of gene banks for the establishment of public policies." Dr. Albarellos' acceptance speech also appears on the website of the 51st Directing Council.

Sérgio Arouca Award for Excellence in Universal Health Care, 2011

176. Dr. Mendoza recalled that the Sérgio Arouca Award for Excellence in Public Health had been created in 2010 by the Ministry of Health of Brazil and PAHEF in cooperation with PAHO. The award recognized leaders who had worked to advance, influence, and strengthen universal health care programs in the Region. Brazilian physician, scholar, and tireless champion of universal health care Sérgio Arouca, whom the award honored, had been such a leader.

177. Dr. Mendoza, the President, and the Director presented the Sérgio Arouca Award for Excellence in Public Health 2011 to the Integrated Management of Adolescent and Adult Illness (IMAI) program under the Ministry of Health in Guyana, represented by the Director of the Adolescent and Young Adult Health unit, Dr. Marcia Paltoo, whose acceptance speech can be found on the website of the 51st Directing Council.

Other Joint PAHEF and PAHO Awards

178. Dr. Mendoza announced that the Clarence H. Moore Award for Voluntary Service had been awarded to the Women's Information Network of Guatemalan Solutions, WINGS, represented by its founder, Ms. Sue Patterson, for its work on improving the lives of Guatemalan families by providing them with education, access, and advocacy in family planning, reproductive health, and other public health programs and services; the Pedro N. Acha Award for Veterinary Public Health had been awarded to Dr. Francisca Samsing, for her undergraduate thesis entitled "Risk analysis of the dioxin, furan, and DL-PCB contamination of pork meat by the feed materials that make up their diet"; and

the Fred L. Soper Award for Excellence in Health Literature had been awarded to Dr. Ana Lucia Lovadino de Lima from the Epidemiological Research, Nutrition, and Health unit at the University of São Paulo, for her article entitled "Causes of the accelerated decline in child undernutrition in Northeastern Brazil (1986-1996-2006)."

179. Those awards were presented at an awards dinner held during the week of the Directing Council.

Matters for Information

Regional Consultation on WHO Reform (Document CD51/INF/2, Rev. 1, and Add. I, Rev. 1)

180. The Director, introducing this item, reviewed the background of the WHO reform initiative, which had begun with informal consultations on the future of financing for WHO in January 2010 and evolved into a comprehensive reform program addressing issues related not only to financing but also to the governance and the core business of WHO. She noted that some confusion had arisen over the meaning of "core business" and clarified that the term referred to the Organization's priority program areas as defined under its Constitution. The Sixty-fourth World Health Assembly had identified five priority areas on which to focus: (a) health systems and institutions, (b) health and development, (c) health security, (d) evidence on health trends and determinants, and (e) convening for better health. She then outlined the rationale, purpose, scope, and expected outcomes of the reform (see Document CD51/INF/2, Rev. 1).

181. The Directing Council, in its capacity as the Regional Committee of WHO, was asked to comment on the agenda and process of WHO reform and to provide guidance on key issues raised in three concept papers, one on WHO governance; one on the scope, terms of reference, and process for an independent evaluation of WHO; and the third on a proposal to create a World Health Forum, convened by WHO and bringing together a variety of stakeholders involved in global health activities. The other regional committees had also been asked to hold consultations, the results of which would be compiled and submitted to a special session of the WHO Executive Board, to be held in November 2011. A draft package of reforms would then be prepared and presented to the regular session of the Executive Board in January 2012 and to the World Health Assembly in May 2012.

182. Dr. Margaret Chan (Director-General, WHO) said that the main objective of the reform was to make WHO a more effective and efficient organization that would better serve its Member States. She emphasized that she had not launched the reform process because WHO was "broken." However, the world had changed a great deal and many new actors had emerged on the global health scene in the 63 years since the Organization's

founding, and WHO needed to strengthen its capacity to support Member States in that new environment.

183. As she had remarked on other occasions, WHO was overextended and underfunded. At every World Health Assembly for the past several years, Member States had adopted more than 20 resolutions, all of which contained mandates for the Secretariat, but the Secretariat lacked sufficient financial and human resources to implement them, particularly as such a large proportion of the resources that it received was highly earmarked. Hence, a central question in the reform process was: in a context of limited resources, how could the Organization best prioritize its activities and carry out the mandates it had received from Member States?

184. Governance was another key aspect of the reform. Internally, there was a need for greater coherence among the Organization's Governing Bodies and better alignment between the policy directions adopted by the regional committees and the decisions taken by the Health Assembly. At the same time, a way had to be found to hear and take account of the views of the many civil society and private sector actors engaged in global health activities, thus heeding Member States' repeated calls for a more inclusive organization. However, that must be done without undermining the supreme decision-making authority of Member States, because WHO must remain a Member-State-driven organization. The World Health Forum was one possible mechanism, but there were others, and she looked forward to hearing the Region's views on that and other issues raised in the three concept papers.

185. The Council met in three roundtable sessions to discuss the concept papers and the other background documentation contained in Document CD51/INF/2, Rev. 1. Each roundtable appointed two rapporteurs, who summarized the discussions and, in collaboration with PASB staff, produced a summary report on the regional consultation. That report (Document CD51/INF/2, Add. I, Rev.1, after revision) was subsequently presented and discussed in plenary.

186. During the discussion, Member States welcomed the opportunity to explore ways of improving WHO's governance, streamlining its methods of work, and ensuring that its priorities were in line with the current needs of Member States. Concern was expressed, however, that the reform process was proceeding too rapidly and that insufficient time was being allowed for a thorough examination of the proposed reforms by Member States. It was emphasized that reform, particularly in the case of a large, complex organization such as WHO, should not be undertaken with undue haste, or give the impression of being undertaken with undue haste, and it was also pointed out that it would undoubtedly prove difficult to reverse any reforms that were instituted and subsequently found to be ill-advised. Several delegates expressed the view that discussions of WHO reform should take place not only at the regional level but also at the subregional level, among the

members of CARICOM, UNASUR, and the various other political and economic integration groups in the Americas.

187. The importance of Member State leadership and ownership of the reform process was stressed. Several delegates remarked that the work of the Working Group on PAHO in the 21st Century could provide a good model for a Member-State-driven approach to reform and suggested that the Working Group's final report[4] should be forwarded to WHO along with the report on the regional consultation on WHO reform.

188. While general support was expressed for the creation of a World Health Forum or similar mechanism, a number of delegations noted the need for greater clarity regarding what its purpose and what its relationship with the World Health Assembly would be, who would participate, and other details. With respect to the proposed external evaluation of WHO, it was suggested that it should be carried out not by an independent consortium of experts but rather by a working group of experts nominated by Member States. One delegate questioned the timing of the evaluation, suggesting that it should not precede the reform process but rather should be conducted after it had been determined what, exactly, Member States expected of WHO.

189. With regard to the Organization's core business, it was emphasized that WHO's primary function was to provide strong leadership of the health sector, particularly in the face of the growing influence of financial and political interests in health matters. The Delegate of Paraguay, speaking on behalf of the ministers of health of the UNASUR countries, said that the main aim of the reform should be to maximize WHO's leadership capacity and improve its technical performance as the highest health authority at the global level. The Organization should not be merely a collection of overlapping programs and strategies that competed for resources and employed fragmented, unintegrated approaches. She also underlined the need for strong leadership on the part of PAHO, as the regional office of WHO, and suggested that the candidates' forum to be held prior to the election of a new Director of PAHO in 2012 should be viewed as an opportunity to identify the principal health challenges at the global and regional levels and to reflect on what PAHO's role should be in meeting those challenges.

190. It was stressed that WHO's function was to provide technical cooperation, not financial cooperation, and that while funding was one aspect of the reform process, the main focus should be on rethinking the Organization from a strategic standpoint, taking into account the strategic directions provided by processes under way at the regional and global levels, such as the upcoming World Conference on Social Determinants of Health, and drawing a clear distinction between issues that should be addressed at the global level and issues requiring a regional approach. In addition, the Organization was encouraged to

[4] Document CD46/29.

support and coordinate its activities with South-South cooperation initiatives and other bilateral and multilateral cooperation platforms.

191. Concern was expressed over increasing donor-driving of WHO's priorities as a result of earmarked funding. At the same time, it was pointed out that donor funding increased overall resource availability, and the Organization was encouraged to take account of both the positive and the negative aspects of such funding.

192. Dr. Chan observed that the problem was not voluntary contributions per se; it was that voluntary funding, particularly earmarked funding, was not always aligned with the priorities that Member States had set for the Organization. Member States in all regions had made it clear that they did not want money to become a de facto priority-setting mechanism, and the Secretariat had heard that message. She noted that another challenge in relation to priority-setting was that priorities in the health sector were set primarily by ministers of health in the World Health Assembly, whereas decisions about funding for WHO were made mainly by ministries of foreign affairs, development, or planning, creating a disconnect which needed to be addressed.

193. She assured the Directing Council that the WHO Secretariat did not intend to proceed hurriedly with reforms on critical issues that would have long-term impact and global or regional implications. However, there were some managerial reforms that could be undertaken fairly quickly—reforms that would help to enhance the efficiency and the transparency of the Secretariat's work and strengthen its accountability to Member States—and as chief administrator of the Organization she felt that it was her responsibility to implement such reforms as soon as possible. The Secretariat would continue to seek the guidance of Member States on all strategic issues and matters relating to funding and priority-setting. A web-based platform for consultations had been set up to collect input on the reform process and she encouraged all Member States to use that platform to express their views and concerns.

194. The Director of the PASB said that the Bureau would continue to facilitate consultations at the regional and subregional levels, ensuring that all documents relating to WHO reform were made available in the four official languages of PAHO. Information on the PAHO in the 21st Century initiative had already been provided to the Director-General's Global Policy Group, but would also be annexed to the document to be submitted to WHO for the report to be compiled for the WHO Executive Board, together with information on other regional consultation mechanisms that might prove useful, such as the CARICOM-Civil Society Forum.

Update on the Modernization of the PASB Management Information System (Document CD51/INF/3)

195. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had been informed in June that the project to modernize the PASB Management Information System was in a pre-implementation phase, during which the appropriate software would be selected. The project would be implemented in two phases, each of one year's duration. Thus, the overall project completion date would be mid-2014. The Committee had also been told that the Bureau was in the process of acquiring the services of an independent consultant whose role would be to identify all of the software products that might be appropriate to the Organization's needs and to ensure that it obtained the best terms possible with the provider finally selected. While welcoming the progress thus far, the Executive Committee had pointed out that the comparable experience of WHO in implementing its Global Management System, and the immense challenges that it had faced, should serve as a cautionary tale. The Committee had sought confirmation that the cost estimates for the project were still valid, and had been told that the Bureau did not expect the cost of the project to exceed the original estimate of $20.3 million.

196. In the ensuing discussion within the Council, one delegate expressed appreciation for the update on progress, and asked whether there had been any revisions to the projected costs of implementation. Also, she noted that the Bureau was suggesting that financial management and procurement services be addressed in the second step of the second phase of implementation, whereas a case might be made for implementing them earlier, given that the External Auditor had suggested that the Organization should make the upgrading of the financial and management accounting system a strategic priority. In addition, she requested that Member States be kept informed on how the future upgrades were achieving the necessary integration with WHO's Global Management System (GSM).

197. Dr. Isaías Daniel Gutiérrez (Area Manager, Planning, Budget, and Resource Coordination, PASB) said that the process was currently at the stage of procuring both the software and the services of the system integrator; it was anticipated that the sums to be expended would be within the amount set forth in the project. With regard to the question concerning the order of implementation stages, he said that no final decision had been made. The document presented a tentative schedule, which might change on the advice of the system integrator, who, in addition to providing information about the software products that were on offer on the market, would advise on the most suitable sequence for software installation. He confirmed that PASB was coordinating with WHO at every step of the process. The technical committee being formed to give guidance on the project would include a WHO official with senior responsibility for the GSM.

198. The Director added that the procurements needed for the upgrade of the management information system, just like any other procurements, were being made in strict conformity with internal control processes and procedures.

199. The Council took note of the progress report.

Report on the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (Document CD51/INF/4)

200. Dr. Marcos Espinal (Area Manager, Health Surveillance and Disease Prevention and Control, PASB) reviewed the events that had led up to the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, notably the initiatives taken by the governments of CARICOM.

201. The Council expressed appreciation for the report on the high-level meeting. There was general agreement that noncommunicable diseases posed a significant challenge to the health systems of the Region, one that required multisectoral action and engagement of the highest level of government. It was pointed out that such diseases had a disproportionately heavy impact on developing countries and lower-income populations, and that they were linked to poverty. There was also a clear link between the incidence of noncommunicable diseases and the achievement of the Millennium Development Goals, in particularly MDG-5 (Improve maternal health), since diseases such as hypertension, diabetes, and heart disease were indirect causes of maternal mortality. Several delegates congratulated the countries of CARICOM for their leadership in bringing the issue of noncommunicable diseases to the attention of the world and pressing for the meeting at the United Nations.

202. Delegates stressed the importance of access to drugs to treat noncommunicable diseases, noting that in many areas, particularly in the less developed countries, the availability of such drugs was limited or non-existent. For that reason, under the PAHO Global Strategy on Public Health, Innovation, and Intellectual Property, some countries were working intensively to make use of the flexibilities existing under the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS Agreement), in line with the Doha Declaration of 2001. It was stressed that the Doha Declaration should apply to drugs for noncommunicable diseases as well as to medicines to treat other categories of disease.

203. It was suggested that one of the most important steps for the future would be to develop indicators to measure the progress that countries were making against noncommunicable diseases. It was also considered important to measure the economic impact of those diseases and to identify their social determinants, and it was pointed out that determining those costs accurately would require the involvement of the financial sector.

204. It was also pointed out that the factors that contributed to noncommunicable diseases were complex, which meant that reducing their impact would demand a multisectoral approach addressing the social, cultural, and economic conditions that significantly impacted people in their daily lives. It was emphasized that many of the most important prevention actions would have to take place outside the health sector, for example in education, transport, agriculture, and food manufacturing.

205. One delegate, speaking on behalf of UNASUR, drew attention to the harmful effects of increasingly urban lifestyles characterized by lack of physical activity, excessively passive entertainment choices, and overconsumption of fast foods, soft drinks and other unhealthy foods. The UNASUR health council (UNASUR-Salud) was resolved to reverse those trends. A promising model for doing so was the success achieved through the WHO Framework Convention on Tobacco Control, and the approaches used in that context could be adapted to bring about the creation of healthy spaces, an increase in people's levels of physical activity, a reduction of unhealthy ingredients in foods, and the establishment of a code regulating the marketing of food to children. Achievement of those objectives would require technical support and regional and international cooperation.

206. Another delegate recalled that a major theme of the High-level Meeting had been the need to form robust partnerships for the exchange of best practices. PAHO could assist in the creation of such partnerships at regional level, in particular in order to draw up regional indicators. Another cautioned that, while the establishment of regional indicators and targets was, in principle, a good idea, it must be ensured that they were aligned with the WHO work that was already under way. Numerous delegates stressed that while the United Nations High-level Meeting had been a significant and satisfying high point, it was important not to think of it as an end, but rather as an important marker along the pathway for action. A representative of the World Heart Federation said that while noncommunicable diseases were responsible for 36 million deaths annually, they were not actively included in the development agenda. She urged that action be taken to rectify that situation.

207. Dr. Espinal agreed that the High-level Meeting should not be seen as the end of the journey but as an important milestone in the fight against noncommunicable diseases. He also agreed with the ideas expressed about the importance of access to medicines, and the need for targets and indicators at both global and regional levels. With regard to the issue of cost, he noted that at the World Economic Forum the economic impact of noncommunicable diseases had been estimated at $30 trillion, whereas the cost of implementing the best practices proposed by WHO had been put at $11 trillion dollars. He added that a meeting in Mexico in mid-November, to be attended by representatives of PAHO, ECLAC, OECD, and Member States, would examine the question of costs in greater detail.

208. The Director paid tribute to the efforts of the CARICOM countries to make the High-level Meeting a reality, and to the Permanent Representative of Jamaica in particular who had been appointed a co-facilitator. She agreed that many of the steps that might be taken specifically to target noncommunicable diseases, such as building cancer or dialysis centers, would be very costly. On the other hand, there were many components of the approach to those diseases that were already in place, and pursuing those would be far less expensive. Examples were strengthening tobacco control, putting into practice the strategy and plan of action on alcohol that had just been approved, progress in salt and trans fat reduction, and trade and agricultural policies to encourage healthy choices.

209. In terms of the budget of PAHO, it was essential not to look at noncommunicable diseases in isolation. Rather, they had to be seen in the context of health systems, of essential medicines, of tobacco control, gender issues, laboratory services, nursing training, human resource development, nutrition, and urban planning and urban health, on which the Council had also approved a plan of action. It was that holistic approach that showed promise for reducing the burden of noncommunicable diseases, rather than any attempt to create a specific NCD Unit.

210. There was a need to continue raising awareness of the importance of the issue and of the need for an intersectoral approach. A sequence of intergovernmental meetings and summits lay ahead, each of which would be an opportunity to repeat and reinforce the message from the High-level Meeting. Similarly, efforts must be made to heighten awareness about noncommunicable diseases in bodies such as the Food and Agriculture Organization of the United Nations, the International Labour Organization, and UNESCO. It was important to remember the lessons learned from the fight against HIV/AIDS, in which thirty years of advocacy had failed to make the world beyond the health sector think seriously about the problem. Only when HIV/AIDS had moved from being a health issue to become a political, economic, and societal one had the stage been set for the recent medical advances that had brought about a reduction of new cases of infection in the world. The same comprehensive approach must be applied to the noncommunicable diseases.

211. Noncommunicable diseases would be a major focus for the Organization in the coming year, as both the Bureau and Member States sought to translate the political declaration of the High-level Meeting into concrete action. An important aspect of that work would be the Governing Bodies' review of the Regional Strategy and Plan of Action for an Integrated Approach to the Prevention and Control of Chronic Diseases, Including Diet, Physical Activity, and Health.

212. The Council took note of the report on the High-level Meeting.

Progress Reports on Technical Matters (Document CD51/INF/5, A-F)

(A) Immunization: Challenges and Outlook; (B) Implementation of the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property; (C) Advances in the Implementation of the WHO Framework Convention on Tobacco Control; (D) Implementation of the International Health Regulations; (E) Progress toward Achievement of the Health-related Millennium Development Goals in the Region of the Americas; and (F) Review of the Pan American Centers.

213. Dr. St. Clair Thomas (Representative of the Executive Committee) summarized the comments made by the Executive Committee during its 148th Session with respect to progress reports on the six topics listed above. Details may be found in the final report of the Committee's 148th Session (Document CE148/FR).

214. In the ensuing discussion, the Directing Council welcomed the progress on immunization but emphasized that the Region must not let down its guard and must continue its surveillance and immunization activities in order to maintain the gains made thus far in the eradication, elimination, and control of vaccine-preventable diseases. Numerous delegates stressed the need to take all necessary steps to maintain the Region's poliomyelitis-, measles-, and rubella-free status. They also noted that the Region remained at risk of the introduction of imported cases of those diseases and underscored the need to encourage other regions to make a firm commitment and step up their efforts to eradicate poliomyelitis and eliminate measles and rubella. It was pointed out that further success in controlling vaccine-preventable diseases would hinge on the availability of affordable vaccines, and strong support was expressed for PAHO's efforts to negotiate favorable vaccine prices through the Revolving Fund for Vaccine Procurement. Several delegates highlighted the need for coordination among PAHO, WHO, and the GAVI Alliance so that more countries could benefit from the low vaccine prices available to the GAVI-eligible countries.

215. Tribute was paid to the Director for launching Vaccine Week in the Americas, which had significantly increased vaccination coverage across the Region and had also helped to strengthen national immunization programs and raise awareness of the importance of immunization. Firm support was voiced for the establishment of a World Vaccination Week.

216. The Council also welcomed the progress on the implementation of the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property. Stressing the importance of securing access to drugs at affordable prices, in particular for the treatment of chronic noncommunicable diseases, delegates described the efforts being made to lower the prices of drugs in their countries, through negotiation with the holders of patents and intellectual property rights. One delegate observed that small countries with limited human capacity were not able to capitalize on some of the initiatives that had been

mentioned in the progress report. That fact was reflected in relatively high prices of pharmaceuticals in such countries. It was suggested that national efforts to achieve lower prices should be pooled at the regional level, giving greater leverage. Another delegate called for greater transparency in pharmaceutical prices, citing cases in which some products were being offered to the PAHO Strategic Fund at prices higher than those prevailing in the local market. It was considered important that PAHO should continue supporting countries in furthering research and innovation in the pharmaceutical field, and should assist in strengthening interaction and cooperation among the key stakeholders within the countries. The importance of PAHO's assistance in combating counterfeit medicines was also highlighted.

217. With regard to the progress report on the implementation of the WHO Framework Convention on Tobacco Control, delegates expressed appreciation to PAHO for its support of their efforts to reduce smoking and exposure to tobacco smoke, with several of them describing the measures their governments had taken to that end. Many had increased taxes on tobacco products, by amounts varying between 10% and 100%, with, in some cases, the extra revenue being dedicated to health initiatives or the promotion of sports and other physical activity. Some countries had enacted new legislation to ban the sale of tobacco products to minors. Many had passed legislation banning smoking in public places or in certain enclosed spaces. Educational materials on the dangers of tobacco use had been made available to schools, to the media, and to the general public. Some governments had banned tobacco advertising and the sponsoring of events by the tobacco industry; some had set up specialized commissions to coordinate the anti-smoking efforts. Some countries were taking action against illicit trade in tobacco products, which, some delegates pointed out, was in the hands of powerful organizations that could best be defeated through regional cooperation.

218. Some governments had enacted legislation mandating warnings, often pictorial, on tobacco product packaging, and others were planning to do so, while some were still debating what proportion of the packaging such warnings should cover. However, it was noted that there was opposition to some of the measures, and not only from the tobacco industry. For example, the tax on tobacco products had been declared unconstitutional in Guatemala, although work was now in hand to restore it. One delegate described an mHealth initiative involving the dissemination via mobile devices of best practices for tobacco-use cessation.

219. Concerning the progress report on implementation of the International Health Regulations (2005), several delegates praised the help and support provided by PAHO to their countries as they worked to put the required core capacities in place. It was pointed out that the pandemic influenza outbreak of 2009 and the earthquake and the ensuing cholera outbreak in Haiti had acted as catalysts to mobilize resources and build capacity to meet the requirements of the International Health Regulations (IHR). However, at the

same time they had revealed weaknesses in some countries' systems, and it was noted that a number of countries would need to request an extension beyond the target date of June 2012 in order to establish the core capacities, in particular in laboratory diagnostics and response preparedness.

220. It was suggested that the Rio + 20 Conference in 2012 and the Fédération Internationale de Football Association (FIFA) World Cup in 2014, both to be held in Brazil, would be opportunities to develop and test plans for managing mass events in the Region in accordance with the Regulations. It was noted, too, that the full operation of the IHR would require a contribution from many bodies within countries, not just the ministries of health. Such broad-based involvement would enable the national IHR focal points to function as efficient conduits of information among the various sectors involved in dealing with public health events of potential international concern.

221. With regard to the progress report on achievement of the Millennium Development Goals, the Council considered the message from the report clear and sobering: progress was being made across the Region, but underlying the regional and national averages were large disparities, which needed to be addressed. That fact underscored the need for solid information, which in turn required a strong capacity within countries to collect data, in order to be able firstly to determine where investments should be made and whether progress was sufficient, and secondly to focus more effectively on vulnerable populations. It was pointed out that national data on health status would be skewed by the figures on the more educated and prosperous segments of the population, who tended to take greater advantage of health programs and services, and the impression would thus be created that countries were doing better than they really were.

222. It was also pointed out that progress was uneven among the Goals themselves, with significant achievements being recorded in areas such as hunger and nutritional status; HIV, including mother-to-child transmission; malaria control and environmental health indicators, but fewer advances in maternal mortality and child mortality. One delegate encouraged PAHO to take fully on board the findings and recommendations of the Commission on Information and Accountability for Women's and Children's Health, which related directly to the achievement of some of the Millennium Development Goals.

223. Dr. Gina Tambini (Area Manager, Family and Community Health, PASB), responding to the comments relating to the progress report on immunization, said that the staff of the Bureau stood ready to support the six Member States representing the Americas on the WHO Executive Board in drawing up a proposal for World Vaccination Week. The Bureau was also working with the WHO Secretariat to address the risk of imported cases and promote global elimination of poliomyelitis, measles, and rubella. In addition, the Bureau was working to strengthen the capacity of the Revolving Fund to negotiate the best possible vaccine prices. It was to be hoped that the GAVI Alliance's

success in negotiating lower vaccine prices would help to exert downward pressure on the prices of vaccines procured through the Revolving Fund and promote greater price transparency.

224. Dr. Rubén Torres (Area Manager, a.i., Health Systems Based on Primary Health Care, PASB), replying to the Council's observations on the progress report on the implementation of the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property, noted that the Pan American Network for Health Technology Assessment was now operational and available to all Member States. With regard to the Pan American Network for Drug Regulatory Harmonization, he reported that the Region now had four reference regulatory authorities. which would be important in enhancing the work in that field. Responding to the comments about high drug prices, and market transparency, he added that in the near future an innovative platform would be launched to provide Member States with reference prices for the drugs sold in all countries of the Region.

225. Dr. Luiz Augusto Galvão (Area Manager, Sustainable Development and Environmental Health, PASB) welcomed delegates' reports on the progress being made by their countries in implementing the Framework Convention on Tobacco Control. He stressed the need to enact implementing legislation to put the Framework Convention into practice and said that PAHO stood ready to assist countries in that area. On illicit trade, he noted that the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products would hold its final meeting in March 2012 and urged all Member States to participate. Much still remained to be done, particularly as the tobacco industry was mounting counter-attacks and seeking to reverse the progress that had been made. Countries must therefore remain steadfast in their resolve to continuing implementing the Framework Convention.

226. Dr. Marcos Espinal (Area Manager, Health Surveillance and Disease Prevention and Control, PASB), referring to the progress report on implementation of the International Health Regulations (2005), said that the issue of extending the deadline for ensuring the core capacities was a decision for Member States to take as sovereign nations. Whatever decision was taken, the Bureau would continue to support countries in building their core capacities. Agreeing with the thoughts expressed about the need to prepare for mass sporting or political events in the context of the IHR, in particular by investing in training and capacity-building, he suggested that it would be useful, when a country was hosting a mass event, for health personnel from other countries to attend as observers to learn how to prepare for their own forthcoming events.

227. With regard to the progress report on the achievement of the Millennium Development Goals, he agreed with the comments made on the importance of data gathering to measure progress and guide future work.

228. The Director, referring to the progress report on the Pan American centers, noted that one of those centers, the Pan American Foot-and-Mouth Disease Center, would be coordinating the 16th Inter-American Meeting at the Ministerial Level on Health and Agriculture (RIMSA16), to be held on 26 and 27 July 2012. The meeting, which would be hosted by the Government of Chile and held in Santiago, offered a unique opportunity for representatives of the health and agriculture sectors to come together and discuss a range of topics, including zoonotic diseases, food safety, food security, and nutrition.

229. The Council took note of the progress reports contained in Document CE51/INF/5, A-F.

(G) Regional Initiative and Plan of Action for Transfusion Safety for 2006-2010: Final Evaluation (Document CD51/INF/5, G)

230. Dr. Rubén Torres (Area Manager, a.i., Health Systems Based on Primary Health Care, PASB) introduced the report on the final evaluation of the Regional Initiative and Plan of Action for Transfusion Safety for 2006-2010, adopted by the 46th Directing Council in 2005, and highlighted some of the findings presented in the report, noting that Canada, the United States of America (including Puerto Rico), and the French territories in the Americas had not been included in the analysis. The evaluation had found that only four countries of the Caribbean subregion had a legal framework for blood services, whereas all but three of the Latin American countries had such frameworks. However, many of them lacked sufficient resources to ensure that that their blood services were functioning adequately. The data showed that the only way to achieve a sufficient supply of blood and ensure equitable access to it was through unpaid voluntary donation. However, many hospitals in the Region continued to require replacement donations, which constituted a major obstacle to the achievement of 100% voluntary donation. The evaluation had also revealed widespread inefficiency in the Region's blood systems, as a result of which large amounts of blood had to be discarded, either because it was found to contain infectious disease markers or because it had passed its expiry date.

231. In view of the evaluation findings, it was recommended that a new regional plan of action on blood safety covering the period 2012-2017 should be included among the topics to be discussed by the Governing Bodies in 2012.

232. In the discussion that followed, several delegates reported on their governments' efforts to expand the availability and ensure the safety of blood and blood products and to encourage unpaid voluntary donation, with one noting that the Ministry of Health in his country had concluded an agreement with the Ministry of Education to include content relating to voluntary donation in the school curriculum. Another said that her Ministry of Health was working with churches, universities, and various other public and private institutions to recruit volunteer blood donors. Lack of information systems for tracking the collection, processing, storage, and use of blood and for patient follow-up was cited as a

major obstacle to quality assurance in blood systems, as was lack of communication and coordination between hospital blood services and blood banks in reporting adverse outcomes. The Delegate of Argentina noted that in 2011 his country had served as the first Latin American host of World Blood Donor Day, observed on 14 June each year.

233. Dr. Torres welcomed the progress reported and thanked all Member States for their participation in the Regional Initiative for Transfusion Safety.

234. The Director commended the Government of Argentina for its organization of the global celebration of World Blood Donor Day, an event which had drawn distinguished participants from around the world, including Ban Soon-taek, the wife of United Nations Secretary-General Ban Ki-moon, and had helped to raise community awareness of the importance of voluntary unpaid blood donation. She also expressed gratitude to the members of the external evaluation team who had conducted the final evaluation of the progress made under the Regional Initiative and would be assisting the Bureau in drawing up the next regional plan of action on blood safety.

235. The Council took note of the progress report contained in Document CD51/INF/5, G.

Progress Reports on Administrative and Financial Matters (Document CD51/INF/6, A-B)

(A) Status of Implementation of the International Public Sector Accounting Standards (IPSAS)

236. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had been informed in June that the Bureau had completed the implementation of the IPSAS, although additional work would be required as new standards were issued. It had been noted that two of the most challenging phases in the implementation process had been the creation of improvisations to enable the Organization's financial information system to work with the new standards, and the determination of the value of all of the Organization's assets as at the implementation date. The Committee had congratulated PAHO on its successful and timely implementation of the IPSAS, acknowledging the importance of the transition to the new standards for PAHO and the entire United Nations system, and welcoming the availability of financial information that could not be provided in the past under the previous accounting standards. The high level of unfunded liabilities for staff entitlements had been noted, and the Bureau had been requested to inform the Committee periodically of progress in funding those liabilities. It had been suggested that the opinion of the Office of Internal Oversight and Evaluation Services should be sought as to which of the funding options proposed in the report would be the most appropriate and have the least impact on the Organization's technical cooperation activities.

237. In the Council's discussion of the progress report, the Bureau's success in implementing the IPSAS in full and on time was applauded and it receipt of an unqualified audit opinion on the financial statements in the IPSAS format was commended. However, concern was expressed about the unfunded liabilities for staff entitlements and after-service health insurance. While the potential ways of funding that deficit, listed in paragraph 15 of Document CD51/INF/6, were considered adequate to avoid serious budgetary problems in the long term, the suggestion made during the Executive Committee session was reiterated; i.e., that the Bureau should report periodically to the Governing Bodies on the situation, and that the opinion of the Office of Internal Oversight and Evaluation Services and of in-house financial experts should be sought to ensure that the matter did not risk impacting the Organization's technical cooperation activities. Information was sought on the rate of annual linear depreciation being used for the Organization's assets. Appreciation was expressed for the training session on IPSAS that had been given during the Executive Committee session in June, which had truly enabled members to understand the complexities of the system. It was suggested that similar training might be provided for personnel in Member States and in the PAHO country offices and that the IPSAS accounting manual might be posted on the Organization's website so that it could be easily accessed by all Member States.

238. Ms. Sharon Frahler (Area Manager, Financial Resources Management, PASB) observed that the External Auditor had given the opinion that as the costs for staff entitlements and after-service health insurance would fall due only over a period of 30 or 40 years, it was not necessary for the Organization to show that it had the necessary funds immediately, merely that it had a plan for covering those expenditures in due course. The Bureau would be making a presentation on the topic at the next session of the Subcommittee on Program, Budget, and Administration. She agreed on the need to consult the Office of Internal Oversight and Evaluation Services, and also the External Auditor.

239. With regard to the Organization's buildings and other assets, she explained that a detailed assessment of their value was required every three years. In the intervening two years, a less in-depth evaluation would be done, unless it became evident that values on the real estate market had changed by more than 5% in one year, in which case a more thorough evaluation would be performed. She said that consideration could be given to placing the accounting manual on the PAHO website, but cautioned that it would change regularly with the issuance of new IPSAS standards.

240. The Council took note of the report.

(B) Master Capital Investment Plan

241. Dr. St. Clair Thomas also reported that in June the Executive Committee had examined a progress report on the work carried out thus far under the Master Capital Investment Plan, including an update on renovations and rebuilding projects undertaken,

notably in Haiti and Chile, following the earthquakes in those countries. It had been reported that in some countries, rather than repairing a badly damaged building or renovating an old one, the Bureau had chosen to relocate the country office to a different facility, in several cases one owned by the host Government and provided rent-free, resulting in considerable savings to the Organization. The Committee had also been informed that the contract for construction of the Emergency Operations Center was expected to be signed shortly and that work on the rehabilitation of the elevators in the Headquarters building had commenced.

242. The Executive Committee had pointed out that there would be substantial expenditures in the current biennium and that the Information Technology Subfund would thus be almost totally depleted, which would represent a challenge for the future. The Committee had also sought clarification of some apparent discrepancies in the figures in the progress report, and had been informed that in most cases those discrepancies were due to the fact that the signing of certain contracts had slipped from 2010 to 2011.

243. The Director noted that there had been some delay in the startup of the work on the Emergency Operations Center, but that it was expected that by the time of the March 2012 session of the Subcommittee on Program, Budget, and Administration it would be possible to see real progress.

244. The Council took note of the report.

Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO (Document CD51/INF/7, A-C)

(A) Sixty-fourth World Health Assembly; (B) Forty-first Regular Session of the General Assembly of the Organization of American States; and (C) Subregional Organizations

245. Dr. St. Clair Thomas (Representative of the Executive Committee) reported that the Executive Committee had received a report in June on the resolutions and other actions of the Sixty-fourth World Health Assembly and the 129th Session of the WHO Executive Board considered to be of particular interest to the PAHO Governing Bodies. Special attention had been drawn to the World Health Assembly resolutions on strengthening nursing and midwifery, prevention and control of cholera, the health-related Millennium Development Goals, and preparations for the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases. The Committee had been informed that the 129th Session of the WHO Executive Board had established a consultative mechanism on the reform of WHO and had asked the Director-General to prepare three concept papers on the following topics: the governance of WHO, an independent evaluation of WHO, and the World Health Forum, as outlined in Resolution WHA64.2. The regional committees had been asked to discuss those papers and the WHO reform process in general prior to the special session of the Executive

Board to be held in November 2011. Accordingly, the matter of WHO reform had been placed on the agenda of the Directing Council (see paragraphs 180 to 194 above).

246. Dr. Manuel Sotelo (Area Manager, External Relations, Resource Mobilization, and Partnerships, PASB) introduced Document CD51/INF/7, which contained a summary of the resolutions and other actions of the Sixty-fourth World Health Assembly, the Forty-first General Assembly of the Organization of American States, and a number of subregional organizations, considered to be of particular interest to the PAHO Governing Bodies. He also drew attention to the large number of international and intergovernmental meetings that would be taking place in the coming months, all of which would be opportunities for PAHO to express its concerns and put forward its aims and, in particular, to reinforce the new prominence given to noncommunicable diseases by the High-Level Meeting of the U.N. General Assembly in New York.

247. In the discussion that followed, appreciation was expressed to the Bureau for its support of the various activities being carried out pursuant to resolutions of the OAS, in particular the advice it was providing to the working group charged with drawing up a Draft Inter-American Convention against Racism and All Forms of Discrimination and Intolerance and its contributions to the OAS's work in the area of protection of the human rights of older persons.

248. The Council took note of the report.

Other Matters

Twenty-fifth Anniversary of the PAHO International Health Program

249. The Council observed the 25th anniversary of PAHO's International Health Program and paid tribute to the Program's founders, in particular Dr. María Isabel Rodríguez (Minister of Health, El Salvador), first coordinator of the Program, who addressed the Council. The text of her remarks and those of the Director may be found on the website of the 51st Directing Council.

Launch of the* Regional Atlas of Subnational Social Vulnerability and Its Impact on Health *and the* Journal of Infectious Diseases *supplement on rubella

250. The Council was informed of the recent release of two publications: the *Regional Atlas of Subnational Social Vulnerability and Its Impact on Health*,[5] the result of a joint project by PAHO and ECLAC's Latin American and Caribbean Demographic Centre (CELADE) aimed at revealing social vulnerabilities and disparities in progress towards

[5] PAHO/CELADE. *Regional Atlas of Subnational Social Vulnerability and Its Impact on Health*. Washington, DC: Pan American Health Organization; 2011.

the MDGs at the municipal level, and a special supplement to the *Journal of Infectious Diseases* on the elimination of rubella and congenital rubella syndrome,[6] guest-edited by Dr. Jon Kim Andrus (Deputy Director, PASB), Dr. Carlos Castillo-Solórzano (Regional Advisor, Vaccines and Immunization, PASB), and Dr. Cuauhtémoc Ruiz Matus (Senior Advisor, Comprehensive Family Immunization, PASB), with contributions by numerous other PAHO staff, as well as staff of WHO and the United States Centers for Disease Control and Prevention.

251. The Delegate of Cuba said that, regrettably, the majority of the delegation from his country's Ministry of Health had not been able to attend the 51st Directing Council because the Government of the United States of America had failed to issue their visas. He assured the Council that Cuba's health authorities had nevertheless followed the proceedings closely through Cuba's diplomatic representatives in Washington, D.C., who had also represented the Ministry at the session.

252. The Director announced the impending retirement of Ms. Sharon Frahler (Area Manager, Financial Resources Management, PASB), Dr. Isaías Daniel Gutiérrez (Area Manager, Planning, Budget, and Resource Coordination, PASB), and Dr. Juan Manuel Sotelo (Manager, External Relations, Resource Mobilization, and Partnerships, PASB) and thanked them for their long years of dedicated service to the Organization.

Closure of the Session

253. Following the customary exchange of courtesies, the President declared the 51st Directing Council closed.

Resolutions and Decisions

254. The following are the resolutions and decisions adopted by the 51st Directing Council:

Resolutions

CD51.R1: Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Argentina, Guatemala, and Haiti

THE 51st DIRECTING COUNCIL,

Bearing in mind the provisions of Articles 9.B and 15.A of the Constitution of the Pan American Health Organization;

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[6] Rubella and congenital rubella syndrome elimination in the Americas. *Journal of Infectious Diseases* (2011) 204(suppl 2): S571-S578. Available at: http://jid.oxfordjournals.org/content/204/6.toc

Considering that Brazil, Chile, and El Salvador were elected to serve on the Executive Committee upon the expiration of the periods of office of Argentina, Guatemala, and Haiti,

***RESOLVES*:**

1. To declare Brazil, Chile, and El Salvador elected to membership on the Executive Committee for a period of three years.

2. To thank Argentina, Guatemala, and Haiti for the services rendered to the Organization during the past three years by their delegates on the Executive Committee.

(Fifth meeting, 28 September 2011)

CD51.R2: Election of Two Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME)

THE 51st DIRECTING COUNCIL,

Bearing in mind that Article VI of the new Statute of the Latin American and Caribbean Center on Health Sciences Information (BIREME) establishes that its Advisory Committee is to be comprised of one representative appointed by the Director of the Pan American Sanitary Bureau and one by the Government of Brazil as permanent members, and that five nonpermanent members are to be selected and named by the Directing Council or the Pan American Sanitary Conference of PAHO from among the BIREME membership (which at this time includes all PAHO Member States, Participating States, and Associated States), taking geographical representation into account;

Recalling that Article VI further states that the five nonpermanent members of the BIREME Advisory Committee should be rotated every three years, and that the Directing Council or the Pan American Sanitary Conference of PAHO may indicate a shorter rotation period in cases where it is necessary to maintain balance among members of the Advisory Committee;

Considering that Bolivia and Suriname were elected to serve on the BIREME Advisory Committee beginning 1 January 2012, on the expiration of the terms of Jamaica and Mexico,

***RESOLVES*:**

1. To declare Bolivia and Suriname elected as nonpermanent members of the BIREME Advisory Committee for a three-year term.

2. To thank Jamaica and Mexico for the services provided to the Organization by their delegates on the BIREME Advisory Committee over the past two years.

(Fifth meeting, 28 September 2011)

CD51.R3: Appointment of the External Auditor of the Pan American Health Organization for 2012-2013 and 2014-2015

THE 51st DIRECTING COUNCIL,

Having considered the report of the Director, *Appointment of the External Auditor of PAHO for 2012-2013 and 2014-2015* (Document CD51/17);

Noting the regulations, rules and practices of the Pan American Health Organization and the practices of the World Health Organization,

RESOLVES:

1. To appoint the Court of Audit of Spain as External Auditor of the accounts of the Pan American Health Organization for the period 2012-2015, in accordance with the principles and requirements stipulated in Financial Regulation XIV.

2. To request the Director:

(a) to establish contractual terms and conditions between the Organization and the appointed External Auditor to cover the modalities of the External Auditor's work in fulfilling its mandate as per Annex B of Document CD51/17, which provides further background information on the appointment of the External Auditor, with particular reference to the requirements of the International Public Sector Accounting Standards.

(b) to express its appreciation to the Comptroller and Auditor General of the United Kingdom of Great Britain and Northern Ireland for the many years of service provided to the Pan American Health Organization, especially with respect to the support of the Organization's recent successful adoption of the International Public Sector Accounting Standards.

(Fifth meeting, 28 September 2011)

CD51.R4: Strategy and Plan of Action on Urban Health

THE 51st DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action on Urban Health* (Document CD51/5);

Recognizing that there are numerous Governing Body mandates dating back to 1992 that highlight the need to address urban health issues and the inequities in health caused by urbanization in the Region, in addition to the opportunity offered by the Health Agenda for the Americas 2008-2017 and the PAHO Strategic Plan 2008-2012;

Recognizing that the urbanization megatrend has rapidly accelerated in the Region and countries have not been able to react and adjust their programs to the wide diversity of cultural, community, family, migration, and socioeconomic challenges posed by this urbanization process;

Having studied the opportunity presented to address many of the most challenging public health problems now confronting the countries in the areas of noncommunicable diseases, injuries, vector-borne and other communicable diseases, and the challenge of tackling the diverse population needs in urban settings, as highlighted in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

Considering that the lack of adequate, systematic consideration of public health criteria in the largely unplanned growth of cities in the Region has resulted in an increase in morbidity and mortality and a widening of the equity gap within cities;

Understanding that, to succeed in advancing public health in the Region, the ministries of health will have to include information in their health surveillance systems that differentiates the gradient of health inequities and their causes and implications for national and city health policies, programs, and services;

Recognizing that achieving urban health is a multisectoral endeavor that involves concerted action to promote physical activity; design safe, effective and accessible public transport options; prevent and reduce injuries; reduce the harmful use of alcohol; and address the particular access and wellness needs of the most vulnerable groups, including children, older persons, and people with special needs;

Further recognizing that countries that adopt this holistic approach, in coordination and synergy with other plans of action, including those of the United Nations specialized agencies, are not only improving the health of their citizens but achieving important environmental and sustainability gains;

Bearing in mind that the implementation of the Strategy and Plan of Action means marshalling a unique combination of stewardship over the health system and its network of services and with the other social actors in urban settings to advocate for and adjust all manner of urban health services that can address the special needs of the social gradient and the heterogeneity of urban populations;

Having requested during the 50th Directing Council that the Pan American Sanitary Bureau prepare a preliminary strategy and plan of action to be presented to the 51st Directing Council,

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action on Urban Health and support its implementation within the context of the specific conditions of each country in order to respond appropriately to the current and future needs and trends in urban health in the Region.

2. To urge the Member States to:

(a) adopt the guidelines, tools, and methods developed by PASB and the Centers of Excellence to support their intersectoral stewardship role, the promotion of social participation, and health services reorientation;

(b) support national, subnational, and local health promotion policies and programs, including the strengthening of social participation, with appropriate legal frameworks and financing mechanisms;

(c) adjust surveillance systems according to national priorities to include determinants and indicators related to urban health, such as gender, age, sexual orientation, socio-economic status, migration conditions, race, ethnicity, indigenous populations, and homelessness and housing conditions;

(d) further the commitment of city and metropolitan authorities to healthy urban planning and development, with consideration of urban health and health equity in national and subnational health policies and plans;

(e) collaborate with city and metropolitan authorities in the development of transport policies and systems that prioritize safe walking, cycling, and public transport; and in urban design regulations and infrastructure that provide for equitable and safe access to recreational physical activity throughout the life course;

(f) assist city and metropolitan authorities with the use of assessment and action tools to address healthy and equitable urban planning and programs more effectively;

(g) raise awareness among key stakeholders and develop social marketing plans and programs;

(h) report back every two years on the progress made, with data for a mid-term evaluation at five years and a final evaluation at ten years;

(i) promote specific health promotion and sustainable development projects in communities, with a focus on vulnerable populations, to encourage social participation and intersectoral action.

3. To request the Director to:

(a) produce and disseminate public health criteria, guidelines, model policies, and legal frameworks for urban health planning, urban health services, and methods for achieving multisectoral action, including health impact assessment, health equity impact assessment, and cross-sector data collection and analysis;

(b) collect and disseminate new information on experiences, lessons learned, and best practices obtained through regional forums, research, observatories, documentation, and the sharing of promising experiences and processes;

(c) further develop health promotion and health determinants approaches into technical cooperation in urban health and Country Cooperation Strategy implementation in the Member States;

(d) promote capacity building for urban health planning and implementation, surveillance, and information systems across the Region;

(e) support ministry of health engagement with city and metropolitan authorities and other relevant sectors, along the lines of the issues itemized in the final report of the roundtable discussions in the 50th Directing Council, the final report of the Urban Health and Health Promotion Forums, and the Global Call to Action on Urbanization and Health.

(Fifth meeting, 28 September 2011)

CD51.R5: Strategy and Plan of Action on eHealth

THE 51st DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action on eHealth* (Document CD51/13);

Recognizing that the review of the current situation indicates that the implementation of *eHealth* (using information and communication technologies in health) in the countries of the Americas hinges on two basic conditions: the existence of efficient means for formulating and implementing *eHealth* policies and strategies (technical viability) and the existence of practical and locally relevant procedures, as well as simple, affordable, and sustainable instruments (programming and financing viability);

Understanding that the objective is to improve the coordination and delivery of services in the health sector, with a view to increasing efficiency, availability, access, and affordability, thus making it possible for the sector to make adjustments and anticipate new contexts in the field of health;

Bearing in mind that the document *Health-for-all Policy for the Twenty-first Century* (1998), commissioned by WHO, recommended the appropriate use of health technologies within the general health-for-all policy and strategy; World Health Assembly resolution WHA51.9 (1998) on cross-border advertising, promotion, and sale of medical products through the Internet; the Agenda for Connectivity in the Americas and Plan of Action of Quito (2003); the United Nations World Summits on the Information Society (Geneva, 2003; and Tunis, 2005); WHO Executive Board resolution EB115.R20 (2005) on the need to formulate *eHealth* strategies; World Health Assembly resolution WHA58.28, which established the linchpins of the WHO *eHealth* strategy; and the eLAC Strategy 2007-2010 of the Economic Commission for Latin America and the Caribbean (ECLAC);

Considering the ample experience of the Region of the Americas in veterinary public health programs, which can also contribute to sustainable national health systems;

Noting that PAHO has collaborated with the countries of the Region to establish the conceptual underpinnings, techniques, and infrastructure necessary for developing national *eHealth* programs and policies;

Recognizing the cross-cutting nature of this strategy and its complementarity with the objectives of the PAHO Strategic Plan 2008-2012 (*Official Document 328*);

Considering the importance of having an *eHealth* strategy and plan of action in place to enable the Member States to effectively and efficiently improve public health in the Region, through the use of innovative information and communication technology tools and methodologies,

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action on *eHealth*, and support their consideration in development policies, plans, and programs, as well as in the proposals and discussions on the national budget, thereby creating the conditions to respond to the challenge of improving public health in the Region through the use of innovative information and communication technology tools and methodologies in their respective countries.

2. To urge the Member States to:

(a) give priority to the use of innovative information and communication technology tools and methodologies, with a view to improving human and veterinary public health in the Region, including public health administration;

(b) prepare and implement interministerial policies, plans, programs, and interventions based on the Strategy and Plan of Action, making the necessary resources and legal framework available and focusing on the needs of at-risk populations in vulnerable situations;

(c) execute the Strategy and Plan of Action, as appropriate, within a framework made up of the health system and information and communication technology services, emphasizing interprogrammatic collaboration and intersectoral action, while monitoring and evaluating program effectiveness and the allocation of resources;

(d) promote greater competencies among policymakers, program managers, and health care and information and communication technology service providers, with a view to formulating policies and programs that facilitate the development of efficient, quality, and people-centered health services;

(e) promote internal dialogue within and coordination between ministries and other public sector institutions and encourage the forging of partnerships among government, the private sector, and civil society as a means of building national consensus and facilitating the sharing of experience on cost-effective models; moreover, ensure the availability of standards for quality, safety, interoperability, and ethics, while respecting the principles of information confidentiality, equity, and equality;

(f) support the capacity to generate information and research for the development of strategies and the implementation of pertinent evidence-based models;

(g) establish an integrated system to monitor, evaluate, and ensure accountability for policies, plans, programs, and interventions, making it possible to increase the surveillance and rapid response capacity for diseases, as well as human and veterinary public health emergencies;

(h) undertake reviews and internal analyses of the relevance and viability of the Strategy and Plan of Action, based on priorities, needs, and national capacity.

3. To request to the Director to:

(a) support coordination and implementation of the Strategy and Plan of Action on *eHealth* at the national, subregional, regional, and inter-institutional levels and facilitate technical cooperation both to and among countries for the preparation and implementation of their national plans of action;

(b) collaborate with the Member States on the implementation and coordination of the Strategy and Plan of Action, furthering its cross-cutting nature through the program areas and different regional and subregional contexts of the Organization;

(c) facilitate the dissemination of studies, reports, and solutions to serve as models for *eHealth*, so that, with the appropriate modifications, they can be used by the Member States;

(d) promote the formation of national, municipal, and local partnerships with other international organizations, scientific and technical institutes, nongovernmental organizations, organized civil society, the private sector, and other entities to facilitate the sharing of capacities and resources and thus increase compatibility between different administrative, technological, and legal solutions in the area of *eHealth*;

(e) promote coordination between the Strategy and Plan of Action and similar initiatives of other international technical cooperation and financing agencies;

(f) report periodically to the PAHO Governing Bodies on the progress and difficulties encountered in the implementation of the Strategy and Plan of Action, as well as its adaptation to specific contexts and needs.

(Sixth meeting, 28 September 2011)

CD51.R6: Plan of Action on Road Safety

THE 51st DIRECTING COUNCIL,

Having examined the *Plan of Action on Road Safety* (Document CD51/7, Rev. 1);

Recognizing the burden that road traffic injuries represent in the Region of the Americas as the leading cause of death in children aged 5 to 14 and the second leading cause of death in people aged 15 to 44, as well as the urgent need to adopt public health measures and promote public policies in coordination with other sectors to reduce the burden of lost lives and suffering caused by road traffic injuries;

Recalling World Health Assembly Resolution WHA57.10 (2004) on road safety and health and the resolution of the United Nations General Assembly, A/RES/58/289 (2004), on improving global road safety; the celebration of World Health Day 2004, with its emphasis on road safety; and the release of the *World Report on Road Traffic Injury Prevention*, the *Global Status Report on Road Safety*, and the status report on road safety in the Region of the Americas;

Recalling also Resolution CD48.R11 (2008) of the Directing Council of the Pan American Health Organization, *Preventing Violence and Injuries and Promoting Safety: A Call for Action in the Region*;

Recalling further that in March 2010 the United Nations General Assembly proclaimed the Decade of Action for Road Safety 2011-2020 (A/RES/64/255);

Recognizing the opportunities offered by the adoption of a public health approach that promotes multisectoral action in which the health sector plays a coordinating role in tackling the urgent need to effectively protect the poor, marginalized, and most vulnerable population, which is the most affected by road traffic injuries in the Region,

RESOLVES:

1. To approve the Plan of Action on Road Safety.

2. To urge the Member States to adopt intersectoral public policies that include, among other measures, the following:

(a) prioritize road safety through the development of national**,** subnational, and local plans for the Decade of Action for Road Safety;

(b) improve the urban road and highway infrastructure;

(c) improve mass transportation policies and laws by adopting the principles of safety, equity, and accessibility to promote safety and protect the human rights of all persons;

(d) reduce the incidence of risk factors (speed and alcohol consumption) in traffic-related injuries and increase the use of protective equipment (helmets, seat belts, and child restraint systems in automobiles);

(e) set urban speed limits at up to 50 km/h, promote decentralization so that local governments can adjust speed limits, and promote public awareness of the need for setting speed limits;

(f) adopt a maximum blood alcohol level for drivers that is less than or equal to 0.05 g/dl;

(g) enforce the laws on compulsory helmet use, taking quality and safety standards into account;

(h) enforce the laws on compulsory seat belt use, taking quality and safety standards into account, and promote seat belt use;

(i) enforce the laws on the compulsory use of child restraint systems in automobiles, taking quality and safety standards into account, and promote the use of these systems;

(j) establish or improve a technical vehicle inspection and testing system;

(k) strengthen the technical and institutional capacity for providing care to victims of road traffic injuries, particularly in the prehospitalization phase, hospital care, and rehabilitation;

(l) improve data on road traffic injuries by designing surveillance services to increase understanding and awareness of the burden, causes, and consequences of road traffic injuries, so that victim prevention, care, and rehabilitation programs and investments can be better targeted, monitored, and evaluated;

(m) promote studies that yield scientific and technical information on the risks associated with distractions, both inside and outside the vehicle, that can cause traffic accidents (for example, the use of electronic devices such as cellular phones

and navigation systems; eating, drinking, or smoking while driving; and highway billboards).

3. To request the Director to:

(a) support the Member States in their efforts to improve road safety and in the preparation of national and subnational plans for the Decade of Action for Road Safety;

(b) facilitate the identification and sharing of good practices for the prevention of road traffic injuries;

(c) encourage and support the national focal points network and foster collaboration with other networks of experts, professionals, and nongovernmental organizations;

(d) provide cooperation for the creation of technical and policy-making capacity to facilitate data collection and dissemination, and promote research and surveillance systems related to the prevention of road traffic injuries;

(e) provide technical assistance to improve prehospital treatment and care for victims of road traffic injuries;

(f) promote associations and collaboration with international agencies, networks of experts, civil society, foundations, the private sector, and other social actors in order to further an intersectoral approach.

(Sixth meeting, 28 September 2011)

CD51.R7: Plan of Action on Psychoactive Substance Use and Public Health

THE 51st DIRECTING COUNCIL,

Having reviewed the *Plan of Action on Psychoactive Substance Use and Public Health* (Document CD51/9);

Recognizing the burden of morbidity, mortality, and disability associated with substance use disorders in the world and in the Region of the Americas specifically, as well as the existing gap in treatment and care for persons affected by such disorders;

Understanding that approaches related to prevention, screening, early intervention, treatment, rehabilitation, social reintegration, and support services are necessary actions to reduce the adverse consequences of psychoactive substance use;

Recognizing that these approaches require improving access to health care services and promoting the health and social well-being of individuals, families, and communities, while protecting and promoting the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

Considering the context and framework for action offered by the Health Agenda for the Americas 2008-2017; the PAHO Strategic Plan 2008−2012; the Hemispheric Drug Strategy and the Hemispheric Plan of Action of the Inter-American Drug Abuse Control Commission of the Organization of American States (OAS/CICAD); the regional *Strategy and Plan of Action on Mental Health* (Document CD49/11 [2009]); and the *World Health Organization (WHO) Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance use disorders (mhGAP)*, which reflect the importance of the issue of substance use and establish strategic objectives for addressing it;

Observing that the Strategy on Substance Use and Public Health approved in 2010 sets out the principal areas of work to be addressed and identifies areas for technical cooperation to address the varying needs of Member States with regard to substance use,

RESOLVES:

1. To approve the Plan of Action on Psychoactive Substance Use and Public Health and support its implementation within the context of each country's specific conditions, in order to respond appropriately to current and future needs in relation to substance use.

2. To urge Member States to:

(a) identify psychoactive substance use as a public health priority and implement national and subnational plans to tackle psychoactive substance use problems that are consonant with their public health impact, especially with regard to reducing existing treatment gaps;

(b) contribute to and participate in the implementation of the Plan of Action.

3. To request the Director to:

(a) monitor and evaluate the implementation of the Plan of Action at five years and at the end of the implementation period;

(b) support the Member States in the preparation and implementation of national and subnational plans on psychoactive substance use within the framework of their specific conditions and public health policies, that take into account the provisions of the strategy on psychoactive substance use and public health;

(c) promote partnerships with governmental and nongovernmental organizations, as well as with international organizations and other regional stakeholders, in support of the multisectoral response required to implement this Plan of Action.

(Seventh meeting, 29 September 2011)

CD51.R8: Strategy and Plan of Action on Epilepsy

THE 51st DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action on Epilepsy* (Document CD51/10);

Recognizing the burden that epilepsy represents globally and particularly in the Region of the Americas in terms of morbidity, mortality, and disability, as well as the gap between the number of people with this disorder and those who receive no treatment;

Understanding that this is an important public health problem whose prevention, treatment, and rehabilitation are feasible through specific evidence-based measures;

Considering the context and justification for action offered by the Health Agenda for the Americas 2008-2017, the PAHO Strategic Plan 2008-2012, the World Health

Organization (WHO) Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance use disorders (mhGAP), and the Global Campaign against Epilepsy: Out of the Shadows;

Observing that the Strategy and the Plan of Action on Epilepsy address the principal work areas and define technical cooperation lines to meet the different needs of the countries,

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action on Epilepsy and their implementation under the particular conditions of each country to provide an appropriate response to current and future needs.

2. To urge the Member States to:

(a) make epilepsy a priority in national health policy by executing specific national programs suited to the conditions of each country, to sustain achievements and make progress toward meeting new goals, especially in relation to reducing the existing treatment gaps;

(b) strengthen legal frameworks as appropriate in order to protect the human rights of people with epilepsy and ensure effective enforcement of the laws;

(c) promote universal equitable access to medical care for all people with epilepsy by strengthening health services in systems based on primary health care and integrated service networks;

(d) ensure the availability of the four anti-epileptic drugs considered essential for treating people with epilepsy, especially at the primary care level;

(e) strengthen neurology services as support for case detection and management at the primary care level, ensuring adequate distribution of the necessary auxiliary diagnostic media;

(f) support effective participation by the community and associations of users and family members in activities designed to secure better care for people with epilepsy;

(g) consider strengthening human resources as key to improving national epilepsy programs, through systematic training geared especially to personnel in primary health care;

(h) promote intersectoral and educational initiatives directed to the population to combat the stigma and discrimination suffered by people with epilepsy;

(i) close the information gap in the field of epilepsy by improving the production, analysis, and use of information, including research;

(j) strengthen partnerships between the health sector, other sectors, and nongovernmental organizations, academic institutions, and key social actors.

3. To request the Director to:

(a) assist the Member States in the preparation and execution of national epilepsy programs within the framework of their health policies, taking the Strategy and Plan of Action into account, with a view to correcting inequities and giving priority to the care of vulnerable and special needs groups, including indigenous populations;

(b) collaborate in the evaluation and restructuring of the countries' neurology and mental health services;

(c) facilitate the dissemination of information and the sharing of positive innovative experiences, and promote technical cooperation among the Member States;

(d) promote partnerships with the International League against Epilepsy (ILAE) and the International Bureau for Epilepsy (IBE), as well as with international agencies, governmental and nongovernmental organizations, and other regional actors in support of the broad multisectoral response needed for the execution of this Strategy and Plan of Action;

(e) evaluate the implementation of the Strategy and Plan of Action and report to the PAHO Directing Council in five years.

(Seventh meeting, 29 September 2011)

CD51.R9: Strategy and Plan of Action for Malaria

THE 51st DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action for Malaria* (Document CD51/11);

Recalling Resolution CD46.R13 (2005) of the 46th Directing Council on malaria and the internationally agreed-upon development goals, including those contained in the Millennium Declaration;

Noting the existence of other relevant mandates and resolutions of the Pan American Health Organization, such as Document CD49/9 (2009), *Elimination of Neglected Diseases and other Poverty-related Infections*, which included malaria among the diseases that may be eliminated in some areas, and Document CD48/13 (2008), *Integrated Vector Management: A Comprehensive Response to Vector-borne Diseases*, which promotes integrated vector management as an integral part of vector-borne disease management in the Region;

Aware that the continuing decline in malaria cases and deaths affirms the Region's progress in combating malaria but also ushers in a unique set of important and evolving challenges for the Region;

Acknowledging that the diversity of the malaria context and challenges faced by the countries of the Region necessitates engagement in a comprehensive program with various combinations of components, together with evidence-based and innovative interventions;

Appreciating the efforts of Member States in recent years to address their respective challenges with malaria, but mindful of the need for further action,

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action for Malaria.

2. To urge the Member States to:

(a) review national plans or establish new ones for the prevention, control, and potential elimination of malaria, employing an integrated approach that addresses the social determinants of health and provides for inter-programmatic collaboration and intersectoral action;

(b) support efforts to consolidate and implement activities to further reduce endemicity and progress toward meeting the targets indicated in the Strategy and Plan of Action for Malaria, including the elimination of malaria where this is considered feasible;

(c) strengthen engagement in efforts to address malaria, including coordination with other countries and relevant sub-regional initiatives in epidemiological surveillance of malaria, surveillance of resistance to antimalarial medicines and insecticides, and monitoring and evaluation;

(d) strengthen commitment by both malaria-endemic and non-endemic countries and by various sectors to fight the disease, particularly in terms of sustained or increased investments and provision of necessary resources;

(e) establish integrated strategies for prevention, surveillance, diagnosis, treatment, and vector control with broad community participation, so that the process helps to strengthen national health systems, including primary health care, surveillance, and alert and response systems, with attention to factors related to gender and ethnicity;

(f) strengthen their focus on highly susceptible populations and occupational groups;

(g) support engagement in the development and implementation of a research agenda that addresses important knowledge and technology gaps in various contexts of malaria work in the Region, for example, the relationship between malaria and agriculture.

3. To request the Director to:

(a) support execution of the Strategy and the Plan of Action for Malaria and provide such technical cooperation as the countries may require to develop and execute national plans of action;

(b) continue advocating for the active mobilization of resources and encouraging close collaboration to forge partnerships that support the implementation of this resolution;

(c) promote and strengthen technical cooperation among the countries, subregional entities and institutions, and form strategic partnerships to carry out activities designed to overcome barriers to malaria efforts in border areas and hard-to-reach populations;

(d) promote cooperation among countries for the production of and access to malaria drugs that meet internationally recognized quality assurance standards, and which are consistent with PAHO/WHO recommendations.

(Seventh meeting, 29 September 2011)

CD51.R10: PAHO Program and Budget 2012–2013

THE 51st DIRECTING COUNCIL,

Having examined the proposed PAHO Program and Budget 2012–2013 (*Official Document 338* and *Addendum IV)*;

Having considered the report of the Executive Committee (Document CD51/2);

Having discussed scenarios D and E, as recommended by the 148th session of the Executive Committee, and further introducing a consensus scenario containing a 3.2% increase in assessed contributions (Addendum IV);

Noting the efforts of the Director to propose a program and budget that takes into account both the economic concerns of Member States and the Organization's public health mandates;

Bearing in mind Article 14.C of the Constitution of the Pan American Health Organization and Article III, paragraphs 3.5 and 3.6, of the PAHO Financial Regulations,

RESOLVES:

1. To approve the program of work for the Bureau as outlined in the PAHO Program and Budget 2012–2013 (*Official Document* 338 and *Addendum IV*).

2. To request the Director to further seek efficiencies and cost containment measures, wherever possible.

3. To appropriate for the financial period 2012–2013 the sum of US$ 310,637,902 in the following manner: (a) $285,100,000 for the Effective Working Budget (sections 1-16) that requires an increase of 3.2% to the assessments of PAHO Member States, Participating States, and Associate Members with respect to the biennium 2010-2011; and (b) $25,537,902 as a transfer to the Tax Equalization Fund (section 17), as indicated in the table that follows:

SECTION	TITLE	AMOUNT
1	To reduce the health, social and economic burden of communicable diseases	23,139,000
2	To combat HIV/AIDS, tuberculosis and malaria	6,479,000

SECTION	TITLE	AMOUNT
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	11,618,000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals	11,613,000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	4,469,000
6	To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions	7,757,000
7	To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	8,012,000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	11,717,000
9	To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development	10,750,000
10	To improve the organization, management and delivery of health services	8,253,000
11	To strengthen leadership, governance and the evidence base of health systems	30,386,000
12	To ensure improved access, quality and use of medical products and technologies	7,115,000
13	To ensure an available, competent, responsive and productive health workforce to improve health outcomes	9,439,000
14	To extend social protection through fair, adequate and sustainable financing	5,171,000
15	To provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the United Nations system and other stakeholders to fulfill the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO's Eleventh General Programme of Work, and the Health Agenda for the Americas	65,426,000

SECTION	TITLE	AMOUNT
16	To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	63,756,000
	Effective Working Budget for 2012-2013 (Parts 1-16)	285,100,000
17	Staff Assessment (Transfer to Tax Equalization Fund)	25,537,902
	Total: All Sections	310,637,902

4. That the appropriation shall be financed from:

(a) Assessments in respect of:

Member States, Participating States, and Associate Members assessed under the scale adopted..... 217,937,902

(b) Miscellaneous Income..... 12,000,000

(c) AMRO share approved at the 64th World Health Assembly..... 80,700,000

TOTAL..... 310,637,902

5. In establishing the contributions of Member States, Participating States, and Associate Members, assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that credits of those States that levy taxes on the emoluments received from the Pan American Sanitary Bureau (PASB) by their nationals and residents shall be reduced by the amounts of such tax reimbursements by PASB.

6. That, in accordance with the Financial Regulations of PAHO, amounts not exceeding the appropriations noted under paragraph 2 shall be available for the payment of obligations incurred during the period from 1 January 2012 to 31 December 2013, inclusive; notwithstanding the provision of this paragraph, obligations during the financial period 2012–2013 shall be limited to the effective working budget, i.e., Sections 1–16 of the appropriations table in paragraph 2.

7. That the Director shall be authorized to make transfers between the appropriation sections of the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; transfers between sections of the budget in excess of 10% of the section from which the credit is transferred

may be made with the concurrence of the Executive Committee, with all transfers of budget credits to be reported to the Directing Council or the Pan American Sanitary Conference.

8. That up to 5% of the budget assigned to the country level will be set aside as the "Country Variable Allocation," as stipulated in the Regional Program Budget Policy. Expenditure in the country variable allocation will be authorized by the Director in accordance with the criteria approved by the 2nd Session of the Subcommittee on Program, Budget and Administration, as presented to the 142nd Session of the Executive Committee in Document CE142/8. Expenditures made from the country variable allocation will be reflected in the corresponding appropriation sections 1–16 at the time of reporting.

9. To estimate the amount of expenditure in the program and budget for 2012–2013 to be financed by other sources at $328,300,000, as reflected in *Official Document 338* and *Addendum IV*.

(Seventh meeting, 29 September 2011)

CD51.R11, Rev. 1: Assessed Contributions of the Member States, Participating States, and Associate Members of the Pan American Health Organization for the Financial Period 2012-2013

THE 51st DIRECTING COUNCIL,

Whereas in Resolution CD51.R10 the Directing Council approved the PAHO Program and Budget 2012-2013 (*Official Document 338* and *Addendum IV*);

Bearing in mind that the Pan American Sanitary Code establishes that the scale of assessed contributions to be applied to Member States of the Pan American Health Organization will be based on the assessment scale adopted by the Organization of American States (OAS) for its membership, and that in Resolution CD51.R10 the Directing Council adopted the new scale of assessments for the PAHO membership for the financial period 2012-2013,

RESOLVES:

To establish the assessed contributions of the Member States, Participating States, and Associate Members of the Pan American Health Organization for the financial period 2012-2013 in accordance with the scale of assessments shown below and in the

corresponding amounts, which represent an increase of 3.2% with respect to the financial period 2010-2011.

Membership	Scale Adjusted to PAHO Membership		Gross Assessment		Credit from Tax Equalization Fund		Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff		Net Assessment	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
	%	%	US$	US$	US$	US$	US$	US$	US$	US$
Member States:										
Antigua and Barbuda	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Argentina	2.408	2.408	2,623,972	2,623,972	307,476	307,476			2,316,496	2,316,496
Bahamas	0.062	0.062	67,561	67,561	7,917	7,917			59,644	59,644
Barbados	0.045	0.045	49,036	49,036	5,746	5,746			43,290	43,290
Belize	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Bolivia	0.049	0.049	53,395	53,395	6,257	6,257			47,138	47,138
Brazil	9.941	9.941	10,832,603	10,832,603	1,269,361	1,269,361			9,563,242	9,563,242
Canada	11.972	11.972	13,045,763	13,045,763	1,528,699	1,528,699	45,000	45,000	11,562,064	11,562,064
Chile	1.189	1.189	1,295,641	1,295,641	151,823	151,823			1,143,818	1,143,818
Colombia	1.049	1.049	1,143,084	1,143,084	133,946	133,946			1,009,138	1,009,138
Costa Rica	0.221	0.221	240,821	240,821	28,219	28,219			212,602	212,602
Cuba	0.183	0.183	199,413	199,413	23,367	23,367			176,046	176,046
Dominica	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Dominican Republic	0.257	0.257	280,050	280,050	32,816	32,816			247,234	247,234
Ecuador	0.258	0.258	281,140	281,140	32,944	32,944			248,196	248,196
El Salvador	0.114	0.114	124,225	124,225	14,557	14,557			109,668	109,668
Grenada	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Guatemala	0.168	0.168	183,068	183,068	21,452	21,452			161,616	161,616
Guyana	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Haiti	0.034	0.034	37,049	37,049	4,341	4,341			32,708	32,708
Honduras	0.051	0.051	55,574	55,574	6,512	6,512			49,062	49,062
Jamaica	0.093	0.093	101,341	101,341	11,875	11,875			89,466	89,466
Mexico	8.281	8.281	9,023,719	9,023,719	1,057,397	1,057,397			7,966,322	7,966,322
Nicaragua	0.034	0.034	37,049	37,049	4,341	4,341			32,708	32,708
Panama	0.158	0.158	172,171	172,171	20,175	20,175			151,996	151,996
Paraguay	0.093	0.093	101,341	101,341	11,875	11,875			89,466	89,466
Peru	0.688	0.688	749,706	749,706	87,850	87,850			661,856	661,856

Membership	Scale Adjusted to PAHO Membership 2012 %	Scale Adjusted to PAHO Membership 2013 %	Gross Assessment 2012 US$	Gross Assessment 2013 US$	Credit from Tax Equalization Fund 2012 US$	Credit from Tax Equalization Fund 2013 US$	Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff 2012 US$	Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff 2013 US$	Net Assessment 2012 US$	Net Assessment 2013 US$
Saint Kitts and Nevis	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Saint Lucia	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Saint Vincent and the Grenadines	0.022	0.022	23,973	23,973	2,809	2,809			21,164	21,164
Suriname	0.034	0.034	37,049	37,049	4,341	4,341			32,708	32,708
Trinidad and Tobago	0.180	0.180	196,144	196,144	22,984	22,984			173,160	173,160
United States of America	59.445	59.445	64,776,593	64,776,593	7,590,503	7,590,503	10,000,000	10,000,000	67,186,090	67,186,090
Uruguay	0.214	0.214	233,194	233,194	27,326	27,326			205,868	205,868
Venezuela	2.186	2.186	2,382,061	2,382,061	279,129	279,129	0	0	2,102,932	2,102,932
Subtotal	99.583	99.583	108,514,547	108,514,547	12,715,701	12,715,701	10,045,000	10,045,000	105,843,846	105,843,846
Participating States:										
France	0.219	0.219	238,642	238,642	27,964	27,964			210,678	210,678
Kingdom of the Netherlands	0.068	0.068	74,099	74,099	8,683	8,683			65,416	65,416
United Kingdom	0.046	0.046	50,126	50,126	5,874	5,874			44,252	44,252
Subtotal	0.333	0.333	362,867	362,867	42,521	42,521			320,346	320,346
Associate Member:										
Puerto Rico	0.084	0.084	91,534	91,534	10,726	10,726			80,808	80,808
Subtotal	0.084	0.084	91,534	91,534	10,726	10,726			80,808	80,808
TOTAL	100.000	100.000	108,968,948	108,968,948	12,768,948	12,768,948	10,045,000	10,045,000	106,245,000	106,245,000

(Seventh meeting, 29 September 2011)

CD51.R12: Plan of Action to accelerate the reduction in maternal mortality and severe maternal morbidity

THE 51st DIRECTING COUNCIL,

Having reviewed the *Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity* (Document CD51/12);

Taking into account the proposed international mandates in the Regional Plan of Action to Reduce Maternal Mortality in the Americas (Document CSP23/10 [1990]); the resolution *Population and Reproductive Health* (CSP25.R13 [1998]); the Regional Strategy for Maternal Mortality and Morbidity Reduction (Document CSP26/14 [2002]); the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (Document CD50/15 (2010)); Resolutions WHA55.19 (2002), WHA57.13 (2004), and EB113.R11 (2004) on reproductive health, adopted by the World Health Assembly and the WHO Executive Board, respectively; the forums of Nairobi, Kenya (1987), Cairo, Egypt (1994), and Beijing, China (1995); the Millennium Declaration (2000); and the Health Agenda for the Americas 2008-2017;

Taking into account Resolution R11/8 of the Human Rights Council of the United Nations (2009), Resolution CD50.R8 of the 50th Directing Council of PAHO (2010) and the technical document *Health and Human Rights* (CD50/12), as well as the high degree of complementarity between this plan and other objectives established in the *PAHO Strategic Plan 2008-2012, Amended* (Official Document 328 [2009]);

Considering the Global Strategy for Women's and Children's Health launched by the United Nations Secretary-General in 2010 and the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

Mindful of the need for scaling up the management of non-communicable diseases (NCDs) and risk factors (diabetes, hypertension, obesity, smoking) in maternal health care protocols, as discussed in the High Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

Emphasizing that maternal mortality is a manifestation of inequity that affects every country in the Region, and that there are cost-effective interventions within the sector to effect the desired reduction that are capable of having a real impact within a short timeframe;

Considering the importance of having a plan of action that makes it possible for Member States to respond effectively and efficiently,

RESOLVES:

1. To approve the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity and to further its consideration in policies, plans, and development programs, as well as in proposals and discussions of national budgets, allowing them to address the issue of improving maternal health.

2. To urge the Member States to:

(a) consider the Health Agenda for the Americas 2008-2017 and the call by the United Nations Secretary General in 2010 to implement a plan to help reduce maternal mortality;

(b) adopt national policies, strategies, plans, and programs that increase women's access to culturally appropriate, quality health services adapted to their needs, including, in particular, promotion and prevention programs based on primary health care provided by skilled personnel; that integrate preconceptional (including family planning), pregnancy, delivery, and postpartum care (including prevention and treatment of HIV infection); and that also take into consideration the provision of these services free of charge to the most vulnerable populations;

(c) promote a dialogue between institutions in the public and private sector and civil society to prioritize women's lives as a human rights and development issue;

(d) promote the empowerment of women and the participation and co-responsibility of men in sexual and reproductive health;

(e) adopt a human resources policy that addresses the issue**s** of recruitment, training, and retention to respond to the needs of women and newborns;

(f) improve the capacity to generate information and research on sexual and reproductive health, maternal mortality, and severe maternal morbidity for the development of evidence-based strategies that permit monitoring and evaluation of their results, in keeping with the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

(g) undertake internal review and analysis of the Plan of Action, for implementation in the national context;

(h) advocate for dedicated public budgets, where applicable, based on strategic results aimed at improving the coverage and quality of care for women and children;

(i) promote the development of social protection programs for women and children.

3. To request the Director to:

(a) support the Member States in implementing the Plan of Action, in keeping with their needs and their particular demographic and epidemiological characteristics;

(b) promote implementation and coordination of the Plan of Action, ensuring its integration into programs;

(c) promote and strengthen information systems and maternal health surveillance, including a regional repository available to all stakeholders, and encourage operations research to design relevant strategies and carry out interventions based on the Region's specific needs and contexts;

(d) support the Member States in developing and creating capacities for training and appropriate distribution of maternal and neonatal health personnel;

(e) consolidate and strengthen technical cooperation with the committees, organs, and rapporteurships of the United Nations and inter-American bodies, in addition to promoting partnerships with other international and regional organizations, scientific and technical institutions, organized civil society, the private sector and others, within the framework of the Regional Working Group for the Reduction of Maternal Mortality;

(f) report periodically to the PAHO Governing Bodies on progress and constraints in implementing the Plan of Action, as well as on changes made to the Plan to adapt it, as necessary, to new circumstances and needs.

(Eighth meeting, 29 September 2011)

CD51.R13: Salary of the Director of the Pan American Sanitary Bureau

THE 51st DIRECTING COUNCIL,

Having reviewed Document CD51/18, *Salary of the Director of the Pan American Sanitary Bureau;*

Considering the revision to the base/floor salary scale for the professional and higher-graded categories of staff of the Pan American Sanitary Bureau, effective 1 January 2011;

Taking into account the decision by the Executive Committee at its 148th Session to adjust the salaries of the Deputy Director and Assistant Director of the Pan American Sanitary Bureau (Resolution CE148.R12),

RESOLVES:

To establish the annual salary of the Director of the Pan American Sanitary Bureau, beginning on 1 January 2011, at US$ 204,391 before staff assessment, resulting in a modified net salary of $145,854 (dependency rate) or $131,261 (single rate).

(Eighth meeting, 29 September 2011)

CD51.R14: Plan of Action to Reduce the Harmful Use of Alcohol

THE 51st DIRECTING COUNCIL,

Having reviewed the *Plan of Action to Reduce the Harmful Use of Alcohol* (Document CD51/8, Rev.1);

Recognizing the burden of morbidity, mortality, and disability associated with the harmful use of alcohol in the world and in the Region of the Americas, as well as the existing gap in treatment and care for persons affected by harmful alcohol consumption;

Considering the context and framework for action offered by the Health Agenda for the Americas, the PAHO Strategic Plan 2008–2012, and the World Health Assembly's Resolution WHA63.13 (2010) on a global strategy to reduce the harmful use of alcohol, which reflect the importance of the issue of harmful alcohol use and establish objectives for addressing it;

Observing that the *WHO Global Strategy to Reduce the Harmful Use of Alcohol* sets out the principal areas of work to be addressed and identifies areas for technical cooperation to address the varying needs of Member States with regard to harmful alcohol consumption;

Considering the recommendations from the WHO meeting of national counterparts for the implementation of the *Global Strategy to Reduce the Harmful Use of Alcohol* and the consultation meeting on the draft regional plan of action;

Recognizing the need for regional coordination and leadership in support of national efforts to reduce the harmful use of alcohol,

RESOLVES:

1. To approve the Plan of Action to Reduce the Harmful Use of Alcohol.

2. To implement the *WHO Global Strategy to Reduce the Harmful Use of Alcohol* through the Plan of Action, within the context of each country's specific conditions, in order to respond appropriately to current and future needs in relation to underage and harmful use of alcohol.

3. To urge Member States to:

(a) identify underage and harmful alcohol consumption as a public health priority and develop plans and/or introduce measures to reduce its public health impact;

(b) recognize that harmful alcohol consumption occurs among non-dependent and dependent individuals alike, and that reducing alcohol-related problems requires a mix of population-wide policies and targeted interventions, as well as access to quality health services;

(c) promote public policies that protect and preserve public health interests;

(d) promote policies and interventions that are evidence-based, equitable, and supported by sustainable implementation mechanisms involving different stakeholders;

(e) promote prevention programs that educate children, young people, and those who choose not to drink alcohol about how to resist social pressure to drink, protect them from such pressure, and support their choice not to drink;

(f) ensure that effective prevention, treatment, and care services are available, accessible, and affordable to those affected**,** including families, by the harmful use of alcohol;

(g) allocate financial, technical, and human resources towards the implementation of national activities outlined in the Plan of Action.

4. To request the Director to:

(a) monitor and evaluate the implementation of the Plan of Action at year five and at the end of the implementation period;

(b) support Member States in the implementation of national and subnational plans and/or interventions to reduce the harmful use of alcohol, within the framework of their public health and social policies, taking into account the *WHO Global Strategy to Reduce the Harmful Use of Alcohol*;

(c) collaborate in the assessment of alcohol policies and services in the national context of countries, with a view to ensuring that appropriate, evidence-based, corrective measures are adopted;

(d) facilitate the dissemination of information and the sharing of positive, innovative experiences, and promote technical cooperation among Member States;

(e) promote partnerships with international organizations and WHO, governmental and nongovernmental organizations, and civil society, taking into consideration any conflicts of interest that some nongovernmental organizations may have;

(f) establish a dialogue with the private sector on how it can best contribute to the reduction of alcohol-related harm, with appropriate consideration of the commercial interests involved and their potential conflict with public health objectives.

(Eighth meeting, 29 September 2011)

CD51.R15: Strategy and Plan of Action on Climate Change

THE 51st DIRECTING COUNCIL,

Having considered the *Strategy and Plan of Action on Climate Change* (Document CD51/6);

Recognizing that climate change is a current and projected threat to health and that it presents challenges to achieving the Millennium Development Goals;

Acknowledging that climate change poses a current and projected threat to public health in the Region of the Americas and that the impacts of this change will be most strongly felt by vulnerable populations living in low-lying and coastal areas, small islands, mountainous regions, water-stressed regions**,** and by the rural and urban poor;

Noting that the United Nations Framework Convention on Climate Change defines "adverse effects of climate change" as meaning changes in the physical environment or biota resulting from climate change which have significant deleterious effects on the composition, resilience or productivity of natural and managed ecosystems or on the operation of socio-economic systems or on human health and welfare;

Recalling the 2008 *Roundtable on Climate Change and its Impacts on Public Health: a Regional Perspective* (Document CD48/16) and its Final Report (Document

CD48/16, Add. II), and the proposed plan of action to protect health from the effects of climate change in the Region of the Americas;

Recalling Resolution WHA61.19 (2008) on climate change and health and the WHO work plan on climate change and health submitted to the Sixty-second World Health Assembly in 2009 (Document A62/11);

Realizing that there is an urgent need for the health sector in the Americas to protect health from the consequences of climate change,

RESOLVES:

1. To endorse the Strategy and approve the Plan of Action on Climate Change and health.

2. To urge the Member States to:

(a) strengthen their capacity to measure the impacts of climate change on health at the national and local levels, focusing on socioeconomic, ethnic, and gender inequities;

(b) strengthen the capacity of health systems for monitoring and analyzing climate and health information to implement timely and effective prevention measures;

(c) build capacity and awareness among public health leaders to provide technical guidance in developing and implementing strategies to address the health effects of climate change;

(d) support the development of training materials, methods, and tools to build capacity within and outside the health sector to address adaptation and mitigation measures to cope with climate change;

(e) promote the engagement of the health sector with all related sectors, agencies, and key national and international partners to implement interventions that reduce current and projected health risks from climate change;

(f) gradually implement the activities proposed in the Plan of Action, in order to empower and strengthen national and local health systems so they can effectively protect human health from current and projected risks related to climate change.

3. To request the Director to:

(a) continue to cooperate closely with Member States to support networks that facilitate the gathering and dissemination of information, and to promote research and surveillance systems related to climate and health;

(b) support the countries' efforts to launch campaigns for raising awareness about climate change, to reduce the health sector's carbon footprint, and to prepare health professionals to implement effective adaptation interventions;

(c) work with countries, subregional integration mechanisms, international agencies, networks of experts, civil society, and the private sector to create partnerships that promote environmentally sustainable actions that take into account the impact on health at all levels;

(d) support Member States in assessing their population's vulnerability to climate change and in developing adaptation options based on these assessments;

(e) assist Member States in implementing the Plan of Action, in developing national plans tailored to local needs, and in informing of their progress in this regard in relevant high-level venues such as the 2012 Earth Summit.

(Ninth meeting, 30 September 2011)

Decisions

Decision CD51(D1) Appointment of the Committee on Credentials

Pursuant to Rule 31 of the Rules of Procedure of the Directing Council, the Council appointed Antigua and Barbuda, Canada, and Honduras as members of the Committee on Credentials.

(First meeting, 26 September 2011)

Decision CD51(D2) Election of Officers

Pursuant to Rule 16 of the Rules of Procedure of the Directing Council, the Council elected Panama as President, Bahamas and Uruguay as Vice Presidents, and Bolivia as Rapporteur of the 51st Directing Council.

(First meeting, 26 September 2011)

Decision CD51(D3) ***Establishment of the General Committee***

Pursuant to Rule 32 of the Rules of Procedure of the Directing Council, the Council appointed Cuba, Guatemala, and the United States of America as members of the General Committee.

(First meeting, 26 September 2011)

Decision CD51(D4) ***Adoption of the Agenda***

Pursuant to Rule 10 of the Rules of Procedure of the Directing Council, the Council adopted the agenda submitted by the Director, as amended (Document CD51/1, Rev. 1).

(First meeting, 26 September 2011)

IN WITNESS WHEREOF, the President of the 51st Directing Council, Delegate of Panama, and the Secretary *ex officio*, Director of the Pan American Sanitary Bureau, sign the Final Report in the Spanish language.

DONE in Washington D.C., United States of America, this thirtieth day of September in the year two thousand and eleven. The Secretary shall deposit the original signed document in the Archives of the Pan American Sanitary Bureau.

_____

Franklin Vergara Jaén
President of the 51st Directing Council
Delegate of Panama

_____

Mirta Roses Periago
Secretary *ex officio* of the 51st Directing Council
Director of the Pan American Sanitary Bureau

AGENDA

1. OPENING OF THE SESSION

2. PROCEDURAL MATTERS

2.1 Appointment of the Committee on Credentials

2.2 Election of the President, Two Vice Presidents, and the Rapporteur

2.3 Establishment of a Working Party to Study the Application of Article 6.B of the PAHO Constitution

2.4 Establishment of the General Committee

2.5 Adoption of the Agenda

3. CONSTITUTIONAL MATTERS

3.1 Annual Report of the President of the Executive Committee

3.2 Annual Report of the Director of the Pan American Sanitary Bureau

3.3 Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Argentina, Guatemala, and Haiti

4. PROGRAM POLICY MATTERS

4.1 PAHO Program and Budget 2012-2013

4.2 Strategy and Plan of Action on Urban Health

4.3 Strategy and Plan of Action on Climate Change

4. PROGRAM POLICY MATTERS (*cont.*)

4.4 Plan of Action on Road Safety

4.5 Plan of Action to Reduce the Harmful Use of Alcohol

4.6 Plan of Action on Psychoactive Substance Use and Public Health

4.7 Strategy and Plan of Action on Epilepsy

4.8 Strategy and Plan of Action on Malaria

4.9 Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity

4.10 Strategy and Plan of Action on *eHealth*

4.11 Panel on Safe Motherhood and Universal Access to Sexual and Reproductive Health

4.12 Roundtable on Antimicrobial Resistance

5. ADMINISTRATIVE AND FINANCIAL MATTERS

5.1 Report on the Collection of Quota Contributions

5.2 Financial Report of the Director and Report of the External Auditor for 2010

5.3 Appointment of the External Auditor of PAHO for 2012-2013 and 2014-2015

5.4 Salary of the Director of the Pan American Sanitary Bureau

6. SELECTION OF MEMBER STATES TO BOARDS AND COMMITTEES

6.1 Election of Two Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME)

7. AWARDS

7.1 PAHO Award for Administration, 2011

8. MATTERS FOR INFORMATION

8.1 [DELETED]

8.2 Regional Consultation on WHO Reform

8.3 Update on the Modernization of PASB Management Information System (PMIS)

8.4 Report on the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

8.5 Progress Reports on Technical Matters:

A. Immunization: Challenges and Outlook

B. Implementation of the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property

C. Advances in the Implementation of the WHO Framework Convention on Tobacco Control

D. Implementation of the International Health Regulations

E. Progress toward Achievement of the Health-related Millennium Development Goals in the Region of the Americas

F. Review of the Pan American Centers

G. Regional Initiative and the Plan of Action for Transfusion Safety for 2006-2010: Final Evaluation

8. MATTERS FOR INFORMATION (*cont.*)

8.6 Progress Reports on Administrative and Financial Matters:

A. Status of Implementation of the International Public Sector Accounting Standards (IPSAS)

B. Master Capital Investment Plan

8.7 Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO:

A. Sixty-fourth World Health Assembly

B. Forty-first General Assembly of the Organization of American States

C. Subregional Organizations

9. OTHER MATTERS

10. CLOSURE OF THE SESSION

LIST OF DOCUMENTS

Official Documents

Official Document 338; Add. I; Add. II, Rev. 1; Add. III, and Add. IV	PAHO Program and Budget 2012-2013
Official Document 340	Financial Report of the Director and Report of the External Auditor for 2010

Program Policy Documents

CD51/1, Rev. 1	Agenda
CD51/2	Annual Report of the President of the Executive Committee
CD51/3	Annual Report of the Director of the Pan American Sanitary Bureau
CD51/4	Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Argentina, Guatemala, and Haiti
CD51/5	Strategy and Plan of Action on Urban Health
CD51/6, Rev. 1	Strategy and Plan of Action on Climate Change
CD51/7, Rev. 1	Plan of Action on Road Safety
CD51/8, Rev. 1	Plan of Action to Reduce the Harmful Use of Alcohol
CD51/9	Plan of Action on Psychoactive Substance Use and Public Health
CD51/10, Rev. 1	Strategy and Plan of Action on Epilepsy

Program Policy Documents *(cont.)*

CD51/11	Strategy and Plan of Action on Malaria
CD51/12	Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity
CD51/13	Strategy and Plan of Action on *eHealth*
CD51/14, Rev. 1	Panel on Safe Motherhood and Universal Access to Sexual and Reproductive Health
CD51/15, Rev. 1, and Add. I	Roundtable on Antimicrobial Resistance
CD51/16, and Add. I	Report on the Collection of Quota Contributions
CD51/17	Appointment of the External Auditor of PAHO for 2012-2013 and 2014-2015
CD51/18	Salary of the Director of the Pan American Sanitary Bureau
CD51/19	Election of Two Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME)
CD51/20	PAHO Award for Administration, 2011

Information Documents

CD51/INF/1	[Deleted]
CD51/INF/2, Rev. 1 and Add. I, Rev. 1	Regional Consultation on WHO Reform
CD51/INF/3	Update on the Modernization of PASB Management Information System (PMIS)
CD51/INF/4	Report on the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

Information Documents *(cont.)*

CD51/INF/5 Progress Reports on Technical Matters:

A. Immunization: Challenges and Outlook

B. Implementation of the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property

C. Advances in the Implementation of the WHO Framework Convention on Tobacco Control

D. Implementation of the International Health Regulations

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F. Review of the Pan American Centers

G. Regional Initiative and the Plan of Action for Transfusion Safety 2006-2010: Final Evaluation

CD51/INF/6 Progress Reports on Administrative and Financial Matters:

A. Status of Implementation of the International Public Sector Accounting Standards (IPSAS)

B. Master Capital Investment Plan

CD51/INF/7 Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO:

A. Sixty-fourth World Health Assembly

B. Forty-first General Assembly of the Organization of American States

C. Subregional Organizations

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Segundo Secretario,
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Washington, D.C.

SAINT LUCIA/SANTA LUCÍA
(absent - ausente)

SAINT KITTS AND NEVIS/ SAINT KITTS Y NEVIS

Chief Delegate – Jefe de Delegación

Hon. Marcella Liburd
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Social Services, Community Development, Culture & Gender Affairs
Basseterre

Delegate – Delegado

Mr. Elvis Newton
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Health & Social Services
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SAINT VINCENT AND THE GRENADINES/ SAN VICENTE Y LAS GRANADINAS

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MEMBER STATES/ESTADOS MIEMBROS *(cont.)*

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Delegates – Delegados

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UNITED STATES OF AMERICA/ESTADOS UNIDOS DE AMÉRICA

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MEMBER STATES/ESTADOS MIEMBROS *(cont.)*

UNITED STATES OF AMERICA/ESTADOS UNIDOS DE AMÉRICA *(cont.)*

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Ministerio de Salud Pública
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Ministerio del Poder Popular para la Salud
Caracas

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Alternate – Alterno

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Chief Delegate – Jefe de Delegación

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Delegates – Delegados

M. Gérard Guillet
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Health Regional Agency
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NETHERLANDS/PAÍSES BAJOS

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Ministry of Health and Sport
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NETHERLANDS/PAÍSES BAJOS *(cont.)*

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Department of Health
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ASSOCIATE STATES/ESTADOS ASOCIADOS

PUERTO RICO

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Asesor del Secretario de Salud
Departamento de Salud
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OBSERVER STATES/ESTADOS OBSERVADORES

PORTUGAL
(absent - ausente)

SPAIN/ESPAÑA

Sra. Carmen Amela Heras
Directora General de Salud Pública
y Sanidad Exterior
Ministerio de Sanidad, Política Social e Igualdad
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SPAIN/ESPAÑA *(cont.)*

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Observador Permanente Adjunto de
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Estados Americanos
Washington, D.C.

Sr. Fernando Fernández-Monje
Becario, Misión Permanente de
España ante la Organización de los
Estados Americanos
Washington, D.C.

REPRESENTATIVES OF THE EXECUTIVE COMMITTEE/ REPRESENTANTES DEL COMITÉ EJECUTIVO

Dr. Daniel Yedlin
Jefe de Gabinete del Ministerio
Ministerio de Salud
Buenos Aires, Argentina

Dr. St. Clair Thomas
Chief Medical Officer
Ministry of Health and the Environment
Kingstown, St. Vincent and the Grenadines

AWARD WINNERS/ GANADORES DE LOS PREMIOS

PAHO Award for Administration, 2011/ Premio OPS en Administración, 2011

Dr. Edward Greene
Guyana

Abraham Horwitz Award for Excellence in Leadership in Inter-American Public Health, 2011/ Premio Abraham Horwitz a la excelencia en liderazgo en la salud pública interamericana, 2011

Dr. Peter Hoetz
United States of America

Clarence H. Moore Award Excellence for Voluntary Service, 2011/ Premio Clarence H. Moore a la excelencia en el servicio voluntario, 2011

Dr. Sue Patterson
Guatemala

AWARD WINNERS/
GANADORES DE LOS PREMIOS *(cont.)*

Manuel Velasco Suárez Award for Excellence in Bioethics, 2011/
Premio Manuel Velasco Suárez a la excelencia en la bioética, 2011

Dra. Laura Adriana Albarellos
México

Pedro N. Acha Award for Excellence in Veterinary Public Health, 2011/
Premio Pedro N. Acha a la excelencia en la salud pública veterinaria, 2011

Dra. Francisca Samsing
Chile

Sérgio Arouca Award for Excellence in Universal Health Care, 2011/
Premio Sérgio Arouca a la excelencia en la atención sanitaria universal, 2011

Integrated Management of Adolescents and Adult Illness Program
Ministry of Health
Guyana

Fred L. Soper Award for Excellence in Public Health Literature, 2011/
Premio Fred L. Soper a la excelencia en la bibliografía de salud pública, 2011

Dra. Ana Lucia Lovadino
Brasil

UNITED NATIONS AND SPECIALIZED AGENCIES/
NACIONES UNIDAS Y AGENCIAS ESPECIALIZADAS

Economic Commission for Latin America and the Caribbean/
Comisión Económica para América Latina y el Caribe

Sra. Inés Bustillo

UN Women/ONU Mujeres

Dr. Michelle Bachelet
Under-Secretary General
and Executive Director

United Nations Population Fund/ Fondo de Población de las Naciones Unidas

Dr. Laura Laski

REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS/
REPRESENTANTES DE ORGANIZACIONES INTERGUBERNAMENTALES

Caribbean Community/
Comunidad del Caribe

Mrs. Myrna Bernard
Dr. Rudolph O. Cummings

Hipólito Unanue Agreement/
Convenio Hipólito Unanue

Dra. Caroline Chang Campos
Dr. Ricardo Cañizares

Organization of American States/
Organización de Estados Americanos

Ambassador Albert R. Ramdin

Inter-American Development Bank/
Banco Interamericano de Desarrollo

Ms. Kei Kawabata

Inter-American Institute for Cooperation on Agriculture/
Instituto Interamericano de Cooperación para la Agricultura

Mr. David Hatch

REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL RELATIONS WITH PAHO / REPRESENTANTES DE ORGANIZACIONES NO GUBERNAMENTALES EN RELACIONES OFICIALES CON LA OPS

Latin American Federation of Hospitals/ Federación Latinoamericana de Hospitales

Dr. Norberto Larroca

Latin American Association of Pharmaceutical Industries/ Asociación Latinoamericana de Industrias Farmacéuticas

Dr. Rubén Abete

National Alliance for Hispanic Health/ Alianza Nacional para la Salud Hispana

Ms. Marcela Gaitán

U.S. Pharmacopeial Convention

Dr. Damian Cairatti

REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL RELATIONS WITH WHO / REPRESENTANTES DE ORGANIZACIONES NO GUBERNAMENTALES EN RELACIONES OFICIALES CON LA OMS

Alzheimer's Disease International/ Enfermedad de Alzheimer internacional

Mr. Michael Splaine

International Alliance of Patients' Organizations/Alianza internacional de organizaciones de pacientes

Ms. Eva Ruiz de Castilla
Mr. Julio Campos

International Bureau for Epilepsy Oficina Internacional para la Epilepsia

Dr. Carlos Acevedo

International Federation of Pharmaceutical Manufacturers Associations/ Federación Internacional de la Industria del Medicamento

Ms. Corry Jacobs
Mr. Andrew Rudman
Mr. Mark Grayson
Mr. Jorge Carrion
Ms. María del Pilar Rubio
Ms. Shira Kilcoyne
Ms. Jacqueline Anne Keith

International Council for Control of Iodine Deficiency Disorders/ Consejo Internacional para la Lucha contra los Trastornos por Carencia de Yodo

Dr. Eduardo Pretell

International Federation of Medical Students' Associations/ Federación Internacional de Asociaciones de Estudiantes de Medicina

Ms. Elizabeth Wiley
Ms. Gabriela Irem Noles Cotito
Ms. Anne-Sophie Thommeret-Carrière
Ms. Sandra Sofia Tang Herrera

International Society of Radiographers and Radiological Technologists

Mrs. Rita Eyer

World Heart Foundation

Ms. Diana Vaca McGhie
Ms. Kelly Worden

REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL RELATIONS WITH WHO / REPRESENTANTES DE ORGANIZACIONES NO GUBERNAMENTALES EN RELACIONES OFICIALES CON LA OMS *(cont.)*

International League Against Epilepsy
Liga Internacional Contra la Epilepsia

Dr. Marco A. Medina

World Self Medication Industry

Dr. Héctor Bolaños

SPECIAL GUESTS/ INVITADOS ESPECIALES

S.A.R. La Infanta Doña Cristina
Directora del Área Internacional de la Fundación "la Caixa" y Presidenta del Instituto de Salud Global de Barcelona (ISGlobal)

Dr. Aníbal Faúndes
Coordinator
Latin American Federation of Obstetrics and Gynecology Societies

Dr. Patrick Kelley
Institute of Medicine

Dr. Susan Foster
Alliance for the Prudent Use of Antibiotics

Dr. José G. Orozco
ReAct Latin America

WORLD HEALTH ORGANIZATION/ ORGANIZACIÓN MUNDIAL DE LA SALUD

Dr. Margaret Chan
Director-General

Dr. Carissa F. Etienne
Assistant Director-General, HSS, Health Systems and Services

Dr. Mario Raviglione
Director, STB Stop TB

Dr. Shekhar Saxena
Director, Mental Health and Substance Abuse, MSD

Dr. Najeeb Mohamed Al Shorbaji
Director, Knowledge Management and Sharing, KMS

Dr. Ian Michael Smith
Advisor to Director-General, DGO

PAN AMERICAN HEALTH ORGANIZATION/
ORGANIZACIÓN PANAMERICANA DE LA SALUD

Director and Secretary *ex officio* of the Council/
Directora y Secretaria *ex officio* del Consejo

Dr. Mirta Roses Periago

Advisers to the Director
Asesores de la Directora

Dr. Jon Kim Andrus
Deputy Director
Director Adjunto

Dr. Socorro Gross
Assistant Director
Subdirectora

Mr. Guillermo Birmingham
Director of Administration
Director de Administración

Dr. Heidi Jiménez
Legal Counsel, Office of Legal Counsel
Asesora Jurídica, Oficina del Asesor Jurídico

Ms. Piedad Huerta
Advisor, Governing Bodies Office
Asesora, Oficina de los Cuerpos Directivos

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