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WORLD HEALTH ORGANIZATION



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FINAL REPORT

The 31st Session of the Subcommittee on Planning and Programming of the Executive Committee was held at the Headquarters of the Pan American Health Organization in Washington, D.C., on 23 and 24 November 1998.

The meeting was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Antigua and Barbuda, Canada, Chile, Ecuador, Mexico, Panama, and United States of America. Also present were observers for Argentina, Bahamas, and Cuba.

Officers

The Subcommittee elected the following officers to serve for the 31st and 32nd Sessions:

<i>President:</i>	(Dr. César Hermida)	Ecuador
<i>Vice President:</i>	(Dr. Giuseppe Corcione)	Panama
<i>Rapporteur:</i>	(Dr. Melba Muñíz Martelón)	Mexico

Dr. George A. O. Alleyne (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Juan Manuel Sotelo (Chief, Office of Analysis and Strategic Planning) served as Technical Secretary.

Opening of the Session

The Director opened the meeting and welcomed the participants. He extended a special welcome to the new Members elected to the Subcommittee by the Executive Committee in September 1998 and to the observers, whose presence was evidence of their interest in and enthusiasm for the work of the Organization. For the benefit of newcomers, he reviewed the functions of the Subcommittee, noting that it provided a less formal environment in which the Member States could examine and share ideas on the work of PAHO. As in previous years, not all the items on the Subcommittee's agenda would be sent on to the Governing Bodies for a decision or resolution. Some items were being presented simply for purposes of information and to obtain the Members' input on the Organization's current activities and future lines of action. He hoped that the session would be characterized by vigorous discussion and exchange of ideas, which would provide the Secretariat with valuable guidance on how to move forward in the various program areas to be examined by the Subcommittee.

**Adoption of the Agenda and Program of Meetings
(Documents SPP31/1, Rev. 1, and SPP31/WP/1)**

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

Presentation and Discussion of the Items

***Violence against Women in the Americas
(Document SPP31/6)***

Dr. Marijke Velzeboer-Salcedo (Coordinator, Program on Women, Health, and Development) presented information on violence against women in the Americas and described some of PAHO's efforts, through the Program on Women, Health, and Development (HDW), to help the health sector in the countries address the problem. She began by pointing out that, although the problem was not new, only recently had violence against women been formally recognized as an abuse against human rights through various international conferences and instruments, including the United Nations Declaration on the Elimination of Violence Against Women, adopted in 1993. She then presented data that illustrated the magnitude and costs of violence against women and its ramifications for the health and development of women and their children.

PAHO's efforts to combat the problem were premised on the conviction that gender-based violence was preventable and that the social constructs that often led to tolerance of such violence could be changed. The Organization considered that the health sector had a key role to play in designing, implementing, and evaluating national policies for addressing violence against women. Accordingly, HDW was working with ministries of health and other policy-making bodies in the countries to develop policies and programs to promote prevention, detection, and attention to violence against women. In addition, the Program had designed a community-based, intersectoral model for the prevention of intrafamily violence, which had been implemented in 10 countries. The document described the main features of the model and the outcomes of its implementation, as well as some of the other activities undertaken by the Program to support the countries in stemming the problem of gender-based violence.

Dr. Velzeboer-Salcedo concluded her presentation by noting that, ultimately, violence against women was rooted in gender-based discrimination and that any attempt to address it must therefore be linked to efforts to empower women. Eliminating violence against women would require a commitment by many sectors and an integrated, public-health approach in which the health sector, women victims of violence, and their advocates participated actively.

The Subcommittee applauded PAHO's efforts to call attention to and develop approaches to the problem of violence against women in the Region. The Subcommittee also agreed that the problem was definitely linked to discrimination and women's lower social status and that eliminating gender-based violence would therefore require approaches that went beyond a traditional biomedical perspective and incorporated a broad range of psychosocial factors. Several delegates pointed out the need for psychosocial and mental health training for health care providers to enable them to detect and deal appropriately with cases of abuse. The importance of incorporating such training into the curricula for health care professionals was also underscored.

It was stressed that violence against women should be viewed essentially as a public health problem, although its multicausal nature required the intervention of a variety of social actors. The need for greater collaboration between the health sector and other sectors, including the legal/criminal justice system, was emphasized, as was the need for greater collaboration between the public and private sectors to combat gender-based violence in the workplace, the community, and the home. PAHO's community-based model was considered a good means for building the necessary intersectoral collaboration and involving a wide array of individuals and institutions. At the same time, it was pointed out that, while community-based models were an effective means of providing treatment and intervention, national policies and approaches were needed in order to address the roots of the problem. The need for national surveillance systems and the development of indicators to provide accurate information on the magnitude of the problem and assess the effectiveness of policies and programs designed to address it was highlighted. Social communication and advocacy were seen as essential to raise awareness of the problem and delegitimize the practice of violence against women.

Several delegates cited the need for further research on the underlying causes of gender-based violence, the characteristics of the perpetrators, and factors such as alcohol and drug use that were often associated with such violence. More studies on the economic and social costs of gender-based violence—including its adverse consequences for the children of abused women—were also considered necessary. In this connection, it was pointed out that measures to address violence against women should be seen as an investment, not as a cost, because they would serve to prolong and enhance the life, health, and well-being of women, men, and children, both now and in future generations.

With regard to the document, a number of suggestions were made. Several delegates pointed out that the terminology used to refer to violence against women was inconsistent and that the terms gender-based violence, gender violence, domestic violence, and family violence were not interchangeable. The terms "gender-based violence" and "violence against women," as defined by the United Nations, were considered the clearest and most precise terms. It was suggested that the document should give greater attention to the very serious problem of discrimination and violence against girls in the Region, as

well as to violence in the workplace, the role of alcohol and drugs in violence against women, and to the situation of women and girls in indigenous and rural communities and of those who lived or worked on the streets, especially sex workers. It was requested that future versions of the document include more information on efforts to address violence against women in the Caribbean. In addition, it was suggested that the document should examine how existing policies and legislation influenced the way in which health care providers and others in the community, including abused women themselves, dealt with gender-based violence. The Subcommittee considered that a key role for PAHO was mobilization of the various social actors—including health professionals, law enforcement agencies, educators, and community leaders—whose involvement was needed in order to end the violence that threatened women and their children.

Dr. Velzeboer-Salcedo noted that the variation in the terms used in the document to refer to the phenomenon of violence against women was due in part to the fact that different countries and communities were using different terminology, depending on the nature of the problems they had identified as priorities, but she agreed that it was important to use uniform terminology in the Organization's documents in order to avoid confusion. In response to a comment from one of the delegates regarding a pilot project undertaken in Argentina to assess gender-based differences in quality of care, she reported that the Program on Women, Health, and Development was also implementing the project in four countries of Central America. That project had yielded a great deal of useful information on how gender influenced the patient-provider relationship. She acknowledged the importance of investigating the role of alcohol use in gender-based violence, the impact of the problem on girls and street kids, and other areas of research mentioned by the Subcommittee. In revising the document, the Program would include more information on the Caribbean experience and would seek to incorporate the delegates' suggestions in order to make the document as useful as possible for the Member States.

The Director pointed out that most of PAHO's experience in regard to the problem of violence against women had been gained from extrabudgetary projects, mainly in Central America, which had focused primarily on addressing the problem through a community-based approach and involvement of abused women themselves. That approach had therefore been most prominent in the early stages of the Organization's work. However, he agreed that it was important to also look at some of the correlates of gender-based violence mentioned by the Subcommittee. While he agreed that the problem should be viewed as a public health problem, he did not think conventional public health approaches would be sufficient to solve it. Innovative strategies would be required. Nevertheless, the first step toward a solution should be to obtain accurate epidemiological information and raise awareness of the problem through standard public health methods. In regard to the impact of legislation on responses to gender-based violence, he noted that

several studies had suggested that in some cases existing laws actually discouraged women from reporting abuse.

Report on PAHO's Response to Hurricane Mitch

At the request of the Director, Dr. Claude De Ville (Chief, Emergency Preparedness and Disaster Relief Program) presented a brief report on the actions taken by PAHO in response to Hurricane Mitch, which caused severe flooding and devastation in Central America during October 1998. He began by outlining the role of the PAHO/WHO representative offices in responding to the emergency. One of the main priorities had been to help the ministries of health in the affected countries assess the situation and identify unmet needs in order to inform the international community and mobilize an international response. Those assessments had been undertaken in collaboration with the United Nations Disaster Assessment and Coordination (UNDAC) Team, the Inter-American Development Bank (IDB), the Economic Commission for Latin America and the Caribbean (ECLAC), and the World Bank. PAHO's participation in the assessments had been crucial in order to ensure that urgent health requirements were not overlooked in the face of huge needs for relief and reconstruction. The Organization had mobilized over three million dollars for emergency relief efforts, but perhaps more important than its mobilization of financial resources had been its role in mobilizing technical resources from all over the world to help the ministries of health in disease control, supply management, water supply and sanitation, and other priority areas.

A major concern had been prevention and control of communicable disease following the hurricane. Accordingly, PAHO had concentrated on vector control, protection of water supplies, and food safety in order to prevent outbreaks. At the same time, the Organization had been concerned with providing balanced and accurate information to the public to counter sensationalistic reports in the mass media, which tended to give the impression that catastrophic outbreaks of communicable disease were inevitable.

Another important area of action had been management of medical supplies and other humanitarian assistance through PAHO's program for supply management in the aftermath of disasters (SUMA), which provided a tool for inventorying, classifying, and registering incoming supplies in emergencies. The SUMA program had been implemented in all the affected countries.

In the longer term, the Organization would continue to work to ensure that health sector needs—especially repair and reconstruction of water supply and sanitation systems—received the priority they deserved in ongoing recovery efforts. In conclusion, Dr. De Ville pointed out that there were many lessons to be learned from the hurricane. In particular, at the country level, it was necessary to ask whether the health sector had been sufficiently prepared and to assess the effectiveness of the disaster prevention and

mitigation measures that PAHO had been promoting for the past several years. Finally, he announced that a major meeting would be held in Santo Domingo on 9-12 February 1999 to evaluate the health sector response to both Hurricane Georges and Hurricane Mitch. That meeting would also afford an opportunity to gauge the effectiveness and assess the shortcomings of emergency response activities in order to be better prepared for future disasters.

The Subcommittee commended PAHO—in particular Dr. De Ville and the staff of the Emergency Preparedness and Disaster Relief Program—for its rapid and effective response to Hurricane Mitch. Several delegates noted that the excellent information provided by PAHO had enabled their governments to know what type of assistance would be most helpful to the affected countries. The importance of PAHO's role in coordinating aid and managing supplies was also emphasized.

Dr. De Ville thanked all the countries that had responded so generously in the aftermath of the disaster. The Director said that the Organization would continue to assist the affected countries in any way it could and would also continue to serve as a source of information to let other countries know how they could best support the Central American countries as they embarked on the long process of reconstruction.

***Fellowships Program of the Pan American Health Organization
(Document SPP31/8, Rev. 1)***

Ms. Nancy Berinstein (Chief, Fellowship Office) presented an overview of the background and operations of the PAHO Fellowships Program. She began by outlining the history and purpose of the Program, which for nearly 60 years had facilitated the international exchange of scientific knowledge and technology by supporting training programs for health practitioners from throughout the Americas. She stressed that the Program was, first and foremost, a technical cooperation program that served to develop human resources and build capacity in the health sector in the countries of the Region. The program originated in 1939 and was incorporated into the WHO Fellowships Program in 1949, when PAHO became the Regional Office of the World Health Organization.

The Fellowships Office, a unit under the Human Resource Development Program within the Division of Health Systems and Services Development, served as the central unit responsible for administering fellowships for individuals from other WHO regions who came to study in the Americas and for fellows from the Americas who studied in the United States, Canada, or in other WHO regions. Prior to the 1980s, the Fellowships Office administered all fellowships within the Americas, but in 1981 the Program was decentralized and responsibility for administering fellowships within Latin America and the Caribbean was shifted to the PAHO representative offices.

The document presented data on the numbers of fellowships awarded by country, by subregion, and by field of study in recent years. Ms. Berinstein noted that the fields of study for which fellowships were awarded reflected the strategic and programmatic orientations of the Organization and that the large number of fellowships awarded in health systems and services developments during the period 1994-1997 was indicative of the increasing importance attached to health sector reform in the countries and within the Bureau.

She concluded by describing three significant trends that would necessitate a reorientation of the Fellowships Program in the future so that it could better meet the countries' training needs: (1) the trend away from development of individuals and toward building of institutional capacity, which made it necessary to determine how the fellowships could best be used to assist that institutional strengthening; (2) the trend away from conventional vertical programs and toward project-based management, which called for new ways of linking or including training as a component of a given project; and (3) growing attention to impact and results, which was the result of limited health budgets and created a need for targeted training in high priority areas.

Dr. Daniel López Acuña (Director, Division of Health Systems and Services Development) stressed that the Fellowships Program should be seen as a mechanism of technical cooperation available to all countries and regions. It was not a separate program with its own source of funding, but rather was part of the overall program and budget of the Organization. He also noted that the administrative costs of the Program had been substantially reduced through a cost-sharing arrangement whereby PAHO received funding from other WHO regions for the administration of fellowships awarded to extraregional fellows, which contributed to the financial health of the Organization and made for more efficient administration of the Program.

The consensus of the Subcommittee was that the Fellowships Program had played a very valuable role in developing human resources and strengthening health systems in the countries. Nevertheless, it was felt that there should be some methodology for measuring the impact of the training provided through the Program, as well as a mechanism for ensuring that fellowship recipients returned to their countries of origin and for monitoring them to determine how the knowledge and skills they had acquired during their training experience were being put to use to enhance the capacity of the health sector at the national level. The Delegate of the Bahamas stated that her country would be willing to serve as a "laboratory" for an evaluation of the impact of PAHO fellowships.

Concern was expressed regarding the overall decrease in the number of fellowships awarded in the Region. It was noted that, while some countries utilized the Fellowships Program to a greater extent than did others, the percentage of the PWR budget earmarked for this Program was determined by each country. Several delegates raised questions as to the validity of the selection criteria and their appropriateness in the light of changing health

needs and the challenges of health sector reform. It was emphasized that, as a technical cooperation program, the Fellowships Program should respond to national priorities and that fellowships should be awarded on the basis of national needs and priorities. It was also pointed out that the external auditor for WHO had expressed a number of concerns regarding the fellowships programs in the various regions, in particular with respect to the criteria for selection of recipients and the purposes for which fellowships were being awarded. Questions were asked regarding the amount of money being spent for the Fellowships Program in relation to expenditures for other technical cooperation activities of the Organization.

One delegate described some modifications that had been introduced at the national level in his country to enhance the effectiveness of the technical cooperation received through the Fellowships Program, including matching of fellowship funds with national funds, awarding of fewer fellowships for longer training periods, and requiring fellows to return to the institutions in which they had been employed prior to receiving the fellowship.

In response to the questions, Ms. Berinstein said that she would supply information on dollar amounts and other statistics directly to the delegates who had requested them. She agreed that monitoring fellowship recipients and measuring the impact of the training received through the Program were very important, and she welcomed the Bahamas' offer to serve as a laboratory for that purpose.

Dr. López Acuña pointed out that it was important to consider not just the dollar amount that was spent on fellowships but also how those funds contributed to institutional capacity building and the development of human resources. He also noted that the amount allocated to fellowships did not remain constant through the years but varied according to the priority assigned to the Fellowships Program by each country. If countries decided to allocate a substantial portion of their PAHO technical cooperation to fellowships, then the figure would rise. However, the Fellowships Program should not be seen as something that took away from the country programs or the Regional programs, but rather as an instrument of technical cooperation and a way of focusing resources. The Program represented a joint effort between the country technical cooperation programs and the Secretariat, and the countries themselves played a prominent role in determining the purposes for which fellowships would be awarded, selecting candidates, and other aspects of the Program. Maximizing its impact and ensuring that fellowships effectively contributed to health development in the countries would therefore require close collaboration between the Secretariat, the country programs, and national authorities.

The Director observed that the decrease in the number of fellowships was partly a result of the successes of the Program in the past. As the countries had strengthened capacity at the national level through training fellowships, it was increasingly possible for them to offer training locally instead of sending health personnel abroad. He also pointed

out that it was extremely difficult to measure the impact of training on the health status of the population, a fact which had been recognized by the external auditor of WHO, whose concerns about the Fellowships Program had related more to inadequacies in the process of selection and follow-up and the administration of fellowships than to the impact of the training. Nevertheless, the Organization would continue to strive to improve both selection and administrative processes, as well as evaluation of the impact that fellowship recipients had in terms of improving health in their countries. In regard to follow-up, he noted that the PAHO Fellowships Office had been successful in tracing several fellows who had failed to return to their countries of origin and had recovered fellowship monies from them.

Integrated Management of Childhood Illness
(Document SPP31/3)

Dr. Yehuda Benguigui (Regional Advisor, Integrated Management of Childhood Illness) reviewed the background and main features of the strategy for integrated management of childhood illness (IMCI) and described some of the challenges and obstacles to implementation of the strategy in the Region of the Americas. The IMCI strategy was developed by WHO and the United Nations Children Fund (UNICEF) to reduce mortality and morbidity in children under 5 and improve the quality of care in health services and at home. In the Region of the Americas, PAHO was collaborating with UNICEF and several other agencies to implement the strategy.

Dr. Benguigui presented a series of statistics on mortality and morbidity in the countries of the Region, which illustrated that the vast majority of childhood illnesses and deaths were due to one or a combination of the five causes specifically targeted by the IMCI strategy: acute respiratory infections (ARI), diarrhea, malnutrition, malaria, and measles. The strategy provided a basic set of assessment, classification, and treatment guidelines, which enabled health care workers to assess the child's overall health status and rapidly detect and treat prevalent childhood illnesses. It thus reduced missed opportunities for detection and proper management of health problems other than the condition for which the child had been brought to a health service and provided an opportunity for the application of preventive measures such as vaccination and treatment of nutritional problems. Another key component of the strategy was education of parents on detection of warning signs and care for the child at home.

Implementing the IMCI strategy in the Americas required adapting the generic materials developed by WHO to the epidemiological and operational situation in each country, training health personnel in how to apply the strategy, and conducting supervision, monitoring, and evaluation after training. Since 1996, 14 countries in the Region had begun implementing the strategy. Initially, implementation efforts had focused on the countries with the highest infant mortality rates, where the strategy could have the

greatest impact in terms of reducing child mortality and morbidity. However, IMCI had also proved beneficial in countries that had relatively low infant mortality rates.

In order to fully implement the strategy and thus improve health conditions for the Region's children and assure them more equitable access to health care of better quality, several challenges would have to be overcome, notably: effective incorporation of the IMCI strategy into health reform processes, continued commitment of the countries to the strategy in order to ensure its sustainability, introduction of the IMCI strategy into training programs for health workers, increased involvement of NGOs in the implementation of the strategy, and adaptation of the strategy to different epidemiological situations in which problems other than those initially targeted by the strategy had priority.

The Subcommittee considered IMCI a sound approach to improving the health conditions of children in the Americas and applauded PAHO for its efforts to promote implementation of the strategy. It was pointed out that the Organization's efforts in that regard had been an important element in the Region's progress toward achieving the goals of the World Summit for Children. The IMCI strategy was seen as a valid approach for all countries, regardless of their infant mortality rates. The Organization was encouraged to continue seeking ways of adapting the strategy to different epidemiological situations and including components such as perinatal care and health problems of premature children, child mental health and psychosocial development, and oral health care. Several delegates indicated that the strategy had been officially adopted in their countries and described the efforts under way to implement it.

It was recommended that future versions of the document include more complete information on the assessment and classification guidelines and other aspects of how the strategy was applied in practice. It was also suggested that the document should include a broader range of examples from the countries to illustrate how the strategy was being implemented and a more detailed breakdown of infant mortality figures in order to reflect differences between countries and subregions, as well as differences between population groups, especially indigenous groups, within countries. Questions were asked with regard to the dynamics of the interagency partnership between PAHO and the various international and nongovernmental organizations involved in the IMCI initiative. The importance of taking advantage of opportunities to promote the IMCI strategy at international venues—such as the UNICEF conference on evaluation of the goals of the World Summit for Children held in Lima, Peru, in November 1998—was underscored.

Dr. Benguigui agreed that it would be advisable for future versions of the document to include more detailed information about the various components of the strategy and about how it was being applied at the health service level. In regard to adapting the strategy to different epidemiological situations, he said that future efforts would be aimed in two directions: reducing infant mortality in countries that continued to have rates of over 40 per 1,000 live births and expanding the strategy to address other

health problems of children in countries that had relatively low infant mortality. Among those problems would be perinatal care, asthma, and accidents. With respect to the UNICEF conference on evaluation of the goals of the World Summit for Children in Lima, he indicated that a proposal was being put forward to change some of the goals identified in 1990 at the Summit, taking into account the objectives and components of the IMCI strategy.

In response to the comments concerning how the IMCI strategy might be integrated into the concept of family health, Dr. Benguigui noted that the Basic Support Project for Institutionalizing Child Survival (BASICS)—a collaborative effort involving the United States Agency for International Development (USAID), PAHO, and UNICEF—was working on a health initiative that focused on the family as a whole and was based on the IMCI strategy. As for the interagency collaboration between PAHO and other organizations, he noted that the same group of agencies were working together to implement the strategy in eight countries with infant mortality rates of ≥ 40 per 1,000 live births. That initiative provided an excellent example of a successful interagency integration. In addition, PAHO and UNICEF were working with several NGOs to develop a common set of IMCI-related materials for use at the community level.

The Director pointed out that the Organization's experience had shown that true interagency collaboration could occur at the local level only if there were a local entity to coordinate the efforts of the various agencies. He also said that in September 1998 he had committed the Organization to work with the countries to save an additional 25,000 child lives every year, a commitment which was based on mass application of the IMCI strategy in the countries. In order to achieve that goal it would be necessary to aggressively "market" the strategy in order to persuade health care professionals, public officials, educators, and others in the countries to adopt it.

Persistent Organic Pollutants
(Document SPP31/4)

Dr. Luiz Augusto Cassanha Galvão (Regional Advisor, Environmental Quality Program) presented information on the problems posed by persistent organic pollutants (POPs) and efforts to address them at the international, regional, subregional, and country levels. POPs were highly stable toxic organic compounds that resisted degradation and therefore persisted for years in the environment, contaminating air, food, water, and soil. Moreover, POPs released in one part of the world could be transported through the atmosphere to regions far from the original source. In humans, exposure to POPs was associated with reproductive health abnormalities and birth defects, cancer, and possible harm to the immune system. They were therefore considered hazardous substances that required priority action.

Following the United Nations Conference on Environment and Development (UNCED) and the adoption of Agenda 21 in 1992, a number of actions had been taken at the international level in response to the problem of toxic chemicals, including POPs. Among the most noteworthy was the establishment in 1994 of the Intergovernmental Forum on Chemical Safety, the creation in 1995 of the Inter-Organizational Program for the Sound Management of Chemicals (IOMC), and the adoption in 1997 of Resolution WHA50.13, "Promotion of Chemical Safety, with Special Attention to Persistent Organic Pollutants." The latter called upon the Member States of WHO to involve health officials in national efforts to implement the decisions of the governing bodies of the United Nations Environment Program (UNEP) and WHO relating to persistent organic pollutants and requested the Director-General to provide technical cooperation to Member States for the exchange of information on toxic chemicals and the implementation of programs for the sound management of chemicals.

In the Region of the Americas, two IOMC-sponsored workshops on the subject had been held. One of the key conclusions from those workshops was that the countries often lacked information about sources and releases of POPs and that there was a severe shortage of adequately equipped laboratories and personnel trained in the management of POPs and other hazardous chemicals. Case studies had been carried out in several countries under a project sponsored jointly by PAHO and the United States Environmental Protection Agency. In addition, the governments of Canada, Mexico, and the United States had developed the North American Regional Action Plan on DDT, which was aimed at reducing human exposure to DDT and levels of the chemical in the environment.

The document proposed several activities for the Bureau's technical cooperation in addressing the problems associated with POPs and implementing Resolution WHA50.13. The first group of activities was oriented toward helping the ministries of health to find alternatives to the use of POPs for public health purposes, such as vector control; reducing or eliminating the use of pesticides; and disposing of unwanted stockpiles of pesticides, especially DDT. Other activities included the development of epidemiological and toxicological information systems, promotion of research on POPs, and sharing of information and expertise among countries. The document provided greater detail on the proposed activities.

The Subcommittee agreed that persistent organic pollutants posed a very serious problem that required global action and intersectoral involvement. Several delegates commented that the transboundary nature of certain POPs pointed up the importance of cooperation between countries and the need for guidance from international organizations such as PAHO. Dissemination of information and facilitation of the sharing of expertise were identified as key roles for the Bureau. The Subcommittee also felt that the health sector in the countries had an important role to play in educating those who utilized these products in their occupations and in promoting government regulation of their use, as well

as advising other ministries and government agencies on the health effects of POPs. Another essential function of the ministries of health was providing accurate information to the public about the health risks associated with pesticides and other toxic chemicals. It was pointed out that it was important to make people aware of the risks and promote alternatives to the use of pesticides, but to avoid creating undue alarm or panic. Several delegates described efforts under way in their countries to address the problem and offered to share their experiences and information with other countries and with the Secretariat.

Reference was made to several studies of the health effects of POPs, notably one in the Arctic region involving Canada, the United States, and six other countries, which had revealed a worrisome accumulation of POPs in the fish and wildlife that were mainstays of the diet of the indigenous populations of the region. It was announced that a scientific and technical evaluation workshop on POPs would be held in Geneva, in January 1999, under the auspices of UNEP, with the aim of producing a comprehensive regionally based assessment of the threats posed by persistent toxic substances to the environment and human health.

In regard to the document, the Subcommittee considered the proposed technical cooperation activities appropriate. Several suggestions were made for improving specific aspects of the document, including the incorporation of more information on the effects of chronic low-level exposure to organochlorine pesticides. Support was expressed for the proposal to phase out the use of DDT and promote alternative methods for the control of malaria vectors. However, it was felt that the document should also underscore the importance of assessing the health effects and cost-effectiveness of any alternative methods that were proposed. The Delegate of Mexico provided additional data on DDT residues in fatty tissue and breastmilk to complement and update the information included in the document. He also suggested that information should be included on the two other environmental cooperation agreements concluded between Canada, Mexico, and the United States: the North American Regional Action Plan on Management of Polychlorinated Biphenyls (PCBs), which was aimed at virtually eliminating PCBs in the environment and ensuring sound management of existing PCBs, and the North American Regional Action Plan on Management of Chlordane, which sought to reduce exposure to chlordane and disallow all remaining authorized uses of the substance.

Dr. Galvão thanked the delegates for their offers of information and for the additional data on DDT. He noted that, for the sake of brevity, relatively few statistics had been included in the document prepared for the Subcommittee, but that the revised version of the document would contain more complete data, as well as more extensive information on subregional and intercountry efforts to reduce exposure to toxic substances other than DDT, including the two North American action plans mentioned by the Mexican delegation. More information on the chronic effects of exposure to POPs was available from the Environmental Quality Program and would also be included. In

response to the comments regarding the Organization's role in information dissemination, he noted that various projects and studies, especially in Central America and Brazil, had provided a good model for how to obtain data and furnish the countries with the information they needed. A challenge for the future would be the development of better indicators of environmental quality, which would further improve the quality of the information that the Organization provided.

Evaluation of PAHO Technical Cooperation in Argentina
(Document SPP31/9, Rev. 1)

Presentations on this item were given by Dr. Argentino Luis Pico (Undersecretary for Health Policies and International Relations, Ministry of Health, Argentina) and Dr. Henri Jouval, Jr. (PAHO/WHO Representative in Argentina). Dr. Pico described Argentina's health policies, health care model, health sector reform process, and the role that PAHO technical cooperation played in the country. The country's four major health policy lines were (1) transformation of the overall organizational culture of the health sector with a view to attaining the goal of health for all as soon as possible and with the greatest possible efficiency; (2) transformation of the health care model, aimed at achieving greater equity, access and coverage, efficiency, and quality of care; (3) prioritization of health promotion and disease prevention; and (4) structural transformation of the sector through operational decentralization and normative centralization, federalism, and coordination between the public, private, and social security subsectors.

In the health sector reform process, the Ministry of Health had assumed a role of leadership, control, and regulation in all three subsectors. At the same time, it had relinquished its operational functions, decentralizing all responsibility for health care delivery to other levels. PASB technical cooperation had been very important in the process of structural change and health sector reform. The principal objectives sought through the technical cooperation provided by the Organization were institutional strengthening and the development of priority areas of action, most of which coincided with the Organization's Strategic and Programmatic Orientations. A key element contributing to the effectiveness of PASB technical cooperation in Argentina was the involvement of the PAHO/WHO Representative in an advisory capacity on high-level consultative and policy-making bodies, including legislative health commissions and various health-related commissions within the executive branch of government.

Dr. Pico described some of the programs and activities carried out in the following priority areas of action during the six-year period (1992-1998) covered by the evaluation of PASB technical cooperation: sectoral leadership, planning, and management; sanitary regulation and control; transformation of the health care model; reduction of avoidable risks; environmental health; development of teaching and research institutions and strengthening of decentralized agencies; strengthening of international cooperation and

technical cooperation between countries; and strengthening of institutional relationships within the health sector and between the health sector and other sectors, including civil society.

PASB technical cooperation had contributed to a number of important achievements during the six-year period. Among those highlighted by Dr. Pico were reformulation of the health care model; creation of the National Drug, Food, and Medical Technology Administration (ANMAT); strengthening of the health information system; implementation of the Tenth Revision of the International Classification of Diseases (ICD-10) throughout the country; technology transfer to enable production of the hemorrhagic fever vaccine (Candid 1); strengthening of the system for regulation of water quality and sanitation; development of a national chemical safety profile; and implementation of the IMCI strategy. In addition, the efficiency and effectiveness of the Ministry of Health had been enhanced through decentralization of some functions, downsizing, and rechanneling of resources.

In the future, efforts would focus on continuing the restructuring of technical cooperation in Argentina and consolidating a holistic, systemic, and integrated approach, adapting the cooperation to the characteristics and needs of the country, optimizing cooperation resources, and, above all, strengthening the steering and leadership capacity of the health sector in intra- and extrasectoral work.

Finally, Dr. Pico mentioned several elements that had facilitated the achievement of the successes described above, notably: political stability and continuity within the Ministry of Health and in the country as a whole; good coordination and cohesiveness within the Ministry; the existence of explicit goals and objectives established by consensus; and the high level of technical and scientific expertise, experience, and commitment of the PAHO/WHO Representative and the numerous PASB consultants who had served the country.

Dr. Jouval affirmed that the work of the PAHO/WHO Representative Office had been greatly facilitated by the continuity within the Ministry and by the support and cooperation received from health officials at all levels. The situation in Argentina during the evaluation period had been characterized by profound structural change and sectoral reform, which had necessitated changes in the configuration of PASB technical cooperation. Accordingly, the Organization's cooperation was oriented mainly toward providing support and filling unmet needs in the process of structural transformation through technology transfer and provision of information. In the context of increasing globalization, PASB had also sought to promote transborder articulation and cooperation among countries.

He then presented statistics on the percentage of the cooperation that had been devoted to each priority area of action mentioned by Dr. Pico, the numbers of consultants, the technical publications produced through the PAHO/WHO Representative Office in Argentina, and the percentage of budget execution by project, which had averaged about 90%. These data were also included in the document. He concluded by noting that the Representative Office had substantially reduced its administrative costs through the introduction of better managerial practices, outsourcing of various services, reduction of national and temporary personnel, improvements in the communications system, and other measures.

The Subcommittee found the presentations extremely informative and instructive and recommended that reports on PASB technical cooperation in other countries be presented periodically at future sessions. The Subcommittee was also impressed with the extent and diversity of the Organization's technical cooperation in Argentina. It was pointed out that cooperation must be characterized by flexibility and variety in order to respond to the needs of countries in a broad range of areas. Several delegates emphasized the importance of the Bureau's role as a catalyst for technical cooperation among countries and mentioned technical cooperation projects that their countries had undertaken with Argentina, most of them with support from PASB. The Representative Office's success in reducing administrative costs while increasing the range and number of services provided was seen as a model to be emulated both by other PAHO/WHO country offices and by governmental agencies in the countries.

Drs. Pico and Jouval were asked to describe any technical, political, and administrative difficulties that had been encountered during the evaluation period and explain how they had been dealt with. In addition, Dr. Jouval was asked to comment further on how the Organization's technical cooperation in Argentina had helped to support and enhance the regulatory and normative functions of the Ministry of Health.

Dr. Pico said that in more than thirty years as a health official in Argentina he had never before encountered such a high degree of commitment and responsiveness to the country's technical cooperation needs as he had experienced in his interactions with Dr. Alleyne, Dr. Jouval, and the entire staff of the Organization. He could therefore sincerely say that there had been no significant problems or conflicts during the evaluation period.

Dr. Jouval agreed that there were no conflicts in the relationship between the PAHO/WHO Representative Office and the Government of Argentina. Nevertheless, there were always certain inherent difficulties when an international organization such as PAHO worked in a sovereign and democratic country. It was the country that determined which policies, strategies, and actions to pursue, and the Organization's function was to provide the country with the necessary support. While PAHO could practice health

advocacy, it must never engage in political activism or attempt to dictate policy, which was the exclusive province of the country's government.

One area in which he had encountered some difficulty was in changing the traditional tendency to view PAHO as an agency with vast resources that could respond to everyone's needs, which was impossible, especially in a large country such as Argentina. Rather, it was necessary to focus the Organization's cooperation in the areas in which it could have the greatest impact. Another difficulty was collaborating with other sectors without weakening or diluting the effectiveness of the health sector. It was therefore essential to strengthen the ministries of health in order to ensure that, in intersectoral efforts, the health sector continued to exercise leadership on health-related matters. In regard to the questions concerning the regulatory/normative functions of the Ministry, he pointed out that the health sector in the countries of Latin America had long been oriented more toward the delivery of health services than toward regulation and enforcement of health regulations. Hence it was necessary to help the countries to develop legislative and regulatory mechanisms and enhance their capacity for monitoring and ensuring compliance with regulations.

The Director agreed that variety must be a hallmark of the Bureau's cooperation, since PAHO was guided by the priorities established by the countries. The Organization would never seek to impose priorities on its Member States. There might be certain activities and mandates that all the countries had agreed the Organization should carry out at the regional level, but at the country level it always sought to respond to national priorities. He also agreed that it was very useful to include evaluations of technical cooperation on the Subcommittee's agenda from time to time because it served to inform the Member States about the variety and means of cooperation in the various countries. In regard to the reduction in administrative costs in the Argentina country office, Dr. Alleyne emphasized that the Organization was constantly seeking ways of reducing such costs in order to make more money available for technical cooperation with the countries. He hoped that the Governing Bodies would trust the Secretariat to continue to seek such economies and not take the view that reductions had to be imposed. The Secretariat was firmly committed to increasing administrative efficiency, not as an end in itself but as a means of enabling the Organization to fulfill its basic purpose: to help the countries improve the health of their people.

Development of Quality Assurance Programs in Health Care
(Document SPP31/7)

Dr. Daniel López Acuña outlined the Bureau's efforts to support the countries in seeking ways of assuring the quality of health services and reducing inequities in health and access to health services of high quality. In order to develop quality assurance programs it was necessary to define the concept of quality. In broad terms, "quality"

referred to the set of characteristics of goods and services that met the needs and expectations of health service users. Any analysis of quality must look not only at the structure of health care (i.e., the physical and human resources utilized and the pertinent standards, policies, and legislation), but also at the process of providing care and at the impact and outcomes of that care.

A number of variables should be taken into account in assessing quality of care, including the skills and competence of the health care provider, the appropriateness and efficiency of the care, the effectiveness of the treatment or service provided, the accessibility of the health care facility, safety and the mitigation of potential risks to the patient, and the acceptability of the care in terms of the expectations of the patient, the health care provider, and the agency that covered the cost of the care. In addition, it was necessary to consider sociocultural, ethnic, and gender factors, which would influence perceptions of quality, as well as the growing concern for patients' rights and social demands for better health care. Accordingly, as an operational definition that attempted to take account of the multiple dimensions and variables, quality might be defined as the appropriate assessment and effective treatment of each service user, minimizing possible risks and combining educational and care functions so as to enable the patient to achieve the best possible outcome from the clinical, functional, and psychosocial standpoints.

In developing effective quality assurance programs, health authorities in the countries faced a number of challenges, including the following: shifting from an emphasis on criteria and indicators of structure to criteria and indicators of process and, above all, outcomes; incorporating a component of perceived quality as well as technical quality; linking quality assurance to continuing education and recertification of health professionals; incorporating technology evaluation processes and evidence-based medicine; developing benchmarks for measuring quality and support mechanisms for achieving them; combining the assessment of prerequisites for quality care (facilities, organization, personnel, and standards or guidelines) with the assessment of performance factors and the effects of the care; and developing ways of measuring the results attributable to health services. Above all, it was essential not to confuse the instruments of quality assurance with the ends sought. Measures such as accreditation of health care professionals and facilities, continuing education, and establishment of standards were not ends in themselves, but rather were instruments for achieving the ultimate aim of quality assurance programs: more effective health care interventions and greater user satisfaction.

A number of countries in the Region were in the process of developing quality assurance programs in the context of health sector reform and in response to the need to contain health care costs, as well as public demands for better access to health services of higher quality. The document described the main features of the initiatives under way in four countries. It also identified the critical areas in which PASB believed it could best support the countries through technical cooperation, and it proposed a series of strategies

for cooperation at the regional and country levels. The Subcommittee was asked to comment on whether those areas were in fact the critical areas in which the countries required PASB technical cooperation for the development of quality assurance programs, as well as on the appropriateness of the proposed strategies.

The Subcommittee found the content of the document and presentation on quality assurance timely and relevant and considered the proposed strategies appropriate. The strategies relating to establishment of an information clearinghouse and sharing of experiences were seen as particularly important. Mobilization of the necessary technical and financial resources to support research and the development of quality assurance programs was identified as another key role for PAHO. The strategy for mobilizing intersectoral support and building partnerships with other agencies and institutions was also seen as valid, since quality assurance was a broad area that required the involvement of a wide range of participants. It was suggested that it might be advisable to prioritize the strategies listed in the document, as they were quite numerous. It was also pointed out that the document did not actually define what constituted quality of care and, while it was recognized that quality was a difficult concept to define, a more precise definition was considered necessary for measuring the effectiveness of quality assurance programs. At the same time, it was emphasized that quality standards could not be the same for all countries or even for all areas within the same country. Given that fact, the Organization should offer a “menu” of technical cooperation possibilities to support the countries in developing quality assurance programs that were suited to their particular needs and priorities.

The importance of ensuring user satisfaction, respecting patients’ rights, and focusing on improved outcomes was stressed. It was pointed out that in order to maintain consistently high quality in health care, it was necessary to incorporate the concepts of quality assurance into the training of health personnel so as to create a culture of quality and excellence. While the Subcommittee agreed that it was essential not to confuse the instruments of quality assurance with the ends sought, refining the instruments was considered important in order to improve quality assurance programs and thus facilitate achievement of the desired ends. Several delegates identified accreditation and recertification of health care professionals and hospitals as good tools for quality assurance. Other suggested tools were review of clinical histories to determine whether recommended assessment and treatment guidelines were being followed, monitoring of nosocomial infections, and analysis of user complaints and results of focus groups to determine how health service users perceived the quality of care and how they could be better served. Several delegates emphasized the need for total quality management programs that encompassed all aspects of health care, in both the public and private sectors. Technology assessment and quality control of medical devices and equipment were also considered essential aspects of health care quality assurance programs.

Several delegates described quality assurance initiatives under way in their countries and offered to share their experiences with other countries. In most cases, those initiatives were being carried out in the framework of health reform processes.

Dr. López Acuña was pleased that the Subcommittee had expressed strong support for the Organization's work in the area of quality assurance. He underscored that PAHO technical cooperation was always intended to support the countries and respond to their needs. The Organization would never attempt to impose an accreditation program or quality standards on any country; rather, the aim was to develop a set of regional instruments, which could then be adapted at the national level to assist the countries in developing quality assurance programs tailored to their needs and the characteristics of their health systems. In regard to the idea of establishing an information clearinghouse on quality assurance, he explained that the objective was to compile and analyze information on the subject with a view to identifying successful and unsuccessful experiences in the development of quality assurance programs and extracting the information that would be most useful to the countries. In order to carry out that strategy and mobilize additional technical and financial resources, the Organization would be seeking extrabudgetary funding. It would also seek to incorporate other partners.

He pointed out that several delegates had mentioned the importance of patients' rights, which PAHO considered an integral part of the promotion of quality assurance programs. He also noted that quality assurance was increasingly linked to continuing education, certification, and recertification of health professionals, an area in which the Caribbean countries had made noteworthy progress, particularly in harmonizing the criteria for licensing of health professionals. Their initiatives might serve as a model for other subregions.

The Director reemphasized that the Organization would never seek to impose quality standards on the countries. Its role was to cooperate with the countries to enable them to develop their own standards and programs. Some might question whether an organization such as PAHO, which was primarily concerned with issues relating to public health, should be involved in an area so closely related to personal health care. However, he felt that issues relating to quality assurance in the provision of health care to individuals were of enormous importance to the countries, and the Organization therefore could not afford to ignore them. Moreover, it was important to remember that the public was made up of individuals. One of the intrinsic difficulties in developing quality assurance programs was how to measure the value of care. The effectiveness of public health interventions was generally measured in terms of outcomes, and the indicators and techniques for measuring how society benefited from improvements in population health had been developed and perfected over time. The instruments for measuring the benefits to society of improvements in individual health were considerably less well developed. That would undoubtedly be a major area of research in the future.

***Strengthening Blood Banks in the Region of the Americas
(Document SPP31/5)***

Dr. José Ramiro Cruz (Regional Advisor, Laboratory and Blood Services) summarized the Bureau's cooperation with the countries to strengthen blood banks and ensure the safety of blood and blood products in the Region. He began by presenting general information on the nature of transfusion medicine and the role of blood banks in collecting, processing, storing, releasing, and assuring the quality of blood products for use in the treatment of patients with serious medical conditions that could not be treated by other means. Because a number of infectious agents could be transmitted through blood, it was essential that all donated blood be screened for the presence of pathogens. Of particular concern were the human immunodeficiency virus (HIV), the hepatitis B virus (HBV), the hepatitis C virus (HCV), and the organisms that caused syphilis and Chagas' disease.

A key element in assuring the quality of blood products was recruitment and selection of donors, but there were marked deficiencies in these processes in many of the Region's blood banks. Unpaid volunteer donors who donated blood repeatedly were generally considered the safest donors, but in many countries only a small proportion of donors were volunteers. After the blood was obtained from donors, it must be screened for the presence of infectious agents and it must undergo immunohematological analysis to ensure that it was accurately typed. However, again, many blood banks showed deficiencies in both the percentage of blood screened and the quality of the serological testing. Another serious problem in many countries was the lack of a total quality assurance program to protect not only patients who received donated blood, but also donors and the personnel who handled the blood in blood banks. Dr. Cruz presented a series of statistics on proportions of volunteer donors, percentage of blood donations screened, and prevalence of transfusion-transmitted infection markers in donated blood in selected countries of Latin America and the Caribbean.

In keeping with the Bureau's strategic and programmatic orientations for the period 1999-2002, PASB was working with national blood commissions and programs to strengthen blood banks in the Region. The activities had been concentrated mainly in the following five areas: (1) promotion of the establishment of a legal framework to regulate blood bank operations and prohibit payment of donors; (2) external serology performance evaluations to improve the quality of serological screening in reference blood banks; (3) promotion of national quality assurance programs; (4) development of a set of regional standards for the work of blood banks, which were published in June 1998; and (5) promotion of distance learning programs for in-service training of blood bank workers. Dr. Cruz emphasized that the Organization's efforts to strengthen blood banks were a collaborative effort involving the regional programs on laboratory and blood services, communicable diseases, AIDS/sexually transmitted diseases, and public policy and health.

Future efforts would be directed toward ensuring that all donated blood in the Region was screened for the presence of HIV, HBV, HCV, and syphilis markers, as well as for *Trypanosoma cruzi* in areas where Chagas' disease posed a significant problem. In addition, the Regional Program for External Serology Performance Evaluation would be strengthened with a view to improving the accuracy of serological screening, and national quality assurance programs would be promoted and supported. Another important line of action would be promotion of repeated, voluntary, unremunerated blood donation. At the country level, analysis of the costs involved in producing blood products would be promoted with a view to improving equity, efficiency, and effectiveness in the allocation and use of resources. Dr. Cruz drew the Subcommittee's attention to several questions raised in the document concerning the role that the ministries of health should play in relation to these areas of activity and invited the delegates to voice their opinions and comment on how PASB could best assist the countries in their efforts to strengthen blood banks at the national level.

The consensus of the Subcommittee was that the ministries of health in the countries should play a prominent role in regulating and monitoring activities relating to the collection, screening, processing, distribution, and use of blood and blood products for transfusion. Another crucial function of the ministries was public information and education about the safety and benefits of blood donation as a means of promoting voluntary unpaid donation. The Subcommittee also identified several important roles for the Bureau, including dissemination of information and sharing of experiences, formulation of standards and guidelines for blood screening, and development of social messages and educational campaigns to help the countries promote voluntary donation. Several delegates emphasized that, with the emergence of new bloodborne infections and the development of new technologies for detecting them, the Bureau's information dissemination function would be particularly important.

In regard to the content of the document, several suggestions were made. It was pointed out that a statement in the document that indicated that only a small proportion of blood donors in the Region of the Americas were volunteers should be clarified, since in Canada and the United States virtually all donors were unpaid volunteers. It was also suggested that the document should mention the need to incorporate guidelines for rational use of blood into the curricula of schools that taught transfusion medicine. In addition, it was pointed out that the document did not emphasize the need to use sterile containers in blood collection and processing and that it contained no information on the window period during which infected donors might test negative or on techniques such as genome amplification testing, which could detect infections at a very early stage and thus reduce the risk that infected blood would be used for transfusion.

Several delegates described efforts undertaken in their countries to improve the blood system and mentioned some of the lessons that had been learned from those efforts.

One delegate noted that, while mandatory HIV testing had helped improve the safety of the blood supply in his country, it had also served as a deterrent to some donors, which had resulted in a blood shortage. In addition, it was pointed out that quality assurance functions should not be performed by operational personnel in blood banks and that, ideally, quality assurance programs should be entirely separate from operational functions.

Dr. Cruz noted that most of the Subcommittee's comments had centered around issues relating to donors and issues relating to appropriate use of blood, both of which were crucial aspects of the strengthening of blood systems. He clarified that the information in the document on voluntary donors referred to Latin America and the Caribbean. In regard to donor recruitment, he emphasized that education of the public was crucial in order to dispel misconceptions about blood donation, such as the commonly held idea that donors could acquire an infection by donating. He agreed that education of professionals in transfusion medicine was also necessary to rationalize the use of blood and prevent it from being wasted or used ineffectively. However, education of the public and of professionals would be a lengthy process, many aspects of which would be outside the direct control of the ministries of health. Hence, in the short term, the best means of strengthening blood banks and preventing the transmission of bloodborne infections was better selection of donors and better screening, which did fall within the purview of the ministries of health. PAHO was therefore directing its efforts primarily toward supporting the ministries in those two areas. The aim was to ensure that 100% of blood in the Region was being screened for HIV, HBV, HCV, syphilis, and, where warranted, *T. cruzi*, and to improve the quality of serological testing. Once that essential first step had been accomplished, the Organization would look at how blood systems in Latin America and the Caribbean could be further strengthened through the introduction of more advanced screening technologies such as genome amplification or leukoreduction, which were already being used in Canada and the United States.

The Director said that the Organization had made a commitment to ensure that, within four years, all donated blood in the Region would be screened at least for HIV, HBV, HCV, and syphilis. The Bureau looked forward to continued collaboration with the countries to achieve that goal.

Feasibility of Developing a Regional Convention on Tobacco Control

The Director reported on the steps he had taken in response to Resolution CSP25.R15, adopted by the 25th Pan American Sanitary Conference in September 1998, which had requested him to study the feasibility of developing a Regional convention on tobacco control. Immediately following the Conference, he had discussed the matter with the Secretary-General of the Organization of American States (OAS), who had been enthusiastic about the idea of PAHO and the OAS working together on a tobacco convention. A number of national ambassadors to the OAS had also expressed support for the idea. In addition, he had consulted colleagues at WHO to make sure that the

development of a convention for the Region of the Americas would not interfere with efforts to develop a global convention, and he had been assured that the development of a Regional convention and promotion of a Regional agenda on tobacco would be perfectly compatible with the global initiative.

There had been some discussion of whether the convention should focus on use of tobacco by children, but the overwhelming consensus among those he had consulted was that such a focus would be too limiting and that the convention should be broader in scope. There had also been discussion with legal authorities at the OAS about whether a declaration should be adopted instead of a convention, but the consensus had been that a convention would be the most appropriate instrument because a declaration would probably have little practical effect. In the spring of 1999, the idea of a convention on tobacco would be presented to a meeting co-sponsored by members of the United States Congress, WHO, and the OAS, providing that an agreement had been reached with the OAS as to the procedure for developing and adopting the convention.

Hence, the next step in the process would be to come to an agreement with the OAS and then prepare a document setting out the legal parameters for the convention and the steps to be taken by PAHO, the OAS, and the Member States. A joint PAHO/OAS working group had been formed for that purpose, and PAHO staff had consulted various eminent legal experts in order to formulate draft recommendations on the parameters necessary for the establishment of a Regional convention.

The Subcommittee welcomed the enthusiasm expressed by WHO and, especially, by the OAS, since political support would be essential for the adoption of a convention and its subsequent ratification by the countries. However, some concern was expressed about whether the introduction of a Regional convention would further complicate the already complex process of developing a global convention. It was pointed out that it might prove extremely difficult to achieve ratification of two conventions.

The Director said that the Organization shared the concerns about the complexity of developing two conventions. However, the Region of the Americas had the opportunity to proceed more rapidly than other WHO regions on the issue of tobacco control, and he felt that it was important to seize that opportunity to raise the matter to the highest political levels. Moreover, WHO officials believed that the development of a Regional convention would complement, not inhibit, the development of a global convention and that, if the Regional convention could be put forward more rapidly, it would lend impetus to the global process. He assured the Subcommittee that PAHO would continue to work in close consultation with WHO experts to avoid any possibility of a conflict between the two instruments.

Other Matters

The Director announced that the Subcommittee's next session had been scheduled for 25 and 26 March 1999.

The Delegate of Canada noted that at least four of the health concerns discussed by the Subcommittee had a particularly adverse effect on aboriginal populations and requested that, where appropriate, future documents include information on the specific health risks faced by those populations.

Closing of the Session

The President commended the Secretariat on the technical quality of the documents and thanked the PAHO staff for their interesting and informative presentations. He also thanked the delegates for their thoughtful and constructive comments. He then declared the session closed.

AGENDA

1. Opening of the Session and Election of Officers
2. Adoption of the Agenda and Program of Meetings
3. Integrated Management of Childhood Illness (IMCI)
4. Persistent Organic Pollutants
5. Strengthening Blood Banks in the Region of the Americas
6. Violence against Women in the Americas
7. Development of Quality Assurance Programs in Health Care
8. Fellowships Program of the Pan American Health Organization
9. Feasibility of Eliminating Tobacco Use in the Americas
10. Evaluation of PAHO Technical Cooperation in Argentina
11. Other Matters

LIST OF DOCUMENTS

<i>Document No.</i>	<i>Title</i>
SPP31/1, Rev. 1	Agenda
SPP31/3	Integrated Management of Childhood Illness (IMCI)
SPP31/4	Persistent Organic Pollutants
SPP31/5	Strengthening Blood Banks in the Region of the Americas
SPP31/6	Violence against Women in the Americas
SPP31/7	Development of Quality Assurance Programs in Health Care
SPP31/8, Rev. 1	Fellowships Program of the Pan American Health Organization
SPP31/9, Rev. 1	Evaluation of PAHO Technical Cooperation in Argentina

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