



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## **SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE**

*32nd Session, 25-26 March 1999*

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# **FINAL REPORT**

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## FINAL REPORT

The 32nd 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 25 and 26 March 1999.

The session was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Canada, Colombia, Cuba, Ecuador, Mexico, Panama, and United States of America. Also present were observers for Brazil, Nicaragua, and Uruguay. One international organization was represented.

### Officers

The following Members, elected as officers by the Subcommittee at its 31st Session in November 1998, continued to serve in their respective positions.

<i>President:</i>	Ecuador	(Dr. César Hermida)
<i>Vice President:</i>	Panama	(Dr. Enelka de Samudio)
<i>Rapporteur:</i>	Mexico	(Dr. Melba Muñiz Martelón)

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 session and welcomed the participants. He was particularly pleased to see a large number of observers from the embassies in Washington, D.C., as their presence was indicative of the interest of the Member States in the life of the Organization. He reviewed the functions and purposes of the Subcommittee, which were to examine and discuss various PAHO programs and initiatives before they were presented to the Executive Committee and the Directing Council, although, as usual, not every item considered by the Subcommittee would need to be forwarded to the Governing Bodies for action. The Subcommittee provided a less formal environment for discussion and interaction among the participants. Its reactions and comments were of great value to the Secretariat in adjusting its program activities in order to better respond to the needs and priorities identified by the Member States.

## **Adoption of the Agenda and Program of Meetings (Documents SPP32/1 and SPP32/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**

#### ***Health in the Summit Processes (Document SPP32/5)***

Dr. Irene Klinger (Chief, Office of External Relations) outlined the various summit meetings that had taken place, or would soon take place, in the Region and described the involvement of the health sector and PAHO in those gatherings. The document and Dr. Klinger's presentation focused on the Summits of the Americas and the Ibero-American Summits.

At the first Summit of the Americas, held in Miami in 1994, PAHO had been assigned a major role in three health-related initiatives: Equitable Access to Basic Health Services, Strengthening the Role of Women in Society, and Partnership for Pollution Prevention. At the second Summit of the Americas, held in Santiago, Chile, in 1998, the countries had recommitted themselves to extending health services to the most vulnerable groups, emphasizing the use of low-cost technologies to enhance health and living conditions and promote greater equity in health. Again, PAHO had been given a key role as coordinator of the initiative "Health Technologies Linking the Americas," which incorporated several of the same objectives established at the Miami Summit, as well as some of the environmental health goals approved at the Summit on Sustainable Development, held in Santa Cruz, Bolivia, in 1996. The document summarized some of the activities that the Organization had undertaken in fulfillment of those mandates. At the third Summit of the Americas, scheduled to take place in 2001 in Canada, it was anticipated that health would be a central issue on the agenda, and PAHO expected to play a leading role in helping to identify the health initiatives that would come out of that Summit.

The Organization had also received several important mandates from the Ibero-American Summits, which had been held yearly since 1991, with the participation of all the Latin American countries as well as Spain and Portugal. One of the principal health initiatives that had emanated from those summits was the Regional Plan for Investment in the Environment and Health (PIAS), developed by PAHO and aimed at strengthening water and sanitation infrastructure in Latin America and the Caribbean. The 1998 Summit had focused on solutions to global economic crises and the social problems they entailed.

That Summit had emphasized the need to detect and address risk situations before an actual crisis developed. Accordingly, the 1999 Ibero-American Summit, to be held in Havana, Cuba, would deal specifically with prevention of the risks of global economic crisis. Given Cuba's commitment to health, it was expected that prevention of health risks would occupy a prominent place in the discussions.

The aforementioned summit processes had provided an excellent opportunity to highlight health as a priority in the Region and they had helped foster the mobilization of resources and political commitment to address health issues. At the same time, they had promoted a greater spirit of Panamericanism as the countries worked together on political, economic, social and development issues. PAHO would continue to seek ways of utilizing summit processes to advance the cause of health. The Subcommittee was invited to comment on how the Organization might enhance its action for health in the framework of the summits.

The Subcommittee commended PAHO on the effectiveness with which it had carried out the various mandates it had received from the summits and for its efforts to continue calling attention to health issues at future summits. The delegates agreed that summit processes had definitely heightened the visibility of health problems and helped to increase political support for health initiatives. It was pointed out that summits at the subregional level provided another opportunity for advocacy of health issues.

Much of the Subcommittee's discussion on this item concerned the need to ensure that the priorities established by the health sector were espoused by political leaders and incorporated into political agendas, since political priorities and technical priorities did not always coincide. The Delegate of Cuba announced that a meeting of health ministers would be held on 18 and 19 October 1999, prior to the 1999 Ibero-American Summit, precisely for the purpose of developing a specific agenda of health issues to be discussed by political leaders at the Summit. In keeping with the overall theme of the Summit, the meeting of health ministers would focus specifically on the effects of globalization on health sector reform processes. Cuba believed that such meetings should always be held prior to the Ibero-American summits and had submitted a formal proposal to that effect to the Director of PASB.

The Organization was encouraged to begin providing input on the agenda for the 2001 Summit of the Americas as early as possible in order to ensure a focus on the issues that had been identified by the health ministers as priorities. Otherwise, there was a risk that PAHO might be drawn into peripheral activities that would divert resources away from its main technical cooperation priorities. In this connection, several questions were asked regarding the linkages between PAHO's regular cooperation activities and its activities in response to mandates from the various summits. It was suggested that, in

preparation for the 2001 Summit, a very brief summary of the document presented to the Subcommittee should be prepared for the presidents and heads of state, since they had limited time to devote to each agenda item. A concise account of the tasks assigned to PAHO and the action taken to date would help them to see where progress had been made and what remained to be done. It was also pointed out that, although the document indicated that significant advances had been made in several areas, it did not reflect much progress with regard to the main health priority identified at the Miami Summit, namely, the achievement of equitable access to health services. It was therefore considered important to redirect efforts toward that central issue, which remained the primary health problem in the hemisphere.

Responding to the Subcommittee's comments, Dr. Klinger said that PAHO was working closely with Canadian officials to promote health as a priority on the agenda for the 2001 Summit of the Americas. The suggestion regarding preparation of a summary document for the presidents and heads of state was a good one. The Secretariat would prepare that summary, and it was working on another document outlining PAHO's activities in relation to the summits, which would be distributed in June during the General Assembly of the Organization of American States (OAS). That document also would be formatted for quick and easy reading. In regard to subregional summit processes, the Organization certainly recognized the importance of those meetings, which often laid the groundwork for regional and global summits. PAHO was actively involved in promoting attention to health in subregional summit processes through subregional initiatives such as the Special Meeting of the Health Sector of Central America (RESSCA) and other subregional gatherings of health ministers.

As for the seeming lack of progress in regard to equitable access to health services, the document presented to the Subcommittee was intentionally brief and did not provide a full account of the achievements under each initiative. However, a detailed evaluation, with quantitative indicators of progress toward equitable access, had been undertaken prior to the Santiago Summit, and the document containing the findings of that evaluation would be made available to any delegate who wished to consult it. With respect to the need to maintain a focus on the Organization's central priorities, the priorities that PAHO had promoted in summit processes were those that had been identified by the ministers of health in the Governing Bodies.

The Director emphasized that he would not want anyone to have the impression that PAHO's involvement in the summit process was somehow taking the Organization away from its central focus. All the areas in which PAHO was involved pursuant to the summits were linked to its purpose as a health organization and its role of supporting health ministers and increasing the visibility of health issues at the national, subregional, and regional levels. He therefore welcomed Cuba's announcement concerning the meeting

of health ministers to be held prior to the Ibero-American Summit, as it would provide an excellent opportunity for health officials to gain entrée to the highest political levels.

The Organization's main aim in the summit process was to ensure that health had a prominent place on political agendas and to provide the health ministries in the countries with a solid technical basis for seeking political support for health initiatives. However, PAHO would never stray from its priorities or areas of expertise. It had chosen very carefully the kinds of issues that it encouraged the Member States to bring to the summits for consideration. It was especially important to promote initiatives that were likely to yield concrete results during the terms of office of the presidents and heads of state, so that, at the next summit, these political leaders would have the opportunity to see the impact of their actions in relation to health.

With regard to PAHO's involvement at the subregional level, the initiative "Health, a Bridge for Peace," implemented after the signing of the Esquipulas peace agreement in Central America, provided a striking example of how health could influence political decision-making and facilitate political processes. At the next summit of Central American presidents, the Organization would be submitting a proposal for reducing the costs of drugs in health services through a subregional program.

### ***Expanded Textbook and Instructional Materials Program (Document SPP32/4)***

Presentations on this item were given by Dr. Pedro Brito (Regional Advisor, Human Resources Development Program) and Dr. Richard Marks (Executive Secretary, Pan American Health and Education Foundation). Dr. Brito explained the nature of the Expanded Textbook and Instructional Materials Program (PALTEX) and its contribution to PAHO technical cooperation. PALTEX was intended to support institutional strengthening and education of health personnel, which had long been technical cooperation priorities of the Organization. PALTEX produced or facilitated the production and distribution of educational materials for schools of health sciences and for in-service training of health service personnel.

Although it produced and distributed books and instructional materials, PALTEX's main aim was not the sale of publications. Rather, it was a component of the Human Resources Development Program, within the Division of Health Systems and Services Development, and thus was an integral part of the Organization's technical cooperation in the area of human resources development. The Program worked in close collaboration with all the technical units of the Organization. In order to make high-quality educational materials available to the countries at low cost, PALTEX employed a strategy that included the formation of working groups to identify educational needs and instructional materials, promotion of intercountry initiatives for the production of

instructional materials, technical evaluation of materials by PAHO technical programs and experts in the Region, centralized large-scale purchasing under PAHEF management, use of PAHO installations at Headquarters and in the countries for logistics and distribution, and distribution by means of a network of points of sale located in educational institutions throughout the Region.

The main challenge for the Program in the immediate future would be to address the great demand for continuing education of health service personnel and the changing educational needs stemming from health reform processes. The Program was supplying an increasing number of publications dealing with health reform, decentralization, and changing health care models and practices. PALTEX was also exploring how it could best contribute to distance education programs, especially through use of the Internet and other electronic communications technologies.

Dr. Marks provided further information on the administrative aspects of the Program and its mode of operation. The counterparts in the administration of PALTEX were the Inter-American Development Bank (IDB), the Pan American Health and Education Foundation (PAHEF), PAHO, and the participating institutions in the countries. The IDB had provided financing through two loans, the first of which had been paid off in 1996. PAHEF was legally responsible for the administration of PALTEX at the regional level. The Foundation was incorporated as a nonprofit organization under the tax laws of the United States and was the borrower on the IDB loan. PAHEF was responsible for negotiating the purchase and production of materials, setting prices in order to ensure cost recovery, coordinating the activities of the PAHO/WHO Representative Offices (PWRs) in administering PALTEX in the countries, and all accounting functions for the Program.

PAHO was the primary counterpart and was responsible for the management of PALTEX as a technical cooperation program. The Organization, mainly through the Human Resources Development Program, oversaw all editorial decision-making with regard to the publication of new materials and the distribution of existing materials, with input and feedback from national and local participating institutions. PAHO was also responsible for hiring of authors and translators, review and editing of text, design and composition, and printing. In addition, it handled logistic arrangements for the distribution of materials at the country level through the PWRs, and it was the guarantor on the IDB loan. The participating institutions at the national level—the fourth counterpart—assumed responsibility for the sale of PALTEX materials without charge to the Program. The Program would not be able to function without the voluntary contribution of those institutions, which bore a major share of the costs associated with the sales operation.



The Program was self-financing and had turned in an excellent financial performance in recent years. More detailed information on the financial status and operations of PALTEX, as well as the types of instructional materials available through the Program, was included in the document.

The Subcommittee applauded PALTEX's role in making instructional materials available at affordable prices. All the delegates who spoke emphasized that the Program had been, and would continue to be, a crucial component of PAHO technical cooperation for human resources development in the countries of the Region. It was pointed out that the Organization's support in developing libraries in small hospitals and health centers had also been important in increasing access to medical texts and facilitating continuing education for the staff of those facilities. PAHO was encouraged to continue that line of action as a complement to the activities of the PALTEX program.

A number of questions were asked about specific aspects of the Program. More information on the plans for incorporating distance education into PALTEX and its use of electronic media was requested. It was pointed out that use of electronic means of dissemination would undoubtedly increase access to the Program's materials, but it might also reduce the production of books and other printed materials, with a consequent impact on revenues. Questions were also asked about the strategy for reinvestment of Program revenues. It was pointed out that the distinction between PALTEX and the PAHO publications program was not entirely clear, and more information on the relationship between the two programs was requested. Other questions concerned the manner in which materials were selected, the peer review process, the way in which the Program had adapted to changing attitudes about health and the shift toward a more holistic approach to health care, and the availability of PALTEX materials in languages other than Spanish.

In reply to the questions concerning distance education, Dr. Brito noted that in recent years distance education had become a very important means of maintaining technical competence, changing attitudes, and improving the performance of health personnel. The need for distance education and other means of providing continuing education would undoubtedly increase in the 21st century with the advent of new technologies and knowledge. Hence, continuing education would be a major thrust of PALTEX in the coming years, as would incorporating the use of the Internet and other electronic media into the Program's technical cooperation strategy. Nevertheless, because access to the Internet remained limited in Latin America, the Program would continue to utilize many printed materials. As for the way in which PALTEX had responded to changes in attitudes about health and the corresponding changes in the education of health professionals, one of the Program's strengths was its flexibility and its reliance on input from participating institutions and interprogrammatic groups in order to identify current educational needs and ensure the relevance of PALTEX materials. In regard to the availability of materials in other languages, the Program had gradually increased the

availability of textbooks and other instructional materials in Portuguese and currently most of the same materials offered in Spanish were also available in Portuguese.

Dr. Marks added that undergraduate medical students in Brazil were able to obtain textbooks easily and at reasonable prices through normal commercial channels, which reduced the demand for PALTEX publications in Portuguese. Moreover, because the market for Portuguese-language materials was relatively small compared to the market for Spanish-language materials, the Program was not able to obtain the same bulk-purchasing discounts and so could not offer its publications in Brazil at such attractive prices. The situation was similar with respect to the availability of publications in French and English. The market for such publications was limited to the Caribbean, since the United States and Canada did not participate in the PALTEX program. Students in the English-speaking Caribbean countries were able to obtain textbooks at subsidized prices through a special books program. With respect to reinvestment of the Program's revenues, those revenues were not as great as they might appear, owing to inflation. However, any earnings were used mainly to expand the Program's activities in the area of continuing education.

As for the distinction between PALTEX and the publications program (DBI), the technical rationale of PALTEX was quite different from that of DBI. PALTEX used the sale of publications as a mechanism for providing technical cooperation to the countries. That cooperation was aimed at enhancing their capacity to train and provide continuing education for health personnel, including development of their own materials, which was not part of the mandate of the Publications Program. The commercial rationale was also different. Unlike DBI, the bulk of PALTEX's operation consisted of purchasing existing materials and reselling them at a discount to facilitate the development of human resources. Direct publishing represented a very small proportion of the Program's activities and gross sales. Another important distinction was that PALTEX was administered by PAHEF, which for accounting and tax purposes was a separate entity from PAHO.

The Director underscored the educational nature of PALTEX, reiterating that it was not a publication sales program. PALTEX had a vital role to play in promoting and building a country's capacity to provide continuing education for health personnel, a need that, for the most part, was not being addressed by other institutions in Latin America. The Program was one aspect of the Organization's efforts to ensure that health information was available to those who needed it. The scientific and technical materials produced by the Publications Program also responded to that need, but there were clear differences in the types of publications supplied by the two programs and in their audiences.

In response to a question from one of the delegates regarding the reasons for PAHEF's administration of the Program, the Director explained that, in accordance with the terms of the IDB loan, it was necessary for PALTEX operations to be administered by an entity that qualified for nonprofit status under the tax laws of the United States. Otherwise, the Organization might well have created a textbooks and instructional materials program similar to its drug procurement program, and such a program would have been administered directly by PAHO. If the Subcommittee wished, at a future meeting the Secretariat would provide more specific information on PAHEF's operations and terms of reference.

With regard to the subject of peer review, he pointed out that not all texts required the same level of scrutiny. For example, didactic manuals that had been thoroughly reviewed by internal committees were not sent out for external peer review. However, all scientific publications were subjected to a rigorous peer review process. As for the availability of materials in French, to the extent that there was a sustainable market for French-language publications, the Organization would attempt to make such publications available. While PALTEX did not generally offer instructional materials in French, many of PAHO's publications on program issues were available in all four official languages of the Organization.

Dr. David Brandling-Bennett (Deputy Director and Chair of the PAHO Publications Committee) pointed out that, as PALTEX had expanded, the distinction between its educational publications and the scientific and technical publications of DBI had blurred somewhat. The PAHO Publications Committee had decided to take up the issue of coordination between PALTEX and the publications program, with a view to ensuring the greatest possible complementarity between the two programs and the highest quality and consistency with PAHO policies in their respective publications. The Committee would also be looking at the implications of increasing use of the Internet for publications purposes and the need for coordination in that area. The Secretariat would update the Subcommittee on the results of those discussions at some future date.

***Provisional Draft of the Program Budget of the Pan American Health Organization, 2000-2001 (Document SPP32/3)***

Mr. Román Sotela (Chief of Budget) presented the provisional draft of the budget for 2000-2001. The overall budget proposal was for \$256,245,000. The WHO portion of the proposal, which was subject to final approval by the World Health Assembly in May 1999, was \$77,725,000. As a result of changes in the WHO methodology for the allocation of funds to the various regions, the amount allocated to the Americas had decreased \$4.9 million, or 6%, from the 1998-1999 level of \$82.6 million. The PAHO portion of the budget proposal was \$178,520,000, which reflected an increase of 5.9% for

the biennium, or 2.95% annually. Hence, the proposed increase in the combined PAHO/WHO budget was 2.0% for the biennium, or 1.0% annually. The PAHO portion would be funded by \$165,020,000 in quotas, an increase of 5.2% for the biennium or 2.6% annually, and \$13,500,000 in miscellaneous income, an increase of 15.4% over the level for 1998-1999. The reduction of the WHO allocation, coupled with a reduction in posts, would signify a program reduction of 2.4%.

The modest 2.0% increase included increases to cover mandatory post-related cost increases, which were projected to rise to \$11 million, or 4.4%, over the biennium, despite a reduction of 13 regular posts. However, no increases had been included to cover non-post inflationary costs, which were estimated at \$3.7 million for the biennium. The Organization would absorb those costs, which would mean a further program reduction of 1.4% with respect to 1998-1999. The percentage of the budget allocated to country programs under the proposal would increase from 41.0% to 41.3%; that increase represented more than half of the total proposed budget increase. Regional and intercountry programs, on the other hand, would decrease from 58.9% to 58.7%. The overall proportion allocated to direct cooperation with the countries would rise from 84.8% to 85.0%.

The Director said that the program reductions were a source of great concern to him. Never in his 18 years with PAHO had the Secretariat presented an initial budget proposal that called for a decrease in program funding. He encouraged the delegates to ask themselves two questions as they considered the budget proposal: were they satisfied with the technical cooperation the Organization was providing and were they satisfied with the Secretariat's efforts over the years to increase efficiency and reduce costs? If they were able to answer "yes" to those two questions, then he urged them to support the budget proposal. The Secretariat was very sensitive to the difficult financial situation of some countries, and it had introduced a number of measures to cut expenditures and find more flexible ways of delivering cooperation. It had also stretched the projection for miscellaneous income in 2000-2001 to the absolute maximum in order to reduce the financial burden on the countries. However, its capacity to absorb further cost increases without an increase in budget was limited. The erosion of the Organization's budget could not continue indefinitely without rendering it incapable of performing the functions which the countries had assigned it.

The Subcommittee voiced unanimous support for the work of the Organization, and several of the delegates expressed unequivocal approval of the budget proposal. Several delegates reported that, despite financial difficulties, health budgets in their countries had been increased or at least maintained because health was considered a high priority. They felt that PAHO deserved similar support. In view of the large reduction in

funding from WHO, the Organization must have support from the countries in order to enable it to continue to play its role of leadership in health and address the serious health problems and inequities that continued to affect large segments of the Region's population.

However, some delegates had reservations about the proposed increase in quotas. It was pointed out that a number of countries, including those with the largest assessments, had substantial arrears in the payment of their quota contributions, which indicated that countries throughout the Region were having financial difficulties. In that context, the practicality of seeking an increase in assessments was questioned. It was also pointed out that the Organization's budget had risen steadily over the past 30 years. The total increase between 1970-1971 and 1998-1999 amounted to 500%, although the growth had slowed considerably in recent years. The Secretariat was encouraged to review the budget proposal prior to its presentation to the Executive Committee, with an eye to identifying areas in which savings might be realized and thus maintaining zero nominal growth.

The Delegate of the United States noted that government officials in his country were hopeful that the national legislature would authorize sufficient funding to pay off the United States' arrears to the United Nations and all its specialized agencies. Those arrears totaled more than one billion dollars; the country owed PAHO about 15 million dollars. However, approval of that funding would be contingent on zero nominal growth in the budgets of all the organizations. A nominal increase in the budget of any agency might undermine the whole effort to settle the country's obligations to the United Nations system.

In relation to the proportional allocation of the budget to the various program areas, it was felt that a significantly larger amount should go to the Program for Prevention and Control of Substance Abuse, especially for tobacco control. It was vital for the Organization to exercise strong leadership in that area, which implied not only mobilizing extrabudgetary resources but also devoting more of PAHO's own resources to tobacco control activities. It was also emphasized that budgetary allocations to all divisions and programs should reflect the emphasis on prevention and health promotion espoused in the Organization's Strategic and Programmatic Orientations. In addition, the Secretariat was encouraged to explore ways of distributing funds so that the allocation for technical cooperation among countries would not be cut.

Mr. Sotela pointed out that the growth in the Organization's budget during the previous 10 years had been due mainly to mandatory post-related cost increases. Under the budget proposal before the Subcommittee, all of the proposed increase would go to cover mandatory post costs. Since the 1992-1993 biennium, 188 posts had been cut in

order to compensate for increasing mandatory post costs and still maintain a balance in the budget between post and non-post funds. During that period, non-post funds had risen only 4% in nominal terms, which necessarily implied a program reduction.

At the invitation of the Director, Mr. Eric Boswell (Chief of Administration) gave his perspective on budgeting issues as a former United States government official within the Department of State. He noted that the Department's budget had remained flat for many years, forcing the Department to absorb all cost increases, which had gradually eaten away at its capacity to function effectively. In his view, all organizations reached a point at which they could no longer endure continuous shrinkage of their budgets without serious consequences, and he believed PAHO had reached that point.

The Director pointed out that during the 1980s, when every country in the Region had grappled with severe financial difficulties, the Governing Bodies had approved an average increase of 13% per biennium in the Organization's budget. During the 1990s, when almost all the countries were enjoying an easier economic situation, the biennial increases had averaged only 3%. He understood that some countries had trouble paying their quota obligations; however, during his tenure as Director, only one country that had been subject to Article 6.B of the PAHO Constitution had failed to meet the requirements of its payment plan. Several countries, such as Cuba and Haiti, had made superhuman efforts to pay their quotas. He considered those facts indicative of the value that the governments placed on the work of the Organization.

While he appreciated the position of the United States, he did not believe that the rule of zero nominal growth should be applied across the board to every agency in the United Nations system. He stressed that the proposed budget did not represent an increase in real terms. On the contrary, even with the proposed nominal increase of 2%, it would be necessary to cut an additional 13 posts, and programs would have to be reduced. The Organization had worked hard to improve efficiency and reduce costs to the utmost, and it would continue to look for savings. However, the day was fast approaching when it would no longer be possible to make minor adjustments and utilize creative management, creative investment, and risk-taking in order to continue offering the kind of cooperation the countries had come to expect of PAHO. He therefore appealed to the delegates to be forceful advocates for the Organization and to encourage their governments to support the budget proposal.

He agreed that it was important to devote more resources to tobacco control and pledged that, before the Executive Committee session in June, the allocation to that area would be increased.

***Monitoring and Evaluation of the Health Sector Reform Processes (Document SPP32/6)***

Dr. Daniel López Acuña (Director, Division of Health Systems and Services Development) began by reviewing the elements that had provided the conceptual framework for PAHO's activities in relation to monitoring and evaluation of health sector reform. Notable events had included the first Summit of the Americas, held in Miami in 1994, at which PAHO had been charged with monitoring and evaluating plans and programs for health sector reform in the countries of the Americas, and the Special Meeting on Health Sector Reform, held at PAHO Headquarters in September 1995 in conjunction with the 38th Directing Council. The Council had adopted Resolution CD38.R14, which requested the Director "to continue to work with the Member States and agencies in the design and development of a process for monitoring health sector reform in the Americas."

In response to those mandates, the Organization had formulated a methodology for monitoring and evaluation of health sector reform processes. The first step in developing the methodology had been the preparation, in 1997, of a baseline for monitoring and evaluating reform, which had been applied in 17 countries. Based on the results of that exercise, an initial version of the methodology had been prepared, tested, and adjusted. The result was the methodology described in the publication "Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean," which was distributed to the Subcommittee during the session. At the same time, guidelines for the preparation of profiles of health services systems had been developed to be used in conjunction with the methodology. Although either instrument could be used alone, it was difficult to analyze health sector reform without also analyzing the context in which health services operated and the organization, resources, and functions of the health system.

The criteria by which PAHO proposed to assess health sector reform processes were equity, quality, efficiency, sustainability, and social participation. The methodology was designed to monitor the dynamic and content of health reform processes and to evaluate their impact in terms of improvement of the five criteria. It had already been applied in nine countries, and by the end of 1999 it would have been applied in all the countries of Latin America and the Caribbean. The document contained a summary of the information derived from the methodology's application in the nine initial countries.

The Subcommittee expressed strong support for PAHO's work in the area of health sector reform. The Organization's role in providing information to the countries was seen as crucial, and the establishment of a clearinghouse on health reform, as mentioned in the document, was welcomed. A number of questions and concerns

regarding the document and the methodology were raised. It was pointed out that the document did not really explain the methodology, and it was suggested that an addendum should be attached wherein more detail on the features and precise nature of the methodology would be presented. In addition, more information was requested on how the information derived from application of the methodology would be utilized. It was pointed out that the countries were already being asked to provide information for a number of other monitoring and data collection exercises, and the Secretariat was asked to limit or consolidate its requests for information to the greatest extent possible.

Several delegates underscored the need for a flexible methodology that could be adapted to the specific context and the characteristics of reform in each country. It was felt that the methodology could be a valuable tool for highlighting successful reform strategies, but that caution should be exercised in attempting to generalize or draw comparisons between countries, which might give rise to errors or false perceptions. It was also pointed out that health reform was an ongoing and multifaceted process influenced by a wide variety of factors, which made it difficult to assess whether changes that occurred were directly attributable to reform measures. As for the criteria by which the impact of health sector reforms should be measured, it was emphasized that in order for reforms to be considered valid, they should lead to improved health indicators and quality of life, which meant improving not only medical and curative services, but also public health, preventive, and health promotion services. In this connection, some delegates thought that the methodology focused excessively on the provision and management of health services, with insufficient attention to factors that influenced health development.

Dr. López Acuña explained that the methodology was described in detail in the aforementioned publication, "Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean." The document prepared for the Subcommittee summarized only the main elements of the methodology and presented some of the findings of its application in several countries. He emphasized that the methodology was intended to be a general framework for identifying some common denominators in the reform processes under way in the Region. However, it could be customized to take account of differences between countries and to analyze certain aspects of health reform in greater depth, depending on the types of reforms that were being emphasized in each country. Building on the general framework, the Secretariat was developing instruments for evaluating progress in specific areas, such as equitable access to health services and the extent to which essential public health functions were being carried out by health authorities. A meeting of experts was scheduled for April 1999 to analyze the first round of application of the methodology and refine it in order to better reflect the trends and impacts of health sector reform processes.



The information derived from the application of the methodology would be used to identify critical areas in which greater technical cooperation was needed. It was also expected to reveal the types of reform measures that had proved most effective and provide input for decision-making at the national level about ongoing reform processes. Responding to a question from one of the delegates, Dr. López Acuña noted that the Secretariat expected that eventually the methodology would be applied in every country of the Region, including Canada and the United States. He assured the Subcommittee that every attempt would be made to consolidate requests for information with requests being made for other purposes, such as the third evaluation of the implementation of the health-for-all strategy. He acknowledged the difficulty of determining whether changes were the result of health reform measures or other factors, especially since health reform was generally a long-term process that did not produce an immediate impact. However, the Secretariat felt that the methodology provided a good general framework for documenting the nature of processes of change and analyzing whether and how they were related to end results.

The Director stressed that it was important to distinguish between technical cooperation on the issue of health sector reform and monitoring of that process. Pursuant to the mandate from the Summit of the Americas and the Directing Council of the Organization, the Secretariat had developed this methodology for monitoring reform. It was recognized that any intervention in a health system, even for purposes of monitoring or evaluation, introduced changes in the system, which made it very difficult to adduce causality. Monitoring was further complicated by the existence of a wide variety of health systems in the Region. Nevertheless, it was important to have a methodology or taxonomy that would reveal what kinds actions were being taken in the area of health reform and which processes were most common.

In relation to the comments regarding the methodology's lack of emphasis on health promotion, he pointed out that, in fact, the reform processes in the countries often did not include many of the prevention and promotion activities that the Organization felt were necessary to improve the public's health. A system designed to monitor processes at the country level could not include elements that were not included in those processes. However, the monitoring methodology would serve to demonstrate such deficiencies in health reform processes, and it would also point up those health reform activities that were not likely to lead to any positive change in health systems.

### ***Workers' Health in the Region of the Americas (Document SPP32/7)***

Dr. Maritza Tennessee (Regional Advisor on Workers' Health) reviewed the background of PAHO's involvement in workers' health, presented data on the health of workers in the Region, and outlined the Organization's principal technical cooperation

activities under the Regional Plan on Worker's Health. An analysis of the situation of workers revealed major economic and social inequities, as well as numerous risks to their health and well-being. A large proportion of workers in Latin America and the Caribbean were employed in the informal sector, where they had no access to health care coverage. Even in the formal sector, in some countries less than half the working population had regular health care coverage. A significant percentage of workers earned incomes that were not sufficient to cover the cost of a basic market basket of goods and services. Exposure to toxic substances, unhealthy and unsafe working conditions, occupational accidents, and psychological stress in the work environment made work a major risk factor for illness, disability, and premature death. Certain groups of workers, especially women and children, were at particularly high risk.

The set of pathologies that most commonly affected workers, given their nature and origin, represented the signs and symptoms of what could truly be called a "syndrome of social injustice," rooted in unequal distribution of wealth and high prevalence of poverty in large segments of the population. This complex problem required an intersectoral, multidisciplinary, and integrated response, with shared responsibility by all the institutions and actors that had a hand in shaping workers' health, including governments, labor organizations, business organizations, universities, the communications media, and international organizations such as PAHO.

The Regional Plan on Workers' Health provided for an approach that was integrated, multisectoral, participatory, and, especially, preventive. Above all, the plan sought to limit workers' exposure to risks and prevent damage to their health through activities in four program areas: quality of work environments, policies and legislation, promotion of workers' health, and comprehensive workers' health services. The plan emphasized national leadership and provided a frame of reference for the countries to use in formulating plans, policies, and programs to improve workers' health. It also envisaged the participation of international, regional, and subregional organizations and other institutions, as well as employers and workers themselves. The document described the activities and expected results for each program area. A separate annex distributed by Dr. Tennessee summarized some of the activities carried out in recent years by the countries, PAHO, and other organizations, and outlined the areas of action for the principal international organizations and other actors concerned with workers' health.

The Secretariat was optimistic that the plan would respond effectively to both the old and new challenges in the area of workers' health. However, its success would depend on collaboration, cooperation, commitment, and coordination among the various institutions and actors involved. Success at the country level would depend primarily on the leadership of the national governments, especially the ministries of health, which had a crucial role to play in facilitating the necessary intersectoral coordination with other

ministries and government agencies. Political will at all levels would also be essential in order to establish a common regional agenda on workers' health.

The Subcommittee applauded the quality of the document, which provided a complete picture of the situation of workers' health in the Region. The prevalence of poverty and low wages, the large numbers of children in the workforce, and the high proportion of the working population employed in the informal sector were considered extremely worrisome. It was pointed out that the issue of workers' health was closely linked to the issue of poverty, which was also discussed by the Subcommittee under a separate agenda item, and it was suggested that there should be some linkage or cross-referencing between the two documents on these subjects. Several delegates noted that factors such as low wages and employment of children not only were risk factors for workers' health, but they also perpetuated the cycle of poverty, which in turn contributed to or exacerbated many health problems. The Subcommittee affirmed that intersectoral action was crucial in order to surmount such problems and agreed that ministries of health should play the leading role in mobilizing all the various actors and coordinating their work.

The Regional Plan was considered a sound framework for action at the national, subregional, and regional levels. However, it was pointed out that the document listed a large number of activities to be carried out under the four program areas, and it was suggested that it might be wise to prioritize them in order to make the most effective use of limited resources. In relation to the activities planned to address the health needs of workers in the informal sector, the difficulty of reaching that population through normal institutional channels was underscored, and clarification of the strategies for improving health services—especially preventive health services—for informal workers was requested. The Secretariat was also asked to comment further on PAHO's collaboration with other international organizations in the area of workers' health and its efforts to promote research on occupational health.

Dr. Tennessee said that, in prioritizing its activities, PAHO responded to the common needs identified by the countries. Accordingly, a top priority at the regional level was the development or strengthening of information systems, which all the countries had indicated was necessary in order to reveal the extent of the problems and assess the effectiveness of the actions taken to address them. The Organization had devoted considerable effort to developing information systems to identify the risk factors associated with occupational morbidity, estimate costs, and thus determine whether the responses being provided were cost-effective, both in economic terms and in terms of health indicators. Another important priority was dissemination of information. PAHO was working to increase the availability of information through the use of modern media, such as CD-ROM, the Internet, and other information networks. It was also collaborating

with the University of California to establish a clearinghouse for the large volume of information on workers' health that existed in Latin America and the Caribbean, most of which had not been published in indexed journals. A third priority was training of human resources in order to remedy the enormous shortage of occupational health personnel, particularly in disciplines related to primary prevention.

In regard to research promotion, PAHO was promoting applied research in five main subject areas: the impact of integration processes on the organization of work and on workers; problems of child workers; women, work, and health; promotion of primary prevention; and promotion of workers' health within health systems. As for the huge challenge of improving the health of workers in the informal sector, the Organization was approaching the problem from several perspectives. First, it believed it was necessary to change the orientation of health services from a strictly curative focus to an emphasis on prevention and health promotion. It was also necessary to extend their outreach into the community and their collaboration with other community organizations in order to make health services more responsive to the needs of the community, including the needs of informal workers. The health services needed to seek out informal workers, rather than waiting for those workers to come to them. Ecuador, which was incorporating workers' health at the primary care level in all 52 provinces of the country, provided an excellent example of this approach.

The Director pointed out that the issue of workers' health could be approached in several ways: one could attempt to change policies on the subject, one could introduce changes in health services for workers, or one could try to modify the environment in which workers performed their jobs. PAHO had chosen to focus mainly on modification of the work environment through preventive measures, although that did not mean that it was inattentive to the need to provide health services for workers. The Organization's view on services was that the normal health services should be capable of dealing with the health problems of everyone, including workers in both the informal and formal sectors. Hence, its efforts focused not the creation of specialized occupational health services, but on enhancing the capacity of regular health services to provide health care for all workers.

In regard to priorities, he said that the priority areas mentioned by Dr. Tennessee were those in which it was considered that the Organization's technical cooperation could be most effective. However, PAHO's resources at the regional level were extremely limited, which made it essential to mobilize national institutions and form partnerships with other agencies in order to carry out all the activities foreseen under the Regional Plan.

***Health and its Contribution to Poverty Alleviation (Document SPP32/8)***

This item was introduced by Dr. Juan Antonio Casas (Director, Division of Health and Human Development), who recalled that on numerous occasions the Director had pointed out that equity in health depended not only on access to health services but, more broadly, on equality of opportunities to lead a healthy and productive life. In the Region of the Americas, the primary factor behind the persistence of gross inequities in health was poverty. It was the main cause of poor health, incapacity, and lack of access to services. Moreover, the highest burden of disease was found among the poor. PAHO had been concerned with relationship between health and poverty for some years, but particularly since the Director's report in 1995 on equity and health. On the global level, as well, various initiatives dealt with the topic of poverty and health. The World Bank had established a thematic group on the subject, and PAHO was working closely with that group to establish a similar interagency group in the Region.

Dr. Edward Greene (Advisor, Public Policy and Health) then presented an overview of the Organization's work in relation to health and poverty alleviation. His presentation focused on five main areas: conceptual issues; the health situation and poverty; issues relating to access, financing, and poverty; initiatives within the health and other sectors to address the issue of health and poverty; and health policy priorities. In order to study the relationship between health and poverty, it was necessary to first define the concept of poverty. The poor had traditionally been considered to be those who were unable to attain a minimal standard of living, or those were below the poverty line, which represented the income level required to meet the basic needs of household members. There was an undeniable and long-established link between poverty and health. On the one hand, poverty limited people's access to food, shelter, and other basic necessities, as a result of which they suffered higher morbidity and mortality. On the other hand, ill health tended to perpetuate poverty because individuals who were sick or disabled had a reduced capacity to work. In addition, illness in a household imposed a greater financial burden on the poor than on the non-poor.

Because of their higher morbidity and risk of mortality, poor people had greater need for health services, but poverty limited their access to those services. Moreover, the health services available to the poor were generally of lower quality than those available to the non-poor, and even when the poor gained access to services, it was more difficult for them to recover from illness due to their compromised nutritional and immunologic status and their substandard living conditions.

A number of initiatives in the countries of the Americas were aimed at improving the health of the poor. In the 1980s, many countries had implemented social emergency funds and social investment funds to mitigate the undesirable social effects of structural

adjustment programs. However, subsequent assessments had shown that those funds had been more effective economically than they had in improving social or health conditions. Their long-term sustainability was also problematic. In the 1990s, the funds had been followed by health reform initiatives, most of which emphasized the attainment of equity. It remained to be seen how effective health reforms would be in closing the gaps between the poor and non-poor in terms of equity in health status and access to health resources.

At the international level, PAHO and other multi- and bilateral agencies were involved in a variety of initiatives. Most of PAHO's activities centered around the generation, compilation, and dissemination of information on the interrelationship of health, equity, and poverty, as well as policy analysis and the promotion of policies designed to improve the health situation of the poor. In the immediate future, PAHO would be promoting the formulation, implementation, and evaluation of policies aimed at improving the measurement of health inequalities among different socioeconomic groups, identifying specific health problems of the poor for concerted attack, targeting public subsidies in health care to benefit the poor, assessing the poverty reduction impact of specific health interventions, mobilizing NGO support for more and better health care for the poor, empowering the poor through the promotion of their health, and promoting health sector participation in poverty reduction initiatives.

Mr. David Gwatkin (World Bank) said that the World Bank appreciated PAHO's leadership in highlighting the linkage between poverty and health and welcomed the opportunity to work with the Organization on the issue. There was growing interest within the Bank in the health of the poor, which had recently given rise to several activities. One was the establishment of the thematic group on poverty and health, of which he was the coordinator. The group sought to increase the extent to which Bank lending for activities in health, nutrition, and population benefited the poor. It was also developing information on intracountry differences in health status and health service use. In that effort, the group had drawn heavily on the information compiled by PAHO. Another activity was the preparation of the World Development Report for 2000-2001, the theme of which would be poverty reduction. An important aspect of that activity was the redefinition of poverty to reflect not only economic factors, but also the social dimensions of poverty, including health.

The Subcommittee affirmed the close connection between poverty and ill health and endorsed PAHO's role in highlighting the linkages between health, poverty, equity, and human development. Improving the health of the poor was seen as a valuable strategy for enhancing their socioeconomic situation and raising their standard of living. At the same time, it was pointed out that improving health would not help to alleviate poverty in the absence of opportunities for employment that would provide people with sufficient income to meet the basic needs of their families. Hence, while the health sector could

make a valuable contribution toward the reduction of poverty, multisectoral action was needed to address the causes that generated and perpetuated the problem. Several delegates stressed the need to ensure special attention to the needs of the poor in the framework of health reform efforts. They pointed out that it should not be assumed that reforms would automatically benefit the poor. Guaranteeing not only equal access but also equal quality of care for the poor was considered especially important. It was felt that health reform should be seen as a process of profound social transformation aimed at promoting the health and human development of all members of society.

In regard to the document, it was pointed out that while it did a good job of showing the relationship between health and poverty it did not clearly address the key issue of how health could help to alleviate poverty. One delegate noted that it failed to recognize the incontrovertible evidence that publicly financed health care systems helped to reduce inequities and alleviate poverty, whereas privately financed systems increased inequity. Moreover, pulling resources away from the public health care services had a negative impact on quality of care and health outcomes among the poor. The same delegate observed that although targeting—which seemed to be the main strategy proposed in the document—could be useful for meeting the health needs of the poor, it did not get at the heart of the problem.

Dr. Greene said that the purpose of the document had been to present an overview of the studies and initiatives in the Region relating to poverty and health. It did not attempt to analyze the findings or outcomes of those activities, although it did suggest some implicit lessons. Nevertheless, he agreed that it was important to address the question of whether health could alleviate poverty. The Organization had several projects that were expected to yield some answers to that question. One was concerned with investment in health and equity as a means of alleviating poverty, and another was looking at how different health management and financing methods might reduce the impact of poverty. The latter had indeed found that publicly financed systems, such as the Canadian system, provided some valuable lessons. All the information derived from that project would be included in the final project report to be produced at a later date. In regard to the need for multisectoral action to alleviate poverty, he pointed out that, while everyone agreed that it was necessary, no one had determined exactly how multisectoral activities could deliver gains to the poor, unless they were targeted to a specific issue. PAHO believed that it was necessary to increase the capacity of health authorities to interface with other agencies in both the public and private sectors in order to develop multisectoral initiatives that would have a real impact on poverty.

The Director noted that a World Bank study had shown that three basic issues needed to be addressed in order to alleviate poverty: inequality of access to land, inequality of access to education, and inequality of access to health. Hence, the thesis that

underlay PAHO's work in this area was that investment in health would help to alleviate poverty. PAHO also espoused the view that inequity and maldistribution of income in themselves, irrespective of poverty levels, were related to health outcomes, and that investment in health could serve to reduce income inequality. The Organization was therefore seeking to provide or produce data that would enable health ministers at the national level to argue in favor of such investment as a means of reducing poverty, inequity, and poor health outcomes resulting from income inequality. Any future documents on poverty and health would make clear the Organization's interests and approach in this area.

The issue of targeting was closely linked to how one conceived of the poor. If it was accepted that the distribution of material resources followed a Gaussian curve and the poor only represented one part of the curve, then the approach to poverty reduction would be social interventions aimed at shifting the curve. But if the poor were seen as a special group because of certain special characteristics, then the appropriate approach was targeting. Another important issue was whether health reforms were affecting the poor negatively. PAHO considered it essential to draw attention to the need to take account of the poor as a special group in the process of reform. It should not be taken as a given that improvement in the general health status would automatically bring about an improvement in the situation of the poor.

***Antimicrobial Resistance and Emerging and Reemerging Diseases (Document SPP32/9)***

Dr. Marlo Libel (Advisor in Communicable Diseases) pointed out that growing movement of people, goods, foodstuffs, and diseases across international borders increased the risk of introduction of new diseases and resurgence of old ones. Another serious threat was the emergence of ever more virulent pathogens due to increasing microbial resistance. He presented data on several of the emerging and reemerging diseases that had threatened the Region in recent years, including cholera, plague, dengue, leptospirosis, yellow fever, hantavirus pulmonary syndrome, and Venezuelan equine encephalitis. In this context, the "Internet society" represented both a challenge and an opportunity for public health officials. While the Internet and other modern communications media could be effective vehicles for the rapid dissemination of information to the public, they could also be the source of rumors that caused undue alarm. Clear guidelines for communicating with the media were required in order to provide accurate information and reduce the possible adverse effects of media coverage of outbreaks.

To respond to these challenges, PAHO was promoting a three-pronged approach consisting of the following components: surveillance of emerging diseases and syndromes,



detection and response to outbreaks, and surveillance and prevention of antimicrobial resistance. A fourth component that cut across the other three was the development of public health laboratory capacity. This approach had been designed on the basis of the recommendations of the expert task force that had developed guidelines for implementing the Regional Plan of Action on Emerging and Reemerging Infectious Diseases, adopted in 1995. The Organization's vision for the 21st century was to ensure the existence of strong national diseases surveillance systems, regional networks to monitor diseases, rapid information exchange, and effective national and international preparedness and response.

Under the surveillance component, the primary activity was the development and implementation of a Regionwide electronic platform for instant communication of disease occurrence. Once in place, the surveillance system would make use of Internet technology. To complement the surveillance system, the Organization was working with the countries to strengthen subregional and national capacity to detect and respond to outbreaks through multidisciplinary outbreak response teams. Also under the outbreak response component, PAHO was working on training materials, including some aimed at improving the quality of media reporting on outbreaks. As for the third component, in order to assess the real magnitude of antimicrobial resistance in the Region and combat the misuse of antibiotics, PAHO was collaborating with several prominent agencies, including the Laboratory Centers for Disease Control in Canada and the Centers for Disease Control and Prevention in the United States. Laboratory strengthening was an important aspect of all three components. The document presented further information on the activities programmed under each component, as well as an account of previous PAHO technical cooperation in relation to emerging and reemerging diseases and antimicrobial resistance.

The Subcommittee considered the three-pronged strategy appropriate, and applauded the Organization's leadership in strengthening capacity for surveillance and outbreak response. A number of questions were asked on specific aspects of the activities described in the document. In regard to the subregional networks of laboratories for surveillance of emerging diseases, more information was requested on plans for the development of such networks in Central America and the Caribbean, since the document mentioned only networks in the Amazon Region and the Southern Cone. Questions were also asked regarding coordination between the subregional networks and existing subregional surveillance centers, such as the Caribbean Epidemiology Center (CAREC). With respect to the electronic platform for reporting of surveillance data, it was suggested that linkage of that system to the Organization's geographic information systems—which were discussed by the Subcommittee under a separate agenda item—would enhance the analysis of information on emerging and reemerging diseases. It was pointed out that there would be many potential users for the electronic system, in addition to public health professionals.

One delegate noted that the existence of different case definitions tended to skew data on outbreaks and inquired about efforts to harmonize case definitions. In regard to the programmed activities in the area of outbreak response, the Secretariat was asked to provide more information on the nature of the regional response team and comment on how it envisaged the sustainability of the country-level multidisciplinary response teams over time. It was pointed out that the activities planned and under way in relation to antimicrobial resistance appeared to be more reactive than proactive, and the need for proactive strategies, such as policies aimed at reducing the indiscriminate use of antibiotics, was underscored.

In response to the last comment, Dr. Libel explained that the document mentioned only a few of the Organization's activities in the area of antimicrobial resistance. One of the major components of the Regional Plan for the Control and Prevention of Antimicrobial Resistance was policy development. Another was promotion of training activities targeting not only medical students but also practicing physicians, through medical associations, in order to raise awareness of the problem and prevent misuse of antibiotics. With regard to the electronic platform, it was intended to be a mechanism to help governments and institutions in the countries stay informed about disease outbreaks in neighboring countries and in the Region as a whole. PAHO was trying to include as much information from the state and municipal levels as possible, since information for the entire country often did not clearly identify problem areas. Utilization of geographic information systems would indeed help to pinpoint areas at high risk for disease transmission.

As for the subregional networks, the two mentioned in the document were those that were currently most developed. However, CAREC was also doing important work in the Caribbean, not only with respect to laboratories, but also in training field epidemiologists and supporting countries in outbreak situations. Establishment of a laboratory network in Central America was also programmed. In regard to the multidisciplinary teams, experience had shown that it took at least two years to train a team. Training had begun initially in Central America in response to Hurricane Mitch. The Organization planned to couple the funding that it had received for that initial training with a subregional field epidemiology project in Central America as a means of sustaining the training of multidisciplinary teams. CAREC was beginning a similar project in the English-speaking Caribbean, and eventually the outbreak response training would be extended to all countries. The regional response team, as one of the delegates had suggested, was a "virtual team." It was not a group of individuals based in Washington who were dispatched to different places in the Region; rather, teams of experts from various countries were mobilized and deployed as the need arose.

With respect to case definitions, there was a PAHO/WHO manual with standard case definitions for all the diseases mentioned in the document. The problem was that the countries adapted those global definitions in different ways, depending on their own local reality and laboratory capabilities. The Organization planned to disseminate the standard case definitions through the electronic platform and it expected that eventually all countries would adopt the same definitions.

### ***Geographic Information Systems in Health (Document SPP32/10)***

Dr. Carlos Castillo Salgado (Coordinator, Special Program on Health Situation Analysis) recalled that information on the Organization's core data/country profile system had been presented to the Governing Bodies in 1997. The current system currently included 117 indicators in five subject areas (demographic data, socioeconomic data, mortality, morbidity and risk factors, and resources, access and coverage of health services). Geographic information systems (GIS) were being incorporated into the core data system in order to enhance the capacity for handling geographically referenced data. PAHO would thus be better able to fulfill its mandate to select, collect, organize, maintain, and use data and information to determine and report on the profile and characteristics of health status in different population groups and geographic areas. This improved platform would allow a more precise identification of areas and groups with the greatest basic unmet health needs and health inequities, as well as those at higher risk of death or disease and the determinants of their higher risk. It would also help to focus interventions and evaluate their impact. At the same time, it would indicate healthy areas with positive indicators, which would help identify health promotion initiatives that had been successful.

GIS were now widely available in a format for personal computers, which had reduced their cost substantially and made their use feasible with the technology currently existing in the health sector in most countries of the Region. Nevertheless, there were several challenges still to be overcome, including the absence of GIS packages geared specifically toward epidemiological and health situation analysis; lack of low-cost, user-friendly applications, especially for the primary care level; lack of geographic databases disaggregated to the lowest local level; fragmented health information systems in the countries; and the need for training in the use of GIS technology.

One of the specific objectives of geographic information systems in health was to facilitate, through a simplified system and Web-based platform, the integration of quantitative and tabular data with geographic mapping data in order to present more complete information on the health situation. Because the system would employ an independent Web-based platform, it could be used easily by personnel in the countries, regardless of whether or not they had GIS programs installed on their computer systems and regardless of their operating system. It would also enable users to quickly access the

regional databases, as well as databases in other countries and regions within a country, which in turn would facilitate rapid analysis of the information.

Dr. Castillo demonstrated how the system could be used to simultaneously access various kinds of data, including mapping, tabular data, and direct data. He also showed how the same indicator could be looked at from a regional perspective, by country, and by local areas within countries. For a given geographic area it was also possible to simultaneously view various indicators, for example, population, overcrowding, and coverage of health services, which would facilitate the targeting of interventions. Utilizing images of Central America, he showed how layers of increasing detail could be added to show the effects of Hurricane Mitch in a specific community, with data on the characteristics of community, access routes to the community, the location of health centers, infrastructure damage caused by the hurricane, areas prone to flooding, areas at high risk for disease transmission, and other information necessary to determine the areas with the greatest need for relief and support interventions.

The Subcommittee agreed that geographic information systems were a valuable tool for analyzing health conditions, identifying problem areas, and targeting interventions, especially because they made it possible to visualize epidemiological data and layer data from different sources. Their use to visualize healthy areas and thus identify effective health promotion activities was also seen as very important. It was pointed out that GIS could be especially helpful to decision-makers, including those who were unaccustomed to dealing with epidemiological data, because they provided a clear and rapid picture of the situation and made it possible to see where resources were most needed. Their potential value for analyzing and evaluating health sector reform processes was also underscored.

In regard to training for the use of GIS, the need to ensure epidemiological training along with training in the use of the system itself was stressed. Several delegates noted that, without such training, there was a risk that the information would be misconstrued. It was considered particularly important to ensure that, when information derived from GIS was presented to the general public through the mass media or other means, such information was interpreted and explained in a clear and simple manner by persons with expertise in epidemiological analysis in order to prevent confusion or misunderstanding.

Several questions were asked regarding technical requirements to access the system and regarding linkages between PAHO's information system and the information systems of other United Nations agencies. In relation to the problems which Dr. Castillo had cited as obstacles to the greater use of GIS, it was suggested that the Pan American Institute of Geography and History might be a good source of maps and geographic data on local levels.

Responding to the questions, Dr. Castillo explained that the speed with which GIS data could be obtained via the Internet depended on both server size and the capacity of telephone lines. PAHO was planning to establish mirror servers for the various subregions to facilitate access to the system. He agreed that the Pan American Institute of Geography and History would be a good resource for mapping. Another good source of maps was national geographic systems, which in some countries were very well developed. As for interconnection with other data systems, PAHO's system was fully compatible with the United Nations statistical system, and the Organization was exploring ways of further articulating all its databases with those of other United Nations agencies. With respect to training, PAHO was emphasizing the use of GIS as a tool to enhance epidemiological analysis and was supporting national institutions in training epidemiologists to utilize these systems effectively. Regarding the contribution that GIS could make to evaluation of health sector reform processes, he said that the Organization was working to increase the usefulness of the systems not just for epidemiological analysis but as a management information tool.

The Director pointed out that geographic information systems provided another means of identifying inequities and gaps in health status and access to services. PAHO believed that they could be a very important instrument for making decisions about how to allocate resources and what kinds of resources to allocate, as well as for evaluating the impact of those resources.

### **Other Matters**

The Director updated the Subcommittee on several initiatives under way within the Organization. He recalled that at the Pan American Sanitary Conference in September 1998 he had mentioned the possibility of collaborating with other agencies involved in health to develop a shared agenda for health in the Americas. He had approached the Inter-American Development Bank and the World Bank, as the two major investors in health in the Region, and was pleased to report that both institutions had been enthusiastic about the idea of working with PAHO to develop such an agenda. Eventually, PAHO hoped that other agencies could be incorporated into this collaborative effort.

Another important initiative concerned essential public health functions. There was a certain lack of clarity in regard to what those functions were. PAHO espoused the view that, since the public was composed of individuals, assuring attention to the health of individuals was one of the public health functions for which the State was responsible, although the State need not necessarily provide health services directly. A small working group had been established under the leadership of Dr. Carlyle Guerra de Macedo, Director Emeritus of PAHO, to study how essential public health functions were being dealt with at the national level and explore how the Organization might exert a positive

influence vis-à-vis schools of public health, schools of medicine, and health ministries to ensure that the proper measures were being taken to attend to the public's health.

Dr. Alleyne also outlined several changes that had been made to improve the functional structure of the Secretariat and enable it to better fulfill the Strategic and Programmatic Orientations established by the Governing Bodies. Those changes included the creation of a new division of vaccines and immunization in order to give greater emphasis to the introduction of new vaccines and strengthen vaccine programs in the countries; restructuring within the Division of Health Systems and Services Development of the areas that dealt with information systems and information technology in order to make it clear that they were different, though complementary, functions; internal changes within the Program on Lifestyles and Mental Health to focus more attention on substance abuse, especially tobacco; creation of a special program on health information to develop tools that would enable the countries to identify inequities; and establishment of a committee on administration aimed at ensuring greater similarity between the Organization's administrative practices at Headquarters and in the countries.

In addition, he announced that Dr. Juan Manuel Sotelo would be moving to another post within the Organization and thanked him for his service as Chief of the Office of Analysis and Strategic Planning (DAP) and as Technical Secretary for the Subcommittee.

In relation to tobacco control, he was happy to report that the OAS remained enthusiastic about the possibility of pursuing a regional convention on the issue. WHO officials also continued to feel that the development of an inter-American convention would strengthen the possibilities for achieving the adoption of a global convention on tobacco control. PAHO was hopeful that a resolution would be adopted by the OAS General Assembly in June 1999 instructing PAHO and the OAS to work together toward the development of a regional convention.

In response to concerns expressed by one of the delegates about the advisability of proceeding with a regional convention on tobacco control—especially if it might interfere with efforts to develop a global convention—the Director reiterated that WHO officials fully supported the effort to develop a regional convention. He had been in contact repeatedly with Drs. Brundtland and Yach, and both maintained that the adoption of an inter-American convention not only would not interfere with global efforts, but would be likely to facilitate them.

In answer to another question concerning proposed amendments to the Constitution of PAHO that were scheduled for consideration by the Directing Council in September, the Deputy Director, Dr. David Brandling-Bennett, said that the proposed

changes would be distributed well in advance of the Executive Committee session in June 1999 in order to meet the mandatory 90-day notice required for the consideration of constitutional changes by the Directing Council.

A delegate pointed out that the practice of including financial information in documents on program activities seemed to have been discontinued and requested that future document prepared for the Subcommittee include information on expenditures or proposed expenditures.

### **Closing of the Session**

The President expressed the Subcommittee's appreciation to all those who had given technical presentations on the various agenda items and to the staff of the Secretariat for their support in ensuring that the meeting ran smoothly. She also thanked all the delegates for their insightful contributions to the discussions and then declared the session closed.

## **AGENDA**

1. Opening of the Session
2. Adoption of the Agenda and Program of Meetings
3. Provisional Draft of the Program Budget of the Pan American Health Organization, 2000-2001
4. Expanded Textbook and Instructional Materials Program
5. Health in the Summit Processes
6. Monitoring and Evaluation of the Health Sector Reform Processes
7. Workers' Health in the Region of the Americas
8. Health and Its Contribution to Poverty Alleviation
9. Antimicrobial Resistance and Emerging and Reemerging Diseases
10. Geographic Information Systems in Health
11. Other Matters



## LIST OF DOCUMENTS

<i>Document No.</i>	<i>Title</i>
SPP32/1 and SPP32/WP/1	Agenda and Program of Meetings
SPP32/3	Provisional Draft of the Program Budget of the Pan American Health Organization, 2000-2001
SPP32/4	Expanded Textbook and Instructional Materials Program
SPP32/5	Health in the Summit Processes
SPP32/6	Monitoring and Evaluation of the Health Sector Reform Processes
SPP32/7	Workers' Health in the Region of the Americas
SPP32/8	Health and its Contribution to Poverty Alleviation
SPP32/9	Antimicrobial Resistance and Emerging and Reemerging Diseases
SPP32/10	Geographic Information Systems in Health

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