PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

36th SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE

Washington, D.C., 25-27 March 2002

Provisional Agenda Item 12

SPP36/11 (Eng.)
19 February 2002
ORIGINAL: ENGLISH

PAN AMERICAN CENTERS

The Executive Committee of the Pan American Health Organization (PAHO) has requested its Subcommittee on Planning and Programming to review the overall issue of the Pan American Centers. This review and analysis sets out the background and current situation of this special mode of technical cooperation of PAHO, which dates back to 1949.

The report analyses the role that Centers have played in technical cooperation, offers a classification of the Centers, and briefly presents the historical and financial trends of these PAHO units. The issues that may impinge upon the future of the Centers are summarized in a final section.

This report is presented to the Subcommittee on Planning and Programming for its review and discussion.

CONTENTS

Page

1. Introduction

The Pan American Centers of the Pan American Health Organization (PAHO) have been a conspicuous, almost unique technical cooperation mode of the Organization, since the first association was formed with PAHO in 1949. Individually or collectively, they have been the subject of scrutiny and debate in the Bureau and Governing Bodies for several decades.

Today, there is renewed interest in defining and articulating what this particular mode of cooperation contributes to the enhancement of the role of PAHO in the Pan American community. The Governing Bodies of the Organization have requested that the Bureau examine the role and function of these Centers.

PAHO is currently operating eight Pan American Centers in seven countries. The role of the Centers in delivering technical cooperation is viewed as an essential component of a comprehensive PAHO approach, which combines formulation of policies and plans, information dissemination, training, research, and direct technical cooperation with Member States.

Each of these units has a different origin, history, and function. Each also has a different relationship with the host country, with the countries of a given subregion, and with the Region as a whole. The PAHO Centers, by virtue of their facilities and resources, as well as their objectives and the characteristics of their staff, are a feature that distinguishes this Organization from other international agencies, including the World Health Organization (WHO) and its Regional Offices. In over five decades, the Centers have developed a broader and deeper scientific and technological capacity in specific areas than Headquarters divisions and programs, and have become important contributors to PAHO technical cooperation.

1.1 *PAHO/WHO Collaborating Centers*

It is important to differentiate PAHO Centers from PAHO/WHO Collaborating Centers. The Collaborating Centers date back to the days of the League of Nations, at which time certain national laboratories were designated reference centers for standardization of biological products. In 1947, as PAHO was reorganizing and WHO was beginning to establish its own operations (the WHO Constitution had not yet been ratified), the World Influenza Center in London was declared a WHO Collaborating Center. In 1949 the Second World Health Assembly adopted a policy by which WHO should not consider the establishment, "under its own auspices of international research institutions," and it opined that "…research in the field of health is best advanced by assisting, coordinating and making use of the activities of existing institutions."

At PAHO, however, the situation evolved in a different manner. From the late 1940s until the mid-1970s, several factors in the Region of the Americas steered PAHO in the direction of using the Pan American Centers as an operational mode for technical cooperation. Among these factors were: (a) the availability of qualified human resources in the fields of public health, environmental health, and veterinary public health in Latin America and the Caribbean; (b) a relative lack of strong research, training, and technical cooperation institutions in the same fields; and (c) a high degree of interest and political support from PAHO Member States for the creation of these specialized institutions. Successive Directors of PAHO accepted the challenge and began to associate the Organization with direct institution-building and research and development efforts, as part and parcel of PAHO's overall program of technical cooperation. Thus, starting in 1949, the Organization began to adopt the Pan American Center approach throughout the Western Hemisphere.

2. The Role of the Centers in PAHO Technical Cooperation

Overall, PAHO Centers have introduced two innovative approaches, or modes, to the long history of PAHO technical cooperation. First, in creating certain of the Centers, or in accepting technical, managerial, and administrative responsibility for others, PAHO decided to concentrate larger-than-average financial resources in specific areas, taking in some cases a major risk by leading ambitious programs into new or experimental fields. The Pan American Center became a catalytic agent, bringing together international funds from PAHO and bilateral and multilateral extrabudgetary support from traditional donors, and from developing countries themselves.

Second, by strengthening research, development, and training efforts in the PAHO Centers, it was possible, in many cases, to strengthen local scientific and technological capacity. Through the work of the Centers, PAHO looked for local talent, solutions, and networks in a developing country setting, with the host country of the Pan American Center as the jump-off point. These solutions were largely based on methods more appropriate to developing countries, as a prerequisite step to the adaptation of foreign technologies, thus introducing the concept of "pre-transfer projects" in fostering the development of more appropriate technological solutions.

In addition, the Centers introduced and capitalized on other approaches that in the 1950s, 1960s, and 1970s were quite innovative, and made the Organization stand out among other international agencies. Some of these approaches included:

- Utilization of national employees as professional and support staff;
- Fostering of research and training facilities in developing countries;
- Development of a competitive capacity, according to developed country standards, thus reinforcing a sense of self-reliance in developing countries;

- Creation of an infrastructure for the development of a scientific information network in the field of public health, and for regional reference laboratories.

Policy formulation, resource mobilization, training, research, information dissemination, and advisory services thus became the main approaches by which the Pan American Centers cooperated with Governments. The visibility of these PAHO units became an important factor in their attracting, in most cases, considerable amounts of extrabudgetary financial resources, particularly in the form of grants. Training constituted a pivotal role for the Centers, particularly in the early decades of their operation. Similarly, research activities and the development of new products, services, and procedures became features by which the Centers acquired a unique identity within PAHO and, by extension, PAHO acquired a unique identity among international organizations. Finally, information dissemination—always a key role and function of the Centers—became even more important in relative terms and in terms of volume, in comparison to other approaches, as information technology developed by leaps and bounds over the last two decades.

The Centers also became the sole source of technical cooperation for the entire Organization in certain fields. From the Virtual Health Library at the Latin American and Caribbean Center on Health Sciences Information (BIREME), to the development of the oil-adjuvant vaccine against foot-and-mouth disease at the Pan American Foot-and-Mouth Disease Center (PANAFTOSA), to the development of special nutritional foodstuffs at the Institute of Nutrition of Central America and Panama (INCAP), the Centers carved for themselves unique technical cooperation niches. Any efforts centered only around PAHO Headquarters and representatives' offices in Member States would have been hard pressed to produce such results.

The physical presence of PAHO in most of the Member States throughout the Hemisphere, in addition to its research, training, and technical cooperation Centers, has contributed to giving PAHO its unique history and role in the Americas.

3. Categories of Centers

PAHO has two categories of Centers: regional and subregional.

The regional Centers are:

- CEPIS - Pan American Center for Sanitary Engineering and Environmental Sciences;
- PANAFTOSA - Pan American Foot-and-Mouth Disease Center;
- BIREME - Latin American and Caribbean Center on Health Sciences Information;
- CLAP - Latin American Center for Perinatology and Human Development; and
- INPPAZ - Pan American Institute for Food Protection and Zoonoses.

The subregional Centers are:

- INCAP - Institute of Nutrition of Central America and Panama (the oldest PAHO Center);
- CFNI - Caribbean Food and Nutrition Institute; and
- CAREC - Caribbean Epidemiology Center.

In the case of the three subregional Centers, PAHO essentially was asked by subregional associations of Member States and territories to manage an institution on their behalf. PAHO contributes with human and financial resources to the Centers; and the States and territories of each Center contribute to their financial upkeep through quota contribution systems. The host Governments contribute in cash and by making facilities available to the Centers. Extrabudgetary (non-regular) funds and, increasingly, the sale of goods and technical services make up an important part of Center income. The subregional Centers have their own governing bodies which meet on a yearly basis and advise the Director of PAHO on policy matters. These subregional Centers also have technical advisory committees which report to the respective Center directors. Some of the staff members of these Centers are PAHO employees (in the case of INCAP, only one), and the rest are contracted under several employment schemes. All employees, however, are under the managerial authority of the Center director, who is a PAHO international civil servant reporting to a PAHO headquarters technical division director, who in turn reports to the Director of PAHO.

The regional Pan American Centers present a more organizationally straightforward relationship as integrated units of the Bureau. Although multiple contractual arrangements also exist in these Centers, a higher proportion of employees are likely to have international civil servant contracts.

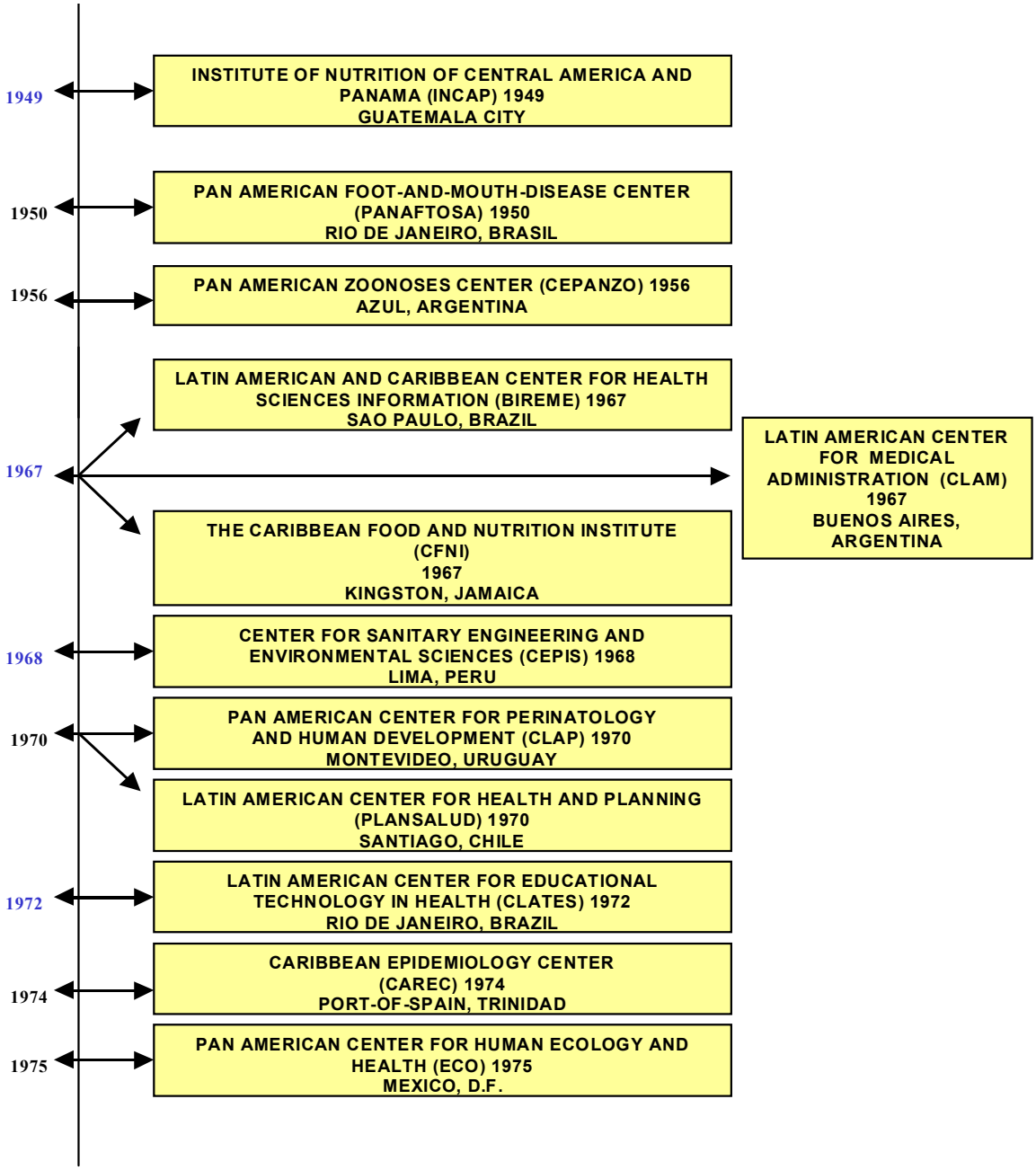
Most of the regional Centers also have technical advisory or scientific advisory committees, but they meet more irregularly. There are other PAHO arrangements or meetings that review the program of some Centers, such as the Inter-American Meeting, at the Ministerial Level, on Health and Agriculture (RIMSA). And there are country-specific bodies addressing exclusively the cooperation of the Center with the host country. The regional Centers reflect more directly the hemispheric policy guidelines of the Governing Bodies of PAHO (Directing Council, Pan American Sanitary Conference), but their own advisory body schemes may also carry significant weight.

The relative weight of extrabudgetary funding seems to be less significant in the case of the regional Centers, but these Centers are becoming quite active in seeking international donor funds. They also tend to receive significant contributions in cash and/or in kind from the host Government and its institutions.

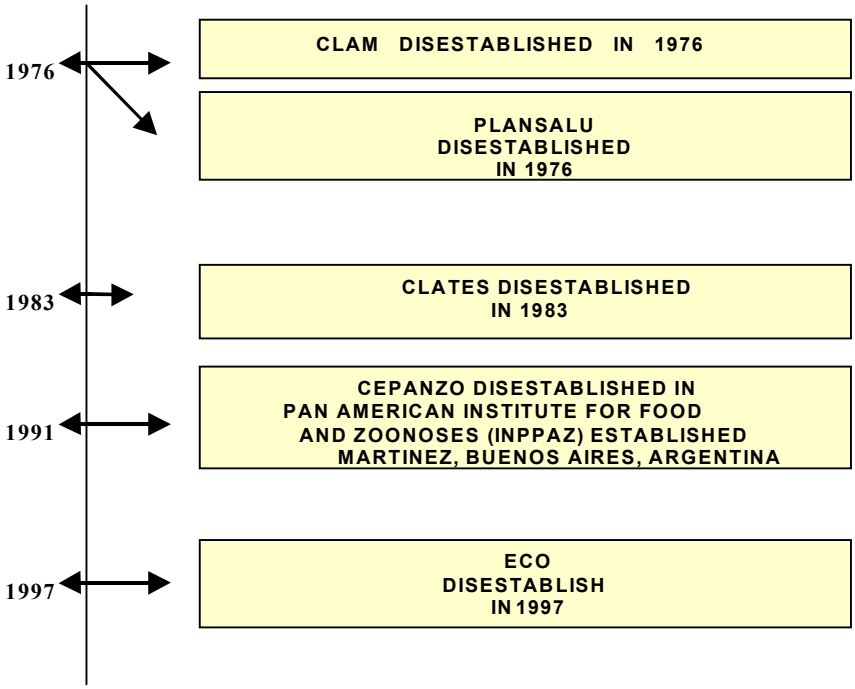
4. Historical Summary

A full description of the Pan American Centers is a monumental task, given, in some cases, more than 50 years of history, each Center's evolution and characteristics, and the complex nature of the issues surrounding most Centers. In order to describe each Center, a time line and a brief outline are presented.

4.1 *Time Line of the Pan American Centers*



Time Line of the Pan American Centers (cont.)



Each Center was established through different actions of Governments, PAHO, and/or its Bureau. Some Centers were already in operation as a national facility when they were incorporated into the Bureau of PAHO. Therefore, there is room for different interpretations as to the actual date of creation or beginning of operation as a PAHO Center.

Subregional Centers

INCAP

Title: Institute of Nutrition of Central America and Panama
Location: Guatemala
Date of establishment: 1949
Organizational locus: Division of Health Promotion and Protection
Program focus: nutrition and public health
Governing body: Council of INCAP (Ministers of Health of Member States of INCAP, and Director of PAHO)
Advisory body: Advisory Council (Directors-General of Health or designated representatives of the Ministers of Health)

CFNI

Title: Caribbean Food and Nutrition Institute
Location: Jamaica
Date of establishment: 1967
Organizational locus: Division of Health Promotion and Protection
Program focus: nutrition and public health
Governing body: Advisory Committee on Policy (Representatives from Ministries of Health and Agriculture)
Advisory body: Scientific Advisory Committee (Representatives from Governments, the Caribbean Community [CARICOM], University of the West Indies, University of Guyana, and PAHO)

CAREC

Title: Caribbean Epidemiology Center
Location: Trinidad and Tobago
Date of establishment: 1974
Organizational locus: Division of Disease Prevention and Control
Program focus: technical cooperation in epidemiology and laboratory technologies
Governing body: CAREC Council (Representatives of Ministries of Health, CARICOM, University of the West Indies and other Caribbean academic institutions, PAHO, and external agencies)
Advisory body: Scientific Advisory Committee

Regional Centers

PANAFTOSA

Title: Pan American Foot-and-Mouth Disease Center
Location: Brazil
Date of establishment: 1950
Organizational locus: Division of Disease Prevention and Control
Program focus: veterinary public health, particularly foot-and-mouth disease; zoonoses
Advisory bodies: COHEFA (Hemispheric Committee against Foot-and-Mouth Disease), COSALFA (South American Committee for Combating Foot-and-Mouth Disease), and RIMSA

BIREME

Title: Latin American and Caribbean Center on Health Sciences Information
Location: Brazil
Date of establishment: 1967
Organizational locus: Division of Health and Human Development
Program focus: health sciences information, particularly the Virtual Health Library
Advisory body: National Inter-institutional Committee (Representatives of the federal Ministries of Health and Education, Government of State of São Paulo, Federal University of São Paulo, and PAHO)

CEPIS

Title: Pan American Center for Sanitary Engineering and Environmental Sciences
Location: Peru
Date of establishment: 1968
Organizational locus: Division of Health and Environment
Program focus: water, sanitation, solid waste disposal, environmental epidemiology and toxicology

CLAP

Title: Latin American Center for Perinatology and Human Development
Location: Uruguay
Date of establishment: 1970
Organizational locus: Division of Health Promotion and Protection
Program focus: promotion of maternal and child health by addressing obstetrical, neonatal, and pediatric problems
Advisory body: advisory group of high-level, internationally recognized experts meets every two years

INPPAZ

Title: Pan American Institute for Food Protection and Zoonoses
Location: Argentina
Date of establishment: 1991
Organizational locus: Division of Disease Prevention and Control
Program focus: regional reference center for food protection
Advisory bodies: RIMSA; International Coordinating Council (Representatives of six Member States of PAHO, Director of PAHO); Committee for Argentine Programs (Representatives of Argentine Ministries of Health and Agriculture, PAHO)

Other Centers were established, and later abolished. As can be seen from the descriptions above, the 1960s was a decade in which the Governing Bodies and PASB were most inclined to establish this mode of technical cooperation. It was not done, however, without some debate. Concerns about Governments falling into arrears in terms of direct quota-paying commitments, or Center-supporting commitments as host Governments, were among the most common issues for discussion. The relative advantages for host countries regarding access to the Centers' technical cooperation was another concern. By 1969, the Executive Committee of PAHO approved a resolution which, after considering that there were a number of multinational centers in the Americas to which a considerable amount of the funds of the Organization was allotted, and noting that the countries in which these multinational centers were situated benefited more directly from the advisory, training, and research activities carried out in them, resolved:

> 1. To recommend to the Directing Council that it request the Director of the Bureau to appoint a study group to draft criteria governing the establishment and operations of centers….

In 1969, a study group was formed to draft the requested criteria concerning the Centers and, as a result, the Pan American Sanitary Conference approved the following Resolution (CSP18.R33), which established guidelines that are still pertinent.

> 1. To approve the following general guidelines for the establishment and operations of multinational centers:
>
> (a) For the purpose of these guidelines, a multinational center shall be defined as an institution or center administered by international staff and supported to a significant degree by international funds, which provides services to all the countries of the Region, or a group of them in a particular area.
>
> (b) The establishment and operation of multinational centers shall be based on the priorities arising out of the planning of the PAHO/WHO program. Under this system, each country's appraisal of its health problems shall determine the extent and nature of the international assistance that will best serve to support the health programs of the Member [States]….
>
> (f) In view of the fact that multinational centers are institutions and are created only when there are no adequate national institutions, international financial assistance is regarded as a long-term obligation. However, each multinational center should be reviewed regularly in planning the program and in the light of its importance in relation to the needs of the participating countries.

(g) In planning a multinational center, the Director shall seek financial and other support from extrabudgetary sources in addition to the regular budget. The host Government should provide premises and, as far as its resources permit, also contribute supplies, personnel, and funds. The choice of a location should take into account the resources of the potential host Government as well as any other factors affecting the services rendered to the countries.

(h) Proposals for multinational centers shall continue to be submitted as part of the PAHO/WHO program and budget to the Executive Committee and the Directing Council or the Conference for consideration and approval….

Questions about the Centers have been raised periodically in the Governing Bodies. In 1977, the Directing Council, in its Resolution CD25.R31, requested the Director to prepare a detailed study of the Centers. The study took more than a year to complete; it was led by an expert advisory group supported by full-time and part-time staff, who were able to carry out detailed visits to all the Centers then in operation. It is the most comprehensive study of the PAHO Centers to date. Many of its findings are as relevant at the present time as they were 23 years ago. Several conclusions of that study deserve serious consideration:

> A major axiom, on which all other conclusions should be based, is that PAHO Centers are an integral part of the PAHO program. Basically, a Center is an organizational modality. Status as a Center carries no program significance, in and of itself, but is a way of achieving program objectives.
>
> One point needs emphasis—a Center is but a method of carrying out the program and must be coordinated with other methods. The first decision is how much effort should be invested in a program area; then comes the decision as to whether a Center is a useful part of the action program. Each situation must be examined on its own merits.
>
> The primary program question is what health areas should have priority; the secondary operating question is whether a given program area would benefit from … a Center as one method for achieving the objective…. The key question is what is the most efficient and effective way to accomplish the goals of the particular [PAHO] program area, not whether there are too many or too few Centers.

The 1978 Pan American Sanitary Conference endorsed the recommendations of the study and, among other things, re-emphasized the need for "regular evaluations of each Center" (Resolution CSP20.R31).

4.2 *The 1980s and 1990s*

Attempting to summarize and analyze the many political, policy, and administrative events that took place in the 1980s and 1990s in relation to the Centers is beyond the scope of this review. Nevertheless, a few events should be highlighted:

- A new Bureau administration came into office in 1983 with a policy approach calling for devolving the Centers to their host countries or groups of countries. Although in 1985 the Directing Council of PAHO endorsed the idea of the eventual transfer of the Centers to the host countries as a long-term goal, there was not much support among Member States and other stakeholders, at that time, for such a transfer.
- In 1983, the Latin American Center for Educational Technology in Health (CLATES) Center in Brazil was eliminated as a PAHO unit.
- In 1989, PAHO produced the document "The Pan American Centers in the 1990s."[1] The criteria have been incorporated into this review.
- Serious policy and financial discussions preceded the closing in 1991, of the Pan American Zoonoses Center (CEPANZO) in Argentina and its re-casting as the new INPPAZ.
- A study was undertaken in 1993 of the research activities of seven of the Pan American Centers (the Pan American Center for Human Ecology and Health (ECO), CFNI, CAREC, PANAFTOSA, CLAP, CEPIS, and INCAP). While emphasizing the crucial role that research has played and should play in the work of the Organization, the study found common Center problems, in light of which it made several recommendations, such as the need for all Centers to have strategic plans for research, to have scientific advisory committees, and to streamline the many types of personnel contracts then existing.
- ECO, located in Mexico, was closed in 1997 and its facilities and local staff were transferred to the Government of Mexico. Some of its human and financial resources were merged into CEPIS in Lima, Peru.

4.3 *The Managerial Legacy of the Centers*

The Centers have provided PAHO with a laboratory in more ways than in the strictly technical-scientific fields for which they are responsible. A number of managerial approaches and processes were pioneered at the Centers. By strengthening research in a developing country environment, it was possible, in some cases, to give a boost to local scientists and researchers, who tended to be more attuned to local problems and their solutions than the large, well-financed research and training institutions in the developed world.

---

[1] George A.O. Alleyne, The Pan American Centers in the 1990s, (PAHO, Health Program Development Area, 1989).

In addition, as far back as the 1950s and 1960s, the Centers introduced innovative approaches not known or widely used in the United Nations and the Organization of American States (OAS), such as the utilization of national employees as professional and support staff; the establishment of institutions to be used as reference laboratories for neighboring countries; and the introduction of precise, user-friendly programming, budgeting, and monitoring procedures.

Some Centers have significant experience in the provision of services, including technical assistance and analyses with private sector groups, and in the transfer of technology directly to private groups through courses, seminars, and in-service training. Others have entered strategic alliances with for-profit companies and will share income from the sale of services to third parties (also for-profit enterprises), or validate diagnostic kits produced by private businesses. One Center derives most of its operating budget from the sale of products and services.

5. Financing

There are essentially five sources of revenue available to the Pan American Centers:

- *PAHO regular funds:* these are the most reliable, but are declining in real terms;
- *Direct country quota contributions:* these are applicable to the three subregional Centers only, and it is theoretically the most important part of the budgets of these Centers;
- *Grants (non-regular or extrabudgetary funds):* a growing item in many Centers, but other Centers have not properly geared up to take full advantage of possibilities in this field;
- *Sales of products and services:* this item presents, arguably, one of the greatest potentials for growth for the Centers, but will require serious policy and regulation consideration; and
- *Host country contributions:* this is what the host country contributes to the upkeep or operations of the Center. These agreements vary significantly from Center to Center.

The combined PAHO and WHO regular budgets for PAHO for the biennium 2000-2001 amounted to US$ 256,245,000. The PAHO regular budget input into the Centers for the 2000-2001 biennium amounted to $23,846,113, or approximately 9.3% of the regular budget. It is allocated as follows:

INCAP	$3,081,845
CFNI	$2,441,713
CAREC	$1,295,100
PANAFTOSA	$6,296,681
CEPIS	$4,800,143
BIREME	$1,001,180
CLAP	$1,885,074
INPPAZ	$3,044,377

Financial issues have long constituted the Achilles' Heel of the Centers. Moreover, as the Executive Committee noted in 1969 in Resolution CE61.R12, a considerable amount of the funding of the Organization is allotted to these units. Either because not enough regular funds are available,[2] or because of problems with the countries' contributions to the Centers, funding is a matter of utmost importance. The financial reports of the Director and of the External Auditor, together with information from the Bureau's Budget Office, confirm that the financial situation of the Centers continues to be a source of concern for the Governing Bodies and the Bureau, in spite of improvements in recent bienniums at Centers such as INCAP. This situation is shared by both regional and subregional Centers. Looking at the income side of the equation, there appears a common problem: the difficulty in collecting the financial contributions of Member States. This situation is particularly acute in the case of the subregional Centers, where the average quota collection rate hovers around 33% for the period 1992-1999,[3] which is a source of concern if one compares it with roughly 74% for PAHO as a whole for the same period. [In that context, a de facto policy dating back decades has now been formalized, in which the regular budget of the Organization becomes the stopgap source of financing for the Centers.]

The sale of services and other private-public partnerships have been seen as a long-term approach to ensure financial stability and financial viability for the Centers. While it is a positive development, further guidelines may be useful in this area.

In the Annex[4] to this report, the financial situation of the Centers is presented in terms of expenditures, which measures actual level of activity for a particular source of funds. Most expenditures by source show a decreasing trend, with the exception of extrabudgetary funds and sale of services in certain Centers.

---

[2] Some individual consultants at the Centers have less than $10,000 per biennium in regular funds to operate throughout Latin America and the Caribbean.

[3] Calculation based upon the Financial Report of the Director and Report of the External Auditor for 1998-1999.

[4] Annex to be distributed separately.

6. The Future of the Centers

Is the Center approach still relevant to international cooperation in public health and environmental health, or is it an outmoded arrangement through which PAHO channels a substantial portion of its technical cooperation? In some instances, it is obvious that a 1950s-1960s approach on the part of some Centers, targeting very narrow technical needs and basic research activities, would be hard to justify. Most PAHO Centers are evolving—or could and should evolve—toward a greater emphasis on technical cooperation for planning and strategic issues, and on being brokers of resources as well as organizers of networks of centers of excellence in their fields. The wisdom of the Pan American Sanitary Conference 31 years ago, when it mandated that "each multinational center shall be reviewed regularly in planning the program and in the light of its importance in relation to the needs of the participating countries," is clearly relevant today.

A 1989 report[5] proposed several criteria concerning the PAHO Centers. It concluded that the Organization's support for Centers should be based on whether they:

- Are fully integrated into the regional programs of which they are part;
- Demonstrate a vigorous, useful, and identifiable presence in the countries, with emphasis on the programs in the countries;
- Demonstrate continued creativity and capacity to seek innovative approaches to the common problems that were the basis for their creation;
- Pay close attention to certain strategic approaches of PAHO technical cooperation, e.g., mobilization of resources, training, dissemination of information, and research; and
- Are sensitive to the need to have Member States involved in the governance of the Centers.

Are the Centers' programs fully integrated into the regional programs they are a part of? This varies a great deal, with the regional Centers usually closer to their headquarters divisions than subregional ones. Some policy decisions, such as transferring responsibility for zoonoses from INPPAZ to PANAFTOSA, have reinforced the links between the two Centers and the divisional management in Washington, D.C. Other Centers report joint programming of activities at the time of the Biennial Program Budget preparation, followed by periodic reviews. Similarly, some Centers report a great deal of joint sponsorship and participation by Centers and divisions at field and Headquarters events. Most Centers report an average of between three and six visits yearly by Center directors to PAHO Headquarters.

---

[5] George A.O. Alleyne**,** op. cit. p. 14

Center publications and research activities tend to be carried out independently of the PAHO Headquarters division. However, in the case of at least one PAHO Center, both the division and Center management have renewed efforts to launch joint publications. In other cases, while the Center and the Headquarters division share important projects, they have different program objectives, resources, and responsibilities.

Do the Centers demonstrate a vigorous, useful, and identifiable presence in the countries, particularly outside the host country? All PAHO Centers are active outside the host countries and have an elaborate process for obtaining country input and feedback in the development of their activities. In the subregional Centers, staff are well acquainted with the Member States and their programs. But the five regional Centers have also developed activities spanning most of Latin America and the Caribbean. While it is common to all Centers that certain activities are restricted to the host country, most operations involve a number of countries. Some of the regional Centers are developing or have developed networks covering most of Latin America and the Caribbean, such as the Pan American Network of Information and Documentation in Sanitary Engineering and Environmental Sciences (REPIDISCA) and the Virtual Health Library.

In some cases, the input of national authorities in the Centers' programming is done indirectly, through the PAHO/WHO representatives and their staff, and through contacts among PAHO managers at their annual meeting.

It should be noted that some Centers, like PANAFTOSA, have traditionally provided technical cooperation to other sectors instead of the public health subsector (i.e., agriculture, especially ranchers). With the transfer of zoonoses, this Center has started relating more to the ministries of health. Most Centers report having very close and active relations with the host country, expressed in multiple ways in their respective fields.

Do the Centers still produce innovative ideas and approaches? Are they still "learning organizations"? Several Centers have been responsible for important breakthroughs over a 50-year span (e.g., Incaparina, Panacrema, the foot-and-mouth disease vaccine, the Fuenzalida anti-rabies vaccine, and Alufloc, the arsenic and toxic-metal remover from drinking water). Those breakthroughs have been used by Governments and the private sector at the subregional, regional, and global levels.

Most Centers are still formulating new procedures, devices, methods, or approaches, such as physician sentinel surveillance sites throughout the Caribbean, new approaches in handling food-borne diseases in many countries of the Americas, new methods for diagnosis, new information systems, and new certification approaches in the areas of water and sanitation. New methods or approaches for carrying out ongoing programs appear to be the most common innovation in the past decade.

6.1 *PAHO Flexibility and the Centers*

The 1978 study on the Centers endorsed by the Pan American Sanitary Conference established two very relevant criteria. First, "a center is but a method of carrying out the program and must be coordinated with other methods. The first decision is how much effort should be invested in a program area; then comes the decision as to whether a Center is a useful part of the action program. Each situation must be examined on its own merits…" because "the primary program question is what health areas should have priority; the secondary operating question is whether a given program area would benefit from … a Center as one method for achieving [its] objective…. The key question is what is the most efficient and effective way to accomplish the goals of a particular [PAHO] program area, not whether there are too many or too few Centers."

From a short-term standpoint in terms of PAHO's history, it may come as a surprise that nearly 40% of the Pan American Centers established by PAHO have been closed, among them:

- Latin American Center for Medical Administration (CLAM - Argentina), closed in 1976;
- Latin American Center for Health and Planning (PLANSALUD - Chile), closed in 1976;
- Latin American Center for Educational Technology in Health (CLATES - Brazil), closed in 1983;
- Pan American Zoonoses Center (CEPANZO - Argentina), closed in 1991;[6]
- Pan American Center for Human Ecology and Health (ECO - Mexico), closed in 1997.

An analysis of the reasons why these Centers were closed is beyond the scope of this review. However, a combination of long-standing financial concerns, an abrupt financial crisis, technical "maturity" on the part of the host country, a particular policy of the PAHO administration, or a receptiveness on the part of the host country to absorb the resources and functions of the Center have been reasons for closing the Centers. The important point to highlight is that, in taking a long-term historical look, it is clear that the Organization has been willing and able to be flexible and act upon financial, political, and technical realities impinging upon the Centers.

---

[6] Part of the resources of CEPANZO were utilized to launch INPPAZ.

Reaffirming the historical evolution of this issue at PAHO, Resolution CD31.R24 approved by the Directing Council in 1985, states, in part:

> Noting that the XVII and XX Pan American Sanitary Conferences drew up general guidelines for the establishment and operation of multinational centers;
>
> Recognizing that the Pan American Centers are integral part of the respective PAHO programs and constitute an effective mechanism for combining the functions of advisory services, teaching, research, and dissemination of information in accordance with the needs of the countries;
>
> Resolves:
>
> 1. To request the Director to continue to take appropriate actions to improve the cost effectiveness and efficiency of the Centers in the use of available resources, including the establishment of new administrative and personnel systems at the Pan American Centers.
>
> 2. To confirm the Organization's long-term goal of working toward the transfer of the administration of the Centers to host countries, if and when national institutions are able to maintain the quality and quantity of services provided to Member [States] under existing administrative arrangements.

6.2 *Program Evaluation of Individual Centers*

Resolution CSP20.R31, adopted by the Pan American Sanitary Conference in 1978, called for "regular evaluations of each center." This mandate has yet to be superseded or countermanded by the Governing Bodies, and therefore is still in force. In light of that Resolution and of discussions in recent meetings of the Governing Bodies, the Director decided to undertake an evaluation of one of the Centers. CEPIS is currently being evaluated in terms of relevance, efficiency, and effectiveness, in a joint exercise by the PAHO Bureau, consultants from the United Kingdom National Audit Office, and private sector consultants.

6.3 *Center Evolution*

Keeping in mind the criteria adopted by the Governing Bodies of PAHO in 1970 and 1978, together with the criteria developed by the Director in 1989, PAHO possesses a good framework to address the issues presented by the Centers and continue managing their development in the future. Recalling that "…a center is but a method of carrying out the [PAHO] program and must be coordinated with other methods," each of the existing Centers can and should evolve in light of the changing technical, social, economic, and political situation in the Americas. There is a growing need for making good use of the

technical excellence and expertise that exist in PAHO Member States, bringing PAHO closer to its roots of acting jointly with the countries and facilitating cooperation among them. The Centers are increasingly favoring the creation of multinuclear networks, with each Center as a hub and other centers of excellence, including but not limited to WHO/PAHO Collaborating Centers, acting in a coordinated fashion to develop other institutional and human resource capabilities in Member States. The role of the Centers should evolve more toward a catalytic one, giving less attention to requests for specific, "retail-type" technical cooperation.

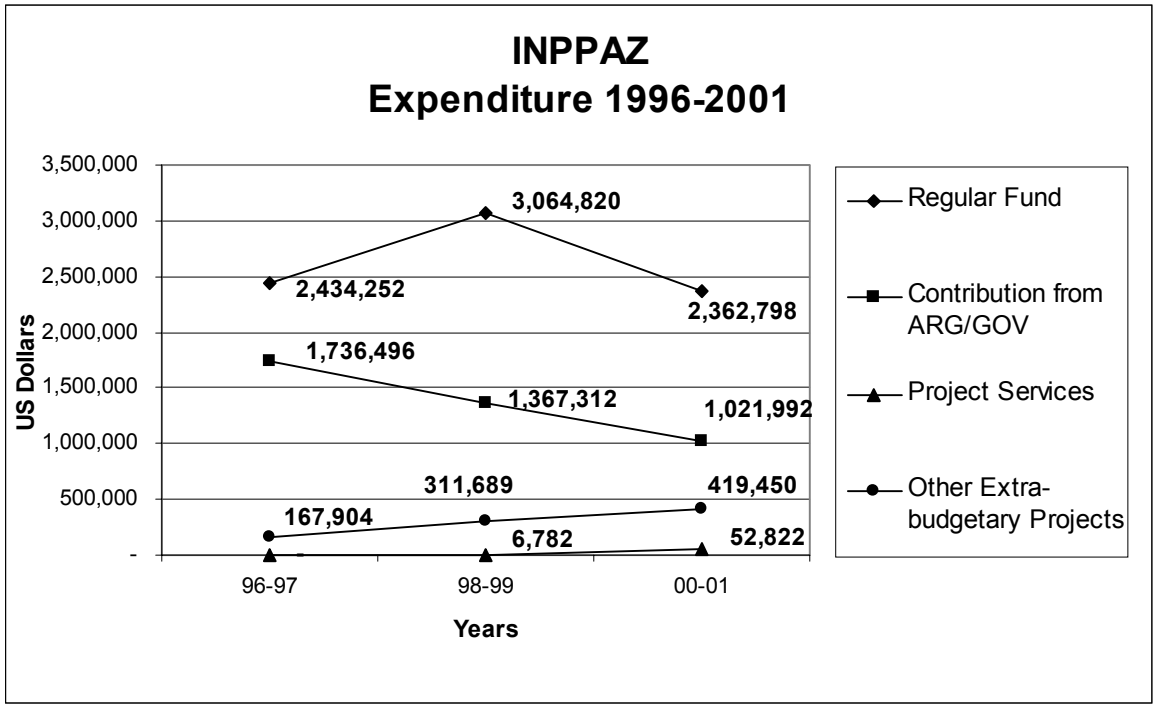
7. Conclusion

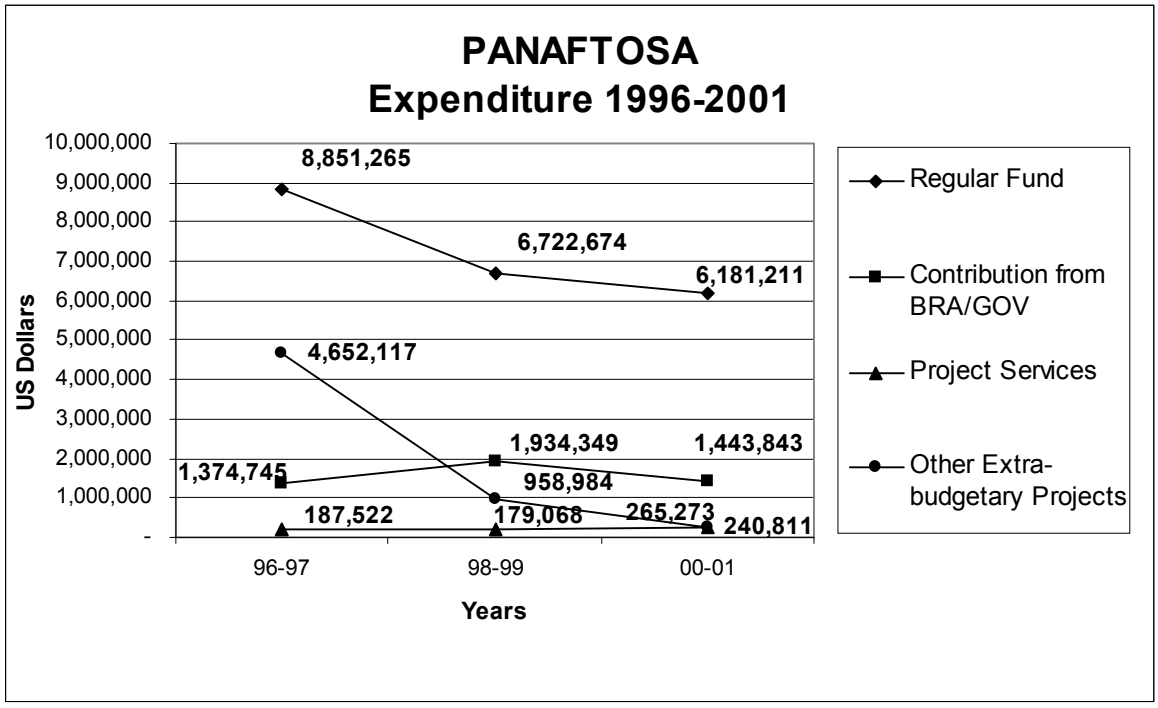
This analysis describes the background and overall situation of the Pan American Centers. The Centers represent a special mode of technical cooperation of PAHO, and have responded in large measure to the needs of the Organization and its Member States. The major concern continues to be their financial viability. The Governing Bodies of PAHO have addressed this issue repeatedly since the 1960s and have established broad guidelines which continue to be relevant to the present situation. In the context of those guidelines, the Pan American Centers have evolved and the analysis shows that they are not immutable, and they can be created, changed, or dissolved depending on a variety of circumstances.

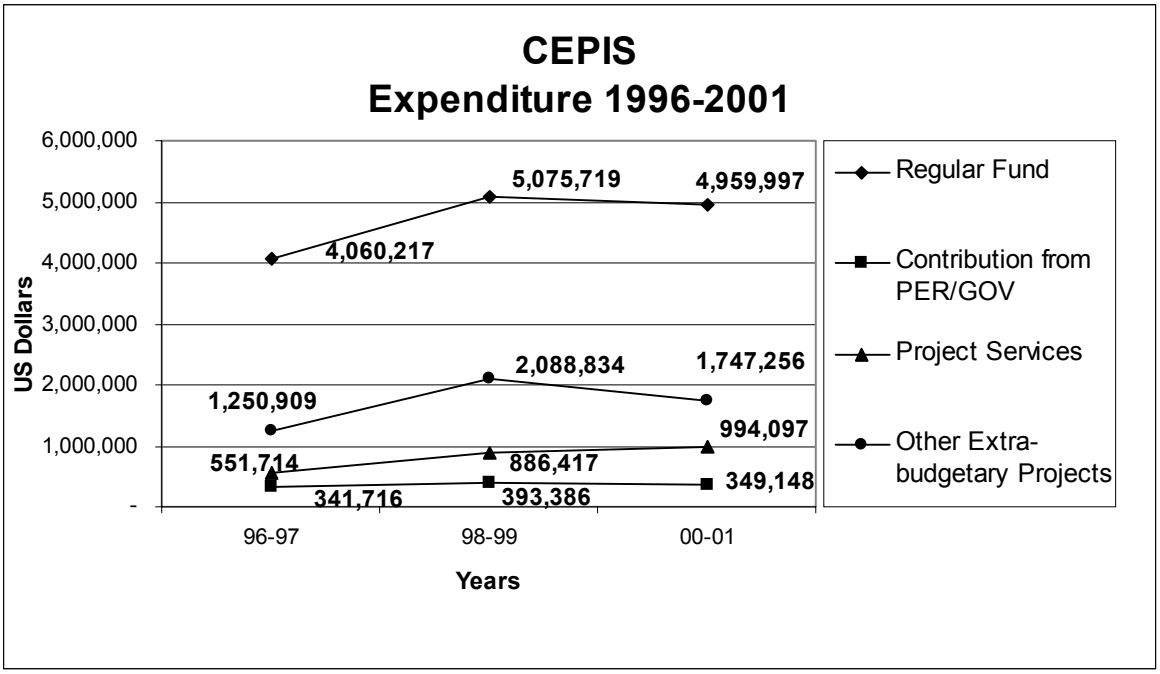
Annex

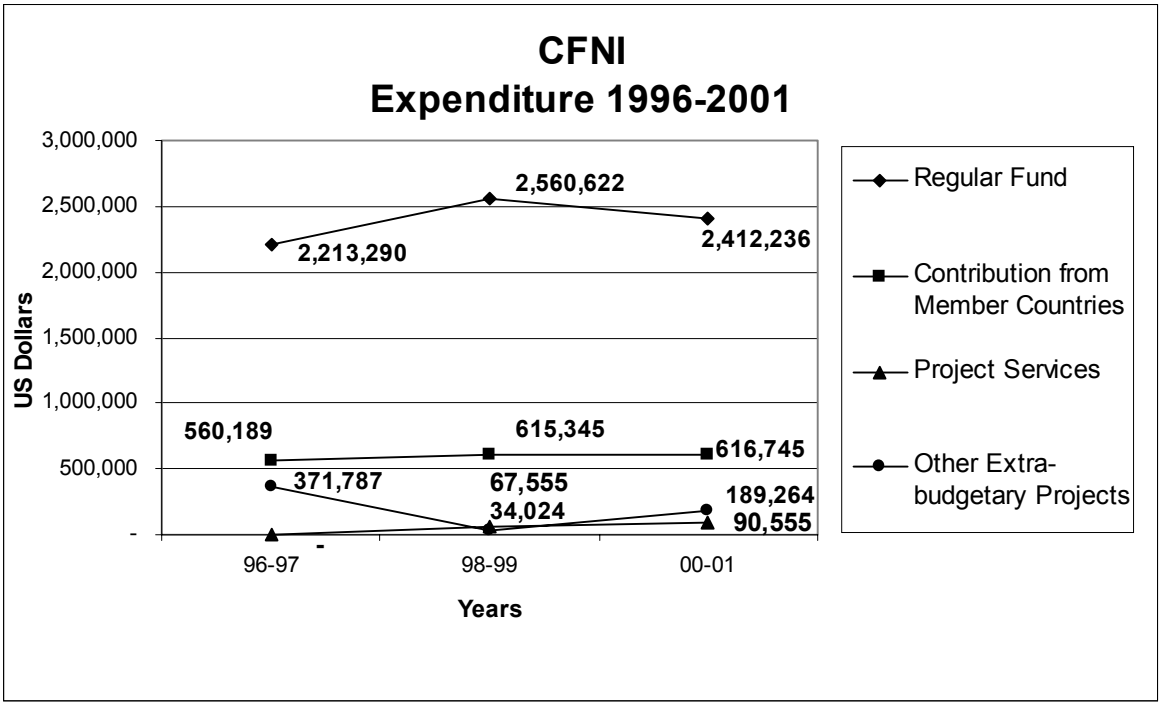
The following charts present expenditures of the Centers over the last two bienniums (1998-1999 and 2000-2001). This approach measures actual level of activity for each source of funding.

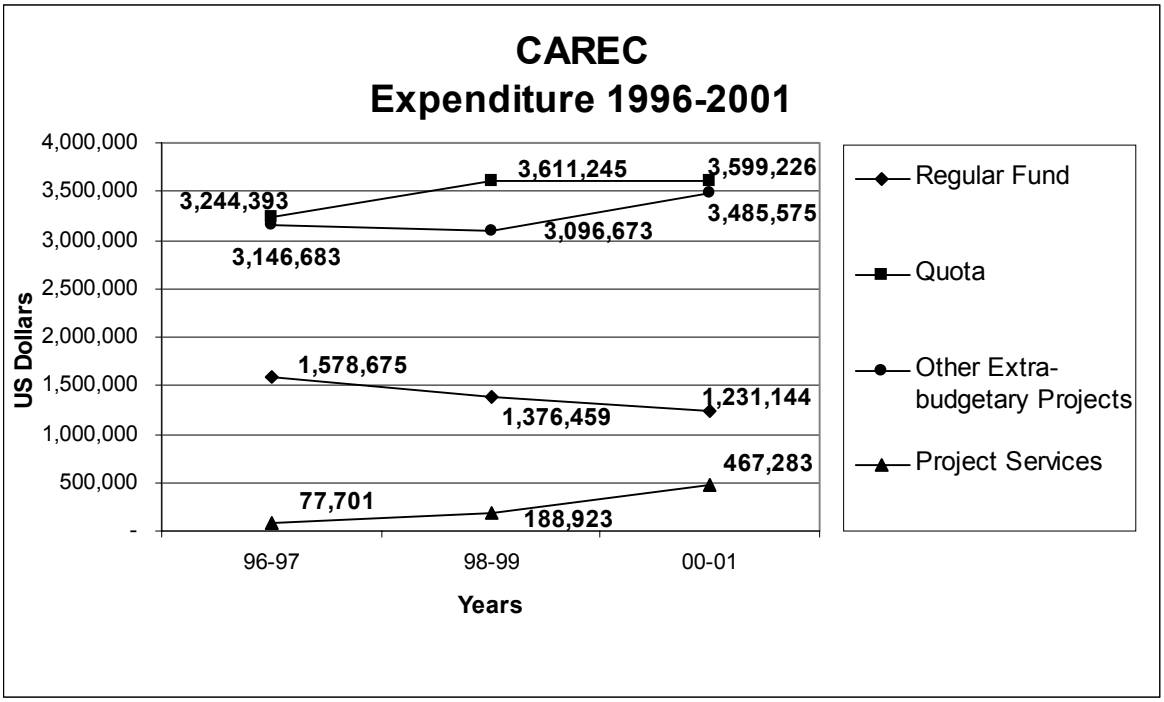
- The "Regular Fund" curve represents the PAHO regular budget contribution to each Center.
- The "PI" curve represents the sale of services by the Center.
- In the case of the subregional Centers, expenditures in relation to the quota contribution of its Member Governments are depicted in the "Quota" curve.
- The biennial trend for extrabudgetary funds is also shown.

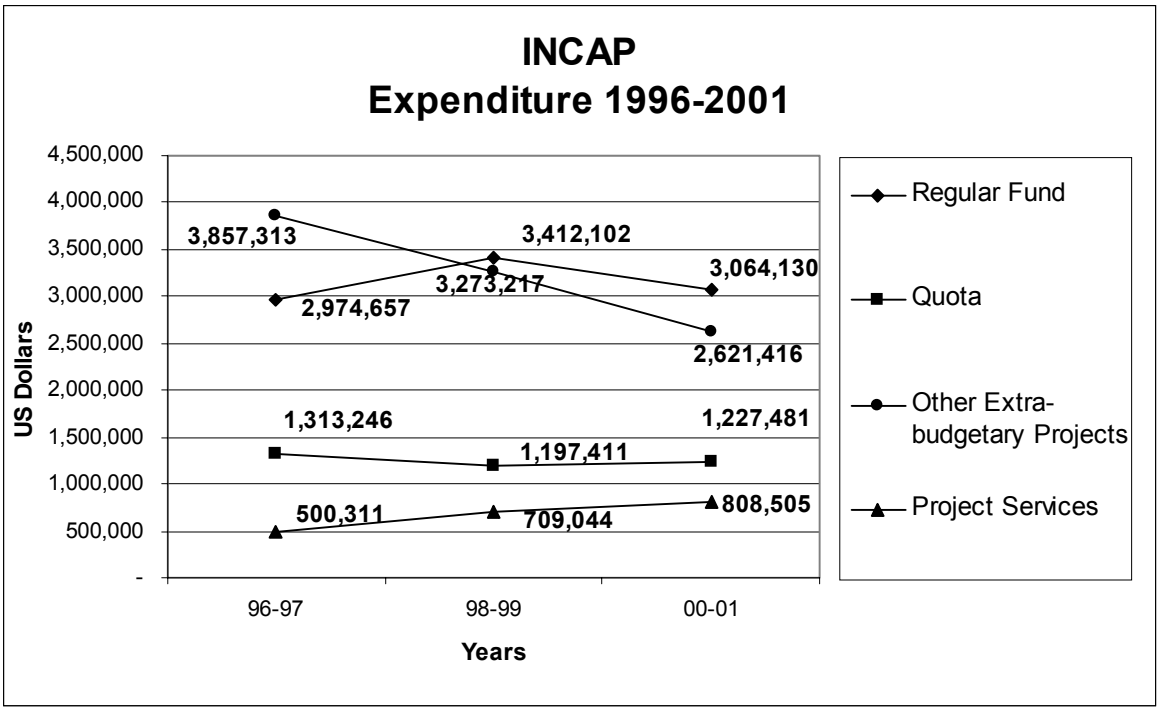

INPPAZ
Expenditure 1996-2001
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
US Dollars
3,064,820
2,434,252
2,362,798
1,736,496
1,367,312
1,021,992
311,689
419,450
167,904
6,782
52,822
96-97
98-99
00-01
Years
Regular Fund
Contribution from ARG/GOV
Project Services
Other Extra-budgetary Projects

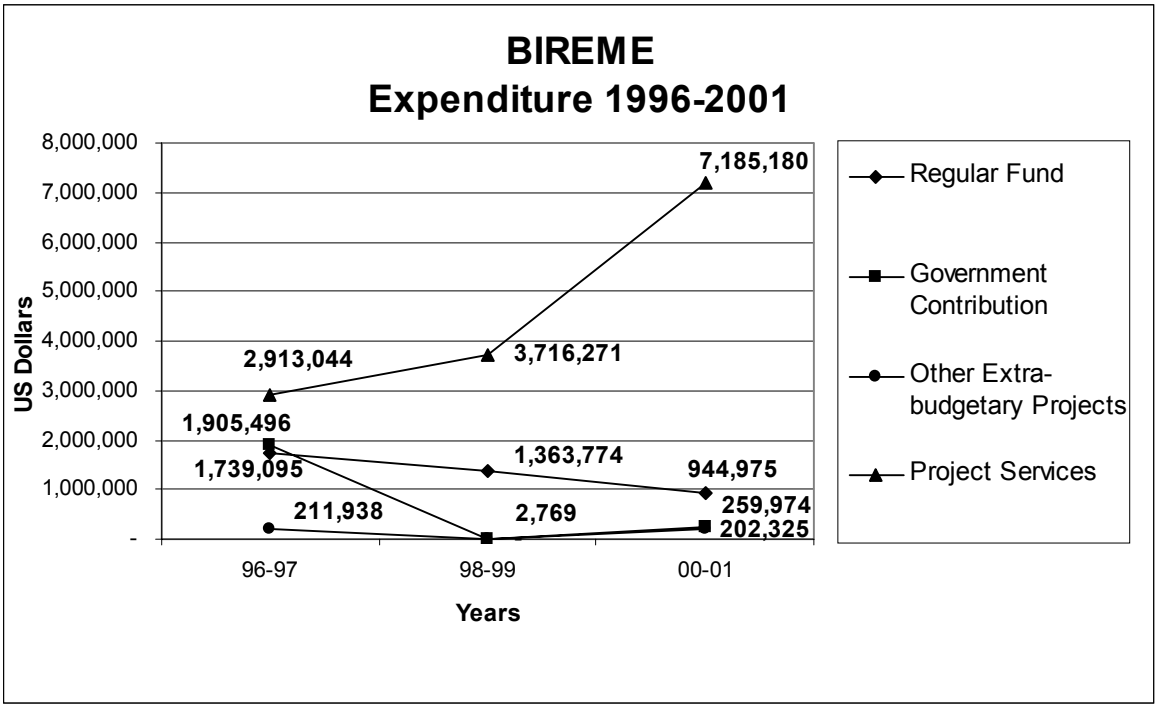

PANAFTOSA
Expenditure 1996-2001
10,000,000
9,000,000
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-
US Dollars
8,851,265
6,722,674
6,181,211
4,652,117
1,934,349
1,443,843
1,374,745
958,984
187,522
179,068
265,273
240,811
96-97
98-99
00-01
Years
Regular Fund
Contribution from BRA/GOV
Project Services
Other Extra-budgetary Projects

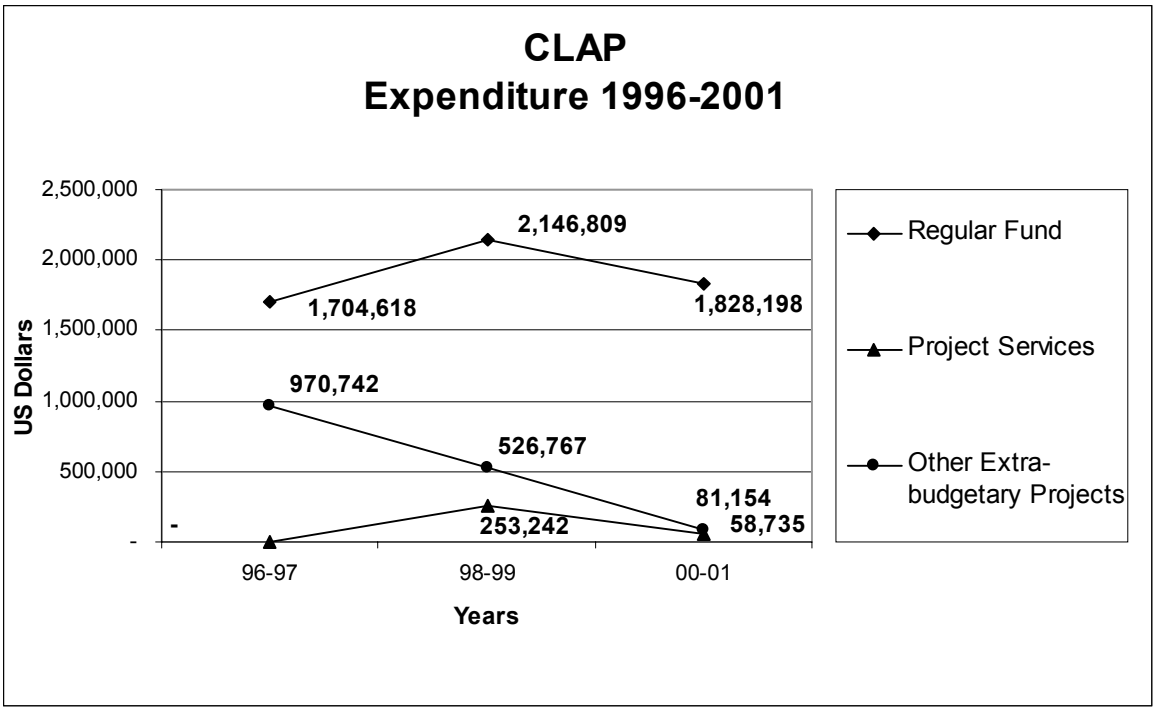

CEPIS
Expenditure 1996-2001
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-
US Dollars
5,075,719
4,959,997
4,060,217
2,088,834
1,747,256
1,250,909
994,097
551,714
886,417
349,148
341,716
393,386
96-97
98-99
00-01
Years
Regular Fund
Contribution from PER/GOV
Project Services
Other Extra-budgetary Projects


CFNI
Expenditure 1996-2001
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
US Dollars
2,560,622
2,412,236
2,213,290
560,189
615,345
616,745
371,787
67,555
189,264
34,024
90,555
-
96-97
98-99
00-01
Years
Regular Fund
Contribution from Member Countries
Project Services
Other Extra-budgetary Projects


CAREC
Expenditure 1996-2001
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
US Dollars
3,244,393
3,611,245
3,599,226
3,146,683
3,096,673
3,485,575
1,578,675
1,376,459
1,231,144
77,701
188,923
467,283
96-97
98-99
00-01
Years
Regular Fund
Quota
Other Extra-budgetary Projects
Project Services


INCAP
Expenditure 1996-2001
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
US Dollars
3,857,313
3,412,102
3,064,130
2,974,657
3,273,217
2,621,416
1,313,246
1,197,411
1,227,481
500,311
709,044
808,505
96-97
98-99
00-01
Years
Regular Fund
Quota
Other Extra-budgetary Projects
Project Services


BIREME
Expenditure 1996-2001
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-
US Dollars
7,185,180
2,913,044
3,716,271
1,905,496
1,739,095
1,363,774
944,975
259,974
211,938
2,769
202,325
96-97
98-99
00-01
Years
Regular Fund
Government Contribution
Other Extra-budgetary Projects
Project Services


CLAP
Expenditure 1996-2001
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
US Dollars
2,146,809
1,704,618
1,828,198
970,742
526,767
81,154
58,735
253,242
96-97
98-99
00-01
Years
Regular Fund
Project Services
Other Extra-budgetary Projects