PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

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58th SESSION OF THE REGIONAL COMMITTEE

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PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING
ACTA RESUMIDA PROVISIONAL DE LA TERCERA REUNIÓN

Tuesday, 26 September 2006, at 8:45 a.m.
Martes, 26 de septiembre de 2006, a las 8.45 a.m.

President/Presidente: *Hon. Dr. Leslie Ramsammy* Guyana

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The meeting was called to order at 8:45 a.m.
Se abre la reunión a las 8.45 a.m.

TRIBUTE TO THE MEMORY OF DR. BARRINGTON WINT
HOMENAJE A LA MEMORIA DEL DR. BARRINGTON WINT

The PRESIDENT said that many had arrived for the 47th Directing Council expecting to see an old friend and colleague, Dr. Barrington Wint of Jamaica. The news of his untimely passing on 7 September after a very brief illness had come as a great shock to the Directing Council and, indeed, the entire PAHO family, bearing in mind his active, recent participation in a wide variety of meetings and other activities. He had long been a source of reason and wisdom, and his carefully considered opinion had been valued in many international and regional forums, including, most recently, the Health Assembly, the Board of the Caribbean Health Research Council, and the Caribbean Accreditation Authority for medical and other health professionals. In addition to representing Jamaica, CARICOM, and the various professional bodies of which he was a member, he had been Program Manager of Health Sector Development at the CARICOM Secretariat, a member of the CARICOM Subcommittee on Health and Disaster Management, and Chair of the interim committee that had established the Pan Caribbean Partnership against HIV/AIDS (PANCAP) from 1998 to 2001. He would always be remembered for his humanity and dedication, and as a skilled professional, colleagues and family man. He would be sorely missed. The PAHO family expressed profound

sympathy to his family and to the Government of Jamaica. A book of condolences would be open for signature for the duration of the Directing Council.

The Members of the Directing Council stood for a minute of silence in tribute to the memory of Dr. Barrington Wint.
Los Miembros del Consejo Directivo, puestos de pie, guardan un minuto de silencio en homenaje a la memoria del Dr. Barrington Wint.

ITEM 3.2: ANNUAL REPORT OF THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU
PUNTO 3.2: INFORME ANUAL DEL DIRECTOR DE LA OFICINA SANITARIA PANAMERICANA
ITEM 8.1: UPDATE ON THE PROCESS OF INSTITUTIONAL STRENGTHENING OF THE PAN AMERICAN SANITARY BUREAU
PUNTO 8.1: ACTUALIZACIÓN DEL PROCESO DE FORTALECIMIENTO INSTITUCIONAL DE LA OFICINA SANITARIA PANAMERICANA

El Dr. VIZZOTTI (Presidente del Comité Ejecutivo) recuerda que en la 138.ª sesión del Comité Ejecutivo, la Directora puso al corriente al Comité sobre los adelantos más recientes en el proceso de fortalecimiento institucional, centrándose en particular en el posicionamiento de la OPS al nivel más alto; el mejoramiento de la sostenibilidad financiera; la reestructuración de la fuerza de trabajo; el logro de la responsabilización individual e institucional y la promoción de la armonización estratégica de los recursos. El Comité oyó un informe de la Dra. Judith Navarro, Gerente del Área de Publicaciones, sobre un estudio de mercado que se realizó para determinar cómo percibían a la OPS los Estados Miembros, los interesados directos externos y el personal, y para determinar el nicho de la Organización dentro del ámbito del desarrollo internacional. El Comité

Ejecutivo agradeció a la Directora su informe y felicitó a la Oficina por sus adelantos en el proceso de fortalecimiento institucional. Los Miembros recalcaron que el fortalecimiento institucional debía ser un proceso constante y se alentó a la Oficina a que siguiera trabajando para abordar los puntos débiles señalados en el documento sobre este tema y en el informe del estudio de mercado. El Comité tomó nota del informe pero no consideró necesario adoptar una resolución al respecto.

La DIRECTORA anuncia que para ilustrar su presentación se proyectará un video sobre el contenido del Informe anual. Al término de la proyección señala que el objetivo del Informe es poner en conocimiento de todos los Estados Miembros los acontecimientos de cooperación técnica de relieve en este período, especialmente los avances logrados en la reducción de las desigualdades en materia de salud, o brechas de salud, a favor de las poblaciones más desfavorecidas.

El Informe consta de tres capítulos, titulados respectivamente “Para reducir las inequidades en salud”, “Para alcanzar a los grupos en desventaja” y “Avanza el desarrollo institucional de la OPS”.

Se ha elegido este año el tema de la reducción de las brechas de salud en las poblaciones más desfavorecidas porque de ese modo se reafirma que la equidad es el principio guía del accionar de la OPS para avanzar en la reducción de las desigualdades, que son evitables e inaceptables. En palabras de otros oradores, éste continúa siendo un continente muy inequitativo en cuanto a la distribución de los ingresos. Por consiguiente,

hay que afrontar el desafío de llegar a las poblaciones más desfavorecidas a fin de ponerlas en situación de igualdad de oportunidades con el resto de la sociedad.

A ese respecto, se ha trabajado con objeto de mejorar los instrumentos para medir y destacar las desigualdades. En el Informe se han incluido muchos ejemplos de ellos, entre otros, el Grupo de trabajo sobre desigualdades en salud, en Argentina; los folletos de indicadores básicos de salud, que se preparan ya en muchos países, algunos de los cuales, como Costa Rica o Panamá, se orientan específicamente a las poblaciones indígenas o poblaciones que se quieren destacar de modo particular; el boletín de inmunizaciones; una publicación con la CEPAL sobre los Objetivos de Desarrollo del Milenio; una encuesta mundial sobre tabaquismo entre los jóvenes; la segunda publicación del boletín de indicadores de género, salud y desarrollo, preparada conjuntamente con el UNIFEM y el UNFPA; la encuesta SABE; y la evaluación de la capacidad de los países con respecto a la implementación del Reglamento Sanitario Internacional, la capacidad de las redes de laboratorio y de vigilancia epidemiológica y la capacidad de preparación de los países para enfrentar emergencias y catástrofes.

También se ha trabajado en el fortalecimiento de la capacidad operativa para implementar intervenciones específicas que puedan reducir esas brechas, así como en el desarrollo de políticas y planes basados en pruebas. En la mayoría de los países se ha trabajado en la formulación de ajustes en sus planes nacionales de salud, con un enfoque centrado en las desigualdades y con acciones específicas para llegar a las poblaciones más desfavorecidas. Es indudable, por ejemplo, que la evaluación de los programas de

inmunización en muchos de los países ha permitido identificar los municipios en los que, por ejemplo, hay que fortalecer los sistemas, introduciendo esos conceptos en la planificación y la política nacional.

En el Caribe de habla inglesa se ha introducido un enfoque estratégico en el fortalecimiento de la evaluación y el mejoramiento de los sistemas de información sanitaria que ha llegado inclusive a manifestarse como una decisión política de los jefes de gobierno del CARICOM en referencia a la necesidad de mejoramiento de la información sanitaria nacional y regional. En Brasil, se adoptaron la metodología y los instrumentos de las funciones esenciales de salud pública al Sistema Único. Se ha avanzado en muchos países en los programas de médicos de familia, o médicos comunitarios, una de las intervenciones importantes de la política nacional para asegurar que ese recurso humano llegue a las poblaciones más desfavorecidas. La oradora manifiesta que se ha avanzado también, por ejemplo, en el observatorio de recursos humanos de la salud, uno de cuyos componentes es dotar de recursos humanos calificados los sitios donde más lo necesitan y con la capacidad para resolver las necesidades específicas de las poblaciones más desfavorecidas. Por último, señala la Segunda Ronda de Negociación de Antirretrovirales, política de gran importancia porque permite resolver el acceso universal al tratamiento.

El capítulo 2 se centra en algunas de las acciones desarrolladas por los países para alcanzar a los grupos más desfavorecidos y se presentan algunos ejemplos de

intervenciones exitosas que pueden ser reproducidas en otros lugares. Se han elegido algunos aspectos específicos, como, por ejemplo, la extensión de la protección social en salud maternoinfantil. Se citan varios ejemplos, como, en Panamá, el plan estratégico para la reducción de la morbilidad materna y perinatal 2006-2009; en Argentina, el trabajo de fortalecimiento del sistema de salud provincial; en Honduras, el programa ACCESO; en Belice y Jamaica, la iniciativa de cooperación técnica horizontal para la ejecución del Programa de Maternidad sin Riesgo; en Haití, donde se ha ampliado la oferta de servicios gratuitos de atención al embarazo y al parto; y se va a celebrar una importante reunión en Honduras para analizar las experiencias en extensión de la protección social a la población maternoinfantil.

En el aspecto del fortalecimiento de la atención primaria y ampliación del acceso en materia de salud y nutrición, el Informe destaca el movimiento resultante de la renovación de la Declaración de Atención Primaria, la revisión de los logros, los obstáculos y las nuevas modalidades de extensión de la atención primaria. Se ha constatado un incremento de la acción interprogramática de apoyo y en torno a la estrategia de atención primaria en todos los planes regionales que impulsan las unidades, en un mejoramiento y en una mayor armonización de la inclusión de los distintos aspectos dentro de la plataforma de la estrategia de atención primaria. Se pueden destacar, por ejemplo, algunos países como la República Dominicana, con el programa nacional de fortalecimiento de la fortificación de alimentos; Honduras, con el programa

de seguridad alimentaria y nutricional; y Guatemala, con el impulso de la lucha contra el hambre, igual que en Brasil.

Asimismo, destacan importantes iniciativas tales como la semana de vacunación de las Américas, en la que de forma simultánea en todo el continente, en la misma semana de abril se vacuna a los grupos que no están siendo alcanzados sistemáticamente por los programas regulares. A ese respecto, es motivo de orgullo que la Región de Europa, siguiendo el ejemplo de la Región de las Américas, celebrará, también en abril, una semana europea de vacunación. La OPS emitió una alerta de viaje en la Copa Mundial de Fútbol, celebrada en Alemania, precisamente para llamar la atención de Europa hacia la necesidad de fortalecer sus acciones de control del sarampión y para fortalecer la capacidad de los países ante el movimiento que se iba a producir con ocasión de esta celebración deportiva. Los deportistas ofrecieron un apoyo irrestricto y, en el marco de ese esfuerzo, se nombró Campeón de la Salud a Ronaldinho, y se contó con la colaboración del caricaturista argentino Fernando Sendra.

Se han realizado acciones en poblaciones específicas, por ejemplo, los escolares, con el fortalecimiento de los programas de salud en las escuelas, entre las que destacan, en Guyana, la aplicación del Plan Visión Nacional 20:20, y en Perú, el proyecto de intervención básica de salud oral con base en las escuelas.

En el campo de la protección de la salud de los niños y los adolescentes, se han constituido comités interinstitucionales; en particular en Honduras, el de la protección

para la niñez huérfana por el VIH/SIDA, que es un componente específico del proyecto apoyado por el Fondo Mundial y, en El Salvador, el Programa Ternura, así como la inclusión dentro del plan regular de vacunación de la vacuna pentavalente.

En el tema de la prevención de la violencia en jóvenes, destaca, en 2005, la Conferencia Internacional "Voces desde el campo: iniciativas locales e investigación sobre la violencia juvenil de pandillas en Centroamérica", cuya finalidad fue establecer un diálogo internacional y multisectorial sobre el tema; asimismo, los proyectos de fomento del desarrollo juvenil y prevención de la violencia juvenil en Argentina, Colombia, El Salvador, Honduras, Nicaragua y Perú.

En materia de igualdad de género y fortalecimiento y capacitación de la mujer, en 2005 se adoptó la política de equidad de género en la OPS y se han producido folletos estadísticos, en particular a nivel nacional, con indicadores diferenciados de ambos sexos en Costa Rica, Guatemala, Honduras, Panamá y Perú; en Chile, se publicó el primer informe anual del Observatorio de Equidad de Género en Salud.

En cuanto a la reducción del estigma y discriminación de las personas con el VIH/SIDA, se diseñó una investigación sobre género y VIH/SIDA, lo cual servirá para la revisión de las normas y protocolos de atención para las personas que viven con el VIH en Belice, Honduras y Nicaragua. Se superó la meta de la iniciativa "Tres millones para 2005" en la Región de las Américas. Se realizaron campañas de comunicación muy innovadoras en Bahamas y en Suriname, y debe destacarse en México la campaña contra la homofobia, y en Belice y Guyana el trabajo específico sobre población que vive con

SIDA en las prisiones. En el segundo periodo extraordinario de sesiones de la Asamblea General de las Naciones Unidas sobre el VIH/SIDA, en junio de 2006, los Estados Miembros adoptaron una nueva declaración política y se celebraron sesiones especiales en la Región de las Américas.

En relación con los pueblos indígenas, en Costa Rica se llevó a cabo el primer Foro nacional de salud de los pueblos indígenas, donde se establecieron alianzas y propuestas conjuntas. En Honduras se trabajó específicamente con los buzos de la población miskito afectados por el síndrome de descompresión aguda, con el apoyo de la OEA. En Colombia se han diseñado modelos de atención de salud para comunidades indígenas, afrodescendientes, y gitanas, que han sido incorporadas en políticas nacionales de protección social. Con el Organismo Alemán de Cooperación Técnica se está concluyendo el proyecto "Mejoramiento de las condiciones ambientales (agua y saneamiento) en las comunidades indígenas", y durante 2006 dentro del proyecto regional de "Atención integrada a las enfermedades prevalentes de la infancia" (AIEPI) se han implementado proyectos en 32 comunidades de pocos recursos, la mayoría de origen indígena. México y Guatemala han informado de avances importantes en la prevención y eliminación del tracoma, particularmente en los Altos de Chiapas.

Con respecto a los adultos mayores, en Belice se adoptó la política para las personas de edad y se estableció el Consejo Nacional de Envejecimiento; en Cuba se creó una comisión para analizar los factores y circunstancias que influyen en la esperanza de

vida y generar propuestas para el sistema de salud y de gobierno. Por su parte, Chile ha elaborado un estudio que sistematiza las experiencias de las instituciones de salud en América Latina en el campo de los adultos mayores.

En materia de discapacidad, se han realizado talleres de capacitación en derechos humanos y discapacidad en Argentina, Brasil, Chile, El Salvador, Guatemala, Honduras y Nicaragua, entre otros. Panamá ha elaborado un plan nacional 2005-2009 y, en Paraguay, se ha garantizado el fortalecimiento de la gestión y operación de la red de servicios de salud mental y se ha mejorado la infraestructura.

Con respecto a las comunidades de zonas de alto riesgo, se distinguen a las poblaciones que viven en zonas sujetas a desastres naturales; se han puesto en práctica planes de ayuda humanitaria sobre saneamiento y atención de la salud en Guatemala; en Guyana, después de las inundaciones de 2005 se apoyó el desarrollo del proyecto de agua, ambiente y saneamiento en escuelas; y se intervino en Haití, en Suriname, y en los Estados Unidos de América.

Con respecto a los habitantes en situación de pobreza, en Venezuela, la misión Barrio Adentro es el eje central de la transformación del sistema de salud; en Perú, el SIS administra fondos para financiar prestaciones para poblaciones en situación de pobreza; en México se ha creado el Seguro Popular; en el Caribe, el programa de pequeñas subvenciones permite mejorar la seguridad alimentaria y nutricional y reducir la pobreza, particularmente en los grupos que están siendo afectados por la conversión de la caña de azúcar; se han aplicado también ejemplos muy interesantes en Saint Kitts y Nevis, en

San Vincente y las Granadinas y en otros países del Caribe. La estrategia de municipios y comunidades saludables representa la implementación local de una de las iniciativas más efectivas de la promoción de la salud, y en el marco de la estrategia de atención primaria dirigida a poblaciones vulnerables se puede citar el ejemplo de Haití, con el éxito de las acciones en la comunidad de Cité-Soleil, que tiene altos índices de violencia.

En cuanto a las poblaciones que viven en zonas fronterizas, el año ha sido muy activo en ese campo, y no solamente en el marco de las inmunizaciones. Cabe destacar el Plan Binacional de Desarrollo de la zona de integración fronteriza, que incluye proyectos de vigilancia y prevención, por ejemplo en el uso de plaguicidas en la frontera entre Colombia y Ecuador, que ha servido para distender la situación de violencia en esa zona, y la acción de frontera saludable 2010, entre México y los Estados Unidos de América, que ha permitido desarrollar otras iniciativas tales como la cooperación horizontal entre países.

En cuanto a las comunidades que viven en zonas endémicas y que están sujetas a una carga desproporcionada de enfermedades infecciosas, se ha desarrollado una acción específica entre el programa regional de la malaria con un desarrollo del plan estratégico de control 2006-2010 y proyectos específicos en México y América Central que están dando excelentes resultados con alternativas para el control de vectores que no utilicen DDT. Hay que mencionar asimismo el Plan Estratégico Regional de Control de la Tuberculosis 2006-2015, que se centra en poblaciones particularmente difíciles tales como las poblaciones móviles y migrantes, y la prevención y vigilancia del Chagas, con

la excelente noticia de la interrupción de la transmisión vectorial en Brasil durante el transcurso del año. También se va avanzando en la implementación de la estrategia global para reducir la lepra y la sostenibilidad de las acciones de control de enfermedades y la ampliación del plan de vacunación con más antígenos para toda la población de niños de las Américas, tratando de que no se amplíe la brecha entre países desarrollados y países en desarrollo con respecto a la introducción de nuevas vacunas que produce el desarrollo de la ciencia y la tecnología. Se ha avanzado también en la vigilancia hospitalaria del rotavirus en 10 países, en preparación para la introducción de esta vacuna.

Finalmente, la oradora destaca que en el último capítulo del Informe figuran varias de las acciones desarrolladas por la Secretaría para cumplir con la resolución aprobada el año 2005, que integra varias de las evaluaciones y recomendaciones de distintos cuerpos, incluidos grupos de trabajo tales como el Grupo de Trabajo sobre la OPS en el Siglo XXI y las evaluaciones de diversos organismos de las Naciones Unidas y de auditoria interna y externa. Esa resolución de fortalecimiento institucional se ha desarrollado de diversas maneras. En primer lugar, se ha creado una Unidad de Desarrollo Institucional dentro de la Organización, que está elaborando indicadores del desempeño a fin de incorporarlos en el nuevo Plan Estratégico 2008-2012, así como para medir el avance de los compromisos establecidos en muchas de esas recomendaciones.

Por lo que se refiere a la planificación y presupuestación, se ha avanzado en la armonización con el Programa General de Trabajo de la Organización Mundial de la

Salud y la definición de puntos focales por área de trabajo, eso es, la creación de una red de puntos focales en la Secretaría para trabajar de manera conjunta con la Organización Mundial de la Salud a fin de asegurar que los resultados mundiales previstos tengan la debida contribución de la Región. Se ha adaptado la formulación en la nueva versión del sistema computadorizado de planificación, presupuestación y financiamiento (AMPES/OMIS), que incorpora la política aprobada en el presupuesto regional por programas, que a su vez incorpora el nivel subregional de presupuesto.

Con la nueva modalidad de cooperación enmarcada en los Planes Regionales de Salud Pública se ha avanzado en la articulación de todos los niveles y socios para el desarrollo a fin de lograr el cumplimiento de objetivos comunes. Se ha aplicado la estrategia de cooperación técnica, que es un instrumento estratégico de diálogo con el país para establecer el papel más apropiado de la cooperación de la OPS en el desarrollo sanitario nacional, que se ha aplicado en Bolivia, Costa Rica, Guyana, Honduras, México, Nicaragua y Venezuela. Por primera vez se ha adaptado ese instrumento originado inicialmente por la Organización Mundial de la Salud para un contexto multinacional, y se ha elaborado una estrategia de cooperación multiregional con los países del Caribe Oriental, lo que ha supuesto un enorme avance para poder apreciar cuales son los puntos más estratégicos en los que los países de esa subregión requieren la cooperación técnica de la Organización. A raíz de esa estrategia de cooperación subregional se ha avanzado también en la reestructuración de la Oficina de Coordinación de Programas para el Caribe con sede en Barbados.

Se ha iniciado un proceso de análisis estratégico y alineamiento de los recursos financieros y humanos en las áreas más importantes y críticas de la Organización. También se ha adoptado un código de principios de ética y conducta y se ha completado la designación del Mediador y del Oficial de Ética, y se esté preparando el sistema de atención de quejas y de revisión de conductas éticas, incluidos los conflictos de intereses. En ese sentido, la OPS va a estar a la cabeza de los organismos internacionales al poder completar una línea de llamado de emergencia del personal para cualquier queja relativa a los contenidos del código de ética y a la política de acoso en el lugar de trabajo. La OPS se va a convertir en la primera organización realmente abierta, y en ese trabajo merece mención especial la labor realizada por la Asociación de Personal y su directiva.

Hay que destacar también el tema de las alianzas y asociaciones. Se ha avanzado mucho en el liderazgo de la convocatoria de los directores regionales de los organismos de las Naciones Unidas y de los directores del sistema interamericano. La oradora dice que la OPS, desde el año 2003, y ella misma, han dedicado un tiempo político importante a la armonización con las organizaciones en el campo internacional y también a través de las Representaciones. Se ha realizado un trabajo importante de liderazgo en la coordinación de la cooperación externa, y agradece a los ministros de manera especial por el respaldo que dan a los Representantes de la OPS para cumplir esa función de coordinación, que es en apoyo a los ministerios y a los gobiernos y no sustituye el papel fundamental de coordinación que desempeñan los países.

Se ha trabajado, por lo tanto, en el fortalecimiento de la presencia de la Organización en todas las redes existentes en la Cumbre de las Américas; en la Cumbre Iberoamericana; en la Cumbre del CARICOM; y en los trabajos con el grupo temático de apoyo al ONUSIDA.

Por último, hay que mencionar el beneficio financiero obtenido por la Organización en 2005, y muy en particular destaca el hecho de que todos los Estados Miembros y Miembros Asociados han pagado alguna porción de su cuota, un hecho sin precedente desde 1990. Ese enorme respaldo ha permitido también incrementar la movilización de contribuciones voluntarias, que han aumentado un 25% respecto al mismo periodo del bienio anterior. La Directora reconoce de manera especial el trabajo del Dr. Anders Nordström en su anterior capacidad al frente del área de Administración General de la Organización Mundial de la Salud, quien implementó desde una perspectiva programática, presupuestaria y de diseño de mecanismos apropiados una verdadera alianza para el incremento de las contribuciones voluntarias a la Organización Panamericana de la Salud para lograr una participación justa en las contribuciones voluntarias que recibe la Organización Mundial de la Salud. Se trata de un principio que defendió el Dr. LEE, y hay que dar las gracias de manera destacada al Dr. Anders Nordström por su compromiso a ese respecto, tanto en su capacidad técnica cuando estuvo al frente de la administración general de la OMS, como en el presente cuando tiene a su cargo la institución en su conjunto.

Ms. CARTWRIGHT (Canada) congratulated the Organization for the work done over the past year to assist countries of the Americas in such areas as reducing health inequities, strengthening operational capacity, and facilitating new health alliances. PAHO also merited praise for its steady work to strengthen the Region's disaster response, including readiness in the event of an outbreak of pandemic of avian influenza. It was encouraging to see that PAHO had moved forward significantly on that front since the previous Directing Council.

Canada welcomed the Organization's stated intention to renew its emphasis on addressing the rise of chronic, noncommunicable diseases such as cancer, and on the health of indigenous peoples. It looked forward with enthusiasm to sharing its knowledge and learning from the work of partners across the Hemisphere in tackling those challenges.

Canada applauded the Organization's continuing efforts to improve its operations. The fine work done in the past year had culminated in recommendations by the Working Group on PAHO in the 21st Century on innovative ways to modernize the Organization and render its work more effective. The Working Group on Streamlining the Governance Mechanisms of PAHO, which Canada had chaired, had made numerous recommendations to render the Organization more effective, which Canada looked forward to discussing. The reorganization of the Pan American Sanitary Bureau further exemplified the heightened focus on accountability, transparency, efficiency, and results-based management.

Canada was a member of the steering group charged with developing the Health Agenda for the Americas and believed that the process of constructing a sound conceptual framework for 2008-2017 was well under way. PAHO's status as a strategic partner in improving the health status of the people of the Americas was demonstrated by the significant support it was given by the Canadian International Development Agency for addressing key health issues such as communicable diseases, immunization, HIV/AIDS, and disaster management in Latin America and the Caribbean. Canada used its biennial program funds, not for work within its borders, but rather to mobilize its health experts to address specific health needs identified by countries. It had supported 20 such projects over the past year and had learned a great deal from that partnership.

Achieving concrete improvements and timely access to quality health care was one of her Government's five key priorities. It was committed to working with provincial and territorial governments to develop a patient wait-time guarantee to ensure that all Canadians received medically necessary services within clinically acceptable wait times. To live up to that commitment, it was prepared to make fundamental improvements in its health system, based on four key areas: research for health policy development and knowledge sharing; information and communication technologies to facilitate communication; creation of networks and sharing of information to improve collaboration; and human resources for effective health care delivery. Canada would share with PAHO and with Member States its best practices and all the knowledge it gained in constructing a more sustainable health system.

La Dra. MUÑOZ (Uruguay) dice que su país está empeñado en liderar cambios para la construcción de un sistema nacional integrado de salud financiado mediante un seguro y apoyado en la estrategia de atención primaria, para aumentar su operatividad. Pero ello ha de ser un esfuerzo intersectorial, no sólo del Ministerio de Salud. En Uruguay se está realizando una encuesta de factores de riesgo, que pondrá de manifiesto la necesidad de modificar los hábitos, prácticas y conductas de la población; por ello es preciso continuar apoyando estrategias que den un impulso nuevo no sólo desde el sector de la salud, sino también desde los sectores de producción y de desarrollo, sobre todo en lo que se refiere a una alimentación más saludable. En ese sentido, la Iniciativa de Comunidades Productivas y Saludables es una de las más importantes que ha lanzado la Organización Panamericana de la Salud, con el objetivo de atender las necesidades de la población más desprotegida y de las comunidades a las que menos llegan no sólo la atención y la promoción de salud adecuadas, sino también la posibilidad de tener un trabajo digno y de insertarse en el aparato productivo del país.

También se han hecho grandes esfuerzos por dar prioridad a cuestiones como el gran retraso en materia de salud bucal, salud ocular y salud mental. Aunque en todas ellas se ha contado con la ayuda de la Organización Panamericana de la Salud, en el de salud ocular se ha recibido también el aporte de Cuba, donde se han operado más de mil cataratas de personas de escasos recursos, algo a lo que no podría haber hecho frente Uruguay aisladamente. Estos son ejemplos de la solidaridad de los países de América: el

panamericanismo sirve no sólo para hacer planes y proyectos, sino también a la hora de actuar.

Uruguay también necesita apoyo en sus ingentes esfuerzos en materia de salud bucal para las actividades de prevención en escolares, con el PRAT, y de recomposición de piezas dentarias en adultos. Recientemente se ha creado un Ministerio de Desarrollo Social para incluir a un millón de uruguayos que están por debajo del umbral de pobreza, de los cuales 300.000 no tenían acceso a la atención médica. Hoy están recibiendo esa atención, inclusive en salud bucal.

En cuanto a la salud mental, se ha recibido apoyo para reconocer a todas las instituciones que prestan atención a estas enfermedades. Queda mucho por hacer en la prevención de estas enfermedades que se dan en los países que, como Uruguay, han sufrido las consecuencias de situaciones económico-financieras muy adversas. Desde 1992 hasta la actualidad, el suicidio es una de las primeras causas de muerte entre la población activa; hay que reconocer que muchas veces las situaciones de impacto económico adverso son una verdadera epidemia en muchos países de la Región. Por todo ello, cabe felicitarse por el enfoque intersectorial que reclama y practica la Organización Panamericana de la Salud; es preciso seguir por este camino.

El Dr. GONZÁLEZ GARCÍA (Argentina) dice que el continente americano es el que tiene mayores diferencias; no es el más pobre, pero sí el más injusto, lo cual genera responsabilidades distintas. América Latina se encuentra en un proceso de mejora

económica y a pesar de ello no se ha logrado reducir las diferencias, lo que pone aún más de relieve las políticas y las estrategias de salud y el sentido no sólo de las políticas nacionales sino de la cooperación internacional y de las organizaciones como la OPS.

En Argentina había un problema grave de accesibilidad a los medicamentos, segundo factor de gasto en las familias pobres, por lo que se puso en marcha REMEDIAR, un agresivo programa público de suministro gratuito de medicamentos en toda la atención primaria. Ese programa es un gran éxito y muestra cómo con imaginación y decisión política se pueden hacer cosas: hoy cubre a 17 millones de personas y cuesta menos de $2 por habitante y año. Además, se pasó del sistema de prescripción por marcas a un sistema de prescripción obligatoria de genéricos, lo cual ha generado una extraordinaria competencia, una gran disminución de los precios y la mejora del acceso y de la calidad de la información.

Argentina ha participado en las negociaciones sobre medicamentos antirretrovirales contra el SIDA y es uno de los países del mundo con menor costo por paciente y año en el tratamiento; hoy trabaja con todas las facultades de medicina y con todas las provincias del país, en el marco del Plan Federal de Salud.

La atención primaria se ha revitalizado en el país; en tres años se ha pasado de atender 80% de las consultas ambulatorias en hospitales a atender casi 60% en los centros de atención primaria, teniendo en cuenta que ha aumentado en 60 millones el total de consultas anuales en ese periodo. Además, existe un programa de recursos humanos y

entrenamiento para todo el personal; en las universidades de todo el país hay 9.000 personas haciendo un posgrado de dos años.

Además de los escenarios sanitarios o los escenarios sociales, es preciso también tener en cuenta los escenarios económicos. Debe darse mayor espacio a las políticas sociales, pues actualmente la economía está creciendo pero en una forma que no asegura la redistribución ni la disminución de la inequidad. El compromiso con el sector de la salud tiene que ver no sólo con razones de justicia social o de salud, sino con razones de armonía social y de la propia gobernabilidad de los países. Por esa razón hay que redoblar los esfuerzos que se han hecho a través de la Organización Panamericana de la Salud, e innovar continuamente las instituciones y los ideales de la salud pública teniendo en cuenta a otros sectores.

Ms. VALDEZ (United States of America) noted that the Director's summary of PAHO's technical cooperation activities reflected the complexity of the public health issues within the Americas and the need for the Secretariat to work with Member States and public and private partners to meet those challenges in cost effective and sustainable ways. Countries continued to grapple with unresolved challenges that affected their populations in an environment of new and emerging health issues. PAHO's technical cooperation helped them to achieve maximum impact, build the necessary national capacity, and strengthen both public and private health systems.

To face the challenges of the twenty-first century, PAHO and Member States must work closely together. The Organization must ensure managerial integrity and credibility, remain efficient yet flexible, and provide a clearly defined roadmap for measurable action over time. It was PAHO's technical excellence both globally and in the Americas that contributed to the health and well-being of citizens and helped to position health strongly in the center of the global policy dialogue. The title of the Director's annual report, "Closing the Gaps in Health in the Least Protected Populations," reflected the shared commitment of Member States and the Organization to work together.

La Lic. VELÁSQUEZ (Venezuela) felicita a la OPS por su eficiente gestión y por el proceso y las iniciativas de modernización que lleva adelante para adecuarla a los nuevos tiempos. Todo ello merece la confianza de los Estados Miembros. Felicita a la Directora por las acciones emprendidas para apoyar a los países y reducir las marcadas desigualdades que se han hecho características de la Región. El apoyo de la Organización en las necesidades sanitarias, orientado hacia la atención primaria y la incorporación efectiva de la promoción de la salud, se ha dejado sentir. Por todo ello cabe felicitarse de esta gestión que lucha incansablemente por mantener los logros, cerrar la agenda inconclusa y hacer frente a las nuevas exigencias.

El apoyo de la OPS para la construcción del sistema público nacional de salud de Venezuela se traduce en la sistematización de la experiencia de Barrio Adentro para que

pueda ser compartida con el resto de la Región. La construcción del sistema público nacional de salud ha sido posible también gracias al inestimable apoyo de Cuba. Cabe destacar el apoyo a los bloques regionales para avanzar hacia la integración, no sólo a través de la armonización sino también para aumentar el acceso a los servicios en la Región. La OPS ha apoyado a Venezuela en la adecuación de los recursos humanos de salud como eje fundamental del cambio de modelo.

Hon. Senator Bernard NOTTAGE (Bahamas) said that the economy of the Bahamas was highly dependent on tourism, and the small but significant outbreak of malaria in one of the islands earlier in the year could have had a deleterious effect on its economy. It had, however, received excellent cooperation and support from PAHO and its Director. Laboratory services had been provided through the Caribbean Epidemiology Center and technical support had been received from the Government of Guyana. The United States of America and its Centers for Disease Control and Prevention and the Government and public health authorities of Canada had also provided support.

PAHO had been collaborating extensively in his country's efforts to provide good quality health care to the population. Member States like Brazil and Nicaragua had provided drugs to counteract the outbreak of malaria, and Canada was assisting with the development of the national health insurance scheme and public health information system. The Government of Cuba was to be thanked for the wide range of technical support given over the past year.

El Dr. RODRÍGUEZ AYBAR (República Dominicana) expresa su particular satisfacción por los avances logrados en el fortalecimiento institucional; las figuras del defensor y del responsable de ética dentro de la OPS sientan un precedente en materia de cooperación. En la República Dominicana, la cooperación de la OPS durante el año ha sido esencial para el avance de programas prioritarios. Las evaluaciones del Programa de Tuberculosis y del Programa Ampliado de Inmunización y la evaluación en curso del Programa de VIH/SIDA han impulsado la reorientación y el impacto de sus actividades, y el apoyo prestado al programa de medicamentos y a las actividades de lucha contra el dengue hablan de la estrecha relación y el compromiso de la OPS con el país. Finalmente, el esfuerzo conjunto en el examen y la renegociación de la reforma de la seguridad social supone una magnífica contribución, el esfuerzo por aumentar la equidad en salud entre los pueblos de la Región.

Hon. H. John MAGINLEY (Antigua and Barbuda) commended the Director and her team at PAHO for the good work which had facilitated the advances made in the Region. Antigua and Barbuda would be hosting the Cricket World Cup in 2007 and was grateful to the many colleagues in the PAHO family who were already providing assistance and support. The Government and people of Cuba in particular were to be thanked for their support for the health system through the “Milagros Mission” as well as for the provision of medical staff for the event itself. Lastly, he paid tribute to the work

of Mrs. Veta Brown, who was retiring after many years' service in the Office of Caribbean Program Coordination.

Hon. Dr. Douglas SLATER (Saint Vincent and the Grenadines) expressed appreciation for the assistance his country had received from PAHO over the past year and endorsed the new initiatives regarding better representation in the individual territories of the Office of Caribbean Program Coordination. He expressed gratitude to Mrs. Veta Brown for the impeccable services she had provided over the years and thanked the Government of Cuba and other countries that had helped his country in many ways. It was reassuring to know that PAHO colleagues could be called upon in time of need: when the Bahamas in particular had stepped in to provide antiretroviral drugs when Saint Vincent's supply had been cut. He fully endorsed the Annual Report of the Director.

Hon. Damian GREAVES (Saint Lucia) said that PAHO's successes should not lead it to become complacent. Poverty within the Region, and inequities both within and between countries, continued to be a source of concern. National governments must strive to ensure that the progress and development achieved through PAHO benefited their population.

La DIRECTORA dice que ha sido un año muy productivo en todos los niveles, pues se han fortalecido las alianzas con otros socios para el desarrollo dentro del sistema

de las Naciones Unidas y el sistema interamericano y se han reforzado las relaciones de la OPS como Oficina Regional de la OMS en el marco del trabajo colectivo de la Organización Mundial de la Salud. Hay que reconocer, especialmente puesto que se está celebrando el Año de los Recursos Humanos en Salud, que mucho de este trabajo ha sido posible gracias a los trabajadores de salud en sentido amplio, no solamente los profesionales, sino todos los que trabajan en organizaciones voluntarias, organizaciones religiosas, inclusive en el campo doméstico, para avanzar en el tema de la salud. Hay que agradecer también a los medios de comunicación el importante papel que están desempeñando actualmente en el fomento de una visión positiva de la salud y su apoyo a muchas de las intervenciones y campañas en favor del tan necesario cambio de comportamiento social e individual.

The PRESIDENT said that the report and ensuing discussion had made it very clear that there was a rich array of collaborative effort within the Region, some coordinated by PAHO, some provided by specific countries. Perhaps the time had come to publicize that collaboration. Best practices in one country could undoubtedly be duplicated in others, and the tools and answers already available need to ensure that no one died of preventable disease and that people with HIV/AIDS received treatment as and when needed.

The meeting was suspended at 10:20 and resumed at 11:00 a.m.
Se suspende la reunión a las 10.20 a.m. y se reanuda a las 11.00 a.m.

TRIBUTE TO THE MEMORY OF DR. JONG-WOOK LEE
HOMENAJE A LA MEMORIA DEL DR. JONG-WOOK LEE

The PRESIDENT recalled the untimely and sudden death of the former Director-General of WHO, Dr. Jong-wook LEE at the start of the Fifty-ninth World Health Assembly in May 2006 —a small man but a giant in public health and a great loss to public health around the world. Many delegates to the present session had been present in Geneva at that sad time. Some, however, had not been able to be there; and he therefore invited all delegates to view a short video about Dr. LEE and after that to pay their own tribute by standing again in a moment of silence.

The Members of the Directing Council stood for a minute of silence in tribute to the memory of Dr. Jong-wook LEE.
Los Miembros del Comité Regional, puestos de pie, guardan un minuto de silencio en homenaje a la memoria del Dr. Jong-wook LEE.

ADDRESS BY THE ACTING DIRECTOR-GENERAL OF WHO
ALOCUCIÓN DEL DIRECTOR GENERAL INTERINO DE LA OMS

The PRESIDENT, welcoming Dr. Anders Nordström to the Session, said that thanks were due to him for stepping in at a difficult time and carrying on the work of the World Health Organization so gracefully.

Dr. NORDSTRÖM: That Monday the 22 of May was indeed a very dramatic, sad day for all of us at the World Health Assembly opening with the announcement from the Spanish Minister that the Director-General was dead. Of course, this was even more dramatic for me personally, knowing what Dr. LEE had asked me to do in this kind of event —a situation that you never think will happen— but still I had to do it. Before addressing you, I would just like to thank Member States and also colleagues across the world in the WHO Regional and Country Offices for what you have done. I would not have been able to take on this task without the very strong support from the team in Geneva and across the world.

Señor Presidente, Honorables Ministros, estimados colegas, tengan ustedes muy buenos días, es un placer para mí el poder estar con ustedes para compartir algunas perspectivas globales que en mi oponión tienen también relevancia regional para todos nosotros. Mirta, gracias por el análisis, una presentación muy interesante.

This is now my sixth Regional Committee. I have highly enjoyed the opportunity to address and share some views with colleagues across the world but also to experience what kind of Organization we are. We are quite a diverse Organization but across the world there is a very, very strong commitment for health, for WHO, and for its core functions.

Last year when I came to this Committee, I unfortunately spent most of my time in bed ill but I understand you had a very good discussion on the General Program of Work. Unfortunately I was not able to be part of that, but the year before that, I was here for the discussion on the program budget and I will mention that again this time. Your discussion and input on the program budget and the way that we move forward in terms of the direction of the Organization and also the discussion around the General Program of Work has highly influenced our work on the Medium-Term Strategic Plan and the program budget you will discuss later in the Session.

I would like, first, to share with you three perspectives, which relate to what you were saying, Mr. President. We have good collaboration and many positive reports, but are we making a difference on the ground? Are we making sure that more people have access to drugs? Are we addressing the major health issues? So, three perspectives: First, if we really want to have an impact on health, where do we need to move? Secondly, we have now a more engaged but also a more complex health architecture. If we would like to capitalize on the benefits and engagements from so many partners, where does the health architecture need to move? Thirdly, where is WHO moving (over and above the election of the Director-General, which I will not be discussing)?

In answer to the first question, I think that today we have very good knowledge about what is needed, especially in this Region. We know what we need to scale up basic health services and to have an impact on reducing poverty; to address the bottlenecks within health systems, in particular regarding human resources; and to address the underlying determinants of health. We also know that we must have a more balanced approach in addressing communicable and noncommunicable diseases. But what are the implications of this knowledge, knowledge we have had now for some time? The realities have become much more complex but sometimes we are trying to manage these complex realities with old solutions. While we do not need to reinvent the wheel, we need to make the wheel move in slightly different ways. We cannot manage what is happening in the environment, what is happening in terms of air pollution, in the same

way as we tackle immunization programs. There are no simple solutions and we need to find efficient ways of dealing with the complexity. This has implications for all of us in terms of the functionality of our ministries and of WHO as an Organization.

The second perspective concerns improvement in how we manage and capitalize on the growing interest from a number of partners. At the global level we have new instruments, new partners, the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, Tuberculosis, and Malaria, etc., and at the local level in countries we also have a growing interest from different stakeholders. For example, there was a very clear message this morning on the engagement of Brazil, Cuba, and Venezuela in south-south cooperation. Of course, this again means that we have a more complex reality, with more partners at all levels. It is not as easy as it was 40 to 50 years ago, when there were just a few agencies and programs within the United Nations system. Sometimes we perceive this engagement from new partners as being a problem. I think we need to turn that perspective around and see the engagement from the private sector, the public sector, the multilateral system, bilateral systems, and neighboring countries as a positive development. But again, as with the health agenda, this means a more complex reality to manage at the global level. WHO has a role to play here in terms of providing leadership and coordination, ensuring that we have a good direction but also that in countries, governments, that is you yourselves, have the main responsibility to maximize the benefit from this engagement. So, the principles agreed to in Paris a couple of years ago in terms of ownership, harmonization, alignment, simplification and focusing on results must now be translated into practice in countries. On the positive side, there is strong agreement among partners that this is what needs to happen.

Turning to the final perspective concerning the direction of WHO, I can say that we are moving in a way that will enable us to respond to this more complex understanding and positioning of health. Sometimes I and my team are being challenged to set clear priorities. We will set priorities but we will not say that we will work on malaria but not tuberculosis or that we will focus on communicable diseases but not on noncommunicable diseases or the broader determinants of health. It would be impossible to ask us to set those kinds of priorities. However, the way we address malaria will be very different from the way in which we address the broader determinants of health. How do we ensure that we are gaining maximum benefit from introducing an enhanced gender perspective in terms of our health planning? Of course, the input from WHO will again be very different. The way forward is for WHO to honor its core functions in a more systematic way.

WHO can do this through the Eleventh General Program of Work, entitled “Engaging for Health,” which has enabled us to capture the complexity of the health

agenda in seven dimensions. These core functions, adopted by the Health Assembly, incorporate an understanding of the need to scale up basic health services but also to tackle broader issues such as strengthening of health systems, addressing the determinants of health, and harnessing new knowledge and technologies. Of course, WHO will not be able to do everything in this complex architecture, so that we need to be clear about where there is complementarity and where WHO can add value.

An important next step for WHO is the Draft Medium-Term Strategic Plan 2008–2013, which you will discuss in detail tomorrow. This gives a six-year perspective in terms of where we should move as Member States and Secretariat, and will, we hope, provide inspiration to other partners on the key health priorities. The Plan has five main areas. The first is support for countries in moving towards equity by ensuring universal coverage with effective public health interventions, reducing gaps in access and in health outcomes for people. The second dimension concerns the strengthening of health security at the global and local levels. The remaining areas relate to influencing the determinants of health, strengthening health systems, and strengthening WHO's role in terms of providing leadership and coordination. Within these five broad areas, we are now suggesting 16 strategic objectives, strengthening the focus on the expected results of our work while keeping in mind our core functions so that we set the right sort of priorities. I would welcome a critical review of what we have placed on the table. Are we focusing on the right results? Are we loyal to our core functions? Are these reasonable costs to enable us to achieve the results? Do these expected results respond to your needs and to your expectations of WHO? There are increased expectations and demands on us as an Organization. We have therefore invested a considerable amount over the last few years in management reforms, in order to provide even better value for the money that you provide through assessed or voluntary contributions. We need to manage these resources in a way that delivers maximum results for the money we are receiving. The result-based management is in focus here, and I would say that WHO is currently taking a lead in this within the United Nations system. But we have also addressed various matters relating to the more practical management of resource-mobilization, and management of financial and human resources. WHO is a knowledge-based organization, a technical, normative organization, so that the majority of our spending is actually on staff, and should be on staff. So the agenda in terms of how we can increase competence, the way we attract, manage and retain staff is critical for our work.

The draft proposed program budget 2008-2009, which again you will discuss tomorrow, has been costed at an all-time high, US$ 4.2 billion. This is very ambitious but it is a very clear reflection of expectations in terms of managing this complex health agenda. There are clear messages from you in resolutions from Health Assemblies and the Regional Committees, for WHO to scale up efforts in relation to noncommunicable

diseases and to the determinants of health, where we have not perhaps paid so much attention in the past. But there are also very clear messages that WHO needs to scale up responses to ensure the maximum benefit from other resources that are coming to countries, GAVI and the Global Fund being two very concrete examples. It has been shown that technical support from WHO has been critical in providing successful leverage of the other resources.

What does this increase in the budget mean for this Region? This refers only to the WHO contribution, not that of PAHO. It is important, however, to have both perspectives, and you will see that in the final document. The WHO part is increasing by 42%, or $84 million, giving a total budget for this Region of $282 million. The financing of the work of WHO has been discussed over a number of years, by the Regional Committees, the Executive Board, and the Health Assembly. We are all concerned at establishing effective financing in order for WHO to be able to carry out its functions, functions that require a degree of independence to ensure that it can provide information and set norms and standards with integrity. We are therefore proposing an increase of 8.6% in the assessed contributions, which will amount to $1 billion. This is still very small, however, and the proportion of the total budget represented by assessed contributions will continue to decline, to 23%. We are also proposing to introduce "negotiated core voluntary contributions." Discussions with partners providing voluntary contributions have shown a positive response to the use of the program budget direction and the expected results as a framework for the allocation of voluntary contributions in a way that aligns better with the Organization's needs. We are also hoping to expand the level of flexible resources, that is, resources that are not earmarked. The United Kingdom has been taking a lead here, but other partners are following suit. Having said that, there are generally very few conditions attached to extrabudgetary resources, since there is a high level of respect for our priorities and the integrity of our work. However, there are major transaction costs: in the last biennium we had 4,600 agreements and are expected to deliver 1,500 reports back to our donors. That is a waste of resources.

Let me turn to the five specific areas of the draft Medium-Term Strategic Plan and draft proposed program budget: strengthening health systems, attaining the United Nations Millennium Development Goals for maternal and child health; paying attention to the determinants of health; implementing the International Health Regulations (2005), and increasing the focus on noncommunicable diseases. We all recognize that strengthening of health systems is crucial to everything we do. If we are to scale up basic health services, we need to tackle the bottlenecks and, as clearly stated in the discussions here, questions related to equity the —gaps in access to health care and health outcomes. It is time also to demystify the strengthening of health systems. We have been talking in vague terms about health reforms for many years, but what does it mean in practice? It means determining how we can improve the organization, management and delivery of

health services, how we can work with both the private and public sectors, and it means assessing the role of government in ensuring equity and quality of care. I was very happy to hear in Dr. Roses' address about intersectoral approaches at the local level, and I remember one of the visits I made to Nicaragua some 10 or 12 years ago to see how the integrated local health system (SILAIS) is working.

Information, the second aspect of health system strengthening, provides the evidence we need to enable us to take the right decisions. We also need to invest more in research. The achievements of the Ministerial Summit on Health Research held in Mexico in November 2004 are being taken forward internally in WHO, and we are very much looking forward to the follow-up meeting in Bamako in a couple of years' time.

The third aspect is, of course, financing: we need effective ways of raising and managing financial resources. Here there are no norms and standards, but WHO can play a crucial role in discussing with countries the different policy options for financing health systems and allocating resources.

One of the most difficult questions across the world is the current shortage of human resources for the health agenda. Even when money is available to ensure supplies, the lack of a motivated work force prevents drugs from reaching patients. We need to start talking about the realities; we will not solve the health work force crisis by training alone. There are more fundamental questions for societies and governments: can we pay people adequate salaries? What should be the size of the public sector? What are the policies in place today? How are we moving from a public-sector approach to a public-private mix? How can we gain a better understanding of why people choose to drive taxis rather than deliver health services? We also need a global perspective on the migration of human resources for health. These are difficult questions that neither WHO nor ministries of health can solve; we need discussions with ministries of finance at the most senior level possible to see what can be done. As I mentioned in my opening remarks to you yesterday, this was one of my key messages when I spoke at the G8 meeting in St. Petersburg, the Russian Federation, in July 2006, and at the Sixteenth International AIDS Conference in Toronto, Canada, in August 2006. I am very pleased that *The World Health Report 2006* focused on this subject and provides an agenda for action over the next 10 years as well as indicating what can be done immediately. Your round table discussions on human resources later in the week will add to the debate. There are also some very encouraging practical examples from this Region, not only what I saw in Nicaragua, but also in Brazil (continuum of care for women and children), Bolivia and Mexico (health insurance programs), and Ecuador (free maternity programs).

The health work force is particularly important in relation to programs for mothers and children. If we are going to attain the Millennium Development Goals we

need to reach every child in every district with a certain set of interventions. We know that we are making good progress at the country level, but there are still major gaps in particular areas or districts of individual countries. Neonatal care and health care for indigenous peoples are other areas of concern in this Region and where we don't see enough progress, as the Director's report shows. I understand that in Guatemala, infant mortality in indigenous communities can be as much as 60% higher than in other parts of the country. This is not simply a question of access to services. There are underlying factors —mothers underweight or dying and a number of other determinants— that also influence the outcome for these populations. There are 45 million indigenous people in the Americas and your five-year strategy for improving the health of those people is of extreme importance. As for people with disabilities, it is a question of human rights and avoidance of discrimination.

There are some good developments in terms of child health. Your performance assessment report shows that 14 of 22 countries will see a reduction in undernutrition in children, and that 20 countries have reduced their child mortality. Your regional newborn health strategy will support this important progress in specific countries. The nutrition agenda is gaining increased attention across not only this Region but across the world. I was very excited to see the target set in Bolivia of "malnutrition zero," an example of a strong political commitment and message.

Immunization is another crucial part of our work and this Region is one of the most successful in rolling out immunization programs. In addition to eradication of poliomyelitis and elimination of measles, you have been at the forefront in introducing new vaccines, such as the rotavirus vaccine, in routine immunization. WHO's partnership with GAVI is essential and we very much appreciate how GAVI has been able to improve access to more and underutilized vaccines, and is now also investing more in health systems. In other areas, however, progress towards the Millennium Development Goals is not so successful and there is still a lot of work to do if we are to reduce overall extreme poverty and maternal mortality, and to improve access to sanitation.

Maternal health is a subject close to my heart, not only because I am married to a midwife, but also because this is an area where we have not seen enough progress; and we remain far from the goals set for 2015. However, there is a growing momentum at the global level and we have had some important Health Assembly decisions recently, including adoption of the strategy on the prevention of sexually transmitted infections, with a strong focus on young people, the strategy on reproductive health, and the strategy on family health, all of which will enable us to take the work forward. During my few months in this office, I have tried to make this a priority. One of the first meetings I had in this role was with Thoraya Obaid, the Executive Director of UNFPA: we reviewed carefully what WHO and UNFPA are doing, especially in countries, and we issued a joint

letter to our respective organizations to encourage all staff to ensure complementarity as we make progress on sexual and reproductive health. Again there are activities in this Region that will make an important contribution to work at the global level in respect of the focus on the health of young people and the impact on them of violence and will provide examples from which countries in other parts of the world can learn. The new regional strategies on HIV/AIDS and sexually transmitted infections are important, and it is encouraging to see the progress being made in countries, such as Bolivia.

In the area of HIV/AIDS, WHO has been able to contribute to the development of guidelines for antiretroviral drugs and to advocacy around HIV/AIDS, and to encourage a multidisciplinary approach, where there has been good progress.

Tuberculosis remains a major problem across the world despite a very strong "Stop TB" partnership. Again you have a very good regional plan but we need to make sure that we can implement it and provide sufficient financial resources to close the gap between rich and poor people, a major challenge in combating tuberculosis.

Similar inequities remain in relation to the burden of malaria and, unfortunately, while a number of countries have seen a decline in the incidence of the disease, others have been reporting increases. Again we have a regional plan, but we need commitment to implement it. I hope that our recent revision of the global strategy for malaria will be helpful in this Region. The strategy now focuses on combination therapy and provision of bednets; but it also reintroduces residual spraying with DDT or other agents, an important component. There are also other approaches as mentioned in your regional presentation here. The Rollback Malaria Partnership is crucial. We have been actively engaged in partnership activities and we will host the next Partnership Board meeting in Geneva in November 2006, just after the one-day session of the Sixtieth World Health Assembly. The meeting should ensure that WHO programs are delivering and that the Partnership is functioning well, with strong commitment from other multilaterals, such as the World Bank, and key governments, such as that of the United States of America.functioning well, with strong commitment from other multilaterals, such as the World Bank, and key governments, such as that of the United States of America.

Let me now turn to the broader determinants of health. Again, this Region has taken the lead in terms of recognizing the underlying factors. We have knowledge but how are we translating this knowledge? What is happening in our environment, for example? Visiting Lima a year ago after an absence of 15 years, I noticed that the level of air pollution had increased quite dramatically with an impact on people's mental health, respiratory infections, etc. So, what can we do as ministers of health, health organizations, and health leaders to influence environmental and social determinants through other sectors? I am very pleased with the work of the Commission on Social

Determinants of Health, and have had meetings with its Chairman, Mike Marmot, a month ago and again yesterday. You will be discussing the work of the Commission later today. I hope that we will be able to act on the Commission's findings on translating knowledge into practice immediately and not wait until its report is published. We need a multisectoral approach at the local level if we are to have an impact on the determinants.

We have not paid sufficient attention to the current epidemic of noncommunicable diseases. They represent some 78% of all deaths in this Region and they will continue to increase. The diabetes epidemic everywhere is shocking. At the Regional Committee for the Western Pacific, held in Auckland, New Zealand, I learned that diabetes rates are escalating. In this Region we will see an 80% increase in deaths related to diabetes over the next 10 years. This is, of course, very closely related to our eating habits, our diets and our lack of physical activity. The strategy on diet, physical activity, and health that we adopted a couple of years ago will be a key approach to tackling noncommunicable diseases. We have in place a very important instrument in the WHO Framework Convention on Tobacco Control. However, there is a challenge to all of us to translate this Convention into practice in countries, to establish national tobacco-control programs, ensure smoke-free environments, and where appropriate to introduce tax on tobacco products, in order to reduce the number of people that are smoking. The Framework Convention shows that WHO can add value by getting Member States around the table and to agree on this kind of instrument.

Another recent major success has been the adoption of the International Health Regulations (2005). All of you who were involved in the negotiations to revise the Regulations have seen how everybody values this instrument. It is much more than an international agreement; it will enable us to ensure that we have the capacity in countries, and the right kind of behaviors in terms of transparency and sharing of information. It gives us an opportunity to prepare not only for the immediate threat of avian influenza but also broader public health threats. There is also the possibility of accelerating the implementation of the International Health Regulations (2005) through the voluntary compliance that was agreed to in May 2006. We are prepared to move WHO but we need your support and your inputs to be able to do the necessary work.

We see no signs globally that the threat of avian influenza is diminishing. We are at a peak in terms of numbers of cases because of the season, but there are outbreaks in birds in more than 50 countries around the world. As of 19 September 2006, there have been 247 confirmed cases and 144 deaths in humans. Preparedness plans are now in place in most countries but in some cases, these are just plans —they have not been tested. We must make sure that they will work in practice so that they can be put into operation if necessary. We are pleased to see the considerable improvements in capacity to manufacture antiviral drugs and that production licenses have been granted to a

number of developing countries. There is a need for more attention to vaccine development and manufacturing capacity. Next month we will launch an initiative to support the expansion of vaccine capacity in certain countries, and I would like here to acknowledge specifically the support we have received from the Government of the United States, including from President Bush himself. I know that Dr. LEE very much appreciated this engagement. In this room, we also have some of the key partners for development assistance, which still plays an important role in improving health in some of the poorest countries. This has been a positive development over the last few years. The volume of assistance has increased, but it needs to be sustained, and its effectiveness improved. WHO needs to move slightly more into this area to work with countries to ensure more effective use of financial resources, but also resources for capacity-building through technical support.

In conclusion, our goal is to make WHO more responsive to the needs of countries, and to ensure that the Organization is working as an effective member of the United Nations system. As I indicated in my remarks at the opening of the Session, WHO is fully engaged in the current debate on how coordination of the work of the system can be improved, especially at the country level. We strongly believe that there is a need for a change in the Resident Coordinator System. At the same time, we must ensure that WHO continues to have a presence and maintains the quality of its work. WHO has had a substantial dialogue with the United Nations High-level Panel on Systemwide Coherence, and we look forward to the report and to discussions on how to take the work forward. There is also a debate within WHO on the implications of United Nations reforms for the Organization; there will be a paper on the subject for consideration by the Executive Board in January 2007 to determine Member States' perceptions of WHO in the broader context of the United Nations system. I am very proud that WHO is perceived as working effectively within the system and that we are at the forefront in many areas. As mentioned by Dr. Roses, collaboration between countries and between the United Nations organizations in this Region is good and provides an example of best practice.

I thank you for this opportunity to be able to share a few perspectives from Geneva. I feel certain that your continued active engagement and your clear direction as Member States and as a governing body will yield success in this Region and contribute to WHO's global success in improving the health of all people.

The PRESIDENT thanked the Acting Director-General for his extensive in-depth review of public health and the roles of WHO and ministries in Member States and

reiterated his concern in relation to equity. Even if the Millennium Development Goal on improving maternal health was attained, namely, reducing the maternal mortality ratio by 75%, some country in 2015 could still have a ratio of 300. That was not acceptable. It was not right that a mother giving birth in the United Republic of Tanzania or Guyana should have less chance of giving birth safely than one living in Washington, D.C., London, or Geneva. Moreover, if a child had a life expectancy of only 30 years in one country compared with maybe 75 years somewhere else then the world had failed. Certain things required global rather than national responsibility, and that was perhaps where the Millennium Development Goals had fallen short. Starting out as a document of equity, it had ended up as accepting a lower level of accomplishment. It represented a good start, but the world must be bold and seek equity; there must be equity in public health to ensure that every child was healthy enough to go to school. Moreover, as he had said earlier in the Session, the Goals should be adjusted to include targets on the chronic diseases. Everywhere in the world, those diseases contributed significantly to morbidity and mortality; to exclude them was to miss an opportunity. As a minister from a poor country, he feared that, as 2015 approached, partners would focus more specifically on the Goal targets to the detriment of activities in other areas.

He agreed with the Acting Director-General that training was not the only answer to the shortage of human resources for health, although still an important component. For poor countries, salaries were the key. Those countries would never in the foreseeable future be able to compete with richer countries. Even if Guyana raised salaries by 300%

immediately, health-care workers would continue to leave the country. It was time to take a broader look at migration of health-care workers.

For want of immunization in childhood, a potential world leader might die. Immunization must never be cut because of the need for an austerity budget. New vaccines were emerging that would help save many more lives. It was vital to ensure the funds and production capacity necessary to secure universal access to those vaccines when they became available.

There were many relatively simple measures that could be implemented to reduce the disease burden. For example, Guyana had been able to reduce malaria by 75% in one year because the Government had been bold enough to provide every family in malarious regions with insecticide-impregnated bed nets.

ITEM 8.6: RESOLUTIONS AND OTHER ACTIONS OF THE FIFTY-NINTH WORLD HEALTH ASSEMBLY OF INTEREST TO THE REGIONAL COMMITTEE

PUNTO 8.6: RESOLUCIONES Y OTRAS ACCIONES DE LA 59.ª ASAMBLEA MUNDIAL DE LA SALUD DE INTERÉS PARA EL COMITÉ REGIONAL

El Dr. VIZZOTTI (Presidente del Comité Ejecutivo) hace referencia a resoluciones de la Asamblea Mundial de la Salud sobre temas técnicos y de política sanitaria y sobre temas administrativos y presupuestarios recogidas en el documento CD47/INF/6. El Comité tomó nota del informe sobre la 59.ª Asamblea Mundial de la Salud, pero no consideró necesario aprobar una resolución sobre este tema.

ITEM 5.1: REPORT ON THE COLLECTION OF QUOTA CONTRIBUTIONS
PUNTO 5.1: INFORME SOBRE LA RECAUDACIÓN DE LAS CUOTAS

El Dr. VIZZOTTI (Presidente del Comité Ejecutivo) indica que se ha registrado una leve mejora de las recaudaciones generales en comparación con los años precedentes, no obstante lo cual los pagos del corriente año registrados hasta el momento revelan una disminución significativa con respecto al mismo período de los años anteriores. Las contribuciones voluntarias al Fondo Fiduciario para los Programas Prioritarios son valiosas y dignas de agradecimiento; sin embargo, los Estados Miembros deben cancelar cuanto antes sus cuotas pendientes.

Mrs. FRAHLER (Area Manager, Financial Management and Reporting), illustrating her remarks with slides, thanked Member States for their significant commitment to paying their quota assessments in a timely manner. The receipts of quota assessments in 2006 were far greater than in recent years, and Member States with approved deferred payment plans were in full compliance with those plans. The quota payments provided critical financial resources for the implementation of the Organization's program activities for the 2006-2007 biennium, which had been approved by the respective Directing Council or Sanitary Conference, and allowed directors and the senior managers to implement the Organization's technical cooperation programs accordingly.

The Report on the Collection of Quota Contributions (Document CD47/22 and Add. I) reflected quota receipts as of July 2006 and 18 September 2006. Since 18 September, PAHO had received additional payments of: US$ 17,324 from Antigua and Barbuda; $35,794 from Costa Rica; and $50,420 from Suriname.

On 1 January 2006, the total arrears of quota contributions for the years prior to 2006 had amounted to $61.7 million, of which $41.2 million, 67%, related to 2005. The remainder related to arrears from the period 2001-2004. Payments on those arrears received as of 18 September 2006 had amounted to $46 million, 75% of the total arrears, which was the highest level of arrears payment in recent years. Collection of 2006 assessments as of 18 September had amounted to $47.7 million, 52% of the $91.8 million total, which was a significant improvement since the Executive Committee meeting in June 2006, and the highest level of current year quota payments since 1999.

In summary, the combined quota collections as of 18 September 2006 totaled $94 million compared with $64 million in 2005, $74 million in 2004, $64 million in 2003 and $65 million in 2002, representing a highly significant commitment by Member States in support of PAHO's mission and mandate.

The impact of timely payments was illustrated in the graph showing the status of the Working Capital Fund. The Fund had decreased from its authorized $15 million ceiling on 31 December 2002, to $11.6 million on December 2003, and $8 million at the end of 2004. By 31 December 2005, however, the Fund had increased to $14.2 million. Currently, it had reached its authorized ceiling of $20 million, which would allow the

Organization to implement program activities in accordance with the 2006-2007 program budget.

As of 18 September, 31 Member States had made quota payments in 2006, 17 had paid their 2006 assessments in full and 7 had made partial payments; 15 had not made any payments. The Secretariat continued to liaise with the Governments in regard to outstanding quotas assessments and proposals to establish deferred payment plans if needed. Pursuant to Article 6.B of the Constitution, the status of the arrears of one Member State had been reviewed by the Working Party to Study the Application of Article 6.B established by the Directing Council at its present Session.

Hon. Senator NOTTAGE (Bahamas) read out the report of the Working Group to study the Application of Article 6.B of the PAHO Constitution contained in Document CD47/22, Add. II, and drew attention to the draft resolution contained therein.

La Dra. MUÑOZ (Uruguay) recuerda que, de conformidad con el acuerdo convenido con la Organización, su país ha efectuado recientemente el pago de su cuota, y solicita que se tenga en cuenta el importante nivel de endeudamiento que Uruguay mantenía con los organismos internacionales y la voluntad del mismo de mantener sus cuentas al día.

Ms. FRAHLER (Area Manager, Financial Management and Reporting) confirmed that the payment mentioned by the Delegate of Uruguay had been received.

The Organization would do everything possible to ensure that if a country was in a difficult economic situation, a deferred payment plan or plan to pay in local currency were set up.

Decision: The proposed resolution was adopted.
Decisión: Se aprueba el proyecto de resolución.

The meeting rose at 12:20 p.m.
Se levanta la reunión a las 12.20 p.m.