



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



144th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 22-26 June 2009

CE144/FR (Eng.)
31 July 2009
ORIGINAL: ENGLISH

FINAL REPORT

CONTENTS

	<i>Page</i>
Opening of the Session	6
 Procedural Matters	
Officers	6
Adoption of the Agenda and Program of Meetings	7
Representation of the Executive Committee at the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas	7
Provisional Agenda of the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas.....	7
 Committee Matters	
Report on the Third Session of the Subcommittee on Program, Budget, and Administration	8
Nongovernmental Organizations in Official Relations with PAHO.....	8
PAHO Award for Administration 2009	10
Annual Report of the Ethics Office	10
 Program Policy Matters	
Proposed PAHO Program and Budget 2010-2011	12
PAHO Strategic Plan 2008-2012 Amended (Draft)	19
New Scale of Quota Contributions	22
Plan of Action on the Health of Older Persons, Including Active and Healthy Aging	23
Elimination of Neglected Diseases and other Poverty-related Infections	25
Policy on Research for Health	28
Strategy and Plan of Action on Mental Health	31
Plan of Action on Adolescent and Youth Health.....	33
Plan of Action for Implementing the Gender Equality Policy.....	35
Policy Framework for Human Organ Donation and Transplantation.....	37
Health and Tourism.....	39
Integrated Health Services Delivery Networks Based on Primary Health Care.....	41
Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)	43
Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP).....	45

CONTENTS *(cont.)*

	<i>Page</i>
 Program Policy Matters <i>(cont.)</i>	
Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment.....	46
Family and Community Health.....	47
The Pan American Health Organization Revolving Fund for Vaccine Procurement	48
 Administrative and Financial Matters	
Report on the Collection of Quota Contributions	54
Interim Financial Report of the Director for 2008.....	55
Changes in Financial Regulations and Financial Rules.....	57
Projects Using the Program Budget Income Exceeding the Authorized Effective Working Regular Budget	59
Proposal for the Establishment of an Audit Committee	60
 Personnel Matters	
Amendments to the PASB Staff Rules and Regulations	61
Contract Reform in PAHO.....	63
Statement by the Representative of the PASB Staff Association.....	63
 Matters for Information	
WHO Proposed Programme Budget 2010-2011 and WHO Medium-Term Strategic Plan 2008-2013 Amended (Draft)	65
Code of Practice on the international recruitment of health personnel: a WHO background document.....	65
Progress Report on Technical Matters.....	67
International Health Regulations, including a Report on the Influenza A (H1N1) Pandemic	67
Preparations for the Roundtable on Safe Hospitals	70
Preparations for the Panel Discussion on the Pan American Alliance for Nutrition and Development to Achieve the MDGs.....	70
Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO	71
Progress Reports on Administrative and Financial Matters	73
Status of Implementation of the International Public Sector Accounting Standards (IPSAS)	73
Master Capital Investment Fund.....	74

CONTENTS (*cont.*)

Page

Other Matters	75
Closure of the Session	75
Resolutions and Decisions	76

Resolutions

CE144.R1	Proposal for the Establishment of an Audit Committee	76
CE144.R2, Corrig.	Collection of Quota Contributions.....	81
CE144.R3	Review of Nongovernmental Organizations in Official Relations with PAHO	82
CE144.R4	Plan of Action for Implementing the Gender Equality Policy....	83
CE144.R5	Family and Community Health.....	85
CE144.R6	Plan of Action on Adolescent and Youth Health.....	87
CE144.R7	Integrated Health Services Delivery Networks Based on Primary Health Care	91
CE144.R8	Strategy and Plan of Action on Mental Health	94
CE144.R9	Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment.....	96
CE144.R10	Proposed Amended Draft of the PAHO Strategic Plan 2008-2012	98
CE144.R11	Elimination of Neglected Diseases and other Poverty-Related Infections.....	99
CE144.R12	Policy Framework for Human Organ Donation and Transplantation.....	112
CE144.R13	Plan of Action on the Health of Older Persons, including Active and Healthy Aging	114
CE144.R14	Health and Tourism.....	117
CE144.R15	Amendments to the Staff Rules and Regulations of the Pan American Sanitary Bureau	120
CE144.R16	Contract Reform in the Pan American Health Organization	121
CE144.R17	Changes in Financial Regulations and Financial Rules	122
CE144.R18	New Assessment Scale for the Budgetary Period 2010-2011 ..	123
CE144.R19	Policy on Research for Health	125

CONTENTS (*cont.*)

Page

Resolutions (*cont.*)

CE144.R20	Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP).....	130
CE144.R21	Proposed PAHO Program and Budget 2010-2011	135
CE144.R22	PAHO Award for Administration 2009	139
CE144.R23	Assessments of the Member States, Participating States, and Associate Members of the Pan American Health Organization for 2010-2011.....	140
CE144.R24	Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)	143
CE144.R25	Provisional Agenda of the 49th Directing Council of PAHO, 61st Session of the Regional Committee of WHO for the Americas.....	154

Decisions

CE144(D1)	Adoption of the Agenda.....	154
CE144(D2)	Representation of the Executive Committee at the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas	154

Annexes

- Annex A. Agenda
- Annex B. List of Documents
- Annex C. List of Participants
- Annex D. Report of the Special Meeting on the PAHO Revolving Fund for Vaccine Procurement in Light of New Challenges

FINAL REPORT

Opening of the Session

1. The 144th Session of the Executive Committee of the Pan American Health Organization (PAHO) was held at the Headquarters of the Organization in Washington, D.C., from 22 to 26 June 2009.
2. The Session was attended by delegates of the following eight members of the Executive Committee elected by the Directing Council: Argentina, Bolivia, Guatemala, Haiti, Mexico, Suriname, United States of America, and Uruguay. The delegation of Trinidad and Tobago was unable to attend owing to pressing responsibilities associated with the influenza A (H1N1) pandemic. Representatives of the following other Member States, Participating States, and Observer States attended in an observer capacity: Brazil, Canada, Chile, Colombia, France, Nicaragua, Paraguay, and Venezuela. In addition, five nongovernmental organizations and two United Nations and specialized agencies were represented.
3. Dr. Jorge Basso (Uruguay, President of the Executive Committee) opened the Session and welcomed members, observers, and PAHO staff.
4. Dr. Mirta Roses (Director, Pan American Sanitary Bureau) also welcomed participants, noting that the Committee had before it a very full agenda, with numerous topics of crucial importance for the future work of the Organization. In addition, several notable events would take place outside the formal session, including a visit by Chilean President Michelle Bachelet¹ and a special technical meeting on the Revolving Fund for Vaccine Procurement. She looked forward to an interesting and productive week.

Procedural Matters

Officers

5. The following Members elected to office at the Committee's 143rd Session continued to serve in their respective capacities at the 144th Session:

<i>President:</i>	Uruguay	(Dr. Jorge Basso)
<i>Vice President:</i>	Suriname	(Dr. Celsius Waterberg)
<i>Rapporteur:</i>	Mexico	(Ms. Ana María Sánchez)

¹ The text of President Bachelet's address appears in Document CE144/DIV/2, available on the PAHO website.

6. The Director served as Secretary ex officio, and Dr. Juan Manuel Sotelo (Area Manager, External Relations, Resource Mobilization, and Partnerships, Pan American Sanitary Bureau [PASB]), served as Technical Secretary.

Adoption of the Agenda and Program of Meetings (Documents CE144/1, Rev. 2 and CE144/WP/1, Rev. 1)

7. The Committee adopted the provisional agenda (Document CE144/1, Rev. 2) without change and also adopted a program of meetings (CE144/WP/1, Rev. 1) (Decision CE144[D1]).

Representation of the Executive Committee at the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas (Document CE144/2)

8. In accordance with Rule 54 of its Rules of Procedure, the Executive Committee appointed the delegates of Uruguay and Suriname, its President and Vice President, respectively, to represent the Committee at the 49th Directing Council. Mexico and Trinidad and Tobago were designated as alternate representatives (Decision CE144[D2]).

Provisional Agenda of the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas (Document CE144/3, Rev. 1)

9. Ms. Piedad Huerta (Advisor, Governing Bodies Office, PASB) presented the provisional agenda of the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas, as contained in Annex A to Document CE144/3, Rev. 1. She noted that, as usual, the agenda included a number of procedural and constitutional matters, as well as many program policy and administrative and financial matters which had been discussed by the Executive Committee. The program policy matters also included a roundtable on safe hospitals, and a panel discussion on the Pan American Alliance for Nutrition and Development to Achieve the Millennium Development Goals.

10. The Director observed that the agenda was fairly lengthy, but as the Executive Committee had worked very efficiently and its comments would greatly enhance the documents, she was confident that the Directing Council would be able to complete the agenda without problem.

11. One innovation was that the reception that had traditionally been held at PAHO on the first Monday of the session would be replaced by a gala dinner on the Tuesday evening at the headquarters of the Organization of American States (OAS). The event was being organized in conjunction with the Pan American Health and Education Foundation (PAHEF) and would include the presentation of the various awards.

12. The Executive Committee adopted Resolution CE144.R25, approving the provisional Agenda of the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas.

Committee Matters

Report of the Third Session of the Subcommittee on Program, Budget, and Administration (Document CE144/4)

13. Ambassador Jorge Skinner-Klee (Guatemala, Vice President of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee on Program, Budget, and Administration (SPBA) had held its Third Session from 11 to 13 March 2009. The session had been attended by representatives of the following members of the Subcommittee elected by the Executive Committee or designated by the Director: Bolivia, Colombia, Guatemala, Mexico, Saint Vincent and the Grenadines, Trinidad and Tobago, and the United States of America. Representatives of Brazil, Canada, Spain, and Suriname had attended in an observer capacity. Trinidad and Tobago had been elected to serve as President of the Subcommittee, Guatemala had been elected Vice President and Mexico had been elected Rapporteur.

14. The Subcommittee had engaged in a very productive exchange of views on a number of important financial, administrative and other issues, including the proposed program budgets of PAHO and WHO for the financial period 2010-2011, the interim financial report of the Director for 2008, a proposal for the establishment of an Audit Committee, proposals for new institutional frameworks for two Pan American centers, the proposed Regional Plan of Action for Implementing PAHO's Gender Equality Policy, and PAHO procurement mechanisms, including the Revolving Fund for Vaccine Procurement. As all of the matters discussed by the Subcommittee were also on the agenda for the 144th Session of the Executive Committee, he would report on those items as they were taken up by the Committee.

15. The Executive Committee thanked the Subcommittee for its work and took note of the report.

Nongovernmental Organizations in Official Relations with PAHO (Document CE144/6)

16. Ambassador Jorge Skinner-Klee (Representative of the Subcommittee on Program, Budget, and Administration) informed the Committee that the Subcommittee had held a closed meeting during its Third Session in order to review the status of eight nongovernmental organizations (NGOs) in official relations with PAHO, and had decided to recommend that the Executive Committee approve the continuation of official relations between PAHO and the American Society for Microbiology (ASM), the

Inter-American Association of Sanitary and Environmental Engineering (AIDIS), the International Diabetes Federation (IDF), the Latin American Federation of the Pharmaceutical Industry (FIFARMA), the March of Dimes Foundation (MOD), the United States Pharmacopeia (USP), and the World Association for Sexual Health (WAS).

17. The Subcommittee had also decided to recommended that relations with the Latin American and Caribbean Association of Public Health Education (ALAESp) be discontinued, with the understanding that they might be renewed at some point in the future on the basis of a new collaborative work plan.

18. In addition, the Subcommittee had made several recommendations concerning the format and content of the information submitted on NGOs seeking admission into official relations with PAHO or renewal of such relations. In particular, it recommended that the information should be presented in a more concise, standardized, and easy-to-follow manner and that it should be made clear how PAHO's collaboration with each NGO was contributing to the achievement of the strategic objectives contained in the Organization's Strategic Plan.

19. In the Committee's discussion of this topic, it was suggested that the Subcommittee's recommendations on the format and content of information on NGOs should be incorporated into the proposed resolution on the item. Specifically, it was suggested that the Director should be asked to submit an annual report on PAHO's collaboration with the NGOs with which it maintains official relations. Those reports should include a list of all NGOs in official relations with the Organization and should indicate the year in which they were due for review. It should also indicate how the Organization's work with the NGOs was contributing to the achievement of the strategic objectives in the Strategic Plan. The proposed resolution was amended accordingly.

20. The Representative of the Inter-American Association of Sanitary and Environmental Engineering (AIDIS) said that his organization had been collaborating with PAHO since 1948 and remained committed to working closely with the Organization in areas of shared interest. Currently, the two organizations were collaborating on six AIDIS programs aimed at ensuring universal access to safe drinking water, wastewater disposal and treatment, and solid waste management in the Region by 2025, with an intermediate goal of achieving the Millennium Development Goals related to environmental health by the target date of 2015.

21. The Committee adopted Resolution CE144.R3, deciding to continue official relations between PAHO and the seven NGOs mentioned in paragraph 16 above, and to discontinue relations with ALAESp.

PAHO Award for Administration 2009 (Documents CE144/5 and CE144/5, Add. I)

22. Ms. Ann Blackwood (United States of America) reported that the Award Committee of the PAHO Award for Administration 2009, consisting of Argentina, Bolivia, and the United States of America, had met on 24 and 25 June. After reviewing the information on the award candidates nominated by Member States, the Committee had decided to confer the PAHO Award for Administration 2009 on Dr. Merceline Dahl-Regis, of the Bahamas, for her contribution to health care management and research and to medical education in primary health care, as well as for her leadership in institutionalizing public health surveillance across all of the Bahamas and in evaluating and redefining the parameters for the Caribbean Cooperation in Health.

23. The Executive Committee extended congratulations to Dr. Dahl-Regis and adopted resolution CE144.R22, noting the decision of the Award Committee and transmitting its report to the 49th Directing Council.

Annual Report of the Ethics Office (Document CE144/7)

24. Mr. Philip MacMillan (Manager, Ethics Office, PASB) explained that the Ethics Office had two primary responsibilities. The first was to provide guidance and advice to personnel in order to ensure compliance with PAHO's standards of conduct. As part of that function, it also provided training. The second main function was to carry out investigations into allegations of misconduct. In addition, the Office was responsible for coordinating PAHO's Integrity and Conflict Management System.

25. At the core of the Office's advisory function was PAHO's Code of Ethical Principles and Conduct, which served as an important guide for staff in their day-to-day activities, and also set out a number of activities for which personnel must obtain the authorization of the Ethics Office. During the past year, the Office had responded to 64 queries from personnel, covering a wide range of topics including outside activities and employment, membership on boards and committees, the receipt of gifts and awards, and the employment of relatives. During the past year, the Ethics Office had received 27 reports about behavior raising ethical concerns. Details of the cases were given in Document CE144/7. The investigations carried out by the Ethics Office had resulted in various actions taken by the Organization, ranging from counseling to summary dismissal.

26. The cornerstone of the Ethics Office's training program was a mandatory on-line course on the Code of Ethical Principles and Conduct, which all Headquarters staff had now completed. The Ethics Office had also carried out briefing sessions for personnel in two country offices and more country visits were envisioned for the near future.

27. The Ethics Office had led the development of several major initiatives during the past year. First, a new policy had just been completed to protect people who reported

wrongdoing or cooperated in an investigation or audit. Second, a protocol had been developed to ensure that to the extent possible all workplace investigations were carried out in a uniform, objective, and transparent manner and in line with established standards. The protocol was in the final stages of the review process and would be implemented shortly. Third, the Standing Committee on Asset Protection and Loss Prevention had been established, with responsibility for ensuring that risks of a financial nature were effectively managed and that all known cases of theft or loss were properly reported and investigated.

28. With regard to future work, the Code of Ethical Principles and Conduct, issued in 2006, would be updated to take account of lessons learned and to expand its coverage to include vendors, suppliers, and contractors. The Ethics Office was also examining the feasibility of implementing an online assessment system, intended to provide an evaluation of the importance of ethical behavior to people working in the Organization and their level of awareness of the various initiatives and policies that were now in place.

29. The Executive Committee commended the Office for promoting an ethical culture in the Organization through its training, educational, and investigative efforts. The Committee was also pleased that the protocol on workplace investigations had been created and urged the Ethics Office to implement it without delay. The new policy to provide protection from retaliation for people who reported wrongdoing was welcomed, and the Office was urged to ensure that staff were made aware of the protection mechanisms and that those mechanisms were given full effect by senior management. One delegate asked whether there was provision for penalties for personnel who made unfounded accusations of wrongdoing. Another delegate supported the plan for an assessment of the level of awareness of ethical issues, noting that a similar survey had been carried out within the Office of the United Nations High Commissioner for Refugees.

30. Several delegates reported on the efforts that their countries were making to combat corruption and unethical or inappropriate behavior among public officials. It was suggested that some of the Ethics Office's training materials might be useful to those efforts.

31. Mr. MacMillan reiterated that the policy to provide protection for people who reported wrongdoing had only just been completed. It would be implemented as soon as possible, but something so important should not be rushed. It was essential to ensure that the policy was credible and that it was only applied for valid reasons. He confirmed that the protection afforded under the policy would not apply if the information provided were intentionally false and that anyone providing false information would be subject to disciplinary action. The Ethics Office had already shared its training program with WHO and the World Bank and would be happy to share it with other bodies.

32. The Director said that the proposal of sharing the training program was a very interesting idea, reflecting the very close interaction between PAHO and its Member States, from which the Organization had frequently drawn tools and instruments for its work. In particular, the materials should be provided to the ministries of health, because the ministries and PAHO had very similar missions and thus were likely to face very similar problems with respect to ethics.

33. She added that, as the Ethics Office pursued its investigations and accumulated experience, the cases it dealt with were added to the training course, subject to proper measures to protect identities. That approach meant that the people taking the course were dealing with real-world situations, which would make them think about their own circumstances and behavior, because in many cases people who infringed rules of ethics were simply unaware that they were doing so. Thus the Ethics Office's educational work had enormous capacity for the prevention of such infringements. The overriding aim was to prevent ethics violations, not to punish people for them if they did occur. In that sense, the work of the Ethics Office was like public health work in general: prevention was of overriding importance. Unfortunately, however, there was no vaccine for unethical behavior.

34. The Committee took note of the report of the Ethics Office.

Program Policy Matters

Proposed PAHO Program and Budget 2010-2011 (Documents CE144/30; CE144/30, Add. I; Official Document 333, and Add. I)

35. Ambassador Jorge Skinner-Klee (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had examined the first draft of the program and budget proposal for 2010-2011, looking at three possible scenarios, all of which had assumed that an increase of \$11.5 million² would be needed in the post portion of the budget in order to maintain the 757 posts envisaged for the 2010-2011 biennium. All the scenarios had also assumed a 2.6% reduction in the WHO portion of the PAHO budget. The proposal put forward in the first draft of the budget had been based on Scenario B, in which 67% of the cost increase would be covered, assessed contributions would increase by 4.3%, and the non-post portion of the budget would decline by 6.0%. It had been explained that the non-post portion of the regular budget represented the impact of each scenario on the Organization's ability to provide technical cooperation. Scenario B called for a total PAHO/WHO regular budget of \$288,516,000, an increase of 3.4% with respect to 2008-2009, and for assessed contributions totaling \$187,816,000, an increase of 4.3%.

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

36. The Subcommittee had requested more information on the basis for the proposed increase in the post portion of the budget and on planned reductions in posts and/or changes in the balance between the post and non-post portions of the budget. The Subcommittee had also asked the Bureau to provide a narrative description of the concrete impact that each scenario would have in terms of the Organization's program and its technical cooperation with Member States. The Bureau had also been asked to indicate the percentages of the total budget allocated to each strategic objective, so that Member States could clearly see the relative priority attached to each one, and to provide more comparative data showing trends and shifts in emphasis from 2008-2009 to 2010-2011, as well as a breakdown of the different types of voluntary contributions, together with specific projections for PAHO trust funds and other types of funds.

37. Subcommittee members had voiced concern about the impact of the current financial crisis on PAHO's budget and the ability of Member States to meet their obligations to the Organization. Delegates had questioned whether a 4.3% increase in assessed contributions was realistic in the present economic climate and had emphasized that the figures in the draft proposal would need to be revised in the light of ongoing changes in the global economic situation and the decisions taken by the World Health Assembly on the WHO program budget for 2010-2011.

38. Dr. Isaías Daniel Gutiérrez (Area Manager, Planning, Budget, and Resource Coordination, PASB) introduced the revised budget proposal contained in *Official Document 333*. He noted that, for the first time, the proposed program budget was divided into three segments: PAHO/WHO base programs, outbreak and crisis response, and government-financed internal projects. The proposal provided a more detailed breakdown of the budget by organizational level than the version presented to the Subcommittee; however, it remained a work in progress because the operational planning process was still under way. Final details would be presented to the 49th Directing Council.

39. Like the proposal examined by the Subcommittee, the proposal before the Executive Committee was based on Scenario B, which called for a 4.3% increase in assessed contributions. The WHO share of the regular budget, approved by the World Health Assembly in May, would decline 1.0%, making the overall proposed increase in the combined PAHO/WHO budget 3.4%. Estimated financing from other sources was projected to increase by 2.6%. The total proposed budget, including both the regular budget and the portion funded by other sources, was \$644,367,000, a 2.9% increase with respect to 2008-2009. The proposal showed the amount and percentage allocated to each strategic objective in the Strategic Plan 2008-2013, as requested by the SPBA. He pointed out that what appeared to be sizeable percentage increases or decreases in some strategic objectives, notably 11 and 15, in fact reflected only the movement of posts from one area in the Organization to another. For example, a number of posts had been moved

from Strategic Objective 16 to Strategic Objective 15 to better reflect the country presence efforts.

40. Drawing attention to the addendum to the budget document, which contained the justification of the proposed increase in assessed contributions and other information requested by the Subcommittee, Dr. Gutierrez reviewed the trend of fixed-term posts funded by the regular budget, which had declined from 1,222 posts in 1980-1981 to 757, the number envisaged for 2010-2011. As had been reported to the SPBA, an increase of 6.3% in the regular budget would be needed to cover the cost of those 757 posts. The post component of the proposed regular budget—i.e., the amount needed to fund fixed-term posts—would make up 69% of the total. The non-post component, which represented the Organization's technical cooperation with countries, would account for 31%.

41. The addendum presented the three scenarios (A, B, and C) and illustrated and explained the negative programmatic impact, particularly in scenarios B and C. Only in Scenario A the non-post component will grow (by 1.79%). In Scenarios B and C it would decrease (by 2.25% and 10.74%, respectively). The Bureau continued to recommend Scenario B. The addendum also contained details on the Bureau's efforts to improve efficiency and productivity. Dr. Gutierrez noted that, while there had been steady gains in efficiency despite the sustained reduction in staff, an analysis of statistical trends appeared to indicate that any further staff cuts would yield no further improvements in efficiency, would reduce productivity, and would negatively affect the Organization's technical cooperation and its ability to carry out its core functions, which could not be delegated to short-term personnel.

42. The Bureau was aware of the difficulties that all Member States were experiencing as a result of the global financial crisis but believed that in times of economic crisis it was essential to invest in health in order to continue progressing in the implementation of the Health Agenda for the Americas and the achievement of the Millennium Development Goals, protect the health gains achieved in the Region thus far, and strengthen health services, which was particularly important in the face of the influenza A (H1N1) pandemic.

43. The Executive Committee discussed the budget proposal on several occasions over a period of four days, with delegates repeatedly expressing concern about the proposed increase in assessments. Concern was also expressed about the impact of the new scale of assessments (see paragraphs 76 to 83 below). While delegates acknowledged PAHO's difficult financial situation and expressed appreciation for the measures taken to reduce costs and increase efficiency and productivity, they also pointed out that their Governments were grappling with severe economic constraints, which had been compounded in some cases by the influenza pandemic, and would therefore be hard-pressed to meet a higher quota contribution. The delegates of Canada and the United States of America reaffirmed their Governments' policy of zero nominal growth in the

budgets of international organizations. The Bureau was requested to draw up a fourth scenario (Scenario D) that would address those concerns.

44. The Committee welcomed the detail provided in the addendum to the budget proposal and expressed gratitude to the Bureau for its efforts to respond to the requests of the SPBA. Some additional comparative data was requested so that Member States could more clearly see trends over time. The table describing the negative programmatic impacts of Scenarios B and C in Section II of the addendum was considered especially helpful, although it was felt that clarification of some of the impacts was needed, notably in respect of Strategic Objective 10. Delegates generally agreed with the proposed increases in funding for the various strategic objectives, but expressed doubt about the proposed reductions for Strategic Objectives 13 and 14, which were considered crucial to the strengthening of health systems based on primary health care and the achievement of universal coverage.

45. Delegates expressed support for the Bureau's efforts to increase the proportion of core voluntary contributions and asked what strategies were in place to increase donor willingness to provide unearmarked funding. The Bureau was asked to break down the data on voluntary contributions by type of contribution and to provide specific projections for PAHO trust funds and other types of funds. Information was also requested on the countries involved in government-financed internal projects and on the impact of such projects on the proposed increases or reductions in funding for the various strategic objectives.

46. Dr. Gutiérrez said that, unfortunately, the vast majority of voluntary contributions continued to be earmarked. The Bureau would certainly strive to mobilize more non-earmarked contributions; however, even if it were successful, an increase in voluntary contributions could not offset a decrease in the regular budget because such contributions, which were unpredictable, could not be used to fund fixed-term posts. As for the funding received by PAHO for government-financed internal projects, such projects were entirely self-financing and so had no financial implications for PAHO. However, they did make a valuable contribution to the achievement of the Organization's strategic objectives and therefore, although they were carried out in a single country, were of benefit to all the peoples of the Americas.

47. Regarding the increases and reductions in funding for some strategic objectives, he explained that they mainly reflected changes in the amount of voluntary contributions anticipated. In the case of Strategic Objective 13, for example, the amount programmed had been overly ambitious, based on what had been mobilized thus far in the current biennium, and the projection for 2010-2011 had therefore been adjusted accordingly. The reduction did not indicate any diminution in the priority accorded to that objective; it was simply a more realistic estimate.

48. Dr. Pedro Brito (Area Manager, Health Systems and Services, PASB), referring to Strategic Objective 10, explained that PAHO had several important mandates relating to strengthening and development of health systems, including the Health Agenda for the Americas 2008-2017; Resolution CSP26.R19 on the extension of social protection in health; Resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance; and Resolution WHA62.12 on primary health care and health system strengthening. Those mandates had become even more critical in the current context. There was a need to strengthen health systems to deal with the increased burden being placed on them as a result of the influenza pandemic and the effects of the economic crisis, which had weakened the capacity of the private sector and social security systems to provide health care coverage and left many middle- and low-income people dependent on public health care services.

49. Those factors accounted for the proposed increase in funding for Strategic Objective 10. As Dr. Gutiérrez had explained, the increase would come from voluntary contributions, not regular budget funds. Happily, the Organization had seen a rising trend in voluntary contributions for the strengthening of health systems, including funds received from WHO voluntary contributions and funding received by countries for health systems strengthening from sources such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the GAVI Alliance. Unfortunately, the situation was not the same for voluntary contributions for strengthening of the health workforce (Strategic Objective 13) and the extension of social protection in health (Strategic Objective 14), areas in which it had proved difficult to mobilize extrabudgetary funding.

50. The Director pointed out that WHO had also adjusted its projections of voluntary contributions downward, both because the forecast for such contributions in the current economic climate was fairly gloomy, but also because for the past five bienniums WHO had not succeeded in mobilizing the extremely ambitious level of voluntary funding projected in its budgets. With regard to the proportion of voluntary funding that was unearmarked, in the case of WHO it was about 5%. PAHO had had somewhat more success in mobilizing flexible voluntary contributions, which currently accounted for 10% of the total.

51. It was important to understand, however, that even if voluntary contributions were not earmarked, they could not normally be used to fund posts. It was also important to understand that in order to mobilize more voluntary contributions, the Organization had to have sufficient staff, which meant that it had to have sufficient regular budget funds to cover salaries and other post-related costs. Thus, it was the regular budget that provided the leverage that enabled PAHO to attract more funding from voluntary contributions.

52. A reduction in the regular budget would hamper not only the Organization's capacity to mobilize voluntary contributions but also—and perhaps even more importantly—its capacity to implement those funds. PAHO might thus find itself in the

same situation as WHO, which had been obliged to carry over into the next biennium more than \$1 billion in extrabudgetary funding simply because it did not have the staff needed to implement the activities for which those resources had been provided. That situation was directly related to the unhealthy ratio between regular and extrabudgetary funding in the WHO budget. At PAHO, although the proportion of regular budget funding had been declining since 2006-2007, that ratio was still manageable, but caution was needed.

53. With regard to government-financed internal projects, the Director stressed that they were always fully aligned with the Organization's strategic priorities. Most of the projects currently under way were aimed at achieving the Millennium Development Goals or strengthening health systems. One included an international cooperation component and was therefore benefiting other countries of the Region. As Dr. Gutiérrez had explained, such projects entailed no staff or other costs for PAHO. However, the funds that it received for that purpose contributed to the Organization's investment portfolio and thus to its miscellaneous income.

54. The Director wished to make it clear that the 6.3% increase in costs for fixed term posts was not an increase in salaries, which had remained virtually frozen in real terms for the past 12 to 15 years. The increase was due to higher costs for staff health insurance, pension contributions, cost-of-living supplements, and other costs over which PAHO had no control. She also pointed out that staff shared in paying those costs through assessments for health insurance and pension funds, and that they were paying an increasing amount.

55. The Bureau would be pleased to prepare a fourth budget scenario, as requested by the Committee. However, no scenario would change the reality of the post costs increase or the fact that without an increase in the regular budget, the Organization's capacity to provide technical cooperation to countries would diminish.

56. The Executive Committee subsequently considered a Scenario D, prepared by the Bureau, which called for a 3.5% increase in assessed contributions and a 2.9% increase in the total budget, including the WHO share and miscellaneous income. Dr. Gutiérrez explained that, under Scenario D, the post component of the budget would increase by 6.3% and the non-post portion would decrease by 3.8%. Broken down by organizational level, Scenario D would result in a 21.86% decrease in non-post regular budget funds for the regional level, an 11.69% increase for the subregional level, and a 3.38% increase for the country level.

57. The Director said that Scenario D would allow the Bureau some flexibility with regard to the non-post component of the budget. The increase in the amount allocated to the subregional level—about \$8 million—would partially offset the \$22 million decrease in the regional portion and thus mitigate the negative impact on the Organization's

technical cooperation with Member States. Scenario C, in contrast, would result in a 33% reduction in non-post funds for the regional level, which would severely compromise the Organization's ability to provide technical cooperation and to mobilize and implement voluntary contributions.

58. The Legal Counsel of the Organization was asked to determine whether it would be possible to submit a proposed resolution to the 49th Directing Council that would include, in brackets, scenarios A, B, C, and D. She responded that there was a legal impediment, as the Executive Committee must present a proposal for the consideration of the Directing Council (Article III, paragraph 3.5 of the Financial Regulations of the Pan American Health Organization; and Chapter IV, Article 14, paragraph C of the Constitution of the Pan American Health Organization).

59. After further discussion and consultation by delegates with authorities in their respective countries, the Executive Committee opted for Scenario D as the program proposal to submit to the 49th Directing Council for its approval and the scale of assessments for 2010-2011 on that basis (Resolutions CE144.R21 and CE144.R23).

60. The Delegate of Mexico observed that the Committee's lengthy discussion of the budget, and its difficulty in arriving at a decision on the matter, reflected Member Governments' keen awareness of the need to ensure responsible use of public resources. She expressed gratitude to the Bureau for its acknowledgement of the economic difficulties that Member States were experiencing as a result of the global crisis and the influenza A (H1N1) pandemic and its recognition of their concerns regarding the proposed increase in assessments. Scenario D, with its proposal for a minimal increase, responded to those concerns. She urged the Bureau to continue to exercise responsible and prudent program and financial management, despite the reduction in the non-post portion of the budget.

61. The Director expressed gratitude to the Committee for its careful consideration of the budget proposal and for its approval of a scenario that provided for a small increase in assessed contributions that nevertheless would have a substantial impact in some countries. The Bureau would do its part by continuing to seek greater efficiencies and attempting to do more with less, but she wished to be clear: PAHO would not be able to continue doing everything that it was currently doing. Some activities would have to be reduced or eliminated altogether.

62. Thanking the Delegate of Mexico for her eloquent statement, she affirmed that Mexico was undoubtedly the country in the Region that had suffered most severely from the combined impact of the economic crisis and the influenza pandemic. The latter had, however, had a positive impact in that it had pointed up the importance of investment in health and strong social protection. PAHO remained convinced that only by investing in people would it be possible to emerge from the crisis successfully. It was especially

critical to invest in the "crisis generation"—the children being born today, who were the Region's future. If the Americas lost a generation, not only would the crisis be more painful and prolonged, but the countries of the Region would continue to feel its impact for years to come.

PAHO Strategic Plan 2008-2012 Amended (Draft) (Documents CE144/31 and Official Document 328)

63. Dr. Isaías Daniel Gutiérrez (Area Manager Planning, Budget, and Resource Coordination, PASB) said that the PAHO Strategic Plan 2008-2012 had been amended in order to maintain consistency with the WHO Medium-term Strategic Plan 2008-2013, which had also been amended (see paragraphs 286 to 289 below), and in order to update the document, clarify some of the expected results, and simplify measurement of the indicators. The proposed changes were summarized in Document CE144/31 and underlined in *Official Document 328*.

64. The Committee welcomed the revisions to the Strategic Plan, applauding in particular the streamlining of the indicators and the inclusion of new indicators relating to the Millennium Development Goals, the increased emphasis on support for research at country level, and the inclusion of paragraphs 91 to 94 on country cooperation strategies, which were seen as crucial for ensuring that PAHO's technical cooperation was well aligned with Member States' needs and priorities. Delegates made a number of suggestions for further refinement of the Strategic Plan, and several delegations submitted detailed comments and suggested amendments in writing.

65. In light of the current influenza pandemic, it was suggested that either influenza A (H1N1) should be added to the list of diseases with pandemic potential in paragraph 72(c) of the amended Strategic Plan or the wording should be made more generic by simply referring to "pandemic influenza viruses." One delegate questioned why the target for indicator 1.7.1 (number of countries that have national preparedness plans and standard operating procedures in place for rapid response teams against pandemic influenza) was not 100% of Member States.

66. Clarification of the concept of "maintenance indicator" and of the rationale for including such indicators, which would not change over time, was sought. Clarification was also requested of the criteria for setting the targets for 2009, 2011, and 2013 and for determining the denominator for baselines and targets in instances in which that figure was not 40, as in the case of indicator 1.7.1 mentioned above. It was suggested that a technical annex should be added to the Strategic Plan, providing explanations of the methodology used to establish indicator values and the reasons for differences in the denominators. It was pointed out that having specific information on the countries that constituted the statistical universe for a particular indicator could facilitate the planning

of technical cooperation between countries, with countries that had made more progress in certain areas helping those that were less advanced.

67. One delegate, emphasizing the value of PAHO's role in purchasing health goods on behalf of Member States through its various procurement mechanisms and noting the extent to which that role had grown in recent years, suggested that procurement on behalf of Member States should be included among the core functions listed in paragraph 76 of the amended Strategic Plan.

68. A number of questions were asked and suggestions made with respect to specific indicators. With regard to indicator 2.4.3 (number of countries reporting malaria surveillance data disaggregated by sex and age to PAHO), for example, it was pointed out that it was critical also to disaggregate data on malaria by region or geographic area. Under Strategic Objective 3, it was suggested that it would be useful to have indicators for unintentional injuries other than road traffic injuries and for preventive screening for breast, cervical, and colorectal cancer and other diseases and conditions. Under Strategic Objective 6, one delegate suggested that there should be an indicator for physical activity, and another inquired why the indicators relating to trans fats and marketing of food to children (indicators 6.5.5 and 6.5.6 in the unamended Strategic Plan) had been removed and whether PAHO intended to continue working in those areas. Referring to indicator 7.1.1, a delegate asked why the indicator referred only to policy recommendations from the report of the Commission on Social Determinants of Health and suggested that recommendations from other peer-reviewed, evidence-based reports should be included.

69. Dr. Gutiérrez said that the Bureau would incorporate the amendments proposed by the Committee and post a revised version of the document on the Organization's website. He suggested that a comment period of 10 days be allowed for Member States to submit additional suggestions via SharePoint.

70. Responding to some of the questions, he explained that maintenance indicators related to objectives that had already been achieved but for which ongoing action was needed in order to maintain the achievement. An example was the eradication of poliomyelitis: continued vaccination was necessary to keep the Americas polio-free. It was necessary to include such indicators in the Strategic Plan in order to ensure that resources would continue to be allocated under the PAHO budget for the required follow-up activities. With regard to the differences in the denominators of some indicators, he explained that where no denominator was given, the universe was considered to be 40: the 35 countries of the Americas, plus France, the Netherlands, and the United Kingdom, which had overseas territories in the Region; Puerto Rico, which was an Associate Member of PAHO; and the Mexico-United States border region, which was considered a distinct unit for programming purposes. If a denominator was less than 40 it was because the indicator in question applied only to some countries or territories. The Bureau would,

as suggested, add a methodological annex and might also add footnotes identifying the countries or territories concerned for all indicators with denominators of less than 40.

71. With regard to the suggestion that procurement on behalf of Member States should be added as a core function, he said that the core functions could not be changed because they had been defined by WHO and were intended to be the same, with needed minor adjustments, for the WHO Secretariat and all the Regional Offices. However, PAHO's procurement function could be incorporated under one of the strategic objectives.

72. Dr. José Luis Di Fabio (Area Manager, Technology, Health Care, and Research, PASB) suggested that an expected result and indicator relating to procurement might be included under Strategic Objective 12: To ensure improved access, quality, and use of medical products and technologies. Dr. Gina Tambini (Area Manager, Family and Community Health, PASB) remarked that an indicator relating to procurement of vaccines might also be added under Regionwide Expected Result (RER) 1, which had to do with access to vaccines.

73. Dr. Jarbas Barbosa da Silva (Area Manager, Health Surveillance and Disease Prevention and Control, PASB) said that PAHO would indeed continue to work on issues such as the elimination of trans fat from foods and marketing of foods to children. Those activities would be delineated individually in the Bureau's biennial work plans, but in the Strategic Plan they would be covered under a single umbrella indicator relating to risk factors for diet-related disorders.

74. Responding to the question on the indicators relating to trans fats and marketing of foods to children, Dr. James Hospedales (Senior Advisor, Prevention and Control of Chronic Diseases, PASB) recalled that in September 2007 PAHO had hosted a landmark meeting with major food producers, at which those companies had committed to eliminate trans fat from their products by the end of 2008. The Bureau was currently contacting the companies, which had agreed to submit data to validate the elimination of trans fat. PAHO was collaborating with WHO on the issue of marketing of foods to children and would be hosting a regional electronic consultation on the subject in August 2009.

75. The Director said that an updated version of the document would be available for comment by 8 July. She emphasized that the Strategic Plan was a "living document" and would continue to be updated and refined as needed.

76. The Executive Committee subsequently adopted Resolution CE144.R10, recommending, subject to the incorporation of the revisions proposed by the Committee, that the 49th Directing Council approve the amended Strategic Plan 2008-2013.

New Scale of Quota Contributions (Document CE144/8)

77. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration), introducing the item, recalled that the Subcommittee had discussed the new scale of quota contributions in March and had asked the Bureau to provide actual dollar figures in addition to the percentage changes in Member States' assessments. In response, an informal document had been distributed, showing 2008-2009 assessments based on the current scale and the same assessments based on the new scale. Those figures were included in the document submitted to the Committee. The Bureau had also been asked to explain how future changes would be applied, given that the Organization of American States revises its quota contributions every three years, whereas PAHO has a two-year budgetary cycle. It had been explained that no changes would be made in the middle of a biennium. Rather, they would apply to the biennium following the one in which they were approved. Thus, if the next revision of the OAS scale of contributions were to be approved during the 2010-2011 biennium, then the revised figures would apply to PAHO's 2012-2013 budget.

78. Mr. Román Sotela (Senior Advisor, Program Budget Management, PASB) explained that the change in quota contributions was the culmination of a three-year process. According to its Constitution, PAHO's scale of quota assessments was based on the latest approved assessment scale applied at the OAS. The latter having adopted a new scale for its members for the period 2009–2011, it had been decided by the PAHO Governing Bodies that PAHO would adopt a corresponding new scale to take effect in the 2010-2011 biennium.

79. Several members of the Executive Committee expressed concern at the prospect of an increase in their PAHO assessments in the present economic climate. Over and above the worldwide recession, some countries' economies (notably Mexico's) had suffered from the direct impact of the A (H1N1) influenza pandemic, while others had suffered an indirect effect as the pandemic had depressed tourism, a staple of their economies. As different options and scenarios had been prepared for the discussion on the 2010-2011 budget proposal, members suggested that a further scenario be prepared to show the effect if assessments remained unchanged.

80. The Director recommended that the debate keep separate the issues of the new scale of assessments and the proposed program budget. Establishment of the scale of assessments was the purview of the OAS General Assembly, not of PAHO's Governing Bodies. It was true that some assessments were increasing, but for a number of countries, notably those in the Caribbean, they were going down. The calculations for the assessments had been based on expectations for 2006, and thus did not take account of the dramatic decline in some countries' gross domestic product (GDP), such as had occurred in Mexico. At the same time, the former scale had in some cases been based on GDP figures that were decades old and needed to be updated. In any case, the decision on

assessments had been made after ample discussion and negotiation, and in her view PAHO could not make changes to figures that had been negotiated by Member States' representatives within the OAS over a period of three years.

81. One delegate supported the Director's view that the proposed quota assessments could not now be changed. Another delegate suggested that, although the new quota assessments would have to be applied at some time, implementation of the new scale could perhaps be postponed. She understood that the figures had been approved at the OAS, but felt that countries' present economic situation demanded that every possibility be examined.

82. The Director pointed out that the issue of when the new scale would take effect had already been decided by the 140th Session of the Executive Committee, which had determined that PAHO would begin applying the scale in the 2010-2011 biennium (Resolution CE140.R5). The 49th Directing Council might decide to override that decision if there were sufficient delegations that supported postponing the change; however, she predicted that there would be strong resistance to not applying the scale that had already been adopted by the OAS.

83. In the Committee's discussion of the proposed resolution on this item, it was suggested that the resolution should make reference to Member States' concerns about the application of the new scale of assessments in the present economic context, but it was subsequently agreed that such concerns would be better located in a revised version of the working document on the item.

84. Bearing all of this in mind, the Executive Committee adopted Resolution CE144.R18, recommending that the 49th Directing Council approve the new scale of assessed contributions to be applied to the program and budget for the budgetary period 2010-2011.

Plan of Action on the Health of Older Persons, Including Active and Healthy Aging (Document CE144/9)

85. The President drew attention to Document CE144/9 and opened the floor for discussion.

86. The Committee expressed support for the proposed Plan of Action on the Health of Older Persons, with several delegates noting that the Plan was consistent with their national policies and priorities relating to the health of older persons. Delegates described the situation with regard to aging in their countries, noting the impact of population aging on economic growth and on social support and health care systems, and underscoring the urgent need for programs to help older persons living in poverty. Several delegates also described programs and initiatives being carried out by their governments for older persons. One delegate stressed the role of personal responsibility in planning for old age,

as well as the need for more modern, integrated and evidence-based approaches to the challenges posed by population aging. He also highlighted the need to raise awareness about global aging issues and the importance of scientific research and policy dialogue. Another delegate drew attention to the importance of seeking linkages with other areas, such as chronic diseases and family and community health. One delegate pointed out that it was important to take advantage of the sociocultural strengths of Latin America, where traditional extended families and social structures provided a means of protecting and supporting older persons. The importance of research and dissemination of knowledge on the health of older persons—the subject of Strategic Area 4 of the Plan of Action—was emphasized.

87. One delegate requested clarification of the meaning of the term “healthy environment,” mentioned under objective 2.1 of the Plan of Action and suggested that activity 2.1.6 should be amended to read: “Execute projects with their respective budgets to promote and protect the health of older through action at the community level.” One delegate suggested that the proposed resolution on this item should mention the recent resolution of the Thirty-ninth General Assembly of the Organization of American States on the human rights of older persons (see Document CE144/INF/5-B). Another suggested that the resolution should make reference to the decision of the Fifth Summit of the Americas to consider the feasibility of preparing an inter-American convention on the rights of older persons (see Document CE144/INF/5-C).

88. The Representative of the United Nations Population Fund said that UNFPA had been working with governments and with other United Nations agencies on the subject of aging. She suggested that when the Plan of Action was operationalized, it would be useful to consider the gender aspects of the issue and how the aging process affected men and women differently.

89. Dr. José Luis Di Fabio (Area Manager, Technology, Health Care and Research, PASB) thanked delegates for their comments and their support for the Plan of Action, noting that the Plan had been developed in collaboration with Member States in the course of a series of national and subregional consultations and therefore reflected their views.

90. Dr. Enrique García Vega (Regional Advisor on Healthy Aging, PASB) observed that, as was explained in the document, the Region had a 40-year “demographic bonus,” or window of opportunity, to prepare to deal with the challenges of population aging, but that was still a relatively short period of time in which to make significant changes in health and social security systems. It was therefore imperative to act rapidly. He agreed on the need to work intensively to help people prepare for old age. The Plan of Action recognized that need and the need for a life-cycle approach. It drew on the experiences of countries of the Region in managing chronic diseases and enhancing the capacity of older persons to take care of themselves. Cooperation between countries would be an important

means of sharing the lessons learned from those experiences and mobilizing resources for activities aimed at improving the health and well-being of older persons. The development of indicators would be one of the most important aspects of the work to be done in this area in the coming years. At present, there was a lack of indicators because many of the countries did not have the primary data needed to assess the impact of specific programs and interventions. The activities envisaged under Strategic Area 4 were intended to strengthen Member States' capacity in that regard.

91. The Director drew attention to the issue of life expectancy. Although many countries in the region had made huge gains in life expectancy over the last 25 years, other countries still had life expectancy of under 60 years. Moreover, even in the most highly developed countries of the Region, some groups had very low life expectancy. That was why PASB was advocating a life-cycle approach, aiming to lay the foundation early in life for healthy and active aging. The goal was to extend life but also to ensure the quality of life.

92. The Committee adopted resolution CE144.R13, recommending that the 49th Directing Council endorse the Plan of Action.

Elimination of Neglected Diseases and other Poverty-related Infections (Document CE144/10, Rev. 1)

93. Dr. Jarbas Barbosa da Silva (Area Manager, Health Surveillance and Disease Prevention and Control, PASB) introduced the proposed resolution on the item, contained in document CE144/10, Rev. 1. He outlined the criteria followed in selecting diseases that were considered neglected and/or poverty-related, namely: (a) technical feasibility of elimination; (b) regional evidence of achievable elimination; (c) cost-effectiveness of strategies and tools; (d) inclusion on the unfinished agenda; and (e) political relevance—i.e., the diseases must be recognized as being of public health importance and have broad international appeal. Based on those criteria, the diseases were divided into three groups: (a) diseases that could potentially be eliminated by 2015; (b) diseases whose burden could be drastically reduced with available tools; and (c) other diseases that needed to be further assessed and for which tools and strategies needed to be developed. He then provided details on the goals and strategies envisaged to combat the diseases targeted, stressing the importance of efforts to reduce inequalities in health care, given that the diseases in question were usually associated with poverty and marginalization. He also emphasized that all the elimination goals envisaged were the same as those established by resolutions of the World Health Assembly or the PAHO Directing Council.

94. In the discussion that followed, Committee members welcomed PAHO's efforts to eliminate neglected diseases and diseases that mainly affected the poorest populations and those with the least access to health services. The approach proposed in the document was applauded. However, one delegate stressed the need for more baseline data for

measuring disease prevalence and for performance indicators, particularly in order to allow for the proper monitoring and evaluation of preventive chemotherapy interventions. The same delegate emphasized the need for increased and sustained research and development for controlling the diseases under discussion and highlighted the need for more local involvement in control programs and the need for strategies to match national priorities and capacities. Another delegate, while welcoming the focus on prevention of Chagas' disease, stressed the need also to work on providing affordable treatment. The Delegate of Haiti questioned the figures given in the document on the population at risk for lymphatic filariasis in his country. The Delegate of the United States of America requested that in preambular paragraph (f) of the proposed resolution "the ethical duty to eliminate infectious diseases for which adequate and cost-effective public health interventions exist..." be amended to read "the importance of working to eliminate infectious diseases for which adequate and cost-effective public health interventions exist..."

95. The Delegate of Brazil, referring to the position taken by his country during the Consultation on a Latin American and Caribbean Trust Fund for the Prevention, Control, and Elimination of Neglected and Other Infectious Diseases, held in December 2008, and to the subsequent written comments submitted by his Government to the Director of PAHO, expressed misgivings about some aspects of the proposed approach to neglected diseases, notably the strategy of mass preventive chemotherapy for lymphatic filariasis, schistosomiasis, and soil-transmitted helminthiasis, which his Government viewed as inappropriate and unsustainable. A better approach would be to strengthen primary health care systems as the principal means for diagnosing and treating those diseases, combining passive detection with active case-finding. Noting that no elimination goal had been established in respect of leishmaniasis, he highlighted the need for measures to reduce transmission of and case fatality rates from the visceral form of the disease. With regard to leprosy, he pointed out that the elimination goal established in Document CE144/10, Rev. 1, seemed to differ from the goal established under the WHO global strategy for 2011-2015, which was to reduce the rate of new leprosy cases with grade 2 disabilities by at least 35% with respect to the 2011 level. He also emphasized the need for research and technological development in order to foster the production of new, or the enhancement of existing, methods, materials, and medicines for the diagnosis, treatment, and control of neglected diseases.

96. Dr. Barbosa da Silva clarified that the figures on lymphatic filariasis in the document referred to the population considered to be at risk for the disease because they lived in areas where environmental conditions were favorable for transmission, not to the population actually infected. The report would be revised to clarify the strategy on filariasis; the idea was not to implement mass treatment everywhere, but rather to identify foci and then undertake mass treatment where it was considered necessary. In the case of helminthiasis and schistosomiasis, there was evidence that mass treatment was effective

in certain high-prevalence areas. The resolution strongly advocated integration of disease elimination efforts with primary care whenever possible.

97. With regard to leprosy, he said that although the World Health Assembly might decide to adjust the elimination strategy based on the conclusions of the recent meeting of global leprosy program managers (New Delhi, 20-22 April 2009), the current elimination strategy was supported by two Health Assembly resolutions which remained valid: WHA44.9 and WHA60.11. The latter was the resolution adopting the WHO Medium-term Strategic Plan 2008-2013, from which the leprosy elimination indicator appearing in Document CE144/10, Rev. 1, had been drawn. That indicator had been reaffirmed by the most recent Health Assembly when it had endorsed the amendments to the Medium-term Strategic Plan (Resolution WHA62.11).

98. The Bureau had not included visceral leishmaniasis as a disease for elimination, or even for control, because of the difficulty of establishing a consensus on what goals could be achieved by 2015. In addition, further research was needed to develop tools for controlling the disease.

99. With regard to preambular paragraph (f) of the proposed resolution, he explained that, while it was generally difficult to establish imperatives in health, the Bureau believed that in the case of diseases for which low-cost methods of diagnosis and treatment were available, an ethical imperative did exist. Responding to the comments regarding research and development, he drew attention to paragraph 2(e) of the proposed resolution, in which the Director was requested to promote research for the development of new tools, methods, and strategies. The resolution did not focus specifically on research because diagnostic and treatment tools were already available for eliminating a number of neglected diseases, and some had in fact already been eliminated in several countries or areas. Nevertheless, it was always important to support scientific and technological development so as to improve existing tools and/or generate new ones.

100. He assured the Committee that the document and proposed resolution would be revised in accordance with delegates' comments and suggestions.

101. The Director observed that although efforts to eliminate many of the neglected diseases targeted by the proposed resolution would have little impact on the indicators for the Millennium Development Goals, those efforts were fundamental to the struggle against poverty, bearing in mind that the diseases in question had a disproportionate impact on poor and marginalized populations. She agreed that local involvement in control efforts was critical, especially in order to improve the environmental conditions that contributed to transmission of the neglected diseases. It was also important to work with the private sector and to promote science and technology. While tools were available to combat most neglected diseases, technological innovation was important in order to develop new diagnostic and treatment methods. The work with neglected and poverty-

related diseases was especially timely given that increased migration, coupled with forecasts of climate change, would have a significant impact in terms of disease transmission.

102. The Committee adopted Resolution CE144.R11 on this item, recommending that the 49th Directing Council adopt a resolution urging Member States to commit themselves to eliminate or reduce neglected diseases and other infections related to poverty for which tools exist by 2015.

Policy on Research for Health (Document CE144/11)

103. Dr. José Luis Di Fabio (Area Manager, Technology, Health Care, and Research, PASB) observed that in recent years, national governments, PAHO and WHO, the international research community, and other partners had been calling for the development and strengthening of national health research systems, and for enhancements in the production and use of research that addressed health, equity, and development needs. It was thus time to formulate a policy to guide the Organization's technical cooperation in research for health over the coming years and to lay the foundations for the development of strategies and action plans addressing the needs of the Region.

104. The policy would also facilitate the implementation of major global research strategies, including WHO's Strategy on Research for Health and the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property, and would bolster ongoing activities related to the Mexico Statement from the Mexico Ministerial Summit on Health Research and encourage an effective regional response to the Call to Action from the Bamako Ministerial Forum on Research for Health, the World Health Report 2008, and the report of the Commission on Social Determinants of Health. He summarized the six interrelated objectives contained within the proposed PAHO policy on research for health, as listed in Document CE144/11, explaining that they were consistent and synergetic with the five goals of WHO's Strategy on Research for Health, also listed in the document.

105. The Executive Committee generally welcomed the document and PAHO's renewed commitment to research, which would help the Organization to achieve its mission of leading strategic collaborative efforts to promote equity in health, combat disease, and improve the quality of life of the people of the Americas. A number of delegates cautioned, however, that expansion of research conducted by PAHO itself could lead to duplication of efforts and dilution of resources. It was stressed that PAHO's strength lay in the translation of research findings into technical guidance for Member States, rather than in conducting pure research itself.

106. Delegates sought clarification of a number of issues in the policy. For example, paragraph 25(c) of the policy stated that PAHO would develop incentives to support

research activities, but did not define the nature of those incentives or indicate how they would be distributed. Similarly, paragraph 27(b) stated that PAHO would assist Member States in developing appropriate research governance structures, but lacked a definition of the nature of such structures.

107. Concerned was expressed at the funding targets set out in paragraphs 27(d) and 37, with one delegate noting that they had been established for developing countries, which not all countries in the Region were. He suggested that Member States should be encouraged to set aside funds dedicated to health research rather than required to commit to specific targets. At the same time, support was expressed for the recommendation that 5% of PAHO's combined core and voluntary budgets should be used in support of research, although it was pointed out that the actual financial implications of that recommendation were not reflected in the document.

108. One delegate suggested that leadership by ministries of health was the only way to link research and innovation with the priorities of social development and public health and to guarantee consistency in the allocation of financial resources and the training of human resources. She also suggested that a new subparagraph (g) should be added to paragraph 22 of the policy, to read: "promote participatory mechanisms for evaluation of the policy on research for health."

109. Another delegate sought more detail on the complementarity of the proposed strategy with the Plan of Action on Public Health, Innovation, and Intellectual Property and with WHO's Strategy on Research for Health. She also asked for clarification of how PAHO would, as stated in paragraph 31(e), "facilitate communication and coordination between the public health and the industrial sectors to encourage the development of new products and procedures that address relevant priorities." She welcomed paragraph 20 of the policy, which articulated the need to support an inclusive and multisectoral approach to research, and highlighted the importance of community-based participatory approaches that would promote the participation of indigenous people in research, including the use of traditional knowledge.

110. Dr. Di Fabio observed that all comments from the Committee would help to improve both the document and the proposed resolution. In particular, he noted that the document would need to be revised in order to bring more clarity to some of the budgetary issues.

111. Dr. Luis Gabriel Cuervo Amore (Senior Advisor, Research Promotion and Development, PASB) stressed that the principal emphasis of the policy was not that PAHO should itself become a research body: rather, it was to assist in building capacity in Member States to make use of research findings in order to identify areas in which further research should be pursued, and to close existing gaps by integrating the knowledge gained into decision-making processes.

112. The Director noted that while the Organization had pursued research activities for many years, including into tropical diseases, human reproduction, and so on, it had lacked a proper policy to determine the most useful emphases and the most appropriate mechanisms to foster progress. The Organization intended to continue having research components in its various activities but now to have them harmonized under a policy, so that the Member States could be confident that PAHO's policy reflected their own national needs and could feel ownership of the policy. It was consequently very important to formulate a policy that would cover two distinct aspects of research: the creation of knowledge and the use of that knowledge once discovered.

113. Referring to the explanation sought about incentives, she noted that some countries had had successful experiences with the use of small grants to guide research towards priority topics, for example by providing support to graduate or post-graduate students whose theses dealt with such topics. PAHO had also been working with the Pan American Health and Education Foundation (PAHEF), which had a program of small grants that were used to steer research towards topics that had been somewhat neglected but that were emerging as issues of significance, such as child obesity or certain aspects of chronic diseases.

114. As to what was meant by "research governance structures," PAHO, in partnership with other United Nations and Inter-American agencies, was working closely to support and strengthen the national bodies responsible for science and technology, many of which had only weak links with ministries of health and the health sector in general. Thus, their research programs tended to overlook the priorities of the health sector, as had been revealed by various studies undertaken in preparation for relevant international conferences such as those of Mexico City and Bamako.

115. In the Committee's consideration of the proposed resolution on this item (Document CE144/11, Annex C) a number of changes were proposed by various delegations. For example, one delegation wished the resolution to contain a provision on maximizing free and unrestricted availability of health information in the public domain, while another considered that such a provision would potentially infringe the data protection obligations of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement). One delegation felt that the resolution should call on PAHO to provide adequate core resources for the implementation of the Policy on Research for Health and for the Plan of Action on Public Health, Innovation, and Intellectual Property, explaining that it sought thereby to prevent the resources allocated to the one area from causing a reduction in those allocated to the other. Another delegation considered that funding of the Plan of Action was a separate issue and that there was no need to mention public health, innovation, and intellectual property in a resolution about health research policy. One delegation felt that the resolution should call for the development of a possible standard for disclosure of economic data on drugs registered for sale, including research and development cost information, while another

said that disclosing such proprietary data would be illegal in his country as it would breach antitrust provisions.

116. In the ensuing discussion the delegation that had proposed the latter provision modified its proposal, explaining that its intention was to promote the creation of mechanisms of transparency for disclosure of information that might be useful for product development, and linking its proposal to several provisions of the policy itself.

117. In light of delegations' fundamentally differing views, a drafting group was established, comprising the delegations of Bolivia, Mexico, Suriname, and the United States of America.

118. During the meeting of the drafting group, the delegations expressed their views on the issues related to intellectual property. Following the respective discussions, they agreed to changes based on the proposals that had been made

119. An amended version of the proposed resolution produced by that group was subsequently submitted to the Executive Committee, which adopted it without further amendment as Resolution CE144.R19, recommending that the 49th Directing Council endorse PAHO's Policy on Research for Health.

Strategy and Plan of Action on Mental Health (Document CE144/12)

120. The President drew attention to Document CE144/12 and opened the floor for discussion.

121. The Committee expressed support for the Strategy and Plan of Action on Mental Health, which was seen as means of achieving international and regional mental health goals, promoting good mental health and preventing mental health disorders, and strengthening access to mental health services. Several delegates described their countries' experiences in providing mental health services and expressed their willingness to collaborate with other Member States on mental health initiatives. The need for technical cooperation, including technical cooperation among countries, for mental health programs was emphasized, as was the need to mobilize financing for such programs. Support was expressed for the proposal in Annex F of the document to form partnerships with other international agencies in order to mobilize financing.

122. The reference in Strategic Area 2 to healthy settings such as schools and communities was welcomed and attention was drawn to the importance of the workplace as a focal area for detection and intervention of mental health disorders. The document's recognition of the issue of co-morbidity in mental health patients was commended. The cross-cutting nature of mental health problems was highlighted and the need to integrate interventions across different settings and age groups was underscored.

123. Strong support was expressed for community-based mental health models and culturally specific approaches, particularly for indigenous peoples. The need for research on mental health of indigenous populations was emphasized, and it was suggested that paragraph 2(g) of the proposed resolution on this item should call for research with an intercultural approach. Support was also voiced for the proposal under activity 4.1.2 to create a regional working group to support the design of mental health training. The role that the WHO Collaborating Centers in the Region could play in that regard was highlighted.

124. Data collection and epidemiological surveillance with regard to mental health were considered essential. Having accurate data on the mental health issues affecting young people was viewed as especially important and the value of sharing experiences and best practices with regard to substance-abuse prevention among youth was emphasized.

125. The Committee expressed some concerns with regard to specific aspects of the Plan, notably some of the indicators. Those relating to comprehensive assessment of health systems and improvement of national information systems and to Strategic Area 3 were cited as examples. It was suggested that each country should select the indicators that were most representative of its particular circumstances. It was also pointed out that there was no reference in the document to the mental health risks associated with the growing number of older persons caring for other older persons, and it was suggested that that issue should be taken into account when the document was revised. Some delegations indicated that they would submit additional comments on the Plan in writing.

126. Noting that the Strategy and Plan of Action was based on a general view of the Region, one delegate said that, in order to avoid automatic extrapolation of concepts, models of care, and institutional structures, each country should assess its own mental health system, using the standardized methodology of WHO if it wished. Her Government did not consider proposed national-level activity 1.1.4 to be appropriate because it would constitute an interference in the public policies of a country and because it went beyond the specific objective of PAHO, which was to provide technical support for local efforts.

127. Dr. José Luis Di Fabio (Area Manager, Technology, Health Care, and Research, PASB) thanked delegates for their suggestions regarding the Plan of Action and their willingness to work with the Bureau in improving the indicators.

128. Dr. Jorge Rodríguez (Senior Advisor, Mental Health, Disabilities, and Rehabilitation, PASB) said that in preparing the Strategy and Plan of Action, the Bureau had received information and contributions from many Member States, as well as from Collaborating Centers and other organizations. Ongoing input from Member States would be important not only in refining the Plan of Action, but also in implementing it, drawing

on the experience of the countries of the Region. He acknowledged the value of horizontal cooperation and noted that some countries of the Region were already implementing such cooperation activities. He agreed that some of the indicators needed refining; the issue was a complex one, given the huge information gap, which made it difficult to have adequate indicators for all countries. Strategic Area 5 of the Plan of Action was aimed precisely at reducing that gap. The Plan also sought to reduce the gap in resources, the majority of which were still concentrated in mental hospitals. He also agreed that mental health was a cross-cutting issue and that inter-programmatic approaches were needed. Such approaches, he noted, could facilitate the mobilization of resources. The integration of mental health into general health systems would be key in the process of modernizing mental health services.

129. The Committee adopted Resolution CE144.R8, subject to revision of the Plan of Action before the forthcoming session of the Directing Council.

Plan of Action on Adolescent and Youth Health (Document CE144/13, Rev. 1)

130. The President drew attention to Document CE144/13, Rev. 1 and opened the floor for discussion.

131. Delegates expressed support for the Plan of Action and described some of the adolescent and youth health initiatives being carried out in their countries. The Plan's integrated and inter-programmatic approach was applauded. Several delegates pointed out that there were clear overlaps between this Plan of Action and other strategies, plans, and initiatives for the Region and stressed the need for PASB and country offices to ensure ongoing coordination and fluid communication across all programs, as well as to work with other agencies of the United Nations system in implementing the Plan. The importance of integrating donor-funded activities, pooling resources, and harmonizing instruments was emphasized.

132. One delegate was pleased to note that the United Nations Convention on the Rights of the Child formed the foundation for the Plan of Action and encouraged an emphasis on youth engagement. Another delegate emphasized the need to recognize the rights and responsibilities of parents and other persons legally responsible for adolescents to provide appropriate direction and guidance on sexual and reproductive matters, physical activity, diet, and the risks of substance abuse and other behaviors. He also pointed out that schools could make a significant contribution to the health and well-being of young people.

133. The Delegate of Mexico appealed to PAHO to help countries combat the influence of powerful multinational corporations whose products, including alcohol and tobacco, had a detrimental effect on the health of minors. He also noted that his country would have difficulty working with the 10 to 24-year age range proposed in the Plan of

Action, since his country's Ministry of Health applied different age criteria in its programs targeting young people.

134. A number of suggestions were made with regard to specific targets and indicators of the Plan of Action. Several amendments to the proposed resolution on the item were also proposed. In particular, the need to ensure consistency in the usage of the terms "adolescent," "youth," and "young people" was emphasized, as was the need to clearly identify which groups were being targeted by proposed activities. In that connection, one delegate suggested that some of the terms and acronyms mentioned in the Plan of Action should be more clearly defined in an annex, including, for example, the terms "adolescent," "youth," and "high-impact country." Concern was expressed that some of the targets, while laudable, might be too ambitious for PAHO to tackle alone, such as the one relating to reduction of deaths from road traffic accidents, for example. Several delegations indicated that they would submit additional comments and suggestions in writing.

135. The Representative of the United Nations Population Fund commended PAHO for its leadership on adolescent and youth health, noting that it had played a crucial role in facilitating coordination among the various United Nations agencies. She reviewed some of the ways in which UNFPA had been working with PAHO over the years in promoting adolescent and youth health and stressed the need for programs to respond to the special physical and mental health needs of young people in the 20-24 age group.

136. Dr. Gina Tambini (Area Manager, Family and Community Health, PASB) said that the Plan of Action had been developed in a participatory process with stakeholders, PASB staff, United Nations agencies, subregional and national counterparts, and adolescents and young people themselves. PAHO was making every effort to ensure that technical advisors at country level worked in a more integrated fashion so as to facilitate coordination on issues that were important to the countries, especially in connection with the Millennium Development Goals and actions for vulnerable populations, including youth and adolescents.

137. Replying to a comment about resources for implementing the Plan, she said that PAHO attached great importance to Strategic Objective 4 of the Organization's Strategic Plan. Efforts were being made to strengthen financial support for that objective, especially through extrabudgetary resources. The Bureau was committed to working with all the countries of the Region with a view to sharing experiences and identifying opportunities for horizontal cooperation. Coordination was a big challenge, but progress was being made with new management models. The Plan of Action would enable countries and organizations to work together even more closely. The establishment of horizontal groups throughout the Bureau would also facilitate an integrated approach.

138. Dr. Matilde Maddaleno (Senior Advisor, Adolescent Health, PASB) said she had taken note of the recommendations made by delegates. She realized the Plan of Action was very ambitious, but its great strength lay in the fact that it was based on interagency agreement. PAHO staff had met with representatives of all the United Nations agencies in the Region, which had agreed on the action to be taken and on the financing of the Plan. Thanks to the pooling of resources for the first Caribbean survey, around \$1 million was currently available. Although those funds would not come directly to PASB, the agencies involved would be placing resources in different countries for the second Caribbean survey. In addition, \$9 million was available in Honduras for a project on sexual and reproductive health that would be carried out jointly by UNFPA, the United Nations Children's Fund (UNICEF), and PASB. The Bureau was working with the Spanish cooperation agency on an initiative for indigenous youth. Referring to the concern expressed about age ranges, she explained that the agencies involved were working to reach consensus on the ages to be used for program and reporting purposes.

139. Dr. Socorro Gross (Assistant Director, PASB) observed that the Plan of Action was particularly important at the present juncture, considering, on the one hand, the Region's "demographic bonus" and, on the other, the high rates of maternal mortality, HIV/AIDS infection, and intentional and unintentional injuries and suicides among adolescents and youth.

140. The Committee adopted resolution CE144.R6 on this item.

Plan of Action for Implementing the Gender Equality Policy (Document CE144/14)

141. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration), introducing the item, reported that the Subcommittee had welcomed the Plan of Action, considering it comprehensive, innovative, and well thought-out, although members had also noted several areas in which the Plan might be strengthened. In particular, it had been felt that some of the proposed indicators should be clarified, expanded, or refocused. The Bureau had been encouraged to identify indicators developed by other international organizations or by national entities that might be of use in monitoring progress in implementing the Gender Equality Policy. The need to ensure that indicators were comparable across countries had been underscored, as had the need to identify indicators that might serve as a basis for decision-making. Several delegates had noted that the proposed Plan of Action offered ample opportunity for collaboration between countries and had emphasized the value of sharing experiences and lessons learned in gender equality initiatives carried out at country level.

142. The Executive Committee voiced solid support for the proposed Plan of Action, which was viewed as a comprehensive framework for continued work towards gender equity by both the Pan American Sanitary Bureau and Member States. The Plan's strategic areas were considered clear and feasible and its potential contribution to the

achievement of the Millennium Development Goals and other gender equality goals was recognized. The Committee emphasized the need for both PAHO and Member States to allocate sufficient resources and to ensure the necessary infrastructure and capacities to implement the Plan. Several delegates described policy and legislative initiatives in their countries aimed at achieving gender equality in reproductive health and other areas.

143. PAHO's leadership with regard to gender equality in health, as described in Annex A-2 to Document CE144/14, was applauded. It was pointed out that two members of the Executive Committee—Bolivia and Mexico—had previously won PASB's competition for mainstreaming gender in the health sector. The competition was welcomed as a means of sharing successful experiences and building the Organization's best practices database on gender mainstreaming.

144. Several further refinements of the indicators in the Plan of Action were suggested. For example, indicators designed to assess the quality of the proposed activities should be incorporated. In the case of the indicators for objective 1.1, an indicator to assess the quality of the gender analysis undertaken in the 2012 edition of *Health in the Americas* might be added. It was felt that further work should also be done on the indicator relating to the contributions of unpaid health care in national health accounts in order to specify the precise nature of those contributions and how they would be reflected in the accounts. It was also suggested that some indicators should be refocused: the indicator on tools for gender and health analysis under objective 2.1, for example, should measure not just how often such tools were accessed but should assess whether they were beneficial to the user and led to actual improvements.

145. The Delegate of the United States of America suggested that the Bureau and Member States might wish to make use of his Government's Quick Health Data Online system (www.healthstatus2010.com/owh/), which was a useful tool for quickly obtaining and analyzing data on gender, race, ethnicity, age, and other demographic variables for use, inter alia, in policy-making.

146. With a view to promoting a "One UN" approach to mainstreaming gender in public policies, the Delegate of Suriname suggested that a new operative paragraph should be added to the proposed resolution on this item, calling on both Member States and the Director to promote and strengthen partnerships with other United Nations agencies and with other organizations to support the implementation of the Plan of Action.

147. Dr. Marijke Velzeboer-Salcedo (Senior Advisor, Gender, Ethnicity, and Health, PASB) thanked the Committee for its support of the Plan of Action, noting that the Bureau had consulted widely with representatives of Member States in drawing up the Plan, which was flexible and could be modified and refined as needed as it was being implemented. The Bureau was aware that some of the indicators remained weak and was

working to strengthen them. In the case of the indicator relating to national health accounts, a meeting was planned with some of the “big thinkers” on the issue in order to design a strategy for incorporating the contribution of unpaid labor. That strategy was expected to yield better indicators.

148. She agreed that it was important to include indicators for measuring the impact of activities undertaken. As one example of such impact, she cited a gender analysis training initiative carried out in the Caribbean, which had resulted in a profile of HIV infection with a gender perspective, which would be used to enhance public policies on HIV/AIDS. With regard to the indicator relating to gender analysis in PAHO’s flagship publication, *Health in the Americas*, she noted that the regional volume had received high marks in a WHO assessment of the 2007 edition, but the country chapters had been found to be lacking in data disaggregation and analysis of information from a gender and ethnicity perspective. The Bureau was working to remedy those shortcomings in the 2012 edition.

149. She congratulated Bolivia and Mexico for winning the gender mainstreaming competition, noting that Bolivia had received the award twice, and encouraged all Member States to continue contributing their experiences to the Organization’s best practices database.

150. Lastly, she welcomed the amendment proposed by Suriname and assured the Committee that PAHO was working closely on gender mainstreaming with other agencies in the United Nations system.

151. The Director said that the Organization was also working with other organizations in the inter-American system and with a network of NGOs involved in issues relating to gender mainstreaming and the empowerment of women. She welcomed the work under way at the national level aimed at advancing gender equality in health. The people involved in those initiatives would be valuable partners with the Bureau in implementing the Plan of Action.

152. The Committee endorsed the Plan of Action, adopting Resolution CE144.R4.

Policy Framework for Human Organ Donation and Transplantation (Document CE144/15, Rev. 1)

153. The President drew attention to Document CE144/15, Rev. 1 and opened the floor for discussion.

154. The Committee welcomed PAHO’s efforts to develop a policy framework for human organ donation and transplantation and stressed the need for strong regulatory systems based on ethical principles in order to ensure the safety of organ recovery and transplantation and equitable access to donated cells, tissues, and organs. The importance

of discouraging organ commercialism and promoting altruistic donation was also underscored, as was the importance of achieving national self-sufficiency in organ donation. Delegates emphasized the need to encourage deceased donation while also ensuring protection and post-transplant monitoring and care for living donors.

155. One delegate questioned the emphasis in the document and proposed resolution on the guidelines and recommendations of the Ibero-American Network/Council on Donation and Transplantation (RDCIT), pointing out that not all Member States of PAHO belonged to RDCIT. She encouraged the Bureau to base the policy framework on WHO's revised Guiding Principles on Human Cell, Tissue, and Organ Transplantation. She also pointed out that many of the European countries mentioned in paragraph 4 of the document, whose organ donation rates PAHO Member States were encouraged to attain, had presumed consent policies, unlike many countries in the Americas. She felt that PAHO Member States should be encouraged to increase their donation rates by raising awareness, promoting the training of transplant coordinators, and other measures.

156. The Delegate of Haiti asked why paragraph 2(f) of the proposed resolution referred specifically to the English-speaking Caribbean countries instead of to the Caribbean countries in general. He also asked whether the references in the resolution to "human cells" should be understood to include embryonic stem cells. Bearing in mind that the use of such cells was still a subject of heated debate around the world, he believed that the text of the resolution should clearly state that the reference to human cells did not include embryonic cells.

157. The Committee expressed solid support for the WHO Guiding Principles on Human Cell, Tissue, and Organ Transplantation; however, some members were of the view that, as the Sixty-second World Health Assembly had postponed consideration of the revised Guiding Principles until 2010, it would be premature for the PAHO Governing Bodies to adopt a resolution on the matter. One delegate inquired whether, if the 49th Directing Council were to adopt a resolution, it would be necessary to adopt another one after the Guiding Principles were approved by the Health Assembly.

158. Dr. José Luis Di Fabio (Area Manager, Technology, Health Care and Research, PASB) noted that the revised Guiding Principles had been discussed by the WHO Executive Board and a resolution adopted. When the Bureau had drawn up its document and proposed resolution, it had been assumed that the Executive Board document and resolution would go to the World Health Assembly for approval in May 2009. As members were aware, that had not happened. However, given the importance of the issue, it had been considered advisable to proceed with the discussion of the matter within PAHO and to put forward a proposed resolution that would provide a framework for ongoing work by both the Bureau and Member States. The Committee might, of course, decide to postpone the adoption of a resolution at the regional level until after the World Health Assembly had approved the revised Guiding Principles. In any case, PAHO would

continue to provide support to Member States with regard to organ donation and transplantation, emphasizing in particular the need to put in place appropriate legal measures based on the Guiding Principles in order to regulate organ donation and transplantation and ensure equitable access to donated organs. As to whether a new resolution would be necessary in 2010, he did not think so because the Guiding Principles referred to in the resolution already existed, having been adopted in 1991. The World Health Assembly would simply be approving updates to the Principles.

159. He clarified that the reference in the resolution to “human cells” did not include embryonic stem cells, precisely because that issue was still under discussion, and said that the reference to “English-speaking Caribbean countries” would be changed to refer to all Caribbean countries.

160. The Committee adopted resolution CE144.R12 on the item.

Health and Tourism (Document CE144/16)

161. The President drew attention to Document CE144/16 and opened the floor for discussion.

162. The Committee stressed the importance of tourism to the sustainable development of countries in the Region, especially in the light of the present international economic crisis, the H1N1 influenza pandemic, and the emergence and reemergence of other communicable diseases such as dengue. It also acknowledged the role of tourism as a means to create wealth and thereby improve the health of individuals in tourist areas. The relevance of PAHO’s initiative on health and tourism to the Declaration of Commitment of Port of Spain on securing citizens’ future by promoting human prosperity, energy security, and environmental sustainability, adopted recently by the Fifth Summit of the Americas, was noted.

163. Health tourism, especially transplant tourism, was identified as an issue that raised some serious concerns with regard to equity and access to health care. The Delegate of Argentina noted that the countries of the Common Market of the South (MERCOSUR) had signed an agreement aimed at halting and sanctioning tourism undertaken for the sole purpose of obtaining transplants. She also underscored the need to raise awareness among tourists of the need to take precautions in order to avoid potential health risks, particularly when traveling abroad, where they might not have ready access to health care.

164. Some delegates felt that the document on this item lacked clarity and focus and recommended that it be revised and made more explicit before it was submitted to the Directing Council. It was suggested, for example, that definitions of terms such as “tourist health” and “health tourism” were needed and that the link between the overall situation analysis and the proposal to establish a regional forum on health tourism should

be clarified. In relation to the latter, it was pointed out that while the functions of the forum were broadly outlined, the document did not indicate how the various issues mentioned might be addressed. It was also pointed out that the proposed resolution requested the Director to draw up a regional plan of action, but the document did not propose any tentative objectives, indicators, or activities for such a plan. It was emphasized that any plan of action eventually formulated should be linked to other stakeholders within the framework of the Organization of American States. One delegate, referring to paragraphs 4(b) and 4(e) of the document, said that the issue of sustainable tourism fell outside the purview of PAHO. Several delegates were of the view that the financial implications of the proposed resolution on this item had been seriously underestimated, particularly in the light of the influenza pandemic and its cost impact on tourist areas, and encouraged the Bureau to revise the budget figures prior to the Directing Council.

165. Dr. Luiz A. Galvão (Area Manager, Sustainable Development and Environmental Health, PASB) thanked delegates for their comments and suggestions. The Bureau would study existing agreements and mandates in the field of health and tourism that might be useful in preparing the final version of the document. With regard to the mandate of PASB in the area of sustainable tourism, he referred to the health issues that were involved in making tourism sustainable, such as ensuring water safety and food quality. The Bureau would revise the document to make it clear that its support for sustainable tourism was only one aspect of its work on health and tourism. With regard to costs, he pointed out that the Bureau's work was aimed at supporting existing actions and facilitating regional dialogue, not technical intervention. That was why the cost estimates were modest; however, they would be revised in view of the impact of the influenza pandemic.

166. The Director said that the Organization's work was geared towards actions relating to the relationship between health and tourism; however, there were no plans to set up a special unit with a budget of its own. PAHO had been working with the Economic Commission for Latin America and the Caribbean (ECLAC) on adapting a methodology that was being used by international financial institutions to measure the economic impact of natural disasters. That methodology was being used to study the impact of the influenza pandemic, including its impact on the tourism sector. In its work on health and tourism, PAHO had partnered with other international organizations, including the World Tourism Organization, the Organization of American States, the World Bank, and various tourism associations and operators.

167. The Committee adopted resolution CE144.R14 on the item, subject to revision of the document in line with the comments and suggestions made by Committee members.

**Integrated Health Services Delivery Networks Based on Primary Health Care
(Document CE144/17)**

168. The President drew attention to Document CE144/17 and opened the floor for discussion.

169. The Executive Committee voiced solid support for the development of integrated health services networks based on primary health care (PHC), which were seen as a means of improving health status, reducing health inequities, extending coverage, enhancing quality of care, and containing health care costs by reducing reliance on costly secondary and tertiary care. The contribution that such networks could make to the achievement of the health-related Millennium Development Goals was also noted. The importance of making health care available close to where people live was stressed. Several delegates described their countries' efforts to ensure universal access to health care through integrated networks of primary health care services. It was emphasized that any strategy to improve health systems should be based on the best evidence available.

170. While the problems of segmentation and fragmentation were acknowledged, it was pointed out that the value of public-private partnerships should not be underestimated, as they could help reduce costs and expand coverage. The Global Fund to Fight AIDS, Tuberculosis, and Malaria was cited as an example of a successful public-private partnership.

171. PAHO was encouraged to synergize its work in this area with that of WHO and to build on existing strategies and frameworks, such as the WHO framework for action set out in the publication *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, the Making Health Systems Work series and the *World Health Report 2008: Primary Health Care—Now More than Ever*.

172. With regard to the document and the proposed resolution on this item, it was felt that the definition of "integrated health services delivery network" in the document should be strengthened and the examples clarified. It was also suggested that the term "appropriate care" should be explained. One delegate, noting that paragraph 10 of the document seemed to reflect a possible shift away from priority disease-centered programs, emphasized that such programs should remain a part of inclusive efforts to improve health for all. Another delegate underscored the need to set clear targets and indicators in order to be able to measure progress in strengthening health systems through the development of integrated health services networks. A third delegate suggested that, rather than referring to gender equity, the document should refer more broadly to non-discrimination, equity, and social justice, which would encompass the concept of gender equity. The same delegate also suggested that the examples of policy instruments and institutional mechanisms for the creation of integrated health service delivery networks should include examples relating to the social determinants of health. Emphasizing the

crucial importance of human resources for the successful implementation of integrated networks, he highlighted the need for attention to equity issues, such as gender gaps in salaries. In the light of the Committee's discussion of family and community health (see paragraphs 199 to 205 below), one delegate suggested that the proposed resolution should encourage Member States to prepare a national plan of action promoting the creation of integrated health services networks with a family and community health approach as the preferred modality for health services delivery.

173. Dr. Hernán Montenegro (Senior Advisor, Health Systems and Social Protection, PASB) explained that Document CE144/17 was an abridged version of a much longer position paper, which provided more comprehensive information, including definitions of terms. The Bureau would revise the document to be submitted to the Directing Council in the light of the Committee's comments and would endeavor to expand and clarify some of the definitions. However, with regard to the definition of "integrated health service delivery network," the term was difficult to define, partly because a number of different definitions existed in the literature on the subject. The one that appeared in Document CE144/17 was adapted from the work of Stephen Shortell, a noted expert on the subject. It had been discussed and endorsed by participants in the various national, subregional, and regional consultations mentioned in paragraph 7 of the document.

174. The definitions in the document had deliberately been kept fairly broad and general so that they would be flexible enough to accommodate the differences in the organization and management of health services in the various countries of the Region. What constituted "appropriate care," for example, would vary from country to country, but in general the term meant that care was provided in a timely manner in an appropriate setting by appropriate personnel using appropriate technology.

175. Although the document was not intended to be, or to lead to, a plan of action—precisely because Member States' characteristics and needs differed widely—the Bureau would attempt to identify some generic indicators, as suggested by the Committee. The purpose of the document was to propose a strategy for operationalizing the renewal of primary health care at the health services level and thus putting into practice the primary health care principles set out in the *World Health Report 2008* and in various World Health Assembly resolutions. The proposal put forward in Document CE144/17 was intended to contribute, in particular, to the implementation of Resolution WHA62.12 in the Region, including the resolution's emphasis on universal access and on people-centered health care.

176. As the document noted (in paragraph 18), not much empirical evidence on the outcomes of integrated care models existed, especially in low- and middle-income countries. Nevertheless, the Bureau was working to identify best practices and build an evidence base, through, inter alia, 11 case studies currently under way in various countries. He therefore welcomed delegates' reports of their countries' experiences and

encouraged other Member States also to share the lessons learned from their experiences with the development of PHC-based integrated health systems.

177. He agreed fully on the potential value of public-private partnerships. As was stated in paragraph 16 of the document, the integration of networks made it possible to form a number of partnerships among health care providers, including public and private providers and even providers in other countries in the case of border regions or the shared-services arrangements that existed among some Caribbean countries.

178. Regarding human resources for integrated networks, he noted that new competencies would be needed, such as the ability to work in multidisciplinary teams, and new positions would have to be created, such as that of integrated care manager. More importantly, the available evidence showed that an integrated care network would not work well if the staff did not feel valued, which meant ensuring that they had adequate working conditions and fair salaries, as well as the opportunity to participate in decision-making within the network.

179. The Director observed that the education of health professionals was a lengthy process and therefore a long-term vision would be needed in order to train human resources and develop the competencies needed for an integrated care model. Nevertheless, the health systems of the Americas did not necessarily suffer from a lack of resources; rather, they suffered from an excess of waste and missed opportunities, owing to the extreme segmentation and fragmentation that characterized the systems.

180. The Bureau's aim in drawing up the document and the longer position paper on which it was based had been to provide a conceptual framework for the strengthening of health systems based on primary health care. The integration of health services was seen as an important aspect of that effort. In addition, consistent with the life-cycle approach of numerous strategies and plans of action adopted recently by the Organization's Governing Bodies, it had been considered important to explore the best ways of organizing health services in order to address the various health needs and health determinants of different population groups.

181. The Committee adopted Resolution CE144.R7 with the amendment relating to family and community health.

Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME) (Documents CE144/18; CE144/18, Rev. 1; and CE144/18, Add. I)

182. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had heard an update during its Third Session on the status of the development of a new institutional framework for BIREME. The proposed new framework comprised three legal instruments—a Statute, a

Headquarters Agreement, and a Facilities Agreement—and was intended to put in place a new governance structure and ensure a stable and balanced source of financing for BIREME's work. The Subcommittee had examined a draft of the Statute. However, as some Subcommittee members had felt that they had not had sufficient time prior to the session to review the draft Statute, it had been suggested that the discussion should continue electronically via SharePoint. The feedback received in the course of that electronic discussion had been incorporated into the revised Statute attached to Document CE144/18, Rev. 1.

183. Dr. Heidi Jiménez (Legal Counsel, PASB) said that the Bureau had worked closely with the Government of Brazil and with various other interested parties in formulating and revising the proposed Statute currently before the Committee, which did indeed include the modifications suggested by Member States following the Third Session of the SPBA. The Bureau was confident that the Statute would provide a solid legal basis for the Center's governance. The Committee was invited to consider the Statute and to forward it to the Directing Council for approval in September 2009.

184. In the ensuing discussion, several amendments were proposed to articles IV (Membership), VI (Advisory Committee), VII (Scientific Committee), and VIII (Secretariat) of the draft Statute.

185. The Delegate of Brazil welcomed the development of a sound institutional framework for the governance, management, and financing of BIREME and affirmed her Government's strong commitment to support the work of the Center in the future. Throughout its 42-year history, the Center had served as an instrument for the sharing and dissemination of health information. It had vastly improved access to scientific information for health professionals and policy-makers in the countries of Latin America and the Caribbean and had also enhanced countries' capacity for the production of such information. By facilitating and democratizing access to information through its Virtual Health Library, BIREME had helped to reduce inequities and bridge the gap between developing and developed countries, thereby also contributing to the achievement of the Millennium Development Goals in the Region. BIREME was an important strategic resource, which should be strengthened. The Government of Brazil believed that the Americas should formulate a regional health information policy, drawing on BIREME's experience and successes.

186. The Director affirmed that the PAHO's 42 years of collaboration with the Government of Brazil through BIREME had been very fruitful. Not only had the Center provided technical cooperation, built capacity, and increased access to scientific and technical information, it had made an invaluable contribution to the development and standardization of Spanish and Portuguese terminology in the field of health, benefiting not only the countries of the Americas but also countries in Africa and other regions. It had also played a crucial role in the development of the WHO Global Health Library.

187. Dr. Jiménez suggested that she should meet with the delegation of Brazil and other interested delegations in order to revise the Statute and incorporate the proposed modifications. She subsequently announced that the following amendments had been made: In Article IV, paragraph 1, the terms “participating states and associate members” had been deleted in order to clarify that the Member States of BIREME were all the Member States of PAHO. In Article VI, paragraph 4(k), the word “permanent” had been deleted from “permanent members,” the intent being to make it possible for any member of the Advisory Committee to request that the Director convene a special session of the Committee. In Article VII, paragraph 1, the phrase “in their individual capacity” had been deleted. The aim of that change was to clarify that experts who were currently working for government agencies could serve as members of the Scientific Committee. However, those experts were appointed as specialists. Accordingly, the last sentence of the paragraph would read: “Members of the Scientific Committee shall be appointed as specialists and rotated every three years.” Those changes were reflected in Document CE144/18, Rev. 1.

188. The Executive Committee adopted Resolution CE144.R24, recommending that the 49th Directing Council approve the new institutional framework for BIREME, including the proposed Statute, as contained in Document CE144/18, Rev. 1.

Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (Documents CE144/19, Rev. 1, and CE144/19, Add. I, Rev. 1)

189. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had been informed that, in January 2009, the INCAP Directing Council had resolved to assume full responsibility for the administration of the Institute, effective September 2009, and to amend the Basic Agreement of INCAP accordingly. The Subcommittee had also been informed that the Director had established several working groups to address the various technical, administrative, and legal aspects of the transfer of administrative responsibility, with a view to ensuring a smooth transition and preserving the Institute’s functionality and leadership in the areas of nutrition and food security. The Subcommittee had taken note of the report and the decision by the Directing Council of INCAP to assume responsibility for autonomous administration of the Institute as of September 2009.

190. Dr. Socorro Gross (Assistant Director, PASB) said that Document CE144/19, Rev. 1, provided an update on progress in the institutional reform process since the March session of the SPBA. Most of the key documents for the transfer of administrative responsibility to the INCAP Directing Council had been approved, although the document establishing the terms of reference and procedure for selecting the next Director of INCAP was still being finalized. The Executive Committee was asked to

adopt a resolution recommending that the 49th Directing Council approve the transfer of responsibility for management of INCAP to its Directing Council.

191. The Director noted that, pursuant to a recommendation of the external auditor for PAHO, who had also served as the external auditor for INCAP, as part of the transfer of administrative responsibility the Institute would be appointing its own auditor.

192. The Executive Committee took note of the report and adopted Resolution CE144.R20, recommending that the Directing Council of PAHO approve the transfer of the administration of INCAP to its Directing Council.

**Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment
(Document CE144/20)**

193. The President drew attention to Document CE144/20 and opened the floor for discussion.

194. The Executive Committee expressed firm support for the Plan of Action. Several members noted that it was fully in line with their national plans and strategies for preventing blindness and visual impairment and several described programs under way in their countries. The importance of intercountry cooperation in this area was highlighted, with several delegates expressing gratitude for the assistance their countries had received through the Cuban eye surgery initiative Operación Milagro (Operation Miracle).

195. One delegate inquired why the Plan established a specific goal with respect to retinopathy of prematurity, noting that the issue was not explicitly addressed in the WHO Action Plan for the Prevention of Preventable Blindness and Visual Impairment (WHO Document A62/7). The Delegate of Suriname, noting that persons of Asian descent were at highest risk of diabetic retinopathy in his country, suggested that objective 1.2.2 in the Plan, which identified Hispanics and persons of African descent as high-risk groups, should be made more generic by amending to read “high-risk groups of certain ethnic origins, depending on the country.” Several delegates indicated that they would submit written comments on the document as well as additional information on their national blindness prevention initiatives.

196. Dr. José Luis Di Fabio (Area Manager, Technology, Health Care, and Research, PASB), thanking the Committee for its support of the Plan of Action, observed that prevention of blindness and visual impairment was part of the unfinished agenda of health problems in the Region, particularly considering that 80% of blindness was either preventable or curable with existing technologies.

197. Dr. Juan Carlos Silva (Regional Advisor for the Prevention of Blindness, PASB) explained that retinopathy of prematurity caused more than half of childhood blindness in Latin America and the Caribbean and for that reason it had been identified as a priority

under the Plan of Action, which had been developed in consultation with experts from numerous countries of the Region. Thanking the Delegate of Suriname for his suggestion, he said that the Bureau would remove the reference to specific ethnic groups in objective 1.2.2. He affirmed that intercountry cooperation was an important component of the Plan.

198. The Executive Committee adopted Resolution CE144.R9, recommending that the Directing Council approve the Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment.

Family and Community Health (Document CE144/21)

199. The President drew attention to Document CE144/21 and opened the floor for discussion.

200. The Executive Committee welcomed the inclusion of the topic of family and community health on the agenda of the Governing Bodies in 2009 and highlighted the cross-cutting nature of the item and its linkage with other matters discussed by the Committee, including health of older adults, health of adolescents and youth, and strengthening of health systems based on primary health care. Delegates stressed the importance of strengthening health services to respond to specific needs of individuals at different stages of their lives and in the context of their families and communities, and also emphasized the importance of strengthening health outreach services through multidisciplinary teams of health workers. It was pointed out that the concept of family and community health would provide an opportunity for many countries to move from a traditional vertical approach to health care to a more integrated horizontal one. One delegate stressed the importance of evaluating both the health and economic impacts of family and community health models in countries in the Region in the light of health reform initiatives currently under way, and underlined the value of sharing successful experiences and best practices. Several delegates described their countries' experiences in developing and strengthening such models and offered to provide information on those experiences to the Bureau and to other countries in the Region.

201. Community-based health care was considered the best way of promoting health and strengthening disease screening, detection, and monitoring, as well as encouraging adherence to treatment. In relation to health promotion, one delegate noted the importance of focusing on both positive determinants of health and negative ones, in particular alcohol consumption and road traffic accidents. He emphasized the fundamental role of community and family action in addressing such risks, especially among adolescents and young people.

202. The family and community health approach was seen as particularly important in the prevention and control of chronic noncommunicable diseases; however, it was pointed out that such diseases were not mentioned in Annex A of Document CE144/21 and it was suggested that Strategic Objective 3 of the PAHO Strategic Plan 2008-2012

should be included among the objectives that would be strengthened and supported by the work to be carried out in this area. It was also suggested that both the document and the proposed resolution on this item should recognize the importance of gender and intercultural approaches in family and community health services.

203. The Representative of the United Nations Population Fund stressed the importance of intercultural approaches in order to address the health needs of indigenous peoples, particularly the reproductive health needs of indigenous women. She also highlighted the importance of encouraging male co-responsibility in the home as a crucial factor in preventing violence and promoting sexual and reproductive health.

204. Dr. Gina Tambini (Area Manager, Family and Community Health, PASB) said she was encouraged by the support expressed for the family and community health approach and thanked delegates for their comments and suggestions, which would help the Bureau to enhance its work in that area. Identification of successful experiences and best practices had formed the basis for the approach put forward in the document, and the Bureau intended to continue facilitating exchanges of experiences among countries. The Bureau saw the family and community health approach as a cross-cutting line of action and agreed that such an approach was important for strengthening health systems and services based on primary care. She stressed the need for a people-centered approach aimed at enhancing the well-being and empowerment of individuals, families, and communities and enabling them to become advocates for and active participants in fostering health.

205. The Committee adopted resolution CE144.R5 on this item, endorsing comprehensive and intercultural family and community health approaches.

The Pan American Health Organization Revolving Fund for Vaccine Procurement (Document CE144/22, Rev. 1)

206. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had discussed a document on all PAHO procurement mechanisms, including the Revolving Fund for Vaccine Procurement. The Subcommittee had been informed that a working group had been established in 2008 to facilitate coordination of PAHO's immunization activities with those of the GAVI Alliance, particularly in relation to the introduction of new vaccines in poor countries and populations in the Region. In the discussion that followed, Subcommittee members had voiced solid support for PAHO's procurement mechanisms, especially the Revolving Fund for Vaccine Procurement. It had been acknowledged that the Revolving Fund had helped the Region to attain high immunization rates, reduce morbidity and mortality from vaccine-preventable diseases, and achieve disease eradication and elimination goals, and that it had also facilitated the introduction of new vaccines.

207. The Delegate of the United States of America, noting that his Government had requested that this item be included on the agenda of the Governing Bodies in 2009, had said that, in his view, the crucial issue with regard to the Revolving Fund was how it fit into the new global health architecture and, especially, its relationship with GAVI. He had underlined the need to ensure that the Revolving Fund and GAVI were not working at cross purposes and had requested that the Bureau revise the document prior to the 144th Session of the Executive Committee, focusing specifically on the Revolving Fund and its relationship with other international organizations for health, in particular the GAVI Alliance.

208. Other members of the Subcommittee had questioned the value of a discussion of the Revolving Fund by the PAHO Governing Bodies, since in their view the Fund had been, and remained, satisfactory. However, it had been pointed out that there appeared to be some nuances to the matter that were not clear to all Member States, and that such a discussion might lead to greater transparency and clarity in regard to the issues involved. The Director, while welcoming the opportunity to discuss PAHO's partnership with GAVI, had suggested that it might be preferable to hold technical discussions on the subject or convene a special meeting of interested parties, including vaccine suppliers.

209. After further discussion, the Subcommittee had agreed that the matter would be placed on the agenda of the Executive Committee; that an informal technical discussion would be held outside the formal session, with participation by other partners, including representatives of GAVI; and that the item would then be discussed by the Executive Committee in formal session.

210. Dr. Socorro Gross (Assistant Director, PASB) introduced Document CE144/22, Rev. 1, noting that it outlined the history, features, and conceptual principles of the Revolving Fund and its benefits for PAHO Member States. She then reported on some of the main points that had emerged from the special technical meeting on the Revolving Fund, held on 23 June 2009 (see Annex D). Highlighting some of the benefits of the Revolving Fund, she said that it ensured that Member States could purchase vaccines at the lowest available price and it provided predictability of demand, which in turn helped to boost production and foster stability and security in the vaccine market. The Fund also helped to reduce the time lag between production of a new vaccine and its introduction into the immunization programs of Member States. It had proved crucial to national and regional strategies for the elimination and control of vaccine-preventable diseases and the response to epidemiological emergencies.

211. Turning to the special technical meeting, she reported that participants had expressed solid support for the Revolving Fund as a means of ensuring universal access to high-quality vaccines at the lowest available price. The continued operation of the Fund had been considered crucial to the introduction of new vaccines. Much of the discussion had centered around the pneumococcal conjugate vaccine; the respective roles

of the Revolving Fund, the GAVI Alliance, and the Advance Market Commitment mechanism in making it available to countries in the Americas and elsewhere; and a supposed conflict associated with a clause in the Revolving Fund procurement contract.

212. She explained that there were two types of pneumococcal vaccine: the polysaccharide vaccine and the conjugate vaccine. The pneumococcal polysaccharide vaccine, which had been introduced in 2006, was not recommended for children under 2 years of age; it was administered mainly to people over the age of 65 and people with chronic and immunosuppressive diseases. The conjugate vaccine was recommended for children under 2.

213. Currently, the 23-valent polysaccharide vaccine and the 7-valent conjugate vaccine were being procured through the Revolving Fund. The 7-valent conjugate vaccine was produced by only one manufacturer. A 10-valent conjugate vaccine, also produced by a single manufacturer, was also available but was not being purchased by PAHO, both because it had not yet been prequalified by WHO and because the Director had declared a one-year moratorium on its procurement during 2009. Moreover, the Region was awaiting the prequalification in 2010 of a 13-valent vaccine, which would be effective against substantially more of the pneumococcal virus strains circulating in Latin America and the Caribbean (84% versus 74% for the 10-valent vaccine and 60% for the 7-valent).

214. The one-year moratorium on procurement of the 10-valent vaccine through the Revolving Fund was related to the supposed conflict that had arisen with regard to a clause in the Fund's procurement contract, according to which vaccine suppliers agreed to sell vaccines to the Fund at the lowest available price. It was the 10-valent vaccine that had been selected as the target vaccine for the pilot of the Advanced Market Commitment mechanism in the countries that were eligible for funding from the GAVI Alliance.

215. In 2007 three of the six GAVI-eligible countries in the Americas had, with support from PAHO, formulated and submitted proposals for GAVI funding to purchase the 7-valent pneumococcal conjugate vaccine, and their proposals had been approved. Seven of the 36 eligible countries in the African Region and one of the six eligible countries in the Eastern Mediterranean Region had submitted applications for GAVI funding for the introduction of the pneumococcal vaccine, which had also been approved. The latter countries were seeking to introduce the 10-valent vaccine, not the 7-valent, because the latter did not offer protection against many of the virus strains circulating in Africa and the Eastern Mediterranean.

216. Despite the approval of their proposals, GAVI had declined to provide funding to the three eligible countries in the Americas for the purchase of the 7-valent pneumococcal conjugate vaccine through the Revolving Fund at the price negotiated with the supplier (\$26.35 per dose for 2008, \$21.75 for 2009). A PAHO-GAVI Working

Group had been set up to study the issue and enhance collaboration between the Organization and the GAVI Alliance with a view to facilitating the introduction of new vaccines and ensuring sustainable and universal vaccination coverage in the countries of the Americas.

217. In the discussion that followed Dr. Gross's presentation, delegates reaffirmed their countries' support for the Revolving Fund and underscored the importance of ensuring equitable access to high-quality drugs and vaccines at affordable prices. The importance of making new vaccines available through the Revolving Fund was also stressed. Concern was expressed about a statement in the document indicating that introduction of the rotavirus vaccine would double Member States' vaccine-purchasing costs and introduction of the pneumococcal vaccine would increase those costs sevenfold. Note was also taken of the delay in introducing the pneumococcal vaccine in the GAVI-eligible countries of the Region, and the Working Group was encouraged to work towards a prompt resolution of the situation causing that delay and to address related issues that might arise in the future when a vaccine was available from only one supplier. Delegates sought clarification of what those issues were and of the nature of the conflict surrounding the pricing clause in the Revolving Fund contract.

218. The Delegate of Suriname said that cervical cancer was a priority disease for his country and inquired when the vaccine against human papillomavirus (HPV), one of causes of the disease, was expected to be available through the Revolving Fund. The Delegates of Brazil and Uruguay expressed the view that, as there was currently insufficient scientific evidence of the cost-effectiveness of introducing the HPV vaccine, it should be removed from the list of vaccines slated for inclusion in the Revolving Fund in the near future.

219. The Delegate of the United States of America said that Dr. Gross's presentation with its emphasis on the pneumococcal vaccine, while interesting, did not get at the heart of the problem, which was that a clause in the Revolving Fund contract for tender obliged the tenderer to provide the lowest price anywhere in the world for the vaccine in question. However, in some cases the price that suppliers were willing to offer the GAVI Alliance might be lower than the price they were willing to offer the Revolving Fund for the PAHO Member States, many of which were middle-income countries. That was the problem that needed to be addressed. He had been very heartened during the technical meeting to hear the Director's assurances that she would find a way to resolve the issue, and he was confident that it would be relatively simple to do so by modifying the language of the clause in question in a way that would leave the Revolving Fund essentially unchanged and would enable manufacturers to offer a competitive price to PAHO without creating a disincentive to their offering a different price to other international institutions such as the GAVI Alliance.

220. Dr. Gross, recalling the Committee's discussion of the budget proposal for 2010-2011 (see paragraphs 35 to 62 above) and the concerns expressed by numerous delegates about the impact of the current economic crisis on their countries, said that, in her opinion, the present was not the time to change a contractual clause that sought to ensure the lowest available price for vaccines procured on behalf of PAHO Member States. Moreover, there was no reason to do so, since the provisions of that clause were not hindering the ability of countries in other regions to purchase the 10-valent pneumococcal conjugate vaccine at the price agreed for the Advance Market Commitment pilot. The one-year moratorium on procurement of the 10-valent vaccine had been established precisely in order to allow the Advance Market Commitment to go forward. That was why she had spoken of a "supposed" conflict: the vaccine at issue was not the vaccine that PAHO was procuring through the Revolving Fund, and PAHO would not attempt to procure the 10-valent vaccine even after the one-year moratorium ended because it was waiting for prequalification of the 13-valent vaccine.

221. The Working Group would, of course, continue looking for alternatives to facilitate the introduction of other new vaccines with sole suppliers that were expected to be prequalified by WHO in the near future. One was the dengue vaccine, which was of great interest to the countries of the Region. The Working Group would also continue working on other issues related to sustainability following the introduction of new vaccines.

222. The HPV vaccine had not yet been prequalified by WHO and therefore could not be procured through the Revolving Fund. According to the information currently available to the Bureau, the lowest market price at which the vaccine was currently available in the Region was \$30 per dose.

223. The Director observed that while introduction of the HPV vaccine might not be a priority for all countries of the Americas, prevention and control of cervical cancer was a regional priority. She understood that some Member States were still in the process of determining whether use of the HPV vaccine would be cost-effective, based on the human papillomavirus strains circulating in their national territories; however, others were anxious to introduce the vaccine as soon as possible. At the same time, introduction of the rotavirus and pneumococcal vaccines was not a priority for some countries because rotavirus and *Streptococcus pneumoniae* were not major causes of illness in their child population, but that did not mean that those vaccines should not be offered through the Revolving Fund.

224. Dr. Cuauhtémoc Ruiz (Senior Advisor, Comprehensive Family Immunization, PASB) added that PAHO was conducting studies of the potential cost-effectiveness of introducing the HPV vaccine in the Caribbean subregion, where the disease burden associated with human papillomavirus appeared to be particularly high. He also pointed out that the HPV vaccine was not intended to be a standalone measure, but rather part of

a comprehensive approach to cervical cancer prevention and control. Whether or not countries chose to introduce the vaccine, they would still need to continue carrying out health promotion and education activities and ensuring preventive screening.

225. The Delegate of the United States said that while it was true that the issue of the pricing clause in the Revolving Fund contract had arisen in relation to the pneumococcal vaccine, it might well arise again in relation to the introduction of other new vaccines. It was therefore important to resolve it in the most generalizable way possible. He inquired whether PAHO Member States might participate in the meetings of the PAHO-GAVI Working Group. He believed that they might be able to provide useful input on the various matters under discussion. His delegation, for example, would be pleased to suggest modified wording of the pricing clause in the Revolving Fund procurement contract with a view to finding a solution that would be satisfactory to the interests of the PAHO Member States and would achieve price parity for the countries of the Region purchasing through the Revolving Fund, while at the same time allowing for the smooth functioning of the GAVI Alliance and its potential financing of the introduction of new vaccines in other regions. It would also be helpful, he said, for Member States to see the terms of reference of the Working Group, as they would then have a clear understanding of the Group's objectives and would be in a better position to suggest creative ways of redirecting its work if it was not addressing the topics that Member States felt it needed to address.

226. The Director said that it had been difficult for her and the other PAHO staff involved to understand the problem that had arisen in relation to the pricing clause in the Revolving Fund contract and the introduction of the pneumococcal vaccine. Never before in the 30-year history of the Revolving Fund had that clause caused any problem with regard to the procurement of existing vaccines or the introduction of new ones. It had been difficult to understand the problem largely because there had been a lack of transparency on the part of some stakeholders; the Revolving Fund contract had been identified as a problem in discussions within the governance structures of the GAVI Alliance and the Advance Market Commitment—discussions to which PAHO had not been privy.

227. The situation as she now understood it was as follows: three of the six GAVI-eligible countries in the Region had submitted proposals for GAVI funding to enable them to introduce the 7-valent pneumococcal conjugate vaccine, and those proposals had been approved. Seven of the GAVI-eligible countries in Africa and one in the Eastern Mediterranean had also submitted proposals for GAVI funding, but those countries wished to introduce the 10-valent vaccine. The problem had arisen when the producer of the vaccine had declined to submit a bid to UNICEF (the vaccine procurement agency for all regions except the Americas) because it did not want to be obliged, in accordance with the Revolving Fund contract, to offer the vaccine to all countries in the Americas at the same price it had agreed to offer to GAVI-eligible countries participating in the Advance

Market Commitment pilot. At the same time, the GAVI Alliance had declined to provide financing to the eligible countries in the Americas for the purchase of the 7-valent vaccine at the price negotiated with the producer by the Revolving Fund (currently \$21.60 per dose), considering that price too high. Consequently, the GAVI-eligible countries in the Americas, although their proposals had been approved by GAVI, had not been able to introduce the pneumococcal vaccine.

228. That was why PAHO was focusing specifically on the issues surrounding the introduction of the pneumococcal vaccine, and it was those issues that the Working Group had been created to address. As to whether Member States could participate in the Working Group's deliberations, she could not speak for the other members of the Group, but PAHO, as an intergovernmental organization dedicated to transparency, certainly had no objection. Indeed, she would welcome participation by a representative of the United States Department of Health and Human Services, as such participation would serve to introduce a much-needed public health perspective into discussions that had thus far been dominated by lawyers and legal concerns.

Administrative and Financial Matters

Report on the Collection of Quota Contributions (Documents CE144/23 and CE144/23, Add. I)

229. Ms. Linda Kintzios (Treasurer and Senior Advisor, Financial Services and Systems, PASB), introducing the item, said that information updated to 15 June 2009 was presented in Document CE144/23, Add. I, and that since that date, the Organization had received further payments, of \$8,560 from Costa Rica, \$309,000 from Peru, and \$18,007 from Saint Kitts and Nevis. The collection of current year assessments amounted to \$13.6 million. The combined collection of arrears and current year's assessments to date totaled \$38 million, which was the third lowest amount collected as of June in the past 10 years. So far in 2009, 19 Member States had made payments towards their past or current quota commitments.

230. As a result of the Director's strategy for increasing the rate of collection of quota assessments, and the demonstrated commitment of PAHO's Member States, over 79% of outstanding arrears had been collected, leaving a balance of only \$6.6 million. Member States had taken advantage of the many different options available for meeting their financial commitments to the Organization, including payment in local currency, payment in installments throughout the year, and deferred payment plans for the settlement of large outstanding arrears.

231. A total of 12 Member States had paid their 2009 assessed contributions in full. All Member States with deferred payment plans were in compliance with those plans and

only one State was potentially subject to the voting restrictions provided for under Article 6.B of the PAHO Constitution.

232. The Director added that the Organization was fully aware of each country's situation with respect to making payments, and thus was not surprised to observe that there was currently something of a delay. The delay was due to a combination of factors, including the fact that some countries had changed their budgetary cycles or procedures. However, the Organization was abreast of the progress of budgetary approval by those countries' legislative authorities, and in the case of almost all of the largest contributors, it had a definite date by which it could expect payment of their contributions.

233. It was important to note that all countries with payment plans were up to date with their payments. Since their priority had been to clear their backlog of debt to the Organization, in some cases that might have caused a delay in the payment of the current year's assessment. Much concern had been expressed as to whether the world economic situation would impact Member States' capacity to honor their commitments to the Organization, but so far that did not seem to be the case, at least for 2009.

234. The Executive Committee adopted Resolution CE144.R2, Corrig., thanking the Member States that had already made payments for 2009, urging the other Member States to pay their outstanding contributions as soon as possible, and recommending to the 49th Directing Council that the voting restrictions contained in Article 6.B of the PAHO Constitution be strictly applied to any Member State that by the opening of that session had not made substantial payments towards its quota commitments.

Interim Financial Report of the Director for 2008 (Official Document 335)

235. Ambassador Jorge Skinner-Klee (Representative of the Subcommittee on Program, Budget, and Administration) said that the Subcommittee had discussed the interim financial report in March and had welcomed the news that PAHO was in a generally strong financial position. The Subcommittee had welcomed, in particular, the Organization's improved position with regard to the collection of arrears. Several delegates had expressed appreciation for the benefits brought to the Region by the Organization's procurement funds, especially the Revolving Fund for Vaccine Procurement. The Subcommittee had also expressed appreciation for the way in which PAHO was managing the recent growth in its volume of resources. Noting the outstanding results for miscellaneous income, the Subcommittee had commended PAHO for its success in preserving capital in the present difficult times.

236. Ms. Sharon Frahler (Area Manager, Financial Resources Management, PASB), summarizing the content of the interim financial report, said that the Organization had experienced a significant increase in its financial resources in recent years, with the total growing from \$537 million in 2006, the first year of the preceding biennium, to \$718.5 million, an increase of \$181.5 million or 33.8%. In 2008, the Organization had

received a total of \$100.1 million in current and previous years' quota assessments, as well as \$16.1 million in miscellaneous income and \$3 million previously loaned to the Revolving Fund for Vaccine Procurement. After deduction of \$94 million in program budget expenditures and \$5.6 million allocated to the Tax Equalization Fund, the excess of income over expenditures for 2008 was \$19.6 million. However, that figure did not reflect some \$11 million in obligations which the Organization had entered into in 2008 but which, under the International Public Sector Accounting Standards currently being introduced (see paragraphs 326 to 333 below), would be implemented in 2009.

237. A total of 24 Member States had paid their 2008 quota assessments in full, eight had made partial payments, and seven had not made any payments for 2008. As of 31 December 2007 there had been a pending quota balance of \$35.4 million which had decreased to \$31 million as of 31 December 2008, which represented a significant decrease in arrears from prior years. As reported above, so far in 2009 the Organization had received over \$24 million of quota arrears, resulting in a current arrearage balance of only \$6.6 million.

238. During 2008, the Organization had received \$48 million for strategic public health supplies to be purchased via the Strategic Fund and the Reimbursable Procurement Fund. That represented an increase of 56% over the corresponding figure for 2006. The Organization had also received \$322 million for the purchase of vaccines and syringes through the Revolving Fund, an increase of 58% over 2006.

239. Trust fund income had totaled \$165 million, comprising \$62 million from governments for external projects, \$91 million from governments for internal projects within their own countries, \$4.4 million from international organizations, and \$7.4 million from private and public sector organizations. Income to other PAHO funds had reached \$30 million. The biennial WHO allocation to the Region of the Americas totaled \$81.5 million, of which PAHO had implemented \$37 million in 2008. The Organization had also implemented \$27 million of WHO voluntary and other funds.

240. PAHO's overall 2008 expenditures had amounted to \$679 million. Purchases of vaccines and syringes through the Revolving Fund had accounted for \$312 million. Regular budget expenditures had totaled \$94 million. Within that amount, \$61.4 million, or 65%, had been utilized for salaries and entitlements of staff members, while \$9.6 million had been used to pay consultants. Travel, contractual services, and seminars and courses had accounted for a total of \$13.9 million, and information technology, general operating expenditures, and other costs had amounted to \$9.1 million.

241. The financial position of the Caribbean Epidemiology Center (CAREC) was strong, with an excess of income over expenditure of \$355,000. In the case of the Institute of Nutrition of Central America and Panama (INCAP), the excess of income over expenditure amounted to \$213,256. The position of the Caribbean Food and

Nutrition Institute (CFNI) was more challenging. It had received regular budget income of \$528,052, had had expenditures of \$292,446, and thus had an excess of income over expenditure of \$235,606. However, the Institute also had an accumulated deficit in its working capital fund, which PAHO was funding, and which with the excess of income over expenditure had now decreased to \$268,670.

242. The Director drew attention to three financial areas that had grown noticeably. Two of them were procurement mechanisms, specifically the Revolving Fund and the Strategic Fund. The increases in those areas reflected the ever-growing importance that countries attached to the procurement of medical supplies on advantageous terms, and were a concrete expression of the technical cooperation that PAHO was providing to its Member States.

243. The third area was the allocation to the Region by WHO of a larger share of its voluntary contributions. She said that it was very important for the countries of the Region, in their role as WHO Member States, to remain vigilant—both at the World Health Assembly and at the Executive Board—in ensuring that the Region received its fair share of WHO voluntary contributions. She noted that PAHO had also been successful in mobilizing more voluntary contributions in recent years.

244. The Committee took note of the Interim Financial Report of the Director.

Changes in Financial Regulations and Financial Rules (Document CE144/24, Rev. 1)

245. Ambassador Jorge Skinner-Klee (Representative of the Subcommittee on Program, Budget, and Administration) recalled that the Subcommittee had heard a report in March on the revisions being made to PAHO's Financial Rules and Regulations in the light of the introduction of the International Public Sector Accounting Standards (IPSAS). The Subcommittee had been informed that an internal working group had been formed to analyze the content of the current Financial Rules and Regulations against the IPSAS requirements and to draft new Financial Regulations for consideration by the present session of the Executive Committee. The Subcommittee had taken note of the report and recommended that the Executive Committee approve the changes to the Financial Regulations and Financial Rules.

246. Ms. Sharon Frahler (Area Manager, Financial Resources Management, PASB) noted that there were four main reasons for making changes to the Financial Regulations. Firstly, the introduction of the International Public Sector Accounting Standards would require the use of new terminology and the introduction of best practices. Secondly, the change to annual audited financial statements, with retention of a biennial program budget, would entail new financial statement requirements. Thirdly, the movement from modified accrual and cash basis accounting to full accrual accounting would have a strong impact on liabilities, surplus, and internal borrowing, and finally the change to

capitalization of property, plant, and equipment, with required expensing of depreciation, would have an impact on the valuation of assets, with a concomitant budgetary effect.

247. She then reviewed the proposed changes as set out in Annex A to Document CE144/24, Rev. 1, noting that they would be submitted to the 49th Directing Council in September. If the Directing Council approved them, then the resultant changes in the Financial Rules would be submitted to the 145th Session of the Executive Committee immediately after the Directing Council.

248. One delegate, while expressing support for the changes proposed in order to facilitate the introduction of IPSAS, observed that the proposed change to Regulation 4.6, giving the Director authority to decide whether to carry a revenue surplus over to subsequent periods, did not include any involvement of the Governing Bodies. She suggested that “and subject to the approval of the Executive Committee” be added at the end of the first sentence. Observing that the existing Regulations 15.1 and 15.2 had been deleted in their entirety, on the grounds that their intent was covered under Regulations III and 7.4, she sought an explanation of how the latter regulations would provide the same budgetary discipline.

249. Ms. Frahler clarified the two different concepts of surplus. The first was the budgetary surplus, whose use would be decided by the Member States, as had always been the case. The new concept was that of revenue surplus. If, for example, the Organization received a higher return on its investments than budgeted, then it was proposed that such extra revenue be used to fund the unfunded parts of the Strategic Plan. In order to permit rapid implementation, it was proposed that the Director should have the authority to decide how to allocate such surplus revenue, so that such funds could be spent starting in January. If it was necessary to submit the matter to the Executive Committee, that could delay implementation for about six months.

250. With regard to Regulations 15.1 and 15.2, she recalled that Member States had requested some amendments several years previously, whereby it was stipulated that detailed reports on financial impact be submitted before new initiatives came to the Executive Committee for approval.

251. The Director said that there was a well-established process in the Organization to identify the unfunded portions of the Strategic Plan. In the event that extra revenue came in, giving her the authority to allocate those resources was intended to allow implementation to start speedily. An alternative to submitting the matter to the Executive Committee, which did not hold its first meeting until June of each year, would be to permit authorization of the revenue allocation by the SPBA, so that implementation of any activity funded by a revenue surplus might start in March.

252. The Executive Committee subsequently considered a proposed resolution on the matter. Ms. Frahler drew attention to Document CE144/24, Rev. 1, which contained a

new version of the proposed changes. There were modifications to the proposed changes to Regulation 4.6, which would authorize the Director to decide how to allocate any revenue surplus to unfunded parts of the Strategic Plan with the concurrence of the SPBA. Changes had also been made to Regulations 9.5 and 12.1(d), and the original text of Regulations 15.1 and 15.2 had been restored in its entirety.

253. The Executive Committee adopted Resolution CE144.R17, recommending that the 49th Directing Council approve the proposed changes to the Financial Regulations.

Projects Using the Program Budget Income Exceeding the Authorized Effective Working Regular Budget (Document CE144/25, Rev. 1)

254. Ambassador Jorge Skinner-Klee (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had heard an update in March on the status of projects approved by the 48th Directing Council for funding from the Holding Account during 2008-2009. It had been reported that, of the five projects that had been started, three required authorization of additional funds over and above the figure projected for the biennium. However, there had been no increase in the total cost of the projects: rather, authorization was needed to spend in 2009 money that had been projected to be spent in a later year. The Director had explained that the Bureau had delayed taking concrete action on some of the approved projects because of cash-flow concerns resulting from delays in the receipt of quota contributions from some countries.

255. The Subcommittee had welcomed the news that total project costs would not increase, and had voiced no objection to the acceleration of the timetables for disbursement. Members had recognized that project costs could change in the implementation phase, but had stressed the importance of obtaining accurate figures as soon as was possible.

256. Mr. Román Sotela (Senior Advisor, Program Budget Management, PASB) recalled that the 48th Directing Council, through Resolution CD48.R1, had approved the use of the Holding Account to fund priority projects as listed in document CD48/22. The Resolution had also called for the Bureau to present to the Executive Committee, at appropriate intervals, an update on the use of those funds.

257. A total of 14 projects had been approved, in four categories, and of those, the following eight were currently under way: 1.A, Emergency Operations Center (EOC) and Knowledge Center (KC); 2.A, Strengthening PAHO's public health information systems; 3.A, Modernize PASB'S corporate management system; 3.C, Strengthen the Organization's capacity to be IPSAS compliant by 2010; 4.A, Improvements to facilities: MOSS upgrades and security measures; 4.B, Improvements to facilities: energy savings measures; 4.E, Improvements to facilities: HQ office tower roof; and 4.F, Improvements to facilities: refurbish headquarters' buildings. As had been reported, three of those

projects had required an adjustment to their costs. The first was the Emergency Operations Center, the initial estimate for which in the current biennium had been \$1 million, but that estimate had now increased to \$1.5 million. However, the latter figure was the total project cost, which remained unchanged; in other words the project was not going over budget—the increased cost resulted from accelerated implementation. In the case of IPSAS compliance, it had originally been envisioned that the cost would be \$200,000 in the current biennium, with a further \$100,000 to be used later, but it was now planned to spend the full amount of \$300,000 in 2008-2009. Again, the project was not going over budget. In the case of project 4.B, Energy-saving measures, the total estimated cost was \$2.9 million, of which \$500,000, for replacement of windows in the Headquarters building, had been allocated to the current biennium. The increase to \$620,000 resulted from a decision to complete the whole of that part of the project in the current biennium, replacing all of the windows in one operation rather than some now and the rest later.

258. The Holding Account currently contained \$25.29 million, placed there at the end of the 2006-2007 biennium. The eight projects under way accounted for \$5,045,000, and the six approved but not yet started brought the total planned expenditure for 2008-2009 to \$7 million, leaving a balance of \$18.29 million.

259. In the discussion that followed, one delegate sought the Director's view on how long it would take to use up all the money in the Holding Account.

260. The Director replied that the expectation was that the first phases of most of the projects under way would be completed in 2010, at which time proposals would be made to the SPBA and the Executive Committee for additional projects. The Bureau had identified projects that would use up almost the whole amount in the Holding Account, and of course it had to be anticipated that some project costs would rise. In addition, there were some approved projects for which the Bureau did not yet have a total cost estimate and for which preliminary studies were under way to determine the final total budgets. Most of the infrastructure projects were expected to be implemented in the 2010-2011 biennium, during which it was expected that roughly the same amount would be spent as in 2008-2009, in other words about \$7 million or a little more. Thus, the total amount in the Holding Account would be used up in about three bienniums.

261. The Committee took note of the report on the progress of projects using income exceeding the authorized regular budget.

Proposal for the Establishment of an Audit Committee (Document CE144/26, Rev. 1 and CE144/26, Rev. 1, Add. I)

262. Ambassador Jorge Skinner-Klee (Representative of the Subcommittee on Program, Budget, and Administration) recalled that the Subcommittee had been informed in March about the process that PAHO was pursuing with a view to establishing an Audit

Committee. That process had included consultations aimed at ascertaining how audit committee functions were handled by agencies inside and outside the United Nations system and by national audit offices. The Subcommittee had also examined draft terms of reference for the PAHO Audit Committee.

263. As several members felt that they had not had sufficient time to review the terms of reference prior to the session, the Subcommittee had recommended that arrangements should be made for electronic submission of comments over a period of six weeks following the session.

264. Dr. Heidi Jiménez (Legal Counsel, PASB) explained that the aim of establishing an Audit Committee was to implement the recommendations of the Organization's external auditors by putting in place a governance framework reflecting international best practices. Specifically, the purpose of the proposed Audit Committee was to serve as an expert advisory committee to assist the Director and the Member States, through the Executive Committee, by providing independent assessment and advice on the operation of the Organization's financial controls and reporting structures, its risk management processes, and the adequacy of its systems of internal and external control. The terms of reference before the Executive Committee had been reviewed extensively by Member States and by the external auditors and incorporated all the comments received by SPBA members during the six-week electronic consultation period.

265. In the ensuing discussion, members of the Committee expressed support for the revised terms of reference and thanked the Bureau for its work in revising them in line with the comments submitted by Member States. Two additional suggestions were made: in paragraph 4(c) of the proposed resolution contained in Document CE144/26, Rev. 1, which fell under the heading "Criteria for Membership," it was suggested that "investigation" should be added after "risk management," and in the third preambular paragraph of the part of the proposed resolution directed to the 49th Directing Council, "the desire to establish a body" should be changed to "the proposal to establish a body."

266. The Executive Committee adopted, with those two amendments, Resolution CE144.R1, recommending that the 49th Directing Council establish an Audit Committee and approve its terms of reference.

Personnel Matters

Amendments to the PASB Staff Rules and Regulations (Document CE144/27)

267. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration) recalled that the Subcommittee had considered the proposed amendments to the Staff Rules and Regulations in March and recommended that the Executive Committee approve the proposed amendments to the Staff Rules. The

Subcommittee had also recommended that the Committee adopt the proposed resolution contained in Document CE144/27 concerning the salary of the Director and the amendment to Staff Regulation 11.2.

268. Ms. Nancy Machado (Human Resources Advisor, PASB) explained that as in previous years, the amendments to PAHO's Staff Rules and Staff Regulations were proposed either on the basis of decisions taken by the United Nations General Assembly pursuant to recommendations made by the International Civil Service Commission (ICSC) or on the basis of PAHO's experience in applying the Staff Rules and Regulations and in the interests of good human resources management.

269. On the basis of United Nations General Assembly decisions and ICSC recommendations, it was proposed that the current post adjustment should be consolidated into the base salary for staff in the professional and higher categories, including the Director, Deputy Director, and Assistant Director. There were also adjustments to education grants.

270. In the category of amendments proposed on the basis of PAHO's experience and in the interests of good human resource management, a number of editorial changes were being made for enhanced clarity, as well as for consistency with the rules of the United Nations system. Changes were proposed to the rules regarding mobility and hardship and the rules regarding home leave, in order to grant those benefits to temporary staff. It was proposed to change the definition of "dependent child" and to modify the rule on assignment grant to clarify that it did not apply to children 21 years of age or older. It was also proposed to amend the special education grant to ensure consistency between staff receiving the education grant and those receiving the special education grant.

271. Additionally, it was proposed to revise the salary of the Director, and to amend the Staff Regulation on conduct and disciplinary measures in order to recognize the Administrative Tribunal of the International Labor Organization as the tribunal before which PAHO staff appeals are heard.

272. In response to a comment from a delegate, she noted that the term "service appointments" in the Staff Rules would eventually be replaced by "continuing appointments," consistent with the implementation of contract reform in PAHO (see paragraphs 274 to 278 below).

273. The Executive Committee adopted Resolution CE144.R15, approving all the Staff Rule changes proposed and recommending that the 49th Directing Council establish the annual salary of the Director at the level proposed and approve the amendment to Staff Regulation 11.2.

Contract Reform in PAHO (Document CE144/28)

274. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had been informed that in December 2008 the United Nations General Assembly had approved new contractual arrangements for the United Nations system as a whole, consisting of three types of contract: fixed-term, continuing, and temporary. PAHO had introduced changes to its short-term consultant contracts on 1 January 2009, and the Bureau was seeking authorization to implement two modifications to temporary contracts with effect from 1 July 2009. The Subcommittee had taken note of the decisions taken by the United Nations General Assembly, and had decided to instruct the Bureau to proceed accordingly with respect to implementation of the relevant changes.

275. Ms. Nancy Machado (Human Resources Advisor, PASB) explained that Document CE144/27 gave details of the changes approved by the United Nations General Assembly in December 2008. In light of those changes, approval was now being sought from the Executive Committee to move forward with the modifications to temporary appointments which had been approved during the Committee's 140th Session, but which the Bureau had been asked not to implement until the General Assembly had approved a similar framework for the United Nations system. The modifications being requested would allow PAHO to issue temporary appointments for a period of up to two years and to harmonize the benefits provided to temporary staff with those of the United Nations common system.

276. The Delegate of the United States of America said that her Government supported the implementation of the new contractual arrangements, but just as the United Nations General Assembly had requested that no continuing contracts be implemented before 1 January 2010, the United States asked that implementation of continuing contracts at PAHO also be delayed until 2010 and requested that the proposed resolution contained in Document CE144/27 be modified in order to reflect that postponement.

277. Ms. Machado affirmed that PAHO would not move forward with any continuing contracts until 1 July 2010 at the earliest.

278. The Executive Committee subsequently adopted Resolution CE144.R16, incorporating the amendment proposed by the Delegate of the United States and recommending that the 49th Directing Council authorize the Director to implement the changes requested.

Statement by the Representative of the PASB Staff Association (Document CE144/29)

279. Dr. Ballayram (Representative of the PASB Staff Association) summarized the matters that the Staff Association wished to bring to the attention of the Executive

Committee, noting that Document CE144/29 contained a more detailed description of the Staff Association's concerns. Those matters were related to employment, career management, good governance, and the Integrity and Conflict Management System.

280. Within the broad area of employment, there were three sub-areas: recruitment, placement, and retention; contractual arrangements; and staff well-being. In all sub-areas, improvements were in hand, but in most cases they had not yet been completed. The area of career management also had three sub-areas: staff development and training; performance management; and the Awards and Recognition Program. Under staff development and training, efforts needed to be made to make staff and management more aware of the existence of WHO Staff Development funds. In the other two sub-areas, all developments were positive and the Staff Association took note of that.

281. The third main area of concern was that of good governance, particularly the sub-area of the role of staff representatives. There was room for greater recognition of the roles of staff representatives by some managers, and for a strengthening of communication between the administration and the Staff Association. The fourth main area was that of the Integrity and Conflict Management System, where the situation was the least positive. There was a need for speedy action to guarantee the principle of trial defense and the right to due process. It would be advisable, too, for the workplace investigation protocol (referred to in greater detail under the Annual Report of the Ethics Office, see paragraphs 24 to 34 above) to be implemented as rapidly as possible. In closing, he reiterated the continued commitment of the Staff Association to the mission of the Organization.

282. The Executive Committee expressed appreciation for the commitment of the staff to the Organization and their contribution to the public health gains that PAHO was attaining in its work with Member States. The Staff Association's concerns about the Organization's internal judicial system were noted, and it was stressed that implementation of the workplace investigation protocol should be a priority.

283. The Director also expressed appreciation for the contribution of the Staff Association to the work of the Organization. In her opinion, the participation of staff representatives in meetings of the administration was advantageous because it allowed an opportunity for exchanges of views and open participation in the discussions on the Organization's policies and programs. She also paid tribute to the contribution that the staff had made to the many positive changes within the Organization, noting that all of the Staff Association's work was done on a voluntary basis, outside paid working hours.

284. Dr. Ballayram thanked the delegates for their encouraging comments and also endorsed the sentiments of the Director. The Staff Association looked forward to continuing to work closely with her in order to improve working conditions, an area in which much progress had already been made. He concurred that it was useful for

representatives of the Staff Association to take part in forums such as the present meeting of the Executive Committee, as that enabled them to report back to the members of the Association on the policies and issues under discussion.

285. The Executive Committee took note of the statement of the representative of the PASB Staff Association.

Matters for Information

WHO Proposed Programme Budget 2010-2011 and WHO Medium-Term Strategic Plan 2008-2013 Amended (Draft) (Documents CE144/INF/1 and CE144/INF/2)

286. Dr. Isaías Daniel Gutiérrez (Area Manager, Planning, Budget, and Resource Coordination, PASB), introducing the item, noted that the draft amended Medium-term Strategic Plan of WHO had been presented to the Sixty-second World Health Assembly in conjunction with the WHO budget proposal for 2010-2011. Both documents had been adopted, with some amendments, by the Health Assembly in May 2009. The approved budget totaled \$4,539,914,000, which reflected a 10% reduction in base programs with respect to the 2008-2009 biennium.

287. The Director clarified that the documents before the Committee were the draft versions submitted to the Health Assembly in May. They had been discussed and amended before being adopted, but the amended versions had not yet been edited and published on the WHO website. They were being presented to the Committee because they provided important background for the discussion of PAHO Strategic Plan 2008-2012 Amended (Draft) and Proposed PAHO Program and Budget 2010-2011.

288. In the discussion that followed, appreciation was expressed for WHO's efforts to keep Member States' assessments at the 2008-2009 level and to reduce the budget from the level originally proposed to the WHO Executive Board in January 2009.

289. The Executive Committee took note of the reports on the WHO Medium-Term Strategic Plan 2008-2013 Amended (Draft) and WHO Proposed Programme Budget 2010-2011.

Code of Practice on the international recruitment of health personnel: a WHO background document (Document CE144/INF/3, Rev. 1)

290. The President drew attention to Document CE144/INF/3, Rev. 1 and opened the floor for discussion.

291. The Executive Committee recognized the crucial importance of the issue of international recruitment of health personnel and its relationship to the larger issue of health systems strengthening. Delegates welcomed the initiative to draw up a global code of practice and identified a number of features that such a code should have. It was

emphasized that it must be voluntary, must adequately balance the interests of source and destination countries, and must take into account the factors that prompted health workers to seek employment outside their countries of origin, such as poor working conditions or lack of recognition of nursing as a profession, for example. It was also emphasized that the code should contain no provisions that might limit people's right to migrate legally in order to seek a better life for themselves and their families.

292. At the same time, the need to monitor the migration of health workers and regulate the practices of recruitment agencies in order to discourage one-way flows of personnel was stressed. It was considered important for destination countries to create incentives to ensure the sufficiency and sustainability of their domestic health workforce, and it was emphasized that countries' efforts to address workforce shortages should not deepen the inequities existing between countries or impair the ability of any country to ensure access to health care for its nationals. In that connection, one delegate supported the inclusion in the code of practice of specific provisions relating to the regulation and monitoring of the activities of recruitment agencies and employers of internationally recruited health personnel. He also favored the establishment of limits on international recruitment of health personnel from countries with critical health workforce shortages, and suggested that one option for balancing the interests of source and destination countries might be to set migration caps for certain categories of professionals and to require health personnel to work for a certain number of years in their country of origin before they would be allowed to emigrate. The same delegate supported the idea of financial compensation of source countries by destination countries in order to enable the former to recover what they had invested in the training of health personnel recruited to work abroad. He cautioned, however, that any provision for such compensation to be included in the code of practice would have to be carefully crafted. One option, he suggested, might be to set up a global compensation fund, which would be administered at the regional level. Another possible measure for ensuring the mutuality of benefits might be to create a system of educational grants to help finance the training of health personnel.

293. Technical cooperation to support research and the compilation of information on health worker migration was identified as a key role for PAHO, as was facilitating the process of consultation on the draft code of practice. In that regard, several delegates raised concerns about the timetable proposed for national and regional consultations and expressed doubt that it would be possible to adequately discuss all the issues involved and reach consensus on a draft global code of practice by May 2010. It was stressed that maximum advantage should be taken of national and subregional mechanisms, particularly observatories of human resources in health and the working group on health worker migration set up by the Eighth Ibero-American Conference of Ministers of Health (2006), in order to advance the consultation process.

294. Several delegates outlined some of the steps their countries were taking to address health workforce issues and to meet the Regional Goals for Human Resources for Health 2007-2015 established by the 27th Pan American Sanitary Conference (Resolution CSP27.R7).

295. Dr. Charles Godue (Senior Advisor, Human Resources for Health Development, PASB) thanked the Committee for its input and assured delegates that their comments would be transmitted to the WHO Secretariat, which had the lead in drafting the global code of practice. The code was intended to be voluntary and to apply to all categories of health personnel in both the public and private sectors. The document before the Committee was not the draft code itself but rather a background paper prepared by WHO to facilitate discussion of the provisions that should be included in the final text of the code. It was considered especially important to hold discussions at the national level with the involvement of all stakeholders, including representatives of government, the private sector, and recruiters and employers of health personnel.

296. The Bureau would do its utmost to facilitate those discussions, but he agreed that time was short. Moreover, Member States were grappling with a number of important issues at the moment—notably the H1N1 influenza pandemic—which would further limit the time available to organize national consultations prior to the 49th Directing Council's discussion of the matter in October.

297. The Director observed that the time available for discussion during the Directing Council would also be limited, as the Council had a very full agenda that included a roundtable and a panel discussion on other important issues. In her view, it might be preferable to move the target date for submission of the draft code to the World Health Assembly to May 2011, in order to allow sufficient time for in-depth discussion at national, subregional, and regional levels. She encouraged PAHO Member States, particularly those that were members of the WHO Executive Board, to broach to the WHO Secretariat their concerns about the proposed timeline for discussion and development of the global code of practice.

298. The Executive Committee took note of the background document on international recruitment of health workers and requested the Bureau to convey its comments to WHO.

Progress Report on Technical Matters (Documents CE144/INF/4- A, B, and C):

International Health Regulations, including a Report on the Influenza A (H1N1) Pandemic (Document CE144/INF/4-A)

299. Dr. Jarbas Barbosa da Silva (Area Manager, Health Surveillance and Disease Prevention and Control, PASB) presented a report on progress in implementing the International Health Regulations (2005) in the Region and an update on the status of the influenza A (H1N1) pandemic as of 22 June 2009.

300. Concerning the H1N1 pandemic, he recalled that WHO had raised the level of pandemic alert to phase 6 on 11 June 2009, as community-level outbreaks were occurring in numerous countries in more than one region and there was a clear upward trend in both case reports and the number of countries reporting cases. As of 22 June, more than 52,160 cases and 231 deaths had been reported in 99 countries or territories. The Americas had recorded more than 43,000 cases in 28 countries.

301. It had become apparent very early on that the Region's efforts to enhance pandemic preparedness and implement the International Health Regulations (2005) had paid off. The response to the initial outbreaks of influenza A (H1N1) had been swift, transparent, and highly cooperative. At the regional level, the Emergency Operations Center had been activated immediately and rapid response teams mobilized. At the national level, health authorities in Mexico, where the pandemic had begun, had taken decisive action to curb the spread of the disease, as had those in the United States and Canada, which had also been affected early on. PAHO would provide ongoing support to countries throughout the Region as the pandemic evolved, working to strengthen surveillance capacity, ensure that health services were prepared to deal with cases of H1N1 influenza, and improve access to influenza vaccines and antiviral agents, especially for vulnerable groups. He emphasized the need to remain vigilant about the threat posed by influenza A (H5N1) (avian influenza), even as the battle against influenza A (H1N1) continued.

302. The H1N1 pandemic had provided the first real test of the revised International Health Regulations (IHR) adopted in 2005 and had demonstrated their effectiveness. The provisions authorizing WHO and PAHO to take into consideration unofficial reports of public health events, had led to a much speedier response to the initial outbreaks of the disease. The establishment of national IHR focal points and the WHO IHR contact point in the Region (at PAHO Headquarters) had provided an effective channel of communication between the Organization and the affected countries. In addition, mechanisms created pursuant to the Regulations, such as the Global Outbreak Alert and Response Network (GOARN), had made it possible to rapidly mobilize teams of experts, both from the Americas and from other regions, to support the affected countries. GOARN had also enabled a much more organized and coordinated international response, which was critical in order to avoid wasteful duplication of effort and ensure that help was being provided where it was really needed.

303. The experience of confronting the pandemic had also revealed some gaps in national public health response capabilities and had highlighted the need to continue building core capacities, particularly with regard to airports, ports, and ground crossings, in order to enable Member States to meet the IHR requirements by the target date of 2012.

304. In that regard, he reported that 27 of the 35 countries in the Region had completed the evaluation of core capacities for surveillance and response, but only 17 of the 35 had evaluated capacities with regard to points of entry. Twenty-seven of the 35 had prepared action plans for ensuring that the required core capacities were in place. All 35 countries had designated a national IHR focal point. In the most recent test to evaluate communication between PAHO and the national focal points, responses had been received from 28 of the 35. Twenty-six of those 28 national focal points were operating 24 hours a day, 7 days a week. He noted, however, that those figures had been compiled before the advent of the H1N1 pandemic; current figures were undoubtedly higher. Unquestionably, the measures taken to implement the Regulations in the face of the pandemic had prepared Member States to deal not just with the present emergency but also with future public health events of international concern.

305. The Director added that PAHO was working in collaboration with WHO to develop guidelines for implementation of the IHR provisions relating to ground crossings. The guidelines would be tested on the Mexico–United States border.

306. In the discussion that followed, Committee members welcomed the progress to date in implementing the International Health Regulations (2005) and expressed gratitude to PAHO and WHO for the support provided in response to the H1N1 pandemic. The importance of accurate and balanced risk communication was stressed. In that connection, it was pointed out that one failing of WHO's pandemic alert classification scheme was that it did not provide a means of conveying information about the severity of illness caused by a pandemic virus. Health professionals knew that the current phase 6 was indicative of the extent to which influenza A (H1N1) had spread worldwide, but the public and the news media tended to interpret the higher alert level as meaning that the disease had become more virulent, which was causing unwarranted fear and even panic in some places. PAHO was urged to work with WHO to rectify that shortcoming and adapt the classification in order to make it more understandable to the general public.

307. The Delegate of Mexico, agreeing that the H1N1 pandemic had put the International Health Regulations (2005) to the test, said that his Government had begun implementing the Regulations, which Mexico accorded the stature of an international treaty, immediately after they were adopted in 2005. It had also drawn up a pandemic preparedness plan. Thanks to those actions, it had been able to respond promptly and contain the spread of the disease. His Government was grateful for the support it had received from PAHO and WHO and from other Member States.

308. While Mexico had been well prepared to deal with the public health aspects of the pandemic, it had been less equipped to deal with its economic repercussions and with the damage it had done, for example, to tourism and trade. Some thought needed to be given to how to address those issues under the International Health Regulations, perhaps by creating a support fund to assist affected countries and also devising mechanisms to

facilitate intersectoral coordination in the response to a pandemic, which had proved to be a major challenge in Mexico's case.

309. The Executive Committee took note of the progress report on implementation of the International Health Regulations (2005) and the update on the influenza A (H1N1) pandemic.

Preparations for the Roundtable on Safe Hospitals (Document CE144/INF/4-B)

310. Dr. Jean-Luc Poncelet (Area Manager, Emergency Preparedness and Disaster Relief, PASB), introducing the report on preparations for the roundtable discussion on safe hospitals to be held during the 49th Directing, said that hospitals were an important aspect of disaster readiness, and observed that the subject of hospital preparedness was especially crucial at the present juncture, with the spread of the H1N1 influenza pandemic. The roundtable was being organized in the context of the regional safe hospitals initiative launched by the Directing Council in 2004; the United Nations World Disaster Reduction Campaign 2008-2009, the theme of which had been "Hospitals Safe from Disasters"; and World Health Day 2009, which had focused on enhancing the resilience and safety of health facilities.

311. The roundtable would feature three discussion panels, which would tackle specific aspects of the overall issue of how to mobilize the political will needed to achieve the goal of safe hospitals. The arrangements for the panels were described in the report. Member States were invited to share their experiences in conjunction with the roundtable, and would have the opportunity to present them through audiovisuals, television, posters, and other media.

312. The Committee took note of the report.

Preparations for the Panel Discussion on the Pan American Alliance for Nutrition and Development to Achieve the MDGs (Document CE144/INF/4-C)

313. Dr. Gina Tambini (Area Manager, Family and Community Health, PASB) introduced the report on preparations for the panel discussion, explaining that the aim of the Pan American Alliance was to address issues relating to nutrition and development through an integrated intersectoral approach. The Alliance had been set up by the directors of the United Nations agencies in the Region in July 2008 at a meeting held in Washington, D.C., convened by the Director of PASB. At that meeting, the regional directors had reviewed the progress made by countries towards achieving the nutrition-related Millennium Development Goals. The Alliance initiative had been proposed to facilitate joint work by all the United Nations agencies, especially through their country teams, to combat malnutrition and promote the achievement of the Goals.

314. The report provided background information and described the objectives, expected results, and methodology for the Panel Discussion. The Bureau had made progress in identifying persons who might participate in the Panel, including the Minister of Health of Peru, the President of Uruguay, the Director of the World Food Programme, and the President of Care International, among others.

315. In the ensuing discussion, delegates highlighted the growing problem of obesity in the Region and asked whether the Alliance would also be addressing that problem.

316. Dr. Tambini said that a regional technical team had been set up with representatives of various United Nations agencies. The idea was to take an integrated approach, working on both malnutrition and the dietary imbalances that led to overweight and obesity.

317. The Director said that the main objective of the Pan American Alliance was to tackle the problem of chronic malnutrition. She also noted, however, that there was scientific evidence that undernourished children who recovered from that condition often became obese later on as a result of the imbalances caused by malnutrition, high-carbohydrate diets, and micronutrient deficiencies. The Alliance focused especially on the highly vulnerable populations, especially indigenous groups. Malnutrition rates in the Region had remained extremely rigid, despite the progress made in reducing child mortality over the last 20 years. The Region had an ample food supply, but access was a problem. The Alliance would identify a number of actions to be taken in areas such as maternal health, education, prenatal care, environmental conditions, access to water, and sanitation. It sought to help governments design integrated social policies targeting vulnerable groups with a life-cycle approach.

318. The Committee took note of the report.

Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO (Documents CE144/INF/5-A, B, and C)

319. Dr. Juan Manuel Sotelo (Manager, External Relations, Resource Mobilization, and Partnerships, PASB) reported on the resolutions and other actions of the Sixty-second World Health Assembly and the 125th Session of the WHO Executive Board; the Thirty-ninth regular session of the General Assembly of the Organization of American States; and the Fifth Summit of the Americas considered to be of particular interest to the PAHO Governing Bodies. He pointed out that the respective documents contained tables indicating the PAHO activities to which each resolution or action was related.

320. The Sixty-second World Health Assembly had taken place amidst great concern over the global economic crisis and the influenza A (H1N1) pandemic. The agenda had comprised 18 items, most of them having to do with health policy matters. The Assembly

had adopted 16 resolutions. Those of primary interest to the Americas were listed in Document CE144/INF/5-A. The 125th Session of the Executive Board had taken place immediately following the Health Assembly. The Executive Board members from the Americas had been Bahamas, Brazil, Canada, Chile, Paraguay, and Peru. The Board had examined reports on the global elimination of measles, the safety and quality of blood products, and birth defects, among other matters.

321. The Thirty-ninth General Assembly of the OAS, held in Honduras in June 2009, had adopted the Declaration of San Pedro Sula: Toward a Culture of Non-Violence, which sought to promote a culture of peace and non-violence and emphasized respect for human rights and the principles of freedom, democracy, solidarity, and tolerance. Document CE144/INF/5-B highlighted the resolutions adopted by the Thirty-ninth General Assembly that were of particular interest to the Governing Bodies of PAHO. The Assembly had also discussed follow-up on the decisions taken at the Fifth Summit of the Americas, held in Trinidad and Tobago in April 2009.

322. At the Fifth Summit, the Heads of State and Government of the Region had adopted the Commitment of Port-of-Spain: Securing Our Citizens' Future by Promoting Human Prosperity, Energy Security, and Environmental Sustainability. Eleven of the 97 paragraphs in the Declaration dealt with health-related issues, including universal access to health care with emphasis on the most vulnerable groups, strengthening of health systems based on primary health care, and prevention and control of chronic noncommunicable diseases. The commitments of the Heads of State and Government in the area of health showed that there was clear political support for the strategies and plans of action adopted by the Governing Bodies of WHO and PAHO. As a member of the Joint Summit Working Group, PAHO would help prepare the reports on follow-up to the commitments and would report on that matter to the PAHO Governing Bodies.

323. The Director welcomed the attention to health issues at both the OAS Thirty-ninth General Assembly and the Fifth Summit of the Americas and highlighted the unifying influence that health could have. Noting that Cuba was a Member State of PAHO, she welcomed the decision by the OAS Thirty-ninth General Assembly on the reintegration of Cuba into the inter-American family. The fact that the Declaration adopted at the Summit included several paragraphs on health issues could be attributed to the close coordination between PAHO and the OAS Secretariat before, during, and after the Summit. PAHO had cooperated in the drafting of the OAS resolution on the influenza pandemic, which had been introduced by Mexico. In addition, PAHO had been responsible for epidemiological surveillance during the Summit meeting, for which purpose it had worked closely with the Caribbean Epidemiology Centre (CAREC) and Canada, which had sent a portable laboratory to the event. The United States Southern Command had taken responsibility for emergency medical services.

324. She wished to draw attention to the fact that the last two meetings of the Program, Budget, and Administration Committee of the Executive Board of WHO had been chaired, with great efficiency and responsibility, by Dr. Merceline Dahl Regis, of the Bahamas, who had distinguished herself as a representative of the Americas.

325. The Executive Committee took note of the reports.

Progress Reports on Administrative and Financial Matters (Documents CE144/INF/6-A and B):

Status of Implementation of the International Public Sector Accounting Standards (IPSAS) (Document CE144/INF/6-A)

326. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had been informed that PAHO expected to have fully implemented the International Public Sector Accounting Standards by January 2010. The major task still under way in March had been the actuarial valuation of long-term liabilities, including terminal entitlements and after-service health insurance for retired PAHO staff. It had been reported that an external actuary would be engaged to calculate those long-term costs. The steps remaining to be completed in the course of 2009 had included submission to the Governing Bodies of proposed changes in the Financial Regulations and Rules, development of accounting manuals, IPSAS training, determination of how to recognize in-kind contributions from Member States in financial statements, identification of inventories held for sale, determination of which entities would be consolidated into PAHO's financial statements, possibly requesting current valuations for PAHO's land and buildings, and coordinating the Organization's interpretation of IPSAS with that of the External Auditor. Some work was also needed on the Organization's computer systems in order to meet basic IPSAS requirements.

327. Ms. Sharon Frahler (Area Manager, Financial Resources Management, PASB) reported that the conversion to IPSAS was exactly on schedule, although it was proving a significant challenge demanding a large amount of PAHO staff time. The Organization had hired a project manager for the conversion, and had also engaged a firm of actuaries for the calculation of the long-term liabilities mentioned above. Those figures were expected to be available by mid-July 2009.

328. In May 2009, PAHO had organized a one-week training course given by Dr. Andreas Bergman, a member of the IPSAS Board, and Ms. Frahler had attended a United Nations IPSAS Task Force meeting.

329. One United Nations agency, the World Food Programme (WFP), had already implemented the IPSAS, and had received an unqualified audit opinion on its implementation process. PAHO was working closely with WFP to learn from its

experience with the conversion, which in the case of the World Food Programme had cost over \$3 million.

330. In the discussion that followed, one delegate drew attention to paragraph 7 of Document CE144/INF/6-A, which referred to limitations of PAHO's various financial and accounting systems. She sought information on the anticipated costs of addressing those limitations and also on whether PAHO's accounting system would be linked to WHO's Global Management System (GSM).

331. Ms. Frahler replied that PAHO had consulted the World Food Programme on whether the latter had considered it preferable to upgrade its computer system before implementing the IPSAS or to proceed with implementation using improvisations. The World Food Programme had decided to make use of improvisations, each of which had been approved by its external auditors. PAHO had decided to adopt the same short-term strategy, although in the long term, the Organization would need a new financial system, able to support accrual accounting and capitalization of fixed assets. A working group was working on the design of such a system and had recently finalized the financial guiding principles.

332. PAHO was experiencing no problems with uploading its data to the GSM system—indeed, PAHO's specialists sometimes seemed to understand the Global Management System better than WHO's own GSM staff. There had been difficulties downloading information from the system to PAHO. But, again, the problem appeared to be with the GSM and its download system, not with PAHO's ability to receive the data.

333. The Committee took note of the report on the status of implementation of the International Public Sector Accounting Standards.

Master Capital Investment Fund (Document CE144/INF/6-B)

334. Ambassador Lionel Maza (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had examined a report on projects funded under the Master Capital Investment Fund that had either been started or were projected for the future. The Subcommittee had taken note of the report, requesting that future versions of such reports show the relationship between projects funded from the Master Capital Investment Fund and those funded from the Holding Account.

335. Mr. Michael Boorstein (Director of Administration, PASB) expressed appreciation to Member States for having agreed to establish the Fund, which provided a mechanism for investing in PAHO's infrastructure as well as a means of having funds available for ongoing expenditures on software licenses and other supports to the Organization's information systems. Details of the projects being funded from the Master Capital Investment Fund could be found in Document CE144/INF/6-B, which showed the

situation as in April 2009. The annexes to that document provided more up-to-date information.

336. Starting with the Real Estate Sub-Fund, he drew attention in particular to the \$97,000 which was to have been spent on enhancements to the country office in Brazil. As the Government of Brazil had funded those enhancements itself, the amount projected for expenditure was still available in the Fund. Also, it had been planned to refurbish the elevators in the Headquarters building in Washington, D.C. in the current biennium, but that project had been deferred until 2010, in part so that the existing elevators would be available to transport materials for another project, the replacement of all the windows in the building. He also noted the impact of the Committee's earlier approval of accelerated funding for the window replacement project, as well as for the Emergency Operations Center (see paragraphs 254 to 261 above).

337. Turning to the Information Technology Sub-Fund, he drew attention in particular to an expenditure of \$42,000 in Chile, where the country office had suffered a break-in and the loss of much of its computer equipment.

338. The Executive Committee took note of the report on the status of the Master Capital Investment Fund.

Other Matters

339. The Director recalled that PAHO's Office of Internal Oversight and Evaluation Services had lacked a Senior Auditor for almost four years, which had been a matter of concern to Member States. The Organization had tried several different ways of attracting the right candidate, including upgrading the description and title of the job and making it a D-1 position, but without success. Now, finally, the Organization seemed to have found a number of suitably qualified candidates. They had completed the examinations set to determine their suitability, and attended interviews, and PAHO was currently checking references. It was hoped that the successful candidate would be selected by the end of July 2009.

340. Noting that Colombia had announced during the March session of the SPBA that it intended to seek a seat on the Executive Committee, she encouraged the various subregions to give some thought to the countries that they would wish to nominate for the election that would be held during the Directing Council.

Closure of the Session

341. Following the customary exchange of courtesies, the President declared the 144th Session of the Executive Committee closed.

Resolutions and Decisions

342. The following are the resolutions and decisions adopted the Executive Committee at its 144th Session:

Resolutions

CE144.R1: Proposal for the Establishment of an Audit Committee

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the document *Proposal for the Establishment of an Audit Committee* (Document CE144/26, Rev. 1) and considered the draft Terms of Reference for the Committee contained therein; and

Noting the report by the Secretariat on the matter,

RESOLVES:

To recommend to the 49th Directing Council that it adopt a resolution along the following lines:

ESTABLISHMENT OF AN AUDIT COMMITTEE

THE 49th DIRECTING COUNCIL,

Having reviewed the document *Proposal for the Establishment of an Audit Committee* (Document CD49/__);

Acknowledging the Organization's ongoing efforts to establish a governance framework that reflects international best practices; and

Noting the proposal to establish an independent expert advisory body to advise the Director of the Pan American Sanitary Bureau and PAHO's Member States on the operation of the Organization's financial controls and reporting structures, risk management process, and other audit-related controls,

RESOLVES:

1. To establish an Audit Committee for the Pan American Health Organization (PAHO).
2. To approve the following Terms of Reference for the PAHO Audit Committee:

Guiding Principle

1. An Audit Committee shall be established by the Directing Council of the Pan American Health Organization (PAHO) to exercise an independent consultative function, providing the Director of the Pan American Sanitary Bureau (“the Director”) and the PAHO Member States, through the Executive Committee, with advice on the operation of the Organization’s financial controls and reporting structures, risk management processes, and other audit-related controls. The Committee shall perform this function through independent reviews of the work carried out by PAHO’s system of internal and external controls, including PAHO’s Office of Internal Oversight and Evaluation Services (IES), the External Auditor, and the administration and management of the Organization. The work of the Audit Committee shall be conducted in accordance with internationally accepted standards and best practices and in compliance with PAHO’s policies, regulations, and rules. The Audit Committee does not substitute the function of the Executive Committee of PAHO or of its Subcommittee on Program, Budget, and Administration (SPBA).

Role of the Committee

2. The PAHO Audit Committee shall:

- (a) review and monitor the adequacy, efficiency, and effectiveness of the Organization’s risk assessment and management processes, the system of internal and external controls (including PAHO’s internal oversight and External Auditor function), and the timely and effective implementation by management of audit recommendations;
- (b) advise on issues related to the system of internal and external controls, their strategies, work plans, and performance;
- (c) report on any matter of PAHO policy and procedure requiring corrective action and on improvements recommended in the area of controls, including evaluation, audit, and risk management;
- (d) comment on the work plans and the proposed budget of the internal and external audit functions;
- (e) advise on the operational implications of the issues and trends apparent in the financial statements of the Organization and significant financial reporting policy issues;
- (f) advise on the appropriateness and effectiveness of accounting policies and disclosure practices and assess changes and risks in those policies; and
- (g) advise the Director in the selection process of the Auditor General of PAHO, and advise the Executive Committee in the selection of the External Auditor.

Membership of the Committee

3. The Audit Committee shall be composed of three members who shall reflect the highest level of integrity and be fully independent from PAHO. The Audit Committee shall be appointed by the Executive Committee of PAHO. Members shall serve in their personal capacity. Each Member shall serve as Chairperson of the Committee for one year on a rotational basis.

Criteria for Membership

4. All members of the Committee must have recent and relevant senior-level financial, audit, and/or other oversight related experience. Such experience should reflect, to the extent possible:

- (a) experience in preparing, auditing, analyzing, or evaluating financial statements that present a breadth and level of complexity of accounting issues that are generally comparable to the breadth and complexity of issues faced by PAHO, including an understanding of relevant accepted accounting principles;
- (b) an understanding of and, if possible, relevant experience in the inspection, monitoring, and evaluation processes;
- (c) an understanding of internal control, risk management, investigation, and procedures for financial reporting; and
- (d) a general understanding of the organization, structure, and functioning of international organizations in the UN system.

Terms of Appointment

5. The Members of the Audit Committee shall be appointed to serve no more than two full terms of three years each. The election cycle shall be fixed upon establishment of the Committee. Members may be reelected for a second and final term of three years, with the exception of the initial three Members of the Committee, who shall be appointed by drawing of lots to serve an initial term of two, three, or four years. Former members of the Audit Committee may be reappointed to the Committee subject to not serving more than two full terms.

Call for Proposals

6. The Director shall recommend a list of qualified candidates. The list will be notified to the SPBA prior to the Executive Committee Session and must include an extended CV of each of the candidates.

7. The list of candidates will be subject to assessment, which may include requests for additional information and subsequent modification. The highest ranked candidates,

according to the Criteria for Membership, will be proposed by the SPBA to the Executive Committee for decision.

Responsibility of Members

8. In performing their functions, Members of the Audit Committee shall neither seek nor receive instructions from any national government authority. They shall act in an advisory, non-executive, capacity and be fully independent from any government or PAHO body, structure, or entity. Members shall be guided solely by their expertise and professional judgment, taking into account the collective decisions of PAHO's Governing Bodies.

9. Members of the Audit Committee shall be required to sign a confidentiality statement at the beginning of their tenure, as well as a PAHO Declaration of Interest Form. Where an actual or potential conflict of interest arises, the Member shall declare such interest to the Committee and will be excused from the Committee's discussion on the corresponding issue.

Meetings and Rules of Procedure

10. The PAHO Audit Committee shall normally meet in regular sessions twice a year. Additional meetings may be scheduled on an *ad hoc* basis as necessary. The Chairperson of the Committee shall determine the timing of meetings and the need for any additional meetings in the course of the year. He/she shall also set the agenda of the meetings, taking into account relevant requests from the Director and/or the Executive Committee of PAHO. The meetings shall be convened by the Secretariat of the Committee on behalf of the Chairperson. Members of the Audit Committee shall normally be given at least four weeks' notice of meetings.

11. The Director, the External Auditor, the Auditor General of PAHO, the Director of Administration of PAHO, and the Financial Resources Manager of PAHO shall attend meetings of the Audit Committee at the invitation of the Chairperson of the Committee.

12. The Audit Committee may decide to meet in closed session from time to time as determined by the Committee.

13. The Audit Committee shall endeavor to work on the basis of consensus.

14. Members serve in their personal capacity and cannot be represented by an alternate attendee.

15. The administrative and secretariat support function of the Audit Committee, including the preparation and maintenance of minutes of the meetings, shall be carried out by independent staff hired on an as needed basis for that purpose, and will report directly to the Chairperson on matters relating to the work of the Audit Committee.

Disclosure

16. The Audit Committee secretariat, observers, and any third party invited by the Committee to attend its sessions shall not make any document or information public without the Committee's prior authorization.

17. Any Audit Committee Member reporting on the Committee's work shall ensure that confidential materials are secured and shall keep other Members adequately informed.

Access

18. The Audit Committee shall have access to all records and documents of the Organization, including, but not limited to, audit reports and work documents of IES and reports issued by the External Auditors.

19. The Audit Committee shall be able to call upon any PAHO staff member or employee, including senior management of the Organization, and request meetings with any parties, as it deems necessary to obtain information relevant to its work.

20. PAHO's External Auditors and Auditor General shall also have unrestricted and confidential access to the Chairperson of the Committee.

21. The Audit Committee may obtain legal or other independent professional advice if it is considered necessary.

Reporting

22. The Chairperson of the Audit Committee shall interact regularly with and report to the Director on the results of the Committee's deliberations, as well as any issues relevant to its business.

23. The Audit Committee shall prepare an annual report of its work for the Executive Committee of PAHO. The Audit Committee may also prepare ad-hoc reports as requested by the Executive Committee. The Director shall be given the opportunity to comment on all reports prior to their submission to the Executive Committee.

Resources

24. The Audit Committee shall be provided with such resources as are necessary to undertake its duties. Funds shall be included in the biennial budget of the Organization to provide for administrative support, travel, and accommodation costs in relation to Committee Members' duties. Such travel shall be conducted in accordance with PAHO regulations and rules. The Members shall serve without remuneration from PAHO.

Review of the Terms of Reference

25. The Executive Committee will periodically review the output of the Audit Committee, assess its effectiveness and make appropriate recommendations, in consultation with the Director, regarding its membership and Terms of Reference. The Terms of Reference of the Audit Committee may be modified by the Directing Council as necessary.

(Second meeting, 22 June 2009)

CE144.R2, Corrig.: Collection of Quota Contributions

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the report of the Director on the collection of quota contributions (Document CE144/23 and Add. I), including a report on the status of the trust fund entitled *Voluntary Contributions for the Priority Programs: Surveillance, Prevention, and Management of Chronic Diseases; Mental Health and Substance Abuse; Tobacco; Making Pregnancy Safer; HIV/AIDS; and Direction*;

Noting the information provided on Member States in arrears in the payment of their quota contributions to the extent that they can be subject to the application of Article 6.B of the Constitution of the Pan American Health Organization;

Noting the provisions of Article 6.B of the PAHO Constitution relating to the suspension of voting privileges of Member States that fail to meet their financial obligations and the potential application of these provisions to those Member States that are not in compliance with their approved deferred payment plan; and

Noting with concern that there are 22 Member States that have not made any payments towards their 2009 quota assessments and that the amount collected for 2009 assessments represents only 14% of total current year assessments,

RESOLVES:

1. To take note of the report of the Director on the collection of quota contributions, including a report on the status of the trust fund entitled *Voluntary Contributions for the Priority Programs: Surveillance, Prevention, and Management of Chronic Diseases; Mental Health and Substance Abuse; Tobacco; Making Pregnancy Safer; HIV/AIDS; and Direction* (Document CE144/23 and Add. I).
2. To encourage Member States to continue to provide financial resources in support of the trust fund entitled *Voluntary Contributions for the Priority Programs:*

Surveillance, Prevention, and Management of Chronic Diseases; Mental Health and Substance Abuse; Tobacco; Making Pregnancy Safer; HIV/AIDS; and Direction.

3. To thank the Member States that have already made payments for 2009 and to urge the other Member States to pay all their outstanding contributions as soon as possible.
4. To request the Director to continue to inform the Member States of any balances due and to report to the 49th Directing Council on the status of the collection of quota contributions.
5. To recommend to the 49th Directing Council that the voting restrictions contained in Article 6.B of the PAHO Constitution be strictly applied to any Member State that by the opening of that session has not made substantial payments toward its quota commitments.

(Second meeting, 22 June 2009)

CE144.R3: Review of Nongovernmental Organizations in Official Relations with PAHO

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the report of the Subcommittee on Program, Budget, and Administration (Document CE144/6); and

Mindful of the provisions of the *Principles Governing Relations between the Pan American Health Organization and Nongovernmental Organizations* (Resolution CESS.R1, January 2007),

RESOLVES:

1. To continue official relations between PAHO and the American Society of Microbiology (ASM), the Inter-American Association of Sanitary and Environmental Engineering (AIDIS), the International Diabetes Federation (IDF), the Latin American Federation of the Pharmaceutical Industry (FIFARMA), the March of Dimes Foundation (MOD), the U.S. Pharmacopeia (USP), and the World Association for Sexual Health (WAS).
2. To discontinue official relations between PAHO and the Latin American and Caribbean Association of Public Health Education (ALAESPE).

3. To request the Director to:
- (a) advise the respective NGOs of the decisions taken by the Executive Committee;
 - (b) continue developing dynamic working relations with inter-American NGOs of interest to the Organization in areas which fall within the program priorities that the Governing Bodies have adopted for PAHO;
 - (c) submit an annual report on relations between PAHO and the nongovernmental organizations in official relations that would allow for the evaluation of the contribution of this collaboration to the strategic objectives defined by the Organization in the Strategic Plan 2008-2012; and
 - (d) continue fostering relationships between Member States and NGOs working in the field of health.

(Second meeting, 22 June 2009)

CE144.R4: Plan of Action for Implementing the Gender Equality Policy

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director *Plan of Action for Implementing the Gender Equality Policy* (Document CE144/14),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

**PLAN OF ACTION FOR IMPLEMENTING THE
GENDER EQUALITY POLICY**

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Plan of Action for Implementing the Gender Equality Policy* (Document CD49/___);

Recalling the Program of Action of the International Conference on Population and Development (Cairo, 1994), the Beijing Declaration and Platform for Action (Beijing, 1995), the recommendations and reports of Beijing plus 10 Conference (2005), the United Nations Economic and Social Council's agreed upon conclusions (1997/2), the United Nations Millennium Declaration (2000), the 2005 World Summit Outcome (United Nations General Assembly Resolution A/RES/60/1), and the World Health

Assembly Resolution WHA58.30 on accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration, the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Pará);

Noting the World Health Assembly resolution on gender mainstreaming (WHA60.25) that urges Member States to formulate strategies to integrate gender in the health systems and requests the Director General to integrate gender analysis and actions into WHO's work;

Recognizing the adoption and implementation of gender equality policies in Member States, the United Nations system, and the inter-American system;

Recalling Resolution CD46.R16 of the 46th Directing Council, adopting the PAHO Gender Equality Policy;

Aware that gender inequalities in health persist in the Region and recognizing the evidence that the integration of gender in health laws, policies, programs, and projects improves equity, efficacy, and efficiency in public health; and

Recognizing that the Plan of Action aims to address persistent gender inequities in health by implementing the Gender Equality Policy in all PAHO and Member States laws, policies, programs, monitoring systems, and research,

RESOLVES:

1. To urge Member States to:
 - (a) adopt and promote the implementation of the Plan of Action for Implementing the Gender Equality Policy as a framework to attain gender equality in health;
 - (b) develop national health plans, policies, and laws for advancing the integration of gender equality in the health systems, and develop specific health policies, programs, and laws with a gender equality perspective and ensure that they are implemented through the establishment or strengthening of a gender office within the Ministry of Health;
 - (c) generate systematic reports on gender inequality in health for planning, advocacy, and monitoring through the production, analysis, and use of information disaggregated by sex and other relevant variables;

- (d) facilitate the establishment of national intersectoral advisory groups that include civil society organizations, to support the health sector in implementing the Plan of Action; and
 - (e) promote and strengthen partnerships with other United Nations agencies and other organizations to support the implementation of the Plan of Action.
2. To request the Director to:
- (a) ensure the implementation of the Plan of Action and support Member States to progress in the implementation of national plans for integrating gender equality in health systems;
 - (b) provide knowledge on advances and best practices for achieving gender equality in health, as well as on threats to reaching it;
 - (c) facilitate monitoring the progress of implementation of the Plan of Action in the Secretariat's work and technical collaboration;
 - (d) rely on the support of a technical advisory group and other internal and external mechanisms that include civil society participation for implementing and monitoring the Plan of Action; and
 - (e) promote and strengthen partnerships with other United Nations agencies and other organizations to support the implementation of the Plan of Action.

(Fourth meeting, 24 June 2009)

CE144.R5: Family and Community Health

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the concept paper *Family and Community Health* (Document CE144/21),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

FAMILY AND COMMUNITY HEALTH

THE 49th DIRECTING COUNCIL,

Having considered the concept paper *Family and Community Health* (Document CD49/___);

Recognizing that the Health Agenda for the Americas 2008–2017 calls for increasing social protection and access to quality health services, tackling health determinants, diminishing health inequalities among countries and inequities within them, reducing the risks and burden of disease, and strengthening the management and development of health workers;

Taking into account the 2008 World Health Report on primary health care and the need to develop and strengthen public policies to extend coverage in the delivery of quality health services with a family and community health orientation; and

Mindful of the international and regional mandates on family and community health, and acknowledging that if the health targets of the Millennium Development Goals are to be achieved at the national, Regional, and global levels they must be fulfilled at the local level with the participation and collaboration of health and social services, families, and communities,

RESOLVES:

1. To urge Member States to:
 - (a) adopt a comprehensive and intercultural family and community health approach as an effective framework for promoting and integrating social policies, local development strategies, public health programs, and health care services aimed at strengthening the coping capabilities of families and communities and ensuring the health and wellbeing of their members;
 - (b) intensify their efforts to ensure universal access to quality individual and collective health services and programs as a critical component of a social protection agenda, through the development of integrated health systems based on primary health care;
 - (c) strengthen the development, governance, management, and performance of integrated networks of health services with a population focus to respond to the specific health needs of individuals at different stages of their life course and in the context of their families and communities; and

- (d) invest in the development of the necessary human resources to sustain the outreach and expansion of multidisciplinary and team-based, primary health care services and public health programs and interventions with a comprehensive and intercultural family and community health approach.
2. To request the Director to:
- (a) support the development of models of care and training of human resources as well as the organization, management, and delivery of health services with a family and community oriented focus to provide comprehensive, continuous, and integrated quality health care with a gender and intercultural approach;
 - (b) promote integration of the family and community health approach in PAHO programs;
 - (c) advocate for the involvement of international agencies, scientific and technical institutions, civil society organizations, the private sector, and others in supporting national and local initiatives on family and community health, with special emphasis on priority countries and socially unprotected areas and populations of the Americas; and
 - (d) facilitate the exchange of experiences and good practices on family and community health between countries, and strengthen mechanisms for operational research and standardized evaluation and monitoring of family and community health activities, in order to allow for international and longitudinal comparisons of their effectiveness and efficiency to be made.

(Fifth meeting, 24 June 2009)

CE144.R6: Plan of Action on Adolescent and Youth Health

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director *Plan of Action on Adolescent and Youth Health* (Document CE144/13, Rev. 1), based on the PAHO Strategic Plan 2008-2012,

RESOLVES:

To recommend that the Directing Council adopt a resolution along the following lines:

PLAN OF ACTION ON ADOLESCENT AND YOUTH HEALTH

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Plan of Action on Adolescent and Youth Health* (Document CD49/___), based on the PAHO Strategic Plan 2008-2012;

Noting the World Health Assembly resolution on the Strategy for Child and Adolescent Health and Development (WHA56.21, 2003) calling on governments to strengthen and expand efforts to strive for full coverage of services and to promote access to a full range of health information for adolescents; the Ibero-American Cooperation and Integration Youth Plan 2009-2015; and Resolution CD48.R5 of the PAHO Directing Council on the Regional Strategy for Improving Adolescent and Youth Health 2010-2018, in which governments formally recognized the differentiated needs of the youth population and approved the elaboration of a plan of action;

Recalling the right of adolescents and youth to the enjoyment of the highest attainable standard of health, as set forth in the Constitution of the World Health Organization, the UN Convention on the Rights of the Child, and other international and regional human rights instruments;

Understanding that successful passage through adolescence and youth is essential for healthy, engaged and economically well-developed societies;

Recognizing that the health of adolescents and youth is a key aspect of economic and social development in the Americas; that their behaviors and health problems are an important part of the overall disease burden; that the cost associated with the treatment of chronic diseases is high; and that effective prevention and early intervention measures are available;

Considering that the outcomes for adolescent and youth health will be more effective if health promotion, primary health care, social protection, and social determinants are taken into consideration when addressing priority health topics for these populations;

Recognizing that PAHO has cooperated with the countries of the Region in establishing conceptual and technical bases and infrastructure for the development of national adolescent and youth health programs and policies;

Concerned that the specific needs of adolescents and youth have not been adequately addressed and that the achievement of international goals will require additional efforts in adolescent and youth health; and

Considering the importance of a plan of action to operationalize the Regional Strategy for Improving Adolescent and Youth Health, that will guide the preparation of future national adolescent and youth health plans, as appropriate, and the strategic plans of all organizations interested in cooperating for health with this age group in the countries of the Americas,

RESOLVES:

1. To endorse the Plan of Action on Adolescent and Youth Health to effectively and efficiently respond to current and emerging needs in adolescent and youth health with specific consideration of prevailing inequalities in health status, and to strengthen the health system response to develop and implement policies, laws, plans, programs, and services for adolescents and youth.
2. To urge Member States to:
 - (a) prioritize the improvement of adolescent and youth health and the reduction of risk factors, by establishing and/or strengthening national programs and ensuring the appropriate resources, and by improving coordination within the health sector and with partners in other sectors to ensure that actions and initiatives in adolescent and youth health and development are implemented, minimizing duplication of efforts and maximizing the impact of limited resources;
 - (b) develop and implement national plans and promote the implementation of public policies guided by the Plan of Action, focusing on the needs of low-income and vulnerable populations;
 - (c) coordinate with other countries in the Region implementation of the activities contained in their plans of action and the dissemination and use of tools that promote adolescent and youth health;
 - (d) implement the Plan of Action, as appropriate, within an integrated health system approach based on primary health care, emphasizing intersectoral action and monitoring and evaluating program effectiveness and resource allocations;
 - (e) promote the collection and use of data on adolescent and youth health disaggregated by age, sex and ethnicity and the use of a gender-based analysis, new technologies (e.g. geographical information systems) and projection models to strengthen the planning, delivery, and monitoring of national plans, policies, programs, laws and interventions related to adolescent and youth health;
 - (f) promote and establish enabling environments that foster adolescent and youth health and development;

- (g) scale up the coverage of and access to quality health services—including promotion, prevention, effective treatment, and ongoing care—to increase their demand and utilization by adolescents and youth;
 - (h) support capacity building for policymakers, program managers, and health care providers to develop policies and programs that aim to promote community development and provide effective quality health services, addressing the health needs of adolescents and youth and their related determinants of health;
 - (i) engage adolescents and youth, their families, communities, schools, and other appropriate institutions and organizations in the provision of culturally sensitive and age-appropriate promotion and prevention programs as part of the comprehensive approach to improving the health and well-being of adolescents and youth;
 - (j) establish partnerships with the media to promote positive images of adolescents and youth which promote appropriate behaviors and commitment to health issues; and
 - (k) promote the collection, use, and sharing of data on adolescent and youth health to strengthen the local and Regional planning, delivery, and monitoring of national plans, programs, and public health interventions related to adolescent and youth health.
3. To request the Director to:
- (a) establish a time-limited technical advisory group to provide guidance on topics pertinent to adolescent and youth health and development;
 - (b) encourage coordination and implementation of the Plan of Action through the integration of actions by PAHO programmatic areas in the national, subregional, regional, and interagency levels;
 - (c) work with the Member States in implementing the Plan of Action according to their own national context and priorities and promote the dissemination and use of the products derived from it at the national, subregional, regional and interagency levels;
 - (d) encourage the development of collaborative research initiatives that can provide the evidence base needed to establish and deliver effective and developmentally and age appropriate programs and interventions for adolescents and youth;

- (e) develop new or strengthen existing partnerships within the international community to identify the human resources, technology, and financial needs to guarantee the implementation of the Plan of Action;
- (f) encourage technical cooperation among countries, subregions, international and regional organizations, government entities, private organizations, universities, media, civil society, youth organizations, faith-based organizations, and communities, in activities that promote adolescent and youth health;
- (g) encourage coordination of the Plan of Action through similar initiatives by other international technical cooperation and financing agencies to improve and advocate for adolescent and youth health in the countries; and
- (h) periodically report to the PAHO Governing Bodies on the progress and constraints evaluated during implementation of the Plan of Action, and consider the adaptation of this Plan to respond to changing contexts and new challenges in the Region.

(Fifth meeting, 24 June 2009)

CE144.R7: Integrated Health Services Delivery Networks Based on Primary Health Care

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director *Integrated Health Services Delivery Networks Based on Primary Health Care* (Document CE144/17), which summarizes the problem of health services fragmentation and proposes the creation of integrated health services delivery networks to address it;

Concerned about the high degree of health services fragmentation and its adverse impact on the general performance of health systems, manifested in difficulty accessing the services, the delivery of services low in technical quality, irrational and inefficient use of the available resources, an unnecessary increase in production costs, and low levels of user satisfaction with the services received; and

Recognizing the commitments made in Article III of the Declaration of Montevideo about the renewal of primary health care, paragraph 49 of the Health Agenda for the Americas 2008-2017; and paragraph 6 of the Iquique Consensus of the XVII Ibero-American Summit of Ministers of Health, which underscore the need to create more comprehensive models of care that include health services networks,

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

**INTEGRATED HEALTH SERVICES DELIVERY NETWORKS BASED ON
PRIMARY HEALTH CARE**

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Integrated Health Services Delivery Networks Based on Primary Health Care* (Document CD49/__) which summarizes the problem of health services fragmentation and proposes the creation of integrated health services delivery networks to address it;

Concerned about the high degree of health services fragmentation and its adverse impact on the general performance of health systems, manifested in difficulty accessing the services, the delivery of services low in technical quality, irrational and inefficient use of the available resources, an unnecessary increase in production costs and low levels of user satisfaction with the services received;

Aware of the need for strengthening health systems based on primary health care (PHC) as an essential strategy for meeting national and international health targets, among them those stipulated in the Millennium Development Goals;

Recognizing that integrated health services delivery networks are one of the principal operational expressions of the PHC approach in health service delivery, helping to make several of its essential elements a reality, namely universal coverage and access; the first contact; comprehensive care; appropriate health care; optimal organization and management; and intersectoral action, etc.;

Aware that integrated health services delivery networks increase access to the system, reduce inappropriate care and the fragmentation of care, prevent the duplication of infrastructure and services, lower production costs, and better meet the needs and expectations of individuals, families, and communities; and

Recognizing the commitments made in Article III of the Declaration of Montevideo on the renewal of primary health care, paragraph 49 of the Health Agenda for the Americas 2008-2017; and paragraph 6 of the Iquique Consensus of the XVII Ibero-American Summit of Ministers of Health, which underscore the need to develop more comprehensive models of care that include health services networks,

RESOLVES:

1. To urge Member States to:
 - (a) take note of the problem of health services fragmentation in the health system and, when applicable, in the subsystems that comprise it;
 - (b) facilitate dialogue with all relevant stakeholders, particularly health service providers and home and community caregivers about the problem of service fragmentation and the strategies to address it;
 - (c) prepare a national plan of action promoting the creation of integrated health services delivery networks with a family and community health approach as the preferred modality for health services delivery in the country;
 - (d) promote human resources education and management compatible with the creation of integrated health services delivery networks; and
 - (e) implement and periodically evaluate the national plan of action for the creation of integrated health service networks.
2. To request the Director to:
 - (a) support the countries of the Region in the preparation of their national plans of action for the creation of integrated health services delivery networks;
 - (b) promote the creation of integrated health services delivery networks along common borders, including, when applicable, plans for cooperation and/or compensation for services between countries (or “shared services” in the case of the Caribbean);
 - (c) develop conceptual and analytical frameworks, tools, methodologies, and guidelines that facilitate the creation of integrated health services delivery networks;
 - (d) support human resources training and health management compatible with the creation of integrated health services delivery networks, including unpaid individuals who provide health care in the home and community;
 - (e) mobilize resources to support the creation of integrated health services delivery networks in the Region, which includes the documentation of good practices and the sharing of information on successful experiences among countries;

- (f) monitor and evaluate the progress of integrated health services delivery networks in the countries of the Region; and
- (g) promote dialogue with the international cooperation/donor community to raise awareness about the problem of health services fragmentation and seek its support for the creation of integrated health services delivery networks in the Region.

(Fifth meeting, 24 June 2009)

CE144.R8: Strategy and Plan of Action on Mental Health

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having studied the report of the Director *Strategy and Plan of Action on Mental Health* (Document CE144/12),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

STRATEGY AND PLAN OF ACTION ON MENTAL HEALTH

THE 49th DIRECTING COUNCIL,

Having studied the report of the Director *Strategy and Plan of Action on Mental Health* (Document CD49/__);

Recognizing the burden from mental and substance abuse disorders—morbidity, mortality, and disability—in the world and in the Region of the Americas in particular, as well as the existing gap in the number of sick people who do not receive any type of treatment;

Understanding that there is no physical health without mental health and that an approach to the health-disease process is necessary not only from the perspective of care for impairments, but also from the angle of protecting positive health attributes and promoting the wellbeing of the population, and, in addition, that from the public health perspective, there are psychosocial and human behavior factors that perform a crucial function;

Considering the context and framework for action offered by the Health Agenda for the Americas, the PAHO Strategic Plan 2008-2012, and the WHO Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance abuse disorders

(mhGAP), which reflect the importance of the issue and define strategic objectives for addressing mental health; and

Observing that the Strategy and Plan of Action on Mental Health address the principal work areas and define areas for technical cooperation to serve the different mental health needs of the countries,

RESOLVES:

1. To endorse the provisions of the Strategy and Plan of Action on Mental Health and its implementation within the framework of the special conditions of each country in order to respond appropriately to current and future mental health needs.
2. To urge Member States to:
 - (a) include mental health as a priority within national health policies, through the implementation of mental health plans that are consonant with the different problems and priorities of the countries, in order to maintain the achievements made and advance toward new goals, especially with regard to reducing existing treatment gaps;
 - (b) promote universal, equitable access to mental health care for the entire population, through strengthening mental health services within the framework of primary health care-based systems and integrated delivery networks and continuing activities to eliminate the old psychiatric hospital-centered model;
 - (c) continue working to strengthen the legal frameworks of the countries with a view to protecting the human rights of people with mental disorders and to achieve the effective application of the laws;
 - (d) promote intersectoral initiatives to promote mental health, with particular attention to children and adolescents and on coping with the stigma and discrimination directed at people with mental disorders;
 - (e) support the effective involvement of the community and of user and family-member associations in activities designed to promote and protect the mental health of the population;
 - (f) regard mental health human resources development as a key component in the improvement of plans and services, through the development and implementation of systematic training programs;

- (g) bridge the existing mental health information gap through improvements in the production, analysis, and use of information, as well as through research, with an intercultural and gender approach; and
 - (h) strengthen partnerships between the public sector and other sectors, as well as with nongovernmental organizations, academic institutions, and key social actors, emphasizing their involvement in the development of mental health plans.
3. To request the Director to:
- (a) support the Member States in the preparation and implementation of national mental health plans within the framework of their health policies, taking into account the Strategy and Plan of Action, endeavoring to correct inequities, and giving priority to care for vulnerable and special-needs groups;
 - (b) collaborate in the assessment of mental health services in the countries to ensure that appropriate corrective measures grounded on scientific evidence are taken;
 - (c) facilitate the dissemination of information and sharing of positive, innovative experiences and promote technical cooperation among the Member States; and
 - (d) promote partnerships with governmental and nongovernmental organizations, as well as with international organizations and other regional actors in support of the multisectoral response that is required in the process of implementing this Strategy and Plan of Action.

(Fifth meeting, 24 June 2009)

CE144.R9: Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the draft Regional Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment (Document CE144/20),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

PLAN OF ACTION ON THE PREVENTION OF AVOIDABLE BLINDNESS AND VISUAL IMPAIRMENT

THE 49th DIRECTING COUNCIL,

Having reviewed Document CD49/___ *Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment*;

Recalling Resolution WHA56.26 of the World Health Assembly on the elimination of avoidable blindness;

Noting that visual disability is a prevalent problem in the Region and is related to poverty and social marginalization;

Aware that most of the causes of blindness are avoidable and that treatments available are among the most successful and cost-effective of all health interventions;

Acknowledging that preventing blindness and visual impairment relieves poverty and improves opportunities for education and employment; and

Appreciating the efforts made by Member States in recent years to prevent avoidable blindness, but mindful of the need for further action,

RESOLVES:

1. To approve the *Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment*.
2. To urge Member States to:
 - (a) establish national coordinating committees to help develop and implement national blindness prevention plans;
 - (b) include prevention of avoidable blindness and visual impairment in national development plans and goals;
 - (c) advance the integration of prevention of blindness and visual impairment in existing plans and programs for primary health care at the national level, ensuring their sensitivity to gender and ethnicity;
 - (d) support the mobilization of resources for eliminating avoidable blindness;

- (e) encourage partnerships between the public sector, nongovernmental organizations, private sector, civil society, and communities in programs and activities that promote the prevention of blindness; and
 - (f) encourage intercountry cooperation in the areas of blindness and visual impairment prevention and care.
3. To request the Director to:
- (a) support the implementation of the *Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment*;
 - (b) maintain and strengthen PAHO Secretariat's collaboration with Member States on the prevention of blindness; and
 - (c) promote technical cooperation among countries and the development of strategic partnerships in activities to protect ocular health.

(Fifth meeting, 24 June 2009)

CE144.R10: Proposed Amended Draft of the PAHO Strategic Plan 2008-2012

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the proposed amended draft of the PAHO Strategic Plan 2008-2012 presented by the Director (*Official Document 328*); and

Anticipating that the Bureau has taken into consideration the comments of the Executive Committee in the finalization of the amended draft of the Strategic Plan,

RESOLVES:

To recommend to the 49th Directing Council the adoption of a resolution along the following lines:

AMENDED PAHO STRATEGIC PLAN 2008-2012

THE 49th DIRECTING COUNCIL,

Having considered the proposed amended draft of the PAHO Strategic Plan 2008-2012 presented by the Director (*Official Document 328*);

Noting that the Strategic Plan was amended to align it with the WHO Medium-Term Strategic Plan 2008-2013, which was also amended and approved at the recent 62nd World Health Assembly; and

Noting that other changes address the need to update the document in order to clarify the expected results and simplify their measurement,

RESOLVES:

To approve the *Amended PAHO Strategic Plan 2008-2012 (Official Document 328)*, including its revised indicators and targets.

(Sixth meeting, 25 June 2009)

CE144.R11: Elimination of Neglected Diseases and other Poverty-Related Infections

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the document *Elimination of Neglected Diseases and other Poverty-related Infections* (Document CE144/10),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

**ELIMINATION OF NEGLECTED DISEASES AND OTHER
POVERTY-RELATED INFECTIONS**

THE 49th DIRECTING COUNCIL,

Having reviewed the document *Elimination of Neglected Diseases and other Poverty-related Infections* (Document CD49/__) and considering:

- (a) the existence of previous PAHO and WHO mandates and resolutions to address neglected diseases and other infections related to poverty that can be eliminated or drastically reduced;
- (b) the Region of the Americas' extensive experience in implementing elimination strategies for communicable diseases and the encouraging advances in reducing the burden of these diseases;

- (c) the need to fulfill the “unfinished agenda,” since the proportion of those affected remains high among the poorest and most marginalized people of the Americas;
- (d) the need to address the social determinants of health in order to effectively reduce the health, social, and economic burden of neglected diseases and other diseases related to poverty;
- (e) the current opportunity to eliminate or drastically reduce the burden of these diseases with available tools; and
- (f) the importance of working to eliminate infectious diseases for which adequate and cost-effective public health interventions exist, but which still continue to afflict the peoples of the Americas,

RESOLVES:

1. To urge the Member States to:
 - (a) commit themselves to eliminate or reduce neglected diseases and other infections related to poverty for which tools exist, to levels so that these diseases are no longer considered public health problems by 2015;
 - (b) identify priority neglected diseases, vulnerable populations that have lagged behind, gaps in epidemiological information, and the priority geographic areas for intervention (“hot spots”) at subnational levels in the countries;
 - (c) review existing specific national plans to control or eliminate these diseases and, where needed, develop new ones that rely on a comprehensive approach and which consider social determinants of health, interprogrammatic strategies, and inter-sectoral actions;
 - (d) work to provide sufficient resources available to ensure the sustainability of national and subnational control programs, including personnel, drug supplies, equipment, and other needs;
 - (e) implement prevention, diagnostic, treatment, vector control, and elimination strategies in an integrated way so that they contribute to the strengthening of national health systems, including primary health care and the health surveillance systems;
 - (f) explore and, where appropriate, promote a range of incentive schemes for research and development, including addressing, where appropriate, the de-linkage of the cost of research and development and the price of health products,

for example, through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries;

- (g) mobilize additional resources and involve potential partners within the countries, as well as bilateral and multilateral development agencies, nongovernmental organizations, foundations, and other stakeholders;
- (h) provide support for the promotion of research and scientific development related to new and improved tools, strategies, technologies, and methods to prevent and control neglected diseases, such as the development of accessible diagnostic tests, safer medications, and timely diagnostic mechanisms to reduce late complications in these diseases; and
- (i) approve the goals and indicators for the elimination and reduction of neglected diseases and other infections related to poverty considered as priorities by the Member States and listed in Annexes A and B.

2. To request the Director to:

- (a) continue advocating for an active mobilization of resources and promote the development of close partnerships to support the implementation of this resolution;
- (b) provide technical cooperation to the countries for preparing national plans of action;
- (c) promote the identification, development, and use of evidence-based interventions that are technically and scientifically sound;
- (d) promote the implementation of current PAHO/WHO guidelines for the prevention and control of the included diseases;
- (e) promote research and scientific development related to new or improved tools, strategies, technologies, and methods for the prevention and control of the neglected diseases;
- (f) support the strengthening of surveillance systems and primary health care, as well as the monitoring and evaluation of the national action plans being implemented;
- (g) strengthen cross-border collaboration among the countries which share the same diseases; and

- (h) continue to support and strengthen the mechanisms for acquiring medications, such as the Strategic Fund, so as to treat neglected diseases at the best cost in order to increase access.

Annexes

(Sixth meeting, 25 June 2009)

Presence of neglected diseases and other infections related to poverty, by country, and total number of countries where each disease occurs in Latin America and the Caribbean, according to the criteria set forth below³

Country	Disease											
	Chagas' Disease	Congenital syphilis	Human rabies transmitted by dogs	Leprosy	Lymphatic filariasis	Malaria	Neonatal tetanus	Onchocerciasis	Plague	Schistosomiasis	Soil-transmitted helminthiasis	Trachoma
Anguilla	-	...	-	-	-	-	-	-	-	-	X	-
Antigua and Barbuda	-	...	-	-	-	-	-	-	-	-	X	-
Argentina	X	X	X	X	-	X	X	-	-	-	X	-
Aruba	-	...	-	-	-	-	-	-	-	-	X	-
Bahamas	-	X	-	-	-	-	-	-	-	-	X	-
Barbados	-	...	-	-	-	-	-	-	-	-	X	-
Belize	X	X	-	-	-	X	-	-	-	-	X	-
Bolivia	X	X	X	X	-	X	X	-	- ^b	-	X	-
Brazil	X	X	X	X ^a	X	X	X	X	X	X	X	X
Cayman Islands	-	...	-	-	-	-	-	-	-	-	X	-
Chile	X	X	-	-	-	-	-	-	-	-	X	-
Colombia	X	X	X	X	-	X	X	X	-	-	X	-
Costa Rica	X	X	-	X	-	X	-	-	-	-	X	-
Cuba	-	X	X	X	-	-	-	-	-	-	X	-
Dominica	-	...	-	-	-	-	-	-	-	-	X	-
Dominican Republic	-	X	X	X	X	X	X	-	-	-	X	-
Ecuador	X	X	-	X	-	X	X	X	X	-	X	-
El Salvador	X	X	X	X	-	X	X	-	-	-	X	-
French Guiana	X	...	-	-	-	X	-	-	-	-	X	-
Grenada	-	...	-	-	-	-	-	-	-	-	X	-
Guadeloupe	-	...	-	-	-	-	-	-	-	-	X	-
Guatemala	X	X	X	X	-	X	X	X	-	-	X	X
Guyana	X	X	-	X	X	X	-	-	-	-	X	-
Haiti	-	X	X	X	X	X	X ^a	-	-	-	X	-
Honduras	X	X	-	X	-	X	X	-	-	-	X	-
Jamaica	-	X	-	X	-	-	-	-	-	-	X	-
Martinique	-	...	-	-	-	-	-	-	-	-	X	-
Mexico	X	X	-	X	-	X	X	X	-	-	X	X

³ PAHO/HSD/CD. Epidemiological Profiles of Neglected Diseases and Other Infections Related to Poverty in Latin America and the Caribbean. Presented at the Consultation on a Latin American and Caribbean Trust Fund for the Prevention, Control and Elimination of Neglected and Other Infectious Diseases. Washington, DC, 15-16 December 2008. Available at: http://new.paho.org/hq/index.php?option=com_joomlabook&Itemid=259&task=display&id=37.

Country	Disease											
	Chagas' Disease	Congenital syphilis	Human rabies transmitted by dogs	Leprosy	Lymphatic filariasis	Malaria	Neonatal tetanus	Onchocerciasis	Plague	Schistosomiasis	Soil-transmitted helminthiasis	Trachoma
Montserrat	-	...	-	-	-	-	-	-	-	-	X	-
Netherlands Antilles	-	...	-	-	-	-	-	-	-	-	X	-
Nicaragua	X	X	-	X	-	X	X	-	-	-	X	-
Panama	X	X	-	X	-	X	X	-	-	-	X	-
Paraguay	X	X	-	X	-	X	X	-	-	-	X	-
Peru	X	X	X	X	-	X	X	-	X	-	X	-
Saint Kitts and Nevis	-	...	-	-	-	-	-	-	-	-	X	-
Saint Lucia	-	...	-	X	-	-	-	-	-	X	X	-
Saint Vincent and the Grenadines	-	...	-	-	-	-	-	-	-	-	X	-
Suriname	X	...	-	X	-	X	-	-	-	X	X	-
Trinidad and Tobago	-	X	-	X	-	-	-	-	-	-	X	-
Turks and Caicos Islands	-	...	-	-	-	-	-	-	-	-	X	-
Uruguay	X	X	-	X	-	-	-	-	-	-	X	-
Virgin Islands (UK)	-	...	-	-	-	-	-	-	-	-	X	-
Virgin Islands (USA)	-	...	-	-	-	-	-	-	-	-	X	-
Venezuela	X	X	X	X	-	X	X	X	-	X	X	-
Total number of Latin American and Caribbean countries where the diseases occur	21	25	11	24	4	21	16	6	3	4	All	3

^a In these countries, the disease is only present as a public health problem

^b Previously endemic area

- No evidence

... No information

Criteria:

Chagas' disease:	Evidence of any type of transmission in the last 10 years (1998-2007)
Schistosomiasis:	Evidence of the disease in the last 10 years (1998-2007)
Lymphatic filariasis:	Evidence of the disease in the last 3 years (2005-2007)
Soil-transmitted helminths:	Evidence of the disease in the last 10 years (2005-2007)
Leprosy:	Evidence of the disease in the last 3 years (2005-2007)
Onchocerciasis:	Evidence of the disease in the last 3 years (2005-2007)
Human rabies transmitted by dogs:	Evidence of the disease in the last 3 years (2006-2008)
Trachoma:	Evidence of the disease in the last 10 years (1998-2007)
Neonatal tetanus:	Evidence of the disease in the last 3 years (2005-2007)
Congenital syphilis:	Evidence of the disease in the last 3 years (2005-2007)
Malaria	Evidence of continuous local transmission in the last 5 years
Plague	Evidence of the disease in the last 3 years (2006-2008)

Epidemiological situation, elimination goals, and primary elimination strategies for selected neglected diseases and other infections related to poverty.⁴

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Chagas' disease	<ul style="list-style-type: none"> – There was evidence of transmission in 21 countries of the Americas. – It is estimated that 8 to 9 million people are currently infected. – 40,000 new cases of vector-borne transmission per year. – Vector-borne transmission by the main vectors has been interrupted in several countries (Uruguay, Chile, Brazil, and Guatemala) and areas (Argentina and Paraguay). – Most countries in Latin America are close to reaching the goal of implementing screening for Chagas in 100% of their blood banks. 	<ul style="list-style-type: none"> – To interrupt domestic vector-borne transmission of <i>T. cruzi</i> (domestic triatomine infestation index of less than 1% and negative seroprevalence in children up to five years of age, with the exception of the minimum represented by cases in children of seropositive mothers). – To interrupt transfusional transmission of <i>T. cruzi</i> (100% blood screening coverage).⁵ – To integrate diagnosis of Chagas' disease in the primary health care system, in order to provide treatment and medical care to all patients for both the acute and chronic phases and to reinforce the supply chain of the existing treatments within countries to scale up access. – To prevent the development of cardiomyopathies and intestinal problems related to Chagas' disease, offering adequate health care to those affected by the various stages of the disease. 	<ul style="list-style-type: none"> – To eliminate vectors in the home through chemical control. – Environment management programs. – Information/Education/Communication (IEC). – Screening of blood samples in blood banks to avoid transmission by blood transfusion. – Screening of pregnant women and treatment to avoid congenital transmission. – Good practices on food preparation to avoid oral transmission. – Etiologic treatment of children – Offer medical care to adults with Chagas' disease.

⁴ PAHO/HSD/CD. Epidemiological Profiles of Neglected Diseases and Other Infections Related to Poverty in Latin America and the Caribbean. Presented at the Consultation on a Latin American and Caribbean Trust Fund for the Prevention, Control and Elimination of Neglected and Other Infectious Diseases. Washington, DC, 15-16 December 2008. Available at: http://new.paho.org/hq/index.php?option=com_joomlabook&Itemid=259&task=display&id=37.

⁵ Based on: WHO. *Elimination of transmission of Chagas Disease*. WHA51.14. Fifty-first World Health Assembly. 1998.

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Congenital syphilis	<ul style="list-style-type: none"> – It is estimated that 250,000 cases of congenital syphilis occur each year in the Region. – In a 2006 survey, 14 countries reported the incidence of congenital syphilis in live births, with a range varying from 0.0 cases per 1,000 live births in Cuba to 1.56 in Brazil. 	<ul style="list-style-type: none"> – To eliminate congenital syphilis as a public health problem (less than 0.5 cases per 1,000 live births).⁶ 	<ul style="list-style-type: none"> – Obligatory notification of syphilis and congenital syphilis for pregnant women. – Universal blood screening during the first prenatal visit (<20 weeks,) during the third trimester, during labor, and following stillbirth and abortion/miscarriage. – Timely and adequate treatment for all expectant mothers with syphilis, and the same for spouses and newborns.
Human rabies transmitted by dogs	<ul style="list-style-type: none"> – The disease has been present in 11 countries in the past 3 years. – Even though the number of human cases is low (16 in 2008) due to country efforts, the number of people who live in risk areas due to rabies in dogs is still high. – The majority of the cases occurred in Haiti and Bolivia. 	<ul style="list-style-type: none"> – To eliminate human rabies transmitted by dogs (zero cases reported to the Epidemiological Surveillance System for Rabies (SIRVERA) coordinated by PAHO).⁷ 	<ul style="list-style-type: none"> – Vaccination of 80% of the canine population in endemic areas. – Care given to 100% of the exposed population at risk with post-exposure prophylaxis when indicated. – Epidemiological surveillance. – Education and communication to increase awareness of the risk of rabies.

⁶ Based on: OPS. *Plan de Acción para la eliminación de la sífilis congénita*. 116.^a Reunión del Comité Ejecutivo. CE116/14. OPS, 1995.

⁷ Based on: PAHO. *15th Inter-American Meeting at the Ministerial Level on Health and Agriculture (RIMSA): "Agriculture and Health: Alliance for Equity and Rural Development in the Americas"*. CD48.R13. Forty-eighth Directing Council.

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Leprosy	<ul style="list-style-type: none"> – There are 24 countries where the disease has been present in the last three years. – Only in Brazil did the national prevalence not reach the “elimination as a public health problem” goal of fewer than one case per 10,000 population. – In 2007, 49,388 cases of leprosy were reported in the Americas, and 42,000 new cases were detected. – In the same year, 3,400 new cases (8% of the total) were detected with grade-2 disability. 	<ul style="list-style-type: none"> – To eliminate leprosy as a public health problem (less than 1 case per 10,000 people) from the first sub-national political/administrative levels.^{8,9} 	<ul style="list-style-type: none"> – Intensified surveillance of contacts. – Treatment with timely multi-drug therapy in at least 99% of all patients. – Define the appropriated introduction of chemoprophylaxis. – Early detection of grade-2 disabilities.

⁸ Based on: WHO. Adoption of Multidrug Therapy for Elimination of Leprosy as a Public Health Problem. Forty-fourth World Health Assembly. WHA44.9. Geneva: WHO, 1991.

⁹ Based on: WHO. Guide to Eliminate Leprosy as a Public Health Problem. Geneva: WHO, 2000.

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Lymphatic filariasis	<ul style="list-style-type: none"> – The disease is present in Brazil, the Dominican Republic, Guyana, and Haiti. – It is estimated that up to 11 million people are at risk of infection. – The population most at-risk is in Haiti (90%). 	<ul style="list-style-type: none"> – To eliminate the disease as a public health problem (less than 1% prevalence of microfilaria in adults in sentinel sites and spot-check sites in the area). – Interrupt its transmission (no children between ages 2 and 4 are antigen-positive). – To prevent and control disability.¹⁰ 	<ul style="list-style-type: none"> – Mass drug administration (MDA) once a year for at least 5 years with coverage of no less than 75% or consumption of diethylcarbamazine (DEC)-fortified table salt in the daily diet. – Surveillance of LF morbidity by local health surveillance systems. – Morbidity case management. – Integration/coordination of MDA with others strategies. – Communication strategies and education in schools.
Malaria	<ul style="list-style-type: none"> – There are 21 malaria-endemic countries in the Region. – Some countries, such as Paraguay and Argentina, are of low endemicity (fewer than one case per 1,000 population at risk) and have well established foci. – In the Caribbean, only Haiti and the Dominican Republic are considered endemic, reporting approximately 26,000 cases in 2007 (90% in Haiti). 	<ul style="list-style-type: none"> – To eliminate malaria in areas where interruption of local transmission is feasible (Argentina, the Dominican Republic, Haiti, Mexico, Paraguay, and Central America).¹¹ – Elimination (zero local cases for 3 consecutive years); pre-elimination (slide positivity rate = < 5 % and <1 case / 1,000 population at risk).¹² 	<ul style="list-style-type: none"> – Prevention, surveillance, early detection and containment of epidemics. – Integrated vector management. – Prompt diagnosis and appropriate treatment of cases. – Intensive pharmacovigilance of possible resistance to treatment and use of results in definition of treatment policy. – Strengthening of primary health care and integration of prevention and control efforts with other health programs. – Community participation.

¹⁰ Based on: WHO. Monitoring and epidemiological assessment of the programme to eliminate lymphatic filariasis at implementation unit level. Geneva: WHO; 2005.

¹¹ Based on: PAHO. Malaria: Progress Report. 142nd Session of the Executive Committee. CE142/16. PAHO. 2008.

¹² Based on: WHO. *Global Malaria Control and Elimination: Report of a Technical Review*. 17-18 January, 2008. WHO. 2008. p.9.

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Neonatal tetanus	<ul style="list-style-type: none"> – The disease has been present in lower rates in 16 countries in the past 3 years. – A total of 63 cases were reported in 2007 (38 in Haiti). – It has been eliminated as a public health problem in all Latin American and Caribbean countries except Haiti. 	<ul style="list-style-type: none"> – To eliminate the disease as a public health problem (fewer than 1 case per 1,000 newborns per year in a municipality or district).¹³ 	<ul style="list-style-type: none"> – Immunization of women of childbearing age with tetanus toxoid. – Identification of high risk areas. – Adequate surveillance. – Clean delivery and post-delivery practices.
Onchocerciasis	<ul style="list-style-type: none"> – It is estimated that 500,000 people are at risk in the Region. – 13 foci exist in Brazil, Colombia, Ecuador, Guatemala, Mexico, and Venezuela. – In 6 foci, transmission appears to have been interrupted following massive drug administration with a coverage of at least 85% of the eligible population. – They are currently undergoing a three-year post-treatment surveillance prior to certification of elimination. 	<ul style="list-style-type: none"> – To eliminate ocular morbidity and to interrupt transmission.^{14,15} 	<ul style="list-style-type: none"> – Mass drug treatment administration at least twice a year in order to reach at least 85% of the eligible population in each endemic area. – Surveillance for signs of ocular morbidity, microfilaria, nodules. – Dermatological care through the primary health care system in areas where skin infection is a problem.

¹³ Basado en: Organización Panamericana de la Salud. *Neonatal Tetanus Elimination: Field Guide*, Second edition. Scientific and Technical Publication No. 602, Washington, D.C., 2005.

¹⁴ Based on: PAHO. *Toward the Elimination of Onchocerciasis (River Blindness) in the Americas. (CD48/10)*. Forty-eighth Directing Council of the Pan American Health Organization. Washington, DC: PAHO; 2008.

¹⁵ Based on: WHO. Certification of elimination of human onchocerciasis: criteria and procedures. Guidelines. WHO; 2001.

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Plague	<ul style="list-style-type: none"> – The disease is present in wild foci in 5 countries with sporadic cases: Bolivia (no reported cases during last 10 years), Brazil, Ecuador, Peru and United States. – Currently the number of cases throughout Latin America is low (around 12 cases per year). – Most of the cases reported are in Peru. – Very few are fatal. – The cases usually occur in small rural villages with extreme poverty. 	<ul style="list-style-type: none"> – To eliminate as a public health problem (zero mortality cases and avoid domiciliary outbreaks). 	<ul style="list-style-type: none"> – Early detection and timely case management. – Surveillance of the wild foci. – Housing and sanitation improvements. – Rodent and vector control. – Intersectoral programs for improvement for storage of crops. – Adequate elimination of agricultural waste. – Extra household installations for farming the “cuyes” (type of guinea pigs used for food consumption).
Trachoma	<ul style="list-style-type: none"> – There is evidence of the presence of the disease in Brazil, Guatemala, and Mexico. – Foci have been confirmed in Brazilian border states but no data was found for neighboring countries. – It is estimated that around 50 million people live in areas at-risk and about 7,000 cases have been identified, mostly in Brazil. 	<ul style="list-style-type: none"> – To eliminate new cases of blindness caused by trachoma (reduction in the prevalence of trachomatous trichiasis to less than 1 case per 1,000 (general population) and reduction in the prevalence of follicular or inflammatory trachoma (FT and IT) to less than 5% in children aged 1-9 years).^{16,17} 	<ul style="list-style-type: none"> – The “SAFE” strategy is used with the following components: <ul style="list-style-type: none"> • To prevent blindness through eyelid surgery to correct the inversion or entropion of the upper eyelid and trichiasis. • To reduce the transmission in endemic areas by washing of the face and by using antibiotics.

¹⁶ Based on: WHO. Report of the Global Scientific Meeting on Future Approaches to Trachoma Control. Geneva: WHO; 1996. p. 4-7.

¹⁷ Based on: WHO. Trachoma control: A guide for programme managers. WHO, 2006.

GROUP 2: Diseases whose prevalence can be drastically reduced (with available cost-effective interventions)			
Disease	Epidemiological Situation	Goals	Primary Strategy
Schistosomiasis	<ul style="list-style-type: none"> – The disease is present in: Brazil, Saint Lucia, Suriname, and Venezuela. – Studies are needed to confirm the elimination of previously endemic areas in the Caribbean. – It is estimated that around 25 million people live at risk in the Americas, mostly in Brazil. – Around 1 to 3 million people are estimated to be infected. 	<ul style="list-style-type: none"> – To reduce prevalence and parasite load in high transmission areas to less than 10% prevalence as measured by quantitative egg counts.^{18,19} 	<ul style="list-style-type: none"> – Chemotherapy for at least 75% of at-risk school-age children. – Improvements of excreta disposal systems and access to drinking water, education.
Soil-transmitted helminthiasis	<ul style="list-style-type: none"> – It is estimated that soil-transmitted helminthiasis is present in all the Region's countries. – Regional estimates put the number of school-age children at risk of the disease at 26.3 million in Latin America and the Caribbean. – 13 of the 14 countries with information available there were one or more areas with prevalence of STH higher than 20%. 	<ul style="list-style-type: none"> – To reduce prevalence among school-age children in high risk areas (prevalence >50%) to less than <20% prevalence as measured by quantitative egg count.²⁰ 	<ul style="list-style-type: none"> – Regular administration of preventive chemotherapy/or mass drug administration (MDA) for at least 75% of at-risk school-age children. If prevalence of any soil-transmitted helminthiasis infection among school-age children is $\geq 50\%$ (high-risk community), treat all school-age children twice each year. If prevalence of any soil-transmitted helminthiasis infection among at-risk school-age children is $\geq 20\%$ and $< 50\%$ (low-risk community), treat all school-age children once each year. – Promoting access to safe water, sanitation and health education, through intersectoral collaboration.

¹⁸ Based on: WHO. *Preventive chemotherapy in human helminthiasis*. Geneva: WHO; 2006.

¹⁹ Based on: WHO. *Schistosomiasis and soil-transmitted helminth infections*. Fifty-fourth World Health Assembly. WHA54.19. Geneva: WHO, 2001.

²⁰ Based on: WHO. *Preventive chemotherapy in Human Helminthiasis*. Geneva: WHO; 2006.

CE144.R12: Policy Framework for Human Organ Donation and Transplantation

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director *Policy Framework for Human Organ Donation and Transplantation* (Document CE144/15, Rev. 1),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

**POLICY FRAMEWORK FOR HUMAN ORGAN
DONATION AND TRANSPLANTATION**

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Policy Framework for Human Organ Donation and Transplantation* (Document CD49/__), which proposes that Member States have a policy framework that will facilitate the strengthening of national capacity to effectively and efficiently address the problem of cell, tissue, and organ donation and transplantation and achieve optimal utilization of the resources allocated for this purpose;

Recognizing the valuable contributions of the Ibero-American Network/Council on Donation and Transplantation (RDCIT) to the promotion and strengthening of national organ donation and transplantation programs in the Region;

Aware of the growing magnitude and usefulness of human cells, tissue, and organs for a wide range of disorders in high- and low-income countries alike;

Committed to the principles of human dignity and solidarity, which condemn the purchase of human body parts for transplantation and the exploitation of the poorest and most vulnerable populations, as well as the human trafficking stemming from such practices;

Convinced that voluntary, unpaid donation of organs, cells, and tissue from deceased or living donors helps guarantee the continued presence of a vital community resource; and

Sensitive to the need for monitoring reactions and adverse events associated with the donation, processing, and transplantation of human cells, tissues and organs as such, and for ensuring that this information is disseminated internationally to optimize the safety and efficacy of transplants,

RESOLVES:

1. To urge Member States to:
 - (a) apply the Guiding Principles on Human Cell, Tissue, and Organ Transplantation in the formulation and execution of their policies, laws, and regulations on human cell, tissue, and organ donation and transplantation, as the case may be;
 - (b) promote equitable access to transplantation services, as national capabilities permit, that serve as the foundation for public support and voluntary donations;
 - (c) fight efforts to obtain economic gain or comparable advantages in transactions with human body parts, organ trafficking, and transplant tourism, and to encourage health professionals to notify the proper authorities when they have knowledge of such practices, in accordance with national capabilities and national law;
 - (d) strengthen national public authorities and capabilities, providing them with support to guarantee the supervision, organization, and coordination of donation and transplantation activities, with special attention to ensuring that, insofar as possible, they use donations of organs from deceased people and protect the health and well-being of living donors;
 - (e) improve the safety and efficacy of donation and transplantation by promoting international best practices;
 - (f) collaborate in the collection of data, especially on adverse reactions and events related to the practices, safety, quality, efficacy, epidemiology, and ethics of donation and transplantation; and
 - (g) stay actively involved in the RDCIT and incorporate the guidelines and recommendations of this Network/Council in their policies, laws, regulations, and practices related to cell, tissue, and organ obtention, donation, and transplantation.
2. Request the Director to:
 - (a) disseminate the updated Guiding Principles on Human Cell, Tissue, and Organ Transplantation as widely as possible to all stakeholders;
 - (b) support Member States and nongovernmental organizations in matters related to the prohibition of trafficking in materials of human origin and transplant tourism;

- (c) continue to gather and analyze regional data on practices, safety, quality, efficacy, epidemiology, and ethics in human cell, tissue, and organ donation and transplantation;
- (d) provide technical assistance to the Member States that request it in the drafting of national laws and regulations on human cell, tissue, and organ donation and transplantation and to set up appropriate systems for this purpose, facilitating international cooperation in particular;
- (e) facilitate Member States' access to appropriate information on the donation, processing, and transplantation of human cells, tissue, and organs, especially data on severe reactions and adverse events; and
- (f) provide technical assistance to the English-speaking Caribbean countries to promote or improve their kidney transplant programs and propose a subregional kidney health service and transplantation system that would ensure the sustainability and viability of this type of program.

(Sixth meeting, 25 June 2009)

CE144.R13: Plan of Action on the Health of Older Persons, Including Active and Healthy Aging

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director *Plan of Action on the Health of Older Persons, Including Active and Healthy Aging* (Document CE144/9),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

**PLAN OF ACTION ON THE HEALTH OF OLDER PERSONS, INCLUDING
ACTIVE AND HEALTHY AGING**

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Plan of Action on the Health of Older Persons, Including Active and Healthy Aging* (Document CD49/__);

Mindful of the United Nations Principles for Older Persons (1991); the international mandates proposed in the International Plan of Action on Aging of Madrid, 2002; the Pan American Sanitary Conference Resolution CSP26.R20 (2002), the regional

implementation strategy approved by the Regional Intergovernmental Conference on Aging (2003); the Brasilia Declaration adopted by the Second Intergovernmental Regional Conference on Aging (2007); the Health Agenda for the Americas 2008-2017; and the Resolution AG/RES.2455 (XXXIX-O/09) of the Organization of American States, "Human Rights and Older Persons," adopted by the 39th Regular Session of the General Assembly of the OAS (San Pedro Sula, Honduras, 4 June 2009);

Recognizing the high degree of complementarity between this strategy and other objectives established in the PAHO Strategic Plan (*Official Document 328*), such as those related to disability (prevention and rehabilitation), mental health, the health of indigenous peoples, nutrition in health and development, and social and economic health determinants (approaches that favor the poor, are gender-sensitive, and human rights-based);

Emphasizing that the exponential shift toward a new demographic and epidemiological situation means not only that countries must rapidly adapt but they must anticipate new contexts, and that only adequate social and health investment can produce healthy and active longevity with benefits in all areas for individuals, families, and society as a whole; and

Considering the importance of having a strategy and plan of action that will enable Member States to respond effectively and efficiently to the needs and demands that the aging population is already rapidly making on health and social security systems, society, and the family,

RESOLVES:

1. To support the present *Plan of Action on the Health of Older Persons, Including Active and Healthy Aging* and its consideration in policies, plans and development programs as well as proposals and the discussion of the national budgets, to enable them to create the conditions for meeting the challenge of aging in their respective countries.
2. Urge the Member States to:
 - (a) consider the United Nations Principles for Older Persons (independence, participation, care, self-fulfillment and dignity) as the foundation for public policies on aging and health, and the need to include older persons when designing and executing these policies;
 - (b) adopt national policies, strategies, plans, and programs that increase access by older persons to health programs and services that meet their needs, including in particular health promotion and disease prevention programs based on primary health care that promote the development of strategies that integrate healthy

- personal and environmental behaviors to achieve active aging throughout the life cycle, with the participation of society as a whole, the family, and the individuals themselves;
- (c) promote an internal dialogue among public sector institutions and between them and the private sector and civil society, with a view to building a national consensus on the issue of the health of older persons and healthy and active aging and its link with national development processes;
 - (d) advocate for the promotion and protection of the human rights and basic freedoms of older persons through the adoption of legal frameworks and implementation mechanisms, chiefly in the context of long-term care services, bearing in mind Resolution CSP26.R20 “Health and Aging” adopted by the 26th Pan American Sanitary Conference (Washington, D.C., United States, 23 September 2002);
 - (e) collaborate with the Permanent Council of the Organization of American States in efforts that include a special meeting of national representatives and experts from the academic sector and civil society, as well as from international organizations, for the purpose of sharing information and best practices and also of examining the feasibility of preparing an inter-American convention on the rights of older persons;
 - (f) support capacity building for training the human resources needed to tend to the health needs of older persons;
 - (g) strengthen the capacity to generate information and research for the development of strategies based on evidence and the needs of this population group, ensuring the ability to monitor and evaluate their results; and
 - (h) conduct an internal review and analysis of the relevance and viability of this strategy in the national context, based on national priorities, needs, and capabilities.
3. Request the Director to:
- (a) support the Member States in the implementation of the strategy and *Plan of Action on the Health of Older Persons, Including Active and Healthy Aging*, in a manner consistent with their needs and the demographic and epidemiological context;
 - (b) promote the implementation and coordination of this strategy and Plan of Action, guaranteeing that it cuts across program areas, the Organization’s different regional and subregional contexts, collaboration with and among countries, the

- strategy design, and the sharing of skills and resources in order to execute its plans on health and aging;
- (c) encourage the development of collaborative research that will yield better knowledge about the impact of aging on health systems and the modeling of future scenarios that will enhance national forecasting capacity in this area, the design of related strategies, and interventions based on the specific needs of the Region's different contexts;
 - (d) support development and capacity building to ensure adequate training and distribution of the necessary human resources for health to the countries to address the health needs of older persons;
 - (e) consolidate and strengthen technical collaboration with the committees, organs, and rapporteurships of United Nations and Inter-American agencies, and promote partnerships with other international and regional agencies, scientific and technical institutions, organized civil society, the private sector, and others in creating a Coalition of the Americas for Healthy Aging that will contribute to the implementation of this strategy and Plan of Action; and
 - (f) report periodically to the PAHO Governing Bodies on progress and constraints in the execution of this strategy and Plan of Action, as well as its adaptation to new contexts and needs, when necessary.

(Sixth meeting, 25 June 2009)

CE144.R14: Health and Tourism

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director *Health and Tourism* (Document CE144/16),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

HEALTH AND TOURISM

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Health and Tourism* (Document CD49/___),

Acknowledging the importance of raising awareness about the relevance of the health/tourism interaction to the promotion of national tourism policies that are favorable to health and concerning fostering the participation of private enterprise, communities, and the mass media;

Acknowledging, as well, the importance of considering health and environmental factors that threaten sustainable tourism in the Region, through an examination of the leading opportunities and barriers that are involved in its development in the Americas;

Considering the need to create a cooperation framework among international, Regional, and specialized health and tourism agencies;

Emphasizing the relevance of producing information based on scientific evidence to determine the impact of tourism on public health and sustainable development in the countries of the Region;

Considering the need to promote epidemiological studies to measure the burden of disease related to tourism and its prevalence in specific population groups and to adopt key indicators for surveillance and for determining the quality of healthy tourism; and

Acknowledging the importance of devising a framework of joint measures with agencies that can promote these measures, as well as a framework for the monitoring and evaluation of a plan of action,

RESOLVES:

1. To endorse the concepts on health and tourism contained in Document CD49/___.
2. To urge Member States to:
 - (a) include health and tourism in their national health plans;
 - (b) conduct assessments of the burden of disease attributed to tourism and examine the perspectives, beliefs, and requirement to lay the foundation for decision-making on the relevance and validity of standards and procedures;
 - (c) promote and maintain sound epidemiological surveillance mechanisms, which could include the establishment of national hotel health surveillance systems in every country in the Region;
 - (d) strengthen their capacity to investigate diseases and outbreaks related to tourist and traveler facilities, in accordance with the International Health Regulations;

- (e) strengthen health system capacity to produce information based on strategic evidence linking health, tourism, and development through the evaluation of current investments, coverage, monitoring, and the quality of national programs;
 - (f) promote, establish, and strengthen information systems and networks for sharing information and good practices in this area; and
 - (g) promote environmental and occupational health methods in the planning, design, construction, and operation of hotels and other tourist facilities.
3. To request the Director to:
- (a) maintain the commitment of the organization to this issue, update its cooperation strategy, and develop a regional plan of action (2010–2020) that encompasses the different program areas;
 - (b) create the Regional Forum on Health and Tourism for knowledge and information sharing and promote partnerships with private and community organizations for the purpose of having countries adopt specific policies linking health and tourism;
 - (c) mobilize resources and act interprogrammatically for effective and sustained application of the regional strategy and plan of action;
 - (d) promote technical cooperation among countries to disseminate the concept of healthy tourism;
 - (e) promote the establishment of and compliance with quality standards for health and tourism to improve the competitiveness of the countries of the Region in tourism;
 - (f) strengthen the capacity of public and private sector personnel, including environmental health and hotel workers, in best practices for tourism and environmental management (such as wastewater and solid waste disposal in tourist facilities, food handling, etc.); and
 - (g) promote the adoption of standards and regulations in countries interested in developing “health travel” as a tourism product (restoration and recovery, surgery, well-being products, other medical procedures).

(Sixth meeting, 25 June 2009)

CE144.R15: Amendments to the Staff Rules and Regulations of the Pan American Sanitary Bureau

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the amendments to the Staff Rules and Regulations of the Pan American Sanitary Bureau submitted by the Director in the Annex to Document CE144/27;

Taking into account the actions of the 62nd World Health Assembly regarding the remuneration of Assistant Directors-General, Regional Directors and the Director-General;

Bearing in mind the provisions of Staff Rule 020 and Staff Regulation 3.1 of the Pan American Sanitary Bureau; and

Recognizing the need for uniformity in the conditions of employment of staff of the Pan American Sanitary Bureau and the World Health Organization, and in the interest of good personnel management,

RESOLVES:

1. To confirm in accordance with Staff Rule 020 the amendments to the Staff Rules that have been made by the Director, with effect from 1 July 2009, concerning: education and special education grant, hardship and mobility allowance, home leave, effective date, definition of dependent child, assignment grant, meritorious within-grade increase, leave without pay, special education grant travel, and conduct and disciplinary measures.
2. To revise the remuneration of staff in the professional and higher categories as of 1 January 2009.
3. To establish the annual salary of the Deputy Director of the Pan American Sanitary Bureau, with effect from 1 January 2009, at US\$ 177,032 before staff assessment, resulting in a modified net salary of \$128,071 (dependency rate) or \$115,973 (single rate).
4. To establish the annual salary of the Assistant Director of the Pan American Sanitary Bureau, with effect from 1 January 2009, at US\$ 175,494 before staff assessment, resulting in a modified net salary of \$127,071 (dependency rate) or \$114,973 (single rate).
5. To recommend to the 49th Directing Council the adoption of the following resolution.

**AMENDMENTS TO THE STAFF RULES AND REGULATIONS OF THE
PAN AMERICAN SANITARY BUREAU**

THE 49th DIRECTING COUNCIL,

Having considered the amendments to the Staff Rules and Regulations of the Pan American Sanitary Bureau submitted by the Director in the Annex to Document CD49/___;

Considering the revision to the base/floor salary scale for the professional and higher-graded categories of staff, with effect from 1 January 2009 (Resolution CE144.R15);

Taking into account the actions of the 62nd World Health Assembly regarding the remuneration of the Regional Directors; and

Recognizing the need for uniformity in the conditions of employment of staff of the Pan American Sanitary Bureau and the World Health Organization and consistency within PASB Staff Rules and Regulations,

RESOLVES:

1. To establish the annual salary of the Director of the Pan American Sanitary Bureau, with effect from 1 January 2009, at US\$ 194,820 before staff assessment, resulting in a modified net salary of \$139,633 (dependency rate) or \$125,663 (single rate).
2. To approve the amendment to Staff Regulation 11.2 clarifying the jurisdiction of the Administrative Tribunal of the International Labour Organization over PAHO appeal matters.

(Sixth meeting, 25 June 2009)

CE144.R16: Contract Reform in the Pan American Health Organization

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Considering those Staff Rule amendments confirmed during the 140th Session of the Executive Committee (Resolution CE140.R14) related to the reform of PAHO's contractual mechanisms (to include fixed-term, continuing, and temporary appointments), for which implementation is pending approval by the Executive Committee;

Acknowledging the need to reduce the administrative burden associated with the management of contracts; and

Recognizing the need for uniformity of appointment types with the World Health Organization and the United Nations Common System,

RESOLVES:

1. To authorize the Director to implement, with effect from 1 July 2009, those Staff Rule amendments which were confirmed during the 140th Session of the Executive Committee (2007) with respect to temporary staff appointments.
2. To authorize the Director to implement, with effect from 1 July 2010, those Staff Rule amendments which were confirmed during the 140th Session of the Executive Committee (2007) with respect to continuing staff appointments.

(Seventh meeting, 25 June 2009)

CE144.R17: Changes in Financial Regulations and Financial Rules

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the report of the Director on the amendments proposed to the Financial Regulations, as they appear in the Annex to Document CE144/24, Rev.1; and

Taking into consideration that the amendments to the Financial Regulations reflect modern and best practices of financial management, and are in line with full adoption of the International Public Sector Accounting Standards (IPSAS), approved by the 27th Pan American Sanitary Conference (Resolution CSP27.R18),

RESOLVES:

To recommend to the Directing Council the adoption of a resolution along the following lines:

CHANGES IN FINANCIAL REGULATIONS

THE 49th DIRECTING COUNCIL,

Having considered the recommendation of the Executive Committee at its 144th Session on the proposed amendments to the Financial Regulations as they appear in the Annex to Document CD49/__; and

Taking into consideration that the amendments to the Financial Regulations reflect modern and best practices of financial management and are in line with full adoption of the International Public Sector Accounting Standards (IPSAS), approved by the 27th Pan American Sanitary Conference (Resolution CSP27.R18),

RESOLVES:

To approve the amendments to the Financial Regulations of the Pan American Health Organization as they appear in the Annex of Document CD49/___ and to make these amendments effective as of 1 January 2010.

(Seventh meeting, 25 June 2009)

CE144.R18: New Assessment Scale for the Budgetary Period 2010-2011

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director *New Scale of Quota Contributions: Application of the latest approved OAS scale of assessments to the PAHO membership for the 2010-2011 biennium* (Document CE144/8),

RESOLVES:

1. To thank the Subcommittee on Program, Budget and Administration for its preliminary review of and report on the application of a new scale of assessed contributions to the PAHO membership.
2. To recommend to the 49th Directing Council that it adopt a resolution along the following lines:

NEW ASSESSMENT SCALE FOR THE BUDGETARY PERIOD 2010-2011

THE 49th DIRECTING COUNCIL,

Having considered the report of the President of the 144th Session of the Executive Committee (Document CD49/___);

Bearing in mind that the Pan American Sanitary Code establishes that the scale of assessed contributions to be applied to Member States of the Pan American Health Organization (PAHO) will be based on the assessment scale adopted by the Organization of American States (OAS) for its membership;

Noting that the 140th Session of the Executive Committee in its Resolution CE140.R5 decided that the new assessment scale of the OAS would be applied by PAHO to biennia subsequent to the 2008-2009 biennium; and

Considering that the 34th Extraordinary Session of the General Assembly of the OAS adopted Resolution AG/RES.1 (XXXIV-E/07) which established a revised assessment scale for its membership applicable to the years 2009, 2010 and 2011,

RESOLVES:

To approve the new scale of assessed contributions, as detailed in the following table, to be applied to the Program and Budget for the Budgetary Period 2010-2011.

Member State	Assessment Rate 2010-2011
Antigua and Barbuda	0.022
Argentina	3.211
Bahamas	0.077
Barbados	0.060
Belize	0.022
Bolivia	0.046
Brazil	7.953
Canada	13.761
Chile	1.073
Colombia	0.839
Costa Rica	0.187
Cuba	0.241
Dominica	0.022
Dominican Republic	0.206
Ecuador	0.206
El Salvador	0.105
France *	0.289
Grenada	0.022
Guatemala	0.187
Guyana	0.022
Haiti	0.045
Honduras	0.045
Jamaica	0.123
Mexico	8.141
Netherlands *	0.090
Nicaragua	0.045
Panama	0.163
Paraguay	0.124
Peru	0.553
Puerto Rico **	0.111
Saint Kitts and Nevis	0.022
Saint Lucia	0.022

Saint Vincent and the Grenadines	0.022
Suriname	0.045
Trinidad and Tobago	0.152
United Kingdom *	0.060
United States	59.445
Uruguay	0.181
Venezuela	2.060
	<u>100.000</u>

* Participating Member

** Associate Member

(Seventh meeting, 25 June 2009)

CE144.R19: Policy on Research for Health

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the document *Policy on Research for Health* (Document CE144/11),

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

POLICY ON RESEARCH FOR HEALTH

THE 49th DIRECTING COUNCIL,

Having reviewed the document *Policy on Research for Health* (Document CD49/__);

Recalling Resolutions WHA58.34 on the Ministerial Summit on Health Research, and Resolution WHA60.15 on WHO's Role and Responsibilities in Health Research; PAHO's Regional Contribution to the Global Ministerial Forum on Research for Health, including the progress report on Resolution WHA58.34 delivered to the 48th Directing Council; and the report by the Advisory Committee on Health Research to the 27th Pan American Sanitary Conference;

Aware that as our rapidly changing world faces significant environmental, demographic, social, and economic challenges, research will be increasingly essential to elucidate the nature and scope of health problems; identify effective, safe, and

appropriate interventions and strategies; address health equity and determinants for health; and fulfill the Millennium Development Goals and the 2008-2017 Health Agenda for the Americas;

Realizing that improving health outcomes requires research that is multidisciplinary and intersectoral;

Acknowledging that research for health is an essential public health function that needs to be further developed and strengthened in Member States;

Affirming PAHO's important roles and responsibilities in research for health, as the leading Regional public health organization;

Recognizing the need to strengthen the public sector's capacity in health research;

Cognizant of the need to better communicate and integrate PAHO's research results and activities throughout the Organization and with its Member States and partners;

Conscious that PAHO and its Member States need to maintain functional governance mechanisms for research for health, and aware that functional national health research systems can gain greater advantage from research by promoting efficiencies, pursuing effective management, and coordinating research for health activities;

Taking into account Resolution WHA61.21 on the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property, and Resolution CD48.R15 of the 48th Directing Council on Public Health, Innovation, and Intellectual Property: a Regional Perspective;

Noting the references to research for health in the report of the Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH), as well as the relevant conclusions and recommendations of WHO's Commission on Social Determinants of Health; and

Taking into account the outcomes of the Global Ministerial Forum on Research for Health (Bamako, 17-19 November 2008), the Regional contributions presented to the Directing Council, the conclusion of the 1st Latin American Conference on Research and Innovation for Health, and WHO's Strategy on Research for Health,

RESOLVES:

1. To endorse PAHO's Policy on Research for Health (Document CD49/___).
2. To urge Member States to:

- (a) recognize the importance of research for health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, include all relevant sectors public and private, align external support around mutual priorities, and strengthen key national institutions;
- (b) consider drawing on PAHO's Policy on Research for Health according to their national circumstances and contexts, and as part of their overall policies on health and health research;
- (c) work with PAHO to strengthen and monitor national health research systems by improving the quality, leadership and management of research for health, focusing on national needs, establishing effective institutional research mechanisms, systematically using evidence to develop health policies, having the necessary skills in place through increased training of health researchers, encouraging research participation and harmonizing and coordinating national and external support;
- (d) establish, as necessary and appropriate, governance mechanisms for research for health to achieve effective coordination and strategic approaches between relevant sectors, ensure the rigorous application of good research norms and standards, including providing protection for human subjects involved in research, and promote an open dialogue between policymakers and researchers on national health needs, capacities, and constraints;
- (e) continue working with PAHO and its specialized centers to support the point of view that holds that research evidence essential for health and development continue to be accessible and available, including, when appropriate, in the public domain;
- (f) promote intersectoral collaboration and quality research to produce the research evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
- (g) initiate or strengthen intercountry and subregional collaboration as a way to obtain efficiencies of scale in research by sharing experiences, best practices, and resources, by pooling training and procurement mechanisms, and by using common and standardized research evaluation methods;
- (h) continue to pursue financing of research for health and its monitoring, as articulated in Resolution WHA58.34 and in line with the Paris Declaration on Aid Effectiveness; and

- (i) establish ethical review boards and implement ethical principles for clinical trials involving human subjects, with reference to the Declaration of Helsinki and other appropriate texts on ethical principles for medical research involving human subjects.

3. To invite Member States, the research for health community, the inter-American system, the UN system, and other international organizations, supporters of research, the private sector, civil society organizations, and other concerned stakeholders to:

- (a) provide support to the PAHO Secretariat for implementing the Policy on Research for Health and monitoring and evaluating its effectiveness;
- (b) collaborate with PAHO, within the framework of the policy, to identify research for health priorities, develop guidelines relating to research for health, develop registries and monitoring mechanisms, and share helpful information and data;
- (c) assist PAHO and its research partners to mobilize and monitor resources for the identified Regional and subregional priorities for research for health;
- (d) collaborate with PAHO to better align and coordinate the global and regional research for health architecture and its governance through the rationalization of existing partnerships, in order to improve coherence and impact and to increase efficiencies and equity;
- (e) pay particular attention to the research cooperation requests from Member States with pressing needs, notably in areas such as technology transfer, research workforce, infrastructure development, and determinants for health, particularly where this will contribute to the achievement of the Millennium Development Goals, health equity, and better health for all; and
- (f) support, where appropriate, technical cooperation aimed at raising research for health standards in Member States.

4. To request the Director to:

- (a) provide leadership in identifying regional priorities for research for health by promoting collaboration systems for detecting research needs and problems jointly with the Member States;
- (b) implement and mainstream the Policy on Research for Health at all levels of the Organization, as well as with partners, and align it with relevant resolutions such as Resolution CD48.R15, *Public Health, Innovation, and Intellectual Property: a Regional Perspective*;

- (c) adhere to the best standards and quality of research within the Organization by ensuring that the highest norms and standards of good research are upheld within PAHO, including technical, ethical, and methodological aspects, disseminate and promote access to research results and advocate their translation into policy and practice, and review and align the architecture and governance of the Organization's research activities and partnerships;
- (d) continue to facilitate the development of PAHO staff with the necessary skills to appropriately and effectively use research in every relevant PAHO activity;
- (e) provide adequate core resources in proposed program budgets for the implementation of the Policy on Research for Health;
- (f) provide support to Member States, upon request and as resources permit, to strengthen national health research systems and the development of efficient intersectoral collaboration;
- (g) collaborate constructively with other international organizations, networks, and stakeholders, including centers of excellence and WHO collaborating centers, to promote efficiencies and achieve a higher impact with this policy;
- (h) support the effective promotion and implementation of WHO's Research for Health Strategy, with periodic reporting to Member States, the active involvement of all relevant constituencies in PAHO, and the development of strategies and action plans for the Policy on Research for Health with the participation of Member States and in consultation with other stakeholders, including civil society; and
- (i) promote transparency, with the collaboration of the Member States and, when appropriate, the dissemination of information useful for research and development and for research findings.

(Seventh meeting, 25 June 2009)

CE144.R20: Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama

Transfer of Administration of the Institute of Nutrition of Central America and Panama to its Directing Council

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director of PASB *Institutional Review of the Institute of Nutrition of Central America and Panama - Transfer of the Administration of the Institute of Nutrition of Central America and Panama to its Directing Council* (Document CE144/19),

RESOLVES:

To recommend to the Directing Council of PAHO that it adopt a resolution along the following lines:

**INSTITUTIONAL REVIEW AND INTERNAL REORGANIZATION OF THE
INSTITUTE OF NUTRITION OF CENTRAL AMERICA AND PANAMA**

Transfer of Administration of the Institute of Nutrition of Central America and Panama to its Directing Council

THE 49th DIRECTING COUNCIL,

Considering that in Article VII of the Basic Agreement for the Institute of Nutrition of Central America and Panama (INCAP), the Member States of INCAP delegated to its Directing Council the authority to request every five years that PAHO take responsibility for the administration of the Institute;

Recognizing that Article LI of the Basic Agreement for INCAP states that INCAP operations be evaluated at least every five years as a basis for proposing possible amendments adapted to the development realities of the Member States;

Pointing out that the Basic Agreement for INCAP entered into force on 22 January 2003, which means that the term stipulated in Articles VII and LI mentioned above has elapsed;

Noting that a participatory process for evaluating the operations of the Institute was carried out in fulfillment of the mandate in Article LI of the Basic Agreement for INCAP and the resolutions of the Directing Council of PAHO concerning periodic evaluation and analysis of the Pan American centers;

Recognizing that the aforementioned evaluation process resulted in a new Institutional Strategic Framework for the Institute, which declares that INCAP is a mature institution that performs a fundamental function in support of the health sector of the social subsystem of the Central American Integration System;

Considering that implementation of the Institutional Strategic Framework requires that INCAP acquire full functional autonomy consistent with its degree of institutional maturity and its status as a full member and the oldest institution in the Central American Integration System (SICA);

Noting that in Resolution II, the LIX Meeting of the Directing Council of INCAP decided to assume the administration of INCAP with full functional autonomy, including the appointment of its Director, as of September 2009, and adopted the necessary adjustments to the Basic Agreement for the Institute to permit its internal reorganization under the authority of its Directing Council; and

Recognizing that the Directing Council of INCAP has the authority to approve the adjustments to the Basic Agreement for INCAP derived from the exercise of the authority delegated to it by the members of INCAP in Article VII of the Basic Agreement,

RESOLVES:

1. To take note of the decision of the Directing Council of INCAP to assume the administration of INCAP with full functional autonomy.
2. To note that the Pan American Health Organization will continue to be part of INCAP as a full member, but that it will no longer be responsible for the administration of the Institute under the terms of Articles VII, XXXIV, XXXV and XXXVI of the Basic Agreement for INCAP.
3. To adopt the Adjustment to the Basic Agreement for the Internal Reorganization of INCAP as adopted by Resolution II of the LIX Directing Council of INCAP (Annex), which becomes an integral part of this resolution and which eliminates articles VII, XXXIV, XXXV and XXXVI and amends Articles XV, XIX, XX and XXXIX of the Basic Agreement for INCAP.
4. To request the Director of PASB to:
 - (a) institute the administrative and legal measures necessary for ensuring the orderly and transparent transfer of the administration of INCAP to the Directing Council of the Institute, in accordance with the Adjustment to the Basic Agreement for INCAP approved by the Directing Council of INCAP and by this Council; and

- (b) ensure that the Organization continues to participate in INCAP as a full member.

Annex

(Seventh meeting, 25 June 2009)

RESOLUTION II^{*}

ADJUSTMENT TO THE BASIC AGREEMENT FOR THE INTERNAL REORGANIZATION OF INCAP^{}**

THE DIRECTING COUNCIL

Whereas Article LI of the Basic Agreement for the Institute states that the Agreement should be reviewed every five years as the grounds for proposing amendments to adapt it to the development situation of the Member States, and Article VII states that PAHO/WHO is responsible for the administration of the Institute at the request of this Council, an arrangement that will be renewed every five years and must be accepted every time by the Directing Council of the Pan American Health Organization, Regional Office for the Americas of the World Health Organization (PAHO/WHO).

Whereas the Basic Agreement for the Institute entered into force on 22 January 2003, which means that the period stipulated in Articles VII and LI mentioned above has ended. In this context, a participatory evaluation of Institute operations was undertaken, resulting in a proposal for a new Institutional Strategic Framework (ISF).

Whereas at its LVIII Meeting in San Salvador on 10 September 2007, this Council adopted the ISF through Resolution V and instructed the Director of INCAP to begin the review and Adjustment of the Basic Agreement for the Institute to align it with its new Strategic Framework.

Whereas the ISF recognizes that INCAP today is a mature institution that is playing a key role in the construction of the new Central America as a region that seeks development in peace, justice, freedom, and democracy and is exercising with great responsibility its respective functions to support the health sector of the Central American Integration System's (SICA) social subsystem.

Whereas implementation of the Institutional Strategic Framework requires INCAP to attain full autonomy consistent with its level of institutional maturity and status as a full member and the oldest institution of the Central American Integration System (SICA).

* Resolution II of the LIX Directing Council of INCAP, 27 January 2009, Tegucigalpa, Honduras.

** This document is a translation of true copy of the adopted resolution.

Whereas this Council, at a Special Meeting held in Panama on 21 February 2008, issued instructions that a proposal be drafted to amend the Basic Agreement to reflect the internal reorganization of the Institute and the mechanisms that will enable it to assume greater programmatic, financial, and administrative autonomy, in line with the ISF.

Whereas this Council, at a Special Meeting held in San Salvador on 23 June 2008, noted that INCAP is a mature institution that plays a key role as a Specialized Institution in Nutrition in Central America and that in the near future can disengage from the administration of PAHO/WHO and administer itself with functional autonomy, guided by its Directing Council, making it advisable to ensure the orderly and transparent transition of its administration.

In light of the above and pursuant to Articles 12 and 17 of the Social Integration Treaty and Article VII of the Basic Agreement for INCAP,

RESOLVES:

- I. To declare that the Directing Council shall take responsibility for the administration of INCAP with full functional autonomy, including the appointment of its Director, in September 2009.
- II. To recognize that the Pan American Health Organization, Regional Office for the Americas of the World Health Organization (PAHO/WHO) shall remain part of INCAP as a regular member, but shall cease to administer the Institute under the terms of Articles VII, XXXIV, XXXV, and XXXVI of the Basic Agreement.
- III. To amend the Basic Agreement for INCAP to permit a reorganization of the Institute, placing it under the administration and authority of this Council. To this end, from the date that this Council takes over the administration of the Institute, as stated in Section I of this Resolution, the following Articles of the Basic Agreement for INCAP shall be amended as follows:

Article XV: Under the principal functions of the Directing Council of INCAP, add a new numeral 2 that reads: "Elect the Director of INCAP, following the procedures approved by this Council." Renumber the other numerals.

Article XIX: INCAP shall be managed by a Director appointed by the Directing Council, who shall be elected according to the procedures approved by this Council. The Director of INCAP shall take responsibility for managing the Institute pursuant to the present Basic Agreement and the duties and functions stipulated by the Directing Council of INCAP.

Article XX: Amend the first paragraph to read, "The Director of INCAP shall be responsible for the implementation of Institute activities according to the rules, regulations, and programmatic and administrative orientations adopted by its Directing Council and as stipulated in the present Basic Agreement." Amend numeral 8 of this Article to read: "Perform the functions delegated to him by the Directing Council and, in general, undertake and execute whatever actions he deems necessary, pursuant to the present Basic Agreement."

Article XXXIX: Replace with the following text: "PAHO/WHO shall contribute resources to the INCAP budget to finance the Institute activities included in the Regional Strategy and Plan of Action on Nutrition in Health and Development for the Americas, the work plans of PAHO/WHO, and others agreed upon by the two institutions. PAHO/WHO financial contributions to INCAP shall be formalized through (i) the signing of periodic general legal instruments and/or (ii) specific instruments for individual activities or projects."

- IV. To declare inapplicable Articles VII, XXXIV, XXXV, XXXVI of the Basic Agreement due to their inconsistency.

CE144.R21: Proposed PAHO Program and Budget 2010-2011

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having examined the proposed Program and Budget of the Pan American Health Organization (PAHO) 2010-2011 (*Official Document 333*);

Having considered the report of the Subcommittee on Program, Budget and Administration (Document CE144/4);

Noting significant mandatory cost increases in fixed-term posts for 2010-2011, despite the Bureau's continuing and cautious efforts to reduce the number of fixed-term posts;

Having examined the Addendum to the PAHO Program and Budget, *Justification for the Proposed Increase in the Assessed Contributions*, in which the Bureau outlines the justification for the increase in assessed contributions, the expected negative programmatic impact on PAHO's technical cooperation, the efforts to improve efficiency and productivity, as well as to improve the performance, monitoring, and assessment process in order to assess the programmatic and financial implementation of the expected results;

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

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

RESOLVES:

1. To thank the Subcommittee on Program, Budget and Administration for its preliminary review of and report on the proposed program and budget.
2. To express appreciation to the Director for the attention given, in the development of the program and budget, to programmatic prioritization and to cost savings through the implementation of instruments to measure efficiency and productivity as well as corporate programmatic performance.
3. To request the Director to incorporate the comments made by the Members of the Executive Committee in the revised *Official Document 333* that will be considered by the 49th Directing Council.
4. To recommend to the 49th Directing Council that it adopt a resolution along the following lines:

PROPOSED PAHO PROGRAM AND BUDGET 2010–2011

THE 49th DIRECTING COUNCIL,

Having examined the proposed Program and Budget of the Pan American Health Organization (PAHO) 2010–2011 (*Official Document 333*);

Having considered the report of the Executive Committee (Document CD49/__);

Noting the significant mandatory cost increases in fixed-term posts for 2010-2011, despite the Pan American Sanitary Bureau's (PASB) continuing and cautious efforts to reduce the number of fixed-term posts;

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

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

RESOLVES:

1. To approve the program of work for the PASB as outlined in the proposed PAHO Program and Budget 2010–2011 (*Official Document 333*).

2. To appropriate for the financial period 2010-2011 the amount of US\$ 339,852,335, which represents an increase to assessments of PAHO Member States, Participating States, and Associate Members of 3.5% with respect to the biennium 2008-2009, as follows:

SECTION	TITLE	AMOUNT
1	To reduce the health, social and economic burden of communicable diseases	23,302,000
2	To combat HIV/AIDS, tuberculosis and malaria	6,324,000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	11,426,000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals	11,694,000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	3,893,000
6	To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions	7,611,000
7	To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	8,068,000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	13,399,000
9	To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development	12,009,000
10	To improve the organization, management and delivery of health services	8,111,000
11	To strengthen leadership, governance and the evidence base of health systems	32,026,000
12	To ensure improved access, quality and use of medical products and technologies	7,565,000
13	To ensure an available, competent, responsive and productive health workforce to improve health outcomes	9,305,000
14	To extend social protection through fair, adequate and sustainable financing	5,207,000
15	To provide leadership, strengthen governance, and foster partnership	65,885,000

SECTION	TITLE	AMOUNT
	and collaboration with Member States, the United Nations system and other stakeholders to fulfill the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO's Eleventh General Programme of Work, and the Health Agenda for the Americas	
16	To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	61,275,000
	Effective Working Budget for 2010-2011 (Parts 1-16)	287,100,000
17	Staff Assessment (Transfer to Tax Equalization Fund)	52,752,335
	Total – All Sections	339,852,335

3. That the appropriation shall be financed from:

- (a) Assessment in respect to:
Member Governments, Participating States, and Associate
Members assessed under the scale adopted239,152,335
- (b) Miscellaneous Income20,000,000
- (c) AMRO share approved at the 62nd World Health Assembly.....80,700,000
- TOTAL339,852,335

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

5. That, in accordance with the Financial Regulations of PAHO, amounts not exceeding the appropriations noted under paragraph 2 shall be available for the payment of obligations incurred during the period from 1 January 2010 to 31 December 2011, inclusive; notwithstanding the provision of this paragraph, obligations during the financial period 2010-2011 shall be limited to the effective working budget, i.e., Sections 1–16 of the table of appropriations in paragraph 2.

6. That the Director of the PASB shall be authorized to make transfers between the appropriation sections of the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; transfers between sections of the budget in excess of 10% of the section from which the credit is transferred may be made with the concurrence of the Executive Committee, with all transfers of budget credits to be reported to the Directing Council or the Pan American Sanitary Conference.

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

8. To estimate the amount of expenditure in the program and budget for 2010–2011 to be financed by other sources at US\$ 355,851,000, as reflected in *Official Document* 333.

(Eighth meeting, 26 June 2009)

CE144.R22: PAHO Award for Administration 2009

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having examined the report of the Award Committee of the PAHO Award for Administration 2009 (Document CE144/5, Add. I); and

Bearing in mind the provisions of the procedures and guidelines for conferring the PAHO Award for Administration, as approved by the 18th Pan American Sanitary Conference (1970) and amended by the 24th Pan American Sanitary Conference (1994), the 124th Session of the Executive Committee (1999), the 135th Session of the Executive Committee (2004), and the 140th Session of the Executive Committee (2007),

RESOLVES:

1. To note the decision of the Award Committee to confer the PAHO Award for Administration 2009 on Dr. Merceline Dahl-Regis, of the Bahamas, for her contribution to health care management and research and to medical education in primary health care, as well as for her leadership in institutionalizing public health surveillance across all of

the Bahamas and in evaluating and redefining the parameters for the Caribbean Cooperation in Health.

2. To transmit the report of the Award Committee of the PAHO Award for Administration 2009 (Document CE144/5, Add. I), to the 49th Directing Council.

(Eighth meeting, 26 June 2009)

CE144.R23: Assessments of the Member States, Participating States, and Associate Members of the Pan American Health Organization for 2010-2011

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Whereas in Resolution CE144.R18 the Executive Committee has recommended that the 49th Directing Council adopt a new scale of assessments for the PAHO membership for the 2010-2011 biennium; and

Whereas in Resolution CE144.R21 the Executive Committee has recommended that the 49th Directing Council approve the PAHO Program and Budget 2010-2011 (Official Document 333),

RESOLVES:

To recommend that the 49th Directing Council adopt a resolution along the following lines:

ASSESSED CONTRIBUTIONS OF THE MEMBER STATES, PARTICIPATING STATES, AND ASSOCIATE MEMBERS OF THE PAN AMERICAN HEALTH ORGANIZATION FOR 2010-2011

THE 49th DIRECTING COUNCIL,

Whereas in Resolution CD49.R__ the Directing Council approved the PAHO Program and Budget 2010-2011 (*Official Document 333*); and

Bearing in mind that the Pan American Sanitary Code establishes that the scale of assessed contributions to be applied to Member States of the Pan American Health Organization will be based on the assessment scale adopted by the Organization of American States (OAS) for its membership, and that in Resolution CD49.R__ the Directing Council adopted the new scale of assessments for the PAHO membership for the biennium 2010-2011,

RESOLVES:

To establish the assessed contributions of the Member States, Participating States, and Associate Members of the Pan American Health Organization for the financial period 2010-2011 in accordance with the scale of assessments shown below and in the corresponding amounts, which represent an increase of 3.5% with respect to the biennium 2008-2009.

Membership	Scale Adjusted to PAHO Membership		Gross Assessment		Credit from Tax Equalization Fund		Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff		Net Assessment	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
	%	%	US\$	US\$	US\$	US\$	US\$	US\$	US\$	US\$
Member Governments:										
Antigua and Barbuda	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Argentina	3.211	3.211	3,839,591	3,839,591	846,939	846,939			2,992,652	2,992,652
Bahamas	0.077	0.077	92,074	92,074	20,310	20,310			71,764	71,764
Barbados	0.060	0.060	71,746	71,746	15,826	15,826			55,920	55,920
Belize	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Bolivia	0.046	0.046	55,005	55,005	12,133	12,133			42,872	42,872
Brazil	7.953	7.953	9,509,893	9,509,893	2,097,697	2,097,697			7,412,196	7,412,196
Canada	13.761	13.761	16,454,876	16,454,876	3,629,624	3,629,624	25,000	25,000	12,850,252	12,850,252
Chile	1.073	1.073	1,283,052	1,283,052	283,016	283,016			1,000,036	1,000,036
Colombia	0.839	0.839	1,003,244	1,003,244	221,296	221,296			781,948	781,948

Membership	Scale Adjusted to PAHO Membership		Gross Assessment		Credit from Tax Equalization Fund		Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff		Net Assessment	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
	%	%	US\$	US\$	US\$	US\$	US\$	US\$	US\$	US\$
Costa Rica	0.187	0.187	223,607	223,607	49,323	49,323			174,284	174,284
Cuba	0.241	0.241	288,179	288,179	63,567	63,567			224,612	224,612
Dominica	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Dominican Republic	0.206	0.206	246,327	246,327	54,335	54,335			191,992	191,992
Ecuador	0.206	0.206	246,327	246,327	54,335	54,335			191,992	191,992
El Salvador	0.105	0.105	125,555	125,555	27,695	27,695			97,860	97,860
Grenada	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Guatemala	0.187	0.187	223,607	223,607	49,323	49,323			174,284	174,284
Guyana	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Haiti	0.045	0.045	53,809	53,809	11,869	11,869			41,940	41,940
Honduras	0.045	0.045	53,809	53,809	11,869	11,869			41,940	41,940
Jamaica	0.123	0.123	147,079	147,079	32,443	32,443			114,636	114,636
Mexico	8.141	8.141	9,734,696	9,734,696	2,147,284	2,147,284			7,587,412	7,587,412
Nicaragua	0.045	0.045	53,809	53,809	11,869	11,869			41,940	41,940
Panama	0.163	0.163	194,909	194,909	42,993	42,993			151,916	151,916
Paraguay	0.124	0.124	148,274	148,274	32,706	32,706			115,568	115,568
Peru	0.553	0.553	661,256	661,256	145,860	145,860			515,396	515,396
Saint Kitts and Nevis	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Saint Lucia	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Saint Vincent and the Grenadines	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Suriname	0.045	0.045	53,809	53,809	11,869	11,869			41,940	41,940
Trinidad and Tobago	0.152	0.152	181,756	181,756	40,092	40,092			141,664	141,664
United States of America	59.445	59.445	71,082,053	71,082,053	15,679,313	15,679,313	5,100,000	5,100,000	60,502,740	60,502,740
Uruguay	0.181	0.181	216,433	216,433	47,741	47,741			168,692	168,692
Venezuela	<u>2.060</u>	<u>2.060</u>	<u>2,463,269</u>	<u>2,463,269</u>	<u>543,349</u>	<u>543,349</u>	<u>0</u>	<u>0</u>	<u>1,919,920</u>	<u>1,919,920</u>
Subtotal	99.450	99.450	118,918,500	118,918,500	26,231,100	26,231,100	5,125,000	5,125,000	97,812,400	97,812,400

Membership	Scale Adjusted to PAHO Membership		Gross Assessment		Credit from Tax Equalization Fund		Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff		Net Assessment	
	2010 %	2011 %	2010 US\$	2011 US\$	2010 US\$	2011 US\$	2010 US\$	2011 US\$	2010 US\$	2011 US\$
Participating Governments:										
France	0.289	0.289	345,575	345,575	76,227	76,227			269,348	269,348
Kingdom of the Netherlands	0.090	0.090	107,619	107,619	23,739	23,739			83,880	83,880
United Kingdom	<u>0.060</u>	<u>0.060</u>	<u>71,746</u>	<u>71,746</u>	<u>15,826</u>	<u>15,826</u>			<u>55,920</u>	<u>55,920</u>
Subtotal	0.439	0.439	524,940	524,940	115,792	115,792			409,148	409,148
Associate Member:										
Puerto Rico	<u>0.111</u>	<u>0.111</u>	<u>132,730</u>	<u>132,730</u>	<u>29,278</u>	<u>29,278</u>			<u>103,452</u>	<u>103,452</u>
Subtotal	0.111	0.111	132,730	132,730	29,278	29,278			103,452	103,452
TOTAL	<u>100.000</u>	<u>100.000</u>	<u>119,576,170</u>	<u>119,576,170</u>	<u>26,376,170</u>	<u>26,376,170</u>	<u>5,125,000</u>	<u>5,125,000</u>	<u>98,325,000</u>	<u>98,325,000</u>

(Eighth meeting, 26 June 2009)

CE144.R24: Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the proposal presented by the Director of the Pan American Sanitary Bureau (“the Director”) for the establishment of a new institutional framework for the governance, management and financing of the Latin American and Caribbean Center on Health Sciences Information (BIREME) as described in the document *Institutional Review of the Latin American and Caribbean Center on Health Sciences Information (BIREME)* (Document CE144/18, Rev. 1),

RESOLVES:

1. To recommend to the Directing Council that it:
 - (a) approve the new institutional framework for the governance, management and financing of BIREME, including the proposed Statute of BIREME as contained in the document *Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)* (Document CE144/18, Rev. 1);

- (b) hold elections at its 49th Directing Council to select the five non-permanent Members of the BIREME Advisory Committee pursuant to the proposed Statute of BIREME.
- 2. To request the Director to invite candidacies from among PAHO's Member States, Participating States and Associate Members for election to BIREME's newly established Advisory Committee at the 49th Session of the Directing Council.
- 3. To recommend to the Directing Council that it adopt a resolution along the following lines:

**ESTABLISHMENT OF A NEW INSTITUTIONAL FRAMEWORK FOR THE
LATIN AMERICAN AND CARIBBEAN CENTER ON HEALTH SCIENCES
INFORMATION (BIREME)**

THE 49th DIRECTING COUNCIL,

Having reviewed the proposal presented by the Director of the Pan American Sanitary Bureau ("the Director") for the establishment of a new institutional framework for the governance, management and financing of the Latin American and Caribbean Center on Health Sciences Information (BIREME) as described in the document *Establishment of a New Institutional Framework for the Latin American and Caribbean Center on Health Sciences Information (BIREME)* (Document CD49/__);

Recognizing that the technical cooperation provided by BIREME to PAHO's Member States, Participating States and Associate Members during the last 42 years in the field of the health scientific information and communication has evolved with the Virtual Health Library and related networks to become a critical and essential scientific knowledge regional "public good" oriented to the development of health research, education and care;

Considering that BIREME has played an important role in the international south-south cooperation with other developing regions of the world through the sharing of experiences and knowledge in health scientific information methodologies, technology, products, services, and networking;

Recognizing that the current institutional framework of BIREME has not been substantially modified in its 42 years of existence and does not adequately meet BIREME's current and future governance, management, and financing needs;

Recognizing the historical importance of the Government of Brazil's contribution to the establishment and continued maintenance of BIREME in that country, particularly

the specific contributions provided by the Ministry of Health, the Ministry of Education, the Secretary of Health of the State of São Paulo, and the Federal University of Brazil;

Bearing in mind the importance of empowering BIREME to better accomplish its strategic functions by means of a contemporary institutional framework to support its governance, management, and financing; and

Considering the need to strengthen BIREME's financial sustainability through the establishment of an adequate funding structure that balances regular and extra-regular sources,

RESOLVES:

1. To approve the Statute of BIREME, attached hereto as an integral part of this Resolution (Annex), effective 1 January 2010.
2. To reaffirm the importance of the cooperation between the Government of Brazil and PAHO for the maintenance of BIREME and to urge the Government of Brazil to continue its support of BIREME and enhance this cooperation.
3. To request the Director to:
 - (a) undertake negotiations with the Government of Brazil in order to conclude a new Headquarters Agreement for BIREME that defines the responsibilities of the Government with regard to the maintenance of BIREME, as well as its privileges and immunities in that country;
 - (b) undertake negotiations with the Government of Brazil, through the appropriate Ministries and the Federal University of São Paulo, in order to conclude a new Facilities Agreement for BIREME's continued operation within the campus of the University, to include issues related to BIREME's physical premises, personnel, journal collection, and other support for the Center; and
 - (c) instruct the Secretariat of BIREME to undertake the necessary measures in order to proceed with the inaugural meetings of the newly established BIREME Advisory Committee and the Scientific Committee in the first semester of 2010.

Annex: Statute of the Latin American and Caribbean Center on Health Sciences Information (BIREME)

(Eighth meeting, 26 June 2009)

PROPOSED STATUTE OF BIREME

Article I Legal Status

The Latin American and Caribbean Center on Health Sciences Information, also known by its original name the Regional Library of Medicine ("BIREME"), is a specialized center of the Pan American Health Organization ("PAHO"), Regional Office for the Americas of the World Health Organization ("WHO"), established pursuant to the resolutions of the Directing Council of PAHO and operating continuously in Brazil, with headquarters in the city of São Paulo, since its creation, effected through an agreement signed between PAHO and the Government of the Federative Republic of Brazil.

Article II Objective

The objective of BIREME is to contribute to health development for the populations of the Region of the Americas, promoting cooperation among countries, the democratization of access to scientific and technical information, legislation and the sharing of knowledge and evidence to support steady improvement of the health, education and research systems.

Article III Functions

To meet its objective, BIREME shall have the following technical cooperation functions, included in the Regional Strategic Plan of PAHO:

1. Support and strengthen health sciences information systems in PAHO Member States.
2. Help develop and strengthen public health actions and policies and national and regional capacities and infrastructure for the acquisition, organization, access, publication, and use of information, knowledge, and scientific evidence regarding health processes and decision-making.
3. Help develop and strengthen networks of institutions and individual producers, intermediaries, and users of scientific, legal, technical, and factual information in health through the cooperative management and operation of information products, services, and events in the common forum of the Virtual Health Library, in cooperation with the complementary national, regional, and international networks.

4. Contribute to the global development of health sciences information and communication through partnerships, programs, networks, and projects among international, regional, and national institutions, with a view to increasing the visibility, access, quality, use, and impact of the scientific and technical output of developing countries and regions.
5. Help develop health science and technical terminology in Spanish, French, English, and Portuguese.
6. Help develop distance education systems in the Region of the Americas, through infrastructure- and capacity-building for access to and the dissemination of information as an integral part of PAHO's Virtual Public Health Campus.
7. Support and promote collaboration among governments, professionals, health workers, consumers, relevant scientific institutions and international organizations, and society at large to establish and strengthen national health information systems that promote education and ongoing research through innovation and the application of information and communication technologies.

Article IV Membership

BIREME Members are defined below under the following categories: Member States, Participating States, and Participating Organizations.

1. Member States of BIREME: All PAHO Member States.
2. Participating States of BIREME: Any WHO Member State may be admitted as a "Participating State of BIREME," under the following conditions:
 - a. the WHO Member State must communicate to the Director* of PAHO its intention to participate in scientific and technical cooperation and to contribute financially to BIREME through annual contributions established by the Advisory Committee of BIREME, as described in Article IX of this document, and recognize the present Statute and follow its respective regulations, and

* In this document, the Director of the Pan American Sanitary Bureau will be referred to as the Director of the Pan American Health Organization.

- b. the Advisory Committee must endorse the proposed membership as a Participating State of BIREME by at least a two-thirds majority of its Members.
3. Participating Organizations of BIREME: Any international public organization with specific expertise in scientific and technical information and communication may be admitted as a “Participating Organization of BIREME,” under the following conditions:
 - a. the international organization must communicate to the Director of PAHO its intention to participate in scientific and technical cooperation and contribute financially to BIREME, through annual contributions established by Advisory Committee of BIREME, as described in Article IX of this document, and recognize the present Statute and follow its respective regulations; and
 - b. the Advisory Committee must endorse the proposed membership as a Participating Organization of BIREME by at least a two-thirds majority of its Members.
4. A Participating State or Participating Organization may withdraw its membership in BIREME by so communicating to the Director of PAHO and the Advisory Committee. Membership shall terminate six (6) months after the Director of PAHO receives the notification.

Article V Structure

BIREME shall consist of the following bodies:

- (1) Advisory Committee
- (2) Scientific Board
- (3) Secretariat

Article VI Advisory Committee

The Advisory Committee is a permanent body of BIREME and performs advisory functions for the Director of PAHO.

1. The Advisory Committee of BIREME shall be made up of designated Members with the following composition:

- b. two (2) permanent members: one (1) appointed by the Representative of the Government of Brazil and one (1) by the Director of PAHO;
 - c. five (5) nonpermanent members, selected and named by the Directing Council of PAHO from among the BIREME membership described in Article IV, taking geographical representation into account.
- 2. The nonpermanent members of the BIREME Advisory Committee should be rotated every three (3) years. However, the Directing Council of PAHO shall be able to indicate a shorter rotation period in cases where it is necessary to maintain balance among the members of the Advisory Committee.
- 3. The number of nonpermanent members of the Advisory Committee may be modified by the Directing Council of PAHO as new BIREME Members are admitted.
- 4. The BIREME Advisory Committee shall:
 - a. make recommendations to the Director of PAHO regarding the programmatic functions of BIREME, based on PAHO's Regional Strategic Plan and Technical Cooperation Work Plan and on recommendations from the Members of BIREME's Scientific Board;
 - b. review the proposal for BIREME's Biennial Work Plan and make recommendations to the Director of PAHO aimed at strengthening and developing national and regional capacity and infrastructure in scientific and technical information;
 - c. review BIREME's Biennial Budget Proposal and make recommendations to the Director of PAHO to strengthen the financing structure;
 - d. propose the annual quota contributions of Participating States and Participating Organizations;
 - e. evaluate BIREME's international cooperation with other regions and make recommendations to the Director of PAHO for its improvement;
 - f. recommend to the Director of PAHO, providing justification, that the number of Nonpermanent Members on the Advisory Committee be modified to maintain geographical balance;

- g. appoint the members of BIREME's Scientific Board;
- h. recommend to the Directing Council of PAHO, when necessary, amendments to this Statute;
- i. recommend to the Director of PAHO the creation of technical committees and working groups to assist BIREME in performing its programmatic functions, executing the Work Plan, and addressing health sector priorities;
- j. adopt internal Rules of Procedure to be approved by all its Members in regular session;
- k. hold an annual regular session. Members of the Advisory Committee may request that the Director of PAHO convene special sessions.

Article VII Scientific Board

The Scientific Board is a permanent body of BIREME and performs advisory functions for the Director of PAHO and the Advisory Committee.

1. The Scientific Board shall consist of at least five international specialists, named for their recognized expertise in scientific research, health information and knowledge management, and scientific and technical communication in health and their knowledge in the areas of research, ethics, development, operations, and financing. Members of the Scientific Board shall be appointed as specialists and rotated every three (3) years.
2. The members of the Scientific Board shall be appointed by BIREME's Advisory Committee, taking into account the thematic diversity and expertise necessary for the Board to perform its functions. Member States of BIREME may each nominate up to two experts, and the Director of PAHO may nominate additional experts, to be included in the list of international experts from which such appointments will be made, also paying due regard to the thematic diversity and expertise necessary for the Board to perform its functions.
3. The Scientific Board shall:
 - a. make recommendations to the Advisory Committee on BIREME's programmatic functions based on the international state-of-the-art in scientific information and communication, which shall include: policies and quality criteria for the selection of content; management

of information, knowledge, and scientific evidence; publication management; information storage and retrieval infrastructure; bibliometrics; infometrics; and science metrics;

- b. advise the Director of PAHO and the Advisory Committee on the methodologies and technologies used by BIREME for the management of information products and services, and recommend the solutions and upgrades needed;
- c. advise the Director of PAHO and the Advisory Committee on the adoption of innovations in scientific information and communication;
- d. advise the Director of PAHO and the Advisory Committee on the preparation and implementation of BIREME's Biennial Work Plan, in keeping with the PAHO Strategic Plan and Biennial Work Plan;
- e. advise the Director of PAHO and the Advisory Committee on the adoption of international partnerships for the development of health science information and communication;
- f. adopt internal Rules of Procedure to be approved by all its Members in regular session;
- g. hold an annual regular session. Three (3) members of this Scientific Board may request BIREME's Advisory Committee to hold special sessions.

Article VIII Secretariat

Subject to the general authority and decisions of the Director of PAHO, the Secretariat is a permanent body of BIREME, responsible for the technical and administrative management and execution of BIREME's Biennial Work Plan and Budget, pursuant to PAHO regulations and standards.

1. The Secretariat shall be comprised of the Director of BIREME and the necessary technical and administrative personnel, as determined by the Director of PAHO and subject to the availability of financial resources.
2. The Director of BIREME shall be appointed by the Director of PAHO, through an international competition, pursuant to the rules and regulations of PAHO.

3. Staff members who hold positions in BIREME shall be appointed pursuant to the rules and regulations of PAHO.
4. The Director of BIREME shall be responsible to the Director of PAHO for the executive management of BIREME, pursuant to PAHO rules and regulations. Responsibilities include:
 - a. prepare, based on PAHO's Regional Strategic Plan, the Proposal for BIREME's Biennial Work Plan and Biennial Budgetary Proposal and submit them to the Advisory Committee for review and recommendations from the Director of PAHO;
 - b. executing Biennial Work Plan and Biennial Budget of BIREME approved by the Director of PAHO as an integral part of PAHO's Biennial Work Plan;
 - c. promoting and establishing collaboration with entities and organizations connected with BIREME's programmatic functions;
 - d. promoting and forging international partnerships for the development of health science information and communication, in keeping with PAHO priorities;
 - e. representing BIREME at events and in initiatives relevant to its programmatic functions as a Specialized Center of PAHO;
 - f. manage BIREME's administrative and financial affairs;
 - g. present an annual progress report on BIREME and submit it to the Advisory Committee for review and recommendations to the Director of PAHO;
 - h. prepare any other report requested by the Director of PAHO, the Advisory Committee, or the Scientific Board of BIREME;
 - i. serve as the Secretary *ex officio* at meetings of the Advisory Committee and Scientific Board;
 - j. accept funds or contributions from individuals or corporations through agreements and/or contracts, as related to BIREME's functions, subject to the conditions established by the Director of PAHO and with his prior written authorization.

Article IX Finance

1. Resources for funding BIREME's Biennial Work Plan shall be obtained from the following sources: the annual contribution from PAHO determined by the Director of PAHO; the annual contribution from the Government of Brazil, pursuant to the agreement signed with PAHO; annual contributions from the Participating States and Participating Organizations of BIREME, and financial resources from projects, sale of services, and voluntary contributions.
2. All annual contributions shall be due on 1 January of each year and are to be paid by 30 June of the same year at the latest.
3. BIREME funds and assets shall be treated as PAHO trust funds and administered pursuant to PAHO's financial regulations.
4. A Working Capital Fund shall be established on behalf of BIREME in accordance with PAHO's rules and regulations.

Article X Privileges and Immunities

The privileges and immunities granted to BIREME in Brazil as a Specialized Center of PAHO, as well as the financial responsibilities of the Government of Brazil in regard to the maintenance of BIREME in Article IX of this Statute, should be reflected in a specific agreement between PAHO and the Government of Brazil.

Article XI Facilities

The arrangements regarding the physical facilities and other services provided to BIREME, headquartered since its creation on the UNIFESP campus in the city of São Paulo, Brazil, should be reflected in an agreement involving PAHO, the Government of Brazil, and UNIFESP.

Article XII Amendments

Amendments to this Statute, as recommended by the BIREME Advisory Committee, shall enter into force on approval by the Directing Council of PAHO.

Article XIII Entry into Force

The provisions of this Statute shall enter into force on the date of its approval by the Directing Council of PAHO.

***CE144.R25: Provisional Agenda of the 49th Directing Council of PAHO,
61st Session of the Regional Committee of WHO for the Americas***

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having examined the provisional agenda (Document CD49/1) prepared by the Director for the 49th Directing Council of PAHO, 61st Session of the Regional Committee of WHO for the Americas, presented as Annex to Document CE144/3, Rev. 1; and

Bearing in mind the provisions of Article 12.C of the Constitution of the Pan American Health Organization and Rule 7 of the Rules of Procedure of the Directing Council,

RESOLVES:

To approve the provisional agenda (Document CD49/1) prepared by the Director for the 49th Directing Council of PAHO, 61st Session of the Regional Committee of WHO for the Americas.

(Eighth meeting, 26 June 2009)

Decisions

Decision CE144(D1) Adoption of the Agenda

Pursuant to Rule 9 of the Rules of Procedure of the Executive Committee, the Committee adopted, without modification, the agenda submitted by the Director (Document CE144/1).

(First meeting, 22 June 2008)

***Decision CE144(D2) Representation of the Executive Committee at the
49th Directing Council, 61st Session of the Regional
Committee of WHO for the Americas***

Pursuant to Rule 54 of its Rules of Procedure, the Executive Committee decided to designate its President (Uruguay) and Vice President (Suriname) to represent the Committee at the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas. The Committee designated Mexico and Trinidad and Tobago as alternate representatives.

(First meeting, 22 June 2008)

IN WITNESS WHEREOF, the President of the Executive Committee, Delegate of Uruguay, and the Secretary ex officio, Director of the Pan American Sanitary Bureau, sign the present Final Report in the Spanish language.

DONE in Washington, D.C., on this twenty-sixth day of June in the year two thousand nine. The Secretary shall deposit the original texts in the archives of the Pan American Sanitary Bureau.

Jorge Basso
Delegate of Uruguay
President of the
144th Session of the Executive Committee

Mirta Roses Periago
Director of the
Pan American Sanitary Bureau
Secretary ex officio of the
144th Session of the Executive Committee

AGENDA

1. OPENING OF THE SESSION

2. PROCEDURAL MATTERS

- 2.1 Adoption of the Agenda and Program of Meetings
- 2.2 Representation of the Executive Committee at the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas
- 2.3 Provisional Agenda of the 49th Directing Council of PAHO, 61st Session of the Regional Committee of WHO for the Americas

3. COMMITTEE MATTERS

- 3.1 Report on the Third Session of the Subcommittee on Program, Budget, and Administration
- 3.2 PAHO Award for Administration 2009
- 3.3 Nongovernmental Organizations in Official Relations with PAHO
- 3.4 Annual Report of the Ethics Office

4. PROGRAM POLICY MATTERS

- 4.1 Proposed PAHO Program and Budget 2010-2011
- 4.2 PAHO Strategic Plan 2008-2012 Amended (Draft)
- 4.3 New Scale of Quota Contributions
- 4.4 Plan of Action on the Health of Older Persons, Including Active and Healthy Aging

4. PROGRAM POLICY MATTERS (*cont.*)

- 4.5 Elimination of Neglected Diseases and other Poverty-Related Infections
- 4.6 Policy on Research for Health
- 4.7 Strategy and Plan of Action on Mental Health
- 4.8 Plan of Action on Adolescent and Youth Health
- 4.9 Plan of Action for Implementing the Gender Equality Policy
- 4.10 Policy Framework for Human Organ Donation and Transplantation
- 4.11 Health and Tourism
- 4.12 Integrated Health Services Delivery Networks Based on Primary Health Care
- 4.13 Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)
- 4.14 Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP)
- 4.15 Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment
- 4.16 Family and Community Health
- 4.17 The Pan American Health Organization Revolving Fund for Vaccine Procurement

5. ADMINISTRATIVE AND FINANCIAL MATTERS

- 5.1 Report on the Collection of Quota Contributions
- 5.2 Interim Financial Report of the Director for 2008

5. ADMINISTRATIVE AND FINANCIAL MATTERS *(cont.)*

- 5.3 Changes in Financial Regulations and Financial Rules
- 5.4 Projects Using the Program Budget Income Exceeding the Authorized Effective Working Regular Budget
- 5.5 Proposal for the Establishment of an Audit Committee

6. PERSONNEL MATTERS

- 6.1 Amendments to the PASB Staff Rules and Regulations
- 6.2 Contract Reform in PAHO
- 6.3 Statement by the Representative of the PASB Staff Association

7. MATTERS FOR INFORMATION

- 7.1 WHO Proposed Programme Budget 2010-2011
- 7.2 WHO Medium-Term Strategic Plan 2008-2013 Amended (Draft)
- 7.3 Code of Practice on the international recruitment of health personnel: a WHO background document
- 7.4 Progress Reports on Technical Matters:
 - 7.4.1 International Health Regulations
(Includes the Report on the Influenza A (H1N1) Pandemic Situation)
 - 7.4.2 Preparations for the Roundtable on Safe Hospitals
 - 7.4.3 Preparations for the Panel Discussion on the Pan American Alliance for Nutrition and Development to Achieve the MDGs

7. MATTERS FOR INFORMATION (*cont.*)

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

7.5.1 Resolutions and other Actions of the 62nd World Health Assembly

7.5.2 Resolutions and other Actions of the 39th General Assembly of the Organization of American States

7.5.3 Report on the Fifth Summit of the Americas

7.6 Progress Reports on Administrative and Financial Matters:

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

7.6.2 Master Capital Investment Fund

8. OTHER MATTERS

9. CLOSURE OF THE SESSION

LIST OF DOCUMENTS

Official Documents

Official Document 328	PAHO Strategic Plan 2008-2012 Amended (Draft)
Official Document 333 and Add. I	Proposed PAHO Program and Budget 2010-2011
Official Document 335	Interim Financial Report of the Director for 2008

Working Documents

CE144/1, Rev. 2	Agenda
CE144/WP/1, Rev. 1	Program of Meetings
CE144/2	Representation of the Executive Committee at the 49th Directing Council, 61st Session of the Regional Committee of WHO for the Americas
CE144/3, Rev. 1	Provisional Agenda of the 49th Directing Council of PAHO, 61st Session of the Regional Committee of WHO for the Americas
CE144/4	Report on the Third Session of the Subcommittee on Program, Budget, and Administration
CE144/5 and Add. I	PAHO Award for Administration 2009
CE144/6	Nongovernmental Organizations in Official Relations with PAHO
CE144/7	Annual Report of the Ethics Office
CE144/8	New Scale of Quota Contributions
CE144/9	Plan of Action on the Health of Older Persons, Including Active and Healthy Aging

Working Documents (*cont.*)

CE144/10, Rev. 1	Elimination of Neglected Diseases and other Poverty-Related Infections
CE144/11	Policy on Research for Health
CE144/12	Strategy and Plan of Action on Mental Health
CE144/13, Rev. 1	Plan of Action on Adolescent and Youth Health
CE144/14	Plan of Action for Implementing the Gender Equality Policy
CE144/15, Rev. 1	Policy Framework for Human Organ Donation and Transplantation
CE144/16	Health and Tourism
CE144/17	Integrated Health Services Delivery Networks Based on Primary Health Care
CE144/18, Rev. 1 and Add. I	Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)
CE144/19, Rev. 1 and Add. I, Rev. 1	Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP)
CE144/20	Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment
CE144/21	Family and Community Health
CE144/22, Rev. 1	The Pan American Health Organization Revolving Fund for Vaccine Procurement
CE144/23 and Add. I	Report on the Collection of Quota Contributions
CE144/24, Rev. 1	Changes in Financial Regulations and Financial Rules

Working Documents (*cont.*)

CE144/25, Rev. 1	Projects Using the Program Budget Income Exceeding the Authorized Effective Working Regular Budget
CE144/26, Rev. 1 and Add. I	Proposal for the Establishment of an Audit Committee
CE144/27	Amendments to the PASB Staff Rules and Regulations
CE144/28	Contract Reform in PAHO
CE144/29	Statement by the Representative of the PASB Staff Association
CE144/30 and Add. I	Proposed PAHO Program and Budget 2010-2011
CE144/31	PAHO Strategic Plan 2008-2012 Amended (Draft)

Information Documents

CE144/INF/1	WHO Proposed Programme Budget 2010-2011
CE144/INF/2	WHO Medium-Term Strategic Plan 2008-2013 Amended (Draft)
CE144/INF/3, Rev. 1	Code of Practice on the International Recruitment of Health personnel: a WHO Background Document
CE144/INF/4	Progress Reports on Technical Matters:
<i>CE144/INF/4-A</i>	International Health Regulations (<i>Includes the Report on the Influenza A (H1N1) Pandemic Situation</i>)
<i>CE144/INF/4-B</i>	Preparations for the Roundtable on Safe Hospitals
<i>CE144/INF/4-C</i>	Preparations for the Panel Discussion on the Pan American Alliance for Nutrition and Development to Achieve the MDGs

Information Documents (*cont.*)

CE144/INF/5	Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO:
<i>CE144/INF/5-A</i>	Resolutions and other Actions of the 62nd World Health Assembly
<i>CE144/INF/5-B</i>	Resolutions and other Actions of the 39th General Assembly of the Organization of American States
<i>CE144/INF/5-C</i>	Report on the Fifth Summit of the Americas
CE144/INF/6	Progress Reports on Administrative and Financial Matters:
<i>CE144/INF/6-A</i>	Status of Implementation of the International Public Sector Accounting Standards (IPSAS)
<i>CE144/INF/6-B</i>	Master Capital Investment Fund

**LIST OF PARTICIPANTS
LISTA DE PARTICIPANTES**

MEMBERS OF THE COMMITTEE/MIEMBROS DEL COMITÉ

ARGENTINA

Sr. Marcelo Rinaldi
Asesor Canciller
Ministerio de Relaciones Exteriores,
Comercio Internacional y Culto
Buenos Aires

Sra. Ana Marcela Pastorino
Consejera
Misión Permanente de Argentina ante la
Organización de los Estados Americanos
Washington, D.C.

BOLIVIA

Dr. Franz Calani
Asesor del Ministro de Salud y Deportes
Ministerio de Salud y Deportes
La Paz

Su Excelencia José E. Pinelo Navarro
Embajador, Representante Permanente
de Bolivia ante la Organización de los
Estados Americanos
Washington, D.C.

Sra. Erika Dueñas
Encargada de Negocios, a.i.
Embajada de Bolivia
Washington, D.C.

Sr. William Torres Armas
Ministro Consejero
Misión Permanente de Bolivia ante la
Organización de los Estados Americanos
Washington, D.C.

Dra. Gisela Vaca Melgar
Representante Alterna de Bolivia ante la
Organización de los Estados Americanos
Washington, D.C.

BOLIVIA (cont.)

Sra. Aylin Oropeza Bleichner
Representante Alterna de Bolivia ante la
Organización de los Estados Americanos
Washington, D.C.

GUATEMALA

Su Excelencia Jorge Skinner Klee
Embajador, Representante Permanente
de Guatemala ante la Organización de los
Estados Americanos
Washington, D.C.

Su Excelencia Lionel Maza
Embajador, Representante Permanente
Alternativo de Guatemala ante la
Organización de los Estados Americanos
Washington, D.C.

Sr. Jorge Contreras
Consejero
Misión Permanente de Guatemala ante la
Organización de los Estados
Americanos
Washington, D.C.

HAITI

Dr Alex Larsen
Ministre de la Santé publique
et de la Population
Ministère de la Santé publique
et de la Population
Port-au-Prince

Dr Ariel Henry
Chef de Cabinet
Ministère de la Santé publique
et de la Population
Port-au-Prince

MEMBERS OF THE COMMITTEE/MIEMBROS DEL COMITÉ (*cont.*)

MEXICO/MÉXICO

Dr. Arturo Cervantes
Director General Adjunto de Prevención
de Accidentes
Secretaría de Salud
México, D.F.

Lic. Ana María Sánchez
Directora de Cooperación Bilateral y
Regional
Dirección General de Relaciones
Internacionales
Secretaría de Salud
México, D.F.

Lic. Katya Puga Cornejo
Jefa, Departamento para el Sistema
Interamericano
Dirección General de Relaciones
Internacionales
Secretaría de Salud
México, D.F.

SURINAME

Dr. Celsius Waterberg
Minister of Health
Ministry of Health
Paramaribo

Dr. Marthelise Eersel
Director of Health
Ministry of Health
Paramaribo

Ms. Saskia Bleau
Protocol Officer
Assistant UN Coordinator
Ministry of Health
Paramaribo

**TRINIDAD AND TOBAGO/TRINIDAD Y
TABAGO**

**UNITED STATES OF AMERICA/ESTADOS
UNIDOS DE AMÉRICA**

Mr. James Kulikowski
Acting Director
Office of Global Health Affairs
Department of Health and Human
Services
Washington, D.C.

Mr. Mark Abdo
Director of Multilateral Affairs
Office of Global Health Affairs
Department of Health and Human
Services
Washington, D.C.

Ms. Ann Blackwood
Director of Health Programs
Office of Technical and Specialized
Agencies
Bureau of International Organization
Affairs
Department of State
Washington, D.C.

Mr. Ted Faris
Program Analyst
Office of Management Policy and
Resources
Bureau of International Organization
Affairs
Department of State
Washington, D.C.

MEMBERS OF THE COMMITTEE/MIEMBROS DEL COMITÉ (*cont.*)

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

Ms. Leah Hsu
International Health Analyst
Office of Global Health Affairs
Department of Health and Human
Services
Washington, D.C.

Ms. Kelly Saldana
Senior Public Health Advisor
Bureau for Latin America and the
Caribbean
US Agency for International Development
Washington, D.C.

Mr. Guillermo Aviles Mendoza
International Health Analyst
Office of Global Health Affairs
Department of Health and Human
Services
Washington, D.C.

Ms. Julia Goldberg
International Health Analyst
Office of Global Health Affairs
Department of Health and Human
Services

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

Ms. Therese Hughes
International Health Analyst
Office of Global Health Affairs
Department of Health and Human
Services
Washington, D.C.

URUGUAY

Dr. Jorge Basso
Director General de Salud
Ministerio de Salud Pública
Montevideo

Excelentísima Dra. María del Lujan Flores
Embajadora del Uruguay ante
la Organización de los Estados
Americanos
Washington, D.C.

Sra. Adriana Isabel Rodríguez
Ministra Consejera
Misión Permanente del Uruguay ante
la Organización de los Estados
Americanos
Washington, D.C.

**NON-MEMBERS OF THE COMMITTEE
OTROS MIEMBROS QUE NO FORMAN PARTE DEL COMITÉ**

BRAZIL/BRASIL

Dra. Márcia Bassit L. da Costa Mazzoli
Secretária Executiva
Ministério da Saúde
Brasília, D.F.

Ministro Eduardo Botelho Barbosa
Assessor Internacional
Ministério da Saúde
Brasília, D.F.

Dr. Leandro Luiz Viegas
Assessor Técnico da Secretaria de
Ciência, Tecnologia e Insumos
Estratégicos
Ministério da Saúde
Brasília, D.F.

Sra. Márcia Rollemberg
Coordenadora de Documentação e
Informação Subsecretaria de Assuntos
Administrativos
Ministério da Saúde
Brasília, D.F.

Dr. Eduardo Hage Carmo
Diretor do Departamento de
Vigilância Epidemiológica
Ministério da Saúde
Brasília, D.F.

Sra. Juliana Vieira Borges Vallini
Assessora Jurídica do Programa Nacional
DST/AIDS
Ministério da Saúde
Brasília, D.F.

Sra. Viviane Rios Balbino
Representante Alternata do Brasil junto à
Organização dos Estados Americanos
Washington, D.C.

CANADA/CANADÁ

Ms. Bersabel Ephrem
Director General
International Affairs Directorate
Health Canada
Ottawa

Ms. Kate Dickson
Senior Policy Advisor
PAHO/Americas
International Affairs Directorate
Health Canada
Ottawa

Ms. Carolina Seward
Policy Analyst
PAHO/Americas
International Affairs Directorate
Health Canada
Ottawa

Ms. Ranu Sharma
Policy Analyst
International Public Health Division
Public Health Agency of Canada
Ottawa

Ms. Sarada Leclerc
Health Specialist, Americas Branch
Canadian International Development
Agency
Quebec

Mr. Darren Rogers
Alternate Representative
Permanent Mission of Canada to the
Organization of American States
Washington, D.C.

NON-MEMBERS OF THE COMMITTEE (*cont.*)
OTROS MIEMBROS QUE NO FORMAN PARTE DEL COMITÉ (*cont.*)

CHILE

Su Excelencia Pedro Oyarce
Embajador, Representante Permanente
de Chile ante la Organización de los
Estados Americanos
Washington, D.C.

Sra. Carla Serazzi
Segunda Secretaria
Misión Permanente de Chile ante la
Organización de los Estados Americanos
Washington, D.C.

Sr. Luis Petit-Laurent
Segundo Secretario
Misión Permanente de Chile ante la
Organización de los Estados Americanos
Washington, D.C.

COLOMBIA

Sr. Carlos Iván Plazas
Encargado de Negocios, a.i.
Misión Permanente de Colombia ante
la Organización de los Estados
Americanos
Washington, D.C.

Sr. Juan Claudio Morales
Consejero
Misión Permanente de Colombia ante
la Organización de los Estados
Americanos
Washington, D.C.

Sr. Carlos Lucien Pineda
Segundo Secretario, Representante
Alternativo de Colombia ante la
Organización de los Estados
Americanos
Washington, D.C.

FRANCE/FRANCIA

Madame Marie-France Pagnier
Ambassadrice, Observatrice permanente
de la France près l'Organisation des
États Américains
Washington, D.C.

Mme Milena Castellnou
Observatrice permanente adjointe de la
France près de l'Organisation des États
Américains
Washington, D.C.

NETHERLANDS/PAÍSES BAJOS

Mrs. Jocelyne Croes
Minister Plenipotentiary of Aruba
The Hague

NICARAGUA

Sr. Luis Alvarado
Ministro Consejero
Misión Permanente de Nicaragua ante la
Organización de los Estados
Americanos
Washington D.C.

Lic. Julieta María Blandón Miranda
Primer Secretaria
Misión Permanente de Nicaragua ante la
Organización de los Estados
Americanos
Washington D.C.

NON-MEMBERS OF THE COMMITTEE (*cont.*)
OTROS MIEMBROS QUE NO FORMAN PARTE DEL COMITÉ (*cont.*)

PARAGUAY

Dra. Esperanza Martínez
Ministra de Salud Pública y
Bienestar Social
Ministerio de Salud Pública y
Bienestar Social
Asunción

Sr. Francisco M. Barreiro P.
Consejero
Misión Permanente del Paraguay
ante la Organización de los Estados
Americanos
Washington, D.C.

Sra. Carla Poletti
Tercera Secretaria
Misión Permanente del Paraguay
ante la Organización de los Estados
Americanos
Washington, D.C.

Sra. Claudia Medina
Misión Permanente del Paraguay
ante la Organización de los Estados
Americanos
Washington, D.C.

Sr. Oscar Báez
Misión Permanente del Paraguay
ante la Organización de los Estados
Americanos
Washington, D.C.

VENEZUELA

Su Excelencia Roy Chaderton Matos
Embajador, Representante Permanente
de Venezuela ante la Organización de
los Estados Americanos
Washington, D.C.

Dra. Carmen Velásquez de Visbal
Ministra Consejera
Misión Permanente de la República
Bolivariana de Venezuela ante
la Organización de los Estados
Americanos
Washington, D.C.

Sra. Valentina Martínez
Attaché
Misión Permanente de la República
Bolivariana de Venezuela ante la
Organización de los Estados
Americanos
Washington, D.C.

Sra. Liz Torres
Segunda Secretaria
Misión Permanente de la República
Bolivariana de Venezuela ante la
Organización de los Estados
Americanos
Washington, D.C.

**OBSERVER STATES
ESTADOS OBSERVADORES**

SPAIN/ESPAÑA

Sr. Javier Sancho
Embajador, Observador Permanente de España
ante la Organización de los Estados Americanos
Washington, D.C.

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

**Inter-American Association of Sanitary and Environmental Engineering
Asociación Interamericana de Ingeniería Sanitaria y Ambiental**

Ing. Carlos Alberto Rosito

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

Ms. Marcela Gaitán

U. S. Pharmacopeia

Dr. Damian Cairatti
Mr. Matthew Hayman

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

**Doctors without Borders
Médicos sin Fronteras**

Mrs. Gemma Ortiz M. Genovese
Ms. Gabriela Chaves
Ms. Emi Maclean

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

International Federation of Pharmaceutical Manufacturers Associations

Ms. Susan Crowley

**UNITED NATIONS AND SPECIALIZED AGENCIES
NACIONES UNIDAS Y AGENCIAS ESPECIALIZADAS**

**United Nations Economic Commission for Latin America and the Caribbean
Comisión Económica para América Latina de las Naciones Unidas**

Sr. Fernando Flores
Sra. Helvia Velloso

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

Ms. Sonia Heckadon
Ms. Rachel Seelig
Ms. Dominica Martin

**PAN AMERICAN SANITARY BUREAU
OFICINA SANITARIA PANAMERICANA**

**Director and Secretary ex officio
of the Committee
Directora y Secretaria ex officio
del Comité**

Dr. Mirta Roses Periago
Director
Directora

**Advisers to the Director
Asesores de la Directora**

Dr. Socorro Gross-Galiano
Assistant Director
Subdirectora

**Advisers to the Director (cont.)
Asesores de la Directora (cont.)**

Mr. Michael Boorstein
Director of Administration
Director de Administración

Dr. Juan Manuel Sotelo
Manager/External Relations,
Resource Mobilization, and Partnerships
Gerente/ Relaciones Externas,
Movilización de Recursos y Asociaciones

Dr. Heidi Jiménez
Legal Counsel, Office of Legal Counsel
Asesora Jurídica, Oficina de la Asesora
Jurídica

THE PAHO REVOLVING FUND FOR VACCINE PROCUREMENT IN LIGHT OF NEW CHALLENGES

Summary Report of a Meeting held on 23 June 2009

1. A meeting was held on 23 June 2009 at the Headquarters of the Pan American Health Organization (PAHO) in Washington, D.C., to discuss various technical and policy issues relating to PAHO's Revolving Fund for Vaccine Procurement and PAHO's collaboration with the GAVI Alliance, the World Bank, and the Advance Market Commitment (AMC) for pneumococcal vaccines. The meeting was convened pursuant to a request made by a representative of the United States of America during the Third Session of the PAHO Subcommittee on Program, Budget, and Administration (SPBA).¹

2. Dr. Socorro Gross, Assistant Director of PAHO, opened the meeting and welcomed participants, extending a special welcome to the Ministers of Health of Haiti, Paraguay, and Suriname and the Vice-Ministers of Health of Brazil and Nicaragua. Other participants included representatives of various PAHO Member States attending the 144th Session of the PAHO Executive Committee, which took place at PAHO Headquarters from 22 to 26 June 2009, and representatives of the GAVI Alliance and the World Bank. The pharmaceutical industry was also represented. In addition, representatives of several PAHO Member States participated in the meeting via online conferencing software.

3. Introductory presentations were made by Alex Palacios of the GAVI Alliance, Susan McAdams of the World Bank, and Cuauhtémoc Ruiz of PAHO, and then the floor was opened for questions and comments. The presentations and discussion are summarized below.

Presentation by Alex Palacios, Special Representative, Executive Office, GAVI Alliance

4. Mr. Palacios began by noting that GAVI has been working with PAHO and with representatives of the World Health Organization (WHO), the World Bank, and the United Nations Children's Fund (UNICEF) to seek practical solutions to differing policies and practices concerning the procurement and delivery of vaccines that pose a challenge to the shared desire to increase access to protection against deadly diseases. While the PAHO-GAVI Working Group is relatively new, the cooperation between the GAVI Alliance and PAHO dates back to the earliest days of GAVI. The members of the Working Group, he said, have held their talks with an open mind and a desire on the part of all to find a practical solution, and other partners have also been helpful, offering ideas

¹ See the report of the SPBA meeting for further information: Document SPBA3/FR.

and precedents for consideration. He acknowledged that numerous parties are waiting to hear that the problem has been solved: donors, news media, the pharmaceutical industry, and of course the countries that are waiting to receive vaccines, which have, understandably, begun to express some frustration.

5. Following the last meeting of the Working Group in late May, a subgroup made up of representatives of PAHO and GAVI was asked to consider one possible approach proposed by PAHO's leadership, and attorneys for both sides were scheduled to meet during the week of 22 June to pursue the idea. He was hopeful, he said, that the attorneys would be able to "do their important work quietly and quickly" and come back to the larger Working Group with their thoughts and considerations. He added that he looked forward to continuing his collaboration with Dr. Gross and other colleagues at PAHO, WHO, UNICEF, and the Bank over the coming months, not just to solve the current problems but also to strengthen collaboration on immunization over the coming years.

Presentation by Susan McAdams, Director, Multilateral Trusteeship and Innovative Financing, Concessional Programs and Global Partnerships, World Bank

6. Ms. McAdams pointed out that more than 7 million people a year die from infectious diseases, most of them in poor countries. Vaccination could prevent the vast majority of these deaths, but unfortunately vaccines are often not available where they are needed. In some cases, as with HIV/AIDS, she said, "we just haven't cracked the science." The larger problem, however, is that market conditions and uncertainties discourage vaccine manufacturers from investing heavily in vaccines for developing countries. The AMC is an initiative designed to break the vicious cycle of uncertain demand, limited supply, and higher prices.

7. While there is a strong market for vaccines, very few vaccine manufacturers are developing and introducing new vaccines at any given point in time; moreover, vaccines tend to be introduced by one company at a time, so at first there is a monopoly. It takes years for a true market to develop and for competition to bring prices down. Thus, there is a long delay in getting vaccines into the market, especially for developing countries, where manufacturers perceive that there is substantial risk and uncertainty about demand.

8. The AMC is designed to fix this market failure by subsidizing the cost of increasing manufacturers' production capacity and enabling them to scale up production in order to meet developing countries' needs. The basic idea underlying the AMC is to provide assurance to manufacturers that a market for a needed vaccine exists, but without distorting normal production incentives. The aim is to secure a financial commitment from donors to subsidize vaccine purchases at a set price for a set period; the vaccine must meet a specified target product profile (i.e., it must contain the right serotypes and meet other requirements as determined by WHO), and must be in demand from GAVI-eligible countries. The target vaccine selected for the pilot AMC is the pneumococcal

vaccine. It was chosen because pneumococcal pneumonia causes more deaths globally than AIDS, tuberculosis, or malaria, including 800,000 child deaths annually, mostly in the world's poorest countries.

9. The AMC is designed to create a market; it is not a purchase guarantee. Donors agree to provide a subsidy in order to fund a well-defined advance market commitment. The size of the subsidy is specified (US\$ 3.50 per dose in the case of the pneumococcal vaccine), as is the sale price (or the price ceiling) for the target vaccine (also US\$ 3.50 per dose for the pneumococcal vaccine), and recipient countries provide co-payment (US\$ 0.10–0.30 per dose initially, depending on country income level, with GAVI co-financing the remainder of the US\$ 3.50 sale price) in order to ensure that the demand is real and not just donor-driven.

10. The donors for the pilot AMC have agreed to pledge a total of US\$ 1.5 billion to fund the subsidy over the next 20 years, and the World Bank has guaranteed all of the donor commitments. The amount pledged will help fund the capital costs of developing needed capacity. It will be paid out for vaccine purchases at a rate of US\$ 3.50 per dose. There is also a limited purchase guarantee, equivalent to 45% of one year's committed capacity, which is offered to vaccine manufacturers in exchange for the production of a vaccine that meets the target product profile and a long-term supply commitment – 10 years in the case of the pneumococcal vaccine – at an agreed price. The goal of the pilot AMC is to guarantee 2 billion doses of the pneumococcal vaccine over the 10-year period at an overall average price of US\$ 4.25 per dose for the period (in 2009 dollars), which translates to US\$ 12.75 for a 3-dose course of immunization, compared to US\$ 200 in the United States.

11. Ms. McAdams stressed that the point of the AMC is, first and foremost, to create a market. "We all benefit when there is a market with competition," she said. "It drives prices down, it enables us to meet demand, it enables us to vaccinate all the kids who need it." A key part of the AMC design is to encourage at least one emerging-market manufacturer to participate in the pilot, she added, as such participation is seen as critical to the long-term success of any vaccine market. She also emphasized that the AMC is a package. It is not a one-year tender, but rather a 10–15 year commitment by the World Bank, GAVI, the donors, and the suppliers. Fundamentally, she said, it is a quid pro quo: a specific subsidy arrangement in exchange for a 10-year supply commitment at a capped low price.

Presentation by Cuauhtémoc Ruiz, Senior Advisor, Comprehensive Family Immunization, PAHO

12. Dr. Ruiz recalled that the Revolving Fund for Vaccine Procurement was launched by PAHO in 1979 as a mechanism for ensuring an uninterrupted supply of essential vaccines, syringes, and other inputs needed for the Expanded Program on Immunization

(EPI). The Revolving Fund, he explained, is based on the principles of equity, quality, access, and Pan-Americanism; it is a cooperation mechanism that guarantees quality, timeliness, quantity, lowest prices, and sustainability. As such, the Fund has played an important role in strengthening and ensuring the financial sustainability of immunization programs in countries, thereby also strengthening national health systems. Thanks largely to the umbrella of protection created by the Fund, the Americas was the first WHO region to eradicate polio and eliminate measles and is well on the way to achieving the elimination of rubella. The Fund has also contributed to a marked increase in the use of seasonal influenza vaccines in the Americas, especially since 2000.

13. An important aspect of the technical cooperation provided through the Fund is support for the enactment of national laws on immunization and the strengthening of national immunization budgets. The most recent data available shows that 99% of funding for national immunization programs in the Latin American and Caribbean countries comes from national sources.

14. Apart from providing technical cooperation, the Revolving Fund is a centralized mechanism for vaccine procurement and it serves as a line of credit made available to countries for vaccine purchases. The Revolving Fund has grown steadily over its 30-year history, the number of vaccines offered climbing from 6 in 1979 to 28 in 2008. The number of countries and territories purchasing through the Fund has also risen – from 8 in 1979 to 41 in 2008 – and the monetary value of the vaccines procured has grown more than a hundredfold – from US\$ 2.3 million to US\$ 271.7 million. By 2012, it is estimated that the Fund will be purchasing more than US\$ 500 million worth of vaccines.

15. The Fund offers benefits for both purchasers and suppliers. For countries it ensures a timely and continuous supply of safe, high-quality, WHO-prequalified vaccines at the lowest prices and enables accelerated and sustainable uptake of new vaccines. For suppliers, it affords long-term purchasing agreements with a single procurer, reliable forecasts, and transparent relations; and it facilitates both planning of production and deliveries and post-marketing pharmacosurveillance.

16. Dr. Ruiz sees three main challenges facing the Fund. One is that new and more expensive vaccines are being produced by single suppliers. The new vaccines include the rotavirus vaccine, the 7-valent pneumococcal conjugate vaccine, and the vaccine against human papillomavirus (HPV). The challenge lies in the fact that these new vaccines are very costly. Adding the rotavirus vaccine at current market prices, for example, would double countries' vaccine budgets, and adding the 7-valent pneumococcal vaccine would raise them sevenfold. In the face of limited funds and competing priorities, it would be difficult for most countries to afford such increases. The Revolving Fund is therefore needed to guarantee low prices. The Fund negotiates prices with vaccine suppliers through competitive public bidding, and one-year contracts are established for an approximate number of doses of a particular vaccine at an agreed price. That price is the

maximum price that the Fund will pay for that vaccine for a period of one year. If the supplier subsequently offers the vaccine at a lower price, under the contract with the Fund, it agrees also to offer that price to the Fund.

17. Other challenges include the emergence of new actors in the field of immunization, including the GAVI Alliance, and the fact that vaccine markets are operating under new models, such as the Advanced Market Commitment. PAHO has been working with GAVI since its inception, contributing to its technical framework and also assisting the GAVI-eligible countries of the Americas in the preparation of proposals and the implementation of GAVI funding.

18. Dr. Ruiz expressed confidence that the Revolving Fund will adapt to the new circumstances and emerge as an even stronger support mechanism for all the countries of the Region. The high levels of poverty and inequity that prevail in the Americas, in his view, make the Revolving Fund indispensable. Although only six of the countries in the Region (Bolivia, Cuba, Guyana, Haiti, Honduras, and Nicaragua) meet the criterion for GAVI funding (2003 gross national income of under US\$ 1,000 per capita), 122 million people in Latin America and the Caribbean, 22% of the population of the subregion, live on less than US\$ 2 per day and 40% of the population cannot afford a basic food basket. Even in Trinidad and Tobago, the country with the highest gross national income per capita in the subregion, 40% of the population lives on less than US\$ 2 per day. In the face of new challenges, he said, the Fund will maintain its key features and remain true to the principles on which it was founded. An even stronger Revolving Fund will continue to ensure that immunization remains a public good and immunization programs remain the most cost-effective and socially acceptable public health intervention.

Questions and comments by meeting participants

19. Representatives of PAHO Member States expressed resounding support for the Revolving Fund and underscored the need to protect and preserve it. “If our choice is whether to defend the Revolving Fund, I believe that we –the countries that are most directly involved- must defend it,” said Ms. Nora Orozco Chamorro, Vice-Minister of Health of Nicaragua. Participants also voiced solid support for the principles of equity, solidarity, and Pan-Americanism underlying the Fund, which was seen as a means of ensuring access to vaccines of high quality, accelerating the introduction of new vaccines, and realizing economies of scale that benefit all countries of Latin America and the Caribbean, irrespective of size or income level. Several participants suggested that other regions of the world should be encouraged to establish their own revolving funds for vaccine procurement. Dr. Ramiro Guerrero, from the Harvard Initiative for Global Health, noted that the need for increased production of existing vaccines, which is being addressed by the pilot AMC, could be addressed by revolving funds which among other benefits, help organize and consolidate demand forecast.

20. Participants also supported the Revolving Fund's single-price approach. "At our EPI managers meeting in 2008 in the Bahamas, when we were told about the tiered price for purchasing vaccines...we unanimously voted for continuation of the Revolving Fund and we implored PAHO to lobby for this continuation," said Dr. Yvonne Monroe of the Ministry of Health of Jamaica. Some participants expressed concern about the possibility that the GAVI-eligible countries of the Americas might purchase vaccines outside the Revolving Fund for lower prices, which they felt could be detrimental to the Fund. It was emphasized that the Revolving Fund has a proven 30-year track record, whereas GAVI and the AMC are relatively new and, in the case of the AMC, untested.

21. Numerous participants stressed the need to bear in mind that the ultimate aim of vaccination is to save children's lives. Dr. Mirta Roses, Director of PASB, pointed out that immunization goals cannot be achieved and diseases cannot be eliminated by vaccinating only poor children. Dr. Márcia Bassit, Vice-Minister of Health of Brazil, agreed. "We mustn't lose sight of our goal, which is to provide complete coverage to all children who need it, regardless of their economic situation," she said.

22. Several participants remarked that the meeting provided an opportunity to identify the most effective elements of the three mechanisms in order to forge a strategy for ensuring access to vaccines for all children in the Americas and elsewhere in the world. Mr. John Fitzsimmons of the United States Centers for Disease Control and Prevention pointed out, for example, that the lessons learned from the Revolving Fund in the area of demand forecasting could prove useful to the AMC pilot. Dr. Esperanza Martínez, Minister of Health of Paraguay, observed that combining the Revolving Fund's successful market approach of centralized, large-scale procurement with the AMC/GAVI strategy of offering subsidies to producers to help defray the research and development costs associated with producing new vaccines could help increase vaccination coverage around the world and save the lives of many children. Dr. Yvonne Monroe, of the Ministry of Health of Jamaica, proposed that the different stakeholders and partners help support PAHO's Revolving Fund to strengthen it and allow other developing countries to have access to the lowest prices for the 10-valent pneumococcal conjugate vaccine, while GAVI-AMC subsidy is provided to eligible countries.

23. A number of questions were asked about GAVI and the AMC. Several participants asked how the two mechanisms would ensure sustainability after their support ends. Dr. Ida Berenice Molina, Head of the Expanded Program on Immunization of Honduras, voiced concern about what might happen if Honduras, a GAVI-eligible country, were to introduce the pneumococcal vaccine but then become ineligible for GAVI support because its per capita gross national income had risen slightly above US\$ 1,000. At current prices, she said, the country would not be able to continue purchasing the vaccine and its immunization program would suffer a serious loss of credibility. She and other participants urged GAVI to revise its eligibility criteria, bearing in mind that in many countries of the Americas, even if gross national income is above

US\$ 1,000, a large proportion of the population continues to live below the poverty line of US\$ 2 per day. Ms. Orozco Chamorro of Nicaragua expressed concern about the lack of representation of developing countries from the Americas on the GAVI Board.

24. Several participants sought information about how the pneumococcal vaccine was selected as the target vaccine for the AMC pilot, how the AMC would manage the supply of various types of pneumococcal vaccine (the 7-valent vaccine currently available and the 10-valent and 13-valent vaccines expected to be available soon), whether AMCs for other vaccines are envisaged, and whether the aim of the AMC is to facilitate the introduction of new vaccines or to scale up the production of existing ones. Dr. Celsius Waterberg, Minister of Health of Suriname, inquired when the vaccine against human papillomavirus (HPV) might be available through GAVI and/or the PAHO Revolving Fund.

25. Mr. Palacios of the GAVI Alliance, responding to some of the questions and comments, said that the AMC has no intention of competing with or harming the Revolving Fund. The Revolving Fund and the AMC, he explained, “are two of a number of mechanisms that are going to run simultaneously, addressing different kinds of issues and problems. There is no intention to compete, no intention to do any harm to the Revolving Fund. We agree that the Revolving Fund has achieved important things, and it can continue to do that and perhaps achieve even greater things in the years ahead.”

26. On the question of eligibility, he reported that a task force is currently reviewing the criteria in order to determine what changes, if any, might need to be made. He also noted that commitments would be maintained through a transition phase to ensure sustainability among countries that are no longer eligible.

27. With regard to sustainability, he said that since 2008 the introduction of any new vaccine with GAVI support has been accompanied by a co-financing requirement for countries. Initially the country contribution is modest, but it increases over time, the aim being that countries will eventually be able to cover their own vaccine costs.

28. The HPV vaccine, he said, is among the vaccines that the GAVI Alliance Board has approved for consideration of future support, subject to the availability of resources. However, he noted, resources are finite, and GAVI anticipates a funding gap of some US\$ 3 billion over the next six to seven years.

29. Ms. McAdams also stated that the AMC is not intended to compete with the PAHO Revolving Fund but rather is intended to work in parallel with it. “If we can hasten the delivery of pneumococcal vaccines, if we can reduce the supply constraints, if we can move more quickly to a competitive market and lower price, everybody benefits.” That is the “key complementarity” between the AMC and the Revolving Fund, she said.

30. As to how the pneumococcal vaccine was chosen for the pilot, she explained that the original idea for the AMC was to encourage and incentivize research and development for an HIV vaccine. However, an independent expert group looked at various potential candidate diseases to be targeted by the pilot, including HIV/AIDS, malaria, tuberculosis, rotavirus disease, pneumococcal disease, and HPV infection, and selected pneumococcal disease because the members of the group felt that accelerating the introduction of the pneumococcal vaccine would have the biggest and most immediate public health impact.

31. Dr. Roses, Director of PASB, said that the PAHO Secretariat has never seen PAHO's relationship with GAVI as a competition, and it had not been aware until recently that there was any problem vis-à-vis GAVI. It had therefore been difficult to understand, she said, why the delegate of the United States had repeatedly requested that the PAHO Governing Bodies discuss the matter. She explained that she had become aware about eight months ago that a clause in the Revolving Fund procurement contract had been identified within GAVI and the AMC as a problem. Nonetheless, she was never invited to talk about the Revolving Fund or address issues with the World Bank or GAVI, and PAHO was never consulted on the design of the AMC, even though the World Bank is located only two blocks from PAHO Headquarters.

32. She reiterated that PAHO has been trying to address issues with GAVI and has tried to be as open and transparent as possible. Nevertheless, while PAHO does not view its relationship with GAVI as a competition, she pointed out that it is clearly being perceived that way by some. Citing an article entitled "Vaccine system hampers African efforts," published in the *Financial Times* on the day of the meeting,² she noted that "the countries of the Americas are being considered guilty for the lack of progress in immunization in Africa" when they have contributed in different ways, even with human resources, towards the progress of vaccination in that Region.

33. Mr. Mark Abdoo, Director of Multilateral Affairs, Office of Global Health Affairs, Department of Health and Human Services of the United States, said that he was pleased to hear that PAHO does not view itself as being in competition with the other players in the global architecture for health, nor do the other players view themselves as being in competition with PAHO. That is important, he said, because "we're all working toward the same goal. Everybody wants to get vaccines into the arms of kids." All regions of the globe need to stand in solidarity, he added, to ensure that children have access to vaccines that will bring lasting improvements to their health. The Americas is fortunate to have the Revolving Fund, he said, "which has functioned outstandingly for a number of years and has helped us make the sustainable and important improvements in

² Jack, Andrew. Vaccine system hampers African efforts. *Financial Times*, 23 June 2009. Available at: http://www.ft.com/cms/s/0/1fef88b8-5f48-11de-93d1-00144feabdc0.html?nclink_check=1. (Accessed on 16 July 2009).

health that our Region has seen,” although whether or not the revolving fund model should be applied in other Regions will be “a long-term discussion.”

34. Mr. Palacios of the GAVI Alliance, responding to Dr. Roses’ comments, said that he agreed that there had been insufficient consultation between GAVI and PAHO. “We are trying to address that in a variety of ways,” he added, including through the PAHO-GAVI Working Group. Although the Working Group is currently focusing on one particular challenge, GAVI’s hope, he said, is that it will become an important mechanism for ongoing communication and consultation.

35. Dr. Ciro de Quadros, Executive Vice President of the Sabin Vaccine Institute and Chair of PAHO’s Technical Advisory Group on Vaccine-Preventable Diseases, said that, like the Director, he was a little puzzled about why a special meeting was being held to discuss the Revolving Fund and the AMC, since the AMC will have very little impact in the Americas and the Revolving Fund is continuing to serve the Region well.

36. Dr. Roses extended thanks to everyone who had participated in the meeting, particularly the ministers of health who had traveled to Washington expressly to attend. Summing up the discussion, she said that it appeared to her that the value of the Revolving Fund had been well established. She pointed out that the Fund had been created 30 years ago to address the same vicious cycle that the AMC is seeking to address today: an insufficient supply of vaccines caused by producers’ reluctance to boost production because there was too much risk and too much uncertainty with regard to demand. The relationship between the Revolving Fund and producers, she emphasized, has been extremely positive. Thanks to the guaranteed demand generated by the Revolving Fund, vaccine manufacturers have been able to scale up production and invest in research and development. When WHO called for an expansion in the production capacity for pandemic influenza vaccines, it was the Americas that allowed producers to do so by increasing demand for seasonal influenza vaccines. The Fund has also enabled the development of producers in emerging markets, which has created greater competition and thus lowered prices, but more importantly from a public health perspective it has ensured a sustained supply of needed vaccines.

37. The issue that has arisen with regard to the AMC and the Revolving Fund relates specifically to the 10-valent pneumococcal conjugate vaccine and concerns a clause in the Fund’s procurement contract which stipulates that producers will offer the Fund the lowest possible price for their vaccines. This issue, she pointed out, has arisen in a market that is highly defective from both an economic and a public health standpoint; because there is only one producer of the pneumococcal vaccine. That, not the Revolving Fund, is the problem, she stressed: there is a lack of competition because there is a single supplier.

38. She reiterated that the problem concerns only the pneumococcal vaccine; there is no problem with any of the other vaccines currently being procured through the

Revolving Fund. The PAHO-GAVI Working Group is therefore focusing on finding a specific solution to that specific problem. “Unique situations such as this of course require unique solutions,” she said, adding that she has made it clear to the Executive Secretary of the GAVI Alliance that she is more than willing to seek such a solution, but “without undermining the principles of the Revolving Fund and, above all, without generating tensions or differences among the countries of the Americas.” To that end, she has declared a one-year moratorium on procurement of the 10-valent pneumococcal vaccine through the Revolving Fund so that the AMC pilot may go forward.

39. From her perspective, the Member States of PAHO had made it clear that they did not see any reason for further discussion on the Revolving Fund, although the discussion within the PAHO Executive Committee would, of course, take place as planned. She appealed to the Executive Committee members to give some thought prior to that discussion to how the problem of the pneumococcal vaccine might be resolved in a way that would be beneficial to all concerned.

- - -