

## **158th SESSION OF THE EXECUTIVE COMMITTEE**

*Washington, D.C., USA, 20-24 June 2016*

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### **FINAL REPORT**

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## CONTENTS

	<i>Page</i>
<b>Opening of the Session</b> .....	6
<b>Officers</b> .....	7
<b>Procedural Matters</b>	
Adoption of the Agenda and Program of Meetings .....	7
Representation of the Executive Committee at the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas.....	7
Draft Provisional Agenda of the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas .....	7
<b>Committee Matters</b>	
Report on the 10th Session of the Subcommittee on Program, Budget, and Administration.....	8
PAHO Award for Administration (2016) .....	9
PAHO Award for Administration: Changes to the Procedures .....	9
Nongovernmental Organizations in Official Relations with PAHO.....	11
Annual Report of the Ethics Office (2015).....	12
Report of the Audit Committee of PAHO .....	14
Appointment of One Member to the Audit Committee of PAHO.....	18
<b>Program Policy Matters</b>	
Preliminary Report of the End-of-biennium Assessment of the Program and Budget 2014–2015/First Interim Report on the PAHO Strategic Plan 2014–2019 .....	18
Interim Assessment of the Implementation of the PAHO Budget Policy .....	22
Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan.....	23
Resilient Health Systems .....	25
Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies .....	27
Health of Migrants .....	30
Plan of Action for Malaria Elimination 2016-2020.....	33
Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021 .....	35
Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 .....	37
Strategy for Arboviral Disease Prevention and Control .....	39
Plan of Action for Disaster Risk Reduction 2016-2021 .....	40
Analysis of the Mandates of the Pan American Health Organization .....	42

**CONTENTS** (*cont.*)

	<i>Page</i>
<b>Administrative and Financial Matters</b>	
Report on the Collection of Assessed Contributions .....	44
Financial Report of the Director and Report of the External Auditor for 2015.....	45
Programming of the Budget Surplus.....	49
Programming of the Revenue Surplus .....	49
After-service Health Insurance .....	49
Report on the Master Capital Investment Fund .....	50
Report of the Office of Internal Oversight and Evaluation Services .....	51
Update on the Appointment of the External Auditor of PAHO for 2018-2019 and 2020-2021 .....	52
<b>Personnel Matters</b>	
PASB Staffing Statistics .....	53
Amendments to the PASB Staff Regulations and Rules .....	55
Statement by the Representative of the PAHO/WHO Staff Association .....	56
<b>Matters for Information</b>	
PAHO Program and Budget 2016-2017: Mechanisms for Interim Reporting to Member States .....	57
Process for the Development of the WHO Program Budget 2018-2019.....	58
Update on WHO Reform .....	60
Status of the PASB Management Information System (PMIS).....	63
Implementation of the International Health Regulations (IHR) .....	64
Update on the Zika Virus in the Region of the Americas .....	66
Implementation of the Sustainable Development Goals in the Region of the Americas .....	69
Regional Plan of Action for Strengthening Vital and Health Statistics: Final Report .....	70
Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006-2015: Final Report .....	72
Strategy and Plan of Action for the Reduction of Chronic Malnutrition: Final Report .....	73
Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Region of the Americas: Final Report .....	75
Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: Final Report .....	76

**CONTENTS** (*cont.*)

	<i>Page</i>
<b>Matters for information</b> ( <i>cont.</i> )	
Progress Reports on Technical Matters .....	78
A. Strategy and Plan of Action on eHealth: Midterm Review .....	78
B. Plan of Action on Adolescent and Youth Health.....	78
C. Plan of Action for the Prevention and Control of Noncommunicable Diseases: Midterm Review .....	79
D. Plan of Action to Reduce the Harmful Use of Alcohol: Midterm Review .....	80
E. Plan of Action on Psychoactive Substance Use and Public Health: Midterm Review .....	81
F. Status of the Pan American Centers.....	82
Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO .....	82
A. Sixty-ninth World Health Assembly.....	82
B. Subregional Organizations.....	83
<b>Closure of the Session</b> .....	85
<b>Resolutions and Decisions</b>	
<i>Resolutions</i>	
CE158.R1 Collection of Assessed Contributions.....	85
CE158.R2 Plan of Action for Disaster Risk Reduction 2016-2021 .....	86
CE158.R3 Strategy for Arboviral Disease Prevention and Control .....	88
CE158.R4 Plan of Action for Malaria Elimination 2016-2020.....	90
CE158.R5 Appointment of One Member to the Audit Committee of PAHO....	92
CE158.R6 Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021 .....	93
CE158.R7 Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan.....	97
CE158.R8 Collection of Assessed Contributions Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 .....	99
CE158.R9 Analysis of the Mandates of the Pan American Health Organization.....	103
CE158.R10 Amendments to the PASB Staff Regulations and Rules .....	104
CE158.R11 Health of Migrants .....	107
CE158.R12 Resilient Health Systems .....	109

## CONTENTS (cont.)

*Page*

### **Resolutions and Decisions (cont.)**

#### ***Resolutions (cont.)***

CE158.R13 PAHO Award for Administration (2016) .....	113
CE158.R14 PAHO Award for Administration – Changes to the procedures.....	113
CE158.R15 Nongovernmental Organizations in Official Relations with PAHO.....	117
CE158.R16 Access and Rational Use of Strategic and High-Cost Medicines and Other Health Technologies .....	118
CE158.R17 Provisional Agenda of the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas .....	123

#### ***Decisions***

CE158(D1) Adoption of the Agenda.....	123
CE158(D2) Representation of the Executive Committee at the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas .....	123
CE158(D3) Programming of the Budget Surplus.....	124

### **Annexes**

- Annex A. Agenda
- Annex B. List of Documents
- Annex C. List of Participants

## FINAL REPORT

### Opening of the Session

1. The 158th 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 20 to 24 June 2016. The Session was attended by delegates of the following nine Members of the Executive Committee elected by the Directing Council: Antigua and Barbuda, Argentina, Bahamas, Chile, Costa Rica, Ecuador, Guatemala, Trinidad and Tobago, and United States of America. Delegates of the following other Member States, Participating States, and Observer States attended in an observer capacity: Brazil, Canada, El Salvador, Honduras, Mexico, Panama, Paraguay, Saint Kitts and Nevis, and Spain. In addition, eight nongovernmental organizations were represented.

2. Dr. Margarita Guevara Alvarado (Ecuador, President of the Executive Committee) opened the session and welcomed participants, noting that the recently concluded Sixty-ninth World Health Assembly had adopted a number of decisions that would affect the work of PAHO. She emphasized that all Member States must work together to achieve the Sustainable Development Goals, building on the progress made towards the Millennium Development Goals. In a context in which various countries were grappling with the effects of natural disasters and social, political or economic crises, every effort must be made to protect vulnerable groups through public policies that emphasized equity and incorporated an intercultural and gender perspective. She expressed gratitude for the international assistance received from PAHO and individual Member States in the wake of the devastating earthquake that her country had suffered in April 2016.

3. Dr. Carissa Etienne (Director, Pan American Sanitary Bureau [PASB]), also welcoming participants, pointed out that the Region had faced numerous public health challenges since the 54th Directing Council in October 2015, including the devastating effects of various natural disasters and the crushing impact of the Zika virus epidemic, which had once again tested the Organization's emergency preparedness and response capacity. The Bureau had mounted timely and effective responses to the outbreak and the natural disasters and supported Member States in dealing with those challenges. She noted that the Committee would be discussing strategies, plans of action, and policy documents on a number of important technical topics. It would also examine key financial, administrative, and personnel matters. The Committee played a vital role in ensuring the efficient and effective functioning of the Organization, and its work during the current Session would set the stage for a successful 55th Directing Council in September. She expressed gratitude in advance to Committee Members for their commitment and dedication during the session.

4. Ms. Piedad Huerta (Senior Advisor, Office of Governing Bodies, PASB) explained a new paperless document distribution system piloted during the 10th Session of the Subcommittee on Program, Budget, and Administration. The system included an

electronic resolution tracking mechanism that would facilitate the circulation of amended versions of proposed resolutions during the session.

### **Officers**

5. The following Members elected to office at the Committee's 157th Session continued to serve in their respective capacities during the 158th Session:

<i>President:</i>	Ecuador	(Dr. Margarita Guevara Alvarado)
<i>Vice President:</i>	Costa Rica	(Dr. María Esther Anchía)
<i>Rapporteur:</i>	Trinidad and Tobago	(Dr. Rhonda Sealey-Thomas)

6. The Director served as Secretary ex officio, and Dr. Isabella Danel (Deputy Director, PASB) served as Technical Secretary.

### **Procedural Matters**

#### ***Adoption of the Agenda and Program of Meetings (Documents CE158/1, Rev. 1, and CE158/WP/1, Rev. 1)***

7. The Committee adopted the provisional agenda proposed by the Director (Document CE158/1, Rev.1) without change; the Committee also adopted a provisional program of meetings (CE158/WP/1, Rev. 1) (Decision CE158[1]).

#### ***Representation of the Executive Committee at the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas (Document CE158/2)***

8. In accordance with Rule 54 of its Rules of Procedure, the Executive Committee appointed Ecuador and Costa Rica, its President and Vice President, respectively, to represent the Committee at the 55th Directing Council, 68th Session of the Regional Committee of WHO for the Americas. Argentina and the United States of America were elected as alternate representatives (Decision CE158[D2]).

#### ***Draft Provisional Agenda of the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas (Document CE158/3, Rev. 1)***

9. Ms. Piedad Huerta (Senior Advisor, Governing Bodies Office, PASB), introducing the provisional agenda of the 55th Directing Council, 68th Session of the Regional Committee of WHO for the Americas (Document CE158/3, Rev. 1), noted that an item on the Framework of Engagement with Non-State Actors had been added to the agenda following the Sixty-ninth World Health Assembly (see "Update on WHO Reform," paragraphs 264 to 277 below). The Bureau would move the report on implementation of the International Health Regulations (2005) from Matters for Information to Program Policy Matters, in accordance with the recommendation made by the Executive Committee

(see “Implementation of the International Health Regulations,” paragraphs 287 to 296 below).

10. In the ensuing discussion, it was noted that the Sixty-ninth World Health Assembly had adopted a resolution on the role of the health sector in international chemicals management,<sup>1</sup> which called on the Director-General of WHO to develop, in consultation with Member States and other relevant stakeholders, a roadmap for the health sector aimed at achieving the 2020 goal for sound chemicals management adopted by the International Conference on Chemicals Management (Dubai, February 2006) and contributing to relevant targets of the 2030 Agenda for Sustainable Development. All WHO regional committees had been urged to include a discussion of the roadmap on their agendas. It was therefore suggested that the Directing Council should discuss the matter under agenda item 7.7, “Implementation of the Sustainable Development Goals in the Region of the Americas.”

11. Ms. Huerta said that a subitem on the roadmap would be added to the agenda under item 7.7.

12. The Executive Committee adopted the proposed resolution contained in Document CE158/3, Rev. 1, with the above-mentioned revisions and additions.

### **Committee Matters**

#### ***Report on the 10th Session of the Subcommittee on Program, Budget, and Administration (Document CE158/4)***

13. Dr. Rhonda Sealey-Thomas (Antigua and Barbuda, President of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee on Program, Budget, and Administration (SPBA) had held its 10th Session on 30 March and 1 April 2016. The Subcommittee had discussed a number of important financial, administrative, and other issues, including an outline of the Financial Report of the Director for 2015, an outline of the end-of-biennium assessment of the program and budget for 2014-2015 and the first interim report on the PAHO Strategic Plan 2014-2019, refinement of the programmatic priority stratification framework for the current PAHO Strategic Plan, the mechanism for interim reporting to Member States on the program and budget for the current biennium, an interim assessment of the implementation of the PAHO Budget Policy, and programming of the budget and revenue surpluses remaining from the 2014-2015 biennium. The Subcommittee had also discussed WHO reform and recommended a candidate to replace an outgoing member of the PAHO Audit Committee. Dr. Sealey-Thomas noted that, as all of the matters discussed by the Subcommittee were also on the agenda of the Executive Committee, she would report on them as they were taken up by the Committee.

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<sup>1</sup> Resolution WHA69.4.



14. The Delegate of Mexico said that paragraph 78 of the report did not accurately reflect the comments made by her delegation in relation to the report presented to the Subcommittee on the Master Capital Investment Plan<sup>2</sup> and requested that the paragraph be amended.

15. The Director suggested that the Mexican delegation should clarify its position when the Committee took up the item on the Master Capital Investment Plan (see paragraphs 218 to 222 below); the Delegate of Mexico agreed to that suggestion. The Director expressed gratitude to the Members of the Subcommittee and to the observers who had participated in its 10th Session for their valuable comments, which had been very helpful to the Bureau in preparing for the Executive Committee session.

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

***PAHO Award for Administration (2016) (Documents CE158/5 and Add. I)***

17. Ms. Gabrielle Lamourelle (United States of America) reported that the Award Committee of the PAHO Award for Administration (2016), consisting of the representatives of the Bahamas, Ecuador, and the United States, had met on 21 June 2016 and examined the information on the candidates nominated by Member States. Following discussions, and recognizing the merits of all three candidates, the Award Committee had decided to recommend that the PAHO Award for Administration (2016) be granted to Dr. Pastor Castell-Florit Serrate of Cuba, for his commendable contributions to public health, reflected in his leadership in the management and administration of the national health system of Cuba, and for his professional trajectory and his contributions to research and teaching on the administrative management of health systems, corroborated by the positions he had held and his numerous publications in national and international journals.

18. The Executive Committee adopted Resolution CE158.R13, awarding the PAHO Award for Administration (2016) to Dr. Pastor Castell-Florit Serrate, of Cuba.

***PAHO Award for Administration: Changes to the Procedures (Document CE158/6, Rev. 2)***

19. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had considered a proposal by the Bureau to amend the guidelines for conferring the PAHO Award for Administration with the aim of enhancing the award's importance and encouraging Member States to present candidates of excellence. The Subcommittee had decided to form a working group consisting of Argentina, Grenada, Honduras, and Mexico to review the proposed changes. The working group had met during the Subcommittee's 10th Session and had decided to recommend some modifications to the amendments proposed by the Bureau. The revised

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<sup>2</sup> Document SPBA10/12.

procedures had been endorsed by the Subcommittee and were presented to the Executive Committee in Document CE158/6.

20. Dr. James Fitzgerald (Director, Department of Health Systems and Services, PASB), expressing thanks to the working group, explained that the proposed changes to the procedures related mainly to the scope of the award. Since its inception, the award had been highly focused on health services. However, the context had evolved and the Organization had adopted new mandates, including the Strategy for Universal Access to Health and Universal Health Coverage. In light of those changes and also the Organization's continued work on the Millennium Development Goals and the future work on the Sustainable Development Goals, a proposal had been made to change the focus of the award, which henceforth would be known as the PAHO Award for Health Services Management and Leadership. The award would be granted to individuals who had shown excellence in leadership in areas having to do with access, coverage, management, development of integrated networks, and similar fields related to health service delivery.

21. In the ensuing discussion, a delegate asked what criteria would be used to assess nominees, noting that it was important to make the criteria clear in order to ensure rigor and transparency in the review process and also to assist Member States in nominating appropriate candidates. She also wondered whether Member States would be expected to endorse candidates who responded through the open call and whether the limit of two nominations per Member State included those submitted by the Member State and those that went through the open call process.

22. Dr. Fitzgerald replied that candidates would be proposed by Member States, which thus would endorse them. Agreeing that it was important to have a defined set of criteria, he noted that general requirements for candidates were set out in paragraph 2 of the procedures. It would be the responsibility of the Award Committee to assess whether candidates met those requirements. When the Bureau issued its call for candidates, it would make explicit the areas of work to which the Award would apply and would issue standardized questionnaires to Member States and also require extensive documentation to back up the candidacies, as explained in paragraph 5 of the procedures. Further details, such as the scores to be allocated to the various criteria, could be worked out prior to the June 2017 session of the Executive Committee.

23. The Director remarked that there was an onus on the Bureau to ensure that candidates were deserving of the award. It relied on Member States to propose candidates who not only had demonstrated significant achievements in health management, but were also of good repute and standing at the national, regional, and global levels. As Dr. Fitzgerald had indicated, an objective method for scoring candidates had not yet been established, but when the Award Committee met in the future it could decide how many points should be awarded for each of the criteria, although such details need not necessarily be included in the procedures.

24. The Executive Committee adopted Resolution CE158.R14, approving the amended procedures and the change in the name of the award.

***Nongovernmental Organizations in Official Relations with PAHO (Document CE158/7)***

25. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that, in accordance with the procedure outlined in the Principles Governing Relations between the Pan American Health Organization and Nongovernmental Organizations, the Subcommittee had held a closed meeting during its 10th Session to review the status of eight NGOs in official relations with PAHO and to consider the application of one organization seeking to enter into official relations with the Organization. The Subcommittee had decided to recommend that the Executive Committee admit *Mundo Sano* into official relations with PAHO and continue official relations between PAHO and the Healthy Caribbean Coalition, the Inter-American College of Radiology, the Interamerican Society of Cardiology, the Latin American and Caribbean Women's Health Network, the Latin American Association of Pharmaceutical Industries, the Latin American Federation of Hospitals, the Panamerican Federation of Associations of Medical Schools, and the Pan American Federation of Nursing Professionals.

26. In the Executive Committee's discussion of the item, it was suggested that, in light of the approval of the Framework of Engagement with non-State Actors (FENSA) by the Sixty-ninth World Health Assembly (see paragraphs 264 to 277 below), the Bureau should revise its procedures concerning collaboration with NGOs, taking into account the four categories accepted by the Assembly. The need to avoid any conflicts of interest was emphasized.

27. A representative of the Latin American Association of Pharmaceutical Industries (ALIFAR, for its acronym in Spanish) affirmed the commitment of the pharmaceutical laboratories represented by the Federation to the quality, safety, and accessibility of medicines and described the Federation's policies and activities with regard to harmonization of pharmaceutical regulations, drug quality standards, and the manufacture, distribution, and marketing of medicines.

28. A representative of the Inter-American Association of Sanitary and Environmental Engineering (AIDIS, for its acronym in Spanish) described the work of his association in the fields of water, sanitation, hygiene, and clean air, adding that AIDIS stood ready to work with PAHO in its areas of technical expertise or in related fields such as communicable diseases and disaster or epidemic response. He also noted that AIDIS and PAHO would jointly host a symposium on water and sanitation prior to the 35th Inter-American Congress on Sanitary and Environmental Engineering, to be held in Cartagena, Colombia from 21 to 24 August 2016. A representative of the Latin American Federation of the Pharmaceutical Industry (FIFARMA, for its acronym in Spanish) affirmed the Federation's commitment to supporting the public health systems in each of the countries of the Region where it was represented. It considered that there was a need to

build inclusive systems in which the central focus was the best possible care of patients. It looked forward to continuing its active partnership with PAHO in the future.

29. Mr. Alberto Kleiman (Director, Department of External Relations, Resource Mobilization, and Partnerships, PASB), expressing thanks to the NGO representatives for the contributions of their organizations, said that the Bureau had taken note of the comments regarding FENSA, which would indeed be implemented, with due application of the criteria defined and approved by the Member States for working not only with NGOs but also with the other categories of non-State actors.

30. The Director expressed her appreciation for the ongoing contributions of the NGOs in official relations with the Organization. The Bureau looked forward to continued collaboration with them in the future, in a spirit of mutual respect and understanding and with full regard for FENSA.

31. The Executive Committee adopted Resolution CE158.R15, renewing official relations between PAHO and the eight organizations listed above for a period of four years and admitting into official relations the NGO *Mundo Sano*, also for four years.

***Annual Report of the Ethics Office (2015) (Document CE158/8)***

32. Mr. Philip MacMillan (Manager, Ethics Office, PASB) introduced the report, highlighting the Ethics Office's main activities in 2015 in four key areas: advice and guidance given to personnel on ethical issues, reports received about possible ethical concerns, cases of fraud and theft or loss of PAHO property and resources, and new initiatives implemented to improve the ethical culture in PAHO and promote a respectful workplace. He reviewed the data presented in the report on consultations from staff, reports of behavior that raised possible ethical concerns, and reports of harassment and inappropriate workplace conduct, noting that further detail could be found in Document CE158/8.

33. He also reported that a number of anonymous reports had been received through the Ethics Help Line concerning senior officials in PASB. The Ethics Office had investigated the allegations and found them to be unfounded. Subsequently, the Office had learned of numerous anonymous e-mail communications on the same allegations, sent outside normal reporting channels and under fictitious names to PAHO officials, WHO, the United Nations Ethics Office, and PAHO's Audit Committee. Pursuant to a decision by the Director, an external investigator had been engaged to make an independent assessment of the allegations, the outcome of which would be included in the report of the Ethics Office to be presented to the Committee in 2017.

34. New initiatives in 2015 included a survey conducted to gauge the ethical climate and work environment at Headquarters and in the country offices and the Respectful Workplace Initiative, led by the Office of the Ombudsperson, which was intended to help reduce conflict and inappropriate workplace conduct. In 2016 the Ethics Office would

implement a new help line that would feature more sophisticated analytical tools and a training program intended to ensure that managers recognized the importance of staff being able to raise good-faith concerns without fear of retaliation.

35. The Audit Committee had recently made some recommendations regarding the structure of the Ethics Office and its dual role of advising on ethical issues and investigating allegations of misconduct (see paragraphs 43 to 58 below). One of those recommendations was that PAHO should follow the United Nations model, in which investigations were carried out by the Office of Internal Oversight Services. However, a 2016 report by the Joint Inspection Unit had noted that if auditors engaged extensively in fraud detection and/or became part of an investigation team, they might find it difficult to be seen as trusted staff when they returned to their purely internal role. That caveat made it clear that investigations carried out by an audit office presented their own distinctive challenges and might not necessarily amount to best practice.

36. He noted that the dual advisory and investigative role was not unique to PAHO's Ethics Office: the ethics offices of the World Bank, the Inter-American Development Bank, the International Fund for Agricultural Development, and others also had that dual responsibility. PAHO's Ethics Office was unique, however, in that it did not report to management, but directly to the Governing Bodies through the Executive Committee. In his view, any decision regarding the structure or responsibilities of the Ethics Office should take that unique and important characteristic into account.

37. Since its establishment, the Ethics Office had attempted to balance the time it spent carrying out its two primary responsibilities; however, that balance had become increasingly difficult to maintain owing to the growing number of reports and the amount of time needed to investigate allegations. The Office had recently taken steps to address the issue by establishing two new professional positions: one to focus solely on investigations and the other on advisory and training roles. With that separation of functions, the Ethics Office would be able to strengthen its focus on prevention, thereby reducing the risk of improper conduct.

38. On the issue of whistleblower protection, PAHO had a robust policy to protect from retaliation any staff who had reported misconduct or cooperated in an investigation. However, whistleblower protection did not and should not reside in the Ethics Office alone; it had to be a collective effort among different offices, including senior management. That helped to ensure that staff who reported wrongdoing would have the necessary institutional support and would not experience any adverse consequences.

39. In the ensuing discussion, appreciation was expressed for the Ethics Office's efforts to promote integrity and ethical conduct, and its plan to develop a training program for managers relating to whistleblower protection was applauded. It was noted that the report indicated that, while the number of reports of ethical concerns appeared to have remained roughly constant, the actual number had risen by about 18%, owing to an increase in the number of issues covered. Information was sought on the reasons for that

increase and on why the number of reports, after increasing for several years, had remained relatively constant at around 50 after 2012. It was suggested that future reports should include a graph showing the number of consultations made at Headquarters and at country offices.

40. Mr. MacMillan said that 72 of the 115 consultations regarding ethical concerns received in 2015 had come from Headquarters staff. Of the 53 reports of behavior that raised possible ethical concerns, 32 had come from Headquarters staff or related to issues at Headquarters. Such statistics would be included in future Ethics Office reports. He noted that, following visits by the Office to PAHO/WHO representative offices, there tended to be an increase in consultations and reports, as the staff of those offices came to understand the resources that were available to them; that trend was likely to continue as the Office expanded its outreach to staff in country offices. He noted, too, that not all of the reports related to serious ethical issues.

41. The Director, commenting on the efforts to change the culture within the Organization, explained that the Respectful Workplace Initiative sought to increase awareness among staff that it was acceptable for them to speak up when they objected to the way they were treated in the workplace and to demand respectful treatment from their supervisors. It was essential to create a respectful workplace where people felt valued and did not fear retaliation if they complained about disrespectful treatment. She hoped that there would thus be a decrease in anonymous reporting, as staff and managers learned to take preventive action to head off misconduct or improper behavior and began to discuss issues between them openly and without subsequent ill-feeling.

42. The Executive Committee took note of the report.

***Report of the Audit Committee of PAHO (Document CE158/9)***

43. Mr. Nicholas Treen (Chair, PAHO Audit Committee), introducing the report of the Audit Committee, outlined the topics of interest to the Committee for 2015-2016 and its plans for the coming year, noting that the report put forward eight recommendations. He also noted that the Committee tracked the action taken on its recommendations and greatly appreciated the Director's willingness to implement them or to explain why they had not been implemented. It also appreciated her openness and readiness to provide the Committee with the information it requested.

44. The Organization's financial statements for 2015 had not been ready in time for the Audit Committee to study them even in draft form before the External Auditors had concluded their audit. That was regrettable, as the Audit Committee could have pinpointed areas in the statements where the External Auditor might see difficulties and discuss with the Director ways to improve the situation. That was one of the most important functions of an audit committee.

45. The Committee had a fruitful relationship with the External Auditor and also with the Office of Internal Oversight and Evaluation Services (IES) (see paragraphs 223 to 227 below), whose recommendations and reports were consistently of high quality. It was pleasing to see that an evaluation culture was being built up in the Organization, as such a culture enabled both learning and accountability. The Committee welcomed the intention of IES to carry out an independent quality assessment of the internal audit function in 2016 and to revise the internal audit charter to comply with United Nations and Institute of Internal Auditors best practices.

46. The Audit Committee had spent considerable time reviewing PAHO's information technology environment, focusing especially on information security, which it had identified as a significant weakness. However, it had already seen improvements that area. The Committee had recommended that the Bureau take steps to ensure compliance with the relevant international standard as soon as possible.

47. The Committee considered the *Mais Médicos* project a superb example of South-South cooperation on a grand scale and was pleased with the way the project was progressing. There were some issues still to be resolved, but the Committee had not identified any major risks. It would, however, like to be more assured that the project support costs, which were now a very significant source of revenue to PAHO, were properly managed. A mechanism for tracking those large amounts was needed, in the interests of greater transparency. One potential difficulty ahead would be how Brazil would sustain the improvements made when the foreign medical professionals were withdrawn. Consequently, the Committee had recommended that a strategy and plan should be developed for that purpose. The termination of the project should not have any negative financial or other repercussions for PAHO.

48. The Audit Committee had examined the areas of ethics and investigations and had made a number of suggestions that had been accepted. Two issues remained to be addressed. One was the provision for whistleblower protection. The Committee considered that there was a conflict of interest, since it would be very difficult for an investigator to protect a whistleblower against retaliation if the whistleblower had taken part in an investigation. That was a significant weakness with potentially disastrous consequences for the investigation function, as it would not be possible to induce people to disclose what they knew if they did not believe that they would be protected against retaliation. The Committee also had some concerns about the Integrity and Conflict Management System and had recommended a peer review of the process. The level of resources devoted to ethics was also a concern, particularly since the investigation burden had grown significantly.

49. Lastly, the Audit Committee had performed a self-assessment against international norms and was working on a questionnaire for obtaining feedback from senior staff of the Bureau and Member States. That would be a preparatory step towards reviewing the Committee's Terms of Reference, which were now about six years old. Issues to be examined included number and timing of meetings; more flexibility in meetings timing;

induction arrangements for new Committee members; access for members to the PAHO intranet, the e-manual and other reference documents; and the creation of Audit Committee intranet and Internet websites.

50. The Executive Committee welcomed the information provided and expressed support for the Audit Committee's recommendations, although questions were raised regarding some of them. A delegate inquired whether the Bureau had accepted all of the recommendations or whether some were still under consideration and, if so, why that was. As to the recommendations concerning the Ethics Office, the same delegate wondered whether it would make sense to implement Recommendation 7 before the results of the peer review proposed in Recommendation 6 had been received. She also asked whether the Audit Committee had taken PAHO's size and resources into account before recommending separation of the ethics and investigation functions and suggested that it might be useful to explore models in other international organizations of similar size to PAHO. As it appeared from the report that the Audit Committee had been concerned about the Ethics Office for some time, she wondered why it had not expressed those concerns in the past.

51. Regarding Recommendation 1, clarification was requested on the difference in the advice that the Audit Committee would give on draft financial statements versus the final version. The Bureau's view on the matter was also sought. A delegate wished to know whether the issue of concern in Recommendation 1 was only the point in time at which the financial statements became available or whether there was also some concern about the process of approving them. Another delegate urged speedy compliance with the recommendation on information security, given its financial and operational implications. Her delegation also urged the Audit Committee to continue to monitor the process of joint evaluation of the Strategic Plan with an eye to how that mechanism might be improved.

52. Mr. Treen said that the Audit Committee was satisfied with the Bureau's implementation of the various oversight and audit recommendations. It was not essential that they all be accepted and implemented, as long as an explanation for non-implementation was provided. He considered it urgent to implement Recommendation 7, even before the peer review, as conflicts of interest in the whistleblower protection area were evident. It was simply not possible that effective protection could be provided by the same entity that conducted investigations. He did not consider that the size of an organization would impede its adoption of the United Nations Secretariat model, which in the Committee's view was the best, with good separation of functions and good clarity as to responsibilities.

53. Ideally, the Audit Committee would like to be provided with virtually final draft financial statements, which it could review to ensure that everything was in order. If not, it could advise the Director on any matters that might arise, notably if it had ascertained that the External Auditor was not going to issue an unqualified opinion. It would be less useful to see a very early draft, when the figures might change, but even that would be better than nothing. The Audit Committee was very interested in the joint evaluation process and



would do whatever it could to help make the process as transparent and as successful as possible.

54. The Director thanked the Audit Committee for its work and expressed gratitude to the departing member, Ms. Amalia Lo Faso, for her dedication and helpfulness. She noted that there were still some recommendations on which there was not yet full consensus. For example, more discussion was needed with regard to Recommendation 1 on the provision of the draft financial statements. The Bureau would not be comfortable making available a very preliminary version of the statements in March, when the Audit Committee's first meeting of year currently took place. One possibility might be to move the meeting to April, by which time the financial statements would be final or nearly final.

55. With regard to *Mais Médicos*, the Bureau agreed with the recommendation to develop a strategy and plan for establishing how the project would finish, but the second part of the recommendation—ensuring sustainability of the primary health care improvements achieved—would have to be the responsibility of the Brazilian Government. On Recommendation 3, the Bureau had placed the project support costs from *Mais Médicos*—some \$56 million<sup>3</sup>—into the general budget so that they were being distributed across the Organization in accordance with the prioritization methodology established by Member States. As to Recommendation 7, the Bureau was examining how the ethics and investigation functions were organized in various organizations, particularly those of the size of PAHO. It agreed that possible conflicts of interest must be avoided, and if the present arrangement of the Ethics Office had the potential for such conflict, then the Bureau would arrange the peer review recommended by the Audit Committee to assist in determining the way forward. She noted, however, that no provision had been made in the Organization's budget to cover the cost of conducting such a review.

56. In addition to the eight recommendations, the Audit Committee had made some informal suggestions, some of which gave rise to difficulties. For example, the Committee considered that it required three meetings per year in place of two to carry out its functions, but it would be very difficult for the Bureau to organize a third meeting. Similarly, the Audit Committee wished to make more country visits, which would also be difficult to arrange. Those issues were still under discussion.

57. She observed that there was a certain feeling in PASB of being over-audited, as the Bureau's activities were subject to examination by multiple bodies. She believed that there was a need for greater clarity on the respective functions of the Audit Committee and the External Auditor and on how those two sets of functions should complement one another.

58. The Executive Committee took note of the report.

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<sup>3</sup> Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

***Appointment of One Member to the Audit Committee of PAHO (Document CE158/10)***

59. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee, having been informed that the term of office of one of member of the Audit Committee would expire in June 2016, had established a working group to review a list of candidates proposed by the Director. The working group had evaluated the three candidates on the basis of the criteria for membership set out in section 4 of the Terms of Reference of the Audit Committee and had decided to recommend that Mr. Claus Andreassen be appointed to serve as a member of the PAHO Audit Committee for a term of three years, from June 2016 to June 2019.

60. The Executive Committee noted the report, with various delegates praising the dedication and expertise of the departing Audit Committee member, Ms. Amalia Lo Faso. The Committee adopted Resolution CE158.R5, appointing Mr. Claus Andreassen to the Audit Committee for a three-year term, from June 2016 to June 2019.

**Program Policy Matters*****Preliminary Report of the End-of-biennium Assessment of the Program and Budget 2014–2015/First Interim Report on the PAHO Strategic Plan 2014–2019 (Document CE158/11, Rev. 1)***

61. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had reviewed an outline of the end-of-biennium assessment of the PAHO program and budget for 2014–2015, which would also serve as the first interim report on the current Strategic Plan 2014–2019. The Subcommittee had also been informed that Member States had played a major role in the assessment, the first stage of which had been self-assessment by national health authorities of progress on the various indicators. The Subcommittee had emphasized that the assessment marked an important organizational change in the relationship and level of collaboration between the Bureau and Member States, as well as an opportunity to improve planning, transparency, and accountability and to build capacity at the national level. Delegates had viewed the assessment as a means of identifying areas in which adjustments or course corrections were needed in order to address gaps and overcome challenges to the improvement of public health. The Subcommittee had requested that the final assessment report include information on progress with respect to impact indicators as well as with respect to output and outcome indicators.

62. Mr. Daniel Walter (Director, Department of Planning and Budget, PASB) introduced the report, which comprised more than 200 pages and assessed numerous dimensions of programmatic and financial performance. It contained an analysis of risks, lessons learned, key interventions, and ongoing challenges, and it also presented much of the evidence used to substantiate the results, ratings, conclusions, and recommendations. He noted that the Region was the first of the WHO regions to conduct such a joint assessment. The exercise had enabled Member States to be actively involved in assessing

the achievement of the results they had helped to define. It had also served to enhance transparency and accountability and to deepen the Organization's commitment to results-based management.

63. Key achievements documented in the report included elimination of mother-to-child transmission of HIV and congenital syphilis in Cuba, elimination of onchocerciasis in Ecuador and Mexico, elimination of rubella and congenital rubella syndrome in the Region, reductions in under-5 child mortality and the consequent achievement of Millennium Development Goal 4 in the Region, and substantial gains in access to and coverage of health services. However, gaps and challenges remained in some areas, including noncommunicable diseases and risk factors, maternal health, health sector financing, and maintenance and strengthening of core capacities for emergency and crisis response. The report provided details on the difficulties in those areas, including factors that were impeding progress and what could be done about them.

64. Turning to the achievement of outputs in 2014–2015, he reported that 57 of the 116 indicators had been either achieved or exceeded, another 57 had been partially achieved, and the remaining two had either been cancelled or not assessed. Of the 57 partially achieved outputs, 49 had had targets that were twice the baseline value and had thus been very ambitious, which had been a factor in their not being fully achieved. That was a lesson learned about setting targets that were motivating yet realistic. As to outcomes under the Strategic Plan, 75 of the 83 indicators had either already been achieved or were on track to be achieved by the end of 2019. However, while the overall outlook for achieving all of the 2019 targets was positive, four outcome indicators had shown a decline from their baseline value in 2014–2015. The reasons for that decline were discussed in sections IV and V and in Annex C of the report.

65. Section V provided information on budget implementation in 2014–2015. He noted that it was difficult to establish a direct correlation between technical achievements and budget execution, since it was not just PAHO resources that affected results; investments by Member States and other actors also had to be taken into account. He also noted that the Organization had begun the biennium with a \$171.9 million funding gap, which amounted to 31% of the total program and budget. By the end of the biennium, the budget had been nearly fully funded. Of the \$549.7 million budgeted for implementation over the two-year period, \$523.8 million had been expended. The main reason for the difference between the 97.5% funding rate and the 93% implementation rate was that some funds had arrived late in the biennium and been budgeted, but there had been insufficient time for full implementation. Fortunately, most of those funds had been carried over into the current biennium.

66. Some key lessons learned from the assessment included the following: the failure to fully achieve some outputs could be attributed both to overly ambitious targets and to the specificity of the indicators; it had been difficult to assess some intersectoral indicators that relied on input and data from outside the health sector; the assessment had revealed what might be termed the “graduation effect”—i.e., a reluctance to report a target as achieved for fear that PAHO support and national investments might be withdrawn or reduced as a

consequence; it had been realized that future assessments needed to track progress against the Sustainable Development Goals and to link the Goals to the Strategic Plan indicators; and rather than waiting until the end of the biennium, the Bureau could do more frequent tracking of outputs and outcomes as part of its regular program monitoring and assessment reviews in order to identify challenges early and implement timely adjustments.

67. The Executive Committee welcomed the report and the joint assessment, affirming that it had contributed to greater transparency and accountability and to stronger results-based management; the report provided a clear picture of the progress made towards the various outputs and outcomes and would enable Member States to identify both successful practices and areas in which greater effort was needed. Several delegates noted that the Region's experience, as the first of the WHO regions to conduct such a joint assessment, could be useful to other regions; in addition, the lessons learned from the exercise could translate into best practices for the countries of the Region, serve as guidance for the formulation of health policies, and lead to greater complementarity between the national and regional levels. The Bureau was asked to comment on how the assessment findings would be used in developing future plans.

68. It was noted that the Region had made significant progress in tackling health disparities and addressing social and environmental determinants of health and that it had achieved a number of historic public health milestones during the biennium, all of which was cause for celebration. At the same time, attention was drawn to several persistent challenges that required intensified effort, including the slow decline in maternal mortality. The need for a continued commitment to women's and children's health and rights, and to ensuring their access to health services, was underscored. Violence against women was also considered a priority public health issue requiring ongoing attention. The need to continue working towards universal health coverage and to strengthen health systems in order to maintain the gains made was emphasized, as was the importance of building and maintaining core capacities for emergency response and management under the International Health Regulations (see paragraphs 287 to 296 below).

69. With regard to funding gaps, it was considered that the adoption of an integrated budget could facilitate the mobilization and strategic allocation of resources to the priority areas identified by Member States. The Bureau was encouraged to expand its donor base, and Member States were encouraged to provide more flexible funding.

70. It was pointed out that some aspects of the assessment methodology remained to be refined, notably how to deal with disagreements between the Bureau and Member States with regard to assessment results. In that connection, a delegate [female] observed that, while the Bureau had had the opportunity to validate results reported by Member States, the latter had not participated in validating the results reported by the Bureau under category 6 of the Strategic Plan (Corporate Services and Enabling Functions). She sought clarification of how the Sustainable Development Goals would be incorporated into future assessments, what was meant by "facilitator" in the report, and how the work on the Framework of Engagement with Non-State Actors had negatively affected resource mobilization by PAHO, as indicated in paragraph 149 of the report. She also suggested that

a note should be added to explain what the Age-friendly Cities and Communities initiative was.

71. Several delegates raised questions about the output and outcome targets that had not been achieved, emphasizing the need to set realistic goals that were measurable and achievable. A member of the Strategic Plan Advisory Group (see paragraphs 84 to 93 below) wondered why some of the indicators remained problematic, despite the considerable time and effort that had been invested in developing, validating, and refining them. It was pointed out that a way needed to be found to assess not only performance in specific program areas, but also the overall performance of essential public health functions such as health promotion, which was seen as essential to prevent noncommunicable diseases, a growing cause of mortality and morbidity in all countries of the Region. The need to find a way to facilitate the collection of information on indicators that required intersectoral work, and to strengthen such work, was also highlighted.

72. Mr. Walter, expressing thanks to delegates for their careful reading of the very lengthy report, pointed out that it was still a draft and would be revised before being submitted in final form to the Directing Council. Member States would thus have the opportunity to submit additional comments after they had had the opportunity to scrutinize the draft more closely. The Bureau would ensure that the Committee's requests for clarification, together with any comments received subsequently, were addressed in the final report.

73. He noted that consultations with some Member States were still ongoing and the results for those countries were therefore not final. The Bureau would continue discussions with those Member States with a view to reaching agreement and finalizing the results prior to the Directing Council. As the rating in a single country could change a result from "partially achieved" to "achieved," it was important to ensure that the results reported were validated and final. He acknowledged that Member States had not had much input into the assessment of category 6, but assured the Committee that it had been an in-depth, well-documented process and said that the Bureau would be happy to explain how it had arrived at the ratings for that category.

74. As to how the assessment findings would be used, he noted that the Bureau had done its own internal assessment prior to undertaking the joint assessment with Member States and had developed its work plans for 2016–2017 and beyond to address the shortcomings identified in that internal exercise. It would continue to use the assessment results in its planning henceforth.

75. The assessment offered the opportunity to take another look at some indicators that appeared not to be realistic or that had proved difficult to measure owing to lack of data. One of the challenges in that regard was that PAHO needed to utilize essentially the same indicators as WHO, and some of those indicators showed some inadequacies. The Bureau would continue to work with the Strategic Plan Advisory Group to enhance the indicators and targets.

76. The Director, emphasizing that the achievements highlighted in the report reflected the efforts of the Bureau and Member States working in tandem, expressed gratitude to the officials in the 51 countries and territories who had taken part in the assessment. She agreed that maternal mortality remained a serious concern. The maternal mortality rate was a direct reflection of the quality of care and the status of health services, but it was also linked to poverty and inequity and to cultural factors. In 2014–2015 the Bureau had allocated significant funding for joint interprogrammatic work on the issue, both at Headquarters and in the country offices. That work would continue, and the issue would remain a priority, in the current biennium and beyond.

77. With regard to reporting on the performance of essential public health functions, she pointed out that some of those functions—such as human resources development and training, quality assurance, monitoring and evaluation, surveillance and research, and strengthening of public health regulations—were already being assessed as part of various program areas. However, there were some that might require a more holistic approach. The Bureau would consider how they might be evaluated. It might not be feasible to undertake such an assessment every biennium, but it could be incorporated into the analysis conducted at the end of every quinquennium.

78. The Committee took note of the report.

***Interim Assessment of the Implementation of the PAHO Budget Policy  
(Document CE158/12)***

79. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had been informed that an interim assessment of the implementation of the budget policy adopted in 2012 had indicated that the policy had delivered the intended results without any unforeseen adverse consequences that would warrant any adjustments prior to the in-depth assessment to be conducted at the end of the current biennium. The Subcommittee had also been informed of several matters that might affect the budget policy, including the shift to an integrated budget in the 2014–2015 biennium, the revision of the programmatic prioritization methodology, and the adoption of WHO's new strategic budget space allocation methodology and the resulting increase in the WHO allocation to the Americas.

80. The Subcommittee had welcomed the findings of the interim assessment and expressed support for the principles underpinning the budget policy, particularly the greater fairness and equity in the allocation of resources. It had also expressed support for the policy's continued application, although it had acknowledged that some adjustments might have to be made in order to accommodate the introduction of integrated budgeting and other changes that had occurred since the policy's adoption. The policy's alignment of resource allocation with national objectives and priorities had been applauded, and support had been expressed for the differential allocation of funding to key countries with special needs.

81. Mr. Daniel Walter (Director, Department of Planning and Budget, PASB) explained that the current policy addressed several weaknesses in the prior budget policy, such as resource allocation criteria that had left some Member States without sufficient budget to support a minimum PAHO presence. The interim assessment had shown that the policy had ensured that all countries received adequate core funding and were able to maintain a minimum PAHO presence and that the allocations of the key countries were protected. The Bureau saw no compelling reason to make any changes before the end-of-biennium assessment of the policy.

82. In the discussion that followed, the high level of compliance with the policy was welcomed, as was the finding that a minimum PAHO presence had been maintained in all countries and territories, including those that had recently become associate members of PAHO. Support was expressed for the Bureau's recommendation that no changes should be made to the policy before the end-of-biennium assessment, at which time the effect of the changes approved since 2012 would be evaluated.

83. The Committee took note of the report.

***Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan (Document CE158/13)***

84. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported on the Subcommittee's consideration of an earlier version of the document on the PAHO-adapted Hanlon prioritization methodology developed jointly by the Bureau and the Strategic Plan Advisory Group. The Subcommittee had congratulated the Advisory Group and the Bureau on the work done to refine the prioritization method and expressed appreciation to Mexico and Canada for their leadership of the process. Delegates had voiced support for the modifications made in order to adapt the Hanlon method for PAHO's use, in particular the addition of inequity and positioning factors. While the need for an objective prioritization formula had been recognized, it had also been considered important to ensure sufficient flexibility to enable the Organization to deal with emergencies that might arise.

85. Mr. Rony Maza (Interim Senior Advisor, Planning and Performance Monitoring and Assessment Unit, PASB) reviewed the background that had led to the development of the Programmatic Priority Stratification Framework, noting that a prioritization methodology was especially necessary when there were many demands but insufficient resources to meet them all. A group of 12 Member States appointed by the Executive Committee had worked closely with the Bureau since 2013 to produce the methodology described in Document CE158/13. The composition of the group had varied somewhat over the years, but all subregions had always been represented. Its members had also represented a number of disciplines, including planning, public health, epidemiological surveillance, international relations, and others, which had enriched the methodology. Several countries had played particularly prominent leadership roles, including Brazil, Canada, Ecuador, El Salvador, and Mexico.

86. The group had conducted a thorough review of some 15 prioritization methods and had concluded that, with some modifications, the PAHO-adapted Hanlon method developed and used to guide the allocation of resources under the PAHO Strategic Plan 2014–2019 would be the best method for the Organization’s purposes. Notable improvements to the methodology included clearer definitions of components and fine-tuning of the scoring criteria, with separation of disease- and non-disease-oriented program areas; simplification of the methodology in order to facilitate its use in countries; and the addition of an inequity factor and an institutional positioning factor. The inequity factor took account of avoidable inequalities in the occurrence of disease and in access to health programs, while the positioning factor rated the extent to which PAHO was uniquely positioned to add value in a program area.

87. Document CE158/13 provided further detail on the refinements made in the methodology and on the priority-rating formula. The Bureau was currently developing training materials on the method and would be offering training for country-level personnel. In addition, a manuscript on the PAHO-adapted Hanlon method was being prepared for publication in a peer-reviewed scientific journal, which would enable planners in other WHO regions and in other organizations to benefit from PAHO’s experience. The journal article would also help to promote PAHO and its work.

88. The Executive Committee welcomed the refined methodology, which was considered a useful tool that would make resource allocation more efficient, more oriented towards needs and priorities, and more equitable. Strong support was expressed for the priority-ranking formula, especially the inequity and institutional positioning factors. Delegates praised the work of the Strategic Plan Advisory Group and expressed gratitude to Mexico, Ecuador, and Canada for their leadership. Delegates also commended the Bureau for its support of the process. It was considered that the participatory process of developing, refining, and testing the methodology constituted a best practice that should be replicated in other situations. The process and the commitment shown by all who had participated in it were seen as a testament to the Pan Americanism that distinguished the Organization. Delegates also welcomed the plan to document what had been learned during the process, both as a means of making the methodology available to others and as a means of enabling members of the wider public health community to review and comment on it.

89. The Delegate of Mexico, Chair of the Strategic Plan Advisory Group, noted that at the Group’s last meeting it had been suggested that the Strategic Plan indicator templates should be adapted to show which of the Sustainable Development Goals was being addressed under each indicator. She emphasized that the proposal was not to modify the indicators themselves, but simply to link them to the Goals. She also noted that the priority stratification exercise had both technical and political components. The Advisory Group had addressed mainly the technical side through the development of the priority-rating formula, but there was still a need to make high-level authorities aware of the methodology in order to bring in the political side. Other delegates agreed on the importance of informing ministers of health and other policy-makers about the methodology.



90. With regard to the proposed resolution contained in Document CE158/13, while the potential usefulness of the methodology at the national level was acknowledged, some delegates felt that it needed to be further tested before Member States were encouraged to adopt and use it and before it could be described as a best practice. It was therefore suggested that the words “best practice” in the resolution be replaced with “useful tool” and that Member States be invited to consider, rather than encourage, its use at the national level to inform priority-setting.

91. Mr. Maza noted that the Advisory Group had endeavored to create a methodology that would be useful not only within PAHO but more broadly. He also noted that a technical team within the Bureau was working on linking the Strategic Plan indicators with the Sustainable Development Goals (see paragraphs 309 to 316 below).

92. The Director said that the process of developing the methodology had demonstrated what the Bureau and Member States could accomplish by working together and had shown the Organization at its best. She thanked the members of the Advisory Group and expressed the hope that, over time, the methodology would be embraced as a best practice and would help to influence prioritization not only in the Region but beyond.

93. The proposed resolution was amended to reflect the suggestions made during the discussion and was adopted as Resolution CE158.R7, which recommends that the Directing Council approve the methodology.

#### ***Resilient Health Systems (Document CE158/14)***

94. Dr. James Fitzgerald (Director, Department of Health Systems and Services, PASB), introducing the policy document on this item, noted that periods of sustained economic growth, coupled with policies to alleviate poverty and improve health in the previous 30 years, had resulted in significant improvements in health outcomes and life expectancy in the Region. Countries’ health systems had become more inclusive and responsive, and access to health services had expanded. Nevertheless, health systems remained vulnerable, as had been demonstrated by the recent outbreaks of Zika virus disease and by the threat of Ebola virus disease. There were also ongoing risks affecting the sustainability and responsiveness of health systems, including weak governance, the growing burden of noncommunicable diseases, and inadequate availability of medicines, health technologies, health workers, and health financing. Moreover, with globalization, health systems were becoming increasingly interlinked and interdependent.

95. The policy document defined health system resilience as the ability to absorb disturbances and respond and recover with the timely provision of needed services, as well as the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises, maintain core functions in a crisis, and, informed by lessons learned, reorganize as required. The document also described the characteristics of a resilient health system and provided policy guidance for Member States to support the development of responsive and adaptive health systems in the face of both immediate and future threats. It advocated an approach aimed at progressively building resilience through actions in the

core policy areas of health system strengthening, social determinants of health, risk reduction, public health surveillance, application of the International Health Regulations and disease outbreak management.

96. The Executive Committee welcomed the Bureau's efforts to promote health system strengthening and resilience. Delegates affirmed the importance of resilience, particularly in the context of recent disease outbreaks and also in the light of the commitments established under the Sustainable Development Goals. The Delegates of Brazil and Ecuador commented that their Governments had seen first-hand the importance of health system resilience as their countries had grappled with Zika virus disease outbreaks (Brazil) and the aftermath of an earthquake (Ecuador).

97. The need for multisectoral collaboration to build resilient systems was highlighted, as was the need for long-term investment. It was pointed out that investing in long-term health system strengthening was more cost-effective than financing short-term emergency response. Delegates noted a number of factors and actions that would contribute to greater health system resilience, including implementation and maintenance of the core capacities under the International Health Regulations, continued effort to achieve universal health coverage, strengthening of essential public health functions, and efforts to address social determinants of health.

98. It was pointed out that strong national health systems must be complemented by strong regional and global leadership to ensure coordinated responses to health emergencies, and PASB was encouraged to continue working with the WHO Secretariat on the development of WHO's new Health Emergencies Program. The need to put in place a normative system with clear rules and protocols, including protocols for managing emergencies and channeling resources and donations, was noted. Strong leadership by the health authority and a transparent and a participatory governance system were seen as paramount. It was also considered essential to maintain robust information systems, including civil registration and vital statistics systems. The importance of promoting a culture of resilience and empowering social actors to contribute to increased resilience was also emphasized.

99. Most delegates expressed support for the content of the policy document. However, one delegate questioned the added value of the document and the accompanying proposed resolution, given that the various global and regional initiatives and agreements mentioned therein—including the Strategy for Universal Access to Health and Universal Health Coverage, the Sustainable Development Goals, and the International Health Regulations—provided a solid normative framework for health system strengthening. She suggested that, in order to avoid duplication of effort and make more effective use of available resources, it might be preferable to reorient the document and the resolution towards reinforcing those existing initiatives, for which financing had already been allocated. Another delegate pointed out that, while the focus of the document was intended to be resilience, in a number of paragraphs it reflected an emphasis on a risk approach. In her view, the focus should be on factors that would enhance health system preparedness

and response capacity and enable health systems to withstand pressures or adversities, especially in an emergency situation.

100. Delegates suggested a number of amendments to the proposed resolution contained in Document CE158/14 in line with the comments made during the discussion. Noting that the proposed resolution asked the Directing Council to approve the policy, one delegate expressed the view that the Governing Bodies should not, as a matter of principle, approve policy documents; such endorsement should be reserved for documents that had been subject to discussion and negotiation by Member State before being submitted to the Governing Bodies. He did not believe that the Bureau required a mandate from Member States in order to proceed with its work in the area of health system resilience, which he strongly supported.

101. Dr. Fitzgerald thanked delegates for their suggestions for improving the document, which the Bureau would bear in mind in revising it for the Directing Council. He noted that the discussion about resilience was central to the development of robust, responsive, adaptive, and predictive health systems that were capable of dealing with both short-term, multi-hazard events and more sustained long-term threats. Health system resilience was also central to the Strategy for Universal Access to Health and Universal Health Coverage. He agreed that long-term investment was far more cost-effective than having to mount a short-term response to a disease outbreak or other emergency. Moreover, investment in resilient and robust health systems that had the capacity to absorb shocks, to be adaptive and responsive, and to be able to reorganize when needed could mitigate the impact of future outbreaks and natural disasters in the Region.

102. The proposed resolution contained in Document CE158/14 was amended to reflect the comments made during the discussion and was adopted as Resolution CE158.R12.

***Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies (Document CE158/15)***

103. Dr. James Fitzgerald (Director, Department of Health Systems and Services, PASB) introduced the policy document, noting that equitable and timely access to comprehensive, high-quality health services and to safe, high-quality, cost-effective medicines, including high-cost medicines, was a requisite for universal access to health and universal health coverage. He also noted that expenditures on medicines and other health technologies accounted for the highest percentage of the cost of treatment and care in the countries of the Region, consuming an ever-larger portion of national health budgets and threatening the sustainability of health systems. The rapid diffusion, adoption, and inappropriate use of new products were major drivers of rising health care costs in health systems and of poor health outcomes.

104. The policy document provided an overview of the multidimensional problem of access to high-cost medicines and other health technologies, proposing policy options that would ensure expanded, sustainable access to such products. It also proposed

comprehensive national policies and/or strategies that would provide sustainable and effective solutions that took the needs of health systems into account.

105. Appropriate legal and regulatory frameworks were critical, not only to guarantee the safety, quality, and efficacy of medicines and other health technologies, but to support the introduction of new products in health systems. Once products were offered in health systems, their rational use, including the development and application of treatment protocols and guidelines, combined with the necessary oversight of prescribing practices, was important. Moreover, mechanisms for incorporating and regulating high-cost technologies would serve as a disincentive to demand for costly but ineffective medicines and health technologies. The policy also examined opportunities for innovation to address the challenges of access to high-cost medicines through multicountry and/or regional action, joint price negotiations, and the pooling of procurement through mechanisms such as PAHO's Revolving Fund for Strategic Public Health Supplies (commonly known as the "Strategic Fund").

106. The Executive Committee welcomed the policy document, commending its integrated approach. Delegates noted that medicines were essential public health goods and underscored the importance of taking action to develop mechanisms that would ensure greater access to essential medicines and health technologies to help achieve universal access to health and universal health coverage.

107. While there was consensus on many aspects of the document—including the importance of evidence-based decision-making; rational prescribing; the use of health technology assessments and other measures when considering the cost of medicines; improved transparency and accountability; emphasis on the quality, safety, and efficacy of medicines; and use of generics and therapeutic equivalents—it was suggested that it could benefit from further work to clarify its objective and scope. It was considered that the focus should be on how health systems could sustainably manage access to medicines and health technologies, including costly new pharmaceutical products, biologicals, medical devices, and single-source health products. Rational use of medicines and health technologies was viewed as key in that regard. Delegates also felt that certain concepts in the document needed clarification, among them "strategic medicines," "high-cost medicines and technologies," "good governance of medicines," "explicit lists of medicines," "quality multisource medicines," "prescription support," "comprehensive national policies," and "comprehensive incentives directed to prescribers."

108. A topic of considerable concern to the delegates who spoke was the pharmaceutical industry and its practices. Several delegates pointed to intellectual property rights and patents as barriers to universal access to health and universal health coverage, noting that life-saving medicines for the treatment of HIV, for example, though available, were financially beyond the reach of most patients. One delegate called for countries to develop mechanisms for managing intellectual property rights and to make full use of the flexibilities for public health provided under the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS Agreement). Another delegate, while acknowledging

the importance of the issue, noted the need to protect the system for drug innovation so that there would be access to drugs not only today but also in the future.

109. Several delegates criticized the pharmaceutical industry's emphasis on profits over people, manifested not only in its aggressive stance on intellectual property rights but in price gouging and misleading drug advertising. One delegate suggested that the resolution should request the Director to develop a framework of ethical principles for the marketing of medicines, together with a code of conduct to guide the behavior of pharmaceutical industry agents with respect to marketing. Another delegate suggested that mechanisms should be put in place to ensure transparency in the market and to strengthen capacity with respect to intellectual property, drug registration, and regulation of the pharmaceutical market.

110. There was consensus on the need for collective price negotiations for strategic products. Delegates noted the success of PAHO's Revolving Fund and Strategic Fund in achieving economies of scale. It was pointed out that the countries of the Southern Common Market (MERCOSUR) had also been successful in lowering prices by purchasing in volume. The importance of stimulating local production of medicines was also highlighted.

111. Several delegates noted that the judicial sector was playing a growing role in determining access to medicines in some countries, emphasizing that it was inappropriate for individuals such as judges—who lacked the medical qualifications to prescribe treatment—to decide whether patients should receive medicines they had requested. The need for the health sector to offer guidance to judges on such matters was noted.

112. Representatives of the Latin American Association of Pharmaceutical Industries (ALIFAR, for its acronym in Spanish) and Latin American Federation of the Pharmaceutical Industry (FIFARMA, for its acronym in Spanish) expressed assurances that their focus was the well-being of populations. They pledged to continue working with the Bureau and with Member States to ensure an adequate supply of quality medicines at a reasonable cost through negotiations with the international pharmaceutical industry.

113. Dr. Fitzgerald, referring to the general scope and overall objectives of the document, recalled that in 2004 the Directing Council had adopted a resolution on access to and rational use of medicines.<sup>4</sup> The related document had been very general, and in a side event held in conjunction with the 54th Directing Council in 2015, Member States had indicated that a more specific approach was needed, one that focused on issues currently impacting health systems in the Region, including the high cost of some medicines. The Bureau had drafted the policy document with that in mind, seeking to address the issues of access to medicines, initiatives for promoting rational use, and the elements in place to support action at the national level. It had also examined how pharmaceutical policies related to health policy, science and technology policy, and economic policy.

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<sup>4</sup> Resolution CD45.R7.

The regulatory component of the policy document spoke to the issues of quality, safety, and efficacy raised by numerous delegates, highlighting the role of government, especially ministries of health, in strengthening regulatory capacity in order to improve access to medicines, including high-cost medicines.

114. With regard to access to single-source products, he pointed out that some essential medicines now fell into that category, including drugs for the treatment of hepatitis C and new cancer treatments. The policy document put forward an approach that involved looking at the characteristics of high-cost products and formulating differentiated strategies, depending on the characteristics of the product concerned, within an overall policy approach that sought to improve access to such products within the health system.

115. The Director commented that this was an agenda item that had generated keen interest and justifiably so, as high-cost medicines and health technologies were one of the reasons for catastrophic expenditure and constituted a major barrier to access to health care.

116. In view of the number of comments on Document CE156/15 and the suggested changes to the proposed resolution contained therein, the Committee decided to form a working group to revise the proposed resolution. Subsequently, Dr. Rubén Nieto (Argentina), chair of the working group, reported that, although opposing visions and interests had been involved, intellectual honesty, enthusiasm, and philosophical commitment had enabled the members of the working group to reach consensus on the text of a proposed resolution to be recommended for adoption by the Directing Council. The revised resolution captured in a balanced manner the concerns and expectations that delegations had expressed during the discussion on the conceptual content of the document.

117. The Executive Committee adopted the resolution as amended by the working group (Resolution CE158.R16). It was agreed that intersessional consultations would be held prior to the 55th Directing Council to agree on revisions to the policy document.

### ***Health of Migrants (Document CE158/16, Rev. 1)***

118. Dr. James Fitzgerald (Director, Department of Health Systems and Services, PASB) introduced the policy document on this item, observing that human migration was currently one of the most challenging areas in global health. An estimated 61.4 million migrants were currently living in the Region. Interregional migration in the Americas had increased significantly, as had migration within countries. Global and national health policies and strategies had not kept pace with growing challenges related to the speed and diversity of modern migration and did not sufficiently address health inequities and the determinants of migrant health, including barriers to health service access, employment, and appropriate living conditions.

119. The policy document presented an analysis of the current migrant health situation in the Americas, acknowledged that migrants constituted an important population group in conditions of vulnerability, and, building on recent PAHO resolutions, presented a set of policy options that Member States could consider in order to address the health needs of this group. The document proposed that the Strategy for Universal Access to Health and Universal Health Coverage should constitute the overarching framework for health system actions to protect the health and well-being of migrants. It noted the need to ensure access to health services that were inclusive and responsive to their health in both transit and destination countries. In addition, it suggested that migrants needed the same level of financial protection with respect to health care as others living in the same territory, regardless of their legal status. Finally, it noted the need for intersectoral action to build individual and community resilience and for the adoption of migrant-sensitive social policies and programs.

120. The Executive Committee welcomed the policy document, considering the health of migrants a timely issue. Delegates recognized the efforts of the Bureau and Member States to guarantee the right to health of mobile populations. Such groups were considered especially vulnerable to threats to their health and well-being, including interrupted access to health care, loss of their health records and information, environmental exposures, and stigma. The need to take gender, cultural, and religious issues into account was highlighted.

121. Support was expressed for the policy areas identified in the document, but several delegates sought additional information on how the priorities would be translated into action in collaboration with stakeholders. Several delegates linked the right of migrants to health care to the right to health, observing that countries that denied health care to migrants based on their immigration status were denying not only the right to health, but on some occasions the right to life itself. At the same time, it was pointed out that not all countries recognized a legally protected right to health, and it was requested that the both the document and the proposed resolution contained therein be modified to reflect that fact. It was suggested that the language used in the Strategy for Universal Access to Health and Universal Health Coverage should be used, adding “where nationally recognized” after references to the right to health and also aligning the text with the language of the WHO Constitution by making reference to “the right to the enjoyment of the highest attainable standard of health”.

122. One delegate, noting that the proposed resolution recommended that the Directing Council should adopt the policy document, suggested that the document should be welcomed but not adopted, since it was not really a policy but an approach, and the word “adopt” had legal implications that would make it difficult to introduce changes down the road. Another delegate suggested that the resolution should request the Director to create a repository of information on successful experiences in migrant health in the countries of the Region to facilitate cooperation and the sharing of experiences among Member States.

123. Clarification of the meaning of the phrase “financial protection” in the resolution was requested, and it was suggested that a provision that called on Member States to ensure that migrants had access to the same level of financial protection in health as other people living in the same territory should, instead, urge them to work toward that objective. It was noted in that regard that some countries were not in a position to ensure such protection even to their own populations. Concerns were also expressed about a related provision that indicated that migrants should have access to interventions beyond the health sector that addressed the determinants of health.

124. Several delegates described their country’s efforts to address the situation of mobile populations, noting the existence of legislation guaranteeing equal access to health services for migrants, sensitivity training for health personnel, reciprocal agreements with neighboring countries on health and other services for migrants, health information systems to monitor migrant health, and health education for migrants. They also mentioned the need for partnerships, networks, and South-South cooperation to deal with migrant health needs, particularly in border areas. One delegate described services provided to migrants prior to their arrival in her country in order to protect not only their health but the health of her country’s citizens. Another delegate brought up the issue of health personnel who migrate to improve their quality of life, a circumstance that had serious implications where health services in their countries of origin were understaffed.

125. Delegates from Central America noted that increased migration had created serious problems in their subregion, increasing the countries’ vulnerability, not only in terms of the burden on health systems and health budgets created by high volumes of new patients, but of imported pathologies as well. The potential problems associated with the return of migrants from the United States, the ultimate destination of most migrants from the subregion, were also noted.

126. Dr. Fitzgerald, welcoming recognition of the relevance and importance of the issue, noted delegates’ acknowledgment that migrants were individuals in a condition of vulnerability and therefore required particular attention to their differentiated needs. He also noted the consensus among the delegates who had spoken that the overarching framework on universal access to health and health coverage provided the necessary strategic and policy orientations required for Member States to address those differentiated needs. He acknowledged the challenges mentioned by the delegates with regard to social, health, and financial protection for migrants, pointing out that such protection was a core element of strategic line 3 of the Strategy for Universal Access to Health and Health Coverage. The term “financial protection,” which was also used in the Strategy, meant ensuring that migrants did not incur catastrophic health expenditures for health services.

127. Concerning the specific actions required at the national level to implement the approach put forward in the policy document, the Bureau was suggesting that the health of migrants should be fully embedded in the national policy dialogue on universal access to health and universal health coverage. It should not be viewed as separate issue; the health



needs of the migrant population should be addressed in the legislative and strategic actions taken at the national level with a view to achieving universal health coverage.

128. The Director, noting that the issue was of obvious concern to many countries in the Region, pointed out that, in addition to including matters relating to migrant health in the discussions on universal access to health and universal health coverage, it was also important to ensure sufficient advocacy, particularly in countries experiencing significant migration, to enable them to conceptualize what protecting the human rights of migrants and ensuring their access to health services would mean and to determine the costs and identify how to guarantee that access.

129. The proposed resolution was revised to incorporate the various changes suggested by delegates and was adopted as Resolution CE158.R11.

***Plan of Action for Malaria Elimination 2016-2020 (Document CE158/17, Rev. 1)***

130. Dr. Marcos Espinal (Director, Department of Communicable Diseases and Health Analysis, PASB) introduced the proposed plan of action, affirming that the Region of the Americas had come a long way in fighting malaria. Nevertheless, two countries continued to report increases in the total number of cases, and malaria must therefore remain a priority.

131. The purpose of the proposed plan of action was to continue progress towards the elimination of local malaria transmission in Member States and prevent the potential reestablishment of the disease. The plan was aligned with the Global Technical Strategy for Malaria and included five lines of action: universal access to good quality malaria prevention interventions, integrated vector management, and malaria diagnosis and treatment; reinforced malaria surveillance towards evidence-based decision-making and response; strengthened health systems, strategic planning, monitoring and evaluation, operational research, and country-level capacity-building; strategic advocacy, communications, and partnerships and collaborations; focused efforts and tailored approaches to facilitate malaria elimination and prevent reestablishment in malaria-free areas.

132. The plan was the product of extensive consultations that had begun in April 2014 and had coincided with the development of the Global Technical Strategy for Malaria. A regional consultation had been held in 2015, with 25 Member States and 15 partner institutions participating. The plan had been further refined with input from the PAHO Technical Advisory Group on Malaria in the Americas, which had met in Colombia in May 2016.

133. The Executive Committee welcomed the plan of action, with delegates voicing support for the achievement of elimination goals and expressing appreciation for the Bureau's support of their efforts in that direction. It was noted that the plan of action recognized that stakeholder commitment and community participation were essential to

forestall malaria resurgences and avoid any waning of prevention and control efforts. Greater coordination among partners and stakeholders in the Region was considered necessary in order to achieve and sustain malaria elimination, and it was suggested that the plan would benefit from strategies to improve such coordination and promote information-sharing. Strengthening and maintaining surveillance at all levels of the health system was considered important in order to enable countries to detect malaria-related threats and respond appropriately with minimal delay. The importance of monitoring for early detection of resistance to antimalarial medicines and insecticides was also highlighted, as was the need to address relevant social, economic, climatic, and environmental determinants of malaria. The Delegate of Argentina was pleased to report that his country had had no autochthonous cases of malaria since 2010 and had begun eliminating the autochthonous transmission of malaria.

134. It was pointed out that the goals and indicators set out in the proposed plan of action related almost exclusively to targets to be achieved by countries; although the plan called for a budget of \$30 million for technical cooperation by the Bureau, there was no reference in the plan to the activities that it would undertake to support countries in achieving the goals. It was requested that the Bureau draw up a list of inputs and activities and include them in the document to be submitted to the Directing Council in order to give Member States a sense of how the funds would be spent and to demonstrate PASB's commitment to the achievement of the plan's joint objectives. The Bureau was also encouraged to consider how the PAHO malaria data verification tool might be enhanced to assist with decision-making and track and improve data-sharing across countries.

135. Dr. Espinal welcomed the suggestion about preparing a list of activities for the Bureau to implement over the next five years and indicated that it would be included in the document for the Directing Council. He noted that Argentina had requested verification of malaria elimination and that it would soon be certified malaria-free.

136. The Director affirmed that the Region's malaria efforts had yielded significant success in terms of one of the Millennium Development Goal targets, but expressed concern about the two Member States that continued to report significant numbers of cases. The situation in Haiti was particularly worrying because of the threat it posed to the Dominican Republic. The Bureau would continue to work with the two countries, with the assistance of some partners in the case of Haiti. She noted, however, that there were governance issues that militated against success in reducing malaria transmission and even in managing malaria cases. That situation posed a challenge for which the Bureau would need to develop strategies beyond the plan's lines of action.

137. The Executive Committee adopted Resolution CE158.R4, recommending that the Directing Council approve the plan of action.

***Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021 (Document CE158/18, Rev. 1)***

138. Dr. Marcos Espinal (Director, Department of Communicable Diseases and Health Analysis, PASB), introducing the proposed plan of action, noted that the recent high-level meeting of the United Nations General Assembly on HIV/AIDS, held in June 2016, had recommended that efforts be made to end HIV/AIDS as a public health threat by 2030. The Region of the Americas still had 2 million people living with HIV and although good progress had been made in ensuring that they had access to treatment, some 47% were still not receiving antiretroviral therapy. HIV/AIDS therefore must remain a top priority. Positive developments included Cuba's certification of the elimination of mother-to-child transmission of HIV, with 17 other countries in the Region on track to receive similar certification in the current biennium. The Bureau was working to ensure that all the countries succeeded in eliminating mother-to-child transmission.

139. The plan of action was aligned with the WHO global health sector strategies for HIV/AIDS, viral hepatitis, and sexually transmitted infections (STIs) for 2016–2021, the UNAIDS “fast-track” global strategy for the same period, and the Global Strategy for Women's, Children's, and Adolescents' Health 2016–2030. It reflected the transition from the Millennium Development Goals to the Sustainable Development Goals (SDGs) and would contribute to the achievement of the relevant target under SDG 3 (ending the AIDS epidemic as a public health problem by 2030). The plan also integrated previous objectives of eliminating mother-to-child transmission of HIV and syphilis with the elimination of other transmissible diseases such as perinatal hepatitis B virus, Chagas disease, and tuberculosis. Its four strategic lines of action were aligned with the strategic directions of the WHO global health sector strategies. The expected results included a substantial reduction in new HIV infections and AIDS-related deaths in comparison with the 2014 baseline, along with reductions in the rate of mother-to-child transmission of HIV, the incidence of congenital syphilis, and new cases of cervical cancer.

140. The Executive Committee welcomed the plan of action and commended the Bureau's work in combating HIV and STIs, which were a major cause of death and disability in the Americas and required a comprehensive approach that included civil society participation and an intercultural and gender perspective. Delegates expressed support for the plan and its emphasis on targeting vulnerable populations, citing their countries' commitment to prevention and control and stressing the need to strengthen HIV/STI surveillance. There was general support for the plan's alignment with global initiatives, although the need also to take local conditions into account was noted. One delegate called for more emphasis on providing lifelong antiretroviral therapy to all children, adolescents, and adults, regardless of CD4 cell count, as a means of drastically reducing new infections and thereby paving the way to an AIDS-free generation. Several delegates mentioned the importance of the fast-track strategy to end HIV infection. The importance of addressing social determinants of health and adopting a human rights approach to the issue was also highlighted.

141. Delegates noted the need to improve access to sexual and reproductive health care and information, combat stigma and discrimination, develop common treatment protocols for use across government programs, and expand the delivery of care beyond outpatient facilities to the primary care system. It was suggested that each country should develop its own basic package of interventions and services, which should include measures to address HIV/STI co-infection. There was general concern about regional shortages of long-acting intramuscular penicillin and intravenous penicillin for syphilis control and the prevention of congenital syphilis, with one delegate calling on the Bureau to work with manufacturers to develop a plan to reduce such shortages.

142. Ensuring the sustainable financing of HIV/STI programs was another area of concern, as was the rising price of HIV drugs, which one delegate described as opportunistic and abusive. In this same vein, another delegate called for lowering intellectual property barriers and the cost of generic drugs, emphasizing that public health interests should prevail over commercial interests. Several delegates mentioned that their countries were considering the introduction of pre-exposure prophylaxis for HIV, with one noting its effectiveness when combined with other prevention mechanisms. Another delegate reported that HIV self-testing kits were now available in private pharmacies in his country.

143. Several delegates requested changes in the document and resolution. One delegate noted that advocacy could be a sensitive issue and suggested clarifying the language in the resolution to ensure a common understanding by all Member States. Other delegates suggested that indigenous groups and women in situations of prostitution (as distinguished from self-identified sex workers) should be included in the list of key populations.

144. Dr. Espinal thanked the delegates for their comments and suggestions and said that the suggested changes in the working document would be incorporated before the Directing Council.

145. Dr. Massimo Ghidinelli (Chief, HIV, Hepatitis, Tuberculosis, and Sexually Transmitted Infections Unit, PASB) welcomed delegates' support for the proposed plan of action and resolution. He pointed out that many of their comments had addressed perceived weaknesses in the political declaration adopted by the United Nations high-level meeting, particularly the issues of key populations and new technologies that could potentially yield tremendous benefits in terms of prevention. He noted that there were great expectations with respect to pre-exposure prophylaxis that would expand the strategic use of antiretrovirals not only to treat HIV infection but to prevent it in individuals at high risk of exposure.

146. The cost of antiretroviral drugs was an ongoing problem. In that connection, he had been pleased hear some delegations at the recent United Nations high-level meeting praise the role of the PAHO Strategic Fund in addressing the issue of costs and establishing group negotiations with suppliers of medicines. Penicillin was becoming a neglected antibiotic and a niche product, which was worrying, as it was the only effective medicine for

preventing mother-to-child transmission of syphilis. He noted that the Bureau had conducted a survey on the nature and extent of the shortages in Member States and that WHO was currently conducting a similar study in other regions and among suppliers to obtain a complete picture of the situation.

147. Dr. James Fitzgerald (Director, Department of Health Systems and Services, PASB) added that penicillin was becoming of limited interest to the pharmaceutical industry, a situation that pointed up the need for a strategic public health supply. The Bureau had identified a supplier of benzathine penicillin and had issued a contract for its purchase; it was now searching for a supplier of penicillin G through the Strategic Fund.

148. The Director observed that ending AIDs as a public health threat by 2030 would require significant levels of investment. Member States would have to provide more domestic funding in an environment in which many were no longer receiving funds from the Global Fund to Fight AIDS, Tuberculosis, and Malaria or other sources. Political commitment at the highest level would thus be extremely important, as would ensuring social protection and access to treatment for vulnerable groups and people living with HIV. Efforts were needed to address the stigma and discrimination that prevented those groups from accessing care and treatment and to change attitudes and build awareness and sensitivity, including among health workers. The Bureau was committed to assisting countries in those efforts.

149. The Executive Committee adopted Resolution CE158.R6, recommending that the Directing Council approve the plan of action.

***Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 (Document CE158/19)***

150. Dr. Marcos Espinal (Director, Department of Communicable Diseases and Health Analysis, PASB) introduced the proposed plan of action, which established a series of general objectives and strategies for addressing the cross-cutting issues and underlying causes of the continued occurrence of neglected infectious diseases (NIDs) in the Region. The plan also described the lessons learned and progress made, suggesting strategic lines of action that would lead the Region down the path toward elimination of such diseases.

151. The objectives and priorities of the plan of action included interruption of the transmission of eight NIDs for which cost-effective tools were available: trachoma, Chagas disease, dog-mediated human rabies, leprosy, taeniasis/cysticercosis, lymphatic filariasis, onchocerciasis, and schistosomiasis. The plan also called for the prevention, control, and reduction of the burden of disease from five NIDs for which there were integrated and innovative management tools: cystic echinococcosis; fascioliasis, human plague, leishmaniasis (cutaneous and visceral), and soil-transmitted helminthiasis. Six lines of action were proposed in order to meet these objectives. Dr. Espinal noted that after certification of elimination, at least three years of post-elimination surveillance would be needed to prevent the reintroduction of the diseases.

152. In the ensuing discussion, delegates expressed support for the plan, which built on the successes of the past decade and set ambitious elimination targets aligned with the WHO roadmap on neglected tropical diseases and with the Sustainable Development Goals. There was consensus on the importance of the role of health systems in the effort to eliminate NIDs. It was suggested that a gap assessment of current systems for the detection and monitoring of other NIDs should be conducted, so that approaches could be developed to address the gaps identified. The importance of surveillance as a critical component for preventing and detecting NIDs was stressed.

153. Delegates suggested a number of improvements to the plan of action, one being the inclusion of a reference to the importance of improved housing conditions in preventing and controlling NIDs. It also was suggested that the plan of action should recommend the establishment of protocols for documenting the historical path of countries or groups of countries in the elimination of particular NIDs. It was further suggested that the proposed resolution to be forwarded to the Directing Council should include a recommendation to promote mechanisms in every country to guarantee the professionalization and stability of technical personnel and the political continuity of program strategies, as their absence had been cause for setbacks in NID elimination. The need to link the vector-control strategies in the plan of action with existing vector-control strategies was highlighted, as was the need for intersectoral efforts, given that many of the activities required, especially in the area of water and sanitation, were beyond the purview of ministries of health. Clarification of the term “subnational” was requested, and the Bureau was asked to explain why efforts to eliminate human rabies had been confined to rabies transmitted by dogs. It was suggested that rabies elimination efforts should be expanded to include other animals that were important in rabies transmission, such as bats.

154. It was pointed out that, like the proposed plan of action for malaria elimination (see paragraphs 130 to 137 above), the plan of action on NIDs focused exclusively on objectives and indicators for countries and failed to include a list of inputs and activities that the Bureau would contribute to support countries. The Bureau was requested to include such a list in the document to be submitted to the Directing Council. It was also pointed out that there were inconsistencies in the proposed schedule for evaluations of the plan of action, and it was suggested that a midterm and a final evaluation should be conducted.

155. Dr. Espinal welcomed delegates’ suggestions for improvement of the plan, which the Bureau would incorporate into a revised version of the document for the Directing Council. A breakdown of Bureau and country inputs and activities would also be included. He pointed out that the fact that certain activities were not mentioned explicitly in the plan did not mean that they were not being carried out. For example, the Bureau had a regional team in Lima to provide technical cooperation in relation to water and sanitation to countries that needed it. Regarding rabies, he acknowledged that transmission by animals other than dogs was a problem in some countries and said that PAHO’s regional technical teams and subregional advisers could conduct a rabies situation analysis where necessary, adding that that information could be included in the plan.

156. The Director acknowledged that it was important for the Bureau to indicate clearly what its responsibilities and activities would be and how they would be measured and affirmed that PASB was working hard with Member States to achieve one of PAHO's key objectives, the elimination of inequity, which, together with poverty, was the root cause of the persistence of neglected infectious diseases. Social and environmental determinants of health also played a major role. She believed that the global focus on health in all policies and the Sustainable Development Goals would be very important in finally eliminating neglected infectious diseases, as would a holistic multisectoral approach.

157. The Committee adopted Resolution CE158.R8, recommending that the 55th Directing Council approve the plan of action.

***Strategy for Arboviral Disease Prevention and Control (Document CE158/20, Rev. 1)***

158. Dr. Marcos Espinal (Director, Department of Communicable Diseases and Health Analysis, PASB) introduced the proposed strategy for arboviral disease prevention and control, pointing out that viral infections transmitted by arthropods were on the rise, both in the Americas and elsewhere in the world. Although the current focus was on the dengue, chikungunya, and Zika viruses, there had been cases of another arboviral disease, Oropuche fever, in Peru. The emergence of new arboviral diseases, coupled with endemic viruses such as dengue and yellow fever, posed a real public health challenge. Between 2000 and 2014, there had been 14 million cases of dengue in the Region, and in 2016 alone 54,000 cases of chikungunya had been reported. The Region was now grappling with the Zika virus. The Bureau was therefore proposing to upgrade the current Integrated Management Strategy for Dengue Prevention and Control, in place since 2003, to an arboviral strategy, as it was clear that a comprehensive, holistic approach to arboviral diseases was needed.

159. The proposed strategy put forward four lines of action with a view to guiding Member States in strengthening surveillance, diagnosis, and case management and adopting a clinical and epidemiological approach that emphasized vector control and active social participation. The expected outcomes were a final integrated strategy for arboviral disease prevention and control, clear guidelines for the diagnosis and clinical management of arboviral diseases, strengthened capacity for differential diagnosis in health services, a network at the country level for strengthening integrated vector management and entomological surveillance, and clear guidelines and standardized diagnostic algorithms to strengthen the technical capacity of the Arboviral Diagnosis Laboratory Network of the Americas.

160. The Executive Committee commended the Bureau for its development of the strategy, agreeing that outbreaks of chikungunya and Zika virus disease had made arboviral diseases a high priority for the Region. Delegates expressed support for the proposed lines of action and noted that tailoring them to the particular circumstances of each country would improve the response to outbreaks, challenges, and the consequences

of arboviral diseases. They encouraged the Bureau to continue providing robust technical support to the Member States to strengthen public health systems.

161. There was consensus on the need for sustainable mosquito control measures, timely clinical diagnosis of disease, strong and responsive surveillance systems, enhanced laboratory diagnostic capacity, and well-trained human resources. One delegate mentioned the importance of collecting and/or sharing clinical samples in order to facilitate the development and validation of diagnostics, therapeutics, and vaccine strategies for a better response to public health emergencies. Another called for investment in training for local technical personnel to improve surveillance and integrated management of arboviral diseases. The importance of sharing experiences and best practices was highlighted. In that connection, a delegate noted the need for partnerships between ministries of health and academia to ensure that the decisions of public health administrators would be based on sound scientific evidence produced in the country. He suggested that such evidence should be stored in a repository accessible to all Member States.

162. Several delegates mentioned the need to encourage the public to participate in the elimination of mosquito breeding sites, which would have the added benefit of reducing the use of pesticides as the main vector control strategy. Several delegates also noted the need for greater emphasis on environmental management in combination with coordinated social participation. It was suggested that a section on environmental management should be included in the strategy.

163. Dr. Espinal said that a paragraph on environmental and solid waste management would be added to the strategy submitted to the Directing Council.

164. The Executive Committee adopted Resolution CD158.R3, recommending that the Directing Council adopt the strategy.

***Plan of Action for Disaster Risk Reduction 2016-2021 (Document CE158/21)***

165. Dr. Ciro Ugarte (Director, Department of Emergency Preparedness and Disaster Relief, PASB) introduced the proposed plan of action, which was intended to build on the lessons learned from the implementation of the Plan of Action on Safe Hospitals 2010-2015.<sup>5</sup> He pointed out that the April 2016 earthquake in Ecuador had borne witness to the country's capacity to evaluate and strengthen the capacity of its health services. Ecuador had demonstrated that the ability to mount a disaster response rested mainly with countries. The objective of the plan of action was precisely that: to strengthen country capacity to reduce disaster risks and take action in accordance with the Sendai Framework for Disaster Risk Reduction 2015-2030, with the aim of preventing deaths, disease, and disabilities.

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<sup>5</sup> See Document CD50/10 and Resolution CD50.R15.



166. The plan of action was grounded in a set of concrete, people-centered activities to be implemented by Member States and the Bureau. The plan comprised four lines of action. The first, recognizing disaster risk in the health sector, involved searching for evidence and identifying threats, vulnerabilities, and response capacity. It also included the establishment of people-centered early warning systems and partnership with the scientific community to secure evidence and prepare health sector personnel. The second line of action, governance of disaster risk management in the health sector, was a multi-institutional and multisectoral responsibility in which the role of the health sector was fundamental. It required that disaster risk reduction be formally incorporated in the structure and day-to-day operations of the health sector. It also required active participation by the national health authority in national disaster risk management, security, and emergency management systems.

167. The third line of action was the promotion of safe, smart hospitals, which were hospitals that were able to remain open when vital services, such as electricity and water, were cut off. The fourth line of action was to improve health sector capacity for disaster preparedness, response, and recovery. Countries' ability to mobilize in emergencies to protect affected populations and begin recovery efforts immediately was also addressed in the plan of action.

168. The plan of action had been extensively discussed in several forums, including one in Nicaragua in 2015, in which 29 Member States had participated. Virtual consultations had also been held with Executive Committee members and others. He noted that the proposed plan of action would end in 2021, while the Sendai Framework would continue until 2030. It would therefore be necessary to take stock in 2021 and decide whether a new plan of action should be prepared.

169. In the ensuing discussion, delegates expressed support for the plan and described their countries' advances in disaster risk reduction. They commended the efforts and progress made by Member States and the Bureau to upgrade early warning systems, improve preparedness, and mitigate the impact of disasters. There was consensus on the need to strengthen national and regional capacity, disaster risk reduction plans, and risk management coordination and to adopt a more comprehensive approach to disaster preparedness and response. It was pointed out that many of the consequences of disasters could be prevented, or at least reduced, if the associated risks were managed through an integrated, multisectoral approach. Coordination with other initiatives, such as the Global Health Security Agenda, was also considered important. Strong national and regional health systems were deemed critical to preventing health crises and supporting timely and effective responses to disasters and disease outbreaks. It was pointed out that greater adherence to the International Health Regulations could help to increase preparedness and resiliency. It was also suggested that joint external evaluations under the new WHO IHR Monitoring and Evaluation Framework (see paragraphs 287 to 296 below) could prove useful in assessing national capacities with regard to disaster risk reduction.

170. It was suggested that, given the multi-threat focus of the plan, reference should be made to “health emergencies” rather than to “disasters,” as the concept of health emergencies was more inclusive and comprised disease outbreaks and other events. It was also suggested that the strategic line of action on governance should call more explicitly for ministries of health to create or strengthen an emergency preparedness and response section or office to serve as a focal point for coordination with technical areas in the health sector and other sectors. In addition, it was suggested that the indicators in the plan of action for evaluating progress should be more specific and that the Bureau should develop operational tools for national implementation of the plan.

171. The Delegate of Ecuador described her country’s disaster preparedness efforts prior to the earthquake, which had included evaluating 123 public hospitals using PAHO’s hospital safety index. After the earthquake, the Government had deployed teams of emergency medical personnel as a first line of response, coupled with the use of mobile medical units. It had also employed centralized management of all humanitarian assistance. She suggested that Ecuador’s experience could serve as an example for other countries.

172. Dr. Ugarte reiterated that disaster prevention and control efforts were mainly the responsibility of countries, noting that some 80% of the regional disaster response team were personnel from ministries of health or national institutions. Every country in the Americas had assumed its responsibilities with regard to disaster risk reduction. The Region had been at the forefront in this area, having identified lessons learned from the evaluation of the response to previous disasters and adopted initiatives on safe hospitals, management of international medical teams, and smart hospitals before the rest of WHO. He had taken note of delegates’ comments and suggestions regarding the document and would see that they were incorporated in the document to be submitted to the Directing Council.

173. The Director noted that PAHO’s program in emergency and disaster preparedness was the product of the cumulative experience of some 40 years. She emphasized that it was important to draw from the collective memory of the Bureau and Member States to advance in this area. Solidarity among Member States was one of the many factors that enabled the Region to respond to disasters in such a timely and appropriate manner. It was important to recognize and build on that solidarity.

174. The Executive Committee adopted Resolution CD158.R2, recommending that the Directing Council approve the plan of action.

***Analysis of the Mandates of the Pan American Health Organization  
(Document CE158/22)***

175. Ms. Piedad Huerta (Senior Advisor, Governing Bodies Office, PASB) introduced the item, noting that in 2013 the Executive Committee had requested that the Bureau develop a tool for organizing and systematizing PAHO mandates that would enable the

Member States and other stakeholders to monitor progress on international commitments in public health. The Committee had also requested that the Bureau organize the information on the resolutions and documents approved by the Governing Bodies of PAHO in a manner consistent with the PAHO Strategic Plan so as to facilitate analysis of the complementarity and execution of the Organization's mandates over time.

176. In 2014, the Bureau had presented a report analyzing the fulfillment of PAHO commitments over a 15-year period (1999-2013). The report had also included information on the institutional repository in which the Organization's documentation was archived. On that occasion, Member States had requested that the Bureau conduct a more in-depth analysis of the resolutions and present a report to the Governing Bodies with a proposal for deciding whether resolutions should be classified as active, conditionally active, or ready to be sunsetted.

177. Accordingly, the Director had formed a working group of representatives from every department in the Bureau to develop a methodology for analyzing resolutions, putting the Governing Bodies Office in charge of its preparation, under the supervision of the Deputy Director. The working group had proceeded to develop a methodology for assessing all the resolutions adopted during the 17-year period from 1999 to 2015 and determining how compliance with mandates would be measured, whether mandates had been superseded by a more recent resolution and, if so, what those resolutions were, and whether progress reports had been submitted to the Governing Bodies and when. To facilitate the assessment, the resolutions had been classified under the categories found in the current Strategic Plan. The working group had also defined the criteria for classifying resolutions. Those criteria were set out in Document CE158/22.

178. Ms. Huerta described the results of the assessment using a series of charts showing the breakdown of the resolutions by status and category. Of the 287 resolutions that had been adopted by the PAHO Directing Council and the Pan American Sanitary Conference during the period 1999-2015, 101 could be considered active, another 24 could be considered conditionally active, and 162 could be considered ready for sunsetting.

179. To conduct the assessment, it had been necessary to construct an enormous database, divided into categories, that included all the resolutions, mandate by mandate. Every department and entity in the Bureau had analyzed the resolutions and written notes corresponding to each mandate. Access to the database would be made available to Member States once the resolution validating the proposals of the working group had been adopted by the Directing Council in September.

180. The working group had found some limitations in determining compliance with mandates by Member States and the Bureau. It had made recommendations on the relevance of the topics, the clarity of the mandates, the inclusion of information on their financial implications, and the commitment to accountability through progress reports. It had also recommended that the Bureau should report periodically to the Governing Bodies on compliance with mandates, which would make it possible to maintain a

prospective list of issues to be addressed, in line with the WHO recommendations on governance reform.

181. In the discussion that followed Ms. Huerta's presentation, delegates congratulated the Bureau on its Herculean effort in conducting the assessment and expressed support for its continuation. There was consensus on the value of reviewing regional mandates, with one delegate suggesting that assessments of this type should become a best practice regionally and in WHO as a whole. Other delegates noted that smart use of the data collected could yield a real saving of time, energy, and resources.

182. Ms. Huerta thanked the delegates on behalf of the working group for their expressions of support and affirmed that the assessments would continue. She requested Member States to continue furnishing information on compliance with mandates in order to enrich the database.

183. The Director commented that the initiative had represented an enormous amount of work. She hoped that the database would be of great utility to the Bureau and to Member States and that it would help to rationalize agendas and requests for agenda items, and she pledged to keep it up to date.

184. The Executive Committee adopted Resolution CE158.R9, recommending that the Directing Council endorse the recommendations for time-limited reporting and for sunseting of resolutions that had been superseded in their entirety by subsequent resolutions or whose commitments were considered to have been met.

## **Administrative and Financial Matters**

### ***Report on the Collection of Assessed Contributions (Documents CE158/23 and Add. I)***

185. Mr. Xavier Puente Chaudé (Director, Department of Financial Resources Management, PASB) introduced the report on the collection of assessed contributions and provided information on the status of receipts of contributions as of 20 June 2016. A total of 81.2% of outstanding arrears had been paid, leaving a balance outstanding of \$8.3 million as of 20 June 2016. That amount comprised \$2.2 million attributable to 2014 and \$6.1 million attributable to 2015 assessments. No Member State was currently subject to Article 6.B of the Constitution. However, one country was in arrears by an amount exceeding two years' contributions, and if it had not made a payment by the time of the opening of the 55th Directing Council, it would become subject to the provisions of Article 6.B.

186. As of 20 June, the Organization had received \$24.4million in payments towards the 2016 assessed contributions, representing only 23.9% of total current year assessments. A total of 11 Member States had paid their 2016 assessments in full, and two had already paid their 2017 assessment, for which the Bureau was most grateful. He thanked those Member States that had already met their obligations to the Organization for the year and

appealed to others to make their assessed contributions in order to ensure the efficient and effective implementation of the PASB program and budget.

187. The Director said that Member States' assessed contributions represented a very important source of flexible funding for core programs and for implementation of the plans of action that Member States had approved. The Bureau therefore relied on Member States to pay their assessed contributions in a timely manner. She thanked those Member States that had already paid for 2016, appealing to the remainder to follow suit.

188. The Delegate of Ecuador stressed her Government's readiness to meet its obligations to the Organization, explaining that the need to allocate resources to deal with the consequences of the earthquake of April 2016 had caused a delay in payment.

189. The Executive Committee adopted Resolution CE158.R1, thanking Member States that had made payments for 2016 and prior years and urging other Member States to pay all outstanding contributions as soon as possible.

***Financial Report of the Director and Report of the External Auditor for 2015 (Official Document 351)***

190. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that, after examining a preliminary, unaudited version of the Financial Report, the Subcommittee had requested that an analysis of the risks associated with the downward trend in voluntary contributions be included in the final version of the report, together with an assessment of the funding level for each category of the regular budget, in order to identify potential risks arising from financing flows. The Bureau had also been asked to provide information on the implications for PAHO of the new scale of assessments adopted by the General Assembly of the Organization of American States in June 2015 and to include information on how the recommendations of the External Auditor had been incorporated into the Organization's practices.

191. Mr. Xavier Puente Chaudé (Director, Department of Financial Resources Management, PASB) summarized the information presented in the Financial Report of the Director, focusing in particular on revenue received in 2015. Consolidated total revenue, including voluntary contributions and funds received for procurement on behalf of Member States, had totaled \$1,460 million, which represented a 15% decrease with respect to 2014. The decline was mainly the result of a decrease in national voluntary contributions, which in turn was the result of exchange rate depreciation. Apart from national voluntary contributions, total revenue had remained fairly stable, ranging between \$800 million and \$900 million per year over the previous three bienniums. PAHO's program and budget—which comprised assessed contributions, miscellaneous revenue, WHO's contribution, and voluntary contributions—had totaled \$226 million, \$20 million more than in 2014, when there had been a delay in receiving some of the amount due from WHO. Miscellaneous income had risen in both 2014 and 2015, thanks to an increase in interest income.

192. Collection of assessed contributions in 2015 had amounted to \$99.5 million, including \$64.8 million for 2015 and \$34.7 million for prior years. Thirty Member States had paid their 2015 assessed contributions in full, 4 had made partial payments, and 8 had made no payments. The total collected in 2015 had been \$7 million lower than in 2014. Consequently, total arrears had increased from \$38.1 million to \$44.2 million from December 2014 to December 2015.

193. PAHO voluntary contributions, excluding national voluntary contributions, had totaled \$61 million in 2015, \$2 million less than in 2014, thus continuing the downward trend of the previous four years. However, that trend appeared to be changing, as the number of contributions with open agreements at year-end had increased for the first time since 2009, rising from 163 in 2014 to 187 in 2015. Deferred revenue from open voluntary contributions had also increased. Revenue from national voluntary contributions implemented by PAHO had fallen from \$793 million in 2014 to \$554 million in 2015 owing to exchange rate depreciation; in local currency, however, the amount had remained the same. The *Mais Médicos* project remained the largest source of national voluntary contribution revenue. The Organization continued to rely on a relatively small group of countries for voluntary contributions, which were a major source of funding for its activities.

194. Revenue from procurement activity on behalf of Member States had decreased from \$668 million in 2014 to \$638 million in 2015 owing to a slight decline in the use of the Revolving Fund for Vaccine Procurement. Use of the Revolving Fund for Strategic Public Health Supplies, on the other hand, had increased in 2015.

195. The Organization had ended the 2014-2015 biennium with a budget surplus of \$0.7 million and a revenue surplus of \$7.9 million. The use of those funds would be discussed separately (see paragraphs 208 to 213 below).

#### *Report of the External Auditor for 2016*

196. Ms. Karen Linda Ortiz Finnemore (Court of Audit of Spain), introducing the report of the External Auditor, said that, in its ongoing work as the Organization's External Auditor, the Court of Audit of Spain had continued to learn about PAHO and had endeavored to tailor its recommendations to enable the Organization to meet its objectives with regard to the principles of transparency and sound financial management. A team consisting of nine auditors had made two visits to PAHO Headquarters during 2015 and 2016 and had also visited the PAHO/WHO representative offices in Brazil, the Dominican Republic, and Haiti. Members of the team had also participated in the 11th and 12th Sessions of the PAHO Audit Committee.

197. As the outcome of that work, the External Auditor had prepared the documents comprising the report of the External Auditor contained in *Official Document 349*, as well as reports to management on the three country office visits. The most significant conclusions of the External Auditor's work were found in the Opinion of the External

Auditor and the Long Form Report on the 2015 Financial Statements Audit. The External Auditor had issued a favorable, or “unmodified,” opinion on the Organization’s financial statements for 2015, which meant that the Auditor had concluded that the financial statements were correct and had been prepared in accordance with the applicable rules, including the International Public Sector Accounting Standards and PAHO’s Financial Regulations and Financial Rules.

198. Mr. Alfredo Campos Lacoba (Court of Audit of Spain), highlighting figures from the financial review contained in the Long Form Report, noted that the Organization had ended 2015 with a net deficit of \$8.8 million, whereas in 2014 it had posted a surplus of \$23.7 million. Total revenue had amounted to \$1,460 million, a 15.5% reduction with respect to 2014. Expenditures had also decreased, dropping from \$1,703.4 million in 2014 to \$1,468.8 million in 2015. Those decreases were the result of reductions in voluntary contributions and in disbursements for the *Mais Médicos* project. Staff and other personnel costs had increased by 9.4%. In general terms, PAHO had sufficient resources to meet its financial obligations, its fund balances and reserves having risen by 6.3% with respect to 2014. It also had sufficient resources to cover employee benefit liabilities in the short term; however, in the medium and long terms, funding those liabilities would remain a challenge, and the External Auditor encouraged the Organization to continue implementing measures to meet those obligations.

199. He then summarized the recommendations put forward in the report, which included various measures aimed at enhancing internal controls and strengthening the database of the *Mais Médicos* project, strengthening the PASB Management Information System, and standardizing procedures for the transfer of knowledge from retiring staff and improving recruitment processes. The External Auditor had also recommended improving the scheduling of implementation of the 2016-2017 program and budget to avoid the accumulation of expenses at the end of the biennium. The majority of past recommendations had been implemented, which demonstrated the Bureau’s commitment to improving its systems and procedures.

200. The Executive Committee welcomed the unmodified audit opinion. Delegates noted with concern the 15.5% decline in revenue and the \$8.8 million deficit in 2015, the large number of retirements of senior staff expected in the next three years, and the growing employee benefits liability. It was acknowledged that factors beyond the Bureau’s control had contributed to the negative budget results in 2015, but PASB was nevertheless encouraged to take steps to prioritize and explore ways of managing the deficit to ensure realistic operation of the Organization. It was also asked to provide information on what was being done to provide for transfer of the knowledge of retiring staff, accelerate the recruitment of new staff, and ensure that the wave of retirements and resulting benefit liabilities did not create a financial burden for the Organization.

201. Concern was also expressed about the decline in voluntary contributions and the failure to implement some contributions in 2015, which had resulted in the return of those funds to the donors. The Bureau was again requested to provide an analysis of the risks

associated with the downward trend in voluntary contributions and an assessment of funding by category. The low rate of collection of assessed contributions was also seen as a concern, and Member States were encouraged to meet their financial obligations to the Organization. Clarification was requested regarding the authorized level of the Working Capital Fund.

202. In response to the latter question, Mr. Puente Chaudé replied that the authorized level of the Working Capital Fund was \$25 million. The amount remaining in the Fund at the end of 2015 had been approximately \$20 million. The deficit in 2015 had been due mainly to lower exchange rates and to a revaluation of PAHO's real estate assets in Latin America. Nevertheless, the overall result for the 2014-2015 had been positive.

203. The decline in voluntary contributions was indeed a concern. However, based on the trend of those contributions thus far in 2016, he believed there was reason for optimism. The rise in deferred revenues, in particular, should enable the Organization to sustain the same level of activity and probably achieve a higher level with respect to activities funded by voluntary contributions in the current biennium.

204. Mr. Gerald Anderson (Director of Administration, PASB), responding to the comments concerning employee benefit liabilities, explained that the pensions of retirees were funded by the United Nations Joint Staff Pension Fund, a global fund covering all of the participating United Nations agencies, including WHO and PAHO. Those pensions were completely funded at the time the staff member retired and, consequently, the pensions of the staff expected to retire in the next few years would have no impact on PAHO's financial capability to implement its program and budget. He also noted that the Bureau had increased the number of human resources staff working on recruitment in order to accelerate the process of filling vacancies.

205. The Director explained that a significant portion of the Region's allocation from WHO had not been received until the last half of 2015, which had made it very difficult to plan expenditures. Although plans and priorities were in place, implementation could not proceed if funds were not available. With respect to voluntary contributions, an oversight mechanism had been instituted at the level of executive management with a view to ensuring that funds were expended in a timely manner in order to avoid having to return contributions to donors.

206. She expressed thanks to the External Auditor and assured the Committee that the Bureau took all audit recommendations seriously. It conducted reviews every six months to monitor follow-up on recommendations. Those reviews represented a significant investment of time, but the Bureau viewed them as part of its responsibility to be accountable for the resources entrusted to the Organization. She also noted that additional information on plans for ensuring knowledge transfer from retirees would be given when the Committee discussed personnel matters (see paragraphs 231 to 240 below).

207. The Executive Committee took note of the report.



***Programming of the Budget Surplus (Document CE158/24)***

208. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had considered a proposal by the Bureau for the use of \$0.7 million in unspent regular budget funds from the 2014-2015 program and budget. It had been proposed, pursuant to Financial Regulation 4.6, that the entire surplus be allocated to the Working Capital Fund, and the Subcommittee had endorsed that proposal.

209. The Committee adopted Decision CD158(D3), endorsing the proposal for programming of the budget surplus contained in Document CE158/24.

***Programming of the Revenue Surplus (Document CE158/25)***

210. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had been informed in March of an anticipated revenue surplus of some \$7.8 million for the 2014-2015 biennium. It had also been informed that the Director would prepare a proposal for the use of the surplus, which the Subcommittee would be asked to examine at its 11th Session in March 2017. The Director had explained that it was customary and beneficial to delay a decision on the use of revenue surpluses, in this case until early 2017, because doing so enabled the Bureau to undertake a better analysis of funding gaps and thus make more targeted recommendations to the Subcommittee.

211. In the ensuing discussion, the Bureau was asked to indicate whether any consideration had been given to using some portion of the surplus to fund the after-service health insurance liability (see paragraphs 214 to 217 below) or some of the pending large capital investment projects (see paragraphs 218 to 222 below).

212. Mr. Gerald Anderson (Director of Administration, PASB) explained that, because PAHO had a biennial program budget, it was better to reserve judgment on what might be the best use of the surplus until the second year of the biennium. He also noted that the Bureau had produced a number of documents outlining the liabilities that would have to be funded in coming years, including after-service health insurance. In addition, the Bureau was currently in the process of developing a proposal that it hoped to present in 2017 on addressing the Master Capital Investment Plan liabilities.

213. The Committee took note of the report.

***After-service Health Insurance (Document CE158/26)***

214. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had heard a report on the steps being taken to ensure sufficient funding for after-service health insurance (ASHI) for retired PAHO staff and their family members. It had been informed that the defined benefit

obligation as of 31 December 2015 had totaled \$300.2 million, with a surcharge on payroll providing approximately \$3.2 million per year towards that liability. The net unfunded liability as of December 31, 2015, had been \$212.6 million. To fund that liability the Bureau and the WHO Secretariat had developed a joint strategy, described in Document CE158/26. The Subcommittee had acknowledged the Bureau's efforts to ensure that it would be able to meet its benefits obligation to staff, and had expressed support for the proposal to merge the actuarial services of PAHO and WHO.

215. In the Executive Committee's discussion of the item, support was expressed for consolidating the assets that PAHO and WHO had set aside for the ASHI liability as a means of achieving efficiencies in asset management. Clarification was requested of a comment in the report of the External Auditor (see paragraphs 190 to 207 above), which indicated that AMRO-funded and PAHO-funded posts would no longer exist.

216. Mr. Gerald Anderson (Director of Administration, PASB) said that, in response to the recommendations of the External Auditor on ASHI, he was representing PAHO in the Global Oversight Committee for staff health insurance. That body met twice a year, and during 2016 one of its major topics had been the merger of the related PAHO assets and WHO assets in order to optimize efficiency and return on investment to enable the two organizations to meet their collective obligations as efficiently as possible. At the next meeting, in November, it was planned to approve the formal resolutions that would implement those arrangements and also to address the overall issue of PAHO's long-term representation on that body. Regarding the question on AMRO -and PAHO-funded posts, he explained that, in the past, there had been separate accounting procedures for approximately 30% of the staff whose posts were funded from the resources allocated to the Region of the Americas (AMRO) by WHO. That situation had ultimately resulted in an accumulated deficit in the Termination and Repatriation Entitlements Fund. As part of the adoption of the integrated budget, the procedures had been changed; now no PAHO staff were considered formally to be WHO staff, and the deficit had been cleared.

217. The Committee took note of the report.

***Report on the Master Capital Investment Fund (Document CE158/27)***

218. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had been informed that the Bureau was carrying out a study of the Washington, D.C., real estate market, pursuant to a request from the Executive Committee in 2015. The study was expected to lead to a self-financing plan for funding the \$50 million needed to carry out repairs in the PAHO Headquarters building. The resultant plan would be presented to the Subcommittee in 2017.

219. In the Subcommittee's discussion of the report, clarification of several points had been requested, including the renovation of the four elevators in the Headquarters building. It had been pointed out that some of the amounts quoted under the Vehicle Replacement

Sub-fund did not seem sufficient to cover the procurement of replacement vehicles of adequate quality from a safety standpoint. In response to those comments, it had been explained that refurbishment of the elevators in the Headquarters building had been considered an urgent repair and had been undertaken on the basis of a competitive bid. With regard to vehicles, some of the figures given were net amounts additional to the proceeds from the sale of existing vehicles, so did not represent the total cost of the new vehicles.

220. In the ensuing discussion by the Executive Committee, further information was requested on the scope of the real estate study, in particular with regard to how such a study would contribute to financing the necessary repairs to the Organization's buildings.

221. Mr. Gerald Anderson (Director of Administration, PASB) recalled that the report on the Master Capital Investment Plan submitted to the Governing Bodies in 2015<sup>6</sup> had detailed all of the components of the estimated \$50 million needed to address the long-term maintenance and repair requirements for the Headquarters building. The purpose of the market study was to develop a plan to generate those \$50 million, based on the financial flows associated with PAHO's use of real estate. PAHO-owned property included not only the Headquarters building, but also an area of land nearby on which a private company had erected a building. PAHO paid rent for part of that building as well as for space in the building housing the General Secretariat of the Organization of American States. PASB had hired a real estate consulting company to assist in analyzing the property owned or rented and the scale of the Organization's office space needs and to advise the Organization on a plan that would allow it over a period of time to generate the \$50 million needed to carry out the necessary repairs. The company had provided a number of reports and options that the Bureau was considering, and it was hoped that it would be possible by the end of the year to provide information on the most suitable options.

222. The Executive Committee took note of the report.

***Report of the Office of Internal Oversight and Evaluation Services  
(Document CE158/28)***

223. Mr. David O'Reagan (Auditor General, Office of Internal Oversight and Evaluation Services, PASB) explained that the Office of Internal Oversight and Evaluation Services (IES) was an independent office, providing advice to the Director and the Bureau on risk management and internal controls. Its two main activities were internal auditing and advice on evaluation activities. Introducing the IES report, he explained that its paragraphs 1 through 13 highlighted the Office's independence, which was maintained through its avoidance of managerial and decision-making activities. That section also outlined the cooperation between IES and other oversight bodies, in particular the External Auditor. Paragraphs 14 through 25 summarized the findings of internal audit activities. In its paragraphs 26 through 32, the report went on to cover evaluation advisory services

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<sup>6</sup> See Document CE156/24, Rev. 1.

and the implementation status of internal audit recommendations, while paragraphs 33 through 38 set out the Office's overall opinion on the Organization's internal control environment, based on IES's own work and on the findings of the other oversight bodies.

224. In the ensuing discussion, it was noted that the Office's independent advisory role added value and could improve PAHO operations, and the Director was encouraged to ensure implementation of the IES recommendations, particularly those arising from the audits on internal processing of medical claims and on telephonic expenditure, which could lead to cost savings and reduction of associated risk. The development of the enterprise risk management activities that were beginning to inform the IES internal audit planning process was considered encouraging. IES was commended for undertaking an internal review of compliance with international audit standards and for swiftly addressing all areas for improvement.

225. Mr. O'Reagan said that there was a rigorous procedure for ensuring implementation of the Office's recommendations, in which executive management met once or twice a year to discuss the status of every pending recommendation.

226. The Director thanked Mr. O'Reagan for his painstaking work of helping the Bureau to improve its controls and ensuring that it understood the recommendations. It was beneficial to the Organization that management could interact closely with IES, discussing its recommendations and the implementation of them. Noting his care not to be drawn into decisions, which might undermine his independence, she added that management not only consulted the Auditor-General on IES audits but also asked him to monitor certain important activities of the Organization, such as the implementation of PMIS, and to provide recommendations where he and his staff thought that controls could be better. There, too, IES added value to the work of the Organization.

227. The Executive Committee took note of the report.

***Update on the Appointment of the External Auditor of PAHO for 2018-2019 and 2020-2021 (Document CE158/29)***

228. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had received an update on the process for appointing a new External Auditor to replace the Court of Audit of Spain, whose term of office as External Auditor would end in 2018. It would therefore be necessary for the 29th Pan American Sanitary Conference in September 2017 to appoint a new External Auditor to serve for the next two bienniums, covering the period 2018-2021. In August, the Bureau would send a *note verbale* to Member States, Participating States, and Associate Members seeking nominations for the position. The deadline for submission of nominations would be 31 January 2017. The requirements for candidates were set out in the annex to Document CE158/29.

229. Mr. Xavier Puente Chaudé (Director, Department of Financial Resources Management, PASB) urged Member States to put forward their best candidates for the position. The Director endorsed that call, noting that it was very important for the Organization to have the best possible External Auditor.

230. The Executive Committee took note of the report.

## **Personnel Matters**

### ***PASB Staffing Statistics (Document CE158/30)***

231. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported on the Subcommittee's review of a report highlighting trends in the Bureau's staffing statistics. The Subcommittee had noted that the Bureau continued to maintain almost exact gender parity among professional staff. While appreciative of that, it had also noted that there was not gender equity at all levels, as women occupied the majority of P1 to P3 posts and men occupied the majority of higher-level posts. Also, women were overrepresented in temporary staff appointments. While the importance of selecting candidates based on merit and competence had been acknowledged, the Bureau had been encouraged to develop workforce planning strategies that would contribute to greater gender equality. Concern had also been expressed about the impacts of the forthcoming wave of retirements on the Organization's performance.

232. The Executive Committee also expressed concern about incomplete gender parity and urged the Bureau to promote gender equality policies in the appointment of staff so as to ensure that gender parity was achieved at all professional grades. It was pointed out that lack of gender parity was a phenomenon that went beyond recruitment processes; gender inequality was determined by a series of sociological factors related to structural inequities in countries. It was emphasized, however, that those inequities should not be reflected in the Organization.

233. Concern was expressed about the forthcoming wave of retirements, and the Bureau was asked to provide a detailed report on its budgetary and operational impact on the performance of the Organization. It was suggested that the report should also include information on strategies to be implemented by the Bureau to try to rectify the shortcomings in gender equity. Several delegates noted the number of retirees hired under temporary appointments or consultant contracts. It was acknowledged that retirees could contribute greatly to knowledge transfer and continuity of programs, and the extension of contracts beyond the age of retirement was viewed as acceptable when it was in the best interests of the Organization. At the same time, it was pointed out that new staff provided different perspectives and experiences that were valuable to an organization. It was suggested that, in future discussions of staffing statistics, the Bureau should provide a brief overall summary explaining the reasons for retirees being rehired. The Bureau was also asked to explain why the Financial Report of the Director for 2015 (see paragraphs 190 to

207 above) indicated a 9.4% increase in personnel costs although the number of staff had decreased.

234. Mr. Paul de la Croix (Interim Director, Department of Human Resources Management, PASB) replied that his department examined very carefully every request to rehire a former staff member. There was a well-established process for such rehires, and they each had to be fully justified. Taking note of the request for more information, he undertook that, in the future, whenever his department received a request from an entity to hire a retiree, it would provide additional statistics to the Director so that she would be aware at all times of the number of retirees working for the Organization and could take that information into account as she considered the new request.

235. Consideration of gender parity was a component of the procedure for recruiting staff, which his department monitored carefully. The issue was included in the hiring recommendation that was submitted to the Director. He added that 2015 had been the first time that there was full gender parity at the level of the PAHO/WHO representatives: 13 representatives of each sex. Work would continue to achieve the same level of parity throughout the Organization. Gender equity was an important aspect of the Bureau's human resources strategy.

236. Mr. Gerald Anderson (Director of Administration, PASB) said that the 9.4% in increase in staff costs was a one-time accounting phenomenon resulting from PASB's decision to fund a long-standing deficit in the Termination and Repatriation Entitlements Fund (see "After-service Health Insurance," paragraphs 214 to 217 above). With regard to the budgetary implications of the wave of retirements, as had been explained in the discussion of the Financial Report of the Director (see paragraphs 190 to 207 above), the costs that PASB accrued on retirement of staff were already covered through contributions to the United Nations Joint Pension Fund, the Termination and Repatriation Entitlements Fund, and the Staff Health Insurance Fund for after-service health insurance. There was thus no budgetary impact on the work of the Organization resulting from staff retirement.

237. The rehiring of retirees for short periods to cover staffing gaps would also have no budgetary impact, since there was already an established program budget for the project or program in question, which covered the cost of the personnel needed for implementation. He affirmed that there was a system in place to address the various impacts of the coming retirements and said that the Bureau would provide more information in future reports so that Member States would have a better sense of how PASB was handling those anticipated impacts. With regard to gender parity, he noted that it had been pointed out in conversations on the subject at WHO that the Region's success in that regard was closely linked to the availability of qualified candidates in the market place. The Region of the Americas and also the European Region were relatively better supplied with qualified professionals than were the other WHO regions. It should be noted, however, that if the Organization was trying to recruit in an area where women were in short supply, it often had to compete with the private sector, which might be able to offer more attractive benefits.

238. The Director assured Member States that executive management was very aware of the need for gender parity and of the dominance of males at the highest levels. The Bureau had a process for selecting the best candidates, but quite often, even when it would prefer to hire a woman, there were just too many relatively better qualified male candidates. Member States could help in that regard, by seeking out qualified female candidates from their populations and putting them forward in response to PAHO vacancy notices.

239. Member States could also help reduce the need to retain or rehire retirees. PAHO/WHO representatives made up a large share of the staff whose contracts were extended beyond retirement age. Often, Member States were reluctant to accept the candidate put forward by the Bureau as the new representative and asked to be given a choice of three candidates as in the past, but there was now a new selection procedure, established by WHO Member States. Once admitted to the roster, any qualified candidate from anywhere in the world was entitled to apply for a position. PASB would then select from among all qualified applicants and present the name of the candidate selected to the Ministry of Health. If the Ministry was unhappy with the choice, the resultant process of consultation and explanation could go on for a year. Meanwhile, the representative in place might have reached retirement age, and there would be no choice but to extend his or her contract or bring back a retired staff member who had the requisite experience. Member States could help by accepting the selection process that they had agreed to in Geneva and by encouraging suitable individuals from their populations to apply to join the candidate roster. The Bureau would continue to be vigilant and would always request strict justification of why a staff member's contract should be extended or a retiree rehired.

240. The Committee took note of the report.

***Amendments to the PASB Staff Regulations and Rules (Document CE158/31)***

241. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had considered several proposed amendments to the Staff Rules during its 10th Session. It had been informed that the amendments were intended to maintain consistency in the conditions of employment of staff of the Bureau and the WHO Secretariat, in light of experience and in the interests of good human resources management. The Subcommittee had also been informed that the majority of the amendments were editorial in nature and were intended to increase clarity and consistency. One new rule had been introduced in order to provide an explicit definition of staff members' obligation to protect the financial interests of the Organization.

242. The Subcommittee had endorsed the proposed amendments to the Staff Rules and Regulations and therefore recommended that the Executive Committee adopt the proposed resolution contained in Annex C to Document CE158/31.

243. The Executive Committee adopted Resolution CE158.R10, confirming the proposed amendments to the Staff Rules and establishing the annual salaries of the Director, the Deputy Director, and the Assistant Director for 2016.

***Statement by the Representative of the PAHO/WHO Staff Association (Document CE158/32)***

244. Ms. Carolina Báscones (President, PAHO/WHO Staff Association) said that the staff of the Organization were grateful to the Executive Committee for the attention it paid to matters having to do with their working conditions. She reaffirmed the staff's commitment to the mandates of PASB and expressed her appreciation to the Director for her readiness to discuss matters openly with staff representatives. That openness reflected not only their interest in understanding the situation facing the staff under certain circumstances, but also a sincere desire to resolve problems.

245. Document CE158/32 outlined the matters of priority concern to the Staff Association. One such issue was the rehiring of retired staff. In that connection, she wished to make the Committee aware that retirees were sometimes hired under service contracts, which were not managed by the Department of Human Resources Management and were therefore not reflected in the Department's staffing statistics.

246. Another issue of concern was the start-up of the PMIS, which had represented an enormous extra workload on the staff, with much of the unplanned time being worked on a voluntary basis without compensation. All of the staff deserved special recognition for their efforts to get the PMIS running. The administration of justice remained a concern, as did the conflict resolution system. The Staff Association had made its position on the matter clear a number of times in the past, and it fully supported the Audit Committee's recommendation that the system must be reviewed and changed (see paragraphs 43 to 58). The staff considered that there was an urgent need for a robust and accurate case-handling system to ensure that the results of investigations were made available within a reasonable timeframe, thereby avoiding uncertainty and speculation while an investigation was ongoing on and enabling matters to be brought to a speedy conclusion. The Staff Association was pleased that the Director had indicated her willingness to review the system and would assist and cooperate as always with enthusiasm and commitment, so that management and staff together could bring about a significant improvement.

247. With regard to gender equity (see paragraphs 231 to 240 above), she pointed out that the issue had to do not only with the selection of staff, but also with their subsequent career development, since it generally took far longer for women to attain promotion than it did for men.

248. In the ensuing discussion, a delegate affirmed that the work of the Organization depended heavily on its staff. For PAHO, as for other organizations, human resources constituted one of the most valuable assets. In her view, the staff had much to contribute to the consideration of the gender issue. It was remarkable that worldwide there were more



women than men with a university education, but there were still more men in the key work positions. One major factor was that women often had so many extra roles; on top of their professional roles, they were often heads of household and mothers, for example. Another factor was that women sometimes tended to doubt themselves and question whether they were qualified for a position, whereas men were confident that they could meet the requirements even if they were less qualified.

249. Ms. Báscones said that the staff would continue to assist the Bureau in its efforts to improve gender equality. Specifically, in future reports of the Ethics Office, the Association would like to see data disaggregated by gender, since a case of harassment, for example, or of retaliation submitted by a woman was not the same as one submitted by a man.

250. The Director acknowledged the value of the staff to the Organization. In particular, she appreciated the readiness of the Staff Association to cooperate with her in an open spirit. They should always talk freely together, and if disagreements arose, they should be handled respectfully and without rancor. She fully agreed that the entire staff was deserving of appreciation for their outstanding contributions to the start-up of the PMIS.

251. The Committee took note of the report.

### **Matters for Information**

#### ***PAHO Program and Budget 2016-2017: Mechanisms for Interim Reporting to Member States (Document CE158/INF/1)***

252. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported that the Subcommittee had examined a report that put forward some options for interim reporting to Member States on the implementation of the Organization's program and budget. It had been proposed that the performance monitoring and assessments (PMAs) conducted by the Bureau every six months might serve as the reporting mechanism. An additional mechanism that could supplement the PMA information, and possibly replace it over time, would be a new PAHO web portal that could keep Member States continuously apprised of financial and programmatic performance. The portal was expected to be operational in 2017.

253. The Subcommittee had welcomed the proposal for creation of the portal, considering it an important tool for transparency and accountability and for providing timely and accurate information to Member States. Some concerns had been raised, however, about the timeline for the development of interim reporting mechanisms. It had been pointed out that, since 2017 would be the end of the biennium, data provided at that point could not really be considered interim midterm information. Moreover, if information was not provided until the end of the current biennium, there would be little opportunity to make adjustments before the start of the 2018-2019 biennium, the last biennium covered under the current Strategic Plan. Several delegates had suggested that

the Subcommittee should propose that the Executive Committee establish an advisory group of Member States to work with the Bureau on defining the type of reporting required.

254. Mr. Daniel Walter (Director, Department of Planning and Budget, PASB) explained that the PMAs, which were conducted Organization-wide every six months, assessed programmatic and financial risks, which enabled the Bureau to make any necessary midterm adjustments. In addition, the annual financial report of the Director included information on actual expenditures versus budgeted expenditures, funding sources, and other data that could supplement the PMA results. The information could be made available online or through the PAHO/WHO representatives in the first quarter of the second year of each biennium, starting in 2017. The Bureau believed that those two sources of information, together with the new portal, would satisfy the requirements set out in Resolution CD54.R16 (2015), including the provision of information on financial and programmatic risks and what was being done to mitigate them.

255. In the discussion that followed, the creation of the portal was welcomed and the Bureau's efforts to promote transparency and accountability were applauded. It was emphasized that the portal should be user-friendly and accessible to all Member States. It was again pointed out that it would be difficult to make any needed course corrections if the monitoring report was not available until 2017, and the proposal that an advisory group of Member States should be established was reiterated.

256. Mr. Walter said that the information would be available in the first quarter of 2017, and would thus be a mid-term report on the current biennium. The information that Member States had requested in Resolution CD54.R16 was regularly gathered internally by the Bureau through the PMAs, and in the short term the Bureau proposed to use those assessments to keep Member States apprised during the biennium on the status of implementation of the program and budget, including financial and programmatic risks and any mid-term adjustments to address them. In the longer term, the information in the web portal would provide the information requested in the resolution and would keep Member States informed not just mid-biennium but continuously throughout the biennium of the status of implementation of the program and budget.

257. The Committee took note of the report.

***Process for the Development of the WHO Program Budget 2018-2019  
(Document CE158/INF/2)***

258. Mr. Daniel Walter (Director, Department of Planning and Budget, PASB) said that a first draft of the WHO Program Budget 2018-2019 would be presented to the 55th Directing Council and to all other WHO regional committees for comment and proposed revisions to the version to be submitted to the WHO Executive Board in January 2017 and then to the World Health Assembly for adoption in May of that year. The Program Budget for 2018-2019 would be the third and final program budget under the WHO Twelfth

General Program of Work for the period 2014-2019. It would also serve as the bridge to the work to be undertaken under the 2030 Agenda for Sustainable Development, as it would address the health-related targets under the Sustainable Development Goals.

259. The reform of WHO's work in health emergency management approved by the Sixty-ninth World Health Assembly in May 2016<sup>7</sup> would also be incorporated into the draft program budget. Apart from an additional amount for the implementation of the new Health Emergencies Program, the overall budget amount of \$4 billion was not expected to change much. The programmatic structure of the program budget was also expected to remain essentially the same, although antimicrobial resistance might become a distinct program area. As in the 2016-2017 biennium, a bottom-up approach would be applied in developing the program budget, starting from country priorities.

260. The Region's share of the WHO program budget would increase in 2018-2019 as a result of the adoption of the new strategic budget space allocation formula. Work on the development of the PAHO program and budget would commence in early August 2016. The first step in that process would be country-level consultations and priority-setting. The timing of PAHO's budget development would thus align more closely with that of WHO. A first draft of the program and budget for 2018-2019 would be ready for discussion by the Subcommittee on Program, Budget, and Administration in March 2017.

261. Executive Committee members welcomed the closer coordination and alignment between PAHO and WHO in the program budget development process and expressed support for the principles and concepts underlying the process. Members were also pleased that the 2018-2019 program budget would take account of the Sustainable Development Goals and welcomed the planned country-level priority-setting; it was hoped that the priority-setting process would be carried out using a standardized methodology. Further information was sought on the anticipated increase in the Region's share of the WHO budget and on what advocacy might be needed from Member States in that regard.

262. Mr. Walter confirmed that PAHO would apply a standardized methodology for priority-setting, namely the refined PAHO-adapted Hanlon methodology (see paragraphs 84 to 93 above). With regard to the Region's allocation from the WHO budget, he noted that it was its share of "budget space" that had increased, which meant that it was entitled to a larger portion of the budget. In the past, however, the Region had not received its full allocation. Member States could help by advocating to ensure that the Americas' share of the WHO budget was fully funded.

263. The Committee took note of the report.

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<sup>7</sup> Decision WHA69(9).

***Update on WHO Reform (Document CE158/INF/3)***

264. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reported on the Subcommittee's consideration of an earlier report on WHO reform, noting that the Subcommittee had encouraged the Bureau to continue implementing applicable areas of WHO reform. WHO's commitment to join the International Aid Transparency Initiative had been applauded and PAHO had been urged also to join the Initiative, either as part of WHO or separately. Governance reform at all three levels of WHO had been seen as paramount to ensuring the effectiveness of the Organization as a whole. While it had been recognized that there was a need to ensure that reform processes were consistent with PAHO's legal status, closer integration of PAHO and WHO on governance matters had been considered important in order to ensure a "One WHO" approach.

265. The Subcommittee had expressed the hope that consensus could be reached on the proposed Framework of Engagement with Non-State Actors (FENSA) before the Sixty-ninth World Health Assembly. It had been emphasized that the framework must ensure accountability, transparency, and effective management of potential conflicts of interest. With respect to emergency and outbreak response, support had been expressed for the proposal put forward in March 2016 by the Director-General's Global Policy Group regarding the establishment of a single program, with one workforce, one budget, one set of rules and processes, and one clear line of authority for WHO Headquarters, regional offices, and countries.

266. Mr. Daniel Walter (Director, Department of Planning and Budget, PASB) provided an update on progress with regard to WHO reform, noting that much had been accomplished since the March 2016 session of the Subcommittee. Overall 84% of reform outputs were in the implementation phase, and the rate of completion was 60%. While governance reform continued to lag behind, significant breakthroughs had been made during the Sixty-ninth World Health Assembly. Reform in the area of emergency and outbreak response, prompted by the Ebola virus disease outbreak, had also been approved during the Health Assembly. A key programmatic reform implemented in both WHO and PAHO was the introduction of bottom-up planning and priority-setting. The WHO web portal was another successful product of WHO reform. The portal, which could be accessed by Member States, provided detailed and relatively current information on financial flows by source. PAHO intended to launch its own portal, modeled on the WHO portal, in 2017. New human resources strategies and risk registers were also examples of products of reform in place at both PAHO and WHO.

267. After lengthy negotiations, the Sixty-ninth World Health Assembly had approved reforms to put in place the Framework of Engagement with Non-State Actors, an important policy to which many Member States of the Region had made significant contributions, including Argentina, which had chaired the intergovernmental working group that had completed the framework. It consisted of several overarching principles and four specific policies on engagement with NGOs, private-sector entities, philanthropic foundations, and

academic institutions. The framework had been recognized by WHO Member States as the first comprehensive policy of its kind among the organizations of the United Nations family.

268. The Member States of the Americas had committed to implementing FENSA in the Region. Accordingly, pursuant to Article 14 of the PAHO Constitution and Rule 7 of the Rules of Procedure of the Directing Council, the Director had included an item on FENSA in the provisional agenda of the 55th Directing Council. The Bureau would prepare a working document and proposed resolution to be posted on the PAHO website at least six weeks before the opening of the Directing Council. The document would reflect PAHO's structure and terminology, but would not modify the substance of the framework as adopted by the Health Assembly.

269. The Executive Committee welcomed the progress on WHO reform, expressing particular satisfaction at the adoption of FENSA. Delegates expressed gratitude to Argentina for its leadership of the intergovernmental working group and to the Bureau for its support during the consultation process. It was noted that the Member States of the Americas had committed to the full implementation of FENSA in the Region, but it was also recognized that, owing to PAHO's legal status as a separate organization, the Framework must be adopted by its Directing Council. To facilitate that process, it was suggested that consultations should be organized prior to the opening of the Council to enable Member States to examine and discuss the working document and proposed resolution to be prepared by the Bureau. More information was requested about how the Framework would be adapted for implementation by PAHO and about the costs associated with its implementation. The Bureau was asked to make the document available at least six weeks in advance or, preferably, earlier.

270. Additional information was also sought on how PAHO's web portal would be linked to the WHO portal and on the Region's participation in the risk register, the staff mobility policy, the International Aid Transparency Initiative, and the new WHO Health Emergencies Program. In relation to the latter, it was pointed out that PAHO had a long history of dealing successfully with health emergencies and had much to share in order to strengthen WHO as a whole. Delegates emphasized that WHO reform should be led by Member States and should be guided by the principles of transparency, accountability, equity, and efficiency. The importance of strengthening WHO's multilateralism and its coordination with other agencies of the United Nations system was also underscored. Strong support was expressed for the concept of "One WHO" and its application in the context of reform was urged. At the same time, the need to preserve PAHO's status as an independent organization was stressed. In that connection, it was considered especially important to analyze the repercussions that participation in the WHO staff mobility policy might have with respect to the maintenance of PAHO's technical quality.

271. It was requested that the document to be prepared for the Directing Council on WHO reform provide a fuller account of the outcomes of the Sixty-ninth World Health Assembly. It was also requested that the document explain how PAHO's emergency response activities would be aligned with the WHO Health Emergencies Program.

272. Mr. Walter assured the Committee that the working documents on FENSA and other aspects of WHO reform would be made available at least six weeks before the opening of the 55th Directing Council. Regarding the linkage between the WHO and PAHO web portals, he explained that PAHO hoped to use the same software as WHO so that the two systems would be identical in terms of content, although the sources of information would differ. PAHO's information would come from the PASB Management Information System (PMIS) (see paragraphs 278 to 286 below), whereas WHO's information came from the Global Management System. In addition, PAHO's system would provide more information on results than was currently available from the WHO portal.

273. Both PAHO and WHO had risks registers. They were not identical, but they were aligned. As to the International Aid Transparency Initiative, PAHO was letting WHO take the lead in analyzing the many requirements for participation and would participate in the Initiative through WHO, at least in the near term.

274. Mr. Gerald Anderson (Director of Administration, PASB), responding to questions about the WHO staff mobility policy, said that PAHO was participating in the Global Mobility Committee as an observer and was thus fully familiar with the mechanisms being used. During the initial voluntary phase of the staff mobility scheme, which was expected to continue through 2018, the Bureau would continue its existing practice of making ad hoc mobility decisions in coordination with the WHO Secretariat. He noted that the Bureau had carried out nine transfers in 2015, including six between PAHO and WHO.

275. The Director pointed out that the risk register, which provided for registration of non-State actors, was in a pilot phase at WHO. The Bureau would continue to work with the WHO Secretariat to implement the register. With regard to the reforms in the area of emergency and outbreak response, the Bureau was currently in discussions with the WHO Secretariat on the details of PAHO's participation in the global program. She emphasized that PAHO collaborated fully with WHO in emergency response, sending personnel where requested by the Director-General and making available other resources to assist in global efforts. However, there were some aspects of the WHO program that would be difficult to implement in the Region, owing to PAHO's status as an organization in its own right. Moreover, she could not in good conscience dismantle an emergency management structure that had been functioning effectively for over 40 years and adopt a brand new structure that had not yet proved itself. To do so would be a disservice to PAHO Member States. PAHO would align itself functionally with WHO and would adhere to common guidelines and processes, but for the time being she did not intend to introduce any structural changes in its emergency response program.

276. With regard to FENSA, she noted that the Bureau had only recently received the document from WHO and so was just beginning work on the document for the Directing Council, which would set out the terminological and other changes that would be needed to render the framework suitable for adoption by PAHO. The Bureau would ensure that the document was made available to Member States as early as possible and would also organize the requested prior consultation.

277. The Committee took note of the report.

***Status of the PASB Management Information System (PMIS) (Document CE158/INF/4)***

278. Dr. Rhonda Sealey-Thomas (Representative of the Subcommittee on Program, Budget, and Administration) reviewed the information provided to the Subcommittee on the progress of the PMIS as of March 2016.

279. Mr. Valentin Prat (Director, Department of Information Technology Services, PASB) gave an overview of the implementation of the PMIS project, noting that it comprised three phases: phase 1, which had gone live in February 2015, had included human resources and payroll; phase 2 had gone live as scheduled in January 2016 and included finance, procurement, and budget, although some non-critical components of that phase remained to be implemented during 2016. Phase 3—the post-go-live phase—had begun in January 2016. That phase would include the enhancements and reports that had been left for 2016, stabilization of the system, and implementation of an e-recruitment module. In addition, during 2016 the Information Technology Services Department would be taking responsibility for support and maintenance. That transition would mark the completion of project implementation.

280. Shortly after the system had gone live, the PMIS Advisory Committee had been created. The Committee met every month and comprised members from departments throughout the Organization. Among other functions, the Committee reviewed progress made on previously approved priorities and made decisions on streamlining recommendations put forward by the PMIS team or by those responsible for the various business processes.

281. As to the budget, out of the initial \$22.5 million, \$17.4 million had been spent by the end of the 2014-2015 biennium. That left \$5.1 million, earmarked for pending components not deemed critical to the go-live process. There was also an additional \$500,000, approved by the Directing Council for implementation of the e-recruitment module. It was not expected that the total approved budget would be exceeded.

282. In the ensuing discussion, the Bureau was congratulated for the successful implementation of phase 2 and for keeping the project within the original approved budget. It was pointed out that the External Auditor had raised a number of issues relating to the PMIS (see paragraphs 278 to 286 above), including that there were system functionalities and enhancements still to be implemented, but there was no detailed strategy, operational plan, or reliable cost calculations for those items. The Bureau was asked to provide an update on progress since the External Auditor's visit with regard to ongoing planning and prioritization for future enhancements, as well as whether the Bureau expected that the costs could be absorbed within the existing information technology maintenance budget.

283. Mr. Prat confirmed that some needed enhancements and adjustments in the system had not yet been started, including some of those that had been identified earlier as being non-critical. It would fall to the PMIS Advisory Committee to prioritize them. He pointed out that a system like the PMIS was dynamic and would need ongoing adjustments.

284. Mr. Gerald Anderson (Director of Administration, PASB) added that when the Bureau had prepared its information technology strategy, which had been presented to the Governing Bodies in 2015,<sup>8</sup> it had decided to allocate a sufficient quantity of resources to the Information Technology Services budget for the future, so as to be able to sustain the system and also to have a predictable flow of funds for other needs. The ongoing adjustments that would be needed would be covered under the strategy, and the calculated amount in the budget should be sufficient to cover the related expenditures.

285. The Director noted that the implementation of the PMIS had represented a tremendous challenge for the staff of the Bureau, who had invested significant amounts of their own time in ensuring that the system could go live. She wished to express her gratitude to the staff for their efforts. There was still a certain level of frustration among some staff members because PMIS was not just a system, it was a change in the manner in which the Bureau did business, a change that would require adjustments in procedures but also in attitudes. The system was operational, the staff were continuing to learn, and the immediate enhancements to be completed were known. Minor difficulties were normal in the introduction of an enterprise resource planning (ERP) system, many of which failed. The system and the Bureau's use of it were heading in the right direction, but there was still some distance to be traveled.

286. The Executive Committee took note of the report.

***Implementation of the International Health Regulations (IHR) (Documents CE158/INF/5 and Add. I)***

287. Dr. Marcos Espinal (Director, Department of Communicable Diseases and Health Analysis, PASB) introduced the reports on this item, noting that Document CE158/INF/5 provided information on States Parties' compliance with administrative requirements under the International Health Regulations (IHRs) and on their progress in meeting the IHR core capacity requirements. It also provided information on recent public health events of international concern, including the Zika virus disease outbreaks in the Americas and elsewhere. He noted that, for the first time since State Party reporting to the World Health Assembly on implementation the Regulations had been introduced in 2011, all 35 States Parties in the Americas had submitted their annual reports.

288. Document CE158/INF/5, Add. I, provided an update on two issues that were critical for the future application of the Regulations, the first one being the status of the

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<sup>8</sup> See Document CE156/26.



new IHR Monitoring and Evaluation Framework<sup>9</sup>, which had not been formally adopted by the Sixty-ninth World Health Assembly in May 2016. The second issue was the 12 recommendations contained in the report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response,<sup>10</sup> which had been discussed during the Sixty-ninth World Health Assembly and had proved to be rather controversial. As a result, the Health Assembly had decided to refer the recommendations to the WHO regional committees for further discussion.<sup>11</sup>

289. Accordingly, the Bureau proposed to hold a face-to-face regional consultation in late July or early August 2016 to consider the relevance for the Americas of each of the 12 recommendations and to define the areas of work of a prospective regional plan on the IHRs and the content of a proposed resolution to be submitted to the 55th Directing Council. The Bureau considered that a solid mandate from the Directing Council would help to establish IHR-related priorities in the Region and facilitate the positioning of Member States of the Americas on the matter in preparation for the January 2017 session of the WHO Executive Board. It would also enable the Bureau to support Member States more effectively. The Committee was therefore invited to consider placing an item on implementation of the IHRs on the Council's agenda as a program policy matter. In view of the timing of the regional consultation, the Committee was also asked to consider allowing the Bureau to publish the working document and proposed resolution on the item at least three weeks, rather than six weeks, prior to the opening of the Directing Council.

290. The Executive Committee welcomed the progress made by Member States in implementing the Regulations and supported the proposal to hold face-to-face consultations on the recommendations of the IHR Review Committee and to place the item on the agenda of the Directing Council as a program policy matter. The Regulations were seen not only as a tool for reducing the international spread of disease, but also as a basis for strengthening health systems and improving surveillance systems, laboratory capacity, and risk communication. It was pointed out that strengthening the IHR core capacities would help to ensure better integration of health systems and enhance their ability to address both day-to-day and emergency needs.

291. Support was expressed for the new IHR monitoring and evaluation framework, although the need to recognize the right of States Parties to construct and validate the procedures, methods, and tools for its application was underlined. The Bureau was asked to develop a system for testing IHR core capacities through simulation exercises. It was felt that such exercises could serve not only to evaluate countries' performance but also to help them to be better prepared to deal with future public health events and emergencies. The Delegate of the United States reported that his country had recently undergone a joint external evaluation, the results of which would be made public in June 2016, and encouraged other Member States to consider also undergoing such an evaluation.

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<sup>9</sup> See WHO Document [A69/20](#)

<sup>10</sup> See WHO Document [A69/21](#)

<sup>11</sup> See Decision [WHA69\(14\)](#)

292. Delegates sought clarification on several points, including what support the Bureau would provide in the event that another extension of the deadline for establishing the core capacities was not approved and whether any further progress had been made with respect to the procedures for voluntary certification of designated airports and ports. An update was requested on the work of the scientific and technical advisory group responsible for mapping the risk of yellow fever and providing guidance on vaccination for travelers.

293. Dr. Espinal assured the Committee that the Bureau would continue to support States Parties in implementing the Regulations, irrespective of whether another extension of the deadline for the core capacities was approved. He noted that the important thing was that governments remained committed to putting the capacities in place for the good of their populations. As to the procedures for voluntary certification of airports and ports, he said that there had been no further developments.

294. Dr. Roberta Andraghetti (Advisor, International Health Regulations, IHR, Epidemic Alert and Response, and Water Borne Diseases Unit, PASB) said that the advisory group on yellow fever risk mapping had held two meetings since its establishment in December 2015 and had agreed on its working methods. The group was currently consulting with authorities in countries with areas at risk for transmission of yellow fever. It was due to hold its next meeting on 28 June 2016.

295. The Director, alluding to the ongoing yellow fever outbreak in Africa, highlighted the need for Member States in the Americas to be on the alert for imported cases of the disease.

296. The Committee noted the report and endorsed the proposal to hold a face-to-face regional consultation on the recommendations of the IHR Review Committee and to place an item on implementation of the IHRs on the agenda of the 55th Directing Council as a program policy matter.

***Update on the Zika Virus in the Region of the Americas (Document CE158/INF/6)***

297. Dr. Silvain Aldighieri (Chief, International Health Regulations, Epidemic Alert and Response, and Water-borne Diseases Unit, PASB) introduced the item, noting that 39 countries and territories in the Region had autochthonous circulation of the Zika virus. Five countries in the Region had reported sexually transmitted cases. Wide variations in the incidence of Zika cases across the Region had made the situation hard to assess, despite intensive efforts over the past six months. The problem was compounded by the co-circulation of the Zika virus with other arboviruses, such as the dengue and chikungunya viruses, which were largely transmitted by the same mosquito, *Aedes aegypti*. Epidemiological studies in Brazil, Colombia, and Puerto Rico had confirmed co-circulation of the three viruses, complicating the diagnosis of Zika.

298. Prior to 2015, cases of microcephaly had been rare. Now there were thousands of confirmed cases believed to be associated with the Zika virus in Brazil, and other countries

of the Region had also reported cases. The Zika virus was also associated with increased incidence of Guillain-Barré syndrome.

299. It had been six months since WHO had declared the Zika epidemic a public health emergency of international concern. The IHR Emergency Committee on Zika Virus had met twice since the declaration, had advised that there was increasing evidence of a causal relationship between the Zika virus and microcephaly, and had confirmed and updated its recommendations on preventing the infection among international travelers. The most recent meeting, in June 2016, had concluded that the forthcoming Olympic Games in Rio de Janeiro in August posed a very low risk of the additional spread of Zika.

300. PAHO's regional strategy for combating the Zika virus had three pillars—detection, prevention, and health services response—along with a cross-cutting line of action consisting of research in all three areas. In December 2015, the Director had activated the Organization's Incident Command System, which had been working at full capacity since 1 February 2016. Some 30 people at Headquarters and in the Representative Offices of the most affected countries had been working full-time on the emergency response. PAHO's system was coordinated with the systems of the five other WHO regions and the global system, which had its own incident command system.

301. In December 2015, the Director had also activated the epidemic response fund to ensure an early response at year's end, and emergency response funds had been received from WHO and some donors since February. There were also commitments from PAHO Member and Observer States. An estimated \$17 million in funding was required for a regional response. Funds had been distributed among surveillance, risk communication, health service response, research, and coordination of the Incident Command System.

302. The response to the Zika emergency was modeled on the response to chikungunya and the preparations for the potential importation of Ebola cases, which had involved the mobilization and deployment of multidisciplinary teams in priority countries and countries with high transmission of the Zika virus. PAHO had mobilized regional and international experts in 25 Central American and Caribbean countries, which had been prioritized because of their situation or history of chikungunya or dengue outbreaks. Laboratory teams were also being mobilized to assist in meeting challenges in the implementation of new technologies.

303. The Executive Committee welcomed the report and commended the Bureau for its swift action to respond to the public health emergency. Delegates called on PASB to continue assisting Member States to prevent, detect, and respond to infectious disease threats, noting the need to collaborate in surveillance and control and in the development of better diagnostic tools. It was felt that the top priority should be reducing the risk to pregnant women and to other women of childbearing age, which would require a whole-of-government response.

304. It was pointed out that in 1996 the Directing Council had adopted a resolution<sup>12</sup> calling on Member States to begin a Hemisphere-wide effort to eradicate *Aedes aegypti*, but there appeared to have been insufficient political will to implement the resolution. That lack of will had led to the current situation, which had dire implications for regional health and health systems. It was considered that the simplest and most sustainable solution to the problem would be to eliminate breeding sites, which meant improving solid waste management.

305. The Delegate of Brazil said that her Government had been working transparently to establish a continuing dialogue with other governments and with international organizations, including PAHO and WHO. The policies implemented in Brazil had focused on mosquito control, care for families, and the formulation and improvement of surveillance protocols. Research efforts had also been intensified and the development of a vaccine promoted, and a vaccine was expected to be ready for testing during 2016. The number of reported cases of arbovirus infection had been declining, with a 90% reduction in Zika cases since their peak in early 2016. With regard to the upcoming Olympic and Paralympic Games, she stressed that the risk of Zika virus transmission was exceedingly low during the winter months when the games would be held, a fact confirmed by recent international scientific research and the recent meeting of the Emergency Committee on Zika Virus.

306. Dr. Aldighieri thanked Member States for their support and Brazil for its participation in the recent Emergency Committee of June 2016 and for the information provided about the Zika situation in Rio de Janeiro and other Olympic venues. He acknowledged the relationship between this agenda item and the item on arboviral disease (see paragraphs 158 to 164 above), noting that the issue of the resolution adopted in 1996 would be addressed under that item.

307. The Director said that the Zika situation had been a learning experience for everyone involved. Political commitment and leadership at the very highest level of government had been important in moving the response forward. She commended the whole-of-government approach seen in many countries and emphasized the importance of strong surveillance systems, which in the case of Brazil had been responsible for alerting the Region to the presence of the Zika virus and to its consequences. She noted with satisfaction that countries were reporting Zika cases in a timely manner, making it possible to characterize the epidemic. She thanked all partners and Member States for their assistance to the Bureau, for working side-by-side to build capacity in countries, and for mounting missions to the affected countries. The challenge for the Region now would be to maintain the same level of commitment in the medium and long terms because *Aedes aegypti* had proved to be highly intractable. The Bureau would continue to work closely with the affected Member States on the research agenda and on surveillance. The Incident Command System would continue to operate at full capacity until the end of

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<sup>12</sup> Resolution CD39.R11 (1996).

September 2016, with operations likely to continue in a reduced mode until at least the end of December, pending a review of the situation.

308. The Committee took note of the report.

***Implementation of the Sustainable Development Goals in the Region of the Americas (Document CE158/INF/7)***

309. Dr. Kira Fortune (Interim Chief, Special Program on Sustainable Development and Health Equity, PASB) introduced the report on implementation of the Sustainable Development Goals (SDGs) in the Region, noting that the Goals were well aligned with PAHO's Strategic Plan 2014-2019. Although health was the specific focus of only one of the SDGs, it was integral to the achievement of all of them. Several of the health targets in the SDGs followed on from the unfinished agenda of the Millennium Development Goals (MDGs) and from various World Health Assembly resolutions and related action plans.

310. The report highlighted the progress made in preparing the Region for the implementation of the Sustainable Development Agenda and formulating the regional approach to the Goals, a process that had included an analysis of how the Goals related to the targets and indicators of the Strategic Plan. Member States had called on the Bureau to assist in the implementation of the health responsibilities under the SDGs and to promote multisectoral approaches. Accordingly, in line with the Plan of Action on Health in All Policies, the Bureau had established a task force on the SDGs and health in all policies. In addition, PAHO and the Organization of American States had established an informal working group to identify joint actions to be undertaken in relation to the SDGs and their targets. The group would work to establish a broader inter-agency alliance on the SDGs in the Region.

311. Several countries had presented reports on their progress in implementing the Sustainable Development Agenda and others were drafting their reports. Overall, the reports showed that countries were committed to the SDGs and willing to commit time and resources for their achievement. The SDG implementation process offered an opportunity for governments to renew their commitment to public health and to work across sectors on the health-related aspects of the Goals. They also afforded an opportunity to establish a regional network and official platform for sharing national experiences in SDG implementation.

312. The Executive Committee welcomed the progress made in planning for the implementation of the SDGs in the Region and voiced strong support for the establishment of a regional network and official platform to facilitate the sharing of experience. Delegates affirmed their governments' commitment to the Goals and acknowledged the need for multisectoral action in order to achieve them. They agreed that the process of implementing the Goals would provide an opportunity for countries to renew their commitment to public health and to promote intersectoral collaboration on the health-related aspects of the Goals. More information was requested on the outcomes of

the various consultations conducted in the Region, particularly with respect to the identification of strengths and challenges in relation to the implementation of the SDGs, and on how the Bureau would contribute to the achievement of the Goals. The need to strengthen mechanisms for measuring progress towards health-related targets was highlighted.

313. Dr. Fortune observed that, whereas the MDGs had been very sector-driven, the SDGs were much more country-driven, a change that marked a significant shift in thinking. The process of monitoring progress towards the SDGs was also expected to be country-driven, with countries selecting from among the numerous indicators those that were relevant to them. While some might criticize the SDGs for being limited from a health standpoint, given that there was only one Goal that dealt specifically with health, they offered enormous potential for working across sectors. One of the activities undertaken by the task force on the SDGs and health in all policies had been an analysis of all 17 SDGs to identify opportunities for health, not only under SDG 3, but beyond. That analysis was available to all Member States.

314. One of the main outcomes of the regional consultations had been a recommendation to build capacity to enable health authorities to work across the 17 Goals, as a result of which the Bureau was working with partners to develop a course on the SDGs to be made available to all Member States. Another outcome had been to continue producing documents such as the one on preparing the Region to achieve the health-related SDGs, mentioned in paragraph 7 of Document CE158/INF/7, taking stock of the work under way, the partners involved, and the related resolutions and mandates. The Bureau was working on a platform where such documents could be accessed by Member States and by the general public.

315. The Director said that the Bureau was providing significant support to Member States in relation to the SDGs, not only from Headquarters, but also in the country offices. The PAHO/WHO representatives were actively engaged in discussions occurring at the national level on the development of national plans for the achievement of the Goals. As had been pointed out, a number of PAHO mandates, including the Strategic Plan, the *Strategy for Universal Access to Health and Universal Health Coverage*, and the Plan of Action on Health in All Policies, were closely aligned with the SDGs, as was the *Health Agenda for the Americas 2008-2017*. The process of formulating a new document for the period after 2017 could afford an opportunity to look at the Region's health agenda against the backdrop of the SDGs.

316. The Committee took note of the report.

***Regional Plan of Action for Strengthening Vital and Health Statistics: Final Report (Document CE158/INF/8)***

317. Dr. Marcos Espinal (Director, Department of Communicable Diseases and Health Analysis, PASB) introduced the final report on the Plan of Action for Strengthening Vital

and Health Statistics, explaining that, although the five-year period covered by the Plan had ended in 2013, the final report was being presented in 2016 because the necessary data had not been available from some countries until 2015. The resolution approving the Plan (Resolution CD48.R6) had urged Member States to promote and coordinate the participation of the different entities and actors involved in the production of vital and health statistics and to prepare and monitor national plans to strengthen and improve health statistics.

318. During the period of the Plan, 20 countries had set up institutional committees to strengthen health information, 35 had conducted assessments on the status of vital statistics, and 29 had formulated national action plans. Birth and death registry coverage had improved as had the quality of the data reported. Nevertheless, persistent challenges remained in several areas, including inaccuracy or vagueness in reporting of causes of death, rounding of birthweight data, and weaknesses in information systems and lack of data for the municipal and provincial or state levels.

319. The Committee was invited to consider recommending the preparation of a new regional plan of action to address those challenges and build on the progress made under the Plan of Action 2008-2013. Noting that resources for the improvement of health information systems had traditionally been limited, Dr. Espinal appealed to Member States to strive to increase support for their health information systems so that they could produce the data needed to design health policies that would benefit their populations.

320. The Executive Committee welcomed the progress made in improving vital and health statistics and expressed support for the proposal to develop an updated plan of action in order to sustain the achievements made under the Plan of Action 2008-2013 and continue to strengthen health information systems and improve the quality of the data produced. It was considered particularly important to improve the quality of death certification data, and the Bureau was urged to support Member States in ensuring adherence to the International Classification of Diseases 10th Revision (ICD-10) in reporting causes of death. The need to improve the timeliness of birth registration and the accuracy of the data reported in some countries was also noted, as was the need to enhance the availability of quality subnational data. The importance of using quality data for evidence-based decision-making was underlined.

321. Delegates emphasized that the new plan should be consistent with the efforts of regional and global partners such as the World Bank and suggested that its focus should be expanded to encompass areas of health information other than vital and health statistics; the plan should also support collection of the information needed to monitor progress under the PAHO Strategic Plan 2014-2019 and the health-related Sustainable Development Goals. Initiatives such as the Health Data Collaborative were seen as useful tools for strengthening national capacity for the collection of data for those purposes. It was pointed out that it was vital to ensure universal civil registration and accurate vital statistics in order to close gaps in gender data, which in turn was essential for achieving gender equality, the empowerment of women and girls, and the realization of human rights. The Bureau was

urged to support Member States in integrating a gender equality perspective into their health information systems.

322. Dr. Espinal thanked Member States for their efforts to improve health information systems in the Region and their support for the proposal to draw up a new plan of action. A critical issue to be addressed under the new plan would be quality of data. It was not sufficient to focus only on the quantity of data collected; it must also be ensured that those data were accurate. It would be equally important to ensure that Member States had the capacity to produce the data needed to track progress towards the Sustainable Development Goals.

323. The Director observed that vital statistics were truly vital: if children were not registered, it was almost as if they did not exist. They had no legal identity and in some countries they were unable to access basic health and education services. While the quality of vital and health statistics had improved in a number of Member States, insufficient progress had been made in the Region overall. Countries had numerous different types of information systems, many of which did not produce the timely and reliable data needed for program delivery and for policy- and decision-making. The problem was particularly acute in the Organization's eight key countries. It was therefore a top priority for the Bureau to continue working with Member States to improve health information systems and to ensure that every child was counted and every death, and its cause, was reported.

324. The Committee endorsed the proposal to formulate an updated regional plan of action to be presented to the Governing Bodies for approval in 2017.

***Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006-2015: Final Report (Document CE158/INF/9)***

325. Dr. Anselm Hennis (Director, Department of Noncommunicable Diseases and Mental Health, PASB) recalled that the 47th Directing Council had approved the Regional Strategy and Plan of Action on Nutrition in Health and Development with aim of improving nutritional status throughout the life course, especially among the poor and other vulnerable groups, contributing to greater equity in health, preventing disease, and extending the life expectancy and improving the quality of life of the peoples of the Americas.

326. During the period covered by the Strategy and Plan of Action (2006-2015), 18 Member States had reviewed policies and programs for tackling malnutrition and 20 had established food and nutrition security policies. Eighteen Member States had established conditional cash transfer programs that had benefited around 130 million people. Thirty-three Member States had adopted the 2006 WHO Child Growth Standards and virtually all countries in the Region had policies to promote breastfeeding. Three countries had increased exclusive breastfeeding rates by more than 25%; however, only 44% of infants under 6 months were exclusively breastfed. The final report contained in Document CE158/INF/9 presented additional data on the current nutrition situation in the Region and



on steps taken by Member States to reduce nutritional deficiencies and promote healthy diets and lifestyles.

327. Data on nutrition were obtained mainly from national health and nutrition surveys of young children and women of reproductive age carried out about every five years; however, only 22 countries conducted such surveys and many conducted them less frequently than every five years. Hence, data gaps remained a significant challenge. To address that and other remaining challenges, including the double burden of over- and undernutrition, the Bureau recommended that Member States fully implement the WHO *Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition* and the PAHO *Plan of Action for the Prevention of Obesity in Children and Adolescents*. Recommended priority actions included strengthening of intersectoral coordination to increase access to healthy foods and opportunities for physical activity; increasing the capacity of the health sector to deliver key nutrition interventions to reduce both stunting and overweight; micronutrient supplementation and staple food fortification to prevent micronutrient deficiencies; fiscal policies and regulation of food marketing and labeling to reduce consumption of sugar-sweetened beverages and energy-dense, nutrient-poor products by children and adolescents; and robust health surveillance systems and the incorporation of nutrition indicators in those systems, coupled with program monitoring and evaluation to measure effects on nutrition.

328. In the discussion that followed, a delegate described his Government's efforts to combat micronutrient deficiencies through improved distribution of micronutrients and fortified foods and through the provision of iron supplements to pregnant women. He noted that the health sector was working with the education sector in his country to improve the quality of foods that children received in school and to regulate the information made available to them. He also noted that efforts to improve nutrition and combat overweight and obesity were sometimes hindered by local customs and conditions.

329. Dr. Hennis underscored the need for intersectoral collaboration to address nutritional issues that fell outside the purview of the health sector. Collaboration with the education and agriculture sectors, for example, was essential. It was to be hoped that the United Nations Decade of Action on Nutrition (2016-2026) would be taken as a clarion call for action to prevent all forms of malnutrition.

330. The Committee took note of the report.

***Strategy and Plan of Action for the Reduction of Chronic Malnutrition: Final Report (Document CE158/INF/10)***

331. Dr. Anselm Hennis (Director, Department of Noncommunicable Diseases and Mental Health, PASB), introducing the final report, noted that the Strategy and Plan of Action for the Reduction of Chronic Malnutrition had been approved by the 50th Directing Council with the goal of contributing to the achievement of Millennium Development Goals (MDGs) 1, 2, 3, 4, and 5 and improving health throughout the life course.

The Strategy had been developed with the aim of complementing the Regional Strategy and Plan of Action on Nutrition in Health and Development (see paragraphs 325 to 330 above), focusing on the reduction of chronic malnutrition as an urgent priority.

332. Summarizing the main achievements under the Strategy and Plan of Action, he reported that 18 countries had established intersectoral food security and nutrition strategies; at least 22 countries had carried out nationally representative health and nutrition surveys to collect data on nutrition disaggregated by gender, ethnicity, wealth quintiles, and geographical area; municipalities in vulnerable conditions in at least 18 countries had implemented programs or intersectoral interventions on food and nutrition; ministries of health had implemented capacity-development programs to improve knowledge of food and nutrition; and 19 countries had established intersectoral municipal or community committees to improve food and nutrition security.

333. Chronic malnutrition had decreased during the period covered by the *Strategy and Plan of Action* (2010-2015), but it remained a problem, particularly among marginalized populations. At the same time, overweight and obesity had increased. Anemia had also declined, but it continued to be a problem, especially among pregnant women. The Bureau recommended that Member States strengthen subnational intersectoral coordination mechanisms to prevent stunting, overweight, and anemia; strengthen the capacity of the health sector to deliver key nutrition interventions, such as the promotion of breastfeeding and healthy eating; maintain programs to provide multi-nutrient supplements and fortified foods; scale up efforts to promote and facilitate breastfeeding; and strengthen nutritional surveillance systems by incorporating nutrition indicators.

334. The Executive Committee acknowledged the progress made but also noted that malnutrition in its various forms remained a serious problem in some countries, despite the considerable effort put forth by governments to tackle it. Delegates underscored the need for intersectoral action, since the issue was not one that could be dealt with by the health sector alone. Poverty alleviation was seen as crucial to the elimination of chronic malnutrition, as was education. It was pointed out that the quality of nutrition early in life had a lifelong impact, and the importance of improving nutrition during pregnancy and early childhood was stressed. It was also considered necessary to evaluate the impact of the various strategies and interventions applied in order to identify why some had been effective while others had not and to share information on successful experiences and best practices. In that connection, it was suggested that the report could be improved through the addition of information on lessons learned from reporting on the Plan of Action indicators. It was noted that, in some cases, problems with monitoring and evaluation and with the flow of data from the subnational to the national level had hindered the collection of information on nutrition and the assessment of the impact of interventions.

335. Dr. Hennis affirmed that robust systems for nutritional surveillance throughout the life course were needed. The Bureau would continue to work with Member States to enhance their ability to collect good nutritional data and also to enable them to monitor and evaluate programs and policies in order to identify why they did not always yield the

expected results. Research was also needed to identify specificities within countries and tailor approaches to address them. While progress had been made in reducing chronic malnutrition due to undernutrition, levels of childhood overweight and obesity had doubled during the period of the Strategy and Plan of Action, and nutritional problems continued to be a significant factor in disability-adjusted life years lost in the Region. Malnutrition in all its dimensions should therefore remain a priority for both the Bureau and Member States.

336. The Director, noting that many countries in the Region were grappling with a double burden of overweight and obesity alongside micronutrient deficiencies and subnutrition, stressed the need for a life-course approach and a focus on lifelong healthy eating, which was fundamental for a healthy and productive life. Moreover, without such an approach, the pendulum could easily swing from undernutrition to obesity, as had already occurred in some countries of the Caribbean. There was also a need for greater multisectoral engagement and surveillance and targeted research to understand why investments and programs were not producing the desired degree of success. The Bureau would support Member States in seeking out partners to enable them to conduct such research. It would also continue to collaborate closely with the Institute of Nutrition of Central America and Panama (INCAP) and the Caribbean Public Health Agency (CARPHA) on the issue of nutrition.

337. The Committee took note of the report.

***Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Region of the Americas: Final Report (Document CE158/INF/11)***

338. Dr. Luis Andrés de Francisco Serpa (Director, Department of Family, Gender, and Life Course, PASB) recalled that the Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Americas had been adopted in 2012 with the aim of establishing emergency interventions to strengthen immunization programs and surveillance of measles, rubella, and congenital rubella syndrome and thus ensure that the Region remained free of endemic transmission of measles and rubella. An interim progress assessment in 2014 had found that the actions taken under the Plan of Action had made it possible to sustain the elimination of both diseases.

339. The Americas had been declared free of rubella and congenital rubella syndrome in April 2015. As for measles, outbreaks had occurred in several countries since 2014 as a result of imported cases and endemic transmission had reemerged in one, Brazil. In August 2016 the International Expert Committee would review the evidence of interruption of transmission in Brazil, where no cases had been reported for more than a year. If the Committee accepted the evidence, the Region could be declared free of measles. Keeping it free of both measles and rubella, however, would require continued commitment by Member States to maintaining high immunization coverage and strong epidemiological surveillance. Paragraph 21 of Document CE158/INF/11 contained a set of recommendations aimed at ensuring that the elimination of the two diseases could be

maintained; as both diseases remained endemic in all other WHO regions, which put the Americas at risk of imported cases, one recommendation was to support the adoption of a resolution by the World Health Assembly in 2017 for the global eradication of measles and rubella.

340. The Executive Committee applauded the elimination of rubella and congenital rubella syndrome and welcomed the progress towards measles elimination. It also supported the recommendations for maintaining elimination, in particular the implementation of strategies to achieve high vaccination coverage rates and of measures to halt transmission promptly in the event of imported cases. It was pointed out that, while countries might not be able to prevent importation, they could prevent transmission by ensuring high population immunity and high-quality surveillance. The need to disaggregate coverage data was underscored; this was considered particularly important in order to identify remote or isolated populations with low vaccination rates. Support was voiced for the adoption of a World Health Assembly resolution calling for global eradication of measles and rubella, although it was felt that caution should be exercised in setting a target date for the achievement of that goal.

341. Dr. Francisco Serpa agreed that it was crucial to maintain high vaccination coverage rates and ensure effective epidemiological surveillance in order to detect any reintroduction of the measles or rubella viruses and act quickly to prevent transmission. He also agreed on the importance of disaggregating data in order to identify low-coverage areas.

342. The Director affirmed that low coverage among some municipalities—in some cases as low as 60%—put the maintenance of elimination at risk. The Bureau would continue to support Member States in achieving and maintaining uniform coverage of 95% or higher in at least 80% of municipalities in order to prevent a buildup of susceptible persons that could potentially maintain transmission in the event of an outbreak of measles or rubella. It would also support Member States in strengthening their epidemiological surveillance and capacity for quick response in the event that transmission were to resume. The PAHO Revolving Fund for Vaccine Procurement was one of key elements of the Bureau's technical cooperation in the area of immunization. Preservation of the Fund would therefore be important in ensuring continued high coverage.

343. The Committee took note of the report.

***Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: Final Report (Document CE158/INF/12)***

344. Dr. Luis Andrés de Francisco Serpa (Director, Department of Family, Gender, and Life Course, PASB), introducing the final report on the Regional Strategy and Plan of Action, noted that the objective of the work undertaken had been to support the countries of the Region in achieving the relevant Millennium Development Goals. An interim progress report presented to the Directing Council in 2013 had underscored the need for continued

effort to reduce neonatal mortality by addressing determinants and inequities that continued to exist. The final report contained in Document CE158/INF/12 outlined the results of the work done during the period covered by the Strategy and Plan of Action (2008-2015), the lessons learned, and the remaining challenges. It also put forward, in paragraphs 14 to 16, recommendations for future action.

345. While much had been achieved, preventable neonatal mortality remained a serious concern in some countries. Some populations continued to have rates of skilled attendance at birth of under 80%. Quality of care and adherence to evidence-based standards for newborn care was limited in many cases. Implementation of community-based interventions varied widely between and within countries. It was therefore essential to continue building on the progress achieved in the five strategic areas of the Strategy and Plan of Action and to pursue the actions envisaged under related global initiatives, including the *Global Strategy for Women's, Children's, and Adolescents' Health* (2016-2030)<sup>13</sup> and the *Every Newborn global action plan*.<sup>14</sup>

346. The Executive Committee welcomed the progress achieved, while also stressing the need for ongoing commitment and effort in order to maintain the gains made and address remaining challenges. The Committee also expressed support for the recommendations for future action set out in the final report, in particular the recommendation to align regional efforts with relevant global initiatives. In that connection, the Bureau was asked to provide more detail on a proposal in the report to establish mechanisms for adopting the strategic objectives and goals of the *Every Newborn global action plan*.

347. Member States that had not already done so were urged to implement a national plan on newborn health. The importance of interventions to address determinants of prematurity, birth defects, sepsis and asphyxia was highlighted, as was the need to identify solutions to problems relating to the coverage and quality of care during childbirth. Early detection and treatment of congenital anomalies and other pathologies were considered crucial to reducing neonatal mortality. The need for joint action to counter the threats posed by the Zika virus was also stressed, particularly in light of its potential consequences for infant and child health, and the value of sharing successful strategies and interventions for dealing with Zika and other challenges was emphasized.

348. Dr. Francisco Serpa observed that the Zika virus outbreak in the Region had served to highlight gaps in maternal and neonatal health programs and underscored the need to strengthen those programs and ensure good antenatal care and skilled attendance at birth. The Bureau would continue to work with Member States to that end. Regarding the Every Newborn plan, he explained that the Bureau was not proposing any change in the elements of the plan; it simply wished to see a focus on ensuring that national plans were in place and on strengthening information systems and improving the quality of care where needed.

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<sup>13</sup> <http://www.who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf>.

<sup>14</sup> [http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf).

349. The Director noted that progress in reducing neonatal mortality had virtually stalled in the last five years. Further reductions in very early neonatal deaths might be difficult to achieve because such cases often required extensive tertiary-level services. However, she was optimistic that it would be possible to continue reducing neonatal deaths from preventable causes by enhancing access to care, ensuring good quality of care at the primary level, and addressing inequalities and other social determinants that were closely correlated with higher neonatal mortality. The current Zika epidemic would undoubtedly have an impact on neonatal mortality rates. Good epidemiological surveillance would be needed to determine which infant deaths were due to Zika virus infection and which were due to other causes.

350. The Committee took note of the report.

***Progress Reports on Technical Matters (Document CE158/INF/13)***

***A. Strategy and Plan of Action on eHealth: Midterm Review***

351. The Delegate of Mexico thanked the Bureau for its support in organizing the 14th Ibero-American Conference of Ministers of Health, which had been held in Mexico and which had focused on the use of information technology to promote healthy lifestyles and combat diseases, especially noncommunicable diseases.

352. The Executive Committee took note of the report.

***B. Plan of Action on Adolescent and Youth Health***

353. A delegate noted that while the report included information on the alarming rise in pregnancies among adolescent girls under 15, there was little information on efforts being made by Member States to increase access to sexual and reproductive health services and information. The links between that important issue and the response to the spread of the Zika virus were also not mentioned. As it was recognized that many countries in the Americas had poor access to sexual and reproductive health services and information for both adolescents and women, the report should include what actions needed to be taken to address that shortcoming as well as steps to change gender norms, that perpetuated that lack of access.

354. Other delegates underscored the seriousness of the problem of violence, including sexual violence, among adolescents and young people. Poverty, lack of education and information, and deficiencies in the justice system were cited as factors that contributed to violence. Education was also seen as key in reducing adolescent pregnancies. The need for a rights-based approach that incorporated a gender perspective and took into account sexual and reproductive rights was stressed, as was the importance of a multisectoral and multidisciplinary approach. Various delegates described the efforts that their Governments were making to improve adolescent and youth health.

355. Dr. Luis Andrés de Francisco Serpa, (Director, Department of Family, Gender, and Life Course Department, PASB) noted that the Plan of Action called for advocacy and legal reforms aimed at ensuring access for adolescents to sexual and reproductive health services. It also called for capacity-building among health service personnel to increase their competence in responding to adolescent and youth health needs. The Plan also recognized the importance of a multidisciplinary and multisectoral approach that addressed social determinants of health. The Plan was now being adjusted to take account of newer challenges, such as the control and management of Zika virus disease, with particular attention to pregnant women, including those in the adolescent age range. He stressed that the Plan did take a rights-based approach, calling for the elimination of discrimination in adolescents' and young people's access to health services, including contraception and other reproductive health services.

356. The Director said that adolescents and youth constituted a group to which the Bureau and Member States needed to pay particular attention. It was a group that was collectively associated with many high-risk behaviors, including tobacco use, alcohol use, high-risk sexual behaviors, and driving while inebriated. Although the report presented generally positive results, both the Bureau and Member States needed to do much more to address the health needs of adolescents and youth. The Bureau would continue working to ensure a much more holistic approach, one that took into consideration the challenges that young people faced and the relevant social and cultural factors. Adolescents and youth were unlikely to seek health care of their own volition, and it was therefore time to rethink how best to reach them.

357. The Committee took note of the report.

*C. Plan of Action for the Prevention and Control of Noncommunicable Diseases: Midterm Review*

358. It was noted that, while the report provided a helpful summary of progress and challenges in preventing and controlling noncommunicable diseases (NCDs) in the Region, it did not clearly address all four of the strategic lines of action in the Plan of Action, and the Bureau was requested to provide the Directing Council with information on progress with regard to the lines of action. Additional detail on the work of the Inter-American Task Force on NCDs was also requested. It was considered important for all countries to share their results so as to increase overall knowledge, perhaps through the Pan American Forum for Action on NCDs. It was also seen as essential for countries to have public policies that took a comprehensive approach to NCDs, with intersectoral cooperation among governments, NGOs, and academic circles. It was suggested that an effective means of persuading high-level political leaders and officials in other sectors of the need for concerted action to combat NCDs might be to make them aware of how much deaths from such diseases were costing their countries. The need to achieve balance between the effort and resources expended on communicable and noncommunicable diseases was noted.

359. Dr. Anselm Hennis (Director, Department of Noncommunicable Diseases and Mental Health, PASB) agreed on importance of multisectoral engagement and stressed the value of information-sharing by Member States concerning initiatives that had been successful. The Pan American Forum could indeed serve as a mechanism for information-sharing, although there had been constraints on the Bureau's ability to work with the Forum while the issue of FENSA (see paragraphs 264 to 277 above) remained pending. He urged Member States to implement the Framework Convention on Tobacco Control, to take steps to prevent the harmful use of alcohol, to create policies and programs on nutrition, and to promote physical activity. He also urged Member States that had not already done so to put in place a national NCD plan by the end of 2016.

360. The Director, stressing the importance of engaging ministers of finance and Heads of State in NCD prevention and control efforts, said that the Bureau was cooperating with several academic institutions to gather data on the economic impact of such diseases. In her discussions with national officials, she had observed an ongoing conviction that the answer to the problem of NCDs was individual behavior change. That was certainly important, but it was not the most effective way to deal with NCDs. Multisectoral action was needed to achieve the maximum effect. It was to be hoped that the necessary political leverage might be obtained through the Inter-American Task Force, but it was also necessary to bring the matter to the attention of subregional bodies such as the Union of South American Nations (UNASUR) and the Community of Latin American and Caribbean States (CELAC).

361. The Committee took note of the report.

*D. Plan of Action to Reduce the Harmful Use of Alcohol: Midterm Review*

362. It was pointed out there appeared to be significant underreporting of alcohol consumption as an underlying cause of disease. A delegate reported that a survey conducted recently in her country had shown that, while tobacco use was declining as a result of legislative and other measures put in place, alcohol consumption was increasing, but that increase was not necessarily being reflected in the statistics produced by the country's health information systems. She emphasized the need for reliable, high-quality information to serve as a basis for decision-making and also the need to increase awareness among health personnel of the importance of reporting alcohol use. She also stressed the need to regulate advertising of alcoholic beverages. Another delegate described what was being done in her country to prevent harmful use of alcohol, notably an increase in taxation on alcoholic drinks, with defined portions of the proceeds being allocated to the promotion of sports and to the treatment of addiction.

363. Dr. Anselm Hennis (Director, Department of Noncommunicable Diseases and Mental Health, PASB) said that there seemed to be insufficient recognition of the adverse impact of the use of alcohol, which was one of the significant causes of disability-adjusted life years lost in the Region. The Region of the Americas had the highest level of alcohol consumption after Europe; it also had a problem with binge drinking among women and one of the earliest ages of onset of alcohol consumption among adolescents. Alcohol



consumption was linked not only to NCDs but also to communicable diseases and to violence and road traffic accidents. But despite the evidence of its harmful effects, little had been done to prevent harmful use of alcohol, the negative effects of which outweighed any potential benefits. Indeed, at the population level, it was now recognized that there was no evidence of any beneficial effects of alcohol use. Clearly, much more needed to be done to raise awareness of alcohol use as a serious public health issue.

364. The Director observed that alcohol consumption was deeply engrained in the culture of many countries of the Region. Moreover, there was a thriving alcohol industry in most of the countries. Reducing alcohol consumption would therefore be very difficult. While Resolution CD51.R14 referred to the “harmful use of alcohol,” what constituted “harmful” had not been defined, and some now held the view that any level of alcohol consumption was harmful and advocated zero consumption. Selling that idea to the communities of the Region would be a truly uphill battle.

365. The Committee took note of the report.

*E. Plan of Action on Psychoactive Substance Use and Public Health: Midterm Review*

366. Strong support was expressed for a public health approach to substance use prevention and treatment, and the Bureau’s efforts to raise awareness of the issue were commended, as was its work with Member States to ensure that all people with a substance use problem had access to the care they needed. The need for comprehensive multisectoral action to prevent substance abuse was emphasized. At the same time, the key role of health authorities in combating the problem was highlighted. It was considered especially important for the health sector to lead efforts to reduce demand for illicit drugs through a public health approach that involved all social actors and drew attention to the impact of illicit drug trafficking and use not only on health, but on public safety, the national economy, and a country’s international competitiveness. The importance of advocacy for a balanced and coordinated allocation of resources and actions to reduce the supply of drugs was highlighted.

367. It was pointed out that the special session of the United Nations General Assembly on the world drug problem held in April 2016 had marked a turning point in the global endeavor to address drug use and abuse. Members of the global community had committed to increase the use of public health approaches to achieve a more balanced approach to the world drug problem. The Bureau was encouraged to continue to work in collaboration with partners such as the United Nations Office on Drugs and Crime, the Commission on Narcotic Drugs, and the Inter-American Drug Abuse Control Commission to promote a public health approach to the issue. Such collaboration was seen as crucial in order to foster multisectoral action in the areas of prevention, treatment, rehabilitation, and social reintegration of persons with substance abuse problems.

368. Dr. Anselm Hennis (Director, Department of Noncommunicable Diseases and Mental Health, PASB) agreed that the special session of the United Nations General

Assembly had indeed represented a potential turning point in terms of global approaches to substance use. There was much work still to be done, however, and PASB would continue to work closely with Member States to implement public health approaches to psychoactive substance use in the Region.

369. The Committee took note of the report.

*F. Status of the Pan American Centers*

370. A delegate, highlighting the important contributions that the Pan American centers had made to PAHO's technical work, expressed concern about the situation of the Latin American and Caribbean Center on Health Sciences Information (BIREME), which appeared to be facing an institutional crisis, as it had recently lost more than 30 staff, currently had no Director, and had moved to a facility where it had to pay rent. The delegate requested additional information on BIREME's functional viability.

371. Dr. Francisco Becerra Posada (Assistant Director, PASB) responded that a new Director had been selected for BIREME and would be taking office by 1 August 2016. The Bureau was currently negotiating a new cooperation agreement with the Ministry of Health of Brazil with a view to ensuring that the center's funding would be secured and that it could continue to function. The new agreement would contain a provision ensuring that the rent would be covered and that BIREME would remain fully operational. Meanwhile, the Bureau had been providing some funding to BIREME, which also drew income from projects. He encouraged Member States to support BIREME by utilizing its services and products.

372. The Committee took note of the report.

***Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO (Document CE158/INF/14)***

*A. Sixty-ninth World Health Assembly*

373. Ms. Piedad Huerta (Senior Advisor, Governing Bodies Office, PASB) summarized the outcomes of the Sixty-ninth World Health Assembly (WHA), stressing the leading role played in the deliberations by certain representatives of the Region of the Americas. The Region had also distinguished itself by a high degree of preparedness for the sessions and had presented at least eight unified regional positions on priority issues, which had had a major impact on the content of the global public health policies endorsed by the Health Assembly.

374. The Health Assembly had adopted 25 resolutions and 19 decisions. As the Assembly had ended only a few weeks before the opening of the Executive Committee session, the Bureau had only had time to prepare a preliminary analysis of the implications

of the resolutions for the Region. More detailed information would be provided to the Directing Council.

375. Several of the resolutions that might impact the agenda of the Council included Resolution WHA69.4, on the role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond, which called for regional consultations to analyze the proposed roadmap. With regard to Resolution WHA69.10 on the Framework of Engagement with non-State Actors (FENSA), as had been noted earlier (see paragraphs 264 to 277 above), it was proposed to add an item on the topic to the agenda of the Directing Council, under Program Policy Matters.

376. The content of Resolution WHA69.20 on promoting innovation and access to quality, safe, efficacious, and affordable medicines for children, had been taken into account in drawing up the policy document on access and rational use of medicines and other health technologies (see paragraphs 103 to 117 above). Similarly, WHA69.22 on global health sector strategies on HIV, viral hepatitis, and sexually transmitted infections, for the period 2016-2021 had been borne in mind in preparing the proposed regional plan of action on the topic (see paragraphs 138 to 149 above).

377. In the discussion that followed, several delegates suggested that a face-to-face meeting should be held before the Directing Council to consider FENSA, (see paragraph 264 to 277 above) the aim being to enable delegations to be better prepared for the discussions by the Council. Delegates also supported the idea of a meeting with both face-to-face and virtual participation. It was also suggested that the topics of access to medicines and health technologies and implementation of the International Health Regulations would also benefit from additional discussion before the Directing Council. It was further suggested that if several face-to-face meetings were to be held, they should be scheduled close together, in the interests of efficiency of travel.

378. The Director agreed that discussion of major topics in advance could facilitate the Directing Council's deliberations. However, if the meetings on the three items (FENSA, IHR, Medicines) were held in Washington, it was likely that only about half of the Organization's Member States would be able to participate. The Bureau did not have the funding to cover travel costs, even for the priority countries. One solution might be to organize face-to-face meetings but to provide the opportunity for long-distance participation through a Web platform.

379. Support was expressed for that idea, and it was pointed out that the discussion on FENSA should be relatively short (one day), as the meeting would not be reopening the content of Framework, but simply examining how it would be implemented in the Region.

#### *B. Subregional Organizations*

380. Mr. Dean Chambliss (Head, Department of Country and Subregional Coordination, PASB) outlined various resolutions and agreements on health-related matters adopted by

subregional integration entities in Central America, the Caribbean, and South America. He reported that the Council of Ministers of Health of Central America (COMISCA) had discussed the health plan for Central America and the Dominican Republic 2016-2020 and committed to include a social determinants of health approach in all policies of the Central American Integration System. A subregional plan of action for the prevention and control of the Zika virus in Central America and the Dominican Republic had also been approved. At the October 2015 meeting of the health sector of Central America and the Dominican Republic (RESSCAD), participants had agreed, inter alia, to map capacities to address the Protocol to Eliminate Illicit Trade in Tobacco Products, to participate in WHO meetings on the implementation of the International Health Regulations, and to strengthen the technical capacity of staff to monitor the use of pesticides.

381. In the Caribbean subregion, the Council for Human and Social Development (COHSOD) of the Caribbean Community (CARICOM) had discussed an evaluation of the Caribbean Cooperation in Health III (CCH III) and the development of the new CCH IV. COHSOD had also discussed activities under way with respect to universal health coverage and the elimination of mother-to-child transmission of HIV/AIDS, strategies to increase vaccination coverage and introduce new vaccines, strengthening of health information systems, and the Caribbean Regulatory System for medicines and health technologies. The Heads of Government of CARICOM had met to agree on actions that Member States would take against the Zika virus.

382. In South America, the Meeting of Ministers of Health of the Andean Area (REMSAA) had discussed an Andean plan for health in border areas. It had also discussed the purchase of drugs through the PAHO Strategic Fund. REMSAA had agreed on a resolution on the elimination of rabies transmitted by dogs and another on safe blood. It had also discussed disaster risk management, including the needs of persons with disabilities, and had agreed to develop a plan on maternal health with an intercultural approach.

383. The Ministers of Health of MERCOSUR, at a special meeting held in February 2016, had issued a declaration on the importance of strengthening vector control in the context of the Zika virus disease outbreak. UNASUR had established an agreement with PAHO for increasing access to high-cost medicines through the Strategic Fund. A memorandum of understanding between PAHO and UNASUR on enhanced cooperation was currently in the process of formal approval. The Pacific Alliance Council of Vice Ministers of Health had defined its health agenda at a meeting in June 2015 and subsequently requested technical support from various multilateral organizations, including PAHO.

384. The Bureau was in the process of establishing new subregional structures for Central and South America, which would strengthen its capacity to support the subregional integration mechanisms that were taking an increasing interest in health matters. The new subregional offices, to be located in San Salvador and Lima, would be operational towards the end of 2016.

385. The Executive Committee expressed appreciation for the information provided. The Bureau's role in assisting subregional organizations in reaching meaningful agreements on health matters was commended, as was its support in decision-making on measures to combat the Zika outbreak.

386. The Executive Committee took note of the reports.

### **Closure of the Session**

387. Following the customary exchange of courtesies, the President declared the 158th Session of the Executive Committee closed.

### **Resolutions and Decisions**

388. The following are the resolutions and decisions adopted by the Executive Committee at its 158th Session:

#### ***Resolutions***

#### ***CE158.R1: Collection of Assessed Contributions***

#### ***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having considered the *Report on the Collection of Assessed Contributions* (Documents CE158/23 and Add. I);

Noting that no Member State is in arrears in the payment of its assessed contributions to the extent that it can be subject to the application of Article 6.B of the Constitution of the Pan American Health Organization;

Noting that 24 Member States have not made any payments towards their 2016 assessments,

#### ***RESOLVES:***

1. To take note of the *Report on the Collection of Assessed Contributions* (Document CE158/23 and Add. I).
2. To thank Member States for their commitment in meeting their financial obligations to the Organization by making efforts to pay their arrears of contributions.
3. To commend Member States that have already made payments for 2016 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 Directing Council on the status of the collection of assessed contributions.

*(First meeting, 20 June 2016)*

***CE158.R2: Plan of Action for Disaster Risk Reduction 2016-2021***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed *Plan of Action for Disaster Risk Reduction 2016-2021* (Document CE158/21), which includes the final report on the Plan of Action on Safe Hospitals 2010-2015,

***RESOLVES***

To recommend that the Directing Council adopt a resolution written in the following terms:

**PLAN OF ACTION FOR DISASTER RISK  
REDUCTION 2016-2021**

***THE 55th DIRECTING COUNCIL,***

Having examined the *Plan of Action for Disaster Risk Reduction 2016-2021* (Document CD55/\_\_\_), which includes the final report on the Plan of Action on Safe Hospitals 2010-2015;

Taking into account the advances made in the implementation of Disaster Preparedness and Response (Resolution CD45.R8) (2004); Safe Hospitals: A Regional Initiative on Disaster-Resilient Health Facilities (Resolution CSP27.R14) (2007); and Plan of Action on Safe Hospitals (Resolution CD50.R15) (2010);

Observing that the implementation of the Plan of Action on Safe Hospitals (Document CD50/10) 2010-2015 has demonstrated advances and challenges that have contributed to the adoption of national programs and policies for safe hospitals, to the implementation of activities aimed at ensuring that all new hospitals are built with a higher level of protection, and to the implementation of measures to cope with climate change in terms both of disaster adaptation and mitigation in order to strengthen existing health facilities;

Recalling that the 2030 Agenda for Sustainable Development, the Paris Agreement on climate change, the Agenda for Humanity and the Sendai Framework for Disaster Risk Reduction 2015-2030 all affirm that the health of the population is a priority in disaster risk reduction, and that therefore special attention should be paid to the capacity to respond to natural events and events caused by human activity, including those of an environmental,

biological, or radiological nature, and emphasize access to medical services after disasters, care for the needs of priority care groups such as persons with disabilities and ethnic groups, a gender approach, and mental health;

Taking into account the conclusions of the Regional Meeting of Health Disaster Coordinators held in Managua, Nicaragua, on October 2015, at which 29 countries and territories of the Region identified advances in disaster risk reduction and prioritized interventions with regard to existing gaps;

Aware of the importance of having a Plan of Action that enables the Member States of the Organization to implement actions to better protect the health of the population against emergencies and disasters,

***RESOLVES:***

1. To approve and implement the *Plan of Action for Disaster Risk Reduction 2016-2021* (Document CD55/\_\_\_).
2. To urge the Member States to:
  - a) strengthen emergency and disaster response programs in the health sector;
  - b) incorporate health sector disaster risk management into national policies, plans, and budgets, and promote the integration of health into national plans and strategies for disaster risk reduction;
  - c) promote initiatives in partnership with the scientific and technological community, academia, and others, to investigate, disseminate, and share good practices in disaster risk management in the health sector, and to include these in human resources training;
  - d) continue implementing the Safe Hospitals initiative and incorporate criteria for disaster mitigation and adaptation to climate change into health facility policies, planning, design, construction, operation, and accreditation;
  - e) strengthen national-level efforts to develop and update the knowledge and procedures of emergency and disaster response teams;
  - f) promote the creation of strategic reserves and the proper management of critical supplies for preparedness, response, and early recovery.
3. To request the Director to:
  - a) collaborate with the Member States in the coordination and implementation of the Plan of Action for Disaster Risk Reduction 2016-2021 at the national, subregional, and regional levels;
  - b) support the development of methodologies, technical guidelines, and information systems to facilitate disaster risk assessment;

- c) promote the strengthening of partnerships with specialized agencies in order to mobilize the human and financial resources and the technology necessary to improve disaster risk management;
- d) report to the Governing Bodies on the advances and limitations in the implementation of this Plan of Action at the end of each biennium and prepare a final evaluation in its last year.

*(First meeting, 20 June 2016)*

***CE158.R3: Strategy for Arboviral Disease Prevention and Control***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having examined the proposed *Strategy for Arboviral Disease Prevention and Control* (Document CE158/20, Rev. 1),

***RESOLVES:***

To recommend that the Directing Council adopt a resolution in the following terms:

**STRATEGY FOR ARBOVIRAL DISEASE PREVENTION AND CONTROL**

***THE 55th DIRECTING COUNCIL,***

Having examined the *Strategy for Arboviral Disease Prevention and Control* (Document CD55/\_\_);

Considering that the Constitution of the World Health Organization establishes that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;”

Considering the environmental, social, and biological factors that have facilitated the emergence and reemergence of different pathogens on a worldwide scale;

Recognizing the difficulties that have hindered proper mosquito control, which has given rise to the emergence and rapid spread of arthropod-borne viruses (arboviruses) in the Region of the Americas;

Aware of the social impact and economic burden of arboviral disease outbreaks and epidemics;

Profoundly concerned about possible severe manifestations and chronic outcomes of new viral diseases in the Region;



Recalling Resolution CD44.R9 (2003), in which a new model was adopted for dengue prevention and control through the integrated management strategy for dengue prevention and control (IMS-dengue);

Recognizing that the current epidemiological context requires a strategy that comprehensively addresses arboviral diseases,

**RESOLVES:**

1. To adopt the *Strategy for Arboviral Disease Prevention and Control* (Document CD55/\_\_\_) in the context of the specific conditions in each country.
2. To urge the Member States, taking into account the shared responsibilities in federated States, and as appropriate to their needs and priorities, to:
  - a) strengthen surveillance systems for early detection of emerging and reemerging arboviruses, as well as outbreak and epidemic monitoring systems;
  - b) prepare a strategy for the integrated control of arboviral diseases (IMS-arbovirus) which takes into account the critical components of IMS-dengue and introduces new tools for arbovirus surveillance in vectors and for prioritized prevention in high-risk populations;
  - c) strengthen national public health laboratories in order to guarantee timeliness and quality in the processes of detection, diagnosis, and laboratory surveillance of arboviral diseases;
  - d) strengthen the Arbovirus Diagnosis Laboratory Network of the Americas (RELDA) by establishing agreements among laboratories as well as effective channels for the exchange of scientific materials and output;
  - e) prioritize and mobilize the necessary resources to implement the strategy and each of its components.
3. To request the Director to:
  - a) support the implementation of the strategy to maintain and strengthen collaboration between the Pan American Sanitary Bureau and the countries and territories to address arboviral diseases;
  - b) continue to strengthen PAHO and WHO activities to produce scientific evidence on the magnitude, trends, health consequences, risk factors, and protection against emerging, reemerging, new, and endemic diseases in the Region;
  - c) continue to support countries and territories, at their request, by providing technical assistance to strengthen the capacity of health systems to address the surveillance of arboviral diseases in a coordinated manner;

- d) facilitate PAHO cooperation with committees, bodies, and human rights rapporteurs of the United Nations and Inter-American systems in order to guarantee implementation of the strategy in the countries and territories of the Region;
- e) prioritize arboviral disease surveillance and control and consider allocating the necessary resources to implement the strategy.

*(Second meeting, 20 June 2016)*

***CE158.R4: Plan of Action for Malaria Elimination 2016-2020***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed *Plan of Action for Malaria Elimination 2016-2020* (Document CE158/17, Rev. 1),

***RESOLVES:***

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

***PLAN OF ACTION FOR MALARIA ELIMINATION 2016-2020***

***THE 55th DIRECTING COUNCIL,***

Having reviewed the *Plan of Action for Malaria Elimination 2016-2020* (Document CD55/\_\_), which proposes the implementation of efforts to accelerate malaria elimination, prevent reintroduction, and achieve the proposed targets for 2019 of the PAHO Strategic Plan 2014-2019;

Recognizing the important achievements made in reducing the malaria disease burden in the Region during the implementation of the *Strategy and Plan of Action for Malaria in the Americas 2011-2015* (Resolution CD51.R9), as reflected in the achievement of malaria-related targets set in the Millennium Development Goals through concerted efforts of Member States and partners;

Aware that despite these achievements, malaria remains a serious threat to the health, well-being, and economy of peoples and nations in the Americas and has historically resurged in areas where commitment and efforts against the disease have weakened;

Aware that malaria elimination efforts will necessitate strengthened coordination among all partners and stakeholders, review and updating of malaria policies and strategic frameworks to accelerate efforts towards malaria elimination, sustained and strengthened surveillance at all levels of the health system, sustained commitment of stakeholders, and

tailored approaches to contextual specificities and preparation for the end game and beyond;

Considering Resolution WHA68.2 of the World Health Assembly, which adopts the global technical strategy and targets for malaria during the period 2016-2030, has a bold vision of a world free of malaria, and aims to reduce malaria incidence and mortality rates globally by at least 90% by 2030, to eliminate the disease in at least 35 new countries, and to prevent its reestablishment in countries that were free of malaria in 2015;

Recognizing that this Plan of Action is the platform for the implementation of the global strategy,

***RESOLVES:***

1. To approve the *Plan of Action for Malaria Elimination 2016-2020* (Document CD55/\_\_\_).
2. To urge the Member States, taking into account their contexts, needs, vulnerabilities, and priorities, to:
  - a) affirm the continuing importance of malaria as a health priority;
  - b) review and update national plans or establish new ones towards malaria elimination, investing appropriate resources and employing tailored approaches that address the social determinants of health and provide for inter-programmatic collaboration and intersectoral action;
  - c) reinforce engagement in efforts to address malaria, including coordination with other countries and relevant subregional initiatives in epidemiological surveillance of malaria, supply chain management, surveillance of resistance to antimalarial medicines and insecticides, and monitoring and evaluation;
  - d) guarantee the availability of key malaria supplies including anti-malarials through effective planning and forecasting of needs and utilizing, as applicable, the PAHO Regional Revolving Fund for Strategic Public Health Supplies for joint procurement;
  - e) strengthen health services and align them accordingly with PAHO/WHO evidence-based guidelines and recommendations on malaria prevention and case management;
  - f) sustain the commitment of both malaria-endemic and non-endemic countries and various sectors to fight the disease, particularly in terms of sustained or increased investments and provision of necessary resources;
  - g) establish integrated strategies and develop capacities to eliminate malaria and prevent the reestablishment of transmission with broad community participation so that the process helps to strengthen and sustain national health systems,

- surveillance, alert and response systems, and other disease elimination programs, with attention to factors related to gender, ethnicity, and social equity;
- h) further intensify efforts focusing on highly susceptible and vulnerable populations and occupational groups;
  - i) support engagement in the development and implementation of a research agenda that addresses important knowledge, operational and technology gaps in malaria elimination and various contexts of malaria work in the Region.
3. To request the Director to:
- a) support the implementation of the Plan of Action for Malaria Elimination and provide technical cooperation, including capacity-building efforts needed for countries to develop and implement national plans of action;
  - b) coordinate Region-wide efforts to eliminate local malaria transmission and prevent its potential reestablishment in malaria-free areas, in collaboration with countries and partners;
  - c) advise on the implementation of national strategic plans for malaria control;
  - d) continue to advocate for the active mobilization of resources among countries, as well as globally, and encourage close collaboration to forge strategic partnerships that support the implementation of national and cross-border efforts, including those targeting vulnerable and hard-to-reach populations;
  - e) employ tailored approaches addressing the social determinants of health and providing for inter-programmatic collaboration and intersectoral action;
  - f) report to the Governing Bodies on the progress of the implementation of the Plan of Action and the achievement of its targets at mid-term and at the end of the implementation period.

*(Second meeting, 20 June 2016)*

***CE158.R5: Appointment of One Member to the Audit Committee of PAHO***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Considering that the 49th Directing Council, through Resolution CD49.R2 (2009), established the Audit Committee of the Pan American Health Organization (PAHO) to function as an independent expert advisory body to the Director of the Pan American Sanitary Bureau (PASB) and PAHO Member States;

Guided by the Terms of Reference of the Audit Committee, which establish the process to be followed in the assessment and appointment by the Executive Committee of the members of the PAHO Audit Committee;

Noting that the Terms of Reference of that Committee stipulate that members shall serve no more than two full terms of three years each;

Considering that a vacancy will exist in the PAHO Audit Committee,

**RESOLVES:**

1. To thank the Director of the PASB and the Subcommittee on Program, Budget, and Administration for their thorough work in identifying and nominating highly qualified candidates to serve on the PAHO Audit Committee.
2. To thank Ms. Amalia Lo Faso for her years of service to the PAHO Audit Committee.
3. To appoint Mr. Claus Andreasen to serve as a member of the PAHO Audit Committee for a term of three years from June 2016 through June 2019.

*(Third meeting, 21 June 2016)*

**CE158.R6: *Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021***

**THE 158th SESSION OF THE EXECUTIVE COMMITTEE,**

Having examined the proposed *Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021* (Document CE158/18, Rev. 1),

**RESOLVES:**

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

**PLAN OF ACTION FOR THE PREVENTION AND CONTROL  
OF HIV AND SEXUALLY TRANSMITTED INFECTIONS 2016-2021**

**THE 55th DIRECTING COUNCIL,**

Having examined the *Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021* (Document CD55/\_\_);

Considering that the Plan is aligned with the World Health Organization (WHO) Global Health Sector Strategies for HIV and sexually transmitted infections (STIs) for 2016-2021, the Global Strategy of the Joint United Nations Program on HIV/AIDS

(UNAIDS) for 2016-2021, and Sustainable Development Goal (SDG) 3,<sup>1</sup> and provides a clear long-term goal of ending AIDS and STI epidemics as public health problems in the Americas by 2030;

Referring to the proposed 2016 World Health Assembly resolution in support of plans and strategies to achieve the above goal at the global level;

Cognizant of the impact these epidemics have in the Americas, especially among key populations and other priority populations in situations of vulnerability;

Acknowledging the need to decrease and eliminate the scourge of stigma, discrimination, and violation of the human rights of key populations and people living with HIV;

Reaffirming that the Plan provides continuity and builds upon the achievements of the previous Regional Strategic Plan for HIV/AIDS/STI (2006-2015) and the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (2010-2015);

Aware of the synergistic effect of the implementation of this Plan with other PAHO plans and strategies approved by the Governing Bodies;

Taking into account that the Plan reflects the priorities and commitment of Member States, civil society, and multilateral and bilateral agencies to end AIDS and STI epidemics in the Americas as a public health problem by 2030,

***RESOLVES:***

1. To approve the *Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021* (Document CD55/\_\_\_).
2. To urge Member States, as appropriate and taking into account their contexts, needs, and priorities, to:
  - a) continue to prioritize the prevention and control of HIV and STIs in the national agendas of the public health and social sectors;
  - b) strengthen the stewardship and governance of the HIV/STI response, with the active participation of civil society, to ensure effective and coordinated interprogrammatic and multisectoral interventions;
  - c) formulate, review, and align national HIV/STI strategies and plans, including setting national goals and targets for 2020 and 2030, in line with global and regional strategies, plans, and targets, and regularly reporting on the progress;

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<sup>1</sup> Ensure healthy lives and promote well-being for all at all ages (Resolution A/RES/70/1 adopted by the General Assembly of the United Nations in 2015).

- d) strengthen comprehensive strategic information systems to describe the HIV/STI epidemic and the continuum of HIV/STI services, increasing the granularity of data for subnational, gender, and other equity analyses;
- e) develop and regularly review norms and guidelines in accordance with the latest WHO recommendations and scientific evidence;
- f) implement high-impact interventions along the continuum of health promotion, HIV/STI prevention, diagnosis, care, and treatment, tailored to the needs of key populations and others in situations of vulnerability and based on local epidemic characteristics, addressing the integrated management of opportunistic infections, other co-infections, and comorbidities;
- g) continue actions already in place to prevent mother-to-child transmission of HIV and congenital syphilis, with special attention to the diagnosis and treatment of maternal syphilis and the second phase of the elimination strategy, which includes the elimination of mother-to-child transmission of other infections relevant to public health, such as hepatitis B and Chagas disease in endemic areas;
- h) develop and implement plans and strategies for the prevention and control of antimicrobial resistance, with special emphasis on gonococcal resistance and HIV drug resistance, and strengthen national laboratory capacity to monitor resistance;
- i) adapt delivery of HIV/STI services based on a people- and community-centered approach, through multidisciplinary teams, including trained lay providers, and an integrated network of health services that increases the resolution capacity of the first level of care, to address the clinical and psychosocial needs of people living with HIV, key populations and others in conditions of vulnerability based on the local epidemic, with culturally, linguistically and age-appropriate approaches, to achieve equity, maximize impact, ensure quality, and eliminate stigma and discrimination;
- j) improve integration of HIV/STI services to adequately address maternal and child health, sexual and reproductive health, HIV co-infections, with special emphasis on TB-HIV, and co-morbidities, including specific interventions for harm reduction in substance and alcohol use disorders, and early identification and treatment of mental illnesses;
- k) strengthen laboratory capacity for screening and diagnosis of HIV, STIs, opportunistic infections and other co-infections, as well as for clinical monitoring, based on the latest WHO recommendations, prioritizing the use of WHO prequalified diagnostics, and ensuring quality assurance practices;
- l) secure the uninterrupted supply of quality-assured and affordable vaccines, medicines, diagnostics, condoms, and other strategic commodities related to HIV/STIs and opportunistic infections, strengthening supply chain management structures and processes, including forecasting, procurement, warehousing, and distribution;

- m) strengthen the technical capacity and competencies of the national health workforce, and address and eliminate stigma, discrimination and other forms of human rights violations in the health sector;
  - n) facilitate the empowerment of civil society and enable engagement in the provision of effective and sustainable health promotion, and HIV/STI prevention, care and treatment services;
  - o) increase and optimize public financing with equity and efficiency for the sustainability of the response to HIV/STI, and integrate prevention, care and treatment interventions into comprehensive, quality, universal, and progressively expanded health services according to need, and with a people-centered approach, noting that, in most cases, public expenditure of 6% of GDP for the health sector is a useful benchmark;
  - p) improve efficiency in the procurement of strategic commodities through regional and subregional mechanisms for price negotiation and procurement, including the Regional Revolving Fund for Strategic Public Health Supplies (Strategic Fund).
3. To request the Director to:
- a) support the implementation of this Plan of Action through a coordinated and interprogrammatic approach to technical cooperation to address integration of the HIV/STI response in the broader universal health access and coverage strategy and in linkage with other regional plans and strategies;
  - b) provide support to Member States for the development and review of national HIV/STI strategies and plans, including target setting and program reviews to monitor progress;
  - c) provide technical support to Member States to strengthen information systems and HIV/STI surveillance and monitoring strategies, and build country capacity to generate quality strategic information on HIV/STI;
  - d) provide technical support to Member States for the development and review of policies and norms, and for the implementation of high-impact interventions along the continuum of HIV/STI prevention, diagnosis, care and treatment, based on latest WHO recommendations and ensuring quality and equity;
  - e) provide support to countries to accelerate the progress towards the elimination of mother-to-child transmission of HIV and congenital syphilis, as well as other mother-to-child transmitted infections relevant to public health, such as hepatitis B and Chagas disease in endemic areas, and coordinate the process of validation of elimination at the regional level;
  - f) advocate for an enabling environment that ensures access to health for people living with HIV, key populations and other groups in conditions of vulnerability, promoting, upon the request of Member States, policies, guidelines, and health-related human rights instruments that address gender inequality,



- gender-based violence, stigma and discrimination, and other restrictions of human rights;
- g) advocate for the empowerment of people and communities and for their meaningful, effective, and sustainable engagement in the provision of care;
  - h) advocate for building the capacity of the national work force to provide good quality and people-centered care in health services free from stigma and discrimination;
  - i) advocate for full funding of the HIV/STI response and the inclusion of HIV/STI prevention, care, and treatment interventions into comprehensive, quality, universal, and progressively expanded health services according to need and with a people-centered approach;
  - j) provide support to Member States through PAHO's Strategic Fund to improve the processes of procurement and supply management and distribution to ensure uninterrupted access to quality-assured and affordable vaccines, medicines, diagnostics, condoms, and other HIV/STI-related commodities, aligned with WHO prequalification;
  - k) present a mid-term review to the Governing Bodies in 2018 and a final report in 2021.

*(Fourth meeting, 21 June 2016)*

***CE158.R7: Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed *Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan* (Document CE158/13);

Considering the importance of having a robust, comprehensive, and objective methodology to guide resource mobilization and allocation for the Organization, consistent with best practices for strategic planning, scientific approaches, and PAHO's values and strategic vision;

Acknowledging the collaborative work of the Pan American Sanitary Bureau (PASB) with the PAHO Strategic Plan Advisory Group (SPAG), including the enthusiasm and commitment displayed by the Group to deliver on the mandate entrusted by the 53rd Directing Council (Resolution CD53.R3 [2014]),

***RESOLVES:***

To recommend that the 55th Directing Council adopt a resolution along the following lines:

## **METHODOLOGY FOR THE PROGRAMMATIC PRIORITIES STRATIFICATION FRAMEWORK OF THE PAHO STRATEGIC PLAN**

### ***THE 55th DIRECTING COUNCIL,***

Having reviewed the *Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan* (Document CD55/\_\_\_);

Considering the importance of having a robust, objective, and systematic methodology to implement the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan;

Recalling the request from the 53rd Directing Council in 2014 (Resolution CD53.R3) for the Director “to continue to undertake consultations with Member States to refine the programmatic priority stratification framework and apply it to future programs and budgets” in order to address weaknesses, including potential bias in the original methodology that might have resulted in giving more weight—and, thus, higher rankings—to disease-oriented programs and the fact that the methodology did not take into account changes in the regional and global public health paradigm;

Acknowledging the valuable input, collaboration, and commitment of the Strategic Plan Advisory Group<sup>1</sup> in advising PASB on conducting extensive analyses of various priority-setting methodologies in order to refine the PAHO-adapted Hanlon methodology;

Recognizing the role that objective and systematic priority setting can have in the process of strategic planning and decision making, especially in the context of multiple demands and resource limitations;

Recognizing the importance of having a scientific methodology consistent with the Organization’s context, values, and strategic vision, including the incorporation of new components such as equity and PAHO’s institutional positioning factor (the Organization’s added value) that are unique to the refined PAHO-adapted Hanlon methodology,

### ***RESOLVES:***

1. To approve the *Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan*.

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<sup>1</sup> At the request of Member States, the Director established the SPAG in October 2014 to provide advice and input on the implementation of the joint monitoring and assessment process and the refinement of the programmatic stratification framework of the PAHO Strategic Plan 2014-2019 (Resolution CD53.R3). It includes 12 members designated by the ministries of health of the Bahamas, Brazil, Canada, Chile, Costa Rica, Ecuador, El Salvador, Jamaica, Mexico, Paraguay, Peru, and the United States of America. The group is chaired by Mexico and co-chaired by Ecuador, and Canada served as the technical lead for the methodology review.

2. To promote awareness of the PAHO-adapted Hanlon methodology as a useful tool in priority setting in public health in the Region and globally.
3. To urge Member States, as appropriate and taking into account their national context, to:
  - a) participate actively in national consultations and apply the methodology in an objective and systematic manner as part of the process for development of the Program and Budget 2018-2019;
  - b) consider the adoption, adaptation, and utilization of this methodology at the national level, to the extent that it is appropriate and relevant, in order to better inform priority setting, thereby guiding the allocation of limited resources to where they can have the greatest public health impact.
4. To request the Director to:
  - a) apply the methodology for the development and implementation of the Program and Budget 2018-2019 in close collaboration with Member States and partners;
  - b) support national consultations in all countries and territories in the Region, while promoting the consistent application of the methodology in line with the components, criteria, and guidelines, in an effort to obtain the clearest and most accurate picture of the public health priorities of the Region;
  - c) report on the application of the programmatic stratification for resource mobilization and resource allocation in the final assessment of the PAHO Strategic Plan 2014-2019 to be presented in 2020;
  - d) support the publication of the PAHO-adapted Hanlon methodology in order to contribute to regional and global scientific knowledge for priority setting in public health and to promote this innovation and its results as a best practice and example of the collaborative work of PASB and Member States;
  - e) consult with Member States on necessary updates and refinements to the methodology for future Strategic Plans and Program and Budgets taking into consideration the lessons learned and experiences from previous biennia.

*(Fifth meeting, 22 June 2016)*

***CE158.R8: Collection of Assessed Contributions Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022***

***The 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed *Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022* (Document CE158/19),

***RESOLVES:***

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

**PLAN OF ACTION FOR THE ELIMINATION OF NEGLECTED INFECTIOUS DISEASES AND POST-ELIMINATION ACTIONS 2016-2022**

***THE 55th DIRECTING COUNCIL,***

Having examined the *Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022* (Document CD55/\_\_\_);

Considering that the World Health Organization (WHO) has provided an overarching framework to address the challenge of prevention, elimination, and control of neglected tropical diseases at the global level;

Considering the Health Agenda for the Americas 2008-2017 (2007), the Strategic Plan of the Pan American Health Organization 2014-2019 (Official Document 345 [2014]), Report on the 16th Inter-American Meeting at the Ministerial Level on Health and Agriculture (RIMSA 16) (Document CD52/INF/3 [2013]), the Plan of Action on Health in All Policies (Resolution CD53.R2 [2014]), the Strategy for Universal Access to Health and Universal Health Coverage (Resolution CD53.R14 [2014]), and the concept paper on Health and Human Rights (Resolution CD50.R8 [2010]);

Acknowledging the impact of neglected infectious diseases on morbidity and mortality, disability, and stigma in the Region of the Americas, especially among high-risk populations and groups in situations of vulnerability;

Recognizing that neglected infectious diseases both reflect and accentuate inequities in coverage of health services by affecting populations at the economic margins of society;

Acknowledging that measures of prevention and treatment of neglected infectious diseases implemented in childhood and among women of childbearing age in the Region may protect these vulnerable groups from acute and chronic illness and premature death and reduce the risk of disability and stigma;

Acknowledging that some neglected infectious diseases are also a risk for the periurban, rural, and agricultural workforce in the Region and impair the economic development of the individuals, families, and communities at risk;

Acknowledging that in the Region there is evidence of the elimination and interruption of transmission of several priority neglected infectious diseases and the elimination as a public health problem of other neglected infectious diseases;

Acknowledging that some countries that have eliminated neglected infectious diseases have implemented monitoring/surveillance measures for the post-elimination phase to prevent reintroduction or recrudescence and consolidate sustainability;

Considering that prevention, elimination, expanded control, and post-elimination monitoring/surveillance of neglected infectious diseases in the Region are possible in each country and territory in the foreseeable future,

**RESOLVES:**

1. To approve the *Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022* (Document CD55/\_\_\_).
2. To urge all Member States, taking into account their epidemiological situation, national context, and priorities, to:
  - a) prioritize neglected infectious diseases and their elimination as an important public health priority, promoting an integrated comprehensive response based on PAHO/WHO recommendations and establishing specific targets to face the challenges entailed by these diseases with the goal of eliminating as many as possible by 2022 or earlier;
  - b) foster interprogrammatic alliances, initiatives, synergies, and activities within and outside of the health system, engaging all relevant partners and stakeholders, including civil society, in the work of prevention, elimination, control, and post-elimination surveillance of neglected infectious diseases;
  - c) promote mechanisms in each country to ensure the professionalization and stability of technical personnel and the political continuity of programmatic strategies;
  - d) establish specific strategies for integrated surveillance and management of vectors of neglected infectious diseases and for strengthening the prevention of select neglected zoonoses through a veterinary public health/One Health approach, including collaboration with animal health and production areas, and outreach and educational interventions for neglected key populations and groups living in vulnerable conditions, with involvement of affected communities and key stakeholders;
  - e) support promotion of treatment, rehabilitation, and related support services through an approach focused on integrated morbidity management and disability prevention for individuals and families afflicted by those neglected infectious diseases that cause disability and generate stigma;
  - f) support the development of health-related policies, regulations, norms, and capacities at the country level for surveillance, screening, diagnosis, care, and treatment of neglected infectious diseases both within and outside of health care settings (according to evidence-based normative guidance developed by PAHO

- 
- and WHO), and ensure their implementation, monitoring, and periodic evaluation;
- g) promote inter-country collaboration and coordination in the monitoring of progress towards elimination goals and monitoring/surveillance in the post-elimination phase;
  - h) ensure inclusion of medicines, diagnostics, and equipment related to neglected infectious disease elimination in national essential medicine lists and formularies; negotiate expedited importation of medicines with the national regulatory, customs, and taxation authorities, and promote access to them through price negotiation processes and national and regional procurement mechanisms such as PAHO's Regional Revolving Fund for Strategic Public Health Supplies;
  - i) strengthen countries' capacity to generate and disseminate timely and quality strategic information (and mapping) on neglected infectious diseases, disaggregated by age, gender, and ethnic group;
  - j) support the development of integrated strategies for provision of safe water, basic sanitation and hygiene, improved housing conditions, health promotion and education, vector control, and veterinary public health based on intersectoral approaches, taking into account and addressing the social determinants of health, for elimination of neglected infectious diseases, and assume a leadership role to champion such access at the highest level of authority;
  - k) eliminate gender, geographical, economic, sociocultural, legal, and organizational barriers that prevent universal equitable access to comprehensive health services for those affected by neglected infectious diseases, following the PAHO Strategy for Universal Access to Health and Universal Health Coverage.
3. To request the Director to:
- a) establish a technical advisory group on elimination and interruption of transmission among humans of neglected infectious diseases that can advise PASB and, through it, the Member States;
  - b) support the implementation of the Plan of Action, especially with respect to strengthening services for innovative and intensified disease surveillance and case management (surveillance, screening, diagnosis, care, and treatment) and preventive chemotherapy of neglected infectious diseases as part of the expansion of primary health care and universal health coverage in the Region of the Americas;
  - c) support Member States in reinforcing national and regional information and surveillance systems on neglected infectious diseases in order to monitor progress in control and elimination and support decision making in countries according to their epidemiological status;
  - d) provide technical assistance to Member States to scale up actions to eliminate neglected infectious diseases, strengthen integrated management of vectors of these diseases, and strengthen the prevention of select neglected zoonoses through a veterinary public health/One Health approach, in keeping with national priorities;
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- e) support Member States in increasing access to affordable neglected infectious disease medicines and commodities, including through price negotiation processes and other mechanisms for sustainable procurement;
- f) promote strategic partnerships, alliances, and technical cooperation among countries in the Region in carrying out the activities included in this Plan of Action considering the future foreseeable goal of elimination and interruption of transmission among humans of select neglected infectious diseases in the Americas;
- g) present a mid-term evaluation in 2019 and a final evaluation report to the Governing Bodies in 2023.

(Sixth meeting, 22 June 2016)

***CE158.R9: Analysis of the Mandates of the Pan American Health Organization***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the report on the *Analysis of the Mandates of the Pan American Health Organization* (Document CE158/22),

***RESOLVES:***

To recommend that the Directing Council adopt a resolution in the following terms:

**ANALYSIS OF THE MANDATES OF THE  
PAN AMERICAN HEALTH ORGANIZATION**

***THE 55th DIRECTING COUNCIL,***

Having reviewed the report on the *Analysis of the Mandates of the Pan American Health Organization* (Document CD55/\_\_), regarding the status of resolutions adopted by the Directing Council and the Pan American Sanitary Conference in their capacity as Regional Committee of WHO for the Americas during the past 17 years (1999–2015), as well as recommendations for sunseting and reporting requirements;

Noting that a number of resolutions have an open-ended requirement for reporting back to the Governing Bodies,

***RESOLVES:***

1. To endorse the recommendations made in *Analysis of the Mandates of the Pan American Health Organization* (Document CD55/\_\_) for sunseting resolutions and reporting, that is, to establish a practice of time-limited reporting and to sunset the

resolutions that have been superseded in their entirety by subsequent resolutions, or whose commitments are considered to have been met.

2. To request the Director to:
  - a) continue the practice of defining the requirements for reporting on the implementation of resolutions, with a specific end date for reporting back to the Directing Council or the Pan American Sanitary Conference;
  - b) present similar analyses of resolutions at least every three years in order to sunset resolutions as appropriate.

*(Sixth meeting, 22 June 2016)*

***CE158.R10: Amendments to the PASB Staff Regulations and Rules***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having considered the amendments to the Staff Rules of the Pan American Sanitary Bureau submitted by the Director in Annex A to Document CE158/31;

Taking into account the United Nations General Assembly's approval of the amended base/floor salary scale for the professional and higher categories;

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

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

***RESOLVES:***

1. To confirm, in accordance with Staff Rule 020, the Staff Rule amendments that have been made by the Director effective 1 July 2016 concerning financial responsibility, notification and effective date of change in status, annual leave, approving, reporting and recording of leave, and medical examination on separation (see Annex).
2. To establish the annual salary of the Assistant Director of the Pan American Sanitary Bureau, beginning from 1 January 2016, at US\$ 175,034 before staff assessment, resulting in a modified net salary of \$136,024 (dependency rate) or \$123,080 (single rate).
3. To establish the annual salary of the Deputy Director of the Pan American Sanitary Bureau, beginning on 1 January 2016, at \$176,463 before staff assessment, resulting in a modified net salary of \$137,024 (dependency rate) or \$124,080 (single rate).



4. To establish the annual salary of the Director of the Pan American Sanitary Bureau, beginning on 1 January 2016, at \$194,136 before staff assessment, resulting in a modified net salary of \$149,395 (dependency rate) or \$134,449 (single rate).

Annex

## Annex

**PROPOSED AMENDMENTS TO THE STAFF RULES OF THE  
PAN AMERICAN SANITARY BUREAU**

**130 Financial Responsibility**

Staff members shall exercise reasonable care in any matter affecting the financial interests of the Organization, its physical and human resources, property, and assets.

**580 Notification and Effective Date of Change in Status**

...

**580.2** A staff member shall be notified in writing in advance of any reduction in grade or salary, the notice period being the same as that specified for termination in Staff Rule 1050.3.

**630 Annual Leave**

...

**630.3** Annual leave accrues to all staff members except:

...

**630.3.3** to those on sick leave under insurance coverage in excess of 30 days;

**670 Approval, Reporting, and Recording of Leave**

The granting of leave under Staff Rules 625, 630, 640, 650 and 655 is subject to the exigencies of service and must be approved in advance by authorized officials. The personal circumstances of the staff member shall be considered to the extent possible. It is the staff member's responsibility to ensure that all leave taken is promptly reported and recorded.

**1085 Medical Examination on Separation**

Prior to separation a staff member may be required to undergo a medical examination by the Staff Physician or by a physician designated by the Bureau. If a staff member fails to undergo this medical examination within a reasonable time limit fixed by the Bureau, then claims against the Bureau arising out of illness or injury which allegedly occurred before the effective date of separation shall not be entertained; furthermore, the effective date of separation shall not be affected.

*(Seventh meeting, 23 June 2016)*

***CE158.R11: Health of Migrants***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed policy document *Health of Migrants* (Document CE158/16, Rev. 1),

***RESOLVES:***

To recommend that the Directing Council adopt a written resolution in the following terms:

**HEALTH OF MIGRANTS**

***THE 55th DIRECTING COUNCIL,***

Having reviewed the policy document *Health of Migrants* (Document CD55/\_\_);

Recognizing that human migration is one of the most challenging priorities in global public health;

Considering that the Universal Declaration of Human Rights and international law recognize the right of individuals to leave any country, including their own, and that the rights and freedoms set forth in the Declaration, including health-related rights, belong to all persons, including migrants, refugees, and other non-nationals;

Considering the urgent need for the majority of countries to strengthen their health systems including from the perspective of the right to health where nationally recognized and promoting the right to the enjoyment of the highest attainable standard of health, with the fundamental goals of achieving universal access to health and universal health coverage;

Recognizing that the plight of migrants has been increasingly recognized and its prominence reflected on the international agenda, more recently in the 2030 Agenda for Sustainable Development;

Observing that for decades PAHO Member States have prioritized the health of migrant and displaced populations, generating arrangements for collaborative responses, and recognizing that PAHO has approved several resolutions that promote the incorporation of the respect for human rights and human security in country health policies, plans, programs, and health-related laws to strengthen the resilience of members of migrant populations in the highest conditions of vulnerability;

Noting that PAHO Member States have demonstrated a heightened appreciation for the development of health policies and programs to address health inequities and improve access to health services;

Recognizing that the Strategy for Universal Access to Health and Universal Health Coverage, adopted by Resolution CD53.R14 (2014), constitutes a framework for the action of health systems to protect the health and well-being of migrants, and recognizing the contributions of prior PAHO strategies and mandates that deal with this issue and are aligned with other related strategies and commitments, including the 2030 Sustainable Development Goals,

**RESOLVES:**

1. To support the policy document *Health of Migrants* (Document CD55/\_\_\_).
2. To urge the Member States, as appropriate to their context, to:
  - a) utilize this policy document in their efforts to generate health policies and programs to address health inequities that affect migrants and to develop targeted interventions to reduce migrants' health risks by strengthening programs and services that are sensitive to their conditions and needs;
  - b) lead the effort to modify or improve regulatory and legal frameworks in order to address the specific health needs of migrant individuals, families, and groups;
  - c) advance towards providing migrants with access to the same level of financial protection,<sup>1</sup> and of comprehensive, quality, progressively expanded health services that other people living in the same territory enjoy, regardless of their migratory or legal status.
3. To request the Director to:
  - a) use the policy document *Health of Migrants* to increase advocacy and promote the mobilization of national resources to develop policies and programs that are sensitive to the health needs of migrant populations;
  - b) develop actions, technical resources, and tools to support the inclusion of the proposed policy elements within PAHO's program of work;
  - c) strengthen interagency coordination and collaboration mechanisms to achieve synergies and efficiency in technical cooperation, including within the United Nations system, and particularly with the International Organization for Migration,

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<sup>1</sup> Financial protection, as established in the Strategy for Universal Access to Health and Universal Health Coverage (Document CD53/5, Rev. 2 [2014]) is a means to "advance toward the elimination of direct payment [...] that constitutes a barrier to access at the point of service, avoiding impoverishment and exposure to catastrophic expenditures. Increasing financial protection will reduce inequity in the access to health services".

- the Inter-American system, and other stakeholders working toward improving the health and protection of migrants in countries of origin, transit, and destination;
- d) facilitate the exchange of experiences among Member States, and generate a repository of information on relevant experiences in the countries of the Region of the Americas.

*(Seventh meeting, 23 June 2016)*

***CE158.R12: Resilient Health Systems***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed *Resilient Health Systems* policy document (Document CE158/14),

***RESOLVES:***

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

**RESILIENT HEALTH SYSTEMS**

***THE 55th DIRECTING COUNCIL,***

Having reviewed the *Resilient Health Systems* policy document (Document CD55/\_\_\_);

Bearing in mind that the health situation of the Americas has improved considerably in recent decades, that social policies aiming to alleviate poverty and improve health and well-being have resulted in significant improvements in life expectancies and health outcomes, and that national health systems are more inclusive and responsive;

Cognizant that policies supporting sustained development and investment in health systems and social and economic stability contribute both directly and indirectly to improved health and well-being, alleviation of poverty, elimination of inequities, and health system resilience;

Observing that health systems remain highly vulnerable to risks that significantly impact local, national, and global health, debilitating the response capacity of health systems and eliminating gains in health outcomes and social and economic development;

Deeply concerned by global disease outbreaks such as the Ebola, chikungunya, and Zika virus outbreaks that have highlighted important structural weaknesses in health systems, particularly weaknesses related to health surveillance, response, and information systems, to the implementation of strategies for infection prevention and control, to the

competencies and capacities of health professionals, to health financing and mobilization of financial resources, and to the organization and delivery of health services;

Noting that fragmented approaches to public health preparedness, including application of the International Health Regulations (IHR or Regulations), constitute a major risk to health and well-being and to social and economic development;

Recalling article 44 of the Regulations and the commitment made by Member States at the 65th World Health Assembly (2012) to further strengthen active collaboration among States Parties, WHO and other relevant organizations and partners, as appropriate, in order to ensure the implementation of the IHR (Resolution WHA65.23 [2012], Document A68/22, Add. I [2015], and Resolution WHA68.5 [2015]), including establishing and maintaining core capacities;

Recognizing that while disease outbreaks and disasters caused by natural phenomena and the impact of climate change represent high-level, immediate risks to the health and well-being of the population, other, more long-term internal and external risks—for example, lack of sustained development, social instability, weak stewardship and capacity in essential public health functions, demographic transitions, migration and rapid urbanization, economic crises, and the growing burden and impact of non-communicable diseases and their corresponding risk factors—affect the sustainability and responsiveness of health systems and influence health outcomes;

Noting that economic downturns remain one of the principal risks affecting health system responsiveness, adaptiveness, and resilience;

Cognizant that the Strategy for Universal Access to Health and Universal Health Coverage (2014), the values of solidarity and equity, and the urgent need for the majority of countries to strengthen their health systems, including from the perspective of the right to health where nationally recognized and the right to the enjoyment of the highest attainable standard of health, provide the foundation for continued health system development in the Americas;

Recognizing that resilience is a critical attribute of a well-developed and well-performing health system whereby health actors, institutions, and populations prepare for and effectively respond to crises, maintain core functions when a crisis hits, and, informed by lessons learned, reorganize if conditions require it;

Bearing in mind that resilient health systems are information- and evidence-informed, responsive, predictive, complex, adaptive, robust, integrated, participatory, and people- and community-centered;

Aware that increasing levels of integration, migration, disasters, and regional/global disease outbreaks highlight the interdependence of national health systems within the global health system framework;

Recalling relevant global frameworks and agreements, including the Sustainable Development Goals, the Paris Agreement on Climate Change, the Sendai Framework for Disaster Risk Reduction, and the International Health Regulations, as well as relevant PAHO mandates, particularly the Strategy for Universal Access to Health and Universal Health Coverage,

***RESOLVES:***

1. To support the *Resilient Health Systems* policy (Document CD55/\_\_\_).
2. To urge Member States to:
  - a) support the development of resilient health systems and societies in the framework of achievement of the Sustainable Development Goals;
  - b) develop resilience in health systems through integration of actions in the core policy areas of health system strengthening, social determinants of health, risk reduction, and public health surveillance and disease outbreak management, implemented within the framework of national sustainable development objectives;
  - c) work in accordance with the national context to gradually develop the resilience of health systems within the framework of the Strategy for Universal Access to Health and Universal Health Coverage;
  - d) build reserve capacity (health workers, financing, medicines, and health technologies) to scale up the response of health services in the event of an acute or sustained risk to the system and to support and coordinate the response of the health service network to the needs of individuals and the community;
  - e) implement a holistic and multisectoral approach to the IHR, including developing, strengthening, and maintaining the capacities and functions called for in the Regulations, as part of strengthening essential public health functions, by embedding the Regulations in national health policy and planning processes, in legislative actions and regulatory frameworks, and in efforts to strengthen the capacity of institutions, networks, and human resources to respond to disease outbreaks of international concern; and work with other partners to support States Parties' IHR implementation;
  - f) strengthen health information systems that support the identification and isolation of public health risks, capture in a timely manner impending risks, and support measured and targeted responses, reporting on system capacity (e.g., health service delivery and utilization, human resource mapping, availability of health financing, and availability of medicines and health technologies), and decision making related to rapid reorganization of health systems and services;
  - g) develop multisectoral frameworks and implement multisectoral actions that focus on risk management and on strengthening the resilience of the health system;

- h) maintain and increase investments in health systems and actions to improve their resilience, in line with the orientations of the Strategy for Universal Access to Health and Universal Health Coverage;
  - i) promote research on the characteristics of resilient health systems to generate further evidence on gaps and on linkages with system resilience.
3. To request the Director to:
- a) provide support to countries, within the framework of the Sustainable Development Goals, in their development of multisectoral plans and strategies that support health system resilience and improved health and well-being;
  - b) advocate, among countries and partners, the importance of resilient health systems and their characteristics, as well as the integrated and long-term actions required to build such systems;
  - c) continue to support countries in strengthening their health systems and developing national plans towards universal access to health and universal health coverage;
  - d) support the development of reserve capacity in health systems (health workers, financing, medicines, and health technologies) to scale up the response of health services in the event of an acute or sustained risk to the system;
  - e) support the response of the health service network to the needs of individuals and the community;
  - f) promote a holistic approach in the application of the IHR through the strengthening of essential public health functions and continue to provide technical cooperation to countries in the assessment of health system readiness in the event of a disease outbreak of international concern;
  - g) provide support to countries in the development of health information systems to improve health surveillance and to monitor system capacity to detect, predict, adapt, and respond;
  - h) intensify cooperation in disaster and other risk reduction efforts within health systems, in the assessment and evaluation of risk, and in risk management, contributing to health system resilience;
  - i) continue to strengthen PAHO efforts to develop scientific evidence on resilient health systems, promote health systems research, and develop methodologies for the assessment of health system performance in situations of risk or stress;
  - j) promote the strengthening of regional cooperation strategies that include information systems, identification of real needs, and support mechanisms, to be considered by the States through their internally defined structures.

*(Seventh meeting, 23 June 2016)*



***CE158.R13: PAHO Award for Administration (2016)***

***The 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having examined the *Report of the Award Committee of the PAHO Award for Administration (2016)* (Document CE158/5, 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), and by the Executive Committee at its 124th (1999), 135th (2004), 140th (2007), and 146th (2010) sessions,

***RESOLVES:***

1. To congratulate the candidates for the PAHO Award for Administration (2016) for their professionalism and outstanding work on behalf of their countries and the Region.
2. The Award Committee recommended that the PAHO Award for Administration (2016) be granted to Dr. Pastor Castell-Florit Serrate, of Cuba, for his commendable contributions to public health, reflected in his leadership in the management and administration of the National Health System of Cuba. Dr. Pastor Castell-Florit Serrate is recognized for his professional trajectory and his contributions to research and teaching on the administrative management of health systems, as is corroborated by the positions he has held and his numerous publications in national and international journals.
3. To transmit the *Report of the Award Committee of the PAHO Award for Administration (2016)* (Document CE158/5, Add. I), to the 55th Directing Council.

*(Eighth meeting, 23 June 2016)*

***CE158.R14: PAHO Award for Administration – Changes to the Procedures***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having examined the proposed amendments to the procedures for conferring the PAHO Award for Administration (Document CE158/6, Rev. 2);

Considering that in 2015 the Executive Committee, in its 156th Session, adopted Resolution CE156.R12, in which it requested a review of the general procedures for conferring this award in order to enhance its importance and encourage Member States to present candidates of excellence in the corresponding area;

Given that, in accordance with Resolution CE156.R12, the Pan American Sanitary Bureau prepared changes to the procedures that were reviewed by a working group formed

specifically for this purpose by the Subcommittee on Program, Budget, and Administration in its 10th Session,

***RESOLVES:***

1. To approve the name change of the award to “PAHO Award for Health Services Management and Leadership” and the amendments to the procedures for conferring this Award as shown in the Annex.
2. To transmit the new procedures for conferring the “PAHO Award for Health Services Management and Leadership” to the 55th Directing Council.

Annex

**Annex**

**PAHO Award for Health Services Management and Leadership**

1. In order to contribute to the improved management of health systems and services, and to recognize significant contributions and leadership in the development and implementation of initiatives that have facilitated the management and expansion of quality comprehensive health services within health systems in the Americas, the Pan American Health Organization is renaming the PAHO Award for Administration as the PAHO Award for Health Services Management and Leadership. The Award will be given annually on a competitive basis and will consist of a diploma and the sum of US\$ 5,000. This sum will be reviewed as appropriate by the Executive Committee on the recommendation of the Director of the Pan American Sanitary Bureau.
2. The Award will be conferred on a candidate who has made a significant contribution in his/her home country and/or throughout the Region of the Americas to improve the development of health systems; the organization, management, and administration of health services; the development of programs, projects, or initiatives that have demonstrated impact on population coverage and access to health services; the expansion of health services to meet the needs of the population, in particular those in situations of greatest vulnerability; the development of quality programs and patient safety programs at the national or institutional level; the organization and management of primary care services at the community level; the development of integrated networks of health services including hospital services; or the production of knowledge and research to achieve change in health service delivery. The Award is conferred in recognition of work completed in the 10 preceding years.
3. Current and former staff members of the Pan American Sanitary Bureau and the World Health Organization are ineligible to be nominated for this Award for activities carried out in the course of their assigned duties in the Organization.
4. The Award Committee will be selected each year during the first session of the Executive Committee and its term will be only for the length of that selection process. The Executive Committee will appoint an Award Committee consisting of the President of the Executive Committee and a delegate and alternate from each subregion. If, despite the appointment of alternate delegates, a vacancy were to occur, the President will make arrangements to cover it. When candidates are submitted from the same Member States represented on the Award Committee, the President of the Executive Committee will designate the alternate delegate from the corresponding subregion.
5. The Director of the Pan American Sanitary Bureau will invite Member States to submit no more than two nominations for the Award. The Bureau will issue an open call for candidates during the first week of November each calendar year. The names of candidates proposed by each Member State must be received by the Director of the Pan American Sanitary Bureau no later than 31 March in the year of the Award, together with

the candidates' curriculum vitae and the documentation supporting the merits of the candidacy. This documentation will include a brief narrative describing the contribution of the candidate's work in the relevant field (see article 2 above). To facilitate the work of the Award Committee, the required information on each candidate will be presented on the standard form provided by the Pan American Sanitary Bureau and included in the call for candidates. This form and the documentation supporting the candidate's merits must be completed in full, with explicit responses to each of the questions. All documentation must be submitted in original form.

6. Nominations received by the Director of the Pan American Sanitary Bureau after 31 March will not be considered for the Award.

7. The Director of the Pan American Sanitary Bureau will forward to the members of the Award Committee copies of the documentation submitted no less than 45 days before the date of the opening of the June session of the Executive Committee. To support the deliberations of the Award Committee, the Pan American Sanitary Bureau will also provide technical comments and any other information on candidates it may deem relevant to the deliberations of the Award Committee.

8. The Award Committee will meet and deliberate on the proposed candidates and will submit its recommendations during the week of the session of the Executive Committee. At least three members of the Award Committee must be present to make a meeting valid. The deliberations of the Award Committee are confidential and not for discussion outside of the Award Committee. The Award Committee will make a recommendation to the Executive Committee, approved by a majority of members present. The Executive Committee will have the final decision on accepting or rejecting recommendations of Award, with the possibility of further deliberations and recommendations by the Award Committee.

9. Candidates not elected may be renominated, following the procedure described above.

10. The winner of the Award will be proclaimed during the Directing Council or the Pan American Sanitary Conference.

11. The Award will be presented to the successful candidate during the appropriate meeting of the Directing Council or the Pan American Sanitary Conference. The cost of his or her travel will be paid by the Pan American Sanitary Bureau, which will make such arrangements in accordance with PAHO's rules and regulations.

12. When such presentation is not practicable, alternatives will include:

- a) receipt of the Award at the Directing Council or the Pan American Sanitary Conference by a member of the delegation of the recipient's country, on his/her behalf;

- b) presentation in the home country by the PAHO/WHO Representative on behalf of the Director of the Pan American Sanitary Bureau.

13. Whatever method is used to present the Award, it will be accompanied by appropriate publicity issued to the news media, both by the Pan American Sanitary Bureau and the government concerned.

14. These procedures may be reviewed by the Executive Committee at any time, as deemed appropriate in light of acquired experience. Proposed amendments must be approved by the Executive Committee and transmitted to the Directing Council or the Pan American Sanitary Conference for its information.

*(Eighth meeting, 23 June 2016)*

***CE158.R15: Nongovernmental Organizations in Official Relations with PAHO***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having considered the report of the Subcommittee on Program, Budget, and Administration on *Nongovernmental Organizations in Official Relations with PAHO* (Document CE158/7);

Mindful of the provisions of the *Principles Governing Relations between the Pan American Health Organization and Nongovernmental Organizations*,

***RESOLVES:***

1. To renew official working relations between PAHO and the following nongovernmental organizations for a period of four years:

- a) Healthy Caribbean Coalition (HCC),
- b) Inter-American College of Radiology (ICR),
- c) Interamerican Society of Cardiology (IASC),
- d) Latin American and Caribbean Women's Health Network (LACWHN)
- e) Latin American Association of Pharmaceutical Industries (ALIFAR, Spanish acronym),
- f) Latin American Federation of Hospitals (FLH, Spanish acronym),
- g) Panamerican Federation of Associations of Medical Schools (PAFAMS),
- h) Pan American Federation of Nursing Professionals (FEPPEN, Spanish acronym).

2. To admit *Mundo Sano* into official relations with PAHO for a period of four years.

3. To take note of the progress report on the status of relations between PAHO and nongovernmental organizations.
4. To request the Director to:
  - a) advise the respective nongovernmental organizations of the decisions taken by the Executive Committee;
  - b) continue developing dynamic working relations with inter-American nongovernmental organizations of interest to the Organization in areas that fall within the programmatic priorities that the Governing Bodies have adopted for PAHO;
  - c) continue fostering relationships between Member States and nongovernmental organizations working in the field of health.

*(Eighth meeting, 23 June 2016)*

***CE158.R16: Access and Rational Use of Strategic and High-Cost Medicines and Other Health Technologies***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having reviewed the proposed policy document *Access and Rational Use of Strategic and High-Cost Medicines and Other Health Technologies* (Document CE158/15),

***RESOLVES:***

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

## **ACCESS AND RATIONAL USE OF STRATEGIC<sup>1</sup> AND HIGH-COST MEDICINES AND OTHER HEALTH TECHNOLOGIES**

### ***THE 55th DIRECTING COUNCIL,***

Having reviewed the policy document *Access and Rational Use of Strategic and High-Cost Medicines and Other Health Technologies* (Document CD55/\_\_\_);

Considering that the Constitution of the World Health Organization (WHO) establishes as one of its basic principles that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition”; and observing that countries of the Region affirmed in Resolution CD53.R14 “the right to health where nationally recognized and promoting the right to the enjoyment of the highest attainable standard of health”;

Recalling Resolution CD53.R14 (2014) on Universal Access to Health and Universal Health Coverage, and United Nations Resolution A/RES/70/1 adopting the Agenda 2030 for Sustainable Development, including Goal number 3, “Ensure healthy lives and promote well-being for all at all ages”;

Recognizing that improving equitable access to and the rational use of medicines and other health technologies contributes to achieving universal access to health and universal health coverage and the achievement of the Sustainable Development Goals;

Taking into consideration that the adoption and implementation of comprehensive policies, laws, regulations, and strategies contribute to improving access to medicines and other health technologies, including those considered strategic and of high cost, and the quality of health services and health outcomes, while ensuring the sustainability of health systems;

Taking into account that a number of high-cost medicines and other health technologies are now considered essential and can significantly improve quality of life and health outcomes when used in accordance with evidence-based clinical practice guidelines;

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<sup>1</sup> A “strategic public health supply” is a product that satisfies the following criteria: it is listed, recognized and recommended by a WHO Expert Committee or Working Group (e.g. essential medicines, WHOPES recommended compounds, HIV diagnostics etc.); it is included in WHO recommended protocols or diagnostic algorithms and is considered highly effective in disease treatment or prevention; when continuously available, it significantly contributes to improvements in mortality rates and patient quality of life, and/or minimizes possibilities of drug resistance in treatment; it is subject to particular challenges in areas of product sourcing, pricing, forecasting, and purchasing; economies of scale are achievable as volumes purchased increase.

[http://www.paho.org/hq/index.php?option=com\\_content&view=article&id=1044&Itemid=989&lang=en#9](http://www.paho.org/hq/index.php?option=com_content&view=article&id=1044&Itemid=989&lang=en#9)

Recognizing that the adoption of some new and high-cost medicines and other health technologies incorporated into health systems do not provide significant added value as they displace effective lower-cost treatments;

Recognizing the need to improve access through comprehensive approaches that focus on improving availability, affordability, and rational use within health systems, as well as the selection processes described in World Health Assembly Resolution WHA67.22;

Recognizing the challenges currently faced by Member States in ensuring access and rational use of high-cost medicines and other health technologies,

***RESOLVES:***

1. To urge Member States, taking into account their context and national priorities, to:
  - a) adopt comprehensive national policies and/or strategies, together with legal and regulatory frameworks, to improve access to clinically effective and cost-effective medicines and other health technologies, which consider the needs of health systems and take into account the overall life-cycle of the medical products from research and development to quality assurance and use, including prescribing and dispensing, and which disincentivize inappropriate demands for medicines and health technologies that are costly and ineffective, or that do not offer sufficient benefits over lower cost alternatives;
  - b) in order to improve the efficacy and efficiency of health systems, *i*) strengthen health institutions, mechanisms, and regulatory capacities to promote good governance and evidence-based decision making on the quality, safety, efficacy and the optimal use of medicines and other health technologies, and *ii*) promote transparency and accountability in the allocation of resources for medicines and other health technologies;
  - c) evaluate and regularly review formularies and lists of essential medicines through transparent and rigorous selection processes and mechanisms based on evidence and informed by health technologies assessment methodologies to meet health needs;
  - d) promote adequate financing and financial protection mechanisms to foster the sustainability of the health system, to improve access and to advance toward the elimination of direct payments—a barrier to access at the point of service—, in order to avoid financial difficulties, impoverishment, and exposure to catastrophic expenditures;
  - e) work together with the pharmaceutical sector to improve transparency and access to timely and comprehensive information, including in relation to comprehensive research and development costs and trends, as well as pricing policies and price structures, supply chain management, and procurement practices in order to



- improve decision-making, avoid waste, and improve affordability of medicines and other health technologies;
- f) strengthen institutional capacities to produce quality health technology assessments of new medicines and other health technologies before their introduction into health systems, with special attention to those considered of high cost;
  - g) promote competition through comprehensive strategies, which may include intellectual property policies that take into account the public health perspective considering the maximization of health-related innovation, the establishment of incentives and regulations that permit the prompt entry and uptake of quality multisource generic medicines<sup>2</sup> and/or therapeutic equivalents, the reduction of tariffs, and the adoption of joint procurement mechanisms that limit fragmentation by pooling the demand;
  - h) adopt effective strategies to improve access to single source or limited source products such as, but not limited to, transparent national and international price negotiations, reimbursement, and pricing policies and strategies, and when appropriate, the use of flexibilities affirmed by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;
  - i) adopt measures to promote access to information on medical products that is impartial and free of conflicts of interest, for health authorities, health professionals, and the general population, in order to promote the rational use of medicines and other health technologies and to improve the prescription and dispensing; and monitor the safe and effective use of these products through solid pharmacovigilance and technovigilance systems;
  - j) recognize the role of prescribers in decisions relating to treatment options and provide support to improve practices so that prescriptions are appropriate, ethical, and based on rational use, employing tools such as clinical practice guidelines, educational strategies, and regulations to address conflicts of interest between prescribers and manufacturers of medical products;
  - k) develop frameworks, including through consultations with all relevant stakeholders, that define ethical principles which, from a public health perspective, guide the development of pharmaceutical advertising and marketing, and codes of conduct that guide the ethical behavior of pharmaceutical representatives;

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<sup>2</sup> WHO uses the term “multisource pharmaceutical products”, defined as “pharmaceutically equivalent or pharmaceutically alternative products that may or may not be therapeutically equivalent. Multisource pharmaceutical products that are therapeutically equivalent are interchangeable” (WHO Expert Committee on Specifications for Pharmaceutical Preparations, WHO Technical Report Series 937, 2006, available at <http://apps.who.int/medicinedocs/documents/s14091e/s14091e.pdf>).

- l) promote the adoption of instruments to improve the quality of examination of patent applications for pharmaceuticals and other health technologies, and to facilitate examiners' access to the necessary information for appropriate decision-making;
  - m) promote the work of national health authorities and other competent authorities, according to the national context, on issues related to patents for pharmaceuticals and other health technologies, and to patenting practices, promoting health-related innovation and fostering market competition.
2. To request the Director to:
- a) support Member States in the development of comprehensive policies and legal frameworks<sup>3</sup> for medicines and health technologies that promote access to essential and strategic medicines and other health technologies, including those considered high-cost;
  - b) support Member States in the development, implementation, and/or review of national legal and regulatory frameworks, policies, and other provisions that permit the prompt entry and uptake of quality multisource generic medicines and/or therapeutic equivalents through comprehensive strategies from a public health perspective;
  - c) support Member States in building capacities and adopting strategies to improve the selection and rational use of medicines and other health technologies based on health technology assessments and other evidence-based approaches to improve health outcomes and efficiencies;
  - d) promote cooperation and the sharing of information, successful experiences, and technical capacity with respect to the cost-effectiveness of medicines and other health technologies, supply chain issues, and best practices in pricing, among other topics, through PAHO's channels and networks, and synthesize and report progress made by Member States in key areas;
  - e) continue to strengthen the PAHO Regional Revolving Fund for Strategic Public Health Supplies and the PAHO Revolving Fund to provide ongoing support to Member States on all aspects related to making quality medicines and health technologies available and more affordable, including providing a platform for supporting participating Member States in the pooling, negotiation, and procurement of high-cost single source and limited source medicines;
  - f) support and encourage the Member States to develop and adopt frameworks that define ethical principles which, from a public health perspective, guide the development of pharmaceutical advertising and marketing, and codes of conduct that guide the behavior of pharmaceutical representatives;

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<sup>3</sup> In accordance with Resolution CD54.R9.

- g) promote the identification and coordination of initiatives that address access to high-cost medicines and other health technologies in the Region in order to contribute to their efficiency and prevent duplication.

*(Ninth meeting, 24 June 2016)*

***CE158.R17: Provisional Agenda of the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas***

***THE 158th SESSION OF THE EXECUTIVE COMMITTEE,***

Having examined the provisional agenda (Document CD55/1) prepared by the Director for the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas, presented as Annex A to Document CE158/3, 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 CD55/1) prepared by the Director for the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas.

*(Ninth meeting, 24 June 2016)*

***Decisions***

***Decision CE158(D1): Adoption of the Agenda***

Pursuant to Rule 9 of the Rules of Procedure of the Executive Committee, the Committee adopted the agenda submitted by the Director, as amended by the Committee (Document CE158/1, Rev. 3).

*(First meeting, 22 June 2015)*

***Decision CE158(D2): Representation of the Executive Committee at the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas***

Pursuant to Rule 54 of its Rules of Procedure, the Executive Committee decided to appoint Ecuador and Costa Rica, its President and Vice President, respectively, to represent the Committee at the 55th Directing Council of PAHO, 68th Session of the

Regional Committee of WHO for the Americas. Argentina and the United States of America were elected as alternate representatives.

*(Ninth meeting, 24 June 2016)*

***Decision CE158(D3):            Programming of the Budget Surplus***

The Executive Committee endorsed the proposal for programming of the budget surplus as set out in Document CE158/24.

*(Seventh meeting, 23 June 2016)*

IN WITNESS WHEREOF, the President of the Executive Committee, Delegate of Ecuador, 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-fourth day of June in the year two thousand sixteenth. The Secretary shall deposit the original texts in the archives of the Pan American Sanitary Bureau. The Final Report will be published on the webpage of the Pan American Health Organization once approved by the President.

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Margarita Guevara Alvarado  
President of the 158th Session of the  
Executive Committee  
Delegate of Ecuador

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Carissa Etienne  
Secretary ex officio of the  
158th Session of the Executive Committee  
Director of the  
Pan American Sanitary Bureau

**Annex A**

**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 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas
- 2.3 Draft Provisional Agenda of the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas

**3. COMMITTEE MATTERS**

- 3.1 Report on the 10th Session of the Subcommittee on Program, Budget, and Administration
- 3.2 PAHO Award for Administration (2016)
- 3.3 PAHO Award for Administration: Changes to the Procedures
- 3.4 Nongovernmental Organizations in Official Relations with PAHO
- 3.5 Annual Report of the Ethics Office (2015)
- 3.6 Report of the Audit Committee of PAHO
- 3.7 Appointment of One Member to the Audit Committee of PAHO

**4. PROGRAM POLICY MATTERS**

- 4.1 Preliminary Report of the End-of-biennium Assessment of the Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019
  - 4.2 Interim Assessment of the Implementation of the PAHO Budget Policy
-

**4. PROGRAM POLICY MATTERS** *(cont.)*

- 4.3 Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan
- 4.4 Resilient Health Systems
- 4.5 Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies
- 4.6 Health of Migrants
- 4.7 Plan of Action for Malaria Elimination 2016-2020
- 4.8 Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021
- 4.9 Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022
- 4.10 Strategy for Arboviral Disease Prevention and Control
- 4.11 Plan of Action for Disaster Risk Reduction 2016-2021
- 4.12 Analysis of the Mandates of the Pan American Health Organization

**5. ADMINISTRATIVE AND FINANCIAL MATTERS**

- 5.1 Report on the Collection of Assessed Contributions
- 5.2 Financial Report of the Director and Report of the External Auditor for 2015
- 5.3 Programming of the Budget Surplus
- 5.4 Programming of the Revenue Surplus
- 5.5 After-service Health Insurance
- 5.6 Report on the Master Capital Investment Fund
- 5.7 Report of the Office of Internal Oversight and Evaluation Services
- 5.8 Update on the Appointment of the External Auditor of PAHO for 2018-2019 and 2020-2021

**6. PERSONNEL MATTERS**

- 6.1 PASB Staffing Statistics
- 6.2 Amendments to the PASB Staff Regulations and Rules
- 6.3 Statement by the Representative of the PAHO/WHO Staff Association

**7. MATTERS FOR INFORMATION**

- 7.1 PAHO Program and Budget 2016-2017: Mechanisms for Interim Reporting to Member States
- 7.2 Process for the Development of the WHO Program Budget 2018-2019
- 7.3 Update on WHO Reform
- 7.4 Status of the PASB Management Information System (PMIS)
- 7.5 Implementation of the International Health Regulations (IHR)
- 7.6 Update on the Zika Virus in the Region of the Americas
- 7.7 Implementation of the Sustainable Development Goals in the Region of the Americas
- 7.8 Regional Plan of Action for Strengthening Vital and Health Statistics: Final Report
- 7.9 Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006-2015: Final Report
- 7.10 Strategy and Plan of Action for the Reduction of Chronic Malnutrition: Final Report
- 7.11 Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Region of the Americas: Final Report
- 7.12 Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: Final Report
- 7.13 Progress Reports on Technical Matters:
  - A. Strategy and Plan of Action on *eHealth*: Midterm Review
  - B. Plan of Action on Adolescent and Youth Health



**7. MATTERS FOR INFORMATION** (*cont.*)

7.13 Progress Reports on Technical Matters (*cont.*)

- C. Plan of Action for the Prevention and Control of Noncommunicable Diseases: Midterm Review
- D. Plan of Action to Reduce the Harmful Use of Alcohol: Midterm Review
- E. Plan of Action on Psychoactive Substance Use and Public Health: Midterm Review
- F. Status of the Pan American Centers

7.14 Resolutions and Other Actions of Intergovernmental Organizations of Interest to PAHO:

- A. Sixty-ninth World Health Assembly
- B. Subregional Organizations

**8. OTHER MATTERS**

**9. CLOSURE OF THE SESSION**

**Annex B**

**LIST OF DOCUMENTS**

**Official Documents**

*Off. Doc. 351* Financial Report of the Director and Report of the External Auditor for 2015

**Working Documents**

CE158/1, Rev. 1	Adoption of the Agenda and Program of Meetings
CE158/2	Representation of the Executive Committee at the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas
CE158/3, Rev. 1	Draft Provisional Agenda of the 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas
CE158/4	Report on the 10th Session of the Subcommittee on Program, Budget, and Administration
CE158/5 and Add. I	PAHO Award for Administration (2015)
CE158/6, Rev. 2	PAHO Award for Administration: Changes to the Procedures
CE158/7	Nongovernmental Organizations in Official Relations with PAHO
CE158/8	Annual Report of the Ethics Office (2015)
CE158/9	Report of the Audit Committee of PAHO
CE158/10	Appointment of One Member to the Audit Committee of PAHO
CE158/11, Rev. 1	Preliminary Report of the End-of-biennium Assessment of the Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019
CE158/12	Interim Assessment of the Implementation of the PAHO Budget Policy
CE158/13	Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan

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**Working documents** (*cont.*)

CE158/14	Resilient Health Systems
CE158/15	Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies
CE158/16, Rev. 1	Health of Migrants
CE158/17, Rev. 1	Plan of Action for Malaria Elimination 2016-2020
CE158/18, Rev. 1	Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021
CE158/19	Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022
CE158/20, Rev. 1	Strategy for Arboviral Disease Prevention and Control
CE158/21	Plan of Action for Disaster Risk Reduction 2016-2021
CE158/22	Analysis of the Mandates of the Pan American Health Organization
CE158/23 and Add. I	Report on the Collection of Assessed Contributions
CE158/24	Programming of the Budget Surplus
CE158/25	Programming of the Revenue Surplus
CE158/26	After-service Health Insurance
CE158/27	Report on the Master Capital Investment Fund
CE158/28	Report of the Office of Internal Oversight and Evaluation Services
CE158/29	Update on the Appointment of the External Auditor of PAHO for 2018-2019 and 2020-2021
CE158/30	PASB Staffing Statistics
CE158/31	Amendments to the PASB Staff Regulations and Rules
CE158/32	Statement by the Representative of the PAHO/WHO Staff Association

## Information Documents

CE158/INF/1	PAHO Program and Budget 2016-2017: Mechanisms for Interim Reporting to Member States
CE158/INF/2	Process for the Development of the WHO Program Budget 2018-2019
CE158/INF/3	Update on WHO Reform
CE158/INF/4	Status of the PASB Management Information System (PMIS)
CE158/INF/5 and Add. I	Implementation of the International Health Regulations (IHR)
CE158/INF/6	Update on the Zika Virus in the Region of the Americas
CE158/INF/7	Implementation of the Sustainable Development Goals in the Region of the Americas
CE158/INF/8	Regional Plan of Action for Strengthening Vital and Health Statistics: Final Report
CE158/INF/9	Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006-2015: Final Report
CE158/INF/10	Strategy and Plan of Action for the Reduction of Chronic Malnutrition: Final Report
CE158/INF/11	Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Region of the Americas: Final Report
CE158/INF/12	Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: Final Report
CE158/INF/13	Progress Reports on Technical Matters <ul style="list-style-type: none"> <li>A. Strategy and Plan of Action on <i>eHealth</i>: Midterm Review</li> <li>B. Plan of Action on Adolescent and Youth Health</li> <li>C. Plan of Action for the Prevention and Control of Noncommunicable Diseases: Midterm Review</li> <li>D. Plan of Action to Reduce the Harmful Use of Alcohol: Midterm Review</li> </ul>

**Information Documents** (*cont.*)

E. Plan of Action on Psychoactive Substance Use and Public Health: Midterm Review

F. Status of the Pan American Centers

CE158/INF/14

Resolutions and Other Actions of Intergovernmental Organizations of Interest to PAHO

A. Sixty-ninth World Health Assembly

B. Subregional Organizations

**Annex C**

**LIST OF PARTICIPANTS/LISTA DE PARTICIPANTES**

**OFFICERS / MESA DIRECTIVA**

<b>President / Presidente:</b>	Dra. Margarita Guevara Alvarado (Ecuador)
<b>Vice-President / Vicepresidente:</b>	Dra. María Esther Anchía (Costa Rica)
<b>Rapporteur / Relator:</b>	Dr. Rhonda Sealey-Thomas (Antigua and Barbuda)

**MEMBERS OF THE EXECUTIVE COMMITTEE / MIEMBROS DEL COMITÉ EJECUTIVO**

**ANTIGUA AND BARBUDA/ANTIGUA Y BARBUDA**

Chief Delegate – Jefe de Delegación

Dr. Rhonda Sealey-Thomas  
Chief Medical Officer  
Ministry of Health and the Environment  
St. John's

**ARGENTINA**

Chief Delegate – Jefe de Delegación

Dr. Rubén A. Nieto  
Secretario de Relaciones Nacionales e  
Internacionales  
Ministerio de Salud de la Nación  
Buenos Aires

Delegate – Delegado

Dra. Miguela Pico  
Subsecretaria de Relaciones Institucionales  
Ministerio de Salud de la Nación  
Buenos Aires

**BAHAMAS**

Chief Delegate – Jefe de Delegación

Dr. Merciana Moxey  
Senior Medical Officer  
Department of Public Health  
Ministry of Health  
Nassau

**CHILE**

Chief Delegate – Jefe de Delegación

Dra. Matilde Maddaleno  
Jefa, Oficina de Cooperación y Asuntos  
Internacionales  
Ministerio de Salud  
Santiago

**COSTA RICA**

Chief Delegate – Jefe de Delegación

Dra. María Esther Anchía  
Viceministra de Salud  
Ministerio de Salud  
San José

Delegates – Delegados

Sra. Maureen Barrantes  
Primera Secretaria, Representante Altern  
de Costa Rica ante la Organización de  
los Estados Americanos  
Washington, D.C.

Sr. Joshua Céspedes Víquez  
Consejero, Representante Altern  
de Costa Rica ante la Organización de  
los Estados Americanos  
Washington, D.C.

**MEMBERS OF THE EXECUTIVE COMMITTEE / MIEMBROS DEL COMITÉ EJECUTIVO (cont.)**

**ECUADOR**

Chief Delegate – Jefe de Delegación

Dra. Margarita Guevara Alvarado  
Ministra de Salud Pública  
Ministerio de Salud Pública  
Quito

Delegates – Delegados

Dra. María Verónica Espinosa Serrano  
Viceministra de Gobernanza y Vigilancia  
de la Salud  
Ministerio de Salud Pública  
Quito

Soc. Peter N. Skerrett Guanoluisa  
Analista de Cooperación y Relaciones  
Internacionales  
Ministerio de Salud Pública  
Quito

Sr. Miguel Loayza  
Segundo Secretario, Representante Alterno  
del Ecuador ante la Organización de los  
Estados Americanos  
Washington, D.C.

Sr. Sebastián Jaramillo  
Tercer Secretario, Representante Alterno  
del Ecuador ante la Organización de los  
Estados Americanos  
Washington, D.C.

**GUATEMALA**

Chief Delegate – Jefe de Delegación

Dr. Luis F. García Ruano  
Viceministro Técnico de Salud  
Ministerio de Salud Pública y  
Asistencia Social  
Guatemala

**TRINIDAD AND TOBAGO/TRINIDAD Y  
TABAGO**

**UNITED STATES OF AMERICA/  
ESTADOS UNIDOS DE AMÉRICA**

Chief Delegate – Jefe de Delegación

Mr. Jimmy Kolker  
Assistant Secretary  
Office of Global Affairs  
Department of Health and Human Services  
Washington, D.C.

Delegates – Delegados

Dr. Nerissa Cook  
Deputy Assistant Secretary of State  
Bureau of International Organization Affairs  
Department of State  
Washington, D.C.

Mr. Mitchell Wolfe  
Deputy Assistant Secretary  
Office of Global Affairs  
Department of Health and Human Services  
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Ms. Ann Blackwood  
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Ms. Emily Bleimund  
Director, Office of Trade and Health  
Office of Global Affairs  
Department of Health and Human Services  
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Mr. Charles Darr  
Lieutenant  
United States Public Health Service  
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Mr. Jose Fernandez  
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**MEMBERS OF THE EXECUTIVE COMMITTEE / MIEMBROS DEL COMITÉ EJECUTIVO (cont.)**

**UNITED STATES OF AMERICA/  
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**MEMBERS OF THE EXECUTIVE COMMITTEE / MIEMBROS DEL COMITÉ EJECUTIVO (cont.)**

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**UNITED STATES OF AMERICA/  
ESTADOS UNIDOS DE AMÉRICA (cont.)**

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