



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



# **33rd SESSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING OF THE EXECUTIVE COMMITTEE**

*Washington, D.C., 2-3 December 1999*

---

SPP33/FR (Eng.)  
3 December 1999  
ORIGINAL: SPANISH

## **FINAL REPORT**

## CONTENTS

	<i>Page</i>
Officers.....	3
Opening of the Session.....	3
Adoption of the Agenda and Program of Meetings.....	4
Presentation and Discussion of the Items.....	4
Virtual Health Library .....	4
Food Protection .....	8
Cardiovascular Disease, with Emphasis on Hypertension .....	12
Participation of the Pan American Health Organization in the United Nations	
Reform in Member States .....	15
Operations of the Subcommittee on Planning and Programming .....	21
Maternal Health.....	27
Repairs to the PAHO Headquarters Building.....	30
Other Matters.....	32
Closing of the Session.....	34
 Annex A: Agenda	
Annex B: List of Documents	
Annex C: List of Participants	

## FINAL REPORT

The 33rd Session of the Subcommittee on Planning and Programming of the Executive Committee of the Pan American Health Organization (PAHO) was held at the Organization's Headquarters in Washington, D.C., on 2 and 3 December 1999.

The session was attended by representatives of the following Members of the Subcommittee elected by the Executive Committee or designated by the Director: Bolivia, Canada, Cuba, Ecuador, Guyana, Mexico, and United States of America. Also present were observers for Brazil and Honduras.

### Officers

The Subcommittee elected the following officers:

<i>President:</i>	Ecuador	(Dr. César Hermida)
<i>Vice President:</i>	Cuba	(Dr. Antonio González Fernández)
<i>Rapporteur:</i>	Bolivia	(Dr. Fernando Cisneros del Carpio)

Sir George Alleyne (Director, Pan American Sanitary Bureau) served as Secretary ex officio, and Dr. Karen Sealey (Chief, Office of Analysis and Strategic Planning) served as Technical Secretary.

### Opening of the Session

The President opened the session and welcomed the participants. The Director added his welcome, noting that the Subcommittee was meeting on 2 December, the anniversary of the founding of PAHO. He was certain that the session would be very productive and the same spirit of open dialogue would characterize it as in past sessions. He looked forward especially to the discussion on the functions of the Subcommittee, which would undoubtedly prove beneficial to the work of the Organization as a whole.

## **Adoption of the Agenda and Program of Meetings (Documents SPP33/1 and SPP33/WP/1, Rev. 1)**

In accordance with Rule 2 of its Rules of Procedure, the Subcommittee adopted the provisional agenda, with the addition, at the suggestion of the Director, of an item on repairs to the PAHO Headquarters Building. The Subcommittee also adopted a program of meetings.

### **Presentation and Discussion of the Items**

#### ***Virtual Health Library (Document SPP33/6)***

Mr. Abel Packer (Director, Latin American and Caribbean Center on Health Sciences Information - BIREME) described the Virtual Health Library (VHL) project, which was launched within BIREME in 1998 as part of the Organization's technical cooperation in the area of scientific and technical information. The aim of the project was to ensure broad and equitable access to scientific and technical health information, as a prerequisite for the full development of health in the Region. The VHL was a network of health information resources on the Internet. Its development and operation were decentralized and were carried out by institutions distributed throughout the Americas—in particular, the national networks of libraries and documentation centers that made up the Latin American and Caribbean health sciences information network, coordinated by BIREME, which had been a major component of PAHO technical cooperation over the last decade. The VHL was expected to become a valuable source of reliable and readily accessible information for health professionals, educators, and decision-makers, as well as the general public.

Implementation of the project would take place in three stages: (1) 1999-2000, the launching period; (2) 2001-2003, the stage in which the VHL would gain momentum and new institutions and information sources would be incorporated into the network; and (3) 2003 and beyond, when the VHL would be fully operational and would serve as a major point of reference for health information products and services in the Region. The document contained information on progress in implementing the VHL thus far and on the results expected by the end of 2000.

The following principles were guiding the implementation process: adoption of the new paradigm represented by the Internet, in which information users interacted directly with networks of sources and with other users; promotion of alliances and consortia of producers, intermediaries, and users of information in order to increase access to information at lower cost; decentralized development and operation, as a means

of spurring the development of expertise in new information and communication technologies at the national and local levels and making the VHL more accessible, equitable, and sustainable; equity in development and operation, ensuring that all countries and all institutions within countries had equal opportunity to participate; attention to local conditions and needs and use of appropriate information technologies, so that participation in the VHL did not entail excessive expense for the countries or become a resource reserved for an elite few; and integrated evaluation and quality control in order to disseminate reliable information that met users' needs.

Continued development and strengthening of the VHL would require the political backing of the Member States. The inclusion of this topic on the Subcommittee's agenda was aimed at eliciting that support within the Governing Bodies.

The Subcommittee expressed decided support for the development of the Virtual Health Library, although it was pointed out that political support must be accompanied by concrete action at the country level in order to develop the technologies and expertise needed to successfully implement the VHL. It was emphasized that the VHL would provide more equitable access to the scientific and technical information needed to advance health development and achieve health for all. Its value as a source of information for human resource training and education was also underscored. Several delegates noted that the library would help overcome traditional barriers to access of information. For example, it would essentially eliminate geographic barriers and make it possible for health personnel and the general public in the countries to access a large volume of health information from all over the world. It would also increase the availability of information from a broader range of sources, including scientific production from Latin America and the Caribbean that has not been readily accessible before now. The Subcommittee also felt that the VHL would help enhance information-sharing and technical cooperation between countries and that it would also be an excellent source of up-to-date information for decision-making and priority setting.

It was pointed out that choices regarding the kind of information that would be made available and the way in which it would be delivered would determine, in large measure, who would receive the information. It was also pointed out that the development of the VHL would require technologies that were relatively costly and complex and that it might thus widen the gap between those who had those resources and those who did not. On the other hand, several delegates observed that, even in the poorest and most remote areas, most health institutions had telephone service and at least one computer and that access to the Internet was expanding rapidly in the Region. In that connection, it was suggested that the PAHO/WHO Representative Offices might play a role in facilitating access for areas and institutions that lacked it. It was also emphasized

that availability of appropriate equipment and technologies was not sufficient to ensure the viability and sustainability of the VHL; it was essential to train and motivate human resources to access and make the best use of the information.

The Secretariat was asked to clarify or elaborate on several issues, including the following:

- Plans for expanding the VHL, which now appeared to be geared mainly toward Spanish-speakers in Latin America, to better serve other parts of the Region, notably the English-speaking Caribbean, and integrate the immense volume of health and scientific information available from the United States and Canada.
- Projected resource requirements for continued development of the VHL, both in monetary and human resource terms.
- Quality control measures to guarantee accuracy and timeliness of the information, and standards to ensure compatibility and integration of data.
- Intellectual property issues in relation to the VHL.
- Criteria for identifying the thematic areas to be developed in the VHL.
- The strategy for training information and health professionals and other potential users of the VHL.

Responding to the Subcommittee's comments, Mr. Packer pointed out that one of aims of the VHL was to help the countries of Latin America and the Caribbean become full participants in the inexorable process of globalization of information. An important aspect of that effort was making the scientific production of the Region available through the VHL so that it could be accessed by other Latin American and Caribbean countries, as well as by users in the United States and Canada and the rest of the world. In regard to the English-speaking Caribbean, it had been an integral part of BIREME since its founding in 1982. The MedCarib database available through BIREME provided access to articles published in medical journals and other sources from the English-speaking Caribbean. During the year 2000, BIREME intended to prioritize the participation of the English-speaking Caribbean countries in the virtual health library. However, an indispensable criterion for including information from those countries in the VHL was that it be published electronically.

In regard to integrating information from outside Latin America and the Caribbean, BIREME has been a partner of the United States National Library of Medicine

(NLM) since its inception. Advances in technology had greatly facilitated interchange with the NLM, providing faster access to information from the United States, but also accelerating the availability of information from Latin America and the Caribbean through the NLM. For example, of the 44 Latin American journals that were indexed on the NLM's Medline database, 8 were now available in electronic format; as a result, they could be accessed internationally within 24 hours of publication. Before the advent of the Internet, it might have taken as long as nine months for an article from one of those journals to be made available internationally.

As concerned international compatibility of data, one of the main strengths of BIREME was its use of "common languages" for organizing and retrieving information. With respect to training, in the pre-implementation phase, training was being approached as an activity external to the VHL. However, the idea was that, once it had been fully implemented, the VHL itself would serve as a vehicle for training. In regard to the issue of quality control, peer review would be the principal mechanism used. BIREME's policy was that if an article or other item of information was not authored by a school of medicine, a recognized research institution, a ministry of health, or another reputable source, it must undergo peer review or it would not be included in the VHL.

The Director pointed out that the Organization had no control over the nature or the quality of the information that was placed on the Internet. The best it could do was to ensure that the information included in the VHL came from reputable and reliable sources with a history and tradition of publishing quality articles related to PAHO's areas of concern. The quality of statistical data on the countries was a different issue. PAHO published only data from official sources. Hence, it could be assumed that national authorities had validated any statistics on the countries available from the Organization through the VHL.

The issue of intellectual property and protection of information published on the Internet was a source of concern for PAHO. The Organization was looking into what rights it could and should claim as to ownership of information. In the meantime, he could state categorically that PAHO would never allow its name to be used as a source of any personal health information or advice for individuals disseminated via the Internet.

With regard to the resources required for the project, while there would be certain costs and human resource requirements for the countries that participated in the VHL, it would not really entail new expenditures for PAHO, since the Organization was simply building on an infrastructure already in place. BIREME had not been expanded and no new staff had been added to implement the VHL. The VHL was the result of the natural progression of a system that already existed. Originally, BIREME had been a traditional library. Then it had progressed to a network, with connections by telephone, fax, and

modem. The Internet had enabled even greater interconnectedness through the creation of “networks of networks,” which would not necessarily increase the amount of information available, but would make it available to many more users.

As for the thematic areas under development, mainly they were topics that had “suggested themselves” because they were areas in which the Organization was active and/or in which a large volume of information already existed, such as adolescent health and environmental health.

### ***Food Protection (Document SPP33/5)***

Dr. Jaime Estupiñán (Director, Pan American Institute for Food Protection and Zoonoses) (INPPAZ) presented a brief overview of the problem of foodborne disease (FBD) in the Americas and described PAHO’s response through the Regional Program for Technical Cooperation in Food Protection. FBD outbreaks in the past decade had given a new dimension to food protection programs in the countries. The frequency of outbreaks—especially those caused by emerging pathogens such as *Escherichia coli* O157:H7—coupled with the need to ensure the safety of food supplies in the face of enormous growth of international trade in food products, had prompted an effort to review and enhance national programs.

To strengthen food protection in the Region, in 1986 PAHO had launched the Regional Program for Technical Cooperation in Food Protection, which was consolidated with the creation of INPPAZ in 1991 to implement the program. The program had two main objectives: (1) to achieve a food supply that was safe, wholesome, nourishing, pleasing, and inexpensive, and (2) to reduce human morbidity and mortality caused by FBDs. The plan of action for technical cooperation under the program included five components: organization of national food safety programs, strengthening of laboratory capabilities, surveillance of FBDs, strengthening of food inspection services, and community involvement in food protection.

Major accomplishments in recent years included the adoption by almost 60% of the countries of integrated food protection programs; development of a regional electronic system to provide information on food legislation; strengthening of national Codex Alimentarius committees in the countries; formation of the Inter-American Network of Food Analysis laboratories; strengthening of laboratory capacity to test for pesticide residues and other chemical contaminants; training of laboratory personnel in methods for rapid detection of emerging pathogens; strengthening of inspection services, especially through training in good manufacturing practices (GMP), sanitation standard operating procedures (SSOP), and the hazard analysis and critical control points (HACCP) methodology; strengthening of national FBD surveillance systems and coordination of the

Regional Information System for Epidemiological Surveillance of FBDs; and joint sponsorship of a seminar on protection of foods sold by street vendors and a workshop on integrating consumer interests into food production and protection activities.

The document contained information on additional achievements under the five components, as well as the strategies, objectives, and goals for the program in the short, medium, and long terms. In the next biennium (2000-2001), technical cooperation would continue to be provided under the same five components, with emphasis on new regulatory, technological, and strategic developments for food protection programs.

The Subcommittee voiced unanimous support for the objectives and strategies set out in the document, although there was some concern that the objectives of the Regional program might be overly ambitious, given the relatively short timeframe proposed. It was pointed out, in that connection, that full implementation of the plan of action would require considerable infrastructure, resources, and commitment on the part of all countries of the Region. Support was also expressed for the work of INPPAZ and for the Secretariat's decision, taken several years earlier, to transfer responsibility for prevention and control of zoonoses from INPPAZ to the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) and make food protection the dominant role of the Institute. Various delegates commented that INPPAZ's progress in strengthening food safety programs and enhancing surveillance of foodborne pathogens and diseases in the Region had confirmed the wisdom of that decision.

It was pointed out that the orientations of PAHO's food protection program were entirely consistent with the emerging global food safety priorities of WHO arising from the recommendations of the United Nations Food and Agriculture Organization (FAO) Conference on International Food Trade Beyond 2000, held in Melbourne, Australia, in October 1999. Several delegates also noted that PAHO was in a position to play a leadership role in the global efforts, as food safety activities were generally more advanced in the Americas than in other WHO regions.

Clarification or additional information was requested on the following matters:

- PAHO's role with respect to that of the other agencies operating in the area of food safety, including FAO, especially in light of the proposal that PAHO become the principal technical cooperation agency and the main source of information and training in food protection in the hemisphere.
- Actual flows of food trade and the safety implications thereof, given the increase in food trade within the Region and its importance for consumers and for the economies of most countries.

- Means of rating the different methodologies for assessing food safety so that governments can be properly advised as to what are workable options in their particular socioeconomic situations, taking into account that the most sophisticated methodologies may not be appropriate or necessary in all contexts.
- Coordination between officials at the local level with respect to responsibilities for food safety and inspection of agricultural produce and practices at the local level.

The Subcommittee also identified several valuable roles for PAHO, in addition to those described in the document. One was providing accurate information on the issue of genetically modified foods and the potential risks they might pose, so that governments, producers, and consumers had a sound basis for decision-making. Another role was facilitating countries' participation in relevant Codex meetings and their understanding of their rights and obligations under World Trade Organization (WTO) agreements such as the Agreement on the Application of Sanitary and Phytosanitary Measures.

Dr. Estupiñán agreed that it was very important to define PAHO's role vis-à-vis FAO and other agencies. The Organization had communicated with all the agencies involved in food safety for that purpose. PAHO's orientation was shaped by the fact that it was a public health entity and food safety was a public health priority. Accordingly, the Organization's efforts focused largely on ensuring the safety of food for national consumption. Still, because PAHO was aware that the economies of many countries depended on the export of food products, an important component of its strategic plan of action was harmonization of food safety standards and legislation in the countries, including compliance with the agreements on Sanitary and Phytosanitary Standards and Technical Barriers to Trade. Moreover, WHO as a whole had been asked in various international trade forums, including the Melbourne conference, to step up its activities in the area of food safety in response to growing concern for consumer health protection.

Though the plan might appear to be somewhat overly ambitious, it should be understood that, to carry out the plan, the Organization would coordinate its efforts with those of other agencies and it would utilize resources and infrastructure that were already in place. For example, it would not be necessary for PAHO to develop any food safety and quality standards, as that work was already being done by the joint FAO/WHO Food Standards Program. Hence, PAHO's role would be to disseminate that body of standards and facilitate its application in the countries. Moreover, the countries themselves had built up considerable infrastructure and expertise in food safety over the years, and the Organization would seek to form alliances and consortia to take advantage of that experience. One of long-term objectives of the plan of action was the establishment of a regional commission on food protection to serve as an advisory body and as an agency for evaluating national programs. PAHO's experience with such bodies—notably the

Hemispheric Commission for the Eradication of Foot-and-Mouth Disease—showed that they were a very effective vehicle for spurring action at the national level and facilitating joint effort at the regional level.

The concern regarding the suitability of inspection methods such as the HACCP methodology in some contexts was valid. Certainly, introduction of the HACCP system required significant investment and a fairly high level of technological development. In some countries, a more appropriate course of action might be to start with the introduction of good manufacturing and production practices. Experience had shown that improving workers' knowledge of food protection principles could lead to marked reductions in contamination problems. For that reason, PAHO was emphasizing the communication and information component of the plan of action.

As for the issue of inspection at the local level, in most countries, the agriculture sector had taken the lead in inspection of local agricultural produce. However, PAHO advocated a coordinated approach through the creation of intersectoral committees or commissions involving both the health and agriculture sectors. The Organization's role was to facilitate such meetings of health and agricultural officials so they could define the role of each sector and coordinate their activities.

The Director said that he had been pleased that the recommendations of the Melbourne conference had called on WHO to take a more aggressive role in relation to food protection. Clearly, assuring food safety was a critical public health function, and organizations devoted to public health must therefore play a leading role in that area. As several delegates had noted, the WHO Executive Board would be discussing the subject in January 2000. In preparation for that discussion, the Secretariat would be happy to provide Executive Board Members from the Americas with additional information on PAHO's activities in the Americas or on the issues raised in the Executive Board document. In regard to additional information on the food safety problems associated with international trade, the Secretariat did not currently have much data on the flow of foods in international commerce and the problems that had arisen, but it would make every effort to compile some information and make it available to delegates prior to the Executive Board session.

He was also pleased that the Subcommittee was satisfied with the work of INPPAZ, although he felt that the Institute had the potential to do much more. Resource constraints had limited the scope of its activities in recent years; however, the Ministry of Agriculture of Argentina, the host country for INPPAZ, had committed itself to contribute a larger share of the financing for the Institute. He was therefore hopeful that INPPAZ would soon have the resources necessary to strengthen its capacity to respond in some of the areas identified by the Subcommittee. As for the decision to shift INPPAZ's focus

toward food protection and away from zoonoses, he pointed out that it had come about as a direct result of recommendations made by the Subcommittee in earlier sessions. He agreed that it had been a wise decision, given the magnitude of the problem of foodborne illness.

In regard to the creation of a hemispheric commission on food protection, he was happy to report that considerable interest had been expressed among high-level officials in the countries.

***Cardiovascular Disease, with Emphasis on Hypertension (Document SPP33/8)***

This item was introduced by Dr. Sylvia Robles (Coordinator, Program on Noncommunicable Diseases), who presented data illustrating the magnitude of the problem of cardiovascular disease in the Region. The two most important cardiovascular diseases, in terms of premature mortality, were ischemic heart disease and cerebrovascular disease. Hypertension was a key risk factor for both diseases and for other cardiovascular diseases. Studies had shown that preventing and controlling hypertension could bring about significant reductions in deaths from cardiovascular causes. Accordingly, the PAHO Program on Noncommunicable Diseases was working to strengthen programs for the prevention and control of hypertension, given their potential impact in the medium and long terms.

Dr. Armando Peruga (Regional Advisor, Noncommunicable Diseases) then provided more specific information on the problem of hypertension, the status of national control programs, PAHO's efforts in this area, and some recommended strategies for closing the gap between present levels of control and the level possible with current scientific knowledge. Studies in the Americas indicated that the prevalence of hypertension was between 8% and 31%, although the data were not always comparable owing to differences in the methodologies and definitions used. While most of the countries had national programs in place, few of those programs were comprehensive, encompassing prevention, control, and management of hypertension. Moreover, although three fourths of the countries had national guidelines for the detection, treatment, and management of hypertension, they were systematically applied and regularly revised in only one third. As a result, a high proportion of hypertension cases went undetected and fewer than two thirds of those detected were being treated. Of those being treated, only 30%-50% were adequately controlled.

Improving hypertension control programs meant detecting and treating more hypertensives, enhancing the quality of care, and improving patient education. While treating hypertension entailed higher expenditure, in most cases the reduction in the costs associated with cardiovascular disease would compensate for that expenditure. In

addition, there was increasing consensus among experts that it was possible to treat hypertension without raising the cost of care, provided that the complexity of care was limited and the lower-cost drugs of proven effectiveness recommended by WHO were utilized.

The PAHO Noncommunicable Diseases Program had developed an approach that integrated health promotion and primary prevention with control of noncommunicable diseases, including hypertension, under the rationale that since many health problems shared the same risk factors, the same strategies could be used to address them. With a view to promoting a concerted effort on hypertension, PAHO had joined with the U.S. National Heart, Lung, and Blood Institute and several other organizations to create the Pan American Hypertension Initiative. The objectives were to increase the detection of individuals with high blood pressure in all health services and to improve patient acceptance of and adherence to treatment. The Organization recommended the following strategies for achieving that objective: development of the surveillance of noncommunicable diseases and their risk factors, including hypertension; promotion of greater community awareness of the problem; implementation of guidelines for cost-effective care; and patient education. The Subcommittee was asked to comment on those strategies and suggest others for strengthening the prevention and control of hypertension in the Region.

The Subcommittee endorsed the overall strategy of preventing and controlling hypertension as a means of reducing rates of cardiovascular disease, as well as the more specific strategies for strengthening hypertension prevention and control programs. It was felt that the activities proposed in the document would contribute to PAHO's efforts to promote health, prevent and control disease, strengthen health systems and services, and forge linkages between health and human development throughout the Americas. Several delegates commented that there was strong justification for PAHO's increased emphasis on cardiovascular diseases, given their growing importance in both developing and developed countries. At the same time, it was pointed out that the health care infrastructure and economic and professional resources in some countries might be insufficient to deal with the new challenges presented by chronic and noncommunicable diseases, such as cardiovascular disease, while simultaneously contending with infectious and parasitic diseases and problems related to malnutrition. It was emphasized that meeting those challenges would require expanded collaboration and partnership between the Organization and the Member States and among the Member States themselves to maximize collective resources.

Members of the Subcommittee suggested that the following points should be added to or emphasized in the document and in the proposed agenda for action:

- The approach to hypertension as a public health problem can contribute valuable strategies for both clinical management and public health approaches to other noncommunicable diseases linked to lifestyle, including diabetes, liver cirrhosis, and some forms of cancer. Integrated approaches that address common risk factors for hypertension (obesity, inactivity, high sodium intake and low potassium intake, excessive alcohol consumption, and others) will also help to lower the risk for other noncommunicable diseases.
- While hypertension is generally regarded as a health problem of older adults, it should be recognized that it can also be a significant cause of maternal mortality among young women, especially when associated with eclampsia. The primary health care approach proposed in the document should therefore incorporate prevention of hypertension during pregnancy.
- Hypertension prevention and control programs should be seen as a high priority from both a public health and an economic perspective. Notwithstanding the cost of pharmaceuticals, controlling hypertension is extremely cost-effective, given the huge economic losses caused by cardiovascular diseases. Moreover, a primary health care approach that emphasizes health promotion, prevention of risk factors, and, where appropriate, nonpharmacologic approaches to treatment, can be highly effective at relatively low cost.
- Research and evaluation of the quality of care provided to patients are needed to determine why a larger percentage of diagnosed hypertensives are not being adequately controlled and identify the failures in current therapeutic approaches, with particular attention to the use of technologies that are costly but may not be particularly effective in controlling the problem.
- Under- and nonutilization of health services should be recognized as one factor in the low levels of detection of hypertension. Community-based programs are needed to raise awareness of the problem and encourage and facilitate the use of services in order to detect more cases of hypertension. Improved quality of care and increased use of nonpharmacologic therapies will also help expand the use of services.
- The document could be enhanced through stronger emphasis on professional and, especially, public education. Much greater effort is needed to educate patients and the general public on how they can better protect their own health.

- The document could also be enhanced through incorporation of the statement that emanated from the March 1999 meeting on the Pan American Hypertension Initiative, or elements from that statement.

Dr. Robles pointed out that several of the delegates had underscored the importance of cardiovascular diseases in developing countries, which represented a change from past. Traditionally, those diseases had been seen as problems mainly of developed countries, but there was now incontrovertible evidence that the developing countries were being equally affected. Indeed, PAHO's information indicated that cardiovascular diseases were the leading cause of premature death in the countries of Latin America and the Caribbean. Primary prevention and control of hypertension was a strategic response that would address not only the risk factors for cardiovascular diseases but for many other noncommunicable diseases, as various delegates had noted. The Organization was working on several integrated, community-based approaches to prevent risk factors for noncommunicable diseases, notably the CARMEN<sup>1</sup> project. Technical cooperation activities under the Pan American Hypertension Initiative and the CARMEN project would complement one another.

***Participation of the Pan American Health Organization in the United Nations Reform in Member States (Document SPP33/4)***

Dr. Irene Klinger (Chief, Office of External Relations) reviewed the main objectives, features, and status of the process of United Nations reform and its impact on PAHO's work at the country level. She began by noting that the document and presentation on this item represented a collaborative effort by the Office of External Relations and the Office of the Assistant Director, who was responsible for overseeing the Organization's technical cooperation at the national level.

United Nations Secretary-General Kofi Annan had initiated a wide-ranging reform program in 1997 aimed at making the United Nations system work more efficiently and strengthening it as a force for sustainable, people-centered development. The objectives of the reform program were greater unity of purpose, increased cost-effectiveness, and coherence of efforts and agility in responding to the needs of Member States. At United Nations Headquarters, one of the key elements in the reform process had been the formation of the United Nations Development Group (UNDG) to enhance the effectiveness and impact of United Nations development operations through facilitation

---

<sup>1</sup> CARMEN is the Spanish acronym for "Actions for the Multifactorial Reduction of Noncommunicable Diseases."

of joint policy formation and decision-making at the central level. The group was composed of the various United Nations agencies engaged in development activities, including WHO.

At the country level, the Secretary-General had asked the participating funds and programs to establish corresponding consultative and collaborative arrangements and to seek to integrate their country-level assistance into a United Nations Development Assistance Framework (UNDAF). United Nations country teams, under the leadership of the United Nations Resident Coordinator, would work closely with governments in preparing the frameworks, permitting a new strategic approach to national development priorities. The first step in formulating the UNDAF would be to conduct a Common Country Assessment (CCA), a comprehensive, multisectoral analysis of the country's situation and development needs. As an additional means of reducing costs and enhancing efficiency, the Secretary-General had proposed that the field operations of all United Nations agencies be placed together in a single United Nations office, or "UN House," under the Resident Coordinator.

PAHO, as the Regional Office of WHO, was called on to play an active role in all aspects of the reform process. In some instances, PAHO would lead the process at the country level, since the PAHO/WHO Representative served as the UN Resident Coordinator in some countries of the Americas and as Deputy Resident Coordinator in others. The United Nations reform process created both challenges and opportunities for the work of PAHO and its efforts to further health development in its Member States. On the one hand, PAHO's leadership role—whether as UN Resident Coordination or as the lead agency in the various interagency task forces or thematic groups that existed at country level—represented a considerable demand on the time of the PAHO/WHO Representative and on PAHO resources in the country. In some cases, PAHO field staff were devoting as much as 25% of their time to the reform process.

On the other hand, the Organization's participation in the CCA and UNDAF formulation process could afford an opportunity to call attention to health issues, promote greater leadership by the ministries of health in establishing national development priorities and strategies, and mobilize additional resources and intersectoral collaboration to address the determinants of health. A more unified United Nations system thus could lead to better and more equitable health outcomes. Nevertheless, PAHO considered that each agency should maintain its programming and budgeting independence and utilize it to contribute to achieving the goals stated in the UNDAF.

The Subcommittee was invited to comment on how the United Nations reform process was being perceived by national authorities, how the ministries of health could

better use the reform process to promote health priorities in development discussions, and how PAHO could better perform its technical cooperation functions in the context of reform.

In the Subcommittee's discussion of this item, support was expressed for the ideals behind the reform process—i.e., enhanced coordination of United Nations cooperation processes at the country level, increased efficiency, and cost-savings. However, a number of concerns were raised as to the concrete impact of the process on the health sector and on PAHO's work in the countries. The main ones are summarized below:

- The priorities established by the UN Resident Coordinator may not coincide with those that the country has established for cooperation in certain sectors or with certain agencies, especially in cases in which the Resident Coordinator is an agency other than PAHO. The Organization has always worked closely with countries to establish priorities and plan cooperation based on needs identified by national authorities, but the same is not true of all agencies. Strategic plans in some countries are developed not on the basis of national consultation and dialogue, but through an internal process among the agencies, generally overseen by the UNDP. Social issues, including health issues, may not receive adequate attention in such strategic plans.
- Coordination among United Nations agencies must be complemented by adequate national coordination in establishing priorities. This is a concern especially in relation to the national focal point for the United Nations reform process. There is a risk that the social sector in general, and the health sector in particular, might not receive sufficient attention if a single national focal point is designated to represent national interests in the reform process, especially if that focal point is the ministry of finance or the ministry of foreign affairs.
- While many health issues are intersectoral in nature, and intersectoral coordination to address them is generally desirable, some issues are specific to the health sector and must be discussed and resolved within the health sector alone. How will those issues be handled within a unified United Nations framework at country level?
- The idea that a single framework for United Nations funds and programs will maximize the mobilization of resources should be approached with caution. In fact, it could lead to increased conditionality and a narrowing of priorities, which ultimately could reduce the volume of resources received by the countries.

- In view of PAHO's recommendation that all the agencies should maintain separate programming and budgeting, what would be the function of the UN House?
- PAHO is in a unique position with respect to the other agencies involved in United Nations reform at the country level. PAHO is older than the other agencies. It has established a strong presence in the countries and has a long history of collaboration with national health authorities. While PAHO, as the Regional Office of WHO, has a responsibility to participate in United Nations reform, it should take care to ensure that its involvement in the process does not detract from its traditional leadership in health in the Americas.

The Subcommittee encouraged PAHO to utilize its unique strengths to exercise leadership in the United Nations reform process at the country level and ensure a prominent place for health on national development agendas. It was emphasized that the real test of the success of reform would be how well it resulted in improved performance and ability by the agencies to deliver cooperation to their clients—the countries. The importance of continuous monitoring and evaluation of the relevance of the UNDAF to country needs and priorities was also underscored.

Dr. Mirta Roses (Assistant Director, PAHO) assured the Subcommittee that PAHO was keenly aware of the need to be mindful of the wishes and priorities of the Member States, which had provided the impetus for United Nations reform and should be the prime beneficiaries of the reform process. She pointed out that the direction that reform processes would take at country level would depend, to a large degree, on the leadership of the overall process of external cooperation within the country. Strong government leadership of the external cooperation process would translate into a strong government presence in the UN reform process at the national level. Without that presence, the process would tend to become an end in itself, rather than a process that would lead to achievement of the stated objectives of more consistent, coherent, cost-effective cooperation that responded to the countries' needs. As the Subcommittee had noted, PAHO had a long tradition of consulting with national authorities to establish its cooperation priorities in each country. The Organization would continue to rely on the governments, and in particular the ministers of health, for guidance on how and to what extent it should contribute to United Nations reform at the country level.

Dr. Klinger stressed the need to use the CCA as a means of incorporating the national vision of the country's development problems into the formulation of the UNDAF and ensuring that it would respond to national needs and priorities. Replying to the comments concerning the drawbacks of establishing a common framework for cooperation and the risk that it might limit the possibilities for mobilizing resources to

address health priorities, she pointed out that health authorities would need to remain vigilant and insist that health was accorded the importance it deserved. Just as they often had to compete with other sectors in negotiations for bilateral and multilateral financing, health authorities would have to be strong advocates for health in the United Nations reform process, both in their dealings with the UN Resident Coordinator and with the national focal point for the reform process. With regard to the role of the UN House, the idea was that costs could be reduced if agencies shared facilities and services. PAHO's decision on whether or not to move its Representative Office to the UN House would depend on the situation in each country and on factors such as whether the Organization already owned or leased its own building.

As for the issue of independence in programming and funding, PAHO's position was that each agency should retain control over those processes, but their programming should respond to the CCA and the UNDAF. As the delegates had pointed out, because of PAHO's history, it enjoyed a rather unique position in the countries and could essentially "wear two hats." It had a responsibility to support the process of United Nations reform and respond to the Secretary-General's requests; however, if it saw that the reform was not responding to the health needs and priorities of its Member States, it might opt to "wear the other hat."

The Director was pleased with the level of interest expressed by the Subcommittee in the topic of United Nations reform, which was of crucial importance to the Organization as a whole. He explained that this item had been included on the Subcommittee's agenda because the Secretariat considered it important to make the Governing Bodies aware of the implications of United Nations reform in terms of PAHO's time, its relationships with its partners, and its independence of thought and action. One of the aspects that most troubled him about the process was the concept of a common development framework. His view was that there could be no single development program, since human development called for action in such a wide range of areas. It must be recognized that health was a vital component of development and that the health sector was an equal partner in the development process. From that standpoint, PAHO was as much a development agency as any other agency, and it would not relinquish its right to speak about what constituted development or allow another agency to assume the responsibility of speaking in its name before the governments of Member States, as had happened in some countries with the UNDP representatives. Representations that were made to governments should be made commonly, cooperatively, and in a collaborative spirit.

He was similarly troubled by the implications of the World Bank's parallel development of a separate framework—the Comprehensive Development Framework

(CDF). There was no evidence that the CDF would be consistent or compatible with the UNDAF, and the existence of two frameworks was unlikely to enhance coordination between the World Bank Group and the United Nations system.

With regard to the issue of focal points in the countries, the concept of a single development framework was based on the precept that there was some single point in the countries where decisions about development were made, but that was not true. In a cabinet system, each minister sought to protect the interests of his/her sector and decisions were made collectively. As Dr. Roses had pointed out, the extent to which the effort at coordination among the agencies would function well would depend on the extent to which the government agreed that there would be pluralism in terms of focal points and that there would be some consensus in terms of where the various areas would come together. In any case, the focal point for PAHO's action at the country level would remain the ministry of health. Ministers of health had told him repeatedly that, regardless of how PAHO participated in the reform process or in the common development framework, they would not want to see a reduction in the dialogue and direct interaction between PAHO and the ministries of health.

As for the UN houses, PAHO would participate in them only if it was to the Organization's advantage to do so. Functional cooperation and mutual self-interest—not physical space—would be the primary considerations in the decision. If participation in the UN House would be detrimental in any way to its relationship, proximity, or ability to communicate with the ministries of health, PAHO would not participate.

The experience with UNAIDS had demonstrated that the Subcommittee's concern over the impact of a common development framework on funding for the countries was quite valid. In essence, coordination and collaboration in the framework of UNAIDS had resulted in a reduction of the funding going to countries. Furthermore, in some countries, a significant amount of money was being put into the coordination effort itself, and the use of funds for coordination at the country level meant a reduction in the funds available for technical cooperation.

It was true that PAHO, with the experience gained over its 97-year history, had a lot to contribute to the reform process at the country level, particularly in terms of relationships with governments and knowledge of the countries. In almost every country, PAHO was the strongest presence numerically, and it was usually the best-developed in terms of programming. Another valuable contribution was the development of indicators for the country assessments. In some countries, the Organization was already working with other agencies to develop indicators within a common framework. Moreover, in most countries, PAHO had more data available than other agencies.

It was the Organization's responsibility—not so much to the United Nations system, but to the countries—to contribute its knowledge and expertise to the reform process at the country level. All of the PAHO/WHO representatives were participating in the CCA and in formulating the UNDAF in their respective countries. Nevertheless, the Director felt strongly that the Organization's participation in United Nations reform in no way should be inimical to its responsibility to its primary clients: its Member States, and in particular the ministries of health. If PAHO had to choose between participating in the coordination mechanism or leading a thematic group at country level and serving its primary clients, it would always give priority to its primary clients. As the Subcommittee had noted, the primary purpose and the foremost consideration in coordination and reform efforts should be improvement in the countries.

***Operations of the Subcommittee on Planning and Programming (Document SPP33/3)***

Dr. Karen Sealey (Chief, Office of Analysis and Strategic Planning) introduced this item, which had been included on the Subcommittee's agenda at the request of the Executive Committee at its 125th Session, held in October 1999. The Executive Committee's proposal to reexamine the operations of the Subcommittee on Planning and Programming (SPP) had coincided with an internal process aimed at strengthening the strategic planning process within the Secretariat. The aim of the Subcommittee's discussion of this topic was to determine whether the current operations of the SPP were appropriate, given the need for effective planning and programming in the challenging regional and global environment. Dr. Sealey began by reviewing the evolution of the SPP since its creation by the Executive Committee in 1979. She then presented highlights of its operations from 1979 through 1998—including the extent and frequency of participation by the various Member States in Subcommittee meetings—and she described the current context in which the Subcommittee was operating. Finally, she suggested several possible issues for discussion by the Subcommittee.

Initially, the SPP had been known as the Subcommittee on Long-term Planning and Programming. It had been conceived of as a "think tank" whose principle function was to identify strategic issues and advise the Executive Committee and the Director on matters pertaining to long-range planning and programming. One of its chief concerns had been implementation and monitoring of the recently adopted regional plan of action for achieving health for all by the year 2000. The Subcommittee had worked in collaboration with the Headquarters Program Committee. That committee had become defunct around 1981, and in 1984 the Executive Committee had formalized the role of the Subcommittee in planning and programming, assigning it a defined set of functions and changing its name to Subcommittee on Planning and Programming.

The functions established by the Executive Committee in 1984 had been modified slightly in 1996, when the Subcommittee's terms of reference and rules of procedure were updated. Its current functions were those adopted in 1996, namely: to advise the Executive Committee on matters relating to general and specific orientations proposed for the Organization and the corresponding monitoring and evaluation reports; the process and methodology of planning; the process of technical cooperation with the countries, including monitoring and evaluation of progress toward the goal of health for all; receipt of the reports from monitoring of health conditions in the Americas and of the economic and social factors that affect health conditions and the health sector; review of special programs, with an emphasis on the formulation and evaluation of those programs; and any other functions assigned to it by the Executive Committee.

One of the underlying objectives of the Executive Committee in creating the SPP had been to increase participation by Member States in the Governing Bodies of the Organization. The document contained statistics on membership and participation by the countries in the 32 Subcommittee sessions held between 1979 and March 1999. A total of 225 delegations had attended those sessions, representing most of the countries of the Region; however, seven Members had participated only once and nine countries had never participated in a Subcommittee session. The delegations had been composed mainly of public health officials from the ministries of health. Thirty-eight ministers of health had attended sessions.

In the early years of its existence, the SPP had focused primarily on topics related to the organization and work of the Secretariat. Gradually the focus had shifted to specific issues of technical cooperation. In recent years, the majority of the topics examined by the SPP had been referred to the Executive Committee for further consideration, which reflected a change in the function of the Subcommittee: whereas in the early years, it had tended to work more as a think tank, between 1994 and 1998 it had become almost a screening body for the Executive Committee. The Subcommittee was asked to consider whether its current functions and operations remained appropriate in the context of rapid global and regional change and in light of the need to strengthen institutional development, long-term planning, and evaluation in order to anticipate and facilitate the Organization's response to change.

In particular, the Subcommittee was asked to contemplate the following questions: To what degree should the SPP be involved in strategic planning and evaluation of regional cooperation? What kind of topics should be discussed by the SPP and to what extent should those topics be related to planning for the long term, rather than planning for the immediate future? What should be the role of the SPP in the evaluation of technical cooperation at country level? What should be the Subcommittee's modality of work in its sessions and what type of documents would be needed to support any

change in the current modality? How often should the Subcommittee meet and might it be possible to utilize telecommunications to continue its work between sessions? How might the differing functions of the SPP and the Executive Committee be better reflected in the modality of work, the matters discussed, and the membership of each body so that the SPP can contribute more effectively to the overall planning and evaluation process for the Organization?

The delegates agreed that it would be desirable for the Subcommittee to return to its long-range planning orientation and for it to function more as a think tank, as it had done originally. It was pointed out that, increasingly, the documents discussed by the Executive Committee and the Directing Council were essentially the same as those that had been examined initially by the Subcommittee and that, as a result, the tenor of the discussion in all three bodies tended to be the same. It was felt that the Subcommittee could contribute more constructively to the work of the Organization if it focused less on current program matters and concentrated instead on enhancing long-term planning processes and on evaluating the outcomes of those processes. At the same time, however, the value of the Subcommittee's role in screening documents and advising the Executive Committee on programmatic matters was recognized. It was pointed out that Executive Committee sessions might well be longer if the Subcommittee ceased to fulfill that screening function. It was also emphasized that, as an advisory body of the Executive Committee, the Subcommittee was not at liberty to set its own agenda but had a responsibility to examine whatever matters were referred to it by the Committee.

In regard to the format and frequency of SPP sessions and participation therein, a number of concrete suggestions were made, including the following:

- Eliminate the fall session and hold only one session each year, which would allow the Secretariat staff more time to prepare and distribute the documents and would afford the delegations more time to circulate them among the appropriate agencies within their respective governments.
- Continue to hold two sessions per year, but make the fall session more of a brainstorming session on a single topic, which could be decided during the spring session, thus providing ample time to prepare the necessary documentation.
- Encourage greater informality and more dialogue in Subcommittee sessions.
- Continue and expand the practice of including discussion questions in the documents and presentations prepared for the Subcommittee as a means of stimulating greater exchange and dialogue.

- Distribute documents at least four weeks—but preferably six weeks—before Subcommittee sessions to give participants the opportunity to thoroughly familiarize themselves with the matters to be discussed and thereby enable them to participate more actively in the sessions.
- Ensure that all slides, overheads, and other visual aids used in Subcommittee sessions are bilingual (English/Spanish) in order to facilitate communication and discussion among the participants.
- Modify the composition of the Subcommittee to include fewer Executive Committee Members in order to avoid repetition of the same topics and comments in the sessions of the other Governing Bodies.
- Seek to ensure broader participation by the Member States, in particular by those that have rarely or never taken part in Subcommittee sessions.
- Lengthen the term of Subcommittee Members in order to foster greater continuity and build a body of experience and expertise that would better enable the SPP to contribute to long-range planning.
- Consider inviting outside technical experts from both the private and public sectors to participate in the drafting of documents and take part in the discussions of the Subcommittee.

The consensus that emerged was that it would be desirable to hold a single session per year, probably in February or March. In order to allow ample time for discussion, it was felt that the session should be three days long, rather than two days, as had been the practice in recent years. The need to circulate the documents well in advance of sessions was underscored.

As for the Subcommittee's participation in the evaluation of PAHO technical cooperation at country level, it was agreed that the SPP should play a role in the evaluation process, although there were differing views on the extent and nature of that role. One delegate proposed that SPP sessions might occasionally be held in countries in which evaluations were being conducted in order to engage the Subcommittee more directly in the process—either at the outset, so that the Subcommittee could provide input on the content of the evaluation, or at the conclusion, so that the Subcommittee could comment and make recommendations relative to the findings of the evaluation. Another delegate suggested that it might be more useful to submit the written evaluations of technical cooperation to SPP Members throughout the year for information and feedback. The Secretariat could then use that feedback to identify shared challenges at country

level, especially those that might impact regional initiatives or improve PAHO's interventions across countries. The evaluative discussions would thus be more issue-specific and less focused on national environments. In any case, the Director was encouraged to carefully weigh the benefits of holding sessions outside PAHO Headquarters against the costs that such a move would entail.

With respect to the topics that should be discussed by the Subcommittee, it was emphasized that they should include practical issues of common interest to the countries, such as how to extend health care coverage to underserved populations. In this connection, the Delegate of Ecuador expressly requested that the subject of universal health insurance be discussed by the Subcommittee during 2000 in order to provide an opportunity for countries that had developed, or were planning to develop, such insurance plans to compare and learn from one another's experiences. It was emphasized that the documents prepared for discussion by the Subcommittee, especially those on programming matters, should always include an analysis of the extent to which the activities envisaged would contribute to greater equity. In addition, it was emphasized that the SPP should seek to ensure linkage between the planning and budgeting processes, as the budget was the visible manifestation of planning. To that end, it was considered essential for the documents to include information on the financial implications of programming matters.

Dr. Sealey said that the Secretariat would make every effort to see that future documents and presentations on programming matters included a discussion of costs and financial implications, as well as an analysis of the degree to which the principle of equity was being incorporated into the Organization's programs and activities. The Secretariat would also ensure that all future visual presentations contained text in both English and Spanish and that documents were distributed at least a month prior to Subcommittee sessions. In response to a comment from one of the delegates, she acknowledged that the document on this item had not explicitly addressed the functional relationship of the SPP to the other Governing Bodies. However, she felt that it was clear from the discussion that the delegates considered it an important function of the SPP to assist the Executive Committee in its role of analyzing issues that were to be sent on to the Directing Council for action.

The Director said that he saw both negative and positive aspects of this overlap of functions. He pointed out that the efficient manner in which the Directing Council generally dispatched its work was often a result of the fact that the issues had been so well "digested" previously by the delegations to the Subcommittee and the Executive Committee sessions. In the case of difficult or contentious matters, it had proved beneficial to have the initial discussion within the SPP, as it had helped build consensus. Nevertheless, the repetition that sometimes characterized discussions in the Governing

Bodies should be avoided to the extent possible. That could be accomplished if the Executive Committee would identify certain specific matters within broader topics on which it wished to receive advice or recommendations from the Subcommittee.

In regard to the membership of the Subcommittee, he agreed that an effort should be made to achieve better balance in Member States' participation in the work of the SPP; however, because the Subcommittee was a subsidiary body of the Executive Committee, he felt that its core membership should be composed of Executive Committee Members. It might be possible to achieve greater continuity, as had been suggested, by designating some permanent or longer-term Members to the Subcommittee in order to build up institutional memory. It was also feasible to enrich the presentations made to the SPP with support from experts in various areas, including experts from Member States and from outside the Organization.

He was enthusiastic about the idea of holding only one session a year; however, the Secretariat would need to consider how best to structure that session so that it would yield the greatest benefit for both the Member States and the staff of the Organization. If it was agreed that the primary function of the Subcommittee should be long-term planning, programming, and the generation of new ideas, longer preparation time would be required. It would probably also be advisable to hold a longer session in order to allow sufficient time to explore topics in depth, as the delegates had proposed. The Secretariat would also look for ways to make the SPP more of a think tank and foster more informal dialogue among participants.

The idea of holding meetings outside PAHO Headquarters was appealing for several reasons. In particular, it would allow Members to see and take part in the process of planning and programming "live" at country level and to appreciate the practical effects of Subcommittee recommendations in the countries. Certainly, it would be more costly to hold sessions outside Headquarters, but if doing so would enhance the functioning of the Organization, he considered the idea worth examining. Moreover, holding the session at country level would in no way preclude discussion of matters relating to the overall planning and programming of the Organization, managerial and policy issues, or current topics of regional and/or global interest, such as the one suggested by the Delegate of Ecuador.

He agreed that it was essential to link any discussion of planning and programming to the budget, whether that was done prospectively or after the budget was approved. Similarly, it was important to examine the financial implications of proposed actions. The Secretariat would strive to ensure that documents presented to the Subcommittee included such financial information.

Finally, he expressed his gratitude to the delegates for the cooperative and nonconfrontational spirit in which they had approached the discussion. It was clear that everyone had the best interests of the Organization as a whole at heart.

***Maternal Health (Document SPP33/7)***

Ms. Carol Collado (Coordinator, Program on Family Health and Population) presented some general considerations in relation to maternal health and examined the lessons suggested by PAHO's work in this area over the years. She began by pointing out that the understanding of what constituted maternal health had changed. For a long time in the history of public health, "maternal health" had been taken to mean the health of women during pregnancy or the perinatal period. However, maternal health was now seen as an outcome of complex interactions that took place at both the individual and societal levels throughout a woman's lifetime, in combination with the characteristics and functioning of health systems and services. At the individual level, maternal health was influenced by numerous factors, including nutritional status, knowledge base, educational level, belief system, inherited tendencies, and specific environmental determinants. At the societal level, cultural and ethnic influences and changing roles for women had an impact on maternal health, as did poverty, economic instability, and the growing gap in the distribution of wealth and possibilities for accessing education, nutrition, and health services.

Despite this reality, health services for women continued to be mainly episodic and reactive, with little attention to cultural and contextual factors that influenced women's health. That deficiency had repercussions not only for the women concerned, but for those whose lives they touched, since there was ample evidence that maternal health affected not only the health of women themselves, but that of their children, their families, the wider community and, ultimately, the entire national development process.

After a century and a half of work in maternal health in the Americas and globally, a number of lessons had been learned. The principal ones were that maternal health must be considered a lifelong process and that attention to women's health must begin long before and continue long after their childbearing years; that quality of care and capacity-building for human relationships were crucial, as it had been demonstrated that women would not use services if they were treated badly; that policy and legislation on women's health must be accompanied by monitoring, evaluation, and enforcement mechanisms; that health authorities must be involved in the development of policy in education, commerce, labor, and other sectors in order to raise awareness of the health impacts of policy-making in those areas; and that health literacy and social participation

were key to changing attitudes and behaviors in relation to maternal health, but that efforts to transmit knowledge and bring about behavioral change must take account of cultural diversity.

Based on those lessons, PAHO advocated a gender-sensitive, lifecycle approach to maternal health that emphasized prevention and health promotion and recognized the myriad factors involved in achieving health. The Organization saw its role in promoting maternal health as one of continuing to support the countries in developing a framework for care that incorporated available knowledge and technology and that recognized the long-lasting intergenerational implications of maternal health; examining existing normative frameworks to assure adequate attention to monitoring, evaluation, and enforcement mechanisms; reviewing and restructuring existing programs to include activities aimed at addressing underlying conditions and determinants that lead to poor outcomes in maternal health; and evaluating health services and the training, distribution, and utilization of the different categories of human resources in the delivery of maternal health care.

The shift to a more holistic approach to maternal health was expected to yield the following outcomes: a change in the vision of maternal health as strictly a women's health issue to a vision that recognized maternal health as a family and community, public health, equity, human rights, and development issue; a policy framework that prioritized maternal health as a means of righting inequities; synergy among partners towards common maternal health goals; action plans and resource distribution oriented toward quality and health promotion; and more women able to exercise their rights and decide freely on matters related to their sexuality and reproductive health free of coercion, discrimination, and violence.

The Subcommittee welcomed the holistic and integrated view of maternal health advocated in the document, which took account of factors such as gender discrimination, domestic violence, and reproductive rights that had a profound impact on maternal health. The Subcommittee also endorsed the view of maternal health as a family and community development issue and applauded the document's recognition of the intergenerational nature of maternal health. The emphasis on improving the health, nutrition, and education of girls in order to improve maternal health outcomes in the long term was considered especially important. The Secretariat was encouraged to consider developing a plan or framework for action in the Region based on the conclusions in the document. PAHO was also encouraged to continue calling attention to socially and politically sensitive issues such as gender-based violence and abortion, which were leading causes of maternal morbidity and mortality. It was suggested that the Organization might want to investigate the possibilities for collaboration on the issue of family violence with the Inter-American Children's Institute, which had a related initiative.

Several delegates described ways in which some of the document's recommendations were being incorporated successfully into maternal health programs in their countries. It was reported that Bolivia and Ecuador, for example, had recently introduced free maternal and child health care programs that addressed the principal causes of high maternal and infant mortality, as well as problems such as low birthweight and child growth and development problems associated with poor maternal health. Equally important, those programs recognized the responsibility of the State and society to promote and protect maternal health.

The importance of intersectoral action to address maternal health issues was underscored. It was pointed out that ministries of health should seek to engage ministries of health, education, labor, finance, and planning in dialogue with a view to highlighting the socioeconomic and development repercussions of maternal death and poor maternal health. The need to develop indicators for monitoring and evaluating efforts to address the multiple determinants of women's health was also emphasized. Several delegates commented on the relationship between maternal health and health sector reform, and the value of maternal health outcomes as a marker of progress in health reform was highlighted. In that connection, it was also pointed out that decisions about how health services were to be provided—especially decisions about private vs. public funding of services—would have a direct impact on women's access to services and therefore on maternal health. Strong support was expressed for the idea that maternal health should be a collective responsibility of society.

A number of suggestions were made regarding additional concerns and recommendations that might be incorporated into a framework or plan of action for maternal health, including the following:

- All policies on maternal health should take into account cultural features in each country; only if cultural traditions and practices are respected will women be willing to come to health services, and only then will it be possible to extend coverage, improve maternal health, and reduce maternal mortality.
- Community outreach programs that identify and support every pregnant woman in the community—regardless of whether or not they use the formal health system—should be promoted.
- Development of local-level maternal health committees should be encouraged; these committees would be responsible for reporting and investigating every maternal death, and input from the committees would feed into existing surveillance systems.

- Maternal health services should include at least four comprehensive obstetric health care facilities and 20 basic obstetric health care facilities per half million population, in accordance with WHO guidelines.
- Professional midwifery programs should be established, subject to a situational analysis in each country that would scrutinize the demand for such services.
- Strategies should be developed for counseling women to make them aware of the importance of good nutrition and healthy lifestyles before they become pregnant.
- Any comprehensive framework for maternal health should take account of the impact on maternal health of changes in women's roles and lifestyles. For example, in some countries, increasing numbers of women are delaying pregnancy to pursue higher education and enter professions. The maternal health issues faced by these women (higher risks associated with later pregnancy, infertility) are different than those faced by younger women.

Ms. Collado noted that, in producing the document, the Family Health and Population Program had consulted extensively with other divisions and programs of the Organization, with a view to incorporating all the determinants and factors that influenced maternal health. Unquestionably, the Subcommittee's comments would help the Program to continue to develop and refine the proposed framework.

### ***Repairs to the PAHO Headquarters Building***

Dr. Richard Marks (Chief, Department of General Services) recalled that the Secretariat had informed the 124th Session of the Executive Committee in June 1999 that some serious problems had been detected in components of the heating and air-conditioning systems at the PAHO Headquarters building. At that time, an engineering consultant had been assessing the situation. The situation assessment had since been completed, and the Secretariat was now in a position to present more complete information on the problems encountered and the recommended course of action for addressing them.

While the building's boilers and chillers were being replaced in 1999, major problems had been discovered in the joints of pipes that supplied the heated and chilled water used to heat and cool the building. On two occasions, pipe joints had broken due to rust and corrosion, causing major damage to ceilings and extensive flooding inside the building. It had been extremely difficult to repair the damage because the water shut-off valves were inaccessible and because the ceilings contained asbestos, which posed a

health threat to workers unless asbestos abatement procedures were performed prior to repair. Sampling in nine sites indicated that the corrosion was generalized, which meant that similar incidents of breakage and flooding were likely.

The engineering consultant had found the pipes to be in extremely poor condition and had estimated that the building's air induction units had, at most, a three-year life span remaining. He had recommended immediate replacement of both pipes and induction units. The work would have three major components: replacement of the shut-off valves to permit independent control of water in 26 vertical zones; asbestos abatement and replacement of all pipe risers and run-outs; and replacement of the induction units and enclosures. The Secretariat estimated the total cost of the work, including costs associated with temporary relocation of staff, at approximately US\$ 7.5 million.

The Members of the Subcommittee pointed out that the Executive Committee, not the SPP, was authorized to make decisions regarding repairs to PAHO buildings; nevertheless, they expressed concern about the impact of waiting to consult the Executive Committee, given the urgent need to remedy the situation and the potential for increased cost if the repairs were delayed. Several questions were asked about the source of funding for the repairs.

Mr. Eric Boswell (Chief of Administration) explained that the matter had been brought to the attention of the SPP because immediate action was needed. The Executive Committee would also be informed about the problem in June 2000, but in the meantime the Secretariat was seeking from the Subcommittee Members—all of whom were also Members of the Executive Committee—a “nod of approval” to proceed with the necessary repairs. To cover the costs, the Secretariat proposed a one-time increase of \$7.5 million in the ceiling of the PAHO Building Fund. The Fund was currently capped at \$500,000.

The Director said that he appreciated the Subcommittee's understanding of the gravity of the situation. He agreed that it was necessary to consult the Executive Committee; however, seven of the nine Members of the Committee were present at the Subcommittee's session. If those Members would agree to the one-time increase in the Building Fund, he would communicate immediately with the two Committee Members who were not present to inform them of the Subcommittee's recommendation and seek their approval.

The Members of the Executive Committee present at the SPP session agreed to authorize the Director to take the necessary action and requested that he communicate formally in writing with Members of the Executive Committee to apprise them of the situation, the action to be taken, and the budgetary implications of that action.

## **Other Matters**

The Delegate of Cuba presented a brief account of the outcomes of the Ninth Ibero-American Summit of Heads of State and Government, in which PAHO had played a leading role and which had yielded several outcomes of interest for the Organization and its Member States. Cuba had served as the host country for the Summit, which had taken place in Havana on 15 and 16 November 1999. The theme of the meeting had been “Ibero-America and the international situation in a globalized economy.” The first event of the Summit had been the inauguration of the Latin American School of Medical Sciences, which had been hailed as a symbol of what the countries could accomplish when they worked together. Although the idea for the school had been conceived less than a year earlier, it had already enrolled 1,929 students, representing 18 countries and 27 ethnic groups, who would return to serve their countries as physicians in geographic areas in which there had previously been no doctors.

A strong tradition of cooperation among the Ibero-American countries had developed since the first Summit, held in Guadalajara (Mexico), in 1991. The heads of state and government had decided to structure and formalize the cooperation process at the fourth Summit, and the Ibero-American Cooperation Agreement had been signed at the fifth Summit. The seventh Summit had decided that it was necessary to further institutionalize the process through the creation of a permanent secretariat. The ninth Summit had approved the establishment of the secretariat in Madrid. At its next session, the Executive Committee might wish to consider the possibilities that the recently created Ibero-American Cooperation Secretariat offered for increased cooperation among the countries in the area of health.

The ninth Summit had adopted the Declaration of Havana, which reaffirmed the value of the summits in promoting unity and collaboration among the Ibero-American countries. At the closing session, the President of Panama had announced that the theme of the tenth Summit, which will be hosted by Panama, would be “Childhood and Adolescence.” In view of the signal importance of that issue for health, the Cuban delegation recommended that it be discussed by the Executive Committee in June 2000, with a view to helping the Organization and the Member States prepare for their participation in the Summit.

The Subcommittee welcomed the creation of the Latin American School of Medical Sciences, which would unquestionably redound to the benefit of traditionally underserved populations in the Region. Several delegates expressed their appreciation to the Government of Cuba for affording students from their countries the opportunity to

prepare for medical careers. Support was also voiced for the idea of discussing within the Executive Committee the role of PAHO in political forums such as the Ibero-American summits.

Dr. Klinger, speaking at the invitation of the Director, said that PAHO viewed its participation in regional summit processes (the Ibero-American summits and the summits of the Americas) as an opportunity to raise the prominence of health issues on political and development agendas. The discussion of equitable access to health services at the 1994 Summit of the Americas in Miami had been a reflection of discussions of the topic of health equity by the ministers of health within the Governing Bodies of the Organization. A number of initiatives and opportunities for resource mobilization had resulted from those discussions, including the integrated management of childhood illness (IMCI) initiative, the health sector reform monitoring initiative, the reduction of maternal mortality initiative, and the measles elimination initiative. The Organization, in collaboration with the Member States had succeeded in mobilizing some \$30-\$35 million to follow up on those efforts. Hence, PAHO considered the collective mandates that emerged from the summits a very important means for advancing health priorities in the Region.

Certainly, the creation of the new Ibero-American Cooperation Secretariat would provide the Organization additional opportunities to advocate for the inclusion of health topics on political and development agendas and mobilize support to implement the plans of action that had come out of the summits. In relation to the tenth Ibero-American Summit, the Secretariat had already begun to discuss with the Government of Panama and the other Member States how the Organization could participate most effectively in that gathering. The Secretariat was also exploring how to utilize the joint plan of action that PAHO had established with the Government of Spain to further the implementation of the collective mandates of the summits.

The Director thanked the Delegate of Cuba for his report on the Ninth Ibero-American Summit and affirmed that the Organization would respond as aggressively as possible to ensure that the issue of health remained high on the agenda at the next summit. In addition, the Secretariat would seek the advice of the Executive Committee as to how PAHO should position itself within the hemispheric political movement which the summits represented. He also expressed the Organization's thanks to the Government of Cuba for hosting the celebration of the 75th anniversary of the signing of the Pan American Sanitary Code.

In regard to the next session of the Subcommittee, the current rules of procedure called for the Subcommittee to hold two regular sessions a year, unless the Executive Committee decided otherwise. The first of the two sessions was to take place after the

Directing Council and prior to the meeting of the WHO Executive Board. The other session was to take place after the WHO Executive Board meeting and before the meeting of the PAHO Executive Committee. He would communicate with the Members of the Subcommittee regarding the dates and agenda for the next session, bearing in mind those rules and the comments made during the discussion of the operations of the SPP. He reiterated his gratitude to the delegates for the cooperative spirit in which they had approached that discussion.

### **Closing of the Session**

The President thanked the delegates for their active and thoughtful participation during the session, which had been very productive. He expressed the Subcommittee's appreciation to the staff of the Secretariat for their efficient assistance and then declared the 33rd Session closed.

## **AGENDA**

1. Opening of the Session
2. Adoption of the Agenda and Program of Meetings
3. Operations of the Subcommittee on Planning and Programming
4. Participation of the Pan American Health Organization in the United Nations Reform in Member States
5. Food Protection
6. Virtual Health Library
7. Maternal Health
8. Cardiovascular Disease, with Emphasis on Hypertension
9. Repairs to the PAHO Headquarters Building
10. Other Matters

## LIST OF DOCUMENTS

<i>Document No.</i>	<i>Title</i>
SPP33/1, Rev. 2	Agenda
SPP33/2, Rev. 2	List of Participants
SPP33/3	Operations of the Subcommittee on Planning and Programming
SPP33/4	Participation of the Pan American Health Organization in the United Nations Reform in Member States
SPP33/5	Food Protection
SPP33/6	Virtual Health Library
SPP33/7	Maternal Health
SPP33/8	Cardiovascular Disease, with Emphasis on Hypertension

**LIST OF PARTICIPANTS  
LISTA DE PARTICIPANTES**

**Members of the Subcommittee  
Miembros del Subcomité**

**Bolivia**

Dr. Fernando Cisneros del Carpio  
Director de Relaciones Internacionales  
Ministerio de Salud y Previsión Social  
La Paz

**Canada  
Canadá**

Mr. Edward M. Aiston  
Director General  
International Affairs Directorate  
Policy and Consultation Branch  
Health Canada  
Ottawa, Ontario

**Cuba**

Dr. Antonio González Fernández  
Jefe del Departamento de  
Organismos Internacionales  
Ministerio de Salud Pública  
La Habana

Dr. Jorge Hadad Hadad  
Director, Escuela Nacional de Salud Pública  
Ministerio de Salud Pública  
La Habana

**Members of the Subcommittee (cont.)**  
**Miembros del Subcomité (cont.)**

**Ecuador**

Dr. César Hermida  
Subsecretario General de Salud Pública  
Ministerio de Salud Pública  
Quito

Dra. Tatiana Neira Alvarado  
Directora de Relaciones Internacionales  
Ministerio de Salud Pública  
Quito

**Guyana**

Dr. Rudolph O. Cummings  
Chief Medical Officer  
Ministry of Health  
Georgetown

**Mexico**  
**México**

Dra. Melba Muñiz Martelón  
Directora de Desarrollo y Gestión Internacional  
Dirección de Asuntos Internacionales  
Secretaría de Salud  
México, D.F.

Lic. María de Lourdes Aranda Bezaury  
Ministra, Representante Alternativa de México  
ante la Organización de los Estados Americanos  
Washington, D.C.

**Members of the Subcommittee** (*cont.*)  
**Miembros del Subcomité** (*cont.*)

**United States of America**  
**Estados Unidos de América**

Ms. Ann S. Blackwood  
Director, International Health Programs  
Bureau of International Organization Affairs  
Department of State  
Washington, D.C.

Mr. Richard S. Walling  
Director, Office of the Americas  
and the Middle East  
Office of International and Refugee Health  
United States Public Health Service  
Department of Health and Human Services  
Rockville, MD

Ms. Mary Lou Valdez  
International Health Program Officer (Americas)  
Office of International and Refugee Health  
United States Department of Health and Human Services  
Rockville, MD

Ms. Carol J. Dabbs  
Chief, Population, Health, and Nutrition Team  
Bureau for Latin America and the Caribbean  
United States Agency for International Development  
Washington, D.C.

**Other Member States**  
**Otros Estados Miembros**

**Brazil**  
**Brasil**

Sr. Roberto P. Coutinho  
Representante Alterno de Brasil  
ante la Organización de los Estados Americanos  
Washington, D.C.

**Honduras**

Lic. David Hernández  
Consejero  
Embajada de Honduras ante la Casa Blanca  
Washington, D.C.

**Pan American Sanitary Bureau  
Oficina Sanitaria Panamericana**

*Secretary ex officio of the Subcommittee  
Secretario ex officio del Subcomité*

Dr. George A. O. Alleyne  
Director

*Advisors to the Director  
Asesores del Director*

Dr. David Brandling-Bennett  
Deputy Director  
Director Adjunto

Dr. Mirta Roses Periago  
Assistant Director  
Subdirectora

Mr. Eric J. Boswell  
Chief of Administration  
Jefe de Administración

Dr. Juan Antonio Casas  
Director, Division of Health and Human Development  
Director, División de Salud y Desarrollo Humano

Dr. Stephen J. Corber  
Director, Division of Disease Prevention and Control  
Director, División de Prevención y Control de Enfermedades

Dr. Ciro de Quadros  
Director, Division of Vaccines and Immunization  
Director, División de Vacunas e Inmunización

Dr. Daniel López Acuña  
Director, Division of Health Systems and Services Development  
Director, División de Desarrollo de Sistemas y Servicios de Salud

**Pan American Sanitary Bureau** (*cont.*)  
**Oficina Sanitaria Panamericana** (*cont.*)

*Advisors to the Director* (*cont.*)  
*Asesores del Director* (*cont.*)

Dr. José Antonio Solís  
Director, Division of Health Promotion and Protection  
Director, División de Promoción y Protección de la Salud

Mr. Peter Toft  
Acting Director, Division of Health and Environment  
Director Interino, División de Salud y Ambiente

Dr. Carlos Castillo Salgado  
Chief, Special Program for Health Analysis  
Jefe, Programa Especial de Análisis de Salud

Dr. Irene Klinger  
Chief, Office of External Relations  
Jefa, Oficina de Relaciones Externas

Dr. Diana Serrano LaVertu  
Chief, Department of Personnel  
Jefa, Departamento de Personal

Dr. Karen Sealey (Technical Secretary/Secretaria Técnica)  
Chief, Office of Analysis and Strategic Planning  
Jefa, Oficina de Análisis y Planificación Estratégica

*Office of Analysis and Strategic Planning*  
*Oficina de Análisis y Planificación Estratégica*

Dr. German Perdomo  
Senior Policy Adviser  
Asesor Principal de Políticas

**Pan American Sanitary Bureau (cont.)**  
**Oficina Sanitaria Panamericana (cont.)**

*Advisers to the Director (cont.)*  
*Asesores del Director (cont.)*

*Legal Counsel*  
*Asesora Jurídica*

Dr. Heidi V. Jiménez

*Chief, Department of General Services*  
*Jefe, Departamento de Servicios Generales*

Dr. Richard P. Marks

*Chief, Conference and Secretariat Services*  
*Jefa, Servicios de Conferencias y Secretaría*

Ms. Janice A. Barahona