



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



49th DIRECTING COUNCIL
61st SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 28 September-2 October 2009

CD49/FR (Eng.)
2 October 2009
ORIGINAL: ENGLISH

FINAL REPORT

CONTENTS

	<i>Page</i>
Opening of the Session	6
Procedural Matters	
Appointment of the Committee on Credentials	6
Election of the President, Two Vice Presidents, and the Rapporteur	6
Establishment of a Working Party to Study the Application of Article 6.B of the PAHO Constitution	7
Adoption of the Agenda.....	7
Establishment of the General Committee	7
Constitutional Matters	
Annual Report of the President of the Executive Committee.....	7
Annual Report of the Director of the Pan American Sanitary Bureau	8
Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Trinidad and Tobago, United States of America, and Uruguay	10
Program Policy Matters	
Proposed PAHO Program and Budget 2010-2011	10
PAHO Strategic Plan 2008-2012 Amended (Draft)	13
New Scale of Quota Contributions	14
Plan of Action on the Health of Older Persons, Including Active and Healthy Aging	16
Elimination of Neglected Diseases and other Poverty-related Infections	18
Policy on Research for Health	20
Strategy and Plan of Action on Mental Health	21
Plan of Action on Adolescent and Youth Health.....	23
Plan of Action for Implementing the Gender Equality Policy.....	25
Policy Framework for Human Organ Donation and Transplantation.....	27
Health and Tourism.....	29
Integrated Health Services Delivery Networks Based on Primary Health Care	31
Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)	33
Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP)	35

CONTENTS (*cont.*)

	<i>Page</i>
Program Policy Matters (<i>cont.</i>)	
Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment.....	36
Family and Community Health.....	37
The Pan American Health Organization Revolving Fund for Vaccine Procurement	39
Roundtable on Safe Hospitals.....	42
Panel Discussion on the Pan American Alliance for Nutrition and Development for the Achievement of the Millennium Development Goals.....	44
Administrative and Financial Matters	
Report on the Collection of Quota Contributions	45
Interim Financial Report of the Director for 2008.....	46
Changes in the Financial Regulations and Financial Rules	47
Proposal for the Establishment of an Audit Committee	48
Salary of the Director and Amendments to the Staff Regulations of the Pan American Sanitary Bureau.....	49
Election of Member States to Boards and Committees	
Selection of One Member State from the Region of the Americas Entitled to Designate a Person to Serve on the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) on the Expiration of the Period of Office of Brazil	50
Selection of Two Member States from the Region of the Americas Entitled to Designate a Representative to the Policy and Coordination Committee of the UNDP/World Bank/WHO Special Program of Research, Development, and Research Training in Human Reproduction on the Expiration of the Periods of Office of Argentina and Mexico.....	50
Election of Five Nonpermanent Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME).....	50
Awards	
PAHO Award for Administration 2009	51
Abraham Horwitz Award for Leadership in Inter-American Health 2009.....	51
PAHO Champion of Health Recognition	52
Establishment of the Sérgio Arouca Award for Excellence in Public Health	52

CONTENTS (*cont.*)

	<i>Page</i>
Matters for Information	
Code of Practice on the International Recruitment of Health Personnel: a WHO background document.....	52
Progress Report on Technical Matters: International Health Regulations (<i>includes the Report on the [H1N1] Pandemic</i>)	55
Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO	59
Progress Reports on Administrative and Financial Matters	61
Status of Implementation of the International Public Sector Accounting Standards (IPSAS).....	61
Master Capital Investment Fund.....	62
Closure of the Session	62
Resolutions and Decisions	62
<i>Resolutions</i>	
CD49.R1 Amendments to the Financial Regulations	63
CD49.R2 Establishment of the Audit Committee of PAHO.....	74
CD49.R3 Amended PAHO Strategic Plan 2008-2012	80
CD49.R4 Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Trinidad and Tobago, United States of America, and Uruguay	80
CD49.R5 Establishment of a New Institutional Framework for the Latin American and Caribbean Center on Health Sciences Information (BIREME).....	81
CD49.R6 Election of Five Nonpermanent Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME).....	91
CD49.R7 New Assessment Scale for the Budgetary Period 2010-2011	92
CD49.R8 PAHO Program and Budget 2010-2011	94
CD49.R9 Assessed Contributions of the Member States, Participating States, and Associate Members of the Pan American Health Organization for 2010-2011	97
CD49.R10 Policy on Research for Health	100
CD49.R11 Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment.....	104
CD49.R12 Plan of Action for Implementing the Gender Equality Policy.....	106
CD49.R13 Family and Community Health.....	108

CONTENTS (cont.)

	<i>Page</i>
Resolutions (cont.)	
CD49.R14	Plan of Action on Adolescent and Youth Health..... 109
CD49.R15	Plan of Action on the Health of Older Persons, Including Active and Healthy Aging 113
CD49.R16	Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP)..... 116
CD49.R17	Strategy and Plan of Action on Mental Health 137
CD49.R18	Policy Framework for Human Organ Donation and Transplantation..... 140
CD49.R19	Elimination of Neglected Diseases and Other Poverty-related Infections 142
CD49.R20	Health and Tourism..... 154
CD49.R21	Salary of the Director and Amendments to the Staff Regulations of the Pan American Sanitary Bureau..... 156
CD49.R22	Integrated Health Services Delivery Networks Based on Primary Health Care 157
Decisions	
CD49(D1)	Appointment of the Committee on Credentials 160
CD49(D2)	Election of Officers..... 160
CD49(D3)	Adoption of the Agenda..... 160
CD49(D4)	Establishment of the General Committee 160
CD49(D5)	Selection of One Member State from the Region of the Americas Entitled to Designate a Person to Serve on the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) on the Expiration of the Period of Office of Brazil 161
CD49(D6)	Selection of Two Member States from the Region of the Americas Entitled to Designate a Representative to the Policy and Coordination Committee of the UNDP/World Bank/WHO Special Program of Research, Development and Research Training in Human Reproduction on the Expiration of the Periods of Office of Argentina and Mexico 161

Annexes

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

FINAL REPORT

Opening of the Session

1. The 49th Directing Council, 61st Session of the Regional Committee of the World Health Organization (WHO) for the Americas, was held at the Headquarters of the Pan American Health Organization (PAHO) in Washington, D.C., from 28 September to 2 October 2009. The agenda and list of participants are attached as Annexes A and C, respectively.

2. Dr. José Gomes Temporão (Brazil, outgoing President) opened the session and welcomed the participants. Opening remarks were made by Dr. Mirta Roses (Director, Pan American Sanitary Bureau), Mr. Héctor Salazar Sánchez (Chief Advisor Social Sector, Inter-American Development Bank), Mr. Albert Ramdin (Assistant Secretary General of the Organization of American States), Dr. Margaret Chan (Director-General, World Health Organization), and Hon. Kathleen Sebelius (Secretary of the Department of Health and Human Services, United States of America, Host Country). The text of their remarks (Documents CD49/DIV/1–6) may be found on the website of the 49th Directing Council:

http://new.paho.org/hq/index.php?option=com_content&task=view&id=1640&Itemid=1425&lang=en.

Procedural Matters

Appointment of the Committee on Credentials

3. Pursuant to Rule 31 of the Rules of Procedure of the Directing Council, the Council appointed Belize, Brazil, and Costa Rica as members of the Committee on Credentials (Decision CD49[D1]).

Election of the President, Two Vice Presidents, and the Rapporteur

4. Pursuant to Rule 16 of the Rules of Procedure, the Council elected the following officers (Decision CD49[D2]):

President: Paraguay (Dr. Esperanza Martínez)

Vice President: Dominica (Hon. John Fabien)

Vice President: Nicaragua (Dr. Guillermo González)

Rapporteur: Dominican Republic (Dr. Bautista Rojas Gómez)

5. The Director served as Secretary *ex officio*, and Dr. Juan Manuel Sotelo (Manager, External Relations, Resource Mobilization, and Partnerships, Pan American Sanitary Bureau) served as Technical Secretary.

Establishment of a Working Party to Study the Application of Article 6.B of the PAHO Constitution

6. The President announced that it would not be necessary to establish a working party to study the application of Article 6.B of the PAHO Constitution as no Member States were currently subject to the voting restrictions provided for under that article.

Adoption of the Agenda (Document CD49/1, Rev. 1)

7. The Council adopted the provisional agenda contained in Document CD49/1, Rev. 1, without change (Decision CD49[D3]). The Council also adopted a program of meetings (Document CD49/WP/1, Rev.1).

Establishment of the General Committee

8. Pursuant to Rule 32 of the Rules of Procedure, the Council appointed Canada, Cuba, and the United States of America as members of the General Committee (Decision CD49[D4]).

Constitutional Matters

Annual Report of the President of the Executive Committee (Document CD49/2)

9. Dr. María Julia Muñoz (Uruguay, President of the Executive Committee) reported on the activities carried out by the Executive Committee and its Subcommittee on Program, Budget, and Administration between September 2008 and September 2009, highlighting the items that had been discussed by the Committee but not sent forward for consideration by the 49th Directing Council and noting that she would report on other items as they were taken up by the Council. The items not sent forward included nongovernmental organizations in official relations with PAHO, the Annual Report of the Ethics Office, a report on projects using the program budget income exceeding the authorized effective working regular budget, amendments to the Pan American Sanitary Bureau (PASB) Staff Rules and Regulations, a statement by a representative of the PASB Staff Association, and the WHO Proposed Program Budget 2010-2011 and the amended WHO Medium-Term Strategic Plan 2008-2013. Details of the discussions and the action taken on those items may be found in the final report of the 144th Session (Document CE144/FR).

10. The Council thanked the Members of the Committee for their work and took note of the report.

Annual Report of the Director of the Pan American Sanitary Bureau (Document CD49/3, Rev. 1)

11. Following the projection of a video that provided an overview of health initiatives carried out in various countries of the Region during the previous year, the Director presented her Annual Report, the theme of which was “Advancing Toward Health for All: Progress in Primary Health Care in the Americas.” She highlighted some of the ways in which PAHO was supporting Member States’ efforts to strengthen their health systems, improve health outcomes, and reduce health inequities through the implementation of primary health care (PHC) approaches. She recalled that in 2003, on the 25th anniversary of the Alma-Ata Declaration on Primary Health Care, Member States had called for renewal of the primary health care strategy. Since then, PAHO had been promoting primary health care as the best means of achieving the goal of health for all.

12. The report contained numerous examples from countries of the Region that demonstrated that PHC-based health systems were indeed effective in improving the coverage, quality, and efficiency of health services. It also gave examples of how PAHO had collaborated with Member States in establishing such systems through technical cooperation in four main areas: expanding access to health care, building people-centered health services, promoting public policy for health, and strengthening health leadership. The Organization had also promoted and provided technical cooperation for the inclusion of primary health care approaches in the health agendas of the various subregional integration groups (the Caribbean Community, MERCOSUR, and others) and in the efforts of the Global Fund to Fight AIDS, Tuberculosis and Malaria and other global initiatives to strengthen health systems.

13. The last chapter of the report highlighted the challenges that remained to be overcome in order to provide access to health care for the 125 million people in the Region who currently lacked it and in order to achieve health for all—challenges which had been compounded by the current financial crisis and rising food and fuel prices. In the face of those challenges, PAHO would continue to champion primary health care and advocate sustained investment in health as a counter-cyclical measure that would help to mitigate the impacts of the crisis and safeguard past health gains.

14. The Directing Council commended the report and congratulated the Director on the achievements of the previous year. In order to ensure that PAHO could continue to play its key role as the premier health institution in the Region, the Organization was encouraged to carry on its efforts to improve the efficiency and effectiveness of its

activities and to strengthen accountability and results-based management. A number of delegates expressed appreciation for PAHO's leadership and technical support in the regional response to the influenza A (H1N1) pandemic. Delegates also expressed solid support for the primary health care strategy and underscored the importance of ensuring universal and equitable access to health care. It was pointed out that although progress had been made in that regard, there was still considerable inequality in access to health services and in health status. Delegates stressed the importance of making the most efficient use of available resources, particularly in the current economic climate, and pointed out that the financial crisis, coupled with the H1N1 pandemic, had exacerbated the situation of the Region's poor and vulnerable populations and increased demand for public health care services.

15. The importance of integrated health service delivery networks in expanding access to services was underscored and PAHO's work in that area was applauded, as was its support for the training of health personnel in Member States. Several delegates described their countries' efforts to achieve universal coverage and ensure health care for vulnerable groups such as mothers, children, and aboriginal peoples.

16. Delegates emphasized the importance of intersectoral action, encompassing both the public and private sectors, and of community involvement in order to address social and environmental factors that determined or affected health. It was pointed out that involving patients as active participants in health promotion and the cultivation of healthy lifestyles would require a profound change in the health care paradigm. Delegates also stressed the importance of subregional and regional collaboration in order to surmount common challenges and achieve shared goals. The Revolving Fund for Vaccine Procurement was cited as one example of an effective regional mechanism for ensuring access to the vaccine needed to bring the current influenza pandemic under control.

17. The importance of learning from the experiences of the past and of sharing experiences and lessons learned was underscored. In that connection, the Delegate of Cuba announced that his Government would host a seminar on primary health care from 23 to 25 November 2009 and invited representatives of all Member States to attend.

18. The Director said that the achievements described in her report reflected the work of hundreds of thousands of health workers, health ministry officials, volunteers, and PAHO and WHO staff, to all of whom she expressed gratitude.

19. The Council thanked the Director and took note of the report.

Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Trinidad and Tobago, United States of America, and Uruguay (Document CD49/4)

20. The Council elected Colombia, Saint Vincent and the Grenadines, and Venezuela to the Executive Committee, replacing Trinidad and Tobago, United States of America, and Uruguay, whose periods of office on the Committee had expired.

21. The Council adopted Resolution CD49.R4, declaring Colombia, Saint Vincent and the Grenadines, and Venezuela elected to membership on the Executive Committee for a period of three years and thanking Trinidad and Tobago, United States of America, and Uruguay for their service.

22. Representatives of Colombia, Saint Vincent and the Grenadines, and Venezuela expressed gratitude to the Council for electing their countries to serve on the Executive Committee and affirmed their governments' commitment to work towards surmounting the health challenges facing the Region.

Program Policy Matters

Proposed PAHO Program and Budget 2010-2011 (*Official Document 333, Add. I, and Document CD49/5, Rev. 1*)

23. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had examined an earlier version of *Official Document 333*, which had incorporated several changes and additions requested by the Subcommittee on Program, Budget, and Administration (see Document SPBA3/FR for details). Three budget scenarios had been proposed, only one of which, Scenario A, would have provided for an increase in the non-post portion of the budget. The budget proposal discussed by the Committee had been based on Scenario B, which had called for a 4.3% increase in assessed contributions. The increase in the total proposed budget, including both the regular budget and the portion funded by other sources, would have been 2.9%.

24. The Committee had discussed the budget proposal on several occasions over a period of four days, with delegates repeatedly expressing concern about the proposed increase in assessments and pointing out that their Governments were grappling with severe economic constraints, which had been compounded in some cases by the Pandemic H1N1. The Committee had therefore asked the Bureau to draw up a fourth scenario that would address those concerns. The Committee had subsequently considered a Scenario D, which had called for a 3.5% increase in assessed contributions and a 2.9% increase in the total budget, including the WHO share and miscellaneous income. After much discussion and consultation by delegates with authorities in their respective

countries, the Executive Committee had decided to accept Scenario D as the basis for the proposed program and budget and the proposed scale of assessments to be submitted to the 49th Directing Council.

25. Under Scenario D, the post component of the budget would increase by 6.3% and the non-post portion would decrease by 3.8%. Broken down by organizational level, Scenario D would result in a 21.86% decrease in non-post regular budget funds for the regional level, an 11.69% increase for the subregional level, and a 3.38% increase for the country level.

26. Dr. Isaiás Daniel Gutiérrez (Manager, Planning, Budget, and Resource Coordination, PASB), expressing thanks to Member States for their input on the budget proposal during and after the 144th Session of the Executive Committee, noted that the proposal was, for the first time, presented in three segments: PAHO/WHO base programs, outbreak and crisis response, and government-financed internal projects. He also noted that the proposal included two proposed resolutions, one concerning the program budget itself and the other establishing the assessed contributions of Member States on the basis of the new assessment scale adopted by the Organization of American States for the 2010-2011 biennium.

27. In the ensuing discussion, Member States acknowledged the hard work that had gone into preparing the budget proposal and expressed gratitude for the Bureau's responsiveness to the concerns raised by delegates during the June session of the Executive Committee. Delegates applauded the detail and transparency of the proposal but recommended that future budget documents should include even more detail and stronger comparative data in order to clearly show trends and shifts in programs and priorities from one biennium to the next. Delegates welcomed the efforts to achieve greater fiscal restraint; however, in the light of the current financial crisis, they also underscored the need for PAHO, like Member States, to continue to exercise budget discipline and austerity, increase efficiency, and prioritize its programs and activities.

28. The Delegate of Mexico, noting the economic impact of the Pandemic (H1N1) on his country, expressed concern about the proposed rise in Member States' assessments and called for zero nominal growth in the budget. The Delegates of Canada and the United States of America said that their Governments continued to advocate zero growth in the budgets of international organizations; the Delegate of Canada added, however, that her Government was satisfied with the justification of the proposed increase provided in the addendum to *Official Document 333* and would support the consensus of the Council on the budget. Some delegates said that their Governments' position on the proposed budget increase would depend on the Council's decision with respect to the new scale of quota assessments (see paragraphs 43 to 50 below).

29. Several delegates expressed concern about the proliferation of health initiatives and funding mechanisms and the resulting fragmentation of cooperation and potential weakening of multilateral institutions such as PAHO. The need for integrated action among all the agencies working to improve public health in the Region was emphasized. Support was expressed for PAHO's efforts to increase the level of core voluntary contributions, and information was requested on specific actions being taken to encourage donors to contribute more flexible funding.

30. Dr. Gutiérrez observed that, despite prudent budget management and steady reductions in the number of fixed-term posts over the previous 20 years, the post portion of the Organization's budget had continued to grow. Consequently, the non-post portion, which funded PAHO's technical cooperation activities, had declined. As was explained in the addendum to *Official Document 333*, in the coming biennium the regional level would be most affected by the reduction in the non-post budget; under Scenario C (zero growth in assessed contributions), for example, the regional share would shrink 34%, which would obviously reduce the Bureau's ability to provide technical cooperation. The Bureau was well aware of the difficult situation that many Member States were experiencing as a result of the global financial crisis and the influenza pandemic, but appealed to the Council to consider approving the budget increase as recommended by the Executive Committee.

31. The Director affirmed that the Organization was continually striving to make its work more efficient and effective. She also noted that none of the proposed budget scenarios would fully cover the cost increases incurred in the 2008-2009 biennium. In fact, PAHO had been absorbing cost increases for several biennia. That, combined with the decline in the United States dollar in recent years, had had a major impact on the Organization's budget and operations.

32. Concerns about the proliferation of global health initiatives and funding mechanisms and the potential for fragmentation had also been expressed within WHO and other forums. There were now about 90 such initiatives, and while they were an important source of financing for international health cooperation activities, they could also represent a considerable burden for the developing countries they were intended to benefit, owing to their differing procedures and reporting requirements. There was also concern about lack of developing country representation and participation in the governance organs of the various new funding mechanisms. At the same time, the developed countries that contributed to such mechanisms were voicing misgivings as to whether the best use was being made of resources.

33. The Paris Declaration on Aid Effectiveness and the recently formed "H4" group of four intergovernmental agencies working in the area of maternal and newborn health (WHO, United Nations Population Fund, United Nations Children's Fund and World

Bank) had responded to those concerns by fostering better alignment and coordination of resources and activities. At the regional level, PAHO had been working to strengthen coordination with the GAVI Alliance (see paragraphs 143 to 153 below) and other funding mechanisms and would continue striving to inform and support Member States with a view to ensuring that the development cooperation they received from all the various sources responded to their needs and priorities and was as effective as possible.

34. With regard to voluntary contributions, for some time PAHO had been encouraging donor countries and agencies to provide financing for broad program areas, rather than for specific projects or activities. In particular, it had sought such financing for the programmatic areas set out in the 2008–2012 Strategic Plan, especially those oriented towards strengthening health services and bolstering the capacity and leadership of national health authorities, and an increasing proportion of voluntary contributions was indeed being provided for program support. The implementation of results-based management, which enabled donors to see how resources were being used, had been important in attracting such contributions.

35. After reaching a compromise on the implementation of the new scale of quota assessments (see paragraph 47 below), the Council adopted the proposed program and budget based on Scenario D, as recommended by the 144th Session of the Executive Committee, appropriating \$339,852,341¹ for the financial period 2010-2011 and approving an increase in Member States' assessments of 3.5% with respect to the 2008-2009 biennium.

36. The Council adopted Resolutions CD49.R8 and CD49.R9.

PAHO Strategic Plan 2008-2012 Amended (Draft) (Official Document 328 and Document CD49/6)

37. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had been informed that the PAHO Strategic Plan 2008-2012 had been amended in order to maintain consistency with the WHO Medium-term Strategic Plan 2008-2013 and in order to update the document, clarify some of the expected results, and simplify measurement of the indicators. The Committee had welcomed the revisions to the Strategic Plan, applauding in particular the streamlining of the indicators and the inclusion of new indicators relating to the Millennium Development Goals, the increased emphasis on support for research at country level, and the inclusion of information on country cooperation strategies, which had been seen as crucial for ensuring that PAHO's technical cooperation was well aligned with Member States' needs and priorities.

¹ Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

38. The Committee had made a number of suggestions for further refinement of the Strategic Plan, and several delegations had submitted detailed comments and suggested amendments in writing. Clarification of the criteria for setting targets and indicators had been requested and it had been suggested that a technical annex should be added to the Strategic Plan, providing explanations of the methodology used to establish indicator values and the reasons for differences in the denominators. It had been pointed out that having specific information on the countries that constituted the statistical universe for a particular indicator could facilitate the planning of technical cooperation between countries. The Committee had adopted Resolution CE144.R10, recommending, subject to the incorporation of the revisions proposed by Member States, that the 49th Directing Council approve the amended Strategic Plan 2008-2012.

39. The Council endorsed the amendments made to the Strategic Plan 2008–2012 in order to align it with the WHO Medium-term Strategic Plan 2008–2013 and to update the document in order to clarify the expected results and simplify their measurement. The importance of consensus-based strategic planning was underscored.

40. Dr. Isaías Daniel Gutiérrez (Manager, Planning, Budget, and Resource Coordination, PASB) said that the Strategic Plan was a “living document” and would continue to be adjusted as needed in order to ensure both that PAHO was fully aligned with WHO and that the Plan responded to the realities of the health context in the Americas.

41. The Director noted that in consulting with Member States concerning the amendments to the Strategic Plan, ample use had been made of modern information and communications technology, which had resulted in considerable savings on travel and meeting costs.

42. The Council adopted Resolution CD49.R3, approving the amended Strategic Plan 2008-2012.

New Scale of Quota Contributions (Document CD49/7)

43. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Committee had examined the issue of the new scale of quota contributions at its 144th Session and that some members had expressed concern at the prospect of an increase in their PAHO assessments in the present economic climate and had suggested that the application of the new scale should be postponed. Others had felt that it would not be appropriate to postpone the implementation of a scale that had already been adopted by the Organization of American States (OAS). It had also been pointed out that the 140th Session of the Executive Committee had decided in 2007 that PAHO would begin applying the scale in the 2010-2011 biennium. Bearing that in mind, the Committee

had ultimately decided to recommend that the 49th Directing Council approve the new scale of assessed contributions to be applied to the program and budget for the budgetary period 2010-2011.

44. In the ensuing discussions, delegates reiterated their Governments' concern at the increases in their PAHO quota contributions that would result from the application of the new scale of assessments. They noted that their economies were already suffering in the current situation of economic and financial crisis, and in some cases had also been impacted by the Pandemic H1N1. Additionally, some delegations suggested that part of the OAS's procedure for calculating assessments, namely that a country's assessment should not change by more than 25% from one period to the next, was not being observed.

45. The Director pointed out that adoption of the OAS scale was mandated by the Pan American Sanitary Code and had been thoroughly discussed at previous Governing Body meetings. However, in the light of the concerns raised by the Executive Committee, the Bureau had held meetings with various delegations since June and was working to find a solution to address those concerns.

46. Mr. Román Sotela (Senior Advisor, Program and Budget Management, PASB) explained that the apparent distortion in the OAS procedure for calculating assessments arose from the decision by the PAHO Governing Bodies not to adopt the transitional scale that the OAS had adopted for the years 2007 and 2008, but rather to wait until the final OAS scale had been calculated for the years 2009-2011. It was that scale that was proposed for adoption by PAHO for the biennium 2010-2011.

47. Following further discussion, Mr. Sotela put forward a compromise proposal, recently prepared by the Secretariat in consultation with some delegations, led by Mexico, under which the transitional OAS scale (2008) would be applied to the PAHO assessments for 2010, and the definitive OAS scale (2009-2011) would be applied for 2011 onwards.

48. Numerous delegations spoke in favor of that solution. The Delegate of Cuba pointed out that because of its anomalous position of being a member of PAHO but not of the OAS, its PAHO assessment was higher than it should have been on the basis of its economic ranking in the Region. Nevertheless, his Government was prepared to pay its quota contribution, in a spirit of solidarity with the Organization. The Delegate of Chile said that although his country's quota was increasing by 99%, Chile too, in a spirit of solidarity, would support the proposal.

49. The Director pointed out that it was not the Organization's habitual practice to have different scales of quota contributions in the two years of a biennium, and that the

compromise proposal should not be seen as setting a precedent, but that for the present occasion it would be a pragmatic solution to the problem. The Delegate of the United States of America supported the Director's view.

50. The Council adopted Resolution CD49.R7, accepting the compromise proposal.

Plan of Action on the Health of Older Persons, Including Active and Healthy Aging (Document CD49/8)

51. Dr. María Julia Muñoz (Representative of the Executive Committee) said that the Executive Committee had expressed support for the proposed Plan of Action on the Health of Older Persons. Several delegates had noted that it was consistent with their national policies and priorities relating to the health of older persons. The Committee had noted the linkages between health of older persons and other areas, such as chronic diseases and family and community health. It had been pointed out that the Plan of Action should consider the gender aspects of the health of older persons and how the aging process affected men and women differently. Delegates had emphasized the importance of research and dissemination of knowledge on the health of older persons. It had been suggested that the proposed resolution on the item should mention the recent resolution of the Thirty-ninth General Assembly of the Organization of American States on the human rights of older persons and that it should make reference to the decision of the Fifth Summit of the Americas to consider the feasibility of preparing an inter-American convention on the rights of older persons. The Committee had adopted Resolution CE144.R13, recommending that the Directing Council endorse the Plan of Action.

52. The Council also expressed firm support for the proposed Plan of Action, with several delegates pointing out that it was in line with, and complementary to, their governments' policies in this area. The Plan's strategic areas, objectives, and goals were described as well-designed, although it was pointed out that they might have to be adapted to the specific situations of individual countries. Overall, however, the Plan of Action provided a good framework within which Member States could work creatively to address the problems of aging.

53. Most delegates who spoke described activities being carried out in their countries to promote the health of older persons, including free or low-cost medicines and care, improvements in nursing home care, sensitization and training for caregivers to the elderly, influenza immunization campaigns, and other initiatives. A number of delegates, notably those from the Caribbean, observed that the need for appropriate policies and actions was becoming more acute, as the elderly segment of the population was growing in size. Some expressed support for the adoption of an international convention on the rights of older persons, whether in the inter-American context or within the United

Nations system. Delegates also mentioned the need to promote the training of health workers in the specific aspects of geriatric care, including attention to the mental health needs of older persons, as well as to educate older persons themselves regarding their special health needs and the responsible use of medication. It was suggested that regional and subregional training programs should be set up for that purpose. Support for such training and for the strengthening of primary health care services for older persons were seen as key roles for PAHO, as were the organization of technical meetings on topics relating to healthy aging, the development of norms and standards, and the preparation of educational messages for use in health facilities and the media.

54. It was pointed out that as caregivers in the family or community context tended to be female, the growing feminization of the elderly age group could lead to problems of care shortages in the future. A related issue was that social structures were changing, leaving numbers of older people to fend for themselves who in the past would have been cared for by their families or communities. It was also pointed out that although efforts were being made to reduce health costs for older persons, some drugs and medical devices frequently used by such persons remained, in many countries, prohibitively expensive.

55. A representative of Alzheimer's Disease International stressed the need to raise public awareness about Alzheimer's disease and other dementias and offered suggestions for national dementia prevention and care strategies.

56. Dr. José Luis Di Fabio (Manager, Technology, Health Care and Research, PASB) thanked delegations for their descriptions of national activities and for their support for the Plan of Action. He said that PAHO was well aware that the political, legal and normative framework was key to the implementation of the Plan of Action and that there were major challenges in adapting health systems and providing appropriate training to caregivers for the elderly and was working to help countries meet those challenges.

57. Ms. Daisy Mafubelu (Assistant Director-General, Family and Community Health, WHO) found it highly appropriate that the Directing Council should be considering this topic on 1 October, the International Day of Older Persons. She encouraged more cities to join the WHO Global Network of Age-friendly Cities, which included Mexico City, New York City, and Rio de Janeiro.

58. The Council adopted Resolution CD49.R15, supporting the Plan of Action.

**Elimination of Neglected Diseases and other Poverty-related Infections
(Document CD49/9)**

59. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had welcomed PAHO's efforts to eliminate neglected diseases and diseases that mainly affected the poorest populations and those with the least access to health services. The approach proposed in the document had been generally supported, although delegates had stressed the need for more baseline data for measuring disease prevalence and for performance indicators, for more local involvement in control programs, and for research and development in order to identify new or better methods, materials, and medicines for the diagnosis, treatment, and control of neglected diseases. One delegate had expressed misgivings about some aspects of the proposed approach to neglected diseases, notably the strategy of mass preventive chemotherapy, which his Government viewed as inappropriate and unsustainable. He had suggested that a better approach would be to strengthen primary health care systems as the principal means for diagnosing and treating neglected diseases, combining passive detection with active case-finding.

60. The Directing Council also expressed general support for the proposed approach. The references in the document to the various WHO strategies and standardized tools for combating neglected tropical diseases were welcomed and PAHO was encouraged to synergize its work in this area with that of WHO. One delegate also noted the possibility of synergies with other disease control activities, given that the drugs used to treat some neglected diseases were effective against a variety of infections. She also underscored the need to improve drug distribution mechanisms. Another delegate highlighted the importance of entomological surveillance, strengthening of diagnostic capacities, and standardization of diagnostic tests. Several delegates stressed the need for community involvement and intersectoral participation in control efforts.

61. The need for baseline data for measuring disease prevalence and for performance indicators was reiterated. The latter were considered especially important for monitoring and evaluation of preventive chemotherapy interventions. The need for research on neglected diseases was also reemphasized, particularly research aimed at measuring the magnitude of the disease burden and establishing the geographic distribution of the diseases under discussion. The effect of climate change on the emergence and reemergence of some diseases was noted.

62. A number of delegates described the actions being taken in their countries to combat neglected and poverty-related diseases and to tackle poverty itself. Some reported that although their countries had been successful in controlling some diseases, other diseases such as malaria, dengue, Chagas' disease, and leptospirosis still posed a risk. Several delegates said that their countries would require ongoing technical and financial

support, notably from the Latin American and Caribbean Trust Fund for the Prevention, Control and Elimination of Neglected and Other Infectious Diseases, in order to meet the reduction and elimination goals proposed in the document.

63. Delegates raised some concerns with regard to specific diseases and the proposed approaches for combating them. The Delegate of Brazil pointed out that the proposed elimination goal for leprosy was not consistent with the WHO Global Leprosy Strategy for 2011-2015 agreed at the Global Leprosy Programme Managers' Meeting held in New Delhi in April 2009, which called for a reduction of at least 35% in the rate of new cases with grade-2 disabilities per 100,000 population by the end of 2015, compared to the baseline at the beginning of 2011. With regard to lymphatic filariasis, he emphasized that mass treatment strategies should be adapted to the specific areas where transmission occurred, as identified by prevalence studies. The proposed strategy of mass preventive chemotherapy for schistosomiasis, in his Government's view, would represent a step backward for the Region. Studies conducted in Brazil had shown that mass chemotherapy had only a transitory effect on schistosomiasis indicators. Countries should focus instead on strengthening capacity for diagnosis and treatment of *Schistosoma mansoni* carriers at the primary care level and on improving environmental sanitation. Lastly, he pointed out that the prevalence of soil-transmitted helminthiasis was not known in the Region, and further studies should be conducted before any mass treatment program was undertaken.

64. The Delegate of Mexico said that the document should include a more in-depth discussion of leishmaniasis, especially the visceral form of the disease, and that leishmaniasis should be included among the Group-2 diseases identified in the document. The Delegate of Argentina, noting that many of the diseases mentioned in the document were not endemic in his country, stressed the need to pay attention to other emerging and reemerging pathologies, such as hemolytic-uremic syndrome, sudden infant death syndrome, malnutrition, tuberculosis, anemia, and HIV/AIDS. He pointed out that there was good potential for the elimination of vertically transmitted Chagas' disease and suggested that it should be included in Group 1. He also suggested that the goal of reducing to seropositivity in expectant mothers to under 1% should be revised, since many women of childbearing age were already infected with the parasite *Trypanosoma cruzi*, and it would therefore be impossible to achieve the goal across the board. He also pointed out that the strategies for combating human rabies transmitted by dogs should include controlling the population of stray dogs.

65. Dr. Jarbas Barbosa da Silva (Manager, Health Surveillance and Disease Prevention and Control, PASB) thanked delegates for their constructive comments, which would help the Bureau improve its approach to neglected and poverty-related diseases. He believed that the approach put forward in the document and the proposed resolution would enable the health sector to fulfill its dual role of addressing the social determinants of health and eliminating or vastly reducing the burden of neglected diseases for which

cost-effective interventions existed. With regard to the goals and indicators proposed in the document, he emphasized that the Bureau had not included any that had not been established by a previous resolution of PAHO or WHO. The goal for leprosy, for example, was the same as that established in the WHO Medium-term Strategic Plan 2008-2013 and the PAHO Strategic Plan 2008-2012. The idea was to eliminate leprosy as a public health problem at the subnational level as well as at the national level, bearing in mind that in some countries in the Region, although the elimination goal had been achieved at the national level, prevalence of the disease remained high at the subnational level. While some of the indicators proposed by Brazil could be added to the proposal, it was crucial to ensure that the resolution adopted by the Directing Council was supported by existing mandates and that indicators were kept simple in order to avoid imposing an undue burden on the information systems of ministries of health.

66. The Director said that the approach put forward was an integrated one that took account of social determinants, environmental factors, and other variables that had contributed to the persistence of the set of diseases identified in the document. Noting that World Rabies Day had been observed on 28 September, she pointed out that the Region was very close to the goal of eliminating canine-transmitted rabies; however, rabies transmitted by wild animals, especially bats, remained a serious problem, which PAHO was working with Member States to address.

67. The Council adopted Resolution CD49.R19, incorporating several amendments proposed by Member States, including, for Brazil, the targets for epidemiological surveillance contained in WHO document “Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy – 2011-2015” (Document SEA-GLP-2009.4).

Policy on Research for Health (Document CD49/10)

68. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had generally welcomed the proposed policy and applauded PAHO’s renewed commitment to research, but had cautioned that expansion of research undertaken by PAHO itself could lead to duplication of efforts and dilution of resources. It had been stressed that PAHO should focus on translating research findings into technical guidance for Member States, rather than on conducting research itself. Delegates had welcomed the inclusive and multisectoral approach to research proposed in the policy and had suggested that there should also be participatory mechanisms for its evaluation. Concern had been expressed about the funding targets established in the policy, and it had been suggested that Member States should be encouraged to set aside funds dedicated to health research rather than being asked to commit to specific targets. Support had been expressed for a recommendation in the document that 5% of PAHO’s combined core and voluntary budget should be used in support of research.

69. The Directing Council also welcomed the policy and concurred with its incremental approach, but, like the Executive Committee, cautioned against duplication of efforts and dilution of resources and emphasized the need to apply research findings to the solution of priority health problems in the Region, including those highlighted under other items on the Council's agenda, such as mental health, health of older persons, health of adolescents and youth, and neglected diseases. The collaborative and solidarity-based aspects of the policy were seen as a beneficial way to direct research towards such problems and to strengthen research facilities and human resources in countries where research capacity was relatively weak. It was pointed out that the restructuring of the Latin American and Caribbean Center on Health Sciences Information (BIREME) would also help to strengthen scientific production and the sharing of information (see paragraphs 119 to 124 below). The concerns regarding funding targets were reiterated, and the importance of community-based participatory research, particularly research that would promote the participation of indigenous people and the use of traditional knowledge, was highlighted.

70. Several delegates described the organization of health research in their countries, offering to share findings and best practices with other Member States. Several also indicated that their countries were participating in the WHO Evidence-Informed Policy Network (EVIPNet). It was suggested that, although governments could serve as strong supporters of health research, PAHO and individual Member States should also seek to build partnerships with the private sector to encourage health research and innovation. Assisting Member States in evaluating the cost-effectiveness of health technologies and interventions was seen as an important role for PAHO in the area of health research.

71. Dr. José Luis Di Fabio (Manager, Technology, Health Care and Research, PASB), welcoming the generally positive comments from delegations, clarified that it was not the intention of the policy that PAHO should carry out research itself. Rather, the Organization's role would be to help Member States identify priorities for research, conduct research, and translate research findings into evidence for decision-making.

72. The Council adopted Resolution CD49.R10, endorsing the Policy on Research for Health.

Strategy and Plan of Action on Mental Health (Document CD49/11)

73. Dr. María Julia Muñoz (Representative of the Executive Committee) said that the Committee had expressed support for the Strategy and Plan of Action on Mental Health, which delegates had considered to be a means of achieving international and regional mental health goals, promoting good mental health and preventing mental health disorders, and strengthening access to mental health services. Support had been expressed for the proposal in Annex F of the document to form partnerships with other international

agencies in order to mobilize financing and for the proposal under activity 4.1.2 to create a regional working group to support the design of mental health training. The reference in Strategic Area 2 to healthy settings such as schools and communities had been welcomed, and attention had been drawn to the importance of the workplace as a focal area for detecting and addressing mental health disorders. The document's recognition of the issue of comorbidity in mental health patients had been commended. Strong support had been expressed for community-based mental health models and culturally specific approaches, particularly for indigenous peoples.

74. The Committee had expressed some concerns with regard to specific aspects of the Plan, notably some of the indicators. It had been suggested that each country should select the indicators that were most representative of its particular circumstances. It had also been suggested that since the Strategy and Plan of Action were based on a general view of the Region, each country should assess its own mental health system, using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS), in order to avoid automatic extrapolation of concepts, models of care, and institutional structures.

75. The Directing Council also expressed firm support for the Strategy and Plan of Action. Delegates stressed the importance of integrating mental health services into general health services, including at the primary care level, an approach that would help reduce costs. Delegates also underscored the importance of decentralization of mental health services, community-based care, multidisciplinary mental health teams, and stakeholder participation in the development, monitoring and evaluation of services. It was emphasized that institutionalization should be the treatment strategy of last resort for persons with mental disorders.

76. The importance of conducting assessments of mental health capacity and needs, including the legal framework and the availability of public financing for mental health services, was also highlighted. Several delegates noted that their countries were utilizing WHO-AIMS for that purpose, which had enabled them to identify weaknesses and strengths in their mental health services and to monitor progress in addressing any deficiencies. One delegate suggested that PAHO should prepare a supplementary report on mental health services at the primary care level in order to identify best practices and strategies for overcoming barriers to effective care. It might also be useful to draw up an inventory of resources available in Member States, such as training programs for mental health care professionals, with a view to forming partnerships. The same delegate stressed the need for financing strategies, noting that the Region had seen examples of mental health programs—some of them very good from a technical standpoint—that had not brought about any real improvements in mental health because no provision had been made for funding them.

77. Delegates highlighted the need for mental health services geared towards the special needs of specific population groups, including children and adolescents, older adults, and indigenous peoples. It was suggested that a reference to indigenous populations should be included in the proposed resolution on this item. One delegate noted the impact of the current economic crisis on mental health. Another delegate called attention to the serious problem of suicide among young people in her country and to the problems created by the stigmatization of persons with mental disorders. Several delegates said that reducing stigmatization of and discrimination against people with mental health problems should be a priority. A third delegate highlighted the need for attention to mental health in the workplace and to the needs of persons responsible for the well-being of others, such as teachers and health workers.

78. Dr. José Luis Di Fabio (Manager, Technology, Health Care and Research, PASB) thanked members for their helpful comments, which would enable the Bureau to enhance its technical cooperation in the area of mental health. He agreed on the value of documenting best practices and sharing experiences, and said that PAHO was preparing several reports to that end, including, for example, a consolidated report on the findings of assessments conducted in the Central American countries using the WHO-AIMS methodology. The adoption of the proposed Strategy and Plan of Action on Mental Health at the present juncture would be especially significant, given that World Mental Health Day would be observed on 10 October, and the year 2010 would see the 20th anniversary of the Caracas Declaration, which had marked the beginning of efforts to restructure mental health services in the Region. The observances planned for those two events would afford an opportunity for the dissemination of information and advocacy on mental health issues.

79. The Council adopted Resolution CD49.R17 on the item, endorsing the Strategy and Plan of Action.

Plan of Action on Adolescent and Youth Health (Document CD49/12)

80. Dr. María Julia Muñoz (Representative of the Executive Committee) said that the Committee had supported the Plan of Action on Adolescent and Youth Health and had applauded its integrated and inter-programmatic approach. Several delegates had pointed out that there were clear overlaps between this Plan of Action and other regional strategies, plans, and initiatives and had stressed the need for the Bureau and the PAHO country offices to ensure coordination and fluid communication across all programs, as well as to work with other agencies of the United Nations system in implementing the Plan. A number of suggestions had been made with regard to specific targets and indicators of the Plan of Action and several amendments to the proposed resolution on the item had been put forward. In particular, the need to ensure consistency in the usage of the terms “adolescent,” “youth,” and “young people” had been emphasized, as had the

need to clearly identify which groups were being targeted by proposed activities. In that connection, one delegate had suggested that some of the terms and acronyms mentioned in the Plan of Action should be more clearly defined in an annex. The Committee had adopted Resolution CE144.R6, recommending that the Directing Council endorse the Plan of Action.

81. The Directing Council expressed support for the proposed Plan of Action, which delegates felt would help to make the situation and needs of adolescents and young people in the Region more visible. Delegates applauded the Plan's evidence-based public health approach and welcomed its comprehensiveness, noting that it recognized the multiplicity of factors that influenced adolescent and youth health and the consequent need for intersectoral and inter-agency action to address those factors. Like the Executive Committee, the Council highlighted the linkages between this Plan of Action and plans and strategies in other areas, such as family and community health and integrated health services delivery networks based on primary health care, and stressed the need for interprogrammatic coordination. Delegates welcomed the revisions made to the Plan in response to the Executive Committee's comments, in particular the Plan's increased focus on vulnerable groups, especially indigenous and impoverished adolescents and youth, and its strengthened emphasis on encouraging the empowerment of young people and their involvement in formulating and carrying out policies and plans aimed at improving their health. It was pointed out, however, that in order for the actions envisaged under the Plan to be successful, sufficient budgetary resources would have to be allocated at country level.

82. With regard to monitoring of progress under the Plan, several delegates commented that specific indicators for individual countries would be needed in order to reflect national realities and measure change at country level with greater sensitivity. Some delegates noted that their countries' programs for adolescents and young people used age ranges different from those proposed in the Plan of Action (10 to 24 years), which might make reporting on progress complicated, but they nevertheless expressed support for the Plan and willingness to coordinate their actions with those of PAHO. Numerous delegates underscored the value of sharing data and best practices. In that connection, the Delegate of Brazil announced that his Government would host an international youth conference in 2010 and suggested that a seminar on adolescent and youth health might be held in conjunction with that event, which would provide an opportunity for the exchange of experiences.

83. Several delegates stressed the need to protect young people's rights with regard to health, including their right to access reproductive health services and other medical services without parental consent. At the same time, the need to recognize the rights and responsibilities of parents and other persons legally responsible for adolescents was emphasized. The role of civil society organizations and schools in promoting adolescent

and youth health was highlighted. Special emphasis was placed on the need to reduce the high rates of adolescent pregnancy in the Region and address mental health issues and problems relating to substance abuse, HIV/AIDS and other sexually transmitted infections, violence, and road traffic injuries and deaths among young people. It was pointed out that special programs were needed for adolescents and youth not enrolled in school and for those being held in detention facilities. The importance of providing youth-friendly services at the primary health care level and training health care professionals to work with youth and adolescents was underscored. Training to enable health care workers to respond appropriately to the sexual and reproductive health needs of young people was considered especially important.

84. Representatives of the United Nations Population Fund and the International Federation of Medical Students' Associations expressed support for the Plan of Action and encouraged the Bureau and Member States to allocate sufficient resources for its full implementation. The representative of the International Federation of Medical Students' Associations pointed out that investment in adolescent and youth health would help to create a culture of health and lead to future generations of healthier adults.

85. Dr. Gina Tambini (Manager, Family and Community Health), noting the serious impact of the current global financial crisis on adolescents and youth, pointed out that investment in the health and development of young people would also promote greater productivity and economic growth in the countries of the Region. She thanked Member States for their support of the Plan and congratulated them on the progress made in providing services for adolescents and youth.

86. Ms. Daisy Mafubelu (Assistant Director-General, Family and Community Health, WHO) said that WHO looked forward to working with PAHO on the implementation of the Plan of Action on Adolescent and Youth Health and expressed confidence that the Plan would contribute to achievement of the Millennium Development Goals and help to save the lives of the thousands of adolescent girls who continued to die each year from causes related to pregnancy and childbirth.

87. The Council adopted Resolution CD49.R14, endorsing the Plan of Action.

Plan of Action for Implementing the Gender Equality Policy (Document CD49/13)

88. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had voiced solid support for the proposed Plan of Action for Implementing PAHO's Gender Equality Policy, adopted in 2005 (Resolution CD46.R16). The Committee had felt that the Plan of Action provided a comprehensive framework for continued work towards gender equality by both the Bureau and Member States. The Plan's strategic areas had been considered clear and feasible and its potential contribution

to the achievement of the Millennium Development Goals and other gender equality goals had been recognized. The Committee had emphasized the need for both PAHO and Member States to allocate sufficient resources and to ensure the necessary infrastructure and capacities to implement the Plan.

89. Several further refinements of the indicators in the Plan of Action had been suggested. In particular, it had been felt that further work should be done on the indicator relating to the contributions of unpaid health care in national health accounts in order to specify the precise nature of those contributions and how they should be reflected in the accounts. It had also been suggested that some indicators should be refocused. With a view to promoting a “One UN” approach to mainstreaming gender in public policies, it had been suggested that a new operative paragraph should be added to the proposed resolution on this item, calling on both Member States and the Director to promote and strengthen partnerships with other United Nations agencies and with other organizations to support the implementation of the Plan of Action. The Committee had recommended that the Directing Council adopt a resolution urging Member States to, among other actions, adopt and promote the implementation of the Plan of Action.

90. In the discussion that followed Dr. Muñoz’s report, delegates expressed strong support for the Plan of Action and affirmed their Governments’ commitment to the achievement of equal rights and opportunities for women and men. Delegates described efforts under way in their countries to promote gender equality and address the health disparities between women and men. Several delegates observed that gender equality initiatives should not be perceived as relating only to women and highlighted the need for greater attention to the specific health needs of men. It was pointed out that men generally died earlier and suffered more from cardiovascular and other noncommunicable diseases than women. Moreover, owing to social and cultural factors, they were less likely to seek health care than women and often waited to do so until their condition was severe or even life-threatening. Several delegates mentioned health promotion and disease prevention initiatives in their countries aimed specifically at men. A number of delegates drew attention to the serious and persistent problem of gender-based violence in the Region and described their countries’ strategies, policies, and programs for addressing it. The need to involve men in those efforts was underscored.

91. The importance of sex-disaggregated statistics and gender analysis in identifying disparities in health was emphasized. It was pointed out that such analysis needed to take account of both the sex-related biological factors and the gender-related social factors that accounted for the differential effect of various health determinants on men and on women. Several delegates also noted the impact of ethnic and cultural factors on health and emphasized the need for disaggregation of data by race and ethnicity. The need to monitor progress under the Plan of Action was stressed, as was the value of sharing best

practices and lessons learned. Delegates welcomed the proposal in the Plan of Action to establish a knowledge platform to facilitate the sharing of experience.

92. A representative of the International Planned Parenthood Federation commended PAHO's Gender Equality Policy and the Plan of Action, and affirmed her organization's commitment to support Member States in implementing it.

93. Dr. Marijke Velzeboer-Salcedo (Senior Advisor, Gender, Ethnicity and Health, PASB) said that the Plan of Action was the product of a broad consultation process involving stakeholders at the national, subregional, and regional levels, as well as civil society partners and PAHO's sister agencies in the United Nations and inter-American systems. She was grateful to all who had participated in those consultations. It was clear from the Council's comments that Member States were strongly committed to implementing the Gender Equality Policy and the Plan of Action at national level. Monitoring and ensuring accountability for implementation would perhaps be the most challenging aspect of the Plan, and she would welcome ongoing input from Member States on how best to address that challenge.

94. She assured the Council that PAHO was well aware of the importance of ethnic and cultural factors. Indeed, that awareness was reflected in the name of her office: Gender, Ethnicity and Health. The Organization also recognized the need to do more to meet men's health needs and improve their life expectancy. PAHO was working closely in that area with Member States, other intergovernmental agencies, and civil society organizations.

95. Dr. Socorro Gross (Assistant Director, PASB) said that the Plan of Action represented a commitment by Member States on an issue that was crucial for health and well-being, for the full exercise of rights, and for the development of the countries of the Region. She had listened carefully to the views and recommendations of Member States and assured the Council that they would be taken fully into account in the implementation of the Plan of Action.

96. The Council adopted Resolution CD49.R12, endorsing the Plan of Action and urging Member States to promote its implementation as a framework for attaining gender equality in health.

Policy Framework for Human Organ Donation and Transplantation (Document CD49/14)

97. Dr. Marthelise Eersel (Representative of the Executive Committee) said that the Committee had welcomed PAHO's efforts to develop a policy framework for human organ donation and transplantation and had stressed the need for strong regulatory

systems based on ethical principles in order to ensure the safety of organ recovery and transplantation and equitable access to donated cells, tissues, and organs. The Committee had also underscored the importance of discouraging organ commercialism and promoting altruistic donation, and the importance of achieving national self-sufficiency in organ donation. Delegates had emphasized the need to encourage deceased donation while also ensuring protection and post-transplant monitoring and care for living donors. The Bureau had been encouraged to base the policy framework on WHO's revised Guiding Principles on Human Cell, Tissue, and Organ Transplantation. The Committee had expressed solid support for those WHO Guiding Principles, although some members had been of the view that, as the Sixty-second World Health Assembly had postponed consideration of them, it would be premature for the PAHO Governing Bodies to adopt a resolution on the matter.

98. Dr. José Luis Di Fabio (Manager, Technology, Health Care, and Research, PASB) had explained that the revised Guiding Principles had been discussed by the WHO Executive Board, but because of the impact of the Pandemic H1N1, the World Health Assembly had decided to defer consideration of the issue to 2010. However, the Guiding Principles were already in existence, having been adopted in 1991, and the World Health Assembly would simply be approving updates to them. For that reason, he did not believe that it would be premature for the Directing Council to adopt a resolution on the subject.

99. In the discussion that followed the Executive Committee report, delegates expressed support for the policy framework and proposed resolution. Most delegates who spoke described how organ donation and transplantation were organized and regulated in their countries. Attention was drawn to the importance of establishing national agencies to encourage and regulate organ donation, and it was suggested that PAHO and WHO could play a leading role in supporting such efforts. The need to provide adequate post-transplant care and monitoring of donors was also underscored.

100. It was generally considered that organ procurement should be carried out within the public health system, as the proliferation of private organ banks had become a serious problem in several countries of the Region. Several delegates stressed the need to control trafficking of organs and discourage transplant tourism, which could deprive local people of their chance to receive a transplant. They also emphasized the importance of transparency at every step in the process and the need to promote equitable access to organs and tissues, especially for vulnerable sectors of the population. One delegate suggested that public-private partnerships could be helpful in promoting ethical donation and transplantation practices.

101. Delegates stressed the importance of encouraging increased use of deceased donations, although it was pointed out that in the culture of some countries the practice was not well-received. Several delegates expressed appreciation for the work of the

Ibero-American Network/Council on Donation and Transplantation (RCIDT) and expressed the hope that its assistance could be extended beyond the Spanish-speaking countries, in particular to the Caribbean. The Delegate of Spain welcomed the success of RCDIT and said that his Government stood ready to continue providing assistance in enhancing the organization of organ donation and transplantation in the Region. Delegates from the Caribbean said that their countries would benefit greatly from PAHO assistance with their kidney transplant and kidney health programs, as envisaged in paragraph 2(f) of the proposed resolution. Delegates also drew attention to the work of the MERCOSUR Intergovernmental Donation and Transplantation Commission (CIDT).

102. Dr. José Luis Di Fabio (Manager, Technology, Health Care and Research) thanked delegates for their comments, and congratulated the countries of the Region on the progress made in developing their transplantation capacities and improving their rates of organ donation, also thanking Spain for its financial and technical support of RCIDT. He added that PAHO was working to assist the Caribbean countries in their efforts to improve their transplant programs, recalling that a meeting had been held in Trinidad and Tobago a few years earlier to allow an exchange of experiences in this area.

103. The Council adopted Resolution CD49.R18, endorsing the policy framework for human organ donation and transplantation.

Health and Tourism (Document CD49/15)

104. Dr. Marthelise Eersel (Representative of the Executive Committee) said that the Executive Committee had stressed the importance of tourism to the sustainable development of countries in the Region, especially in the context of the present international economic crisis, the H1N1 influenza pandemic, and the emergence and reemergence of other communicable diseases such as dengue. Health tourism, especially transplant tourism, had been identified as an issue that raised some serious concerns with regard to equity and access to health care. Some delegates had felt that the document on the item lacked clarity and focus and had recommended that it be made more explicit. It had been suggested, for example, that definitions of terms such as “tourist health” and “health tourism” were needed, and that the issues to be addressed by the proposed regional forum on health tourism should be clarified. It had also been pointed out that the proposed resolution requested the Director to draw up a regional plan of action, but the document did not propose any tentative objectives, indicators, or activities for such a plan. Several delegates had been of the view that the financial implications of the proposed resolution on this item had been seriously underestimated, particularly in the light of the influenza pandemic and its cost impact on tourist areas, and the Secretariat had been asked to revise the budget figures.

105. Following the report by the Executive Committee, several delegates described actions being taken by their countries to manage tourism, stressing its importance to their national economies. Several delegates pointed out that health and tourism intersected in three different areas, the first being the provision of a healthy environment which tourists would wish to visit. In this area, delegates stressed the importance of programs relating to clean water, food safety, waste management, and prevention of violence against tourists. The second was the need to make provision for caring for visitors who fell ill, an important aspect of which was the question of the terms, particularly financial, on which tourists should receive health care. The third area related to health care for the local population who might be made ill by diseases brought in by visitors. The importance of epidemiological surveillance systems at ports of entry and of efficient health information systems for hotels was highlighted.

106. One delegate felt that the document should describe more clearly the symbiotic relationship of health and tourism, and the contribution that both made to a country's economic and social development. He also stressed that healthy tourism could contribute to global health, and that any investments in ensuring healthy tourism should be seen as bringing value-added to a country's economy. Most Member States expressed their support for the proposal to create a Regional Forum on Health and Tourism, although two argued that it would duplicate existing mechanisms and would go beyond the scope of PAHO's remit. The Delegate of the United States of America suggested that, rather than setting up a new forum, PAHO and WHO should advocate for health considerations to be integrated into current forums for tourism development. He also stressed that issues of sustainability and environmental concerns, including climate change, belonged within the purview of other organizations.

107. The Council also discussed medical tourism, including organ transplant tourism. The delegate of Argentina reported that his Government had proposed, in the framework of MERCOSUR, an agreement designed to prohibit traffic in human cells, tissue, and organs, and to discourage transplant tourism between members of MERCOSUR. Other delegates stressed the need for proper accreditation of facilities that provided medical services to tourists.

108. Dr. Luiz Galvão (Manager, Sustainable Development and Environmental Health, PASB) thanked the delegates for their useful comments, which would help improve the document. Replying to concerns about the Regional Forum on Health and Tourism, he explained that the forum was the mechanism through which PAHO would coordinate its work with other sectors. The new forum would not duplicate existing mechanisms or give rise to a separate organization for tourism issues. Referring to the observation that the Forum would go beyond the scope of PAHO's mandate, he explained that the United Nations Environment Program and the International Labor Organization, as well as the environment secretariats of Member States, would be invited to participate in the Forum.

109. The Director confirmed that aspects of tourism such as labor issues or the environment would remain the responsibility of the relevant international bodies, and that many of the concepts and definitions relating to tourism came directly from the World Tourism Organization, with which PAHO had a close working relationship. But for the health aspects of tourism, such other bodies looked to PAHO, and in the wider context to WHO, for guidance.

110. The Council adopted Resolution CD49.R20, endorsing the concepts in Document CD49/15 and supporting the establishment of the Regional Forum on Health and Tourism.

Integrated Health Services Delivery Networks Based on Primary Health Care (Document CD49/16)

111. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had voiced solid support for the development of integrated health services networks based on primary health care, which the Committee had seen as a means of improving health status, reducing health inequities, extending coverage, enhancing quality of care, and containing health care costs. The Committee had also acknowledged the contribution that such networks could make to the achievement of the health-related Millennium Development Goals. The importance of making health care available close to where people live had been stressed. It had been pointed out that the value of public-private partnerships should not be underestimated, as they could help reduce costs and expand coverage. The Global Fund to Fight AIDS, Tuberculosis, and Malaria had been cited as an example of a successful public-private partnership. PAHO had been encouraged to synergize its work in this area with that of WHO and to build on existing strategies and frameworks. The Committee had emphasized the need to set clear targets and indicators for measuring progress in strengthening health systems through the development of integrated health services networks.

112. With regard to the document and the proposed resolution on this item, some members of the Executive Committee had felt that the definitions of some terms, including “integrated health services delivery network,” should be strengthened and the examples clarified. In the light of the Committee’s discussion of family and community health, it had also been suggested that the proposed resolution on the item should encourage Member States to prepare a national plan of action promoting the creation of integrated health services networks with a family and community health approach as the preferred modality for health services delivery. The Committee had adopted Resolution CE144.R7, incorporating the amendment relating to family and community health.

113. Like the Executive Committee, the Council strongly supported the proposed approach to the integration of health services delivery through networks and the

development of health systems based on primary health care. Delegates felt that the approach would help to reduce fragmentation and segmentation of health systems and improve access to health services for poor and underserved populations. It was pointed out, however, that primary health care should not be seen solely or mainly as a strategy for providing health care for the poor, but rather as a means of achieving greater coverage and equity in health care systems. It was also pointed out that the hospital-dominated health care delivery systems that prevailed in many countries, with their heavy reliance on complex and expensive technologies, had driven up costs and limited access to health care, but had not produced better health outcomes. The need to address the issues of health care coverage and social protection for those who lacked them, particularly in developing countries, was emphasized.

114. Delegates reaffirmed their support for the principles of primary health care set out in the Declaration of Alma-Ata, highlighting in particular the importance of health promotion, community participation, and government responsibility and accountability. The importance of intersectoral action to address social and environmental determinants of health was also stressed, as was the need to train sufficient human resources to work at the primary care level. Enhancing response capacity and ensuring quality of care and user satisfaction at the primary care level were considered crucial to the success of integrated health services delivery networks. One delegate, observing that users who were not satisfied with the services provided at the primary care level would be more likely to seek care directly from the secondary or tertiary level, highlighted the need for quality management systems that took account of the views of both users and providers of health services. Another delegate drew attention to the influence of the Internet and other sources of information on health care consumers' ideas and expectations with regard to health care.

115. Delegates described a variety of strategies and initiatives in their countries for developing health services delivery networks based on primary health care, including a system centered around polyclinics, a mobile health care program designed to reach isolated and marginalized populations, the use of telehealth technologies to strengthen capacity at the local primary health care level, and the creation of regional and national "macronetworks" of specialized health care centers to deal with health needs that could not be managed within local-level networks. Several delegates highlighted the value of public-private partnerships in extending health services, although it was also pointed out that public and private health entities sometimes transmitted differing messages with regard to the provision and the consumption of health services.

116. It was emphasized that any strategy for improving health service delivery systems should be based on the best available evidence, including the significant body of work amassed by WHO on the subject. PAHO was encouraged to ensure that its work in this area was in synergy with that of WHO and that efforts were not being duplicated. It was

also emphasized that there must be flexibility in the design and operation of health care networks in order to accommodate the heterogeneous health needs of different populations and the differing socioeconomic characteristics of countries. At the same time, it was pointed out that countries of the Region shared some common characteristics and health problems and could therefore learn from one another's experiences. Numerous delegates stressed the importance of monitoring and evaluating the performance of integrated health services delivery networks. The inclusion of some general progress indicators in the document on this item was welcomed, and it was suggested that a timeframe for evaluating the impact of the proposed strategies should be established.

117. Dr. Hernán Montenegro (Senior Advisor, Health Systems and Social Protection, PASB) expressed gratitude to the Member States that had participated in and supported the national, subregional, and regional consultations that had provided input on the regional policy for developing integrated health services delivery networks. He believed that the document and the proposed resolution on this item reflected the views and concerns expressed by delegates. They presented an approach aimed at renewing and operationalizing the primary health care strategy and recognized the importance, for example, of flexibility, user satisfaction, intersectoral action, public-private partnerships, and monitoring and evaluation of progress. With regard to the latter, PAHO would continue to strive to develop indicators and methodologies for measuring the performance of health services delivery networks and of health systems in general, ensuring that its efforts in that area were in synergy with those of WHO. The Organization would also continue to compile information on the experiences of Member States in developing and implementing integrated networks based on primary health care. Such information would be a valuable source of evidence and best practice.

118. The Council adopted Resolution CD49.R22 on this item, urging Member States to prepare a national plan of action promoting the creation of integrated health services delivery networks with a family and community health approach as the preferred modality for health services delivery in the country.

Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME) (Document CD49/17)

119. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had heard an update in June on progress in developing a new institutional framework for BIREME comprising three legal instruments: a Statute, a Headquarters Agreement, and a Facilities Agreement. The Committee had been informed that the purpose of the new institutional framework was to put in place a new governance structure and ensure a stable and balanced source of financing for BIREME's work. The Committee had examined a draft of the Statute and had proposed several amendments to Article IV, concerning membership of BIREME; Article VI, relating to the proposed

Advisory Committee; Article VII, which dealt with the proposed Scientific Committee; and Article VIII, concerning the Secretariat of BIREME. Those changes had been incorporated into a revised version of the document and were reflected in Document CD49/17. The Committee had adopted Resolution CE144.R24, recommending that the 49th Directing Council approve the new institutional framework for BIREME, including the proposed Statute.

120. In the discussion that followed Dr. Muñoz's report, delegates expressed gratitude for the work of BIREME and support for the proposed new institutional framework, which they felt would enhance the Center's capacity for information management and dissemination.

121. The Delegate of Brazil said that it was a source of pride for his country to serve as the host country for BIREME, which had made a huge contribution to the production and dissemination of scientific information in the Region and had played a pioneering role in the use of information technologies such as CD-ROM. Brazil applauded the Center's role in increasing access to health information in Portuguese through the WHO ePORTUGUÊSe network, which used the Virtual Health Library model developed by BIREME. His Government fully supported the new institutional framework.

122. The Director said that development of the new institutional framework was part of an ongoing process of reviewing the situation of all Pan American centers in order to adapt them to the changing needs of the Region and the priorities established by Member States in the Strategic Plan 2008-2012 and other policy and planning documents. A great deal of change had taken place in the previous two decades in the area of knowledge management, which had become crucial to the advancement of many health activities. The collaboration between the Government of Brazil, PAHO, and BIREME had worked extraordinarily well. The Center had become a valuable resource not only for the PAHO Member States but for Member States in other WHO regions and for WHO itself. Not only did it serve as a repository of information, but it had played a key role in the formation of networks of national health libraries, thereby facilitating the exchange of scientific information throughout the Americas and the rest of the world. The existence of those collaborative networks had contributed to progress on a number of fronts in the field of public health.

123. She expressed gratitude to the Government of Brazil for its support of the Center over the years and to the Director of BIREME and the Organization's Legal Counsel for their hard work on the new institutional framework.

124. The Council adopted Resolution CD49.R5, approving the Statute of BIREME.

Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP) (Document CD49/18)

125. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Committee had been informed at its 144th Session that the INCAP Directing Council had resolved to assume full responsibility for the Institute's administration, effective September 2009, and to amend its Basic Agreement accordingly. The Committee had also been informed that the Director had established several working groups to address the various technical, administrative, and legal aspects of the transfer of administrative responsibility, with a view to ensuring a smooth transition and preserving the Institute's functionality and leadership in the areas of nutrition and food security. Most of the key documents for the transfer of administrative responsibility to the INCAP Directing Council had been approved, although the terms of reference and procedure for selection of the next director of INCAP were at that time still being finalized. The Executive Committee had adopted Resolution CE144.R20, recommending that the Directing Council of PAHO approve the transfer of the administration of INCAP to its Directing Council.

126. The Delegate of Guatemala observed that Guatemala's Ministry of Health shared premises with INCAP, and that the support received from the Institute and the exchange of experience with it had been positive. Her country unconditionally supported the proposal in the document for the restructuring of INCAP and looked forward to the establishment of its Directing Council.

127. Dr. Socorro Gross (Assistant Director, PASB) reported that the procedure for selecting the next director of INCAP had been approved by the requisite majority and a list of potential candidates was being prepared in cooperation with the President of the INCAP Directing Council. It was hoped that a selection could be made at the latter's next session, to be held in December. The rest of the documents were expected to be finished very soon, and PAHO would then be in a position to transfer the management of INCAP to its Directing Council as soon as auditing was completed in late December or early January. PAHO would remain a part of INCAP, since it would continue to sit on its Directing Council, and the Organization would also continue to support nutrition-related initiatives in agreement with that Council.

128. The Director observed that the transfer of administration had been a process of several years' duration during which INCAP had been progressively strengthened in preparation for its administrative separation from the Organization. The new structure would facilitate the mobilization of resources for INCAP and strengthen the Institute, enabling it to play a more active role in addressing the problems of undernutrition and malnutrition due to excess, which had been highlighted during the recent panel discussion (see paragraphs 163 to 167 below).

129. The Council adopted Resolution CD49.R16, requesting the Director to institute the measures necessary for an orderly transfer of the administration of INCAP to its Directing Council.

Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment (Document CD49/19)

130. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had expressed firm support for the proposed Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment and had recommended that the Directing Council approve it. Several members had noted that the Plan was fully in line with their national plans and strategies for preventing blindness and visual impairment and several had described programs under way in their countries. In response to a query from a delegate, it had been explained that retinopathy of prematurity caused more than half of childhood blindness in Latin America and the Caribbean and for that reason it had been identified as a priority under the Plan of Action. It had been suggested that objective 1.2.2 in the Plan, which identified Hispanics and persons of African descent as high-risk groups for diabetic retinopathy should be made more generic by amending it to read “high-risk groups of certain ethnic origins, depending on the country.” That suggestion had been incorporated into the revised version of the Plan submitted to the Council.

131. The Directing Council welcomed PAHO’s efforts with respect to the prevention of blindness and visual impairment and supported the plan of action, which was viewed as a means of enhancing eye care services and achieving the objectives of the global initiative Vision 2020. The importance of strengthening eye care at the primary care level was emphasized, as was the need to strengthen infrastructure and human resources for eye care. Delegates highlighted the impact on eye health of population aging and the rising prevalence of diabetes and other noncommunicable diseases. Delegates also underscored the importance of early screening to detect retinopathy in children. The importance of partnerships and technical cooperation among countries in eye care and blindness prevention was stressed. A number of delegates mentioned that nationals of their countries had received assistance through the Cuban–Venezuelan eye surgery program *Misión Milagro* (Mission Miracle) and expressed gratitude to the Governments of Cuba and Venezuela. One delegate suggested that PAHO should provide resources to support and strengthen the program so that it could serve more countries.

132. The Delegate of Cuba said that *Misión Milagro* had been launched by his country in collaboration with Venezuela in July 2004. The program had begun in Venezuela and had subsequently been extended to 33 countries in the Americas and Africa. More than 1.6 million patients had received eye surgery, mainly to correct cataract; about 268,000 of those patients had traveled to Cuba for surgery and all of their transportation, food and

lodging, and medical care had been provided free of charge. The rest had undergone surgery, performed by Cuban physicians, in their countries. The program's success showed that the problem of avoidable blindness could be largely eliminated.

133. Dr. José Luis Di Fabio (Manager, Technology, Health Care and Research) said that avoidable blindness was part of the unfinished agenda of health problems that could be prevented or cured with currently available technology, and that the Plan of Action, in combination with the Organization's work on neglected diseases such as trachoma and onchocerciasis, would enable rapid progress towards its elimination. It was clear that it was important to build on international initiatives such as Vision 2020 and to promote sharing of experiences and cooperation between countries through programs such as *Misión Milagro*, which had indeed had a significant impact on the prevalence of avoidable blindness in the Region. He thanked delegates for sharing information about initiatives under way in their countries and said that PAHO would be pleased to post such information on its website in order to make it more readily available to other countries.

134. The Council adopted Resolution CD49.R11, approving the plan of action.

Family and Community Health (Documents CD49/20 and CD49/20, Corrig.)

135. Dr. María Julia Muñoz (Representative of the Executive Committee) said that the Executive Committee had welcomed the inclusion of the topic of family and community health on the agenda of the Governing Bodies in 2009. The Committee had highlighted the cross-cutting nature of the item. Delegates had stressed the importance of strengthening health services to respond to specific needs of individuals at different stages of their lives and in the context of their families and communities, and had also emphasized the importance of strengthening health outreach services through multidisciplinary teams of health workers. The family and community health approach had been seen as particularly important in the prevention and control of chronic noncommunicable diseases, and it had been suggested that Strategic Objective 3 of the PAHO Strategic Plan 2008-2012 should be included among the objectives that would be strengthened and supported by the work to be carried out in this area. It had also been suggested that both the document and the proposed resolution on the item should recognize the importance of gender and intercultural approaches in family and community health services.

136. The Council expressed general agreement with the concept paper (Document CD49/20). The family and community health approach was seen as a key aspect of the primary health care strategy, the development of integrated health services delivery networks, and the achievement of universal health care coverage. Several delegates remarked that successful implementation of the family and community approach would require a fundamental shift in the health care model and the philosophy of health care

delivery, and that it would also require the strengthening of health infrastructure and response capacity at the primary care level. To that end, it was considered necessary to provide incentives to encourage health professionals to choose careers in family and community medicine and to promote greater social recognition and economic rewards for such professionals. It was suggested that the concept paper should discuss the skills required of doctors working in community and family health settings and that those skills should be incorporated into medical school curricula. A representative of the International Federation of Medical Students' Associations affirmed that careers in primary health care, particularly in rural or underserved areas, were often not considered attractive because of poor remuneration and insufficient opportunity for professional advancement. She suggested that involving medical students in community health care projects from the earliest stages of their education would help both to meet local health care needs and to build needed capacity. Such practical work experience would also equip them with skills that could not easily be taught in a hospital environment.

137. Some delegates felt that the document and the proposed resolution on this item should give more emphasis to specific actions required to address social and economic determinants of health, particularly isolation, exclusion, and poverty, and should focus more on programmatic areas within the area of family and community that were key to the achievement of the Millennium Development Goals. One delegate suggested that paragraph 12(e) of the document should focus on overall health in psychosocial terms rather than on the purely biomedical aspects of physical and mental health. Another delegate stressed the need to view health as a continuum from infancy through old age. Several delegates said that health and access to health care should be considered rights, and some noted that their national constitutions enshrined the right to health.

138. Delegates described the actions being taken by their countries to implement the family and community health approach and highlighted specific features of the approach that were considered especially important in their national contexts. Numerous delegates stressed the need to identify and address, through intersectoral action, the social, environmental, and behavioral determinants of health. Collaboration between the health and education sectors in promoting healthy habits and lifestyles was considered especially important. The importance of identifying risks and addressing the changes in risk factors that occurred over the course of a person's life was also underscored.

139. Many delegates also emphasized the need to ensure universal access to and coverage of health care services. It was pointed out that community health programs should apply an intercultural approach that took into account the differing needs of different ethnic groups and cultures, with due regard for indigenous populations and their traditional medicine. The importance of a gender perspective was also stressed. Several delegates highlighted the need for an integrated, comprehensive, and multidisciplinary approach to family and community health services. Several delegates described team

approaches to health care being pursued to good effect in their countries. Some delegates mentioned the need for more attention to the special needs of older persons, men, and children between the ages of 9 and 12. It was also considered important to address health problems faced by street children, as well as the effects of migration, violence, substance abuse, and the illicit drug trade on the health of individuals, families, and communities. Several delegates called for special attention to be paid to establishing primary care clinics, outreach programs, and home-care services. Several also drew attention to the need for greater attention to chronic and noncommunicable diseases at the primary care level. The importance of disease prevention and health promotion, and of community involvement in those activities, was underlined.

140. Dr. Gina Tambini (Manager, Family and Community Health, PAHO) said that she was greatly encouraged to hear how countries were responding to the challenges they faced in their efforts to improve their family and community health services. The family and community health approach was based on the concept of health as a human right. It recognized the need for health services to be people-centered and to address the social, economic, and environmental determinants of health. It also recognized the need for intercultural approaches, intersectoral action, and other features highlighted by delegates. Indeed, the need for intersectoral action was reflected in the Bureau's own work on the topic, which involved staff in multiple program areas. The Bureau was fully committed to supporting Member States in meeting the challenges of transforming their health systems and implementing more integrated and comprehensive models of care.

141. Ms. Daisy Mafubelu (Assistant Director-General, Family and Community Health, WHO) said that, in her view, the family and community health approach was essential to the achievement of the Millennium Development Goals, especially Goals 4, 5, and 6, and she therefore encouraged all countries to adopt health care models based on family and community health.

142. The Council adopted Resolution CD49.R13 on the item.

The Pan American Health Organization Revolving Fund for Vaccine Procurement (Document CD49/21)

143. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that this item had been discussed by both the Subcommittee on Program, Budget, and Administration and the Executive Committee at the request of a representative of a Member State, who had highlighted the need to examine how PAHO's Revolving Fund fit into the new global health architecture and, especially, its relationship with the GAVI Alliance. He had underlined the need to ensure that the Revolving Fund and GAVI were not working at cross-purposes. Some members of the Subcommittee had questioned the value of a discussion of the Revolving Fund by the PAHO Governing Bodies, since in

their view the Fund had been, and remained, satisfactory. However, it had been pointed out that there appeared to be some nuances to the matter that were not clear to all Member States, and that such a discussion might lead to greater transparency and clarity in regard to the issues involved. It had therefore been agreed that the matter would be placed on the agenda of the Executive Committee; that an informal technical discussion would be held outside the formal session, with participation by other partners, including representatives of GAVI; and that the item would then be discussed by the Executive Committee in formal session. A report of the technical discussion was annexed to the annual report of the Executive Committee (Document CD49/2).

144. The Executive Committee's discussion of the matter had focused in particular on the various types of pneumococcal conjugate vaccine and on some problems that had arisen with regard to access to the vaccine by the GAVI-eligible countries in the Americas. The Committee had been informed that, with a view to surmounting some obstacles relating to the implementation of the Advanced Market Commitment mechanism, the Director of PAHO had declared a moratorium on procurement of the 10-valent pneumococcal conjugate vaccine, the vaccine selected for the Advanced Market Commitment pilot. The Director had also established a PAHO/GAVI Working Group to seek ways of ensuring access to the pneumococcal vaccine for all countries of the Region.

145. Members of the Executive Committee had affirmed their support for the Revolving Fund and underscored the importance of ensuring equitable access to drugs and vaccines of high quality at the lowest available price for all public immunization programs in Member States. The importance of the Revolving Fund as a cooperation mechanism that facilitated the introduction of new vaccines of high quality had also been emphasized.

146. In the Directing Council's discussion of the item, delegates expressed unequivocal support for the Revolving Fund and opposed any attempt to weaken it or undermine the principles of solidarity and Pan-Americanism on which it was founded. Delegates also expressed firm opposition to any action that might interfere with the Fund's ability to procure vaccines at the lowest available price. It was pointed out that the Fund enabled small States to enjoy the economies of scale that resulted from bulk purchasing of vaccines. It was also pointed out that the Fund not only provided timely access to vaccines at affordable prices, but that it also ensured that the vaccines purchased were of high quality. The Fund's role in facilitating the introduction of new vaccines was highlighted. Several delegates noted that their countries' public immunization programs were entirely dependent on the Revolving Fund for procurement of vaccines.

147. The Delegate of Jamaica said that in the Caribbean subregion a significant proportion of the vaccines administered by the private sector were obtained from governments, which procured vaccines through the Revolving Fund. She emphasized that competitive procurement and consolidation of vaccine orders through the Fund had helped to keep vaccine prices affordable for the Caribbean countries, which were not large purchasers and so were not in a position to negotiate competitively with vaccine manufacturers on their own. She also pointed out that another benefit of the Revolving Fund was its ability to respond rapidly to urgent vaccine orders because of established contracts with suppliers. In addition, it had facilitated emergency inter-country loans of vaccines because countries had felt confident that any lent supplies of vaccine would quickly be replenished through the Fund. The Delegate of Argentina pointed out that not only had the Fund facilitated equitable access to quality vaccines at affordable prices, but it had also helped to strengthen epidemiological surveillance systems, laboratory networks, and surveillance of events supposedly attributable to vaccination or immunization (ESAVIs). He also reported that the health ministers of the Union of South American Nations (UNASUR), at a meeting held in Ecuador in August 2009, had called for the strengthening of the Revolving Fund as the principal strategy for negotiation and procurement of vaccines for the Region, including in particular the vaccine against influenza A (H1N1).

148. Numerous delegates pointed out that the Revolving Fund would have a crucial role to play in ensuring the availability and affordability of the H1N1 vaccine. The Delegate of El Salvador, supported by a number of other delegates, stressed that the influenza pandemic should be viewed as a problem of all humanity and that solidarity, not ability to pay, should be the principle guiding the actions taken in response to it, including those affecting the availability and price of the vaccine. She also suggested that PAHO should convene a high-level meeting to analyze the characteristics of vaccine production and to seek ways of mitigating the high cost of vaccines on the budgets of the countries of the Region.

149. The Delegates of Canada and the United States of America, both noting that their countries were members of the GAVI Alliance, welcomed the collaboration between PAHO and GAVI through the PAHO-GAVI Working Group and encouraged both parties to work towards an arrangement that would both protect the Revolving Fund and allow timely implementation of the Advance Market Commitment. Delegates also called on PAHO to support technology transfer and other measures that would boost vaccine production capacity in the countries of the Region.

150. Dr. Socorro Gross (Assistant Director, PASB) thanked delegates for their expressions of support for the Revolving Fund and said that the Organization was committed to maintaining and strengthening the Fund and its underlying principles of solidarity, Pan-Americanism, quality, and affordability. She assured the Council that

PAHO and GAVI were working together in a spirit of mutual respect and collaboration towards the common goal of ensuring access to vaccines for all children and adults who needed them.

151. Ms. Daisy Mafubelu (Assistant Director-General, Family and Community Health, WHO) commended the Member States of the Region for their leadership in the area of immunization, as manifested, for example, in the elimination of measles, a success that the other WHO regions were striving to emulate. WHO was a member of the PAHO-GAVI Working Group and would continue working to find amicable ways of dealing with the issues under discussion, while ensuring that the Region's achievements in the control of vaccine-preventable diseases were preserved.

152. The Director said that the observance of the 30th anniversary of the Revolving Fund would afford an opportunity to reflect on the Fund's future and its role in meeting the challenges posed by the advent of costly new vaccines that could easily double or triple countries' immunization budgets. She intended to propose that matter as a topic for discussion by the Governing Bodies in 2010. PAHO was working actively on the issue of technology transfer and enhancement of vaccine production capacity and had long supported public-private partnerships for that purpose. Through the Regional Vaccine System (SIREVA) it also contributed to the development of new vaccines, provided support for clinical trials, and participated in post-marketing surveillance of vaccines. She affirmed that PAHO would continue working with the GAVI Alliance towards the shared goal of universal immunization.

153. The Council took note of the report on the PAHO Revolving Fund for Vaccine Procurement.

Roundtable on Safe Hospitals (Documents CD49/22 and CD49/22, Add. I)

154. A roundtable discussion was convened to allow countries to share their views on the topic of safe hospitals. Dr. Jean-Luc Poncelet (Manager, Emergency Preparedness and Disaster Relief, PASB) opened the discussion, noting that until 1985, when a hospital in Mexico City had been destroyed by an earthquake, not much thought had been given to the question of how to keep hospitals safe from disasters. Much had changed since then, as countries had realized that such hospital disasters could be avoided. Some countries had already shown that it was possible to safeguard hospitals. Nevertheless, there were still many cases of hospital services breaking down under the strain of a major disaster. Safe hospitals had been the theme of World Health Day 2009, and the topic for the roundtable had been chosen to follow up on the issue.

155. Dr. Claude de Ville de Goyet (Public Health Emergency Preparedness Consultant) then delivered a keynote address in which he stressed that hospital safety was

more than a medical issue; it was also an economic, social, and political issue. Many of the hospitals in highly vulnerable areas had been rendered completely nonfunctional as a result of natural disasters, coupled with human shortcomings and poor planning. The tragedy of the Mexico City hospital in 1985 had been a turning point in the international health community's approach to hospital safety. It had become clear that disaster preparedness entailed more than training staff for disaster response and mass casualty management; it was also necessary to ensure the safety of the physical structure of hospitals. Additional lessons had been learned from subsequent disasters, including hurricanes, earthquakes, and floods.

156. Defining a safe hospital as one that could continue to operate or even expand its capacity following a disaster, Dr. de Ville de Goyet outlined some of the main aspects to be considered in efforts to ensure that hospitals met that standard, such as conducting a vulnerability analysis using the safety index developed by PAHO. He also discussed factors to be considered in building new facilities and in deciding whether or not to retrofit old ones. The cost of designing new facilities for disaster resilience was moderate if planned at the early stages. Retrofitting existing facilities was not always a cost-saving measure, given that the cost of retrofitting could be as high as 40% of the replacement value. Moreover, the public health and political return from opening one new hospital might exceed that of retrofitting two or three existing facilities. He concluded his presentation by describing progress made in the Americas and lessons learned, in particular that a piecemeal approach to risk management did not work, that hospital safety was not merely an emergency management issue but also a sustainable development issue, and that ministries of health should lead the process of risk reduction.

157. Delegates then participated in one of three discussion panels. Panel 1 discussed the question "How can financing be obtained to improve hospital safety?" Panel 2 discussed lessons learned in the implementation of national safe hospitals, and Panel 3 addressed the question of who is actually responsible for protecting hospitals in the event of a disaster.

158. Dr. Poncelet presented the final report of the discussion groups. He prefaced his report by referring to a recent news report about the collapse of a hospital in Padang, Indonesia, caused by an earthquake. That incident served as a timely reminder of the importance of the issues discussed during the roundtable.

159. Summarizing the conclusions of the discussion panels, he said that three main points had emerged: (1) there was consensus on the main principles of safe hospitals; (2) there had been progress in the Region, but because that progress would not become evident unless disaster struck, it was important to publicize successes; and (3) it was essential to translate theory into practice by implementing projects that had been shown to be feasible. Participants had stressed the importance of measuring the impact of

disasters not only in economic terms, but also in social terms, particularly the social cost of a prolonged breakdown of services. They had pointed out that retrofitting must be done very selectively, but it must be done. Funding for that purpose did exist, mostly from the public budget, but priorities must be established to ensure that funds were used wisely.

160. All three panels had emphasized the need for high-level political commitment and had stressed that ministries of health should take the lead in safe hospital initiatives, although other ministries must also be involved. Within ministries of health, all departments should be involved, not just the disaster preparedness department. The Hospital Safety Index had been recognized as a very useful tool, and countries had been encouraged to apply it systematically in health facilities at all levels. It had been emphasized that the performance of hospitals in disaster situations should be documented in order to identify successes and call attention to what had been lost as a result of not having safe hospitals. Finally, participants in the roundtable had recommended that the Council should call on PAHO to step up its efforts and its advocacy role to encourage governments to implement practices and procedures that would make hospitals safer; urge Member States, with PAHO's support, to develop national work plans aimed at achieving the goal of safe hospitals; and request the Bureau to prepare a regional progress report to be presented to the Directing Council in 2010.

161. The full report on the roundtable discussions and conclusions may be found in Document CD49/22, Add. I.

162. The Council took note of the report on the roundtable.

Panel Discussion on the Pan American Alliance for Nutrition and Development for the Achievement of the Millennium Development Goals (Documents CD49/23, Rev. 1 and CD49/23, Add. I)

163. The panel discussion was moderated by Ms. Sara Ferrer Olivella (United Nations Development Program–Spain MDG Achievement Fund). The panelists were Dr. Oscar Ugarte Ubilluz (Minister of Health, Peru), Mr. Pedro Medrano (Regional Director for Latin America and the Caribbean, World Food Program), Mr. Ricardo Uauy (President, International Union of Nutritional Sciences), and Dr. Mirta Roses Periago (Director, PASB). Dr. Ugarte Ubilluz gave a presentation on the approach taken by Peru to combat the country's very high rate of malnutrition. The Director described the conceptual underpinnings of the Alliance, while Mr. Medrano spoke on the importance of an interagency approach to the problems of malnutrition. Mr. Uauy discussed the social, biological and economic determinants of maternal and infant nutrition.

164. Commenting on the panel presentations, Ms. Joy Phumaphi (Vice President of Human Development, World Bank), stressed that prevention and control of nutritional deficiencies had been slow so far; Ms. Carmen María Gallardo Hernandez (Vice President, United Nations Economic and Social Council) underlined the need to integrate health, education, housing and other sectors in the intergovernmental dialogue to address nutrition; and Mr. David Oot (Associate Vice President, International Program, Save the Children) emphasized that many determinants of health lay outside the scope of health sector interventions—hence the importance of the Alliance in integrating many different sectors.

165. In the plenary discussion that followed, members of the Directing Council welcomed the creation of the Pan American Alliance for Nutrition and Development. Several delegates described their countries' efforts to tackle nutritional issues, most observing that they were adopting a multisectoral approach to the fight against malnutrition. It was reported that even in countries where indicators for the nutritional situation were satisfactory, steps were being taken to guarantee the nutrition of vulnerable groups such as children, the elderly, and pregnant women. Several delegates laid particular emphasis on issues relating to breastfeeding of infants, including the promotion of exclusive breastfeeding, the need to make provisions to enable nursing mothers to feed their babies at their place of work or education, and control of the marketing of breastmilk substitutes.

166. Some delegates noted that countries' nutritional situation had worsened as a result of the economic crisis and the effects of climate change. One delegate added that part of the Region's nutrition problems arose from a failure to stimulate local agriculture, particularly in the context of cheap food imports from countries whose governments subsidized their agricultural industry. Several delegates referred to the problems of obesity in their populations, particularly among adolescents, and suggested that the Alliance could play an important role to play in promoting healthier eating habits.

167. A report on the discussions was later given by Dr. Gina Tambini (Manager, Family and Community Health, PASB), who summarized the contributions of the panelists and delegations. Her report may be found in Document CD49/23, Add. I.

Administrative and Financial Matters

Report on the Collection of Quota Contributions (Documents CD49/24 and CD49/24, Add. I)

168. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had been informed that the combined collection of arrears and current year assessments as of 15 June 2009 had totaled \$38 million, which was the third

lowest amount collected at that point in the past 10 years. Nineteen Member States had made payments towards their past or current quota commitments, 12 Member States had paid their 2009 assessed contributions in full, all Member States with deferred payment plans were in compliance with those plans, and only one Member State was potentially subject to the voting restrictions provided for under Article 6.B of the PAHO Constitution.

169. Ms. Sharon Frahler (Manager, Financial Resources Management, PASB) thanked Member States for their continuing payment of their quota assessments, observing that timely receipt of quota contributions avoided any interruption of PAHO's technical cooperation programs. She explained that Document CD49/24 showed the situation of quota contributions as at 31 July 2009, and Document CD49/24, Add. I updated the information to 21 September 2009. Since the preparation of the latter document, a further \$199,874 had been received from Puerto Rico and a further \$1,482,123 from Brazil.

170. Total quota contributions for 2009 paid so far amounted to \$43.6 million, 46% of the year's total assessment of \$95.7 million. Total arrears of quota contributions paid to date amounted to \$25.1 million, which had reduced the pending balance of arrears to \$6 million. Thus, the combined payment of arrears and current year's assessments amounted to \$69 million, as compared with \$53 million in 2008 and \$79 million in 2007.

171. A total of 19 Member States had paid their quota contributions for 2009 in full, 8 Member States had made partial payments, and 12 Member States had made no payments for the current year. The PAHO Secretariat stayed in close contact with Member States concerning their outstanding payments. As at the opening of the 49th Directing Council, no Member State was subject to the provisions of Article 6.B of the PAHO Constitution.

172. The Council took note of the information provided on the collection of quota contributions.

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

173. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had been informed by Ms. Sharon Frahler (Manager, Financial Resources Management, PASB) that in 2008 the Organization had received a total of \$100.1 million in current and previous years' quota assessments, as well as \$16.1 million in miscellaneous income and \$3 million previously loaned to the Revolving Fund for Vaccine Procurement. After deduction of \$94 million in program budget expenditures and \$5.6 million allocated to the Tax Equalization Fund, the excess of income over expenditures for 2008 had been \$19.6 million. However, that figure did not reflect some \$11 million in 2008 obligations that would be implemented in 2009. A total of 24

Member States had paid their 2008 quota assessments in full, eight had made partial payments, and seven had made no payments for 2008. The pending quota balance on 31 December 2008 had been \$31 million.

174. Ms. Frahler had also noted that the Organization's procurement activities on behalf of Member States had grown substantially in recent years. In 2008, PAHO had received \$48 million for strategic public health supplies to be purchased via the Strategic Fund and the Reimbursable Procurement Fund, an increase of 56% over the corresponding figure for 2006, and \$322 million for the purchase of vaccines and syringes through the Revolving Fund, an increase of 58%. Trust fund income had totaled \$165 million for 2008 and income to other PAHO funds had amounted to \$30 million. The biennial WHO allocation to the Region of the Americas had totaled \$81.5 million, of which PAHO had implemented \$37 million by the end of 2008. It had also implemented \$27 million of WHO voluntary and other funds. PAHO's overall 2008 expenditures had amounted to \$679 million, with purchases of vaccines and syringes through the Revolving Fund accounting for almost half that amount. Regular budget expenditures had totaled \$94 million.

175. Ms. Frahler had also reported on the financial status of the Caribbean Epidemiology Center (CAREC), the Institute of Nutrition of Central America and Panama (INCAP), and the Caribbean Food and Nutrition Institute (CFNI). She had described the financial position of CAREC and INCAP as strong, with income exceeding expenditures in 2008 for both centers. CFNI had also had an excess of income over expenditure, but it had an accumulated deficit in its working capital fund, which PAHO was funding. Following the successful outcome of 2008, that deficit had decreased to about \$268,000.

176. Following the report by the representative of the Executive Committee, Ms. Frahler thanked Member States for their support to PAHO, as manifested in the payment of their quota contributions. She also expressed the Organization's thanks to Dr. Chan and WHO for the previous year's allocation to the Region of the Americas, which had been the highest level of funding ever received by PAHO from WHO.

177. The Council took note of the interim financial report.

Changes in the Financial Regulations and Financial Rules (Document CD49/25)

178. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had been informed of several proposed changes to the Organization's Financial Rules and Regulations by Ms. Sharon Frahler (Manager, Financial Resources Management, PASB), who had explained that the changes were necessitated by the introduction of the International Public Sector Accounting Standards

and the resulting move from modified accrual and cash basis accounting to full accrual accounting. In the Committee's discussion of this item, one delegate had observed that the proposed change to Regulation 4.6, giving the Director authority to decide whether to carry a revenue surplus over to subsequent periods, did not include any involvement of the Governing Bodies and had suggested that "and subject to the approval of the Executive Committee" should be added at the end of the first sentence.

179. Ms. Frahler had explained that "revenue surplus" was a new concept, which referred, for example, to higher-than-expected returns on the Organization's investments, and that the aim of the proposed change to Regulation 4.6 was to utilize such extra revenue to fund the unfunded parts of the Strategic Plan. In order to permit rapid implementation, it was proposed that the Director should have the authority to decide how to allocate such surplus revenue, so that the funds could be spent starting in January. She added that if it was necessary to submit the matter to the Executive Committee, which generally met in June, implementation could be delayed for up to six months.

180. The Director had then suggested that, as an alternative to obtaining authorization from the Executive Committee for the use of revenue surpluses, such authorization might be obtained from the Subcommittee on Program, Budget, and Administration, so that implementation of any activity funded by a revenue surplus could start in March.

181. The Executive Committee had agreed to that proposal, and the corresponding change had been incorporated in the version of Regulation 4.6 that appeared in Document CD49/25. The Committee had adopted Resolution CE144.R17, recommending that the 49th Directing Council approve the proposed changes to the Financial Regulations.

182. Ms. Frahler, recalling that many of the changes had been made necessary by the adoption of the International Public Sector Accounting Standards, said that the new standards were expected to be fully implemented by 1 January 2010.

183. The Council adopted Resolution CD49.R1, approving the proposed changes in the Financial Regulations.

184. The resultant proposed revisions to the Financial Rules were subsequently adopted by the Executive Committee (Resolution CE145.R1), which met immediately following the closure of the 49th Directing Council.

Proposal for the Establishment of an Audit Committee (Document CD49/26)

185. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had discussed the proposed terms of reference of the Audit Committee in June 2009. An earlier version of the terms of reference had been examined

by the Subcommittee on Program, Budget, and Administration in March and revised in the light of Member States' comments. It had been explained that the aim of establishing an Audit Committee was to implement the recommendations of the Organization's external auditors by putting in place a governance framework reflecting international best practices. Specifically, the purpose of the proposed Audit Committee was to serve as an expert advisory committee to assist the Director and the Member States, through the Executive Committee, by providing independent assessment and advice on the operation of the Organization's financial controls and reporting structures, its risk management processes, and the adequacy of its systems of internal and external control.

186. The Executive Committee had expressed support for the revised terms of reference, and had adopted, with two minor amendments, Resolution CE144.R1, recommending that the 49th Directing Council establish the Audit Committee and approve its terms of reference.

187. The Director recalled that the establishment of an audit committee had been one of the recommendations of the Working Group on PAHO in the 21st Century, and expressed confidence that it would both enhance transparency and support results-based management, as well as bringing PAHO into line with the practice of other international organizations, including WHO. She also announced that after a long search the Organization had secured the services of an Auditor General, Mr. David O'Regan, thus allaying a repeatedly expressed concern of the Governing Bodies.

188. In the ensuing discussion, the creation of the Audit Committee and the appointment of the Auditor General were welcomed. One delegate observed that the Audit Committee would assist Member States in exercising their governance responsibilities vis-à-vis the Organization.

189. The Directing Council adopted Resolution CD49.R2, establishing the Audit Committee and approving its terms of reference.

Salary of the Director and Amendments to the Staff Regulations of the Pan American Sanitary Bureau (CD49/27)

190. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had endorsed a proposed amendment to Staff Regulation 11.2, concerning the resolution of contractual disputes between the Pan American Sanitary Bureau and members of the PASB staff and had also established the salaries of the Deputy Director and the Assistant Director, effective 1 January 2009. The Committee had recommended that the Directing Council approve the proposed amendment to Staff Regulation 11.2 and establish the gross annual salary of the Director at \$194,820.

191. The Council adopted Resolution CD49.R21, setting the salary of the Director of the Pan American Sanitary Bureau with effect from 1 January 2009 and approving an amendment to Staff Regulation 11.2, concerning the resolution of contractual disputes between the Pan American Sanitary Bureau and members of the PASB staff.

Election of Member States to Boards and Committees

Selection of One Member State from the Region of the Americas Entitled to Designate a Person to Serve on the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) on the Expiration of the Period of Office of Brazil (Document CD49/28)

192. The Council selected Ecuador as the Member State entitled to designate a person to serve on the Joint Coordinating Board (Decision CD49[D5]).

Selection of Two Member States from the Region of the Americas Entitled to Designate a Representative to the Policy and Coordination Committee of the UNDP/World Bank/WHO Special Program of Research, Development, and Research Training in Human Reproduction on the Expiration of the Periods of Office of Argentina and Mexico (Document CD49/29)

193. The Council selected Guatemala and Paraguay as the Member States entitled to designate a representative to the Committee (Decision CD49[D6]).

Election of Five Nonpermanent Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME) (Document CD49/30)

194. The Council elected Argentina, Chile, Dominican Republic, Jamaica, and Mexico to serve on the BIREME Advisory Committee. In order to bring about the requisite staggering of the terms of office, the Council decided, by drawing of lots, that Argentina, Chile, and the Dominican Republic would serve for three years and that Jamaica and Mexico would serve for two years.

195. The Council adopted Resolution CD49.R6 on this item.

Awards

PAHO Award for Administration 2009 (Document CD49/31)

196. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had been informed that the Award Committee of the PAHO Award for Administration, 2008, which had met during the Committee's 144th Session, had decided that the award should be conferred on Dr. Merceline Dahl-Regis, of the Bahamas, for her contribution to health care management and research and to medical education in primary health care, as well as for her leadership in institutionalizing public health surveillance across all of the Bahamas and in evaluating and redefining the parameters for the Caribbean Cooperation in Health. The Executive Committee had extended congratulations to Dr. Dahl-Regis and adopted Resolution CE144.R22, noting the decision of the Award Committee and transmitting its report to the 49th Directing Council.

197. The President and the Director conferred the PAHO Award for Administration on Dr. Merceline Dahl-Regis. Dr. Dahl-Regis' acceptance speech (Document CD49/DIV/8) can be found on the website of the 49th Directing Council.

198. A delegate of the Bahamas also spoke, thanking PAHO for the honor bestowed on Dr. Dahl-Regis and on the Bahamas. He paid tribute to her dedication, noting that with Dr. Dahl-Regis as Chief Medical Officer, the people of the Bahamas could sleep easy at night no matter what health dangers threatened.

Abraham Horwitz Award for Leadership in Inter-American Health 2009

199. Dr. Benjamin Caballero (President of the Board of Trustees, Pan American Health and Education Foundation) recalled that for 41 years the Foundation had partnered with PAHO in fostering the goal of protecting life and improving health in the Americas. As part of that process, several awards for excellence in inter-American public health were presented every year. For 2009, the Fred Soper Award for Excellence in Health Literature had been awarded to Dr. Guilherme Luiz Guimarães Borges of Mexico; the Clarence H. Moore Award for Voluntary Service had been awarded to the Latin American and Caribbean Transgender Network (REDLACTRANS); and the Pedro N. Acha Award for Veterinary Public Health had been awarded to Dr. Ilane Hernández Morales of Mexico. Those awards were presented at an awards dinner held during the week of the Directing Council.

200. Dr. Caballero announced that the Abraham Horwitz Award for Leadership in Inter-American Health 2009 had been awarded to Dr. Eduardo Pretell Zárata of Peru, Regional Coordinator for the Americas International Council for Control of Iodine

Deficiency Disorders. Dr. Pretell Zárate was widely recognized as the leading expert on iodine deficiency disorders in the Region of the Americas. He had been a pioneer in the identification and prevention of iodine deficiencies during pregnancy, which result in irreversible brain damage in the newborn. Throughout his career Dr. Pretell Zárate had combined his outstanding scientific work with public service, having been Minister of Health of Peru from 2000 to 2001 and President of the Peruvian National Academy of Medicine from 2005 to 2007.

201. Dr. Caballero, the President, and the Director conferred the Abraham Horwitz Award for Leadership in Inter-American Health 2009 on Dr. Eduardo Pretell Zárate. Dr. Pretell Zárate's acceptance speech (Document CD49/DIV/9) can be found on the website of the 49th Directing Council.

PAHO Champion of Health Recognition

202. The President recognized the Sesame Workshop as a PAHO Champion of Health for its invaluable efforts to promote children's health through its celebrated program Sesame Street and announced that representatives of the Sesame Workshop would receive the Champion of Health Recognition at a subsequent ceremony. A video was projected which showed recent educational clips in which the characters of Sesame Street gave health-related advice, notably concerning handwashing and proper coughing and sneezing etiquette.

Establishment of the Sérgio Arouca Award for Excellence in Public Health

203. Dr. José Gomes Temporão (Minister of Health, Brazil) announced the establishment of a new award for excellence in public health. The award will honor Brazilian public health physician Sérgio Arouca.

Matters for Information

Code of Practice on the International Recruitment of Health Personnel: a WHO background document (Document CD49/INF/1)

204. Dr. Marthelise Eersel (Representative of the Executive Committee) reported that the Executive Committee had welcomed the initiative to draw up a global code of practice on the international recruitment of health personnel and had identified a number of features that such a code should have. It had been emphasized that the code must be voluntary, must adequately balance the interests of source and destination countries, and must take into account the factors that prompted health workers to seek employment outside their countries of origin. It had also been emphasized that the code should contain no provisions that might limit people's right to migrate legally in order to seek a better

life for themselves and their families. The need to regulate the practices of recruitment agencies had been stressed. It had been considered important for destination countries to create incentives to ensure the sufficiency and sustainability of their domestic health workforce, and it had been emphasized that countries' efforts to address workforce shortages should not deepen the inequities existing between countries or impair the ability of any country to ensure access to health care for its nationals. Support had been voiced for the establishment of limits on international recruitment of health personnel from countries with critical health workforce shortages, and it had been suggested that migration caps should be set for certain categories of professionals.

205. The Executive Committee had raised concerns about the timetable proposed for national and regional consultations on the draft code of practice and had expressed doubt that it would be possible to adequately discuss all the issues involved and reach consensus before the next World Health Assembly in May 2010.

206. Dr. Manuel Millar Dayrit (Director, Department of Human Resources for Health, WHO) gave an overview of the work done since 2004, when World Health Assembly Resolution WHA57.19 had called, *inter alia*, for a code of practice to be prepared. A draft version of the code had been presented to the 124th Session of the Executive Board in January 2009, but Member States had considered that further consultations on it were needed. The Regional Committees in all the WHO regions had considered the issue during 2009, and had been generally supportive of the development of the code and of its voluntary nature; however, the regional discussions had also made it clear that the code was only one of many strategies and approaches for addressing health workforce issues. Nevertheless, global leadership on the issue and a global code of practice were considered necessary.

207. The Council generally welcomed the content of the draft code of practice. Delegates felt that the document could go further, but was a good first step. In particular, it attempted to balance the interests of both source and destination countries. It was reemphasized that both the "push" and the "pull" factors influencing the international migration of health personnel should be examined and that no provisions should be established that would impede the right of health personnel to migrate legally. It was also suggested that the code of practice should address more explicitly the need to ensure that internationally recruited health workers enjoyed the same working conditions as nationals of the destination country. One delegate noted that a voluntary code of conduct for the recruitment of foreign-educated nurses had been developed by the private sector in his country and pointed out that such initiatives might serve as a model for certain aspects of the WHO code of practice.

208. It was suggested that the draft code should contain provisions for better monitoring of the activities of recruiting agencies and employers of internationally

recruited health workers. It should seek to limit recruitment of workers from countries already suffering a shortage, with specific provisions on how that shortage should be measured. Delegates suggested that limits might be set on emigration by members of specific professions, taking into account in particular those that were considered a priority for the source country, or alternatively that recommendations should be formulated on how many years certain professionals should be required to work in their own country before emigrating. It was emphasized that the implementation of the code, once it was final, must be monitored and evaluated.

209. It was pointed out that if working conditions for health workers in some countries were better and more secure, they would be more inclined to stay in their country of origin. Accordingly, it was felt that countries should examine the root causes of why they were losing their health personnel and should work together on eliminating specific shortcomings. Ways had to be found to make it more attractive for health care workers from developing countries to stay in their countries of origin, while still respecting their right to emigrate for better opportunities. It was suggested that both developed and developing countries should draw up plans of their future health workforce needs in order to be able to determine the quantities of personnel they needed to train or to recruit from elsewhere. Delegates emphasized the need for all countries to train sufficient health personnel and identified human resources development and planning as key areas for PAHO technical support. It was suggested that developed destination countries and developing source countries might collaborate on human resource training initiatives.

210. Delegates expressed the hope that destination countries might make a greater contribution to the resources expended by source countries in training medical personnel, pointing out that it was unfair that taxpayers in developing countries were subsidizing the training of health workers who then left to seek their future in the developed world. It was suggested, for example, that systems of grants might be set up to compensate source countries that lost the investment made in training personnel who then left the country to work elsewhere. It was also suggested that health personnel might be required to work for a certain number of years in their own countries as a condition for receiving an educational grant to pursue studies abroad.

211. Several delegations reiterated their concerns regarding the schedule for regional consultations prior to the Executive Board session in January 2010.

212. In response to the comments made, Dr. Dayrit stressed that the code was only one of multiple strategies that could be employed to address the push and the pull factors affecting migration of health workers. He agreed that the schedule for completion of the consultations was challenging, but development of the code was a Member State initiative and it was important to move forward with the process. The intention of the WHO Secretariat was to prepare a report incorporating all the input from the regional

consultations, together with a revised version of the draft code of conduct, which would be submitted to the Executive Board in January 2010. The Board would then decide whether the matter should go to the World Health Assembly in May 2010 or to some other negotiating mechanism. Nevertheless, the process was open-ended and consultations on the subject would continue.

213. The Council took note of the information received on the draft code of practice.

Progress Report on Technical Matters: International Health Regulations (*includes the Report on the [H1N1] Pandemic*) (Document CD49/INF/2, Rev. 1)

214. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had heard a progress report in June on the implementation of the International Health Regulations (2005) in the Region and an update on the status of the influenza A (H1N1) pandemic. Dr. Jarbas Barbosa da Silva (Manager, Health Surveillance and Disease Prevention and Control, PASB) had reported that, as of 22 June, more than 52,160 cases and 231 deaths had been reported in 99 countries or territories. The Americas had recorded more than 43,000 cases in 28 countries. It had become apparent very early on that the Region's efforts to enhance pandemic preparedness and implement the International Health Regulations (2005) had paid off. The response to the initial outbreaks of H1N1 influenza had been swift, transparent, and highly cooperative.

215. It had been pointed out that the H1N1 pandemic had provided the first real test of the International Health Regulations (2005) and had demonstrated their effectiveness. However, the experience of confronting the pandemic had also revealed some gaps in response capabilities and had highlighted the need to continue building core capacities, particularly with regard to airports, ports, and ground crossings, in order to enable Member States to meet the International Health Regulation requirements by the target date of 2012.

216. The Executive Committee had stressed the importance of accurate and balanced risk communication. It had been pointed out that one failing of WHO's pandemic alert classification scheme was that it did not convey information about the severity of illness caused by a pandemic virus. The public and the news media tended to interpret higher alert levels as meaning that a disease had become more virulent, which in the current influenza pandemic had caused unwarranted fear and even panic in some places. PAHO and WHO had been urged to rectify that shortcoming and adapt the classification in order to make it more understandable to the general public.

217. Following Dr. Muñoz's report, Dr. Barbosa da Silva presented a brief progress report on the implementation of the International Health Regulations (2005) and updated the Directing Council on the status of the influenza A (H1N1) pandemic in the Region

and on the Organization's response to it. He reported that the majority of countries in the Region had completed assessments of their surveillance and response capacities, but only 18 had conducted assessments of their capacities at points of entry and the same number had drawn up action plans for meeting the core capacity requirements. As had been noted in the Executive Committee report, the current pandemic had pointed up weaknesses in response capacity and shown where remedial action was needed.

218. Turning to the status of the pandemic, he recalled that an outbreak of an influenza-like illness had been reported in Mexico in April 2009. The infectious agent had subsequently been identified as influenza A (H1N1). The virus had spread rapidly, first to the United States and Canada and then to other countries in the Americas and in other regions. WHO had raised the pandemic alert level from phase 5 to phase 6 on 11 June 2009, thus declaring the first influenza pandemic of the 21st century. Although much remained unknown about the new influenza virus, it was clear that it had the capacity to spread rapidly and that its spread had intensified dramatically with the start of winter in the southern hemisphere. The majority of cases had occurred in adolescents and young people, although most deaths had occurred among middle-aged adults. The attack and case-fatality rates were as yet unknown, but it was known that the latter rate had been relatively low. As of late September 2009, transmission of the virus appeared to be leveling off or declining in most parts of the Region, although a slight upsurge in case reports had been noted in recent weeks in Canada, Mexico, and the United States of America.

219. From the outset of the epidemic, the Organization had activated the Emergency Operations Center at PAHO Headquarters, which had operated 24 hours a day during the critical period following the first outbreaks. It had also, with the support of various countries of the Americas and Europe, mobilized 132 experts who were dispatched to various countries in the Region to provide technical assistance in areas such as virology, epidemiology, and laboratory and health services strengthening. With the support of various donors, PAHO had distributed 766,820 oseltamivir treatments, 1.5 million doses of seasonal influenza vaccine, 12,650 kilograms of personal protective equipment for health care workers, and 12 real-time polymerase chain reaction machines to enhance laboratory diagnostic capabilities in Member States. The Organization was currently providing Member States with technical support in identifying the priority groups to be targeted for vaccination against H1N1 influenza. Once the vaccine became available, it would be offered through the Revolving Fund for Vaccine Procurement. The price per dose was expected to be around \$7.

220. Summarizing the lessons learned from the response to the pandemic thus far, he said that various meetings of experts had highlighted the need not only to have pandemic preparedness plans but to implement certain measures, such as purchasing of personal protective equipment, before a pandemic occurred. They had also underscored the

importance of good epidemiological surveillance and of having a small set of highly informative indicators to enable ministries of health to monitor the situation as it evolved. The importance of accurate public information, provided by authoritative sources such as PAHO and ministries of health, had been stressed.

221. In the ensuing discussion, delegates reported on the evolution and current situation of the pandemic in their respective countries, the populations most affected, and the actions taken by their governments, including plans for responding to expected new outbreaks during the winter months in the northern hemisphere and priority target populations for the H1N1 vaccine. Most delegates said that their countries intended to administer a single dose of the vaccine and were planning to target pregnant women, infants and young children, and persons suffering from chronic diseases such as diabetes, asthma, or heart disease, or immunodeficiency disorders such as HIV/AIDS. Health care workers, childcare providers and teachers, police and military personnel, and emergency response personnel would also be top-priority groups for vaccination.

222. It was emphasized that success in achieving a high rate of H1N1 vaccination coverage would hinge on effective communication of the fact that the risks associated with the vaccine were low. Delegates underscored the need to ensure timely supplies of the vaccine during the influenza season in both the northern and the southern hemispheres and stressed that the vaccine must be kept affordable for developing countries. The need for continued vaccination against seasonal influenza alongside vaccination for H1N1 influenza was also underscored. One delegate expressed concern about the possibility that a single vaccine containing both H1N1 and the seasonal influenza strains might be produced, pointing out that the vaccine would then have to be administered to a larger target population, which would increase countries' vaccine costs substantially. She underscored the importance of following WHO recommendations with regard to the target groups for the H1N1 vaccine.

223. Measures taken to curb the spread of the virus included social distancing and cancellation of public events; isolation of suspected and confirmed cases in hospitals and other health care facilities; surveillance and screening at airports and other points of entry; health education and disease prevention campaigns aimed at the general public and specific high-risk populations; education for medical professionals about the nature of the virus and training for health care providers, especially at the primary care level, in rapid detection and treatment of cases; and prompt antiviral treatment of patients exhibiting signs and symptoms of influenza, particularly those with comorbidities or other risk factors. A delegate from the Caribbean noted that the Caribbean Community, in collaboration with PAHO, had prepared a protocol for dealing with cases of H1N1 influenza detected aboard cruise ships.

224. Several delegates said that their countries had emulated Mexico's response and thanked the Government of Mexico for its willingness to share its experiences and expertise with other countries. Several delegates highlighted the need to weigh the pros and cons of containment strategies versus mitigation strategies and to make decisions in that respect on the basis of the best available evidence. The Delegate of Mexico said that while the social distancing measures implemented in his country had been highly effective in containing the spread of the virus, they had virtually paralyzed the country and caused enormous economic damage. Consequently, his Government had now adopted a more focused approach, recommending school closures and similar measures only when warranted by the number of cases in a particular community or area. The Delegate of Chile said that her Government had adopted a similar approach precisely in order to limit the pandemic's social and economic impact as much as possible. It had also instituted a strategy of aggressive treatment of both confirmed and suspected cases, which had helped to reduce virus shedding and to keep mortality low. The Delegate of the United States of America affirmed the value of early treatment but cautioned that overuse of antiviral medicines could lead to drug resistance.

225. All the delegates who spoke underscored the need for international cooperation in order to control this and future influenza pandemics and other public health emergencies of international concern. Delegates also commended the ongoing role of PAHO and WHO in facilitating international communication and coordination in respect of the H1N1 pandemic and affirmed their countries' commitment to continue collaborating with both organizations and with other countries in order to halt the pandemic. Several delegates pointed out that the pandemic had provided an opportunity to strengthen health and epidemiological systems and to enhance collaboration between the health sector and other sectors and between the public and private sectors. They emphasized, however, that the health sector should lead the response to such public health emergencies.

226. Dr. Margaret Chan (Director-General, WHO) commended the ministries of health of the Region for their leadership in the difficult and stressful situation created by the emergence of the new influenza virus. One of the lessons learned from the pandemic was that ministries of health must have certain powers in order to respond quickly and decisively to such situations, and she encouraged Member States to examine their legal frameworks with a view to ensuring that their health ministries had those powers. On the question of whether the H1N1 strain would be added to the seasonal vaccine for the southern hemisphere, she said that the WHO Strategic Advisory Group of Experts (SAGE) would be issuing a recommendation shortly.

227. Evidence from all six WHO regions indicated that early treatment with oseltamivir had been very helpful in reducing the severity of disease, and WHO was currently mobilizing resources to ensure that all Member States would have adequate supplies of both antiviral medications and the pandemic vaccine once it became

available. It was important for countries to take steps immediately to ensure that they had the necessary infrastructure and capacity to carry out vaccination campaigns and to reach the recommended target populations. It was also important not to rely entirely on pharmaceutical interventions. Preventive measures such as social distancing were also important, although of course the pros and cons had to be weighed.

228. Dr. Barbosa da Silva said that PAHO was planning a series of workshops aimed at preparing immunization personnel in Member States to plan and carry out effective H1N1 vaccination campaigns.

229. The Director said that the Revolving Fund for Vaccine Procurement was in the process of obtaining bids from potential suppliers of the H1N1 vaccine. The cost per dose from the six suppliers that had submitted bids ranged from \$4 to \$9. The Organization was working on the assumption that one dose of the vaccine would be sufficient and that universal vaccination was neither necessary nor desirable, as massive use of the vaccine would increase the risks of adverse events. PAHO would conduct post-marketing surveillance of the vaccine and refine its recommendations on the basis of the evidence compiled.

230. The Council took note of the report.

Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO (Documents CD49/INF/3-A, B, and C)

231. Dr. María Julia Muñoz (Representative of the Executive Committee) said that the Committee had heard a report during its session in June on the resolutions and other actions of the Sixty-second World Health Assembly and the 125th Session of the WHO Executive Board, the thirty-ninth regular session of the General Assembly of the OAS, and the Fifth Summit of the Americas that were considered to be of particular interest to the PAHO Governing Bodies. It had been noted that the Sixty-second World Health Assembly had taken place amidst great concern over the global economic crisis and the H1N1 influenza pandemic. The Assembly had adopted 16 resolutions; those of primary interest to the Region of the Americas were listed in Document CD49/INF/3-A. The 125th Session of the Executive Board had been held immediately following the Health Assembly. The Board had examined reports on the global elimination of measles, the safety and quality of blood products, and birth defects, among other matters.

232. The General Assembly of the OAS had been held in Honduras in June 2009. It had adopted the Declaration of San Pedro Sula: Toward a Culture of Non-Violence. Document CD49/INF/3-B highlighted the General Assembly resolutions that were considered to be of particular interest to the Governing Bodies of PAHO.

233. The Fifth Summit of the Americas, held in Trinidad and Tobago in April 2009, had adopted the Commitment of Port-of-Spain: Securing Our Citizens' Future by Promoting Human Prosperity, Energy Security, and Environmental Sustainability. Document CD49/INF/3-C highlighted that 17 of the 97 paragraphs in the Declaration dealt with health-related issues, including universal access to health care with emphasis on the most vulnerable groups, strengthening of health systems based on primary health care, and prevention and control of chronic noncommunicable diseases. The Committee had been informed that, as a member of the Joint Summit Working Group, PAHO would help prepare the reports on the follow-up to health-related Summit commitments and would report on the matter to the PAHO Governing Bodies.

234. Mr. David Morris (Director, Summits of the Americas Secretariat, OAS) expressed appreciation for the collaboration of PAHO in the preparations for the Fifth Summit of the Americas. The Summits Secretariat considered health to be not only a specific issue that was addressed in a number of Summit commitments, but also a crosscutting theme that was related to other issues discussed at the Fifth Summit of the Americas, such as human prosperity, energy security, environmental sustainability, public security, and strengthening democratic governance. He noted with satisfaction that the Directing Council had repeatedly underscored the importance of monitoring and evaluation of results: that had been the orientation that had led the Fifth Summit to adopt a Declaration of Commitment rather than a mere declaration and plan of action. He looked forward to continued collaboration with PAHO in the preparations for the next Summit, to be held in Cartagena, Colombia, in 2012.

235. The Delegate of Trinidad and Tobago, host country for the Fifth Summit, expressed her Government's appreciation to the States and organizations that had contributed to the success of the event. Members of the Caribbean Community had assisted in the areas of security, logistics, personnel, and the use of physical facilities and airports. PAHO and WHO had provided technical support and personnel, and Canada and the United States of America had provided critical support in the areas of health services and training for emergency and disaster response. The Summit had provided a unique opportunity for her country's health system to be at its maximum preparedness. She was happy to report that all health services had functioned efficiently during the Summit. Her Government would be applying the lessons learned from the Summit experience as it prepared to host the Commonwealth Heads of Government Meeting in November 2009.

236. Dr. Juan Manuel Sotelo (Manager, External Relations, Resource Mobilization and Partnerships, PASB) reaffirmed PAHO's commitment to ensuring that its technical cooperation activities were in line with relevant decisions of the Sixty-second World Health Assembly, the thirty-ninth regular session of the OAS General Assembly, and the Fifth Summit of the Americas. The Organization was working closely with the Joint Summit Working Group and with representatives of Member States who served on the

Summit Implementation Review Group (SIRG) and was actively involved in following up on and implementing the mandates laid down in the Declaration of Commitment.

237. The Council took note of the reports on this item.

Progress Reports on Administrative and Financial Matters (Document CD49/INF/4)

Implementation Status of the International Public Sector Accounting Standards (IPSAS) (Document CD49/INF/4-A)

238. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had been informed in June 2009 that the implementation of the International Public Sector Accounting Standards (IPSAS) was on schedule and that the steps remaining to be completed in the course of 2009 included submission to the Governing Bodies of proposed changes in the Financial Regulations and Rules, development of accounting manuals, IPSAS training, determination of how to recognize in-kind contributions from Member States in financial statements, identification of inventories held for sale, determination of which entities would be consolidated into PAHO's financial statements, possibly requesting current valuations for PAHO's land and buildings, and coordinating the Organization's interpretation of IPSAS with that of the External Auditor. The Committee had also been told that some work would be needed on the Organization's computer systems in order to meet basic IPSAS requirements.

239. In addition, the Committee had been informed that PAHO was working closely with the World Food Program, which had already implemented the IPSAS, in order to learn from its experience. Following the World Food Program's example, PAHO had decided, as a short-term strategy, to make use of improvisations in its computer system rather than upgrading the system before implementing the IPSAS, although in the long term, the Organization would need a new financial system, able to support accrual accounting and capitalization of fixed assets. The Committee had been informed that a working group was designing such a system and had recently finalized the financial guiding principles.

240. Ms. Sharon Frahler (Manager, Financial Resources Management, PASB) reported that implementation of the IPSAS was proving very challenging, but was still on schedule for completion by January 2010.

241. The Council took note of the information provided.

Master Capital Investment Fund (Document CD49/INF/4-B)

242. Dr. María Julia Muñoz (Representative of the Executive Committee) reported that the Executive Committee had been informed in June 2009 of the progress of several projects funded under the Master Capital Investment Fund. Information on those projects appeared in Document CD49/INF/4-A. Mr. Michael Boorstein (Director of Administration, PASB) had drawn attention to three of those projects in particular. One had concerned enhancements to the country office in Brazil. Mr. Boorstein had noted that, as those enhancements had been funded by the Government of Brazil itself, the amount projected for expenditure was still available in the Fund. He had also noted that the project for refurbishment of the elevators in the Headquarters building in Washington, D.C. had been postponed until 2010, in part so that the existing elevators would be available to transport materials for another project, the replacement of all the windows in the building. Lastly, he had drawn attention to an expenditure of \$42,000 in Chile, where the country office had suffered a break-in and the loss of much of its computer equipment.

243. Following Dr. Muñoz's report, the Director expressed the Organization's gratitude to the Government of Uruguay, which had recently provided a permanent home for the PAHO country office and the Latin American Center for Perinatology and Human Development (CLAP) in Montevideo.

244. The Council took note of the information provided.

Closure of the Session

245. Following the customary exchange of courtesies, the President declared the 49th Directing Council closed.

Resolutions and Decisions

246. The following are the resolutions and decisions adopted by the 49th Directing Council:

Resolutions

CD49.R1: Amendments to the Financial Regulations*

THE 49th DIRECTING COUNCIL,

Having considered the recommendation of the Executive Committee at its 144th Session on the proposed amendments to the Financial Regulations as they appear in the Annex to Document CD49/25;

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

RESOLVES:

To approve the amendments to the Financial Regulations of the Pan American Health Organization as they appear in the Annex of Document CD49/25 and to make these amendments effective as of 1 January 2010.

(Second plenary, 28 September 2009)

Annex

CD49.R1, Annex

**FINANCIAL REGULATIONS
OF THE PAN AMERICAN HEALTH ORGANIZATION**

Regulation I - Applicability and Delegation of Authority

- 1.1 These Regulations shall govern the financial administration of the Pan American Health Organization.
- 1.2 The Director of the Pan American Sanitary Bureau is responsible for ensuring effective financial administration of the Organization in accordance with these Regulations.

* Attached is a final version of the Financial Regulations as adopted by the 49th Directing Council.

- 1.3 Without prejudice to Regulation 1.2, the Director may delegate in writing to other officers of the Organization such authority and related accountability as he or she considers necessary for the effective implementation of these Regulations.
- 1.4 The Director shall establish Financial Rules, including relevant guidelines and limits for the implementation of these Regulations, in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization.

Regulation II - The Budgetary and Financial Reporting Periods

- 2.1 The budgetary period shall be a biennium consisting of two consecutive calendar years beginning with an even-numbered year.
- 2.2 The financial reporting period shall be a calendar year.

Regulation III - The Program and Budget

- 3.1 The program and budget proposals for the budgetary period, as referred to in Article 14.C of the Constitution shall be prepared by the Director of the Pan American Sanitary Bureau. The program and budget proposals shall be presented in United States dollars.
- 3.2 The program and budget proposals shall be divided into parts and shall include such information annexes and explanatory statements as may be requested on behalf of the Pan American Sanitary Conference (hereinafter referred to as "Conference"), the Directing Council, or the Executive Committee, and such further annexes or statements as the Director may deem necessary and useful.
- 3.3 The Director shall submit the program and budget proposals to the Executive Committee for examination and recommendation.
- 3.4 The Executive Committee shall submit the program and budget proposals, and any recommendations it may have thereon, to the Conference or the Directing Council within the timeframe stipulated in the corresponding Rules of Procedure.
- 3.5 The program and budget proposals for the following budgetary period shall be approved by the Conference or the Directing Council in the year preceding the biennium to which the program and budget proposals relate.
- 3.6 Supplemental proposals may be submitted by the Director when deemed necessary.
- 3.7 The Director shall prepare supplemental proposals in a form consistent with the program and budget proposals for the budgetary period and shall submit such proposals to the Executive Committee for examination and recommendation. The Executive Committee shall submit the supplemental proposals, and any recommendations it may have thereon, to the Conference or Directing Council within the timeframe stipulated in the corresponding Rules of Procedure.

Regulation IV - Regular Budget Appropriations

- 4.1 The Regular Budget appropriations approved by the Conference or the Directing Council shall constitute an authorization to the Director to enter into commitments and make payments for the purposes for which the Regular Budget appropriations were approved and up to the amounts so approved.
- 4.2 Regular Budget appropriations shall be available for making commitments in the budgetary period to which they relate for delivery of programmed goods and services in that same budgetary period or, exceptionally, in the first year of the subsequent budgetary period for delayed delivery of such programmed goods and services due to unforeseen circumstances.
- 4.3 Transfers within the total amount appropriated may be made to the extent permitted by the terms of the budget resolution adopted by the Conference or the Directing Council.
- 4.4 Any balance of the Regular Budget appropriation not committed by the end of the current budgetary period, shall be used to replenish the Working Capital Fund to its authorized level, after which any balance will be available for subsequent use in accordance with the resolutions adopted by the Conference or Directing Council.
- 4.5 Any deficit of revenue over expenses of the Regular Budget appropriation at the end of the current budgetary period shall be funded first by the Working Capital Fund to the extent possible, and then by borrowing or by other authorized means.
- 4.6 Any excess of revenue over the Regular Budget appropriation at the end of a budgetary period shall be considered a revenue surplus and shall be available for use in subsequent periods to cover the unfunded portion of the Strategic Plan, as determined by the Director and with the concurrence of the Subcommittee on Program, Budget, and Administration.
- 4.7 An accrual shall be established for undisbursed commitments that have been charged against Regular Budget appropriations during the current financial reporting period and that cover the cost of goods or services which were delivered during the financial reporting period.
- 4.8 Any commitments for goods and services due to be delivered in subsequent budgetary periods that exist against the Organization at the end of the current budgetary period shall be established as commitments against future Regular Budget appropriations unless otherwise stated in these Regulations.

Regulation V - Provision of Regular Program Budget Funds

- 5.1 The Regular Budget appropriations shall be financed by assessed contributions from Member States, Participating States, and Associate Members (hereinafter referred to as

“Members”) and the budgetary estimate of Miscellaneous Income. Assessments shall be determined in accordance with Article 60 of the Pan American Sanitary Code.

- 5.2 Adjustments shall be made to the amount of the assessed contributions of the following budgetary period in respect of:
- (a) Supplemental Regular Budget appropriations approved in the current budgetary period for which Members have not been assessed; and
 - (b) Assessed contributions of new Members under the provisions of Regulation 6.10.

Regulation VI - Revenue - Assessed Contributions

- 6.1 The Conference or the Directing Council shall adopt the total Program and Budget, and the amount of the assessments, determined in accordance with Regulation 5.1, for the budgetary period. The assessed contributions of Members shall be divided into two equal annual installments. In the first year of the budgetary period, the Conference or Directing Council may decide to amend the amount of assessments to be applied to the second year of the budgetary period.
- 6.2 After the Conference or the Directing Council has adopted the Program and Budget, the Director shall inform Members of their commitments in respect of contributions for the budgetary period and request them to pay the first and second installments of their contributions.
- 6.3 If the Conference or the Directing Council decides to amend the amounts of the assessments, or to adjust the amount of the Regular Budget appropriations to be financed by assessed contributions from Members for the second year of a biennium, the Director shall inform Members of their revised commitments and shall request them to pay the revised second installment of their assessed contributions.
- 6.4 Installments of assessed contributions shall be due and payable as of 1 January of the year to which they relate.
- 6.5 As of 1 January of the following year, the unpaid balance of such assessed contributions shall be considered to be one year in arrears.
- 6.6 Assessed contributions shall be denominated in U.S. dollars and shall be paid in either U.S. dollars or other currencies as determined by the Director.
- 6.7 Payments in currencies other than U.S. dollars shall be credited to Members' accounts at the United Nations rate of exchange in effect on the date of receipt or at the market rate of exchange should conversion of excess currency be deemed prudent.
- 6.8 Payments made by a Member shall be applied against its oldest outstanding assessed contribution.

- 6.9 The Director shall submit to the regular session of the Conference or the Directing Council a report on the collection of assessed contributions.
- 6.10 New Members shall be required to make an assessed contribution for the budgetary period in which they become Members. If membership begins at any time during the first year of a budgetary period, new Members will be assessed for the full two-year period. If membership begins at any time during the second year of a budgetary period, new Members will be assessed for the second year only.

Regulation VII - Working Capital Fund and Internal Borrowing

- 7.1 A Working Capital Fund shall be established, along with its authorized level, and financing, in accordance with Resolutions adopted by the Conference or Directing Council.
- 7.2 Title to financial resources constituting the Working Capital Fund shall remain with the Pan American Health Organization.
- 7.3 The Working Capital Fund shall be made available to meet any temporary financial resource requirements of the Regular Budget. The Fund shall be reimbursed in accordance with Regulations 4.4 and 7.1.
- 7.4 The Working Capital Fund shall be made available to finance unforeseeable and extraordinary expenses, replenish existing funds to authorized levels, or other authorized purposes. The Fund shall be reimbursed in accordance with Regulations 4.4 and 7.1.
- 7.5 The Director, with the prior and written concurrence of a majority of the members of the Executive Committee, shall have the authority to borrow funds.

Regulation VIII - Revenue - Other Sources

- 8.1 Other sources of revenue not otherwise identified in these Regulations shall be reported as Miscellaneous Income.
- 8.2 Voluntary contributions, donations, and bequests, either in cash or in kind, may be accepted by the Director, provided that these contributions can be used by the Organization, and that any conditions which may be attached to them are consistent with the objectives and policies of the Organization.
- 8.3 Donations and bequests received without a specific purpose shall be reported as Miscellaneous Income unless otherwise specified by the Director in accordance with Regulation IX.
- 8.4 The Director is authorized to levy a charge (hereinafter referred to as "Program Support Costs") on voluntary contributions in accordance with applicable resolutions of the

Conference or Directing Council. These Program Support Costs will be used to reimburse all, or part of, the indirect costs incurred by the Organization in respect of the administration of corresponding activities.

- 8.5 Revenue generated from sales and services will be used to reimburse all or part of the direct and indirect costs incurred by the Organization in respect of the administration of its activities.
- 8.6 Revenue from Services Charges on procurement funds will be used to capitalize the respective fund or to reimburse all or part of the costs incurred by the Organization in respect of the administration of its activities.

Regulation IX - Funds

- 9.1 Funds shall be established to enable the Organization to effectively record and report on all sources of revenue.
- 9.2 Individual subsidiary ledger accounts shall be established to effectively record and report on voluntary contributions.
- 9.3 Special Funds or Accounts shall be established by the Director as necessary to meet the requirements of the Organization.
- 9.4 The purpose of any Fund or Account established under Regulation 9.3 shall be specified and subject to the Financial Regulations and Financial Rules.
- 9.5 In establishing any Special Fund or Account under Regulation 9.3, the Director may stipulate that the use of the cash balance of the Fund or Account is restricted for pooling or internal borrowing purposes consistent with the terms and conditions of the funding sources.

Regulation X - Custody of Financial Resources

- 10.1 The Director shall designate the financial institutions in which the financial resources in the custody of the Organization shall be kept.
- 10.2 The Director may designate external investment managers and/or custodians.

Regulation XI - Investments

- 11.1 Investment policies and guidelines shall be established in accordance with best industry practice, having due regard for the preservation of principal, assurance of adequate liquidity, and maximization of total yield.

- 11.2 Financial Resources in excess of immediate cash requirements may be pooled and invested.
- 11.3 Investment income, regardless of the source of funds, shall be credited as Miscellaneous Income to the Regular Budget unless otherwise stipulated in these Regulations, in resolutions adopted by the Conference or Directing Council, or as decided by the Director.

Regulation XII - Internal Control

- 12.1 The Director shall establish and maintain an effective internal control structure with operating policies and procedures based on best industry practice, in order to:
 - (a) ensure efficient and effective financial administration,
 - (b) safeguard assets,
 - (c) accomplish the strategic objectives and goals in line with the mission of the Organization, and
 - (d) maintain an internal oversight function reporting to the Director.

Regulation XIII - Accounts and Financial Statements

- 13.1 The Director shall establish and maintain a chart of accounts in accordance with the accounting standards adopted by the Conference or Directing Council.
- 13.2 Financial statements shall be prepared for each financial reporting period in conformity with the Standards referred to in Regulation 13.1.
- 13.3 The financial statements shall be presented in United States dollars. The accounting records may, however, be kept in such currencies as the Director may deem necessary.
- 13.4 The financial statements shall be submitted to the External Auditor by a date mutually agreed upon with the Director.
- 13.5 The Director may make such *ex gratia* payments as deemed to be necessary in the interest of the Organization. *Ex gratia* payments will be disclosed in the financial statements.
- 13.6 The Director may authorize, after full investigation, the write-off of any asset other than assessed contributions. Write-offs will be disclosed in the financial statements.
- 13.7 The Conference or Directing Council may stipulate a reserve for doubtful accounts, representing all or a portion of the outstanding assessed contributions due from a Member State subject to the restrictions of Article 6.B of the Constitution.

Regulation XIV - External Audit

- 14.1 The Conference or the Directing Council shall appoint an External Auditor of international repute to audit the accounts of the Organization. The Auditor appointed may be removed only by the Conference or the Directing Council.
- 14.2 Subject to any special direction of the Conference or the Directing Council, each audit which the External Auditor performs shall be conducted in conformity with generally accepted common auditing standards and in accordance with the Additional Terms of Reference set forth in the Appendix to these Regulations.
- 14.3 The External Auditor, in addition to rendering an opinion on the financial statements, may make such observations as deemed necessary with respect to the efficiency of the financial procedures, the accounting system, the internal financial controls, and in general, the administration and management of the Organization.
- 14.4 The External Auditor shall be completely independent and solely responsible for the conduct of the audit.
- 14.5 The Conference or the Directing Council may request the External Auditor to perform certain specific examinations and issue separate reports on the results.
- 14.6 The Director shall provide the External Auditor with the facilities required for the performance of the audit.
- 14.7 For the purpose of making a local or special examination or for effecting economies of audit cost, the External Auditor may engage the services of any national Auditor-General (or equivalent title) or commercial public auditors of known repute or any other person or firm that, in the opinion of the External Auditor is technically qualified.
- 14.8 The External Auditor shall issue a report including its opinion, on the audit of the financial statements prepared by the Director pursuant to Regulation XIII. The report shall include such information as deemed necessary in regard to Regulation 14.3 and the Additional Terms of Reference.
- 14.9 The report(s) of the External Auditor shall be completed and provided to the Director together with the audited financial statements no later than 15 April following the end of the financial reporting period to which they relate. The Director will provide the report to the Executive Committee which shall examine the financial statements and the audit report(s) and shall forward them to the Conference or the Directing Council with such comments as deemed necessary.

Regulation XV - Resolutions involving Expenses

- 15.1 The Conference, the Directing Council, and the Executive Committee shall not make decisions involving expenses unless it has before it a report from the Director on the administrative and financial implications of the proposal.
- 15.2 Where, in the opinion of the Director, the proposed expense cannot be made from the existing appropriations, it shall not be incurred until the Conference or the Directing Council has made the necessary appropriations, unless such expense can be made under the conditions of the resolution of the Directing Council relating to the Emergency Procurement Revolving Fund.

Regulation XVI - General Provisions

- 16.1 These Regulations may be amended only by the Conference or the Directing Council.
- 16.2 In case of doubt as to the interpretation and application of any of the foregoing Regulations, the Director is authorized to rule thereon.
- 16.3 The Financial Rules established or amended by the Director as referred to in Regulation 1.4 shall be confirmed by the Executive Committee and reported to the Conference or the Directing Council for its information.

**ADDITIONAL TERMS OF REFERENCE GOVERNING THE EXTERNAL AUDIT
OF THE PAN AMERICAN HEALTH ORGANIZATION**

1. The External Auditor shall perform such audit of the accounts of the Pan American Health Organization, including all Trust Funds, Special Funds, and Special Accounts, as deemed necessary to support the opinion:
 - (a) that the financial statements are in accord with the books and records of the Organization;
 - (b) that the financial transactions reflected in the statements have been in accordance with the rules and regulations, the budgetary provisions, and other applicable directives of the Organization;
 - (c) that the financial resources have been verified by the certificates received direct from the Organization's depositaries or by actual count;
 - (d) that the internal controls, including the internal audit, are adequate in view of the extent of reliance placed thereon;

- (e) that the procedures applied to the recording of all assets, liabilities, surpluses and deficits conform with industry best practices.
2. The External Auditor shall be the sole judge as to the acceptance in whole or in part of certifications and representations by members of the staff of the Organization and may proceed to such detailed examination and verification as needed.
3. The External Auditor shall have free access at all convenient times to all books, records and other documentation which are, in the opinion of the External Auditor necessary for the performance of the audit. Information classified as privileged and which the Director agrees is required by the External Auditor for the purposes of the audit, and information classified as confidential, shall be made available upon request. The External Auditor shall respect the privileged and confidential nature of any information so classified which has been made available and shall not make use of it except in direct connection with the performance of the audit. The External Auditor may bring to the attention of the Conference or the Directing Council any denial of information classified as privileged which, in their opinion, was required for the purpose of the audit.
4. The External Auditor shall have no power to disallow items in the accounts but shall bring to the attention of the Director for appropriate action any transaction that creates doubt as to legality or propriety. Audit objections, to these or any other transactions, arising during the examination of the accounts shall be immediately communicated to the Director.
5. The External Auditor shall express an opinion on the financial statements of the Organization. The opinion shall include the following basic elements:
 - (a) identification of the financial statements audited;
 - (b) a reference to the responsibility of the entity's management and responsibility of the External Auditor;
 - (c) a reference to the audit standards followed;
 - (d) a description of the work performed;
 - (e) an expression of opinion on the financial statements as to whether:
 - (i) the financial statements present fairly the financial position as at the end of the financial reporting period and the results of the operations for such period;
 - (ii) the financial statements were prepared in accordance with the stated accounting policies;

- (iii) the accounting policies were applied on a basis consistent with that of the preceding financial reporting period unless disclosed in the financial statements.
 - (f) an expression of opinion on the compliance of transactions with the Financial Regulations and legislative authority;
 - (g) the date of the opinion and the signature of the External Auditor;
 - (h) the External Auditor's name and position;
 - (i) the place where the report has been signed;
 - (j) a reference to the report of the External Auditor on the financial statements, should one be provided.
6. The report of the External Auditor to the Conference or Directing Council on the financial operations of the financial reporting period should mention:
- (a) the type and scope of examination;
 - (b) matters affecting the completeness or accuracy of the accounts, including, where appropriate:
 - (i) information necessary to the correct interpretation of the accounts;
 - (ii) any amounts that ought to have been received but which have not been brought to account;
 - (iii) any amounts for which a legal or contingent liability exists and which have not been recorded or reflected in the financial statements;
 - (iv) expenses not properly substantiated;
 - (v) whether proper books of accounts have been kept; where in the presentation of statements there are deviations of a material nature from a consistent application of generally accepted accounting principles, these should be disclosed.
 - (c) other matters that should be brought to the notice of the Conference or the Directing Council such as:
 - (i) cases of fraud or presumptive fraud;
 - (ii) wasteful or improper expense of the Organization's money or other assets (notwithstanding that the accounting for the transaction may be correct);
 - (iii) expense likely to commit the Organization to further outlay on a large scale;
 - (iv) any defect in the general system or detailed regulations governing the control of receipts and disbursements, or of supplies and equipment;

- (v) expense not in accordance with the intention of the Conference or the Directing Council, after making allowance for duly authorized transfers within the Program Budget;
 - (vi) expense in excess of Regular Budget appropriations as amended by duly authorized transfers within the Program Budget;
 - (vii) expense not in conformity with the authority that governs it.
- (d) the accuracy of the inventory and fixed assets as determined by a physical count and examination of the records.
- (e) transactions accounted for in a previous financial reporting period, about which further information has been obtained, or transactions in a later financial reporting period about which the Conference or the Directing Council should have early knowledge.
7. The External Auditor may make such observations with respect to findings resulting from the audit and such comments on the financial report as deemed appropriate to the Conference or the Directing Council, or to the Director.
8. Whenever the External Auditor's scope of audit is restricted, or insufficient evidence is available, the External Auditor's opinion shall refer to this matter, making clear in the report the reasons for the comments and the effect on the financial position and the financial transactions as recorded.
9. In no case shall the External Auditor include criticism in any report without first affording the Director an adequate opportunity of explanation on the matter under observation.
10. The External Auditor is not required to discuss or report any matter which is considered immaterial.

CD49.R2: Establishment of the Audit Committee of PAHO

THE 49th DIRECTING COUNCIL,

Having reviewed the document *Proposal for the Establishment of an Audit Committee* (Document CD49/26);

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

Noting the proposal to establish an independent expert advisory body to advise the Director and PAHO's Member States on the operation of the Organization's financial

controls and reporting structures, risk management process, and other audit-related controls,

RESOLVES:

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

Annex

(Second plenary, 28 September 2009)

CD49.R2, Annex

TERMS OF REFERENCE FOR THE AUDIT COMMITTEE OF PAHO

Guiding Principle

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

Role of the Committee

2. The PAHO Audit Committee shall:
 - (a) review and monitor the adequacy, efficiency, and effectiveness of the Organization’s risk assessment and management processes, the system of internal and external controls (including PAHO’s internal oversight and External Auditor

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

Membership of the Committee

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

Criteria for Membership

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

- (a) experience in preparing, auditing, analyzing, or evaluating financial statements that present a breadth and level of complexity of accounting issues that are generally comparable to the breadth and complexity of issues faced by PAHO, including an understanding of relevant accepted accounting principles;

- (b) an understanding of and, if possible, relevant experience in the inspection, monitoring, and evaluation processes;
- (c) an understanding of internal control, risk management, investigation, and procedures for financial reporting; and
- (d) a general understanding of the organization, structure, and functioning of international organizations in the UN system.

Terms of Appointment

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

Call for Proposals

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

7. The list of candidates will be subject to assessment, which may include requests for additional information and subsequent modification. The highest ranked candidates, according to the Criteria for Membership, will be proposed by the SPBA to the Executive Committee for decision.

Responsibility of Members

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

9. Members of the Audit Committee shall be required to sign a confidentiality statement at the beginning of their tenure, as well as a PAHO Declaration of Interest Form. Where an actual or potential conflict of interest arises, the Member shall declare

such interest to the Committee and will be excused from the Committee's discussion on the corresponding issue.

Meetings and Rules of Procedure

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

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

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

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

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

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

Disclosure

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

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

Access

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

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

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

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

Reporting

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

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

Resources

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

Review of the Terms of Reference

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

CD49.R3: Amended PAHO Strategic Plan 2008-2012

THE 49th DIRECTING COUNCIL,

Having considered the proposed amended draft of the PAHO Strategic Plan 2008-2012 presented by the Director (*Official Document 328*) and Document CD49/6;

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

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

RESOLVES:

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

(Third plenary, 29 September 2009)

CD49.R4: Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Trinidad and Tobago, United States of America, and Uruguay

THE 49th DIRECTING COUNCIL,

Bearing in mind the provision of Articles 9.B and 15.A of the Constitution of the Pan American Health Organization;

Considering that Colombia, Saint Vincent and the Grenadines, and Venezuela were elected to serve on the Executive Committee upon the expiration of the periods of office of Trinidad and Tobago, United States of America, and Uruguay,

RESOLVES:

1. To declare Colombia, Saint Vincent and the Grenadines, and Venezuela elected to membership on the Executive Committee for a period of three years.

2. To thank Trinidad and Tobago, United States of America, and Uruguay for the services rendered to the Organization during the past three years by their delegates on the Executive Committee.

(Fifth plenary, 30 September 2009)

CD49.R5: Establishment of a New Institutional Framework for the Latin American and Caribbean Center on Health Sciences Information (BIREME)

THE 49th DIRECTING COUNCIL,

Having reviewed the proposal presented by the Director of the Pan American Sanitary Bureau (“the Director”) for the establishment of a new institutional framework for the governance, management and financing of the Latin American and Caribbean Center on Health Sciences Information (BIREME) as described in the document *Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)* (Document CD49/17);

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

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

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

Recognizing the historical importance of the Government of Brazil’s contribution to the establishment and continued maintenance of BIREME in that country, particularly the specific contributions provided by the Ministry of Health, the Ministry of Education, the Secretariat of Health of the State of São Paulo, and the Federal University of São Paulo;

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

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

RESOLVES:

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

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

Proposed Statute of BIREME

Article I Legal Status

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

Article II Objective

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

Article III Functions

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

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

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

Article IV Membership

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

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

* Includes PAHO Member States, Participating States, and Associate Members.

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

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

Article V Structure

BIREME shall consist of the following bodies:

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

Article VI Advisory Committee

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

1. The Advisory Committee of BIREME shall be made up of designated Members with the following composition:
 - a. two (2) permanent members: one (1) appointed by the Representative of the Government of Brazil and one (1) by the Director of PAHO;

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

- i. recommend to the Director of PAHO the creation of technical committees and working groups to assist BIREME in performing its programmatic functions, executing the Work Plan, and addressing health sector priorities;
- j. adopt internal Rules of Procedure to be approved by all its Members in regular session;
- k. hold an annual regular session. Members of the Advisory Committee may request that the Director of PAHO convene special sessions.

Article VII Scientific Committee

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

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

- b. advise the Director of PAHO and the Advisory Committee on the methodologies and technologies used by BIREME for the management of information products and services, and recommend the solutions and upgrades needed;
- c. advise the Director of PAHO and the Advisory Committee on the adoption of innovations in scientific information and communication;
- d. advise the Director of PAHO and the Advisory Committee on the preparation and implementation of BIREME's Biennial Work Plan, in keeping with the PAHO Strategic Plan and Biennial Work Plan;
- e. advise the Director of PAHO and the Advisory Committee on the adoption of international partnerships for the development of health science information and communication;
- f. adopt internal Rules of Procedure to be approved by all its Members in regular session;
- g. hold an annual regular session. Three (3) members of this Scientific Committee may request BIREME's Advisory Committee to hold special sessions.

Article VIII Secretariat

Subject to the general authority and decisions of the Director of PAHO, the Secretariat is a permanent body of BIREME, responsible for the technical and administrative management and execution of BIREME's Biennial Work Plan and Budget, pursuant to PAHO regulations and standards.

1. The Secretariat shall be comprised of the Director of BIREME and the necessary technical and administrative personnel, as determined by the Director of PAHO and subject to the availability of financial resources.
2. The Director of BIREME shall be appointed by the Director of PAHO, through an international competition, pursuant to the rules and regulations of PAHO.
3. Staff members who hold positions in BIREME shall be appointed pursuant to the rules and regulations of PAHO.
4. The Director of BIREME shall be responsible to the Director of PAHO for the executive management of BIREME, pursuant to PAHO rules and regulations.

Responsibilities include:

- a. prepare, based on PAHO's Regional Strategic Plan, the Proposal for BIREME's Biennial Work Plan and Biennial Budgetary Proposal and submit them to the Advisory Committee for review and recommendations from the Director of PAHO;
- b. executing Biennial Work Plan and Biennial Budget of BIREME approved by the Director of PAHO as an integral part of PAHO's Biennial Work Plan;
- c. promoting and establishing collaboration with entities and organizations connected with BIREME's programmatic functions;
- d. promoting and forging international partnerships for the development of health science information and communication, in keeping with PAHO priorities;
- e. representing BIREME at events and in initiatives relevant to its programmatic functions as a Specialized Center of PAHO;
- f. manage BIREME's administrative and financial affairs;
- g. present an annual progress report on BIREME and submit it to the Advisory Committee for review and recommendations to the Director of PAHO;
- h. prepare any other report requested by the Director of PAHO, the Advisory Committee, or the Scientific Committee of BIREME;
- i. serve as the Secretary *ex officio* at meetings of the Advisory Committee and Scientific Committee;
- j. accept funds or contributions from individuals or corporations through agreements and/or contracts, as related to BIREME's functions, subject to the conditions established by the Director of PAHO and with his prior written authorization.

Article IX Finance

1. Resources for funding BIREME's Biennial Work Plan shall be obtained from the following sources: the annual contribution from PAHO determined by the Director of PAHO; the annual contribution from the Government of Brazil, pursuant to the agreement signed with PAHO; annual contributions from the

- Participating States and Participating Organizations of BIREME, and financial resources from projects, sale of services, and voluntary contributions.
2. All annual contributions shall be due on 1 January of each year and are to be paid by 30 June of the same year at the latest.
 3. BIREME funds and assets shall be treated as PAHO trust funds and administered pursuant to PAHO's financial regulations.
 4. A Working Capital Fund shall be established on behalf of BIREME in accordance with PAHO's rules and regulations.

Article X Privileges and Immunities

The privileges and immunities granted to BIREME in Brazil as a Specialized Center of PAHO, as well as the financial responsibilities of the Government of Brazil in regard to the maintenance of BIREME in Article IX of this Statute, should be reflected in a specific agreement between PAHO and the Government of Brazil.

Article XI Facilities

The arrangements regarding the physical facilities and other services provided to BIREME, headquartered since its creation on the UNIFESP campus in the city of São Paulo, Brazil, should be reflected in an agreement involving PAHO, the Government of Brazil, and UNIFESP.

Article XII Amendments

Amendments to this Statute, as recommended by the BIREME Advisory Committee, shall enter into force on approval by the Directing Council of PAHO.

Article XIII Entry into Force

The provisions of this Statute shall enter into force on the date of its approval by the Directing Council of PAHO.

(Fifth plenary, 30 September 2009)

CD49.R6: Election of Five Nonpermanent Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME)

THE 49th DIRECTING COUNCIL,

Having adopted Resolution CD49.R5 which establishes the new Statute of the Latin American and Caribbean Center on Health Sciences Information (BIREME);

Noting that the governance structure described in the new Statute of BIREME calls for the establishment of an Advisory Committee;

Bearing in mind that Article VI of the new Statute of BIREME establishes that the Advisory Committee of BIREME is to be comprised of one representative appointed by the Director of PASB and one by the Government of Brazil as permanent members, and that five nonpermanent members are to be selected and named by the Directing Council or the Pan American Sanitary Conference of PAHO from among the BIREME membership [which at this time include all PAHO Member States, Participating States, and Associate State(s)], taking geographical representation into account;

Recalling that Article VI further states that the five nonpermanent members of the BIREME Advisory Committee should be rotated every three (3) years, and that the Directing Council or the Pan American Sanitary Conference of PAHO may indicate a shorter rotation period in cases where it is necessary to maintain balance among members of the Advisory Committee,

RESOLVES:

1. To elect three Member States to serve on BIREME's Advisory Committee for a three-year term, and two Member States for a two-year term effective 1 January 2010.
2. Thereafter, to elect the nonpermanent members of the Advisory Committee on a staggered basis so that no election would take place in 2010, two members would be elected in 2011, and three members in 2012.
3. To declare Argentina, Chile, and Dominican Republic elected as nonpermanent members on the Advisory Committee of BIREME for a period of three years.
4. To declare Jamaica and Mexico elected as nonpermanent members on the Advisory Committee of BIREME for a period of two years.

(Fifth plenary, 30 September 2009)

CD49.R7: New Assessment Scale for the Budgetary Period 2010-2011

THE 49th DIRECTING COUNCIL,

Having considered the report of the President of the 144th Session of the Executive Committee (Document CD49/2) and the *New Scale of Quota Contributions* (Document CD49/7);

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

Noting that the 140th Session of the Executive Committee, after having considered the application of the OAS transitional scales for years 2007 and 2008, decided in Resolution CE140.R5 (June 2007) to defer the application of a definitive assessment scale of the OAS to biennia subsequent to the 2008-2009 biennium;

Considering that the 34th Extraordinary Session of the General Assembly of the OAS in November 2007 adopted Resolution AG/RES.1 (XXXIV-E/07) which established the definitive assessment scale for its membership applicable to the years 2009, 2010 and 2011;

Taking into account that various Member States have expressed concern over the financial impact for them of applying the definitive OAS scale at this time,

RESOLVES:

To approve the application of two OAS scales to the PAHO 2010-2011 biennium, as follows: the transitional OAS scale (2008) to the year 2010 and the definitive OAS scale (2009-2011) to the year 2011, in order to determine the assessed contributions for PAHO, as detailed in the following table, to be applied to the Program and Budget for the Budgetary Period 2010-2011.

Member State	Assessment Rate 2010	Assessment Rate 2011
Antigua and Barbuda	0.024	0.022
Argentina	4.282	3.211
Bahamas	0.084	0.077
Barbados	0.080	0.060
Belize	0.026	0.022
Bolivia	0.060	0.046
Brazil	7.626	7.953
Canada	13.761	13.761
Chile	1.112	1.073

Member State	Assessment Rate 2010	Assessment Rate 2011
Colombia	0.807	0.839
Costa Rica	0.150	0.187
Cuba	0.496	0.241
Dominica	0.017	0.022
Dominican Republic	0.165	0.206
Ecuador	0.165	0.206
El Salvador	0.084	0.105
France *	0.289	0.289
Grenada	0.022	0.022
Guatemala	0.150	0.187
Guyana	0.022	0.022
Haiti	0.060	0.045
Honduras	0.060	0.045
Jamaica	0.163	0.123
Mexico	6.513	8.141
Netherlands *	0.090	0.090
Nicaragua	0.060	0.045
Panama	0.130	0.163
Paraguay	0.165	0.124
Peru	0.443	0.553
Puerto Rico **	0.111	0.111
Saint Kitts and Nevis	0.022	0.022
Saint Lucia	0.024	0.022
Saint Vincent and the Grenadines	0.022	0.022
Suriname	0.060	0.045
Trinidad and Tobago	0.180	0.152
United Kingdom *	0.060	0.060
United States	59.445	59.445
Uruguay	0.223	0.181
Venezuela	2.747	2.060
	<u>100.000</u>	<u>100.000</u>

* Participating Member

** Associate Member

(Fifth plenary, 30 September 2009)

CD49.R8: PAHO Program and Budget 2010-2011

THE 49th DIRECTING COUNCIL,

Having examined the proposed Program and Budget of the Pan American Health Organization (PAHO) 2010-2011 (*Official Document 333*), its Addendum, and Document CD49/5, Rev. 1;

Having considered the report of the Executive Committee (Document CD49/2);

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

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

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

RESOLVES:

1. To approve the program of work for the PASB as outlined in the proposed PAHO Program and Budget 2010-2011 (*Official Document 333*).
2. To appropriate for the financial period 2010-2011 the amount of US\$ 339,852,341, which represents an increase to assessments of PAHO Member States, Participating States, and Associate Members of 3.5% with respect to the biennium 2008-2009, as follows:

SECTION	TITLE	AMOUNT
1	To reduce the health, social and economic burden of communicable diseases	23,302,000
2	To combat HIV/AIDS, tuberculosis and malaria	6,324,000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	11,426,000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals	11,694,000

SECTION	TITLE	AMOUNT
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	3,893,000
6	To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions	7,611,000
7	To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	8,068,000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	13,399,000
9	To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development	12,009,000
10	To improve the organization, management and delivery of health services	8,111,000
11	To strengthen leadership, governance and the evidence base of health systems	32,026,000
12	To ensure improved access, quality and use of medical products and technologies	7,565,000
13	To ensure an available, competent, responsive and productive health workforce to improve health outcomes	9,305,000
14	To extend social protection through fair, adequate and sustainable financing	5,207,000
15	To provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the United Nations system and other stakeholders to fulfill the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO's Eleventh General Programme of Work, and the Health Agenda for the Americas	65,885,000
16	To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	61,275,000
	Effective Working Budget for 2010-2011 (Parts 1-16)	287,100,000
17	Staff Assessment (Transfer to Tax Equalization Fund)	52,752,341
	Total – All Sections	339,852,341

3. That the appropriation shall be financed from:

(a) Assessments in respect to:

Member States, Participating States, and Associate
Members assessed under the scale adopted239,152,341

(b) Miscellaneous Income20,000,000

(c) AMRO share approved at the 62nd World Health Assembly.....80,700,000

TOTAL339,852,341

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

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

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

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

allocation will be reflected in the corresponding appropriation sections 1-16 at the time of reporting.

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

(Fifth plenary, 30 September 2009)

CD49.R9: Assessed Contributions of the Member States, Participating States, and Associate Members of the Pan American Health Organization for 2010-2011

THE 49th DIRECTING COUNCIL,

Whereas in Resolution CD49.R8 the Directing Council approved the PAHO Program and Budget 2010-2011 (*Official Document 333*), its Addendum, and Document CD49/5, Rev. 1;

Bearing in mind that the Pan American Sanitary Code establishes that the scale of assessed contributions to be applied to Member States of the Pan American Health Organization will be based on the assessment scale adopted by the Organization of American States for its membership, and that in Resolution CD49.R7 the Directing Council adopted the new scale of assessments for the PAHO membership for the biennium 2010-2011,

RESOLVES:

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

ASSESSMENTS OF THE MEMBER GOVERNMENTS, PARTICIPATING GOVERNMENTS AND
ASSOCIATE MEMBERS OF THE PAN AMERICAN HEALTH ORGANIZATION FOR 2010-2011

(1) Membership	(2) Scale Adjusted to PAHO Membership		(3) Gross Assessment		(4) Credit from Tax Equalization Fund		(5) Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff		(6) Net Assessment	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
	%	%	US\$	US\$	US\$	US\$	US\$	US\$	US\$	US\$
Member Governments:										
Antigua and Barbuda	0.024	0.022	28,698	26,307	6,330	5,803			22,368	20,504
Argentina	4.282	3.211	5,120,251	3,839,591	1,129,427	846,939			3,990,824	2,992,652
Bahamas	0.084	0.077	100,444	92,074	22,156	20,310			78,288	71,764
Barbados	0.080	0.060	95,661	71,746	21,101	15,826			74,560	55,920
Belize	0.026	0.022	31,090	26,307	6,858	5,803			24,232	20,504
Bolivia	0.060	0.046	71,746	55,005	15,826	12,133			55,920	42,872
Brazil	7.626	7.953	9,118,879	9,509,893	2,011,447	2,097,697			7,107,432	7,412,196
Canada	13.761	13.761	16,454,876	16,454,876	3,629,624	3,629,624	25,000	25,000	12,850,252	12,850,252
Chile	1.112	1.073	1,329,687	1,283,052	293,303	283,016			1,036,384	1,000,036
Colombia	0.807	0.839	964,980	1,003,244	212,856	221,296			752,124	781,948
Costa Rica	0.150	0.187	179,364	223,607	39,564	49,323			139,800	174,284
Cuba	0.496	0.241	593,098	288,179	130,826	63,567			462,272	224,612
Dominica	0.017	0.022	20,328	26,307	4,484	5,803			15,844	20,504
Dominican Republic	0.165	0.206	197,301	246,327	43,521	54,335			153,780	191,992
Ecuador	0.165	0.206	197,301	246,327	43,521	54,335			153,780	191,992
El Salvador	0.084	0.105	100,444	125,555	22,156	27,695			78,288	97,860
Grenada	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Guatemala	0.150	0.187	179,364	223,607	39,564	49,323			139,800	174,284
Guyana	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Haiti	0.060	0.045	71,746	53,809	15,826	11,869			55,920	41,940
Honduras	0.060	0.045	71,746	53,809	15,826	11,869			55,920	41,940
Jamaica	0.163	0.123	194,909	147,079	42,993	32,443			151,916	114,636
Mexico	6.513	8.141	7,787,996	9,734,696	1,717,880	2,147,284			6,070,116	7,587,412
Nicaragua	0.060	0.045	71,746	53,809	15,826	11,869			55,920	41,940
Panama	0.130	0.163	155,449	194,909	34,289	42,993			121,160	151,916

(1) Membership	(2) Scale Adjusted to PAHO Membership		(3) Gross Assessment		(4) Credit from Tax Equalization Fund		(5) Adjustment for Taxes Imposed by Member States on Emoluments of PASB Staff		(6) Net Assessment	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
	%	%	US\$	US\$	US\$	US\$	US\$	US\$	US\$	US\$
Member Governments:										
Paraguay	0.165	0.124	197,301	148,274	43,521	32,706			153,780	115,568
Peru	0.443	0.553	529,722	661,256	116,846	145,860			412,876	515,396
Saint Kitts and Nevis	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Saint Lucia	0.024	0.022	28,698	26,307	6,330	5,803			22,368	20,504
Saint Vincent and the Grenadines	0.022	0.022	26,307	26,307	5,803	5,803			20,504	20,504
Suriname	0.060	0.045	71,746	53,809	15,826	11,869			55,920	41,940
Trinidad and Tobago	0.180	0.152	215,237	181,756	47,477	40,092			167,760	141,664
United States of America	59.445	59.445	71,082,053	71,082,053	15,679,313	15,679,313	5,100,000	5,100,000	60,502,740	60,502,740
Uruguay	0.223	0.181	266,655	216,433	58,819	47,741			207,836	168,692
Venezuela	2.747	2.060	3,284,757	2,463,269	724,553	543,349	0	0	2,560,204	1,919,920
Subtotal	<u>99.450</u>	<u>99.450</u>	<u>118,918,501</u>	<u>118,918,500</u>	<u>26,231,101</u>	<u>26,231,100</u>	<u>5,125,000</u>	<u>5,125,000</u>	<u>97,812,400</u>	<u>97,812,400</u>
Participating Governments:										
France	0.289	0.289	345,575	345,575	76,227	76,227			269,348	269,348
Kingdom of the Netherlands	0.090	0.090	107,619	107,619	23,739	23,739			83,880	83,880
United Kingdom	0.060	0.060	71,746	71,746	15,826	15,826			55,920	55,920
Subtotal	<u>0.439</u>	<u>0.439</u>	<u>524,940</u>	<u>524,940</u>	<u>115,792</u>	<u>115,792</u>			<u>409,148</u>	<u>409,148</u>
Associate Member:										
Puerto Rico	0.111	0.111	132,730	132,730	29,278	29,278			103,452	103,452
Subtotal	<u>0.111</u>	<u>0.111</u>	<u>132,730</u>	<u>132,730</u>	<u>29,278</u>	<u>29,278</u>			<u>103,452</u>	<u>103,452</u>
TOTAL	<u>100.000</u>	<u>100.000</u>	<u>119,576,171</u>	<u>119,576,170</u>	<u>26,376,171</u>	<u>26,376,170</u>	<u>5,125,000</u>	<u>5,125,000</u>	<u>98,325,000</u>	<u>98,325,000</u>

(5) This column includes estimated amounts to be received by the respective Member Governments in 2010-2011 in respect of taxes levied by them on staff members' emoluments received from PASB, adjusted for the difference between the estimated and the actual for prior years.

(Fifth plenary, 30 September 2009)

CD49.R10: Policy on Research for Health

THE 49th DIRECTING COUNCIL,

Having reviewed the document *Policy on Research for Health* (Document CD49/10);

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

Aware that as our rapidly changing world faces significant environmental, demographic, social, and economic challenges, research will be increasingly essential to elucidate the nature and scope of health problems; identify effective, safe, and appropriate interventions and strategies; address health equity and determinants for health; and fulfill the Millennium Development Goals and the 2008-2017 Health Agenda for the Americas;

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

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

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

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

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

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

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

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

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

RESOLVES:

1. To endorse PAHO's Policy on Research for Health (Document CD49/10).
2. To urge Member States to:
 - (a) recognize the importance of research for health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, include all relevant sectors public and private, align external support around mutual priorities, and strengthen key national institutions;
 - (b) consider drawing on PAHO's Policy on Research for Health according to their national circumstances and contexts, and as part of their overall policies on health and health research;
 - (c) work with PAHO to strengthen and monitor national health research systems by improving the quality, leadership and management of research for health, focusing on national needs, establishing effective institutional research mechanisms, systematically using evidence to develop health policies, having the necessary skills in place through increased training of health researchers, encouraging research participation and harmonizing and coordinating national and external support;
 - (d) establish, as necessary and appropriate, governance mechanisms for research for health to achieve effective coordination and strategic approaches between relevant sectors, ensure the rigorous application of good research norms and standards, including providing protection for human subjects involved in research, and

- promote an open dialogue between policymakers and researchers on national health needs, capacities, and constraints;
- (e) continue working with PAHO and its specialized centers to support the point of view that holds that research evidence essential for health and development continue to be accessible and available, including, when appropriate, in the public domain;
 - (f) promote intersectoral collaboration and quality research to produce the research evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
 - (g) initiate or strengthen intercountry and subregional collaboration as a way to obtain efficiencies of scale in research by sharing experiences, best practices, and resources, by pooling training and procurement mechanisms, and by using common and standardized research evaluation methods;
 - (h) continue to pursue financing of research for health and its monitoring, as articulated in Resolution WHA58.34 and in line with the Paris Declaration on Aid Effectiveness;
 - (i) establish ethical review boards and implement ethical principles for clinical trials involving human subjects, with reference to the Declaration of Helsinki and other appropriate texts on ethical principles for medical research involving human subjects.
3. To invite Member States, the research for health community, the inter-American system, the UN system, and other international organizations, supporters of research, the private sector, civil society organizations, and other concerned stakeholders to:
- (a) provide support to the PAHO Secretariat for implementing the Policy on Research for Health and monitoring and evaluating its effectiveness;
 - (b) collaborate with PAHO, within the framework of the Policy, to identify research for health priorities, develop guidelines relating to research for health, develop registries and monitoring mechanisms, and share helpful information and data;
 - (c) assist PAHO and its research partners to mobilize and monitor resources for the identified Regional and subregional priorities for research for health;
 - (d) collaborate with PAHO to better align and coordinate the global and regional research for health architecture and its governance through the rationalization of

- existing partnerships, in order to improve coherence and impact and to increase efficiencies and equity;
- (e) pay particular attention to the research cooperation requests from Member States with pressing needs, notably in areas such as technology transfer, research workforce, infrastructure development, and determinants for health, particularly where this will contribute to the achievement of the Millennium Development Goals, health equity, and better health for all;
 - (f) support, where appropriate, technical cooperation aimed at raising research for health standards in Member States.
4. To request the Director to:
- (a) provide leadership in identifying regional priorities for research for health by promoting collaboration systems for detecting research needs and problems jointly with the Member States;
 - (b) implement and mainstream the Policy on Research for Health at all levels of the Organization, as well as with partners, and align it with relevant resolutions such as Resolution CD48.R15, *Public Health, Innovation, and Intellectual Property: a Regional Perspective*;
 - (c) ensure that the highest norms and standards of good research are upheld within PAHO, including technical, ethical, and methodological aspects, disseminate and promote access to research results and advocate their translation into policy and practice, and review and align the architecture and governance of the Organization's research activities and partnerships;
 - (d) continue to facilitate the development of PAHO staff with the necessary skills to appropriately and effectively use research in every relevant PAHO activity;
 - (e) provide adequate core resources in proposed program budgets for the implementation of the Policy on Research for Health;
 - (f) provide support to Member States, upon request and as resources permit, to strengthen national health research systems and the development of efficient intersectoral collaboration;
 - (g) collaborate constructively with other international organizations, networks, and stakeholders, including centers of excellence and WHO collaborating centers, to promote efficiencies and achieve a higher impact with this policy;

- (h) support the effective promotion and implementation of WHO's Research for Health Strategy, with periodic reporting to Member States, the active involvement of all relevant constituencies in PAHO, and the development of strategies and action plans for the Policy on Research for Health with the participation of Member States and in consultation with other stakeholders, including civil society;
- (i) promote transparency, with the collaboration of the Member States and, when appropriate, the dissemination of information useful for research and development and for research findings.

(Fifth plenary, 30 September 2009)

CD49.R11: Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment

THE 49th DIRECTING COUNCIL,

Having reviewed Document CD49/19 *Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment*;

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

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

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

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

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

RESOLVES:

1. To approve the Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment.

2. To urge Member States to:
 - (a) establish national coordinating committees to help develop and implement national blindness prevention plans;
 - (b) include prevention of avoidable blindness and visual impairment in national development plans and goals;
 - (c) advance the integration of prevention of blindness and visual impairment in existing plans and programs for primary health care at the national level, ensuring their sensitivity to gender and ethnicity;
 - (d) support the mobilization of resources for eliminating avoidable blindness;
 - (e) encourage partnerships between the public sector, nongovernmental organizations, private sector, civil society, and communities in programs and activities that promote the prevention of blindness;
 - (f) encourage intercountry cooperation in the areas of blindness and visual impairment prevention and care.
3. To request the Director to:
 - (a) support the implementation of the Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment;
 - (b) maintain and strengthen the Secretariat's collaboration with Member States on the prevention of blindness;
 - (c) promote technical cooperation among countries and the development of strategic partnerships in activities to protect ocular health.

(Seventh plenary, 1 October 2009)

CD49.R12: Plan of Action for Implementing the Gender Equality Policy

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director, *Plan of Action for Implementing the Gender Equality Policy* (Document CD49/13);

Recalling the Program of Action of the International Conference on Population and Development (Cairo, 1994), the Beijing Declaration and Platform for Action (Beijing, 1995), the recommendations and reports of Beijing plus 10 Conference (2005), the United Nations Economic and Social Council's agreed upon conclusions (1997/2), the United Nations Millennium Declaration (2000), the 2005 World Summit Outcome (United Nations General Assembly Resolution A/RES/60/1), and the World Health Assembly Resolution WHA58.30 on accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration, the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Pará);

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

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

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

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

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

RESOLVES:

1. To urge Member States to:
 - (a) adopt and promote the implementation of the Plan of Action for Implementing the Gender Equality Policy as a framework to attain gender equality in health;
 - (b) develop national health plans, policies, and laws for advancing the integration of gender equality in the health systems, and develop specific health policies, programs, and laws with a gender equality perspective and ensure that they are implemented through the establishment or strengthening of a gender office within the Ministry of Health;
 - (c) generate systematic reports on gender inequality in health for planning, advocacy, and monitoring through the production, analysis, and use of information disaggregated by sex and other relevant variables;
 - (d) facilitate the establishment of national intersectoral advisory groups that include civil society organizations, to support the health sector in implementing the Plan of Action;
 - (e) promote and strengthen partnerships with other United Nations agencies and other organizations to support the implementation of the Plan of Action.
2. To request the Director to:
 - (a) ensure the implementation of the Plan of Action and support Member States to progress in the implementation of national plans for integrating gender equality in health systems;
 - (b) provide knowledge on advances and best practices for achieving gender equality in health, as well as on threats to reaching it;
 - (c) facilitate monitoring the progress of implementation of the Plan of Action in the Secretariat's work and technical collaboration;
 - (d) rely on the support of a technical advisory group and other internal and external mechanisms that include civil society participation for implementing and monitoring the Plan of Action;
 - (e) promote and strengthen partnerships with other United Nations agencies and other organizations to support the implementation of the Plan of Action.

(Seventh plenary, 1 October 2009)

CD49.R13: Family and Community Health

THE 49th DIRECTING COUNCIL,

Having considered the concept paper *Family and Community Health* (Document CD49/20);

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

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

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

RESOLVES:

1. To urge Member States to:
 - (a) adopt a comprehensive and intercultural family and community health approach as an effective framework for promoting and integrating social policies, local development strategies, public health programs, and health care services aimed at strengthening the coping capabilities of families and communities and ensuring the health and wellbeing of their members;
 - (b) emphasize specific actions to address the determinates of health and advocate for improved social and economic conditions, especially of young men and women;
 - (c) intensify their efforts to ensure universal access to quality individual and collective health services and programs as a critical component of a social protection agenda, through the development of integrated health systems based on primary health care, focusing on key programmatic areas for the achievement of the Millennium Development Goals;

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

(Eighth plenary, 1 October 2009)

CD49.R14: Plan of Action on Adolescent and Youth Health

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Plan of Action on Adolescent and Youth Health* (Document CD49/12), based on the PAHO Strategic Plan 2008-2012;

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

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

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

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

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

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

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

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

RESOLVES:

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

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

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

(Eighth plenary, 1 October 2009)

CD49.R15: Plan of Action on the Health of Older Persons, Including Active and Healthy Aging

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Plan of Action on the Health of Older Persons, Including Active and Healthy Aging* (Document CD49/8);

Mindful of the United Nations Principles for Older Persons (1991); the international mandates proposed in the International Plan of Action on Aging of Madrid, 2002; the Pan American Sanitary Conference Resolution CSP26.R20 (2002), the regional implementation strategy approved by the Regional Intergovernmental Conference on Aging (2003); the Brasilia Declaration adopted by the Second Intergovernmental Regional Conference on Aging (2007); the Health Agenda for the Americas 2008-2017; and the Resolution AG/RES.2455 (XXXIX-O/09) of the Organization of American States, "Human Rights and Older Persons," adopted by the 39th Regular Session of the General Assembly of the OAS (San Pedro Sula, Honduras, 4 June 2009);

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

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

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

RESOLVES:

1. To support the present *Plan of Action on the Health of Older Persons, Including Active and Healthy Aging* and its consideration in policies, plans and development programs as well as proposals and the discussion of the national budgets, to enable them to create the conditions for meeting the challenge of aging in their respective countries.
2. Urge the Member States to:
 - (a) consider the United Nations Principles for Older Persons (independence, participation, care, self-fulfillment and dignity) as the foundation for public policies on aging and health, and the need to include older persons when designing and executing these policies;
 - (b) adopt national policies, strategies, plans, and programs that increase access by older persons to health programs and services that meet their needs, including in particular health promotion and disease prevention programs based on primary health care that promote the development of strategies that integrate healthy personal and environmental behaviors to achieve active aging throughout the life cycle, with the participation of society as a whole, the family, and the individuals themselves;
 - (c) promote an internal dialogue among public sector institutions and between them and the private sector and civil society, with a view to building a national consensus on the issue of the health of older persons and healthy and active aging and its link with national development processes;
 - (d) advocate for the promotion and protection of the human rights and basic freedoms of older persons through the adoption of legal frameworks and implementation mechanisms, chiefly in the context of long-term care services, bearing in mind

Resolution CSP26.R20 “Health and Aging” adopted by the 26th Pan American Sanitary Conference (Washington, D.C., United States, 23 September 2002);

- (e) collaborate with the Permanent Council of the Organization of American States in efforts that include a special meeting of national representatives and experts from the academic sector and civil society, as well as from international organizations, for the purpose of sharing information and best practices and also of examining the feasibility of preparing an inter-American convention on the rights of older persons;
 - (f) support capacity building for training the human resources needed to tend to the health needs of older persons;
 - (g) strengthen the capacity to generate information and research for the development of strategies based on evidence and the needs of this population group, ensuring the ability to monitor and evaluate their results;
 - (h) conduct an internal review and analysis of the relevance and viability of this strategy in the national context, based on national priorities, needs, and capabilities.
3. Request the Director to:
- (a) support the Member States in the implementation of the strategy and *Plan of Action on the Health of Older Persons, Including Active and Healthy Aging*, in a manner consistent with their needs and the demographic and epidemiological context;
 - (b) promote the implementation and coordination of this strategy and Plan of Action, guaranteeing that it cuts across program areas, the Organization’s different regional and subregional contexts, collaboration with and among countries, the strategy design, and the sharing of skills and resources in order to execute its plans on health and aging;
 - (c) encourage the development of collaborative research that will yield better knowledge about the impact of aging on health systems and the modeling of future scenarios that will enhance national forecasting capacity in this area, the design of related strategies, and interventions based on the specific needs of the Region’s different contexts;

- (d) support development and capacity building to ensure adequate training and distribution of the necessary human resources for health to the countries to address the health needs of older persons;
- (e) consolidate and strengthen technical collaboration with the committees, organs, and rapporteurships of United Nations and Inter-American agencies, and promote partnerships with other international and regional agencies, scientific and technical institutions, organized civil society, the private sector, and others in creating a Coalition of the Americas for Healthy Aging that will contribute to the implementation of this strategy and Plan of Action;
- (f) report periodically to the PAHO Governing Bodies on progress and constraints in the execution of this strategy and Plan of Action, as well as its adaptation to new contexts and needs, when necessary.

(Eighth plenary, 1 October 2009)

CD49.R16: Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP)

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

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama* (Document CD49/18);

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

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

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

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

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

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

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

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

RESOLVES:

1. To take note of the decision of the Directing Council of INCAP to assume the administration of INCAP with full functional autonomy.
2. To note that the Pan American Health Organization will continue to be part of INCAP as a full member, but that it will no longer be responsible for the administration of the Institute under the terms of Articles VII, XXXIV, XXXV and XXXVI of the Basic Agreement for INCAP.
3. To adopt the Adjustment to the Basic Agreement for the Internal Reorganization of INCAP as adopted by Resolution II of the LIX Directing Council of INCAP (see Annex B), which becomes an integral part of this resolution and which eliminates articles VII, XXXIV, XXXV and XXXVI and amends Articles XV, XIX, XX and XXXIX of the Basic Agreement for INCAP.

4. To request the Director of PASB to:
 - (a) institute the administrative and legal measures necessary for ensuring the orderly and transparent transfer of the administration of INCAP to the Directing Council of the Institute, in accordance with the Adjustment to the Basic Agreement for INCAP approved by the Directing Council of INCAP and by this Council;
 - (b) ensure that the Organization continues to participate in INCAP as a full member.

Annexes

CD49.R16, Annex A

**BASIC AGREEMENT OF THE INSTITUTE OF NUTRITION
OF CENTRAL AMERICA AND PANAMA**

Guatemala, 27 August 1998

The Representatives of the Republics of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, hereinafter “the Member States,” and the Pan American Health Organization, Regional Office for the Americas of the World Health Organization, hereinafter “PAHO/WHO”:

CONSIDERING:

That the Institute of Nutrition of Central American and Panama, hereinafter “INCAP” or “the Institute,” was founded with cooperation from the Pan American Sanitary Bureau and the W.K. Kellogg Foundation through an Agreement signed by the Member States of Central America and the Pan American Sanitary Bureau on 20 February 1946.

That the founding agreement for INCAP was extended and modified on 14 December 1949, and that on 17 December 1953 the Parties adopted a Basic Agreement to provide a permanent foundation for the organization of the Institute.

That, when the Basic Agreement went into force on 1 January 1955, INCAP was established as a permanent technical entity whose objective is to contribute to the development of nutrition science, promote its practical application, and strengthen the technical capacity of the Central American States to solve their food and nutrition problems.

That Central America’s transition toward a new institutional order with an integrated strategic vision demands review and updating of the legal and institutional framework of

INCAP to align its actions with the current and future situation and needs of its Member States and ensure the effective and efficient achievement of its mission.

That the XIV Meeting of Presidents, held in Guatemala in October 1993, welcomed the regional initiative on food and nutrition security in the countries of Central America promoted by the Ministers of Health, informing its follow-up with technical and scientific support from INCAP and PAHO/WHO, with the support of the Secretary-General of the Central American Integration System.

That INCAP is an institution directly linked with the Central American Integration System, charged with providing support for the fulfillment of its social objectives.

That, in order to respond to the food and nutrition priorities of the Central American States, within the health sector reform processes, it will be necessary to review and update the Basic Agreement for INCAP.

AGREE:

With the full power and authority vested in the Representatives of the Member States and PAHO/WHO, to adopt this Basic Agreement for the Institute of Nutrition of Central America and Panama, which shall replace and render null and void the Basic Agreement for INCAP currently in place, adopted on 17 December 1953.

VISION

ARTICLE I

Within the framework of Central American integration, INCAP is a leader, a self-sustainable, permanent institution in the field of food and nutrition in Central America and beyond.

MISSION

ARTICLE II

The mission of INCAP, as a specialized institution in food and nutrition, is to support the efforts of the Member States, providing technical cooperation to achieve and maintain the food and nutrition security of their populations through its basic functions of research, information and communication, technical assistance, human resources training and development, and the mobilization of financial and nonfinancial resources in support of its mission.

INSTITUTIONAL FUNCTIONS AND POLICIES

ARTICLE III

The following institutional policies shall serve as the framework for the exercise INCAP functions:

1. Direct technical assistance: Strengthen the operating capacity of national institutions through new methodological and evaluational approaches designed to promote the application and transfer of technology and nutrition education at the community level while developing models to evaluate the results and impact of this cooperation.
2. Human resources training and development: Identify needs, develop programs, and support human resources education and training in food and nutrition in the Member States.
3. Research: Conduct research at all levels, emphasizing operations research to find solutions to priority problems, promoting linkages through scientific and technical cooperation to build or strengthen the research capability of the Member States through training activities in universities and research centers.
4. Information and communication: Process, organize, disseminate, and transmit scientific and technical information in health, food, and nutrition to the different levels and sectors of the Member States and the international community to support decision-making and strengthen documentation centers, as well as the planning, implementation, and evaluation of food and nutrition activities at the national and subregional level.
5. Mobilization of financial and nonfinancial resources: Promote the necessary actions to acquire and manage financial, technological, human, and institutional resources to guarantee a permanent, diversified source of income and promote the sale and marketing of food and nutrition services and technology transfer.

STRATEGIES

ARTICLE IV

INCAP shall direct its work to implementing the Central American Food and Nutrition Security Initiative, as a strategy to combat the effects of poverty and promote human

development, adopted by the Council of Ministers of Health of the area and approved by the Presidents of Central America at the XIV Meeting of Presidents.

ARTICLE V

The food and nutrition security strategy is grounded in the criteria of equity, sustainability, productivity, sufficiency, and stability to guarantee access, production, consumption, and adequate biological utilization of food, coordinating crop and livestock production with agroindustry and profitable marketing mechanisms, giving priority to small and medium-sized producers, and involving the business sector in the implementation of this initiative.

MEMBERSHIP

ARTICLE VI

The Republics of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama and the Pan American Health Organization are full Members of INCAP. Full Members have the right to speak and to vote during the deliberations of the meetings of the Advisory Board and Directing Council.

ARTICLE VII

PAHO/WHO has two levels of linkage with INCAP. On the one hand, it is a full Member, the highest authority of the Institute; and on the other, by request of the Directing Council, it is responsible for the administration of the Institution, which shall be reconstituted every five years and must be accepted each time by the Directing Council of PAHO/WHO. In order to discharge the latter duty, the Director of PAHO/WHO is responsible for the legal representation and operation of INCAP, which he can fully or partially delegate.

ARTICLE VIII

Other States may become full Members of the Institute, once the Directing Council of INCAP has unanimously approved their admission, the Secretary-General of the Central American Integration System has issued a favorable decision in this respect, and the State has accepted and become a party to the present Basic Agreement.

ARTICLE IX

Associate Members consist of foundations, agencies, and institutions whose mission is aligned with the vision and mission of INCAP and whose application and membership

have been unanimously approved by the Directing Council. Associate Members may participate, at their own expense and with the due consent of the Directing Council of INCAP, in the deliberations of the regular meetings of the Advisory Board and Directing Council of INCAP, without the right to vote.

ARTICLE X

Individuals or legal entities may participate in the meetings of the Advisory Board and Directing Councils as Observers, with the right to speak, with prior unanimous approval of the Council Members for each meeting.

ARTICLE XI

In order to guarantee the rights and benefits inherent to their status, all Members of INCAP shall fulfill in good faith the obligations contracted under the present Basic Agreement. They shall, in addition, furnish all types of assistance in any action that INCAP takes under the present Agreement. Any Associate Member of the Institute may withdraw with written notice to the Office of the Director, which shall communicate any withdrawal notices received to the Directing Council. Six months from the date in which withdrawal notices are received, the provisions of the current Basic Agreement shall cease to be in effect for the Associate Member that wishes to withdraw, and its ties with INCAP shall be severed, maintaining the obligation to honor financial commitments and other obligations stemming from this Basic Agreement until the date of withdrawal.

GOVERNING BODIES

ARTICLE XII

The Governing Bodies of INCAP are the Directing Council, the Office of the Director, the Advisory Board, and the External Advisory Committee.

DIRECTING COUNCIL

ARTICLE XIII

The supreme governing body of INCAP is its Directing Council, comprised of the Ministers of Health of the full Member States and the Director of PAHO/WHO. In the event of an impediment to their attendance, the Ministers of Health may be represented in the Directing Council of INCAP by the respective Vice Minister. If these officials cannot attend the meeting, the Ministers of Health and the Director of PAHO/WHO may appoint another high official duly authorized to make decisions to represent them.

ARTICLE XIV

The Directing Council shall ensure that INCAP operates within the framework of its vision, mission, and institutional policies, and in accordance with the terms of the present Agreement.

ARTICLE XV

The principal mandates of the Directing Council of INCAP are to:

1. Define and guide the action and general policies of INCAP.
2. Approve the plans, programs, and projects of the Institute.
3. Approve the financial policy and biennial budget of INCAP, and set the quota contributions of its Member States.
4. Approve the reports on the work of the Institute.
5. Approve the statutes, rules, and regulations of INCAP by a minimum two-thirds vote.
6. Encourage national and regional authorities to support the efforts of INCAP to find solutions to the food and nutrition problems of the Member States.

ARTICLE XVI

The Directing Council of INCAP regularly meets once a year, according to its regulations. In special circumstances, when two or more of its full Members consider it necessary and submit a written request, the Council shall call a special session.

ARTICLE XVII

The location of the annual regular meeting of the Directing Council of INCAP shall rotate as follows: Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama, unless the Council agrees to hold it in another location.

ARTICLE XVIII

Each Member of the Directing Council of INCAP shall have the right to vote. Decisions shall be made with one-half of the votes plus one. If on the date of the opening of the regular meetings of the Directing Council a Member State is in arrears in an amount that

exceeds two (2) full years of quota contributions, its voting rights shall be suspended. However, the Directing Council may restore the right to vote if the Member State has agreed to a special payment plan or its failure to pay has been deemed to be due to circumstances beyond its control.

OFFICE OF THE DIRECTOR

ARTICLE XIX

The Office of the Director of INCAP shall be headed by a Director appointed by the Director of PAHO/WHO. The Director of INCAP shall be responsible for managing the Institute according to the delegation of authority conferred by the Director of PAHO/WHO.

ARTICLE XX

The Director of INCAP shall be responsible for the activities of the Institute, pursuant to the rules, regulations, programmatic and administrative orientations of PAHO/WHO, and the terms of the present Basic Agreement. The Director of INCAP has the following functions:

1. Administer the Institute in accordance with its mission, functions, policies, plans, programs, and projects, determined and approved by the Directing Council of INCAP.
2. Appoint technical, scientific, and administrative personnel pursuant to the current regulations and supervise their optimum performance and development to implement the work plan of INCAP.
3. Convene meetings of the Directing Council and Advisory Board and serve as Secretariat *ex officio* for them.
4. Prepare the biennial program budget proposal of INCAP for consideration and modification by the Members of the Directing Council at least one month prior to the regular meeting of the Directing Council.
5. Present the annual activities report and financial statements of the previous year, as well as the short-, medium, and long-term plans, programs, projects, and budget to the regular meeting of the Directing Council. The Director shall submit additional reports when one of the full Members so requests it or when he deems it necessary.

6. Submit the statutes, rules, and regulations necessary for the organization and administration of the Institute to the Directing Council for consideration.
7. Within his area of authority, comply and ensure compliance with the Basic Agreement and the statutes, rules, and regulations.
8. Exercise the functions delegated to him by the Directing Council and the Director of PAHO/WHO, and in general, undertake and carry out the actions that he deems necessary, pursuant to the present Basic Agreement.
9. Encourage national, regional, and international authorities to search for solutions to improve food and nutrition security.
10. Establish, maintain, and strengthen cooperation and mutual understanding with Central American institutions and international cooperation agencies.

ADVISORY BOARD

ARTICLE XXI

The Advisory Board of INCAP is the technical advisory body of the Directing Council of INCAP.

ARTICLE XXII

The Advisory Board of INCAP shall be comprised of the general directors designated by the Ministry of Health of each of the Member States, or by a senior official of the Ministry of Health with the respective delegation of authority; the Director of the Institute, who shall serve as Technical Secretary; and a representative of PAHO/WHO designated by the Director of PAHO/WHO.

ARTICLE XXIII

The Advisory Board of INCAP has the following functions:

1. Support the orientation of and compliance with the resolutions of the Directing Council and functions of INCAP.
2. Periodically monitor and evaluate INCAP's technical cooperation to the Member States through decentralized actions.
3. Submit technical proposals to the Directing Council of INCAP.

4. Prepare the agenda for presentation at the annual regular meeting of the Directing Council of INCAP.

ARTICLE XXIV

The Advisory Board shall regularly meet twice a year. Special meetings may be convened when at least two Member States, the Director of INCAP, or the PAHO/WHO Representative designated by its Director so request it. Pertinent specialists and advisers may participate in the meetings of the Advisory Board, as may observers representing other institutions invited by the Advisory Board.

ARTICLE XXV

The Advisory Board shall elect a Director-General from the meeting's host country as Chair and a Vice Chair from the next host country, who shall exercise their functions during the regular and special meetings held for one calendar year.

ARTICLE XXVI

The site of the regular meetings shall rotate among the Member States in the order indicated for the meetings of the Directing Council of INCAP. The Director of INCAP shall issue the call at least 30 days in advance and shall set the dates after consultation with the host Government. In the case of special meetings, the Director of the Institute, in consultation with the Council Chair, shall determine the place and date.

ARTICLE XXVII

The country in which the meeting will be held shall provide the Advisory Board with an appropriate site in which to hold the Council's work sessions .

ARTICLE XXVIII

The quorum for the meetings shall be a simple majority of the Members.

ARTICLE XXIX

The agenda for each meeting shall be proposed by the Technical Secretariat in consultation with the Chair of the Advisory Board and should be sent to Council Members, together with the invitation, at least 30 days prior to the meeting. The agenda shall be adopted by the Members of the Advisory Board at the start of the meeting and should be linked with the agenda established in the regulations of the Directing Council of INCAP.

ARTICLE XXX

The final report of the meetings shall be prepared by the Technical Secretariat and sent to each of the Members within one month of the meeting.

EXTERNAL ADVISORY COMMITTEE

ARTICLE XXXI

INCAP shall have an External Advisory Committee, comprised of one representative designated by each of the Ministers of Health of the Member States, one representative from PAHO/WHO, and four international experts appointed by the Director of INCAP after prior consultation with the Directing Council of INCAP.

ARTICLE XXXII

The External Advisory Committee shall perform the following functions for the Governing Bodies of INCAP:

1. Formulate recommendations for the planning, administration, execution, and evaluation of INCAP programs.
2. Suggest new programs and projects suitable to the context of this Basic Agreement.
3. Assist INCAP with the identification of opportunities and mobilization of resources.
4. Express its opinion about any other matter submitted to it for consideration.

ARTICLE XXXIII

The continued existence, frequency, and regulation of the External Advisory Committee are as follows:

1. The External Advisory Committee shall be permanent in nature, and its members individuals with technical and administrative expertise in health, food, nutrition, and related disciplines.
2. The External Advisory Committee shall hold regular meetings every four years and special meetings when the Governing Bodies of INCAP deem it necessary.

3. The Directing Council of INCAP shall adopt regulations for governing the operations of the External Advisory Committee.

PAHO/WHO AND INCAP LINKAGE

ARTICLE XXXIV

The Director of PAHO/WHO shall appoint the administrative officer of INCAP as the immediate collaborator and subordinate of the Director of the Institute, in charge of administrative support functions and supervising the application of the administrative policies, rules, and procedures of PAHO/WHO, as well as those specific to INCAP.

ARTICLE XXXV

INCAP shall be linked programmatically to PAHO/WHO. As a Central American institution, its activities should therefore be part of the Organization's work plan in the fields of human resources development, direct technical assistance, research, information and communication, and the mobilization and development of financial resources. INCAP's activities with national programs are coordinated through the PAHO/WHO Representative Offices.

ARTICLE XXXVI

PAHO/WHO is responsible for supervising the programmatic activities of INCAP. The Office of Administration of PAHO/WHO and its respective units are responsible for supervising the administrative actions of the Institute.

INCAP HEADQUARTERS

ARTICLE XXXVII

INCAP headquarters shall be located in the Republic of Guatemala, with which a headquarters agreement shall be established. INCAP headquarters may be transferred to any other full Member country when its Directing Council deems it appropriate. The Government of INCAP's host country is obligated to grant the Institution, without cost and for the entire length of its existence, the buildings in which it is housed, as well as the land on which they are constructed, for use in the manner it deems most suitable for the exercise of its functions, permitting INCAP to make the necessary expansions and improvements.

FINANCING OF INCAP

ARTICLE XXXVIII

The Member States shall contribute to the regular budget of INCAP through fixed quotas in U.S. dollars, in amounts that shall be determined by the Directing Council and submitted for the approval of the respective Governments.

ARTICLE XXXIX

PAHO/WHO shall maintain and/or increase its support for the regular budget of INCAP, providing the technical, administrative, and financial resources approved by the Directing Council of that Organization.

ARTICLE XL

Associate Members of INCAP shall contribute to its financing through quotas that shall be determined by the Directing Council.

ARTICLE XLI

In all cases, the quota contributions determined shall be paid annually in U.S. dollars to the Office of the Director of INCAP within the first three months of the respective year.

ARTICLE XLII

INCAP can receive financial resources from the Food and Nutrition Foundation of Central America and Panama (FANCAP), the Trust Fund, the sale and marketing of services, and other sources, once their origin has been examined.

LEGAL STATUS AND AUTHORITY

ARTICLE XLIII

INCAP shall have its own legal status with the legal authority to execute and enter into all types of activities and contracts; acquire, possess, administer, or dispose of any type of moveable rights and property, according to the legal provisions in effect in each Member State; appear before the judicial, administrative, or any other type of authority, and in general, take any action or make any arrangement conducive to the fulfillment of its purposes or necessary for the execution of its activities.

ARTICLE XLIV

Legal representation of INCAP shall be the responsibility of the Director of the Institute or whosoever is exercising his functions; this authority may be delegated exclusively for the purposes of judicial representation.

PRIVILEGES AND IMMUNITIES

ARTICLE XLV

INCAP and its property, whatsoever its nature and location, shall enjoy immunity against all judicial or administrative procedures in the territory of all the Member States and cannot be subject to search, embargo, legal proceedings, precautionary or execution measures, unless the Directing Council of INCAP expressly waives that immunity. In sum, it shall be understood that such waivers do not cover any forced action or execution measures or compliance.

ARTICLE XLVI

INCAP property, whatsoever its nature, shall be exempt in all full Member States from all variety of direct and indirect taxes, duties, and tariffs, be they national, departmental, or municipal, with the exception of contributions that constitute payment for public services.

ARTICLE XLVII

The facilities, administrative and branch offices, files, correspondence, and all documents that are the property of the Institution or in its possession under any other name, shall be inviolable.

ARTICLE XLVIII

The Institute shall, in the territory of all the full Member States, enjoy the franking privilege established in the Inter-American postal conventions in force . No manner of censorship or control shall be applied to any type of correspondence or other official communications of the Institute.

ARTICLE XLIX

INCAP can possess, without being bound by fiscal ordinances, regulations, or moratoria of any nature, funds and foreign currency of any type and keep its accounts in any

currency; it shall be free to convert its funds and foreign currency and transfer them from one Member State to another, or within any of the Member States.

**PRIVILEGES AND IMMUNITIES
OF INCAP REPRESENTATIVES AND STAFF**

ARTICLE L

In all the Member States, INCAP representatives and staff shall be granted the following privileges and immunities:

1. They shall enjoy immunity from any legal proceeding related to activities carried out in the exercise of their functions.
2. They shall be exempt from taxes on salaries and emoluments paid by the Institute.
3. They and their spouses and minor children shall be exempt from all immigration restrictions and searches of aliens.
4. With regard to the international movement of funds, they shall be granted exemptions equal to those enjoyed by the staff of a similar category in the accredited diplomatic missions to the respective Government.
5. They may import, duty-free, their furniture and personal effects when they occupy their post in the country in question.
6. In times of national or international crisis, they and their dependents shall be granted repatriation facilities analogous to those enjoyed by the staff of the diplomatic missions.
7. The immunity against all legal processes indicated in point 1 and the tax exemption on salaries and emoluments paid by the Institute shall be common to all representatives and staff of INCAP; and points, 3, 4, 5, and 6 shall apply only to non-nationals of the country in which the application of those rights is requested.
8. The aforementioned privileges and immunities notwithstanding, all persons who enjoy them shall be obliged to respect the laws and regulations of the Member State in which they reside.

9. The privileges and immunities indicated are granted to the representatives and staff of the Institute exclusively for its sake. The Governing Bodies of the Institute can waive them if, in their opinion, they prevent the application of justice, and they can be waived without detriment to the interests of the Institute.

GENERAL PROVISIONS

ARTICLE LI

Compliance with the present Basic Agreement shall be evaluated at least every five years as the basis for proposing modifications that can be adapted to the development situation of the Member States.

ARTICLE LII

If the number of Member States is reduced to one as the result of withdrawals, the Institute shall be liquidated, and the profits from the goods belonging to it shall be divided among the States that have been full Members, in proportion to their total contributions to the Institute.

ARTICLE LIII

This Basic Agreement shall go into effect upon ratification by all the signatories, in accordance with their respective internal or constitutional procedures. The ratification instruments shall be deposited with the General Secretariat of the Central American Integration System and the Secretariat of the Organization of American States, who shall notify the other signatories of their deposit. Once this Basic Agreement goes into effect, the Basic Agreement signed on 17 December 1953 shall be null and void.

TEMPORARY ARTICLES

ARTICLE LIV

The current internal rules of both the Directing Council and the Advisory Board of INCAP shall remain in force; likewise the existing rules and regulations related to personnel and financial aspects in all matters that do not contravene the present Basic Agreement.

ARTICLE LV

The financial commitments that the Member States have contracted up to the time that the present agreement goes into effect shall remain in force until all pending quota contributions are paid in full.

The INCAP Council, meeting in Belize City, Republic of Belize, on 3 September 1997, reviewed and approved, as a first step, the present Basic Agreement, which shall be sent to the General Secretariat of the Central American Integration System so that the pertinent action can be taken with the Member States.

In witness whereof, the undersigned duly authorized Representatives of the Parties sign the present Basic Agreement in 11 originals of equal tenor, in the city of Guatemala de la Asunción, Republic of Guatemala, on the 27th day of August 1998.

For the Government of the Republic
of Belize:

_____ [signature]
Hon. Salvador Fernández
Minister of Health and Sports
Represented by:
Hon. Michael Bejos, Adviser
Embassy of Belize in Guatemala

For the Government of the Republic
of Costa Rica

_____ [signature]
Dr. Rogelio Pardo Evans
Minister of Health

For the Government of the Republic
of El Salvador

_____ [signature]
Dr. Eduardo Interiano
Minister of Public Health and
Social Assistance

For the Government of the Republic
of Guatemala

[signature]

Ing. Marco Tulio Sosa Ramírez
Minister of Public Health and Social
Assistance

For the Government of the Republic
of Honduras

[signature]

Dr. Marco Antonio Rosa
Secretary of Health

For the Government of the Republic
of Nicaragua

[signature]

Dr. Lombardo Martínez Cabezas
Minister of Health

For the Government of the Republic
of Panama

[signature]

Dr. Aída Moreno de Rivera
Minister of Health

Represented by: Enelka G. de Samudio
General Secretary of the
Ministry of Health

For the Pan American Health
Organization, Regional Office for the
Americas of the World Health
Organization

[signature]

Dr. George A.O. Alleyne
Director

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

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

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

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

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

RESOLVES:

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

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

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

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

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

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

(Eighth plenary, 1 October 2009)

CD49.R17: Strategy and Plan of Action on Mental Health

THE 49th DIRECTING COUNCIL,

Having studied the report of the Director *Strategy and Plan of Action on Mental Health* (Document CD49/11);

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

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

Considering the context and framework for action offered by the Health Agenda for the Americas, the PAHO Strategic Plan 2008-2012, and the WHO Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance abuse disorders (mhGAP), which reflect the importance of the issue and define strategic objectives for addressing mental health;

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

RESOLVES:

1. To endorse the provisions of the Strategy and Plan of Action on Mental Health and its implementation within the framework of the special conditions of each country, in order to respond appropriately to current and future mental health needs.
2. To urge Member States to:
 - (a) include mental health as a priority within national health policies, through the implementation of mental health plans that are consonant with the different problems and priorities of the countries, in order to maintain the achievements made and advance toward new goals, especially with regard to reducing existing treatment gaps;
 - (b) promote universal, equitable access to mental health care for the entire population, through strengthening mental health services within the framework of primary health care-based systems and integrated delivery networks and continuing activities to eliminate the old psychiatric hospital-centered model;
 - (c) continue working to strengthen the legal frameworks of the countries with a view to protecting the human rights of people with mental disorders and to achieve the effective application of the laws;

- (d) promote intersectoral initiatives to promote mental health, with particular attention to children and adolescents and on coping with the stigma and discrimination directed at people with mental disorders;
 - (e) support the effective involvement of the community and of user and family-member associations in activities designed to promote and protect the mental health of the population;
 - (f) regard mental health human resources development as a key component in the improvement of plans and services, through the development and implementation of systematic training programs;
 - (g) bridge the existing mental health information gap through improvements in the production, analysis, and use of information, as well as through research, with an intercultural and gender approach;
 - (h) strengthen partnerships between the public sector and other sectors, as well as with nongovernmental organizations, academic institutions, and key social actors, emphasizing their involvement in the development of mental health plans.
3. To request the Director to:
- (a) support the Member States in the preparation and implementation of national mental health plans within the framework of their health policies, taking into account the Strategy and Plan of Action, endeavoring to correct inequities, and giving priority to care for vulnerable and special-needs groups, including indigenous peoples;
 - (b) collaborate in the assessment of mental health services in the countries to ensure that appropriate corrective measures grounded on scientific evidence are taken;
 - (c) facilitate the dissemination of information and the sharing of positive, innovative experiences, as well as the available resources in the Region, and promote technical cooperation among the Member States;
 - (d) promote partnerships with governmental and nongovernmental organizations, as well as with international organizations and other regional actors in support of the multisectoral response that is required in the process of implementing this Strategy and Plan of Action.

(Ninth plenary, 2 October 2009)

CD49.R18: Policy Framework for Human Organ Donation and Transplantation

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director, *Policy Framework for Human Organ Donation and Transplantation* (Document CD49/14), which proposes that Member States have a policy framework that will facilitate the strengthening of national capacity to effectively and efficiently address the problem of cell, tissue, and organ donation and transplantation and achieve optimal utilization of the resources allocated for this purpose;

Recognizing the valuable contributions of the Ibero-American Network/Council on Donation and Transplantation (RDCIT) to the promotion and strengthening of national organ donation and transplantation programs in the Region, as well as the important work of other subregional entities in this area;

Taking into account the fact that some countries have developed institutional capabilities, as well as appropriate regulatory frameworks and information systems, for organ donation and transplantation in the Region;

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

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

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

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

RESOLVES:

1. To urge Member States to:
 - (a) apply the Guiding Principles on Human Cell, Tissue, and Organ Transplantation in the formulation and execution of their policies, laws, and regulations on human cell, tissue, and organ donation and transplantation, as the case may be;
 - (b) promote equitable access to transplantation services, as national capabilities permit, that serve as the foundation for public support and voluntary donations;
 - (c) fight efforts to obtain economic gain or comparable advantages in transactions with human body parts, organ trafficking, and transplant tourism, and to encourage health professionals to notify the proper authorities when they have knowledge of such practices, in accordance with national capabilities and national law;
 - (d) strengthen national public authorities and capabilities, providing them with support to guarantee the supervision, organization, and coordination of donation and transplantation activities, with special attention to ensuring that, insofar as possible, they use donations of organs from deceased people and protect the health and well-being of living donors;
 - (e) improve the safety and efficacy of donation and transplantation by promoting international best practices;
 - (f) collaborate in the collection of data, especially on adverse reactions and events related to the practices, safety, quality, efficacy, epidemiology, and ethics of donation and transplantation;
 - (g) stay actively involved in the RDCIT and other subregional donation and transplantation entities (MERCOSUR Intergovernmental Donation and Transplantation Commission, among others);
 - (h) incorporate the pertinent guidelines and recommendations in their policies, laws, regulations, and practices related to cell, tissue, and organ procurement, donation, and transplantation, such as those related to the creation of umbilical cord cell banks, the diagnosis of brain death, and quality and safety systems for organ, tissue, and cell donation.

2. Request the Director to:
 - (a) disseminate the updated Guiding Principles on Human Cell, Tissue, and Organ Transplantation as widely as possible to all stakeholders;
 - (b) support Member States and nongovernmental organizations in matters related to the prohibition of trafficking in materials of human origin and transplant tourism;
 - (c) continue to gather and analyze regional data on practices, safety, quality, efficacy, epidemiology, and ethics in human cell, tissue, and organ donation and transplantation;
 - (d) provide technical assistance to the Member States that request it in the drafting of national laws and regulations on human cell, tissue, and organ donation and transplantation and set up appropriate systems for this purpose, facilitating international cooperation in particular, and provide support to the bilateral cooperation activities that the countries have undertaken in this area;
 - (e) facilitate Member States' access to appropriate information on the donation, processing, and transplantation of human cells, tissue, and organs, especially data on severe reactions and adverse events;
 - (f) provide technical assistance to the Caribbean countries to promote or improve their kidney transplant programs and propose a subregional kidney health service and transplantation system that would ensure the sustainability and viability of this type of program.

(Ninth meeting, 2 October 2009)

CD49.R19: Elimination of Neglected Diseases and Other Poverty-Related Infections

THE 49th DIRECTING COUNCIL,

Having reviewed the document *Elimination of Neglected Diseases and other Poverty-related Infections* (Document CD49/9), and considering:

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

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

RESOLVES:

1. To urge the Member States to:
 - (a) commit themselves to eliminate or reduce neglected diseases and other infections related to poverty for which tools exist, to levels so that these diseases are no longer considered public health problems by 2015;
 - (b) identify priority neglected diseases, vulnerable populations that have lagged behind, gaps in epidemiological information, and the priority geographic areas for intervention (“hot spots”) at subnational levels in the countries;
 - (c) review existing specific national plans to control or eliminate these diseases and, where needed, develop new ones that rely on a comprehensive approach and consider social determinants of health, the International Health Regulations (2005), when appropriate, interprogrammatic strategies, and inter-sectoral actions;
 - (d) work to provide sufficient resources to ensure the sustainability of national and subnational control programs, including personnel, drug supplies, equipment, health promotion materials, and other needs;
 - (e) implement prevention, diagnostic, treatment, vector control, and elimination strategies in an integrated way and with broad community participation, so that they contribute to the strengthening of national health systems, including primary health care and the health surveillance systems;
 - (f) explore and, where appropriate, promote a range of incentive schemes for research and development, including addressing, where appropriate, the de-linkage of the cost of research and development and the price of health products, for example, through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries;

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

2. To request the Director to:

- (a) continue advocating for an active mobilization of resources and promote the development of close partnerships to support the implementation of this resolution;
- (b) provide technical cooperation to the countries for preparing national plans of action and submitting financing proposals to the trust fund for the elimination of neglected diseases and other poverty-related infections and to other sources ;
- (c) promote the identification, development, and use of evidence-based interventions that are technically and scientifically sound;
- (d) promote the implementation of current PAHO/WHO guidelines for the prevention and control of the included diseases;
- (e) promote research and scientific development related to new or improved tools, strategies, technologies, and methods for the prevention and control of the neglected diseases and their consequences;
- (f) support the strengthening of surveillance systems and primary health care, as well as the monitoring and evaluation of the national action plans being implemented;
- (g) strengthen cross-border collaboration among the countries which share the same diseases;
- (h) continue to support and strengthen the mechanisms for acquiring medications, such as the Strategic Fund, so as to treat neglected diseases at the best cost in order to increase access.

Annexes

(Ninth plenary, 2 October 2009)

CD49.R19, Annex A

Presence of neglected diseases and other infections related to poverty, by country, and total number of countries where each disease occurs in Latin America and the Caribbean, according to the criteria set forth below²

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

² PAHO/HSD/CD. Epidemiological Profiles of Neglected Diseases and Other Infections Related to Poverty in Latin America and the Caribbean. Presented at the Consultation on a Latin American and Caribbean Trust Fund for the Prevention, Control and Elimination of Neglected and Other Infectious Diseases. Washington, DC, 15-16 December 2008. Available at: http://new.paho.org/hq/index.php?option=com_joomlabook&Itemid=259&task=display&id=37.

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

^a In these countries, the disease is only present as a public health problem ^b Previously endemic area
- No evidence... No information

Criteria:

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

Epidemiological situation, elimination goals, and primary elimination strategies for selected neglected diseases and other infections related to poverty.³

This annex details the diseases proposed for elimination and the epidemiological situation, goals, and strategies. The strategies should be adopted by the countries in a manner consistent with their health policies, epidemiological situation, and structure of their health services networks.

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Chagas' disease	<ul style="list-style-type: none"> – There was evidence of transmission in 21 countries of the Americas. – It is estimated that 8 to 9 million people are currently infected. – 40,000 new cases of vector-borne transmission per year. – Vector-borne transmission by the main vectors has been interrupted in several countries (Uruguay, Chile, Brazil, and Guatemala) and areas (Argentina and Paraguay). – Most countries in Latin America are close to reaching the goal of implementing screening for Chagas in 100% of their blood banks. 	<ul style="list-style-type: none"> – To interrupt domestic vector-borne transmission of <i>T. cruzi</i> (domestic triatomine infestation index of less than 1% and negative seroprevalence in children up to five years of age, with the exception of the minimum represented by cases in children of seropositive mothers). – To interrupt transfusional transmission of <i>T. cruzi</i> (100% blood screening coverage).⁴ – To integrate diagnosis of Chagas' disease in the primary health care system, in order to provide treatment and medical care to all patients for both the acute and chronic phases and to reinforce the supply chain of the existing treatments within countries to scale up access. – To prevent the development of cardiomyopathies and intestinal problems related to Chagas' disease, offering adequate health care to those affected by the various stages of the disease. 	<ul style="list-style-type: none"> – To eliminate vectors in the home through chemical control. – Environment management programs. – Information/Education/Communication (IEC). – Screening of blood samples in blood banks to avoid transmission by blood transfusion. – Screening of pregnant women and treatment to avoid congenital transmission. – Good practices on food preparation to avoid oral transmission. – Etiologic treatment of children – Offer medical care to adults with Chagas' disease.

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

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Congenital syphilis	<ul style="list-style-type: none"> – It is estimated that 250,000 cases of congenital syphilis occur each year in the Region. – In a 2006 survey, 14 countries reported the incidence of congenital syphilis in live births, with a range varying from 0.0 cases per 1,000 live births in Cuba to 1.56 in Brazil. 	<ul style="list-style-type: none"> – To eliminate congenital syphilis as a public health problem (less than 0.5 cases per 1,000 live births).⁵ 	<ul style="list-style-type: none"> – Obligatory notification of syphilis and congenital syphilis for pregnant women. – Universal blood screening during the first prenatal visit (<20 weeks,) during the third trimester, during labor, and following stillbirth and abortion/miscarriage. – Timely and adequate treatment for all expectant mothers with syphilis, and the same for spouses and newborns.
Human rabies transmitted by dogs	<ul style="list-style-type: none"> – The disease has been present in 11 countries in the past 3 years. – Even though the number of human cases is low (16 in 2008) due to country efforts, the number of people who live in risk areas due to rabies in dogs is still high. – The majority of the cases occurred in Haiti and Bolivia. 	<ul style="list-style-type: none"> – To eliminate human rabies transmitted by dogs (zero cases reported to the Epidemiological Surveillance System for Rabies (SIRVERA) coordinated by PAHO).⁶ 	<ul style="list-style-type: none"> – Vaccination of 80% of the canine population in endemic areas. – Care given to 100% of the exposed population at risk with post-exposure prophylaxis when indicated. – Epidemiological surveillance. – Education and communication to increase awareness of the risk of rabies. – Control of the canine population – Action to prevent reintroduction

⁴ Based on: WHO. *Elimination of transmission of Chagas Disease*. WHA51.14. Fifty-first World Health Assembly. 1998.

⁵ Based on: OPS. *Plan de Acción para la eliminación de la sífilis congénita*. 116.^a Reunión del Comité Ejecutivo. CE116/14. OPS, 1995.

⁶ Based on: PAHO. *15th Inter-American Meeting at the Ministerial Level on Health and Agriculture (RIMSA): "Agriculture and Health: Alliance for Equity and Rural Development in the Americas"*. CD48.R13. Forty-eighth Directing Council.

GROUP 1: Diseases that have a greater potential for being eliminated (with available cost-effective interventions)			
Disease	Epidemiological situation	Goals	Primary strategy
Leprosy	<ul style="list-style-type: none"> – There are 24 countries where the disease has been present in the last three years. – Only in Brazil did the national prevalence not reach the “elimination as a public health problem” goal of fewer than one case per 10,000 population. – In 2007, 49,388 cases of leprosy were reported in the Americas, and 42,000 new cases were detected. – In the same year, 3,400 new cases (8% of the total) were detected with grade-2 disability. 	<ul style="list-style-type: none"> – To eliminate leprosy as a public health problem (less than 1 case per 10,000 people) from the first sub-national political/administrative levels.^{7,8,9} 	<ul style="list-style-type: none"> – Intensified surveillance of contacts. – Treatment with timely multi-drug therapy in at least 99% of all patients. – Define the appropriated introduction of chemoprophylaxis. – Early detection of grade-2 disabilities.

⁷ Based on: WHO. Adoption of Multidrug Therapy for Elimination of Leprosy as a Public Health Problem. Forty-fourth World Health Assembly. WHA44.9. Geneva: WHO, 1991.

⁸ Based on: WHO. Guide to Eliminate Leprosy as a Public Health Problem. Geneva: WHO, 2000.

⁹ Instead of the goal of elimination, Brazil will adopt the targets recommended for epidemiological surveillance of the disease contained in WHO document “Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy- 2011-2015” (SEA-GLP-2009.4)

- Number of new cases detected per year and rate per 100,000 population
- Number of new cases with grade 2 disability per year and rate per 100,000 population
- Proportion of patients who complete their treatment in a timely manner as a proxy for cure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CD49.R20: Health and Tourism

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Health and Tourism* (Document CD49/15);

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

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

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

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

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

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

RESOLVES:

1. To endorse the concepts on health and tourism contained in Document CD49/15.
2. To urge Member States to:
 - (a) include health and tourism in their national health plans, considering relevant aspects for tourism, such as proper nutrition, physical activity, hygiene, security, and protection against health risks;

- (b) conduct assessments of the burden of disease attributed to tourism and examine the perspectives, beliefs, and requirements to lay the foundation for decision-making, following the recommendations issued by the Regional Forum on Health and Tourism;
 - (c) promote and consider the existing health surveillance and risk assessment mechanisms, which could include the national hotel systems in every country in the Region;
 - (d) promote an approach based on the strengthening of favorable environments, the promotion of healthy behaviors, and people's control over their health determinants;
 - (e) strengthen their capacity to analyze public health events and outbreaks related to tourist and traveler facilities, in accordance with the International Health Regulations;
 - (f) strengthen the health system's capacity to produce information based on strategic evidence linking health, tourism, and development through the evaluation of current investments, coverage, monitoring, and the quality of national programs;
 - (g) promote, establish, and strengthen information systems and networks for sharing information and good practices in this area;
 - (h) promote environmental and occupational health methods in the planning, design, construction, and operation of hotels and other tourist facilities that will make it possible to systematize information for the design of methodologies for the health certification of facilities as value added for the industry;
 - (i) promote the development of healthy communities that will benefit both the population and the tourism industry.
3. To request the Director to:
- (a) maintain the commitment of the organization to this issue, update its cooperation strategy, and develop a regional plan of action (2010-2020) that encompasses the different program areas;
 - (b) create the Regional Forum on Health and Tourism to examine the concept of healthy tourism, promote technical cooperation among countries, foster knowledge and information sharing, and encourage partnerships with private and

- community organizations for the purpose of having countries adopt specific policies linking health and tourism;
- (c) mobilize resources and act interprogrammatically for effective and sustained application of the regional strategy and plan of action;
 - (d) promote the establishment of and compliance with quality standards for health and tourism to improve the competitiveness of the countries of the Region in tourism;
 - (e) strengthen the capacity of public and private sector personnel, including environmental health and hotel workers, in best practices for tourism and environmental management (such as wastewater and solid waste disposal in tourist facilities, food handling, etc.);
 - (f) promote the adoption of standards and regulations in countries interested in developing “health travel” as a tourism product (restoration and recovery, surgery, well-being products, other medical procedures).

(Ninth plenary, 2 October 2009)

CD49.R21: Salary of the Director and Amendments to the Staff Regulations of the Pan American Sanitary Bureau

THE 49th DIRECTING COUNCIL,

Having considered the amendments to the Staff Rules and Regulations of the Pan American Sanitary Bureau submitted by the Director in the Annex to Document CD49/27;

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

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

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

RESOLVES:

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

(Ninth plenary, 2 October 2009)

CD49.R22: Integrated Health Services Delivery Networks Based on Primary Health Care

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Integrated Health Services Delivery Networks Based on Primary Health Care* (Document CD49/16) which summarizes the problem of health services fragmentation and proposes the creation of integrated health services delivery networks to address it;

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

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

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

Aware that integrated health services delivery networks increase access to the system, reduce inappropriate care and the fragmentation of care, prevent the duplication

of infrastructure and services, lower production costs, and better meet the needs and expectations of individuals, families, and communities;

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

RESOLVES:

1. To urge Member States to:
 - (a) take note of the problem of health services fragmentation in the health system and, when applicable, in the subsystems that comprise it;
 - (b) facilitate dialogue with all relevant stakeholders, particularly health service providers and home and community caregivers about the problem of service fragmentation and the strategies to address it;
 - (c) prepare a national plan of action promoting the creation of integrated health services delivery networks with a family and community health approach as the preferred modality for health services delivery in the country;
 - (d) promote human resources education and management compatible with the creation of integrated health services delivery networks;
 - (e) implement and periodically evaluate the national plan of action for the creation of integrated health service networks.
2. To request the Director to:
 - (a) support the countries of the Region in the preparation of their national plans of action for the creation of integrated health services delivery networks;
 - (b) promote the creation of integrated health services delivery networks along common borders, including, when applicable, plans for cooperation and/or compensation for services between countries (or “shared services” in the case of the Caribbean);

- (c) develop conceptual and analytical frameworks, tools, methodologies, and guidelines that facilitate the creation of integrated health services delivery networks;
- (d) develop a guidance document for the implementation of the Integrated Health Service Delivery Networks in conjunction with the interested parties;
- (e) support human resources training and health management compatible with the creation of integrated health services delivery networks, including unpaid individuals who provide health care in the home and community;
- (f) mobilize resources to support the creation of integrated health services delivery networks in the Region, which includes the documentation of good practices and the sharing of information on successful experiences among countries;
- (g) develop an audit and evaluation framework, which includes performance indicators and monitoring mechanisms, for evaluating the action plans and the progress of the implementation of the Integrated Health Service Delivery Networks;
- (h) promote dialogue with the international cooperation/donor community to raise awareness about the problem of health services fragmentation and seek its support for the creation of integrated health services delivery networks in the Region.

(Ninth plenary, 2 October 2009)

Decisions

CD49(D1): Appointment of the Committee on Credentials

Pursuant to Rule 31 of the Rules of Procedure of the Directing Council, the Council appointed Belize, Brazil, and Costa Rica as members of the Committee on Credentials.

(First meeting, 28 September 2009)

CD49(D2) Election of Officers

Pursuant to Rule 16 of the Rules of Procedure of the Directing Council, the Council elected Paraguay as President, Dominica and Nicaragua as Vice Presidents, and the Dominican Republic as Rapporteur of the 49th Directing Council.

(First meeting, 28 September 2008)

CD49(D3) Adoption of the Agenda

Pursuant to Rule 10 of the Rules of Procedure of the Directing Council, the Council adopted, without modification, the agenda submitted by the Director (Document CD49/1, Rev. 1).

(First meeting, 28 September 2009)

CD49(D4) Establishment of the General Committee

Pursuant to Rule 32 of the Rules of Procedure of the Directing Council, the Council appointed Canada, Cuba, and the United States of America as members of the General Committee.

(First meeting, 28 September 2009)

CD49(D5) Selection of One Member State from the Region of the Americas Entitled to Designate a Person to Serve on the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) on the Expiration of the Period of Office of Brazil

The Directing Council selected Ecuador as the Member State from the Region of the Americas entitled to designate a person to serve on the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) for a period of four years, commencing on 1 January 2010.

(Fifth meeting, 30 September 2009)

CD49(D6) Selection of Two Member States from the Region of the Americas Entitled to Designate a Representative to the Policy and Coordination Committee of the UNDP/World Bank/WHO Special Program of Research, Development, and Research Training in Human Reproduction on the Expiration of the Periods of Office of Argentina and Mexico

The Council selected Guatemala and Paraguay as the Member States from the Region of the Americas entitled to designate a representative to serve on the Policy and Coordination Committee of the UNDP/World Bank/WHO Special Program of Research, Development, and Research Training in Human Reproduction for a period of three years, commencing 1 January 2010.

(Fifth meeting, 30 September 2009)

IN WITNESS WHEREOF, the President of the 49th Directing Council, Delegate of Paraguay, and the Secretary *ex officio*, Director of the Pan American Sanitary Bureau, sign the Final Report in the Spanish language.

DONE in Washington D.C., United States of America, this second day of October in the year two thousand and nine. The Secretary shall deposit the original signed document in the Archives of the Pan American Sanitary Bureau.

Esperanza Martínez
President of the 49th Directing Council
Delegate of Paraguay

Mirta Roses Periago
Secretary *ex officio* of the 49th Directing Council
Director of the Pan American Sanitary Bureau

AGENDA

1. OPENING OF THE SESSION

2. PROCEDURAL MATTERS

- 2.1 Appointment of the Committee on Credentials
- 2.2 Election of the President, Two Vice Presidents, and the Rapporteur
- 2.3 Establishment of a Working Party to Study the Application of Article 6.B of the PAHO Constitution
- 2.4 Establishment of the General Committee
- 2.5 Adoption of the Agenda

3. CONSTITUTIONAL MATTERS

- 3.1 Annual Report of the President of the Executive Committee
- 3.2 Annual Report of the Director of the Pan American Sanitary Bureau
- 3.3 Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Trinidad and Tobago, United States of America, and Uruguay

4. PROGRAM POLICY MATTERS

- 4.1 Proposed PAHO Program and Budget 2010-2011
- 4.2 PAHO Strategic Plan 2008-2012 Amended (Draft)
- 4.3 New Scale of Quota Contributions

4. PROGRAM POLICY MATTERS *(cont.)*

- 4.4 Plan of Action on the Health of Older Persons, Including Active and Healthy Aging
- 4.5 Elimination of Neglected Diseases and other Poverty-Related Infections
- 4.6 Policy on Research for Health
- 4.7 Strategy and Plan of Action on Mental Health
- 4.8 Plan of Action on Adolescent and Youth Health
- 4.9 Plan of Action for Implementing the Gender Equality Policy
- 4.10 Policy Framework for Human Organ Donation and Transplantation
- 4.11 Health and Tourism
- 4.12 Integrated Health Services Delivery Networks Based on Primary Health Care
- 4.13 Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)
- 4.14 Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP)
- 4.15 Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment
- 4.16 Family and Community Health
- 4.17 The Pan American Health Organization Revolving Fund for Vaccine Procurement
- 4.18 Roundtable on Safe Hospitals

4. PROGRAM POLICY MATTERS (*cont.*)

- 4.19 Panel Discussion on the Pan American Alliance for Nutrition and Development for the Achievement of the Millennium Development Goals

5. ADMINISTRATIVE AND FINANCIAL MATTERS

- 5.1 Report on the Collection of Quota Contributions
- 5.2 Interim Financial Report of the Director for 2008
- 5.3 Changes in the Financial Regulations and Financial Rules
- 5.4 Proposal for the Establishment of an Audit Committee
- 5.5 Salary of the Director and Amendments to the Staff Regulations of the Pan American Sanitary Bureau

6. SELECTION OF MEMBER STATES TO BOARDS AND COMMITTEES

- 6.1 Selection of One Member State from the Region of the Americas Entitled to Designate a Person to Serve on the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) on the Expiration of the Period of Office of Brazil
- 6.2 Selection of Two Member States from the Region of the Americas Entitled to Designate a Representative to the Policy and Coordination Committee of the UNDP/World Bank/WHO Special Program of Research, Development and Research Training in Human Reproduction on the Expiration of the Periods of Office of Argentina and Mexico
- 6.3 Election of Five Nonpermanent Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME)

7. AWARDS

- 7.1 PAHO Award for Administration 2009

8. MATTERS FOR INFORMATION

- 8.1 Code of Practice on the International Recruitment of Health Personnel: a WHO background document

- 8.2 Progress Report on Technical Matters: International Health Regulations (*includes the Report on the [H1N1] Pandemic 2009*)

- 8.3 Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO:

- 8.3.1 Resolutions and other Actions of the 62nd World Health Assembly

- 8.3.2 Resolutions and other Actions of the 39th General Assembly of the Organization of American States

- 8.3.3 Report on the Fifth Summit of the Americas

- 8.4 Progress Reports on Administrative and Financial Matters:

- 8.4.1 Status of Implementation of the International Public Sector Accounting Standards (IPSAS)

- 8.4.2 Master Capital Investment Fund

9. OTHER MATTERS

10. CLOSURE OF THE SESSION

LIST OF DOCUMENTS

Official Documents

Official Document 328	PAHO Strategic Plan 2008-2012 Amended (Draft)
Official Document 333	Proposed PAHO Program and Budget 2010-2011
Official Document 333, Add. I	Addendum to the Proposed Program and Budget 2010-2011
Official Document 335	Interim Financial Report of the Director for 2008

Working Documents

CD49/1, Rev. 1	Agenda
CD49/2	Annual Report of the President of the Executive Committee
CD49/3, Rev. 1	Annual Report of the Director of the Pan American Sanitary Bureau
CD49/4	Election of Three Member States to the Executive Committee on the Expiration of the Periods of Office of Trinidad and Tobago, United States of America, and Uruguay
CD49/5, Rev. 1	Proposed PAHO Program and Budget 2010-2011
CD49/6	PAHO Strategic Plan 2008-2012 Amended (Draft)
CD49/7	New Scale of Quota Contributions
CD49/8	Plan of Action on the Health of Older Persons, Including Active and Healthy Aging

Working Documents (*cont.*)

CD49/9	Elimination of Neglected Diseases and other Poverty-Related Infections
CD49/10	Policy on Research for Health
CD49/11	Strategy and Plan of Action on Mental Health
CD49/12	Plan of Action on Adolescent and Youth Health
CD49/13	Plan of Action for Implementing the Gender Equality Policy
CD49/14	Policy Framework for Human Organ Donation and Transplantation
CD49/15	Health and Tourism
CD49/16	Integrated Health Services Delivery Networks Based on Primary Health Care
CD49/17	Institutional Reform of the Latin American and Caribbean Center on Health Sciences Information (BIREME)
CD49/18	Institutional Review and Internal Reorganization of the Institute of Nutrition of Central America and Panama (INCAP)
CD49/19	Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment
CD49/20 and Corrig.	Family and Community Health
CD49/21	The Pan American Health Organization Revolving Fund for Vaccine Procurement
CD49/22 and Add. I	Roundtable on Safe Hospitals

Working Documents (*cont.*)

CD49/23, Rev. 1 and Add. I	Panel Discussion on the Pan American Alliance for Nutrition and Development for the Achievement of the Millennium Development Goals
CD49/24 and Add. I	Report on the Collection of Quota Contributions
CD49/25	Changes in the Financial Regulations and Financial Rules
CD49/26	Proposal for the Establishment of an Audit Committee
CD49/27	Salary of the Director and Amendments to the Staff Regulations of the Pan American Sanitary Bureau
CD49/28	Selection of One Member State from the Region of the Americas Entitled to Designate a Person to Serve on the Joint Coordinating Board of the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) on the Expiration of the Period of Office of Brazil
CD49/29	Selection of Two Member States from the Region of the Americas Entitled to Designate a Representative to the Policy and Coordination Committee of the UNDP/World Bank/WHO Special Program of Research, Development and Research Training in Human Reproduction on the Expiration of the Periods of Office of Argentina and Mexico
CD49/30	Election of Five Nonpermanent Members to the Advisory Committee of the Latin American and Caribbean Center on Health Sciences Information (BIREME)
CD49/31	PAHO Award for Administration 2009

Information Documents

CD49/INF/1	Code of Practice on the International Recruitment of Health Personnel: a WHO background document
CD49/INF/2, Rev. 1	Progress Report on Technical Matters: International Health Regulations (<i>includes the Report on the [H1N1] Pandemic 2009</i>)
CD49/INF/3	Resolutions and other Actions of Intergovernmental Organizations of Interest to PAHO:
<i>CD49/INF/3-A</i>	Resolutions and other Actions of the 62nd World Health Assembly
<i>CD49/INF/3-B</i>	Resolutions and other Actions of the 39th General Assembly of the Organization of American States
<i>CD49/INF/3-C</i>	Report on the Fifth Summit of the Americas
CD49/INF/4	Progress Reports on Administrative and Financial Matters:
<i>CD49/INF/4-A</i>	Status of Implementation of the International Public Sector Accounting Standards (IPSAS)
<i>CD49/INF/4-B</i>	Master Capital Investment Fund

**LIST OF PARTICIPANTS/
LISTA DE PARTICIPANTES**

MEMBER STATES/ESTADOS MIEMBROS

**ANTIGUA AND BARBUDA/ANTIGUA Y
BARBUDA**

Chief Delegate – Jefe de Delegación

Mr. John Jarvis
Permanent Secretary
Ministry of Health, Sports, and
Youth Affairs
St. John's

Delegate – Delegado

Ms. Rhonda Sealey-Thomas
Chief Medical Officer
Ministry of Health, Sports, and
Youth Affairs
St. John's

ARGENTINA

Chief Delegate – Jefe de Delegación

Dr. Juan Manzur
Ministro de Salud
Ministerio de Salud
Buenos Aires

Delegates – Delegados

Dr. Eduardo Bustos Villar
Secretario de Determinantes de la Salud
y Relaciones Sanitarias
Ministerio de Salud
Buenos Aires

Dr. Máximo Diosque
Secretario de Promoción y Programas
Sanitarios
Ministerio de Salud
Buenos Aires

Alternates – Alternos

Dr. Oscar Balverdi
Ministro de Salud de la
Provincia de San Juan
Ministerio de Salud
San Juan

ARGENTINA (cont.)

Alternates – Alternos (cont.)

Dra. Cristina Liliana Uria
Ministra de Salud de la Provincia
de Río Negro
Ministerio de Salud
Río Negro

Dr. Ángel Francisco Giano
Ministro de Salud y Acción Social
de la Provincia de Entre Ríos
Ministerio de Salud
Entre Ríos

Lic. Sebastian Tobar
Director Nacional de Relaciones
Internacionales
Ministerio de Salud
Buenos Aires

Sr. Maximiliano Ojeda
Coordinador de Ceremonial
Ministerio de Salud
Buenos Aires

Sra. Valeria Zapemoschny
Coordinadora de Prensa y
Comunicación Social
Ministerio de Salud
Buenos Aires

Su Excelencia Rodolfo Gil
Embajador, Representante Permanente
de Argentina ante la Organización de
los Estados Americanos
Washington, D.C.

Ministro Martín G. Bustillo
Representante Alternativo de Argentina ante
la Organización de los Estados
Americanos
Washington, D.C.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

ARGENTINA (cont.)

Alternates – Alternos (cont.)

Sra. Ana M. Pastorini
Consejera, Representante Alternata
de Argentina ante la Organización de
los Estados Americanos
Washington, D.C.

BAHAMAS

Chief Delegate – Jefe de Delegación

Senator Hon. Dion Foulkes
Minister of Labor and Social Development
Ministry of Labor and Social Development
Nassau

Delegates – Delegados

His Excellency Cornelius Smith
Ambassador
Embassy to the Commonwealth of
The Bahamas
Washington, D.C.

Dr. Merceline Dahl-Regis
Chief Medical Officer
Ministry of Health and Social Development
Nassau

Alternates – Alternos

Mrs. Elizabeth Keju
Under Secretary
Ministry of Health and Social Development
Nassau

Ms. Rhoda Jackson
Charged' Affairs and Interim
Representative
Permanent Mission of The Bahamas
to the Organization of American States
Washington, D.C.

Ms. Bridgett McKay
Second Secretary
Embassy of the Commonwealth of
The Bahamas
Washington, D.C.

BARBADOS

Chief Delegate – Jefe de Delegación

Hon. Donville Inniss
Minister of Health
Ministry of Health
St. Michael

Delegates – Delegados

Mr. Ronald Fitt
Permanent Secretary
Ministry of Health
St. Michael

Dr. Elizabeth Ferdinand
Senior Medical Officer of Health
Ministry of Health
St. Michael

Alternates – Alternos

Mr. Danny Gill
Director, Planning and
Research Unit
Ministry of Health
St. Michael

Ms. Donna Forde
Counselor, Alternate Representative of
Barbados to the Organization of
American States
Washington, D.C.

BELIZE/BELICE

Chief Delegate – Jefe de Delegación

Hon. Pablo Saul Marin
Minister of Health
Ministry of Health
Belmopan City

Delegates – Delegados

Dr. Michael Pitts
Director of Health Services
Ministry of Health
Belmopan City

MEMBER STATES/ESTADOS MIEMBROS (cont.)

BELIZE/BELICE (cont.)

Delegates – Delegados (cont.)

Ms. Kendall Belisle
First Secretary, Alternate Representative
of Belize to the Organization of
American States
Washington, D.C.

BOLIVIA

Chief Delegate – Jefe de Delegación

Dr. Ramiro Tapia
Ministro de Salud y Deportes
Ministerio de Salud y Deportes
La Paz

Delegates – Delegados

Dra. Janette Vidaurre
Coordinadora de Relaciones
Internacionales
Ministerio de Salud y Deportes
La Paz

Su Excelencia José E. Pinelo
Embajador, Representante Permanente
de Bolivia ante la Organización de los
Estados Americanos
Washington, D.C.

Alternates – Alternos

Sra. Gisela Vaca
Primera Secretaria, Representante Alternata
de Bolivia ante la Organización de los
Estados Americanos
Washington, D.C.

Sra. Aylin Oropeza
Primera Secretaria, Representante Alternata
de Bolivia ante la Organización de los
Estados Americanos
Washington, D.C.

BRAZIL/BRASIL

Chief Delegate – Jefe de Delegación

Dr. José Gomes Temporão
Ministro da Saúde
Ministério da Saúde
Brasília

Delegates – Delegados

Dr. Francisco Eduardo de Campos
Secretário de Gestão do Trabalho
e da Educação na Saúde
Ministério da Saúde
Brasília

Dr. Luiz Fernando Beskow
Diretor de Programa da Secretaria
Executiva
Ministério da Saúde
Brasília

Alternates – Alternos

Dr. Paulo E. Gadelha Vieira
Presidente da Fundação Oswaldo Cruz
Rio de Janeiro

Dr. José Luiz Telles de Almeida
Diretor do Departamento de Ações
Programáticas Estratégicas da
Secretaria de Atenção a Saúde
Ministério da Saúde
Brasília

Ministro Eduardo Botelho Barbosa
Assessor Especial do Ministro
para Assuntos Internacionais
Ministério da Saúde
Brasília

Dr. Eduardo Hage Carmo
Diretor do Departamento de
Vigilância Epidemiológica
Ministério da Saúde
Brasília

MEMBER STATES/ESTADOS MIEMBROS (cont.)

BRAZIL/BRASIL (cont.)

Alternates – Alternos (cont.)

Dr. Leandro Luiz Viegas
Chefe da Assessoria de Assuntos
Internacionais de Saúde
Ministério da Saúde
Brasília

Ministro Silvio José Albuquerque e Silva
Chefe da Divisão de Temas Sociais
Ministério da Saúde
Brasília

Sr. Luis Renato Strauss
Chefe Da Divisão de lá Prensa da
Assessoria de Comunicação Social
Ministério da Saúde
Brasília

Sra. Juliana Vieira Borges Vallini
Assessora Jurídica do Programa Nacional
DST/AIDS
Ministério da Saúde
Brasília

Sra. Viviane Rios Balbino
Secretária
Missão Permanente do Brasil junto à
Organização dos Estados Americanos
Washington, D.C.

CANADA/CANADÁ

Chief Delegate – Jefe de Delegación

Dr. Karen Dodds
Assistant Deputy Minister
Health Canada
Ottawa

Delegates – Delegados

Mr. Martin Methot
Director
International Affairs Directorate
Health Canada
Ottawa

CANADA/CANADÁ (cont.)

Delegates – Delegados (cont.)

Ms. Kate Dickson
Senior Policy Advisor
PAHO/Americas
International Affairs Directorate
Health Canada
Ottawa, Ontario

Alternates – Alternos

Ms. Carolina Seward
Policy Analyst
PAHO/Americas
International Affairs Directorate
Health Canada
Ottawa, Ontario

Ms. Jane Billings
Senior Assistant Deputy Minister
Public Health Agency
Ottawa, Ontario

Ms. Ranu Sharma
Senior Policy Analyst
Planning and Public Health
Integration Branch
Public Health Agency
Ottawa, Ontario

Ms. Sarada Leclerc
Health A/Team Leader
Canadian International Development
Agency
Gatineau, Quebec

His Excellency Graeme Clark
Ambassador, Permanent Representative
of Canada to the Organization of
American States
Washington, D.C.

Mr. Darren Rogers
Alternate Representative of Canada
to the Organization of American States
Washington, D.C.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

CHILE

Chief Delegate – Jefe de Delegación

Dra. Jeannette Vega
Subsecretaria de Salud Pública
Ministerio de Salud
Santiago

Delegates – Delegados

Sra. Paula Forttes Valdivia
Directora del Servicio Nacional
del Adulto Mayor
Ministerio de Salud
Santiago

Sr. José Miguel Huerta
Jefe de la Oficina de Cooperación y
Asuntos Internacionales
Ministerio de Salud
Santiago

Alternates – Alternos

Dra. Helia Molina
Jefa de la División de Políticas Públicas
Saludables y Promoción
Oficina de Cooperación y Asuntos
Internacionales
Ministerio de Salud
Santiago

Sra. María Jesús Roncarati Guillon
Coordinadora de Proyectos
Oficina de Cooperación y Asuntos
Internacionales
Ministerio de Salud
Santiago

Su Excelencia Pedro Oyarce
Embajador, Representante Permanente
de Chile ante la Organización de los
Estados Americanos
Washington, D.C.

Sr. Luis Petit-Laurent
Primer Secretario
Misión Permanente de Chile ante la
Organización de los Estados
Americanos
Washington, D.C.

COLOMBIA

Chief Delegate – Jefe de Delegación

Dr. Carlos Ignacio Cuervo
Viceministro de Salud y Bienestar
Ministerio de la Protección Social
Santa Fe de Bogotá

Delegate – Delegado

Sra. Sandra Mikan
Segunda Secretaria, Representante
Alternativa de Colombia ante la
Organización de los Estados
Americanos
Washington, D.C.

COSTA RICA

Chief Delegate – Jefe de Delegación

Dr. Daniel Salas Peraza
Director de Mercadotecnia de la Salud
Ministerio de Salud
San José

Delegate – Delegado

Sra. Maritza Chan Valverde
Ministra Consejera
Misión Permanente de Costa Rica ante
la Organización de los Estados
Americanos
Washington, D.C.

CUBA

Chief Delegate – Jefe de Delegación

Dr. Eleuterio R. González Martín
Viceministro de Docencia e
Investigaciones
Ministerio de Salud Pública
La Habana

MEMBER STATES/ESTADOS MIEMBROS (cont.)

CUBA (cont.)

Delegates – Delegados

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

Sr. Jorge Bolaños
Jefe de la Sección de Intereses
Washington, D.C.

Alternate – Alterno

Sr. Damián Cordero
Segundo Secretario
Jefe de la Sección de Intereses
Washington, D.C.

DOMINICA

Chief Delegate – Jefe de Delegación

Hon. John Fabien
Minister for Health and Environment
Ministry for Health and Environment
Roseau

Delegate – Delegado

Dr. Dorian Shillingford
Chairman
Dominica Medical Board
Ministry for Health and Environment
Roseau

**DOMINICAN REPUBLIC/REPÚBLICA
DOMINICANA**

Chief Delegate – Jefe de Delegación

Dr. Bautista Rojas Gómez
Secretario de Estado de Salud Pública
y Asistencia Social
Secretaría de Estado de Salud Pública
y Asistencia Social
Santo Domingo

**DOMINICAN REPUBLIC/REPÚBLICA
DOMINICANA (cont.)**

Delegates – Delegados

Dra. Tirsis Quezada
Subsecretaria de Desarrollo Institucional
Secretaría de Estado de Salud Pública
y Asistencia Social
Santo Domingo

Sr. Luis Fernández Guzmán
Ministro Consejero, Representante Alterno
de la República Dominicana ante la
Organización de los Estados
Americanos
Washington, D.C.

Alternates – Alternos

Sr. José Luis Domínguez Brito
Consejero, Representante Alterno de la
República Dominicana ante la
Organización de los Estados
Americanos
Washington, D.C.

Sr. Francisco Cruz
Consejero, Representante Alterno de la
República Dominicana ante la
Organización de los Estados
Americanos
Washington, D.C.

ECUADOR

Chief Delegate – Jefe de Delegación

Dra. Caroline Chang
Ministra de Salud Pública
Ministerio de Salud Pública
Quito

Delegates – Delegados

Sra. Elizabeth Moreano
Representante Alternata
Misión Permanente del Ecuador ante la
Organización de los Estados
Americanos
Washington, D.C.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

ECUADOR (cont.)

Delegates – Delegados (cont.)

Dra. Mariuxi Vera
Funcionaria Despacho Ministerial
Ministerio de Salud Pública
Quito

Alternates – Alternos

Dr. Edgar Godoy
Asesor Despacho Ministerial
Ministerio de Salud Pública
Quito

Dr. William Córdova
Funcionario Despacho Ministerial
Ministerio de Salud Pública
Quito

EL SALVADOR

Chief Delegate – Jefe de Delegación

Dra. María Isabel Rodríguez
Ministra de Salud Pública
y Asistencia Social
Ministerio de Salud Pública
y Asistencia Social
San Salvador

Delegates – Delegados

Dr. Eduardo Espinoza
Viceministro de Salud Pública
y Asistencia Social
Políticas Sectoriales
Ministerio de Salud Pública
y Asistencia Social
San Salvador

Su Excelencia Luis Menéndez Leal
Embajador, Representante Interino de
El Salvador ante la Organización de los
Estados Americanos
Washington, D.C.

EL SALVADOR (cont.)

Alternate – Alterno

Sra. Carolina Sánchez
Consejera, Representante Alternativa
Misión Permanente de El Salvador ante
la Organización de los Estados
Americanos
Washington, D.C.

FRANCE/FRANCIA

Chief Delegate – Jefe de Delegación

S.E. Madame Marie-France Pagnier
Ambassadeur, Observateur permanent
de la France près l'Organisation des
États Américains
Washington, D.C.

Delegates – Delegados

M. Gérard Guillet
Observateur Permanent Adjointe de
la France près de l'Organisation des
États Américains
Washington, D.C.

Professeur Jacques Drucker
Conseiller santé près l'Ambassade
de France aux États-Unis
Washington, D.C.

GRENADA/GRANADA

Chief Delegate – Jefe de Delegación

Ms. Ingrid Jackson
Attaché, Alternate Representative of
Grenada to the Organization of
American States
Washington, D.C.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

GUATEMALA

Chief Delegate – Jefe de Delegación

Dra. Silvia Palma de Ruiz
Viceministra de Hospitales
Ministerio de Salud Pública
y Asistencia Social
Guatemala

Delegates – Delegados

Dr. Israel Lemus
Director General
Sistema Integral de Atención en Salud
Ministerio de Salud Pública
y Asistencia Social
Guatemala

Lic. Bernardita Lourdes Xitumul
Directora del Departamento de
Cooperación Internacional y
Planificación Estratégica
Ministerio de Salud Pública
y Asistencia Social
Guatemala

GUYANA

Chief Delegate – Jefe de Delegación

Hon. Dr. Leslie Ramsammy
Minister of Health
Ministry of Health
Georgetown

Delegates – Delegados

Dr. Sonia Chehil
Mental Health Advisor
Ministry of Health
Georgetown

Ms. Amanda Ramsammy
Ministry of Health
Georgetown

HAITI/HAITÍ

Chief Delegate – Jefe de Delegación

Dr Alex Larsen
Ministre de la Santé publique
et de la Population
Ministère de la Santé publique
et de la Population
Port-au-Prince

Delegate – Delegado

Dr Ariel Henry
Membre du Cabinet
Ministère de la Santé publique
et de la Population
Port-au-Prince

JAMAICA

Chief Delegate – Jefe de Delegación

Hon. Rudyard Spencer
Minister of Health
Ministry of Health
Kingston

Delegates – Delegados

Dr. Jean Dixon
Permanent Secretary
Ministry of Health
Kingston

Dr. Sheila Campbell-Forrester
Chief Medical Officer
Ministry of Health
Kingston

MEXICO/MÉXICO

Chief Delegate – Jefe de Delegación

Dr. José Ángel Córdova Villalobos
Secretario de Salud
Secretaría de Salud
México, D. F.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

MEXICO/MÉXICO (cont.)

Delegates – Delegados

Dr. Jorge Valdez García
Director General de Calidad y Educación
en Salud
Secretaría de Salud
México, D.F.

Lic. Ana María Sánchez
Directora de Cooperación Bilateral
y Regional
Secretaría de Salud
México, D.F.

Alternates – Alternos

Sra. Flor de Lis Vásquez Muñoz
Representante Alterna de México ante
la Organización de los Estados
Americanos
Washington, D.C.

Lic. Eduardo Jaramillo
Director General Adjunto
Secretaría de Salud
México, D.F.

Sr. Alberto Del Castillo
Representante Alterno de México ante la
Organización de los Estados
Americanos
Washington, D.C.

Sra. Rosa Zárate
Codirectora Centro Colaborador
OPS/México
Universidad Autónoma de México
México, D.F.

Sra. Susana Salas
Asuntos Internacionales
Universidad Autónoma de México
México, D.F.

NICARAGUA

Chief Delegate – Jefe de Delegación

Dr. Guillermo González
Ministro de Salud
Ministerio de Salud
Managua

Delegates – Delegados

Dr. Alejandro José Solís Martínez
Director General de Planificación
y Desarrollo
Ministerio de Salud
Managua

Sra. Agnes María Alvarado Guevara
Segunda Secretaria
Misión Permanente de Nicaragua ante la
Organización de los Estados
Americanos
Washington D.C.

PANAMA/PANAMÁ

Chief Delegate – Jefe de Delegación

Dr. Franklin Vergara
Ministro de Salud
Ministerio de Salud
Ciudad de Panamá

Delegates – Delegados

Dr. Julio Santamaría Rubio
Viceministro de Salud
Ministerio de Salud
Ciudad de Panamá

Sr. Félix Bonilla
Secretario General
Ministerio de Salud
Ciudad de Panamá

MEMBER STATES/ESTADOS MIEMBROS (cont.)

PANAMA/PANAMÁ (cont.)

Alternates – Alternos

Su Excelencia Guillermo Cochez
Embajador de la República de Panamá
ante los Estados Unidos de América
Washington D.C.

Lic. Gabriel Cedeño
Director de Asuntos Internacionales
Ministerio de Salud
Ciudad de Panamá

Sra. Menitza Xiomara Mandiche Piza
Consejero, Representante Alterno
de Panamá ante la Organización de los
Estados Americanos
Washington D.C.

Sr. Milton Ruiz
Consejero, Representante Alterno
de Panamá ante la Organización de los
Estados Americanos
Washington D.C.

PARAGUAY

Chief Delegate – Jefe de Delegación

Dra. Esperanza Martínez
Ministra de Salud Pública y
Bienestar Social
Ministerio de Salud Pública y
Bienestar Social
Asunción

Delegates – Delegados

Dra. María Cristina Guillen
Ministerio de Salud Pública y
Bienestar Social
Asunción

Lic. Enrique García de Zuñiga
Ministerio de Salud Pública y
Bienestar Social
Asunción

PARAGUAY (cont.)

Alternates – Alternos

Dr. Iván Allende Criscioni
Ministerio de Salud Pública y
Bienestar Social
Asunción

Dra. María del Carmen Gómez
Ministerio de Salud Pública y
Bienestar Social
Asunción

Dr. Diego Ariel Gamarra
Ministerio de Salud Pública y
Bienestar Social
Asunción

Lic. Ana María Paredes
Ministerio de Salud Pública y
Bienestar Social
Asunción

Sr. Francisco Barreiro
Consejero, Representante Alterno de
Paraguay ante la Organización de los
Estados Americanos
Washington D.C.

PERU/PERÚ

Chief Delegate – Jefe de Delegación

Dr. Oscar Ugarte Ubilluz
Ministro de Salud
Ministerio de Salud
Lima

Delegates – Delegados

Excelentísima Sra. María Zavala
Valladares
Embajadora, Representante Permanente
del Perú ante la Organización de los
Estados Americanos
Washington, D.C.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

PERU/PERÚ (cont.)

Delegates – Delegados (cont.)

Sr. Orlando Velorio Pérez
Ministro, Representante Alterno del Perú
ante la Organización de los Estados
Americanos
Washington, D.C.

Alternates – Alternos

Sr. Carlos Jiménez
Representante Alterno del Perú ante la
Organización de los Estados
Americanos
Washington, D.C.

Sr. Giancarlo Gálvez
Tercer Secretario, Representante Alterno
del Perú ante la Organización de los
Estados Americanos
Washington, D.C.

**SAINT KITTS AND NEVIS/
SAINT KITTS Y NEVIS**

Chief Delegate – Jefe de Delegación

Hon. Rupert Emmanuel Herbert
Minister of Health and Environment
Ministry of Health and Environment
Basseterre

Delegates – Delegados

Dr. Patrick Martin
Chief Medical Officer
Ministry of Health and Environment
Basseterre

His Excellency Izben C. Williams
Ambassador, Permanent Representative
of Saint Kitts and Nevis to the
Organization of American States
Washington, D.C.

SAINT LUCIA/SANTA LUCÍA

Chief Delegate – Jefe de Delegación

His Excellency Michael Louis
Ambassador, Permanent Representative
of Saint Lucia to the Organization of
American States
Washington, D.C.

**SAINT VINCENT AND THE GRENADINES/
SAN VICENTE Y LAS GRANADINAS**

Chief Delegate – Jefe de Delegación

Hon. Dr. Douglas Slater
Minister of Health and the Environment
Ministry of Health and the Environment
Kingstown

Delegates – Delegados

Her Excellency La Celia A. Prince
Ambassador, Permanent Representative
of Saint Vincent and the Grenadines to
the Organization of American States
Washington, D.C.

Mr. Omari S. Williams
Counselor, Alternate Representative of
Saint Vincent and the Grenadines to the
Organization of American States
Washington, D.C.

Alternate – Alterno

Mr. Asram Y. S. Soleyn
Counselor
Embassy of Saint Vincent and
the Grenadines to the United States
of America
Washington, D.C.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

SURINAME

Chief Delegate – Jefe de Delegación

Dr. Marthelise Eersel
Director of Health
Ministry of Health
Paramaribo

Delegates – Delegados

Dr. Virginia Asin-Oostburg
Deputy Director of Health
Ministry of Health
Paramaribo

Ms. Miriam Naarendorp
Pharmacy Policy Coordinator
Ministry of Health
Paramaribo

**TRINIDAD AND TOBAGO/
TRINIDAD Y TABAGO**

Chief Delegate – Jefe de Delegación

Senator the Honourable Jerry Narace
Minister of Health
Ministry of Health
Trinidad and Tobago

Delegates – Delegados

Dr. Anton Cumberbatch
Chief Medical Officer
Ministry of Health
Port-of-Spain

Ms. Sandra Jones
Acting Permanent Secretary
Ministry of Health
Port-of-Spain

Alternate – Alterno

Mr. Garth A. Lamsee
First Secretary
Embassy of the Republic of
Trinidad and Tobago
Washington, D.C.

UNITED KINGDOM/REINO UNIDO

Chief Delegate – Jefe de Delegación

Professor Sir Liam Donaldson
Chief Medical Officer
Department of Health
London

Delegate – Delegado

Dr. Nicholas Banatvala
Head of Global Affairs
Deputy Director International
Department of Health
London

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

Chief Delegate – Jefe de Delegación

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
Department of Health and Human
Services
Washington, D.C.

Delegates – Delegados

Ms. Ann Blackwood
Director of Health Programs
Office of Technical and Specialized
Agencies Bureau of International
Organization Affairs
Department of State
Washington, D.C.

Mr. John Monahan
Interim Director, Office of Global
Health Affairs
Counselor to the Secretary
Department of Health and
Human Services
Washington, D.C.

MEMBER STATES/ESTADOS MIEMBROS (cont.)

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

Alternates – Alternos

Mr. Mark Abdo
Director for Multilateral Affairs
Office of Global Health Affairs
Department of Health and
Human Services
Washington, D.C.

Dr. Stephen Blount
Director, Coordinating Office on
Global Health
Centers for Disease Control and
Prevention
Atlanta, Georgia

Mr. Edwin Brown
Deputy Director
Office of International Health
and Biodefense
Bureau of Oceans, Environment
and Science
Department of State
Washington, D.C.

Dr. Nerissa Cook
Deputy Assistant Secretary for Global
and Economic Issues
Bureau of International Organizations
Affairs
Department of State
Washington, D.C.

Ms. Kim D'Aria-Vazira
Population Policy Officer
Bureau of Population, Refugees
and Migration
Department of State
Washington, D.C.

Mr. Robert Downes
Director
Office of Human Security
Bureau of International Organizations
Affairs
Department of State
Washington, D.C.

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

Alternates – Alternos (cont.)

Mr. Edward Faris
Program Analyst
Office of Management Policy
and Resources
Bureau of International Organizations
Affairs
Department of State
Washington, D.C.

Dr. Roger Glass
Director, Fogarty International Center
National Institutes of Health
Department of Health and
Human Services
Washington, D.C.

Mr. James Kulikowski
Acting Director
Office of Global Health Affairs
Department of Health and
Human Services
Washington, D.C.

The Honorable Nicole Lurie, M.D.
Assistant Secretary for Preparedness
and Response
Department of Health and Human
Services
Washington, D.C.

Dr. Peg Marshall
Senior Advisor for Maternal and
Child Health and Infectious Diseases
Bureau for Latin America and the
Caribbean
U.S. Agency for International
Development
Washington, D.C.

Dr. Jay McAuliffe
Acting Team Leader
Coordinating Office on Global Health
Department of Health and Human
Services
Atlanta, Georgia

MEMBER STATES/ESTADOS MIEMBROS (cont.)

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

Alternates – Alternos (cont.)

Ms. Kathy Saldana
Senior Technical Advisor for Health
Systems and Public Health
Bureau for Latin America and the
Caribbean
U.S. Agency for International
Development
Washington, D.C.

Dr. Paul Seligman
Latin American Director
Office of International programs
U. S. Food and Drug Administration
Department of Health and Human
Services
Washington, D.C.

Ms. Susan Thollaug
Team Leader
Health, Population and Nutrition Team
Bureau for Latin America and the
Caribbean
U.S. Agency for International
Development
Washington, D.C.

Ms. Mary Wakefield
Administrator
Health Resources and Services
Administration
Department of Health and Human
Services
Washington, D.C.

Ms. Leah Hsu
International Health Analyst
Office of Global Health Affairs
Department of Health and
Human Services
Washington, D.C.

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

Alternates – Alternos (cont.)

Ms. April Springfield
Senior Advisor
Office of Global Health Affairs
Department of Health and
Human Services
Washington, D.C.

Ms. Nina Wadhwa
International Health Analyst
Office of Global Health Affairs
Department of Health and
Human Services
Washington, D.C.

Ms. Vanessa De La Ossa
Advisor
Office of Human Security
Bureau of International Organizations
Affairs
Department of State
Washington, D.C.

Dr. James Herrington
Director, Fogarty International Center
Division of International Relations
Department of Health and
Human Services
Washington, D.C.

Mr. Jorge F. Christian
Assistant Director
Office of International Programs
Latin America Office
U.S. Food and Drug Administration
Rockville

URUGUAY

Chief Delegate – Jefe de Delegación

Dra. María Julia Muñoz
Ministra de Salud Pública
Ministerio de Salud Pública
Montevideo

MEMBER STATES/ESTADOS MIEMBROS (cont.)

URUGUAY (cont.)

Delegates – Delegados

Dra. Beatriz Rivas
Directora de la División de
Cooperación Internacional
Ministerio de Salud Pública
Montevideo

Excelentísima Dra. María del Lujan Flores
Embajadora, Representante Permanente
del Uruguay ante la Organización de los
Estados Americanos
Washington, D.C.

Alternate – Alterno

Sra. Cristina Carrión
Ministra Consejera, Representante Alternata
del Uruguay ante la Organización de los
Estados Americanos
Washington, D.C.

VENEZUELA

Chief Delegate – Jefe de Delegación

Dra. Indira Corado Frontado
Viceministra de Redes de Salud Colectiva
Ministerio del Poder Popular para la Salud
Caracas

VENEZUELA (cont.)

Delegates – Delegados

Su Excelencia Roy Chaderton Matos
Embajador, Representante Permanente
de la República Bolivariana de
Venezuela ante la Organización de los
Estados Americanos
Washington, D.C.

Dra. Carmen Velásquez de Visbal
Ministra Consejera
Misión Permanente de la República
Bolivariana de Venezuela ante la
Organización de los Estados
Americanos
Washington, D.C.

Alternates – Alternos

Sr. David Rojas
Segundo Secretario, Representante
Alternata de la República Bolivariana de
Venezuela ante la Organización de los
Estados Americanos
Washington, D.C.

Sra. Valentina Martínez
Abogada
Misión Permanente de la República
Bolivariana de Venezuela ante la
Organización de los Estados
Americanos
Washington, D.C.

**ASSOCIATE MEMBERS/
MIEMBROS ASOCIADOS**

PUERTO RICO

Dr. Lorenzo González Feliciano
Secretario de Salud
Departamento de Salud
San Juan

PUERTO RICO (cont.)

Dr. Raúl G. Castellanos Bran
Asesor del Secretario de Salud
Departamento de Salud
San Juan

**OBSERVER STATES/
ESTADOS OBSERVADORES**

SPAIN/ESPAÑA

Excmo. Sr. Javier Sancho
Embajador, Observador Permanente de
España ante la Organización de los
Estados Americanos
Washington, D.C.

Sr. José M. de la Torre
Observador Permanente Alternativo de
España ante la Organización de los
Estados Americanos
Washington, D.C.

SPAIN/ESPAÑA (cont.)

Dra. Paloma Temiño de Dios
Misión de España ante la Organización
de los Estados Americanos
Washington, D.C.

Dr. Carlos Rico
Misión de España ante la Organización
de los Estados Americanos
Washington, D.C.

**REPRESENTATIVES OF THE EXECUTIVE COMMITTEE/
REPRESENTANTES DEL COMITÉ EJECUTIVO**

Dr. Marthelise Eersel
Director of Health
Ministry of Health
Paramaribo, Suriname

Dra. María Julia Muñoz
Ministra de Salud Pública
Ministerio de Salud Pública
Montevideo, Uruguay

**AWARD WINNERS/
GANADORES DE LOS PREMIOS**

**PAHO Award for Administration 2009/
Premio OPS en Administración 2009**

Dr. Merceline Dahl-Regis
The Bahamas

**PAHO Champion of Health Recognition/
Reconocimiento al Campeón de la Salud
de la OPS**

Sesame Workshop/Plaza Sésamo
Mr. Lauren Ostrow
Ms. Marie-Cecile Girard
Mr. Daniel Labin
Ms. Ginger Brown
Mr. Javier Williams
Dr. Charlotte Cole
Ms. Gema Jara

**Abraham Horwitz Award for Leadership
in Inter-American Health 2009/
Premio Abraham Horwitz al Liderazgo en
la Salud Interamericana 2009**

Dr. Eduardo A. Pretell Zárate
Perú

**Clarence H. Moore Award for Voluntary
Service/
Premio Clarence H. Moore al servicio
voluntario**

Ms. Marcela Romero
Redlactrans (Red de America Latina y el
Caribe de Personas Transgénero)
Argentina

**Fred L. Soper Award for Excellence in
Health Literature/
Premio Fred L. Soper a la Excelencia**

Dr. Guilherme Luiz Guimaraes Borges
México

**Pedro N. Acha Award for Veterinary
Public Health/
Premio Pedro N. Acha a la Salud Pública
Veterinaria**

Dr. Ilane Hernández Morales
México

**UNITED NATIONS AND SPECIALIZED AGENCIES/
NACIONES UNIDAS Y AGENCIAS ESPECIALIZADAS**

**Economic Commission for Latin America
and the Caribbean/
Comisión Económica para América
Latina y el Caribe**

Sra. Inés Bustillos

**United Nations Development Programme/
Programa de las Naciones Unidas para el
Desarrollo**

Mr. Bernardo Kliksberg

**REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS/
REPRESENTANTES DE ORGANIZACIONES INTERGUBERNAMENTALES**

**Caribbean Community/
Comunidad del Caribe**

Dr. Rudolph O. Cummings
Dr. Edward Greene
Dr. Jerome Walcott

**Organization of American States/
Organización de Estados Americanos**

Ambassador Albert Ramdin

**Inter-American Institute for Cooperation
on Agriculture/
Instituto Interamericano de Cooperación
para la Agricultura**

Mr. David Hatch
Ms. Priscila Henríquez

**Inter-American Development Bank/
Banco Interamericano de Desarrollo**

Mr. Héctor Salazar-Sánchez
Ms. Meri Hellerante

**Hipólito Unanue Agreement/
Convenio Hipólito Unanue**

Sr. Oscar Feo

**The Global Fund to Fight AIDS,
Tuberculosis and Malaria/
Fondo Mundial de lucha contra el SIDA,
la Tuberculosis y la Malaria**

Dr. Anthony Seddoh
Ms. Anne Bwomezi

**The World Bank/
Banco Mundial**

Dr. Amparo Gordillo Tobar
Dr. Fernando Lavadenz

**REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL
RELATIONS WITH PAHO / REPRESENTANTES DE ORGANIZACIONES NO
GUBERNAMENTALES EN RELACIONES OFICIALES CON LA OPS**

**American Society for Microbiology/
Sociedad Interamericana de
Microbiología**

Ms. Lily Schuermann

**Inter-American College of Radiology/
Colégio Interamericano de Radiología**

Sr. Rodrigo Restrepo

**Inter-American Association of Sanitary
and Environmental Engineering/
Asociación Interamericana de Ingeniería
Sanitaria y Ambiental**

Ing. Carlos Alberto Rosito

**Latin American Association of
Pharmaceutical Industries/
Asociación Latinoamericana de
Industrias Farmacéuticas**

Dr. Rubén Abete

**REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL
RELATIONS WITH PAHO / REPRESENTANTES DE ORGANIZACIONES NO
GUBERNAMENTALES EN RELACIONES OFICIALES CON LA OPS (cont.)**

**National Alliance for Hispanic Health/
Alianza Nacional para la Salud Hispana**

Ms. Marcela Gaitán

**Pan American Federation of Nursing
Professionals/
Federación Panamericana de
Profesionales de Enfermería**

Lic. Neris Gonzáles

**REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN
OFFICIAL RELATIONS WITH WHO / REPRESENTANTES DE ORGANIZACIONES NO
GUBERNAMENTALES EN RELACIONES OFICIALES CON LA OMS**

**Alzheimer's Disease International/
Enfermedad de Alzheimer internacional**

Mr. Michael Splaine

**International Federation of Medical
Students' Associations/
Federación Internacional de
Asociaciones de Estudiantes de
Medicina**

Ms. Knakita Keyana Clayton-Johnson
Ms. Christa Preuss
Ms. Jessica Valeria Tang Herrera

**Doctors without Borders/
Médicos sin Fronteras**

Mrs. Gemma Ortiz M. Genovese
Ms. Gabriela Chaves

**International Council for Control of
Iodine Deficiency Disorders/
Consejo Internacional para la Lucha
contra los Trastornos por Carencia de
Yodo**

Dr. J. Burrow
Dr. Eduardo Pretell
Mr. D. P. Haxton

**International Alliance of Patients'
Organizations/
Alianza Internacional de Organizaciones
de Pacientes**

Mr. Myrl Weinberg

**International Association for Dental
Research/
Asociación Internacional para la
Investigación Dental**

Dr. Christopher Fox

**International Federation of
Pharmaceutical Manufacturers
Associations/
Federación Internacional de la Industria
del Medicamento**

Ms. Susan Crowley
Mr. Richard Kjeldgaard
Ms. Cory Jacobs

**REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN
OFFICIAL RELATIONS WITH WHO / REPRESENTANTES DE ORGANIZACIONES NO
GUBERNAMENTALES EN RELACIONES OFICIALES CON LA OMS (cont.)**

**International Federation of
Pharmaceutical Manufacturers
Associations/
Federación Internacional de la Industria
del Medicamento (cont.)**

Mr. Leo Farber
Ms. Jackie Keith
Ms. Maria Claudia García
Mr. Normand Laberge
Ms. Edyta Malinowski

**International League Against Epilepsy/
Liga Internacional contra la Epilepsia**

Dr. Theodore William

**International Pediatric Association
Asociación Pediátrica Internacional**

Prof. Sergio Cabral
Prof. William Keenan

**International Special Dietary Foods
Industries/
Federación Internacional de Industrias de
Alimentos Dietéticos**

Ms. Jackie Keith
Ms. Mardi Mountford
Ms. Andrea Durkin

**World Self-Medication Industry/
Industria Mundial de la Automedicación
Responsable**

Lic. Héctor Bolaños

**SPECIAL GUESTS/
INVITADOS ESPECIALES**

Ms. Sara Ferrer Olivella
UN/Spain Millennium Development Goal
Achievement Fund

Mr. Pedro Medrano
Regional Director for America and
the Caribbean World Food Program

Dr. Ricardo Uauy
President of the International Union
of Nutritional Sciences

Dr. Joy Phumaphi
Vice President, Human Development
Network, World Bank

Ms. Carmen María Gallardo Hernández
Vice President, UN Economic and Social
Council

**SPECIAL GUESTS/
INVITADOS ESPECIALES (cont.)**

Mr. David Oot
Associate Vice President, Department of
Health and Nutrition
International program Leadership Division
Save the Children

Dr. Claude de Ville de Goyet
Consultant

Ms. Myriam Urzúa
Economic Commission for Latin America
and the Caribbean

Lic. Laura Gurza
General Coordinator
Civil Protection System
Mexico

**WORLD HEALTH ORGANIZATION
ORGANIZACIÓN MUNDIAL DE LA SALUD**

Dr. Margaret Chan
Director-General
Geneva

Ms. Daisy Mafubelu
Advisor to the Director-General/FCH

Dr. Manuel Dayrit
Director, HSS/HRH

Dr. Timothy Evans
Assistant Director-General/IER/IEA

Dr. Lorenzo Savioli
Director HTM/NTD

Dr. Jorge Bermudez
Executive Secretary UNITAID

**PAN AMERICAN HEALTH ORGANIZATION
ORGANIZACIÓN PANAMERICANA DE LA SALUD**

**Director and Secretary *ex officio* of the
Council/
Directora y Secretaria *ex officio* del
Consejo**

Dr. Mirta Roses Periago

**Advisers to the Director
Asesores de la Directora**

Dr. Socorro Gross
Assistant Director
Subdirectora

**Advisers to the Director/
Asesores de la Directora (cont.)**

Mr. Michael A. Boorstein
Director of Administration
Director de Administración

Dr. Juan Manuel Sotelo
Manager/External Relations,
Resource Mobilization and Partnerships
Gerente/ Relaciones Externas,
Movilización de Recursos y Asociaciones

Dr. Heidi Jiménez
Legal Counsel, Office of Legal Counsel
Asesora Jurídica, Oficina de la Asesora
Jurídica