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**ANNUAL REPORT OF THE DIRECTOR OF THE
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(Washington, D.C)**

Thank you, Mr. President. First of all, let me offer you my congratulations on having being elected by the Council to this office. I have no doubt that you will discharge it with distinction.

I also wish to thank Dr. Nakajima for the remarks he made this morning about the general panorama in which the World Health Organization functions, and I would be remiss if I did not express my gratitude to Dr. Boufford, and her country, which has been generous over the years in hosting this meeting, and has demonstrated its support in ways much more tangible than merely being hosts.

I am pleased to present the Report of the Director for the year 1995. This is the first year of my administration and one for which I can genuinely say that I take responsibility. Mr. President, the overwhelming sensation of this first year has been one of gratitude to the Member Governments and coupled with that gratitude, satisfaction and pride in the staff of the Pan American Health Organization.

First, I believe it is important, primarily for new Ministers of Health and perhaps as a reminder to the veterans, to go over very briefly what are the basic functions of the Directing Council. As you know, the Sanitary Conference meets every four years and in the intervening years its functions are carried out by the Directing Council. Constitutionally, you are charged with determining the general policies of the Organization, providing a forum for the exchange of information and ideas relating to disease prevention and health promotion in the Americas, reviewing my report and, as the occasion demands, reviewing the budget of the Organization. But I have always emphasized that you are essentially a policy-making body and the Constitution makes it abundantly clear that your focus is the Western Hemisphere, and your task is to improve the health of the Americas.

I would first like to present to you some of the most important aspects of the scenario in which we have worked and then refer more specifically to the printed report that you have before you. I do the former not to display any knowledge of mine or prowess in analyzing current events, but because I, like all of my colleagues, am convinced of the need to be alive to world and hemispheric currents that undoubtedly affect our ability to cooperate technically with you and your ability to respond.

The year 1995 marked the mid-year of a decade that opened with much promise for us in the Americas. There was optimism about the chances for real human development and I will look at 1995 through the perspective of some of those main elements of human development that I have discussed with you on several occasions. I will begin, if you will permit me, with the economic climate, and I

* **Pan American Health Organization, Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization.**

will cite extensively from the report of the Inter-American Development Bank for 1995, which focuses mainly on the problems of Latin America and the Caribbean, because the economies of most of the countries of the north were relatively stable. When you read that report, you find that during 1995 the Region's economic reforms were put to the test, as the after-shock of the financial crisis in one of our major countries in December 1994 swept over the continent. In the early months of 1995, economic developments were dominated by these disturbances and there was fear among us of an international crisis on the scale of the 1982 debt crisis. The regional impact of this local crisis was nevertheless dramatic, because it brought in its wake a slow-down in the average rate of the Region's economic growth; but, indeed, the majority of our countries still grew. We also noted that the majority managed to squeeze inflation out of their economies and the Region continued to increase its integration into the world markets. I said that economic growth in the Region slowed in 1995, falling from the 5% recorded in 1994 to only about .6% in 1995, if we took the Region as a whole, but if we excluded Argentina and Mexico, the rate of growth in the rest of the Region was about 4.2% which was only marginally less than in 1994.

We think that the Region benefitted during 1995 from generally favorable external conditions, and this is in part because the industrial economies experienced moderate but steady economic growth and prices of many of the Region's products remained fairly firm. Another point that is of importance to us, is that the international interest rates declined steadily after the substantial increase in 1994, and as the outlook for low inflation gradually brightened in the United States and prospects of fiscal consolidation improved, we found that long-term interest rates in this country tended to decline, and by the end of 1995 we were approaching the lows recorded in the first months of 1994. These lower interest rates led to lower debt service for our countries and a possibility of increasing capital flows from the north to the south.

The crisis that affected us at the beginning of 1995 was important because it highlighted our Region's continued vulnerability to volatile international capital flows. But also, it demonstrated to my satisfaction and to the satisfaction of many of the persons to whom I speak, an increased resilience of the economies to such disturbances. This is in sharp contrast with 1982 when a similar disturbance plunged our Region into a decade-long recession with shocks that had lasting effects. So we held our breaths in 1995, to see if the shocks were to plunge our Region into an economic crisis similar to that of the 1980s, as we recalled with some pain the disastrous effect on the social sector. This did not occur.

Much of the debate on social reform in our Region in 1995 was directed towards the reorganization of the State in terms of its transition from a productive to a normative entity. Almost every country in our Region reexamined its institutions, and one of our colleagues from the Economic Commission for Latin America and the Caribbean (ECLAC), Rolando Franco, summarized the transitions that were taking place. There was a recognition that there is a variety of actors that wish and clamor to be involved in social policy. We have discussed some of them in the Executive Committee — nongovernmental organizations, private sector, etc. We found that there was an emphasis on decentralized decision-making. There was a definite shift towards targeting the most needy segments of the population. These transitions found expression in various sectors, including health.

But there was also a recognition that, in spite of growth in the early 1990s, there was a huge backlog of social needs to be met: rising unemployment, increasing poverty, and perhaps even worse than the increasing poverty was the increasing gap between poor and rich and the increasing maldistribution of incomes. This continued to be a source of concern to us throughout 1995.

The other aspect of human development that is always important for us is the political situation — political rights and freedoms are important for us. We were pleased to note that in 1995 the democratic process was firmly entrenched in our countries. Six governments changed democratically in 1995. We were pleased and proud, if I could mention one country specifically, to see what happened in Haiti to mark the evolution of a democratic process. We are modestly proud of the role we tried to play in the very difficult circumstances in that country.

The global international political situation also occupied our thinking. Perhaps one of the major events of 1995 was the fiftieth anniversary of the United Nations. Many of you are aware of the special session of the United Nations General Assembly in October 1995, when nearly 150 Heads of State and Government gathered in New York to commemorate the fiftieth anniversary. The session began with praise for the Organization's past accomplishments and calls for its democratization and reform. Many speakers called for an expansion of the membership of the Security Council, the need for greater transparency, democratization, and accountability. This call was heard not only in the United Nations itself, but in many of its organs. Speakers deplored the current financial crisis and highlighted the need for Member States to pay their dues. The session concluded with the adoption of a declaration on the occasion of the anniversary, which emphasized that the anniversary must be seized as an opportunity to redirect the Organization to greater service to human kind, especially to those who are suffering and were deeply deprived. It ended by saying: this is the practical and moral challenge of our time.

On several occasions during 1995, both inside and outside PAHO, we have discussed that redirection, and we have tried to put forward the view that much of that redirection might be towards health. We have observed on occasion that, with the end of the cold war, and the end of one basic motive for struggle between nations, there is need for some other great challenge for the world. We have modestly asked why couldn't health be that great challenge for the world?

The Secretary-General put forward his agenda for development, and he focused on peace as a foundation of that development. I could not help but recall the efforts of the Ministers of Health of Central America and Panama, when they saw health as a bridge for peace.

The Secretary-General referred to the economy as the engine of progress and stated that improved education, health, shelter, together with increased employment, would contribute directly to reducing poverty and its consequences. But we note the dominant theme of interdependence of nations throughout the discussions and the discourse of the Secretary-General. That interdependence of nations is very important for us, and I have said that I will no longer use the expression in this Region of donor countries, because we are all givers and we are all receivers. Some give more than others, some receive more than others, but, I repeat, we are all givers and we are all receivers.

Much of the discussion on the fiftieth anniversary included a strong call for the reform of the whole UN system, and by extension, of the whole international system. There was a call for administrative reform. But perhaps the most strident call was for reform of governance of the United Nations system. And believe me, this is something that will affect all international organizations, including this one.

I recommend to you the report of the UN Global Governance Commission, because it also points out that the world needs a new vision that can galvanize people everywhere to achieve higher level

cooperation in areas of common concern and shared destiny. If I had had to appear before that Commission, I certainly would have said to them that they could find in the health of our people that new vision that can galvanize people. The Commission pointed out that when the United Nations system was created, Nation States were dominant and Governments had few rivals. In that context, at that time, nation and government were coterminous. The developments over the years have shown us that there are many other actors at the national level that wish to participate with legal governments in the governance of a particular country. This is part of the angst that attends United Nations reform and finds expression in many of the agencies and institutions of the United Nations system, including the World Health Organization. I will mention this again. But in spite of the calls to reform, and in spite of the criticisms, one could see this idea of interconnectedness and interdependence coming through clearly.

Interdependence and interconnectedness were thrown into sharp relief in mid-1995 when the Ebola epidemic struck Zaire and focused the world's attention on the emerging diseases. It brought immense public and media interest to these diseases and I am proud that the World Health Organization came through with flying colors, demonstrating its capacity and efficiency of response. On a mini-scale the outbreaks of dengue in our Region, the outbreaks of leptospirosis in Central America brought home to us very clearly how we are all connected together.

Reference to the political level must not ignore the steady movements towards subregional integration in the Americas. During 1995 we saw the Central American Presidents meeting twice and designing, defining and refining the instruments of integration. We saw the countries of CARICOM moving slowly but surely forward and setting in place many of the mechanisms to strengthen and widen the Caribbean integration movement. The Association of Caribbean States was formed and we saw the countries of the Southern Cone, MERCOSUR, advocating that the issue of health should have a dominant place in the discussions of that grouping. As a matter of policy we supported these movements. In 1995 a major political event, perhaps of a different nature, took place in Beijing in an International Conference and I will refer to this again.

It is against this background of a Region that showed its economic resilience, a stable democratic climate and practice, awareness of the international attention to the UN System and reform, and the growing insistence of other actors to participate in the governance of intergovernmental organizations, and ever bearing in mind the burden of health problems that stop many of our people from realizing their full potential, that we developed our work. It is in that context that I invite you to examine the report which you have before you and which is complemented by the interim financial report.

You will note a change in the format and size of this report. You will note that it has a dominant theme which is equity. It goes into an analysis of our health situation and describes our work under the headings of the strategic and programmatic orientations that you approved. It describes the evaluation of our technical cooperation, some aspects of the management of the Secretariat to which I would like to draw your attention, and then it ends with some vignettes of the major accomplishments of the technical cooperation of the Pan American Health Organization in the past year.

I have undertaken to write an essay every year as an introduction to the report and because I said, right at the beginning of my administration, that equity and panamericanism would be the two dominant themes or principles that underlie most of what we did; the first of these essays deals with equity. I have said before that we have to be champions of that search for equity and social justice that finds expression in Health for All.

It came home to me in my first year how things have changed, in the sense that many of the persons and institutions have shifted their approach from one that focuses on means, to one that focuses on ends. It has become increasingly untenable to accept rapid economic growth without an attendant better distribution of wealth and some consideration of social equity. We found that social equity is gaining respectability as an economic end. I saw part of my responsibility as relating many of the philosophical concepts about equality and equity to the Pan American Health Organization's work in health, and I prefer to express equity as implying fairness. That sounds almost trite and I acknowledge that perhaps one must go beyond that and give more character to the idea of equity, so I accepted and developed three possible interpretations that imply the translation of equity into manifestations of equality of access, equality of the utilization and equality of outcome. I believe that current efforts to renew the call of Health for All are nothing more than validating, once and again, the timelessness of the principles of equity and social justice.

I refer in the essay to some of the main approaches developed in the strategic and programmatic orientations and how many of the activities that flow from them point out the importance of the theme of equity. This quest for equity is one of the driving forces behind the nearly universal preoccupation with sector reform, not only in the Americas, but in most of the world. I make reference to the Ottawa Charter for Health Promotion and point out that health promotion's major thrust has been, and will continue to be, the creation of favorable opportunities within communities, cities and schools, and even factories, whereby citizens can mobilize themselves to reduce the inequities that make for ill health. I end the essay by making reference to something I have said to you before — my first message to you — when I referred to the need for us to move toward a world that recognizes differences but avoids otherness and I have postulated that there should be no otherness in health.

As this report shows, our work in health can have practical implications for the search for social justice and I end by the phrase from one of my favorite philosophers, Karl Popper who writes Man has created new worlds — of language, of music, of poetry, of science; and the most important of these is the world of the moral demands for equality, for freedom and for helping the weak.

We then go on to the various aspects of the technical cooperation and as our first chapter points out, it is not enough to speak in abstract terms about equity, it behoves us in the health sector to monitor the human condition. It behoves us in the health sector to show where inequity exists, what can be done about it and the effect of the interventions to reduce it. In our Region, it is not a matter of pride that we have more inequity in our system than others do, and it is only by identifying the gaps in equity and access, that effective actions can be taken to target populations at greatest risk. To this end, the Organization has been working to define a set of core data that can be of help in trend assessment analyses. You will hear more about this anon, but we started 1995 with the idea that the day would come sooner, rather than later, when all countries would have a basic set of core data about their health situation, and these would be accessible throughout the Americas so that the data from Antigua and Barbuda would be available in Argentina and vice versa. This chapter sets out what has been done in an initial way to demonstrate the inequity that exists in the distribution of resources for health and in the health status of the population. We have a methodology that divides the countries according to their income status and we show, for example, that if we look at one manifestation of inequities in the health status, we will find that the percentage of newborns in the Region of the Americas with low birth weight, that is less than 2,500 grams, is closely correlated with this grading of countries.

Infant mortality is also closely correlated with the gradation of countries. One can use the percentage of pregnant women receiving prenatal care from trained personnel, as well as a percentage of live births attended by trained personnel as indicators of accessibility to health services. If you look at these by countries, you see the same trend. Those who are better off have better indicators. We can also show, although the analysis is not as detailed as yet for 1995, the same measure of inequity within our countries. And we ask ourselves if in some areas there can be a demonstration of equitable and equal access to some services, like immunization, why can it not be done in the others. In 1995 we continued to look for ways in which this might be done.

We refer again in this chapter to the effort of the ministers of health of Central America to make practical the concept of a bridge for peace, and we say, not facetiously, we now need to mobilize the same energy to build a bridge for equity. PAHO is committed to work towards the consolidation of information systems in our Member States that would help to document the impact of health interventions and also support the development of health policies that would lead us down the path to sustainable human development. When the countries work in collaboration and with the assistance of international technical agencies to address health problems, significant achievements can be accomplished for population groups at risk.

I believe that when you set up the Strategic and Programmatic Orientations you intended us to use them, so you will find discussion of our work under these headings in the next chapters. These Orientations not only inform the planning and programming of the Organization's work, but they are also reflected in how our Bureau is structured. Under the heading of Health and Human Development we describe the issues of health sector reform and what we have done to assist the countries. Through our Country Offices PAHO has provided direct support for 26 national health sector reform processes in the Americas.

We believe, as I have said before, that this process is guided by and directed towards enhancing equity in our part of the world and we have postulated and have worked with countries along two main tracks in health sector reform; that is, organization of the health systems and financing of these health systems once they have been organized. We have had numerous discussions with our Member States persuading them not to start the other way around — not to start with discussions in detail of the financing of the services before one determines what kinds of health services one wishes to finance.

The meeting on health sector reform held approximately one year ago was a major event. It was the largest meeting of its kind held in our Region and was a direct follow-up to the charge given to us in the Summit of the Americas that we should follow what was taking place in the Americas in terms of health sector reform. Most of the documentation that was produced has been helpful in our work in the countries.

In the area of health systems and services, we have worked to help our countries reorganize their systems and services as an aspect of health sector reform. Whether these systems can be reorganized depends on many factors which we set out here in the Report.

One of the collaborative projects that we entered upon with the Inter-American Development Bank was a regional health study that looked at the whole Caribbean and tried to define what are the areas that merit intense attention and what should be some of the projects that should be developed. We include under the issue of health services the matter of human resources development. We took a decision in 1995 that the major focus of our efforts in human resources development would be

strengthening the capacity to evaluate the performance of persons in the services and helping them to maintain and improve their skills. Within that area of health services, technology and essential drugs are of great importance for us partly because the pharmaceutical sector has been directly affected by the countries' shift towards free market economies. Our cooperation has sought to ensure that commercial considerations do not override quality, safety, effectiveness, and availability criteria regarding pharmaceutical supplies. Support for the harmonization of drug regulation that has emerged from various subregional economic and trade integration initiatives has been a significant aspect of cooperation in this area.

We also sought to strengthen the capacity of our countries' laboratories to deal with some of the common problems. In the Disaster Preparedness and Mitigation Program, we focused not only on our response to disaster, but on emphasizing that our work has to deal with the whole continuum from mitigation to prevention, right through to development, and one of the major efforts in 1995 was to strengthen the countries' capacity in mitigation, and render their health facilities less vulnerable to natural disasters. Oral health has often been neglected, although there are some outstanding results in this particular area. An impact assessment conducted on Jamaica's national program of salt fluoridation showed an overall caries reduction of more than 83%. Eighty-six percent of children under 6 years old were reported to be free of caries.

In the third area of Health Promotion and Protection, much of the emphasis was on the healthy municipalities. We refer to this as developing the concept of healthy spaces. We believe that healthy spaces represent the loci within which the principles of health promotion will be applied. Thus, we have helped countries to develop this idea of healthy spaces, healthy municipalities, healthy schools, and healthy factories. You will hear more about violence and health so I will not refer to this area of our cooperation. I will refer, however, to the issue of family and population health because a new approach to all family and population health has allowed us to respond to several of the lines of action proposed in the World Summit for Children and the Fourth World Conference on Women in Beijing.

I announced on the first day I took office that one of the programs we would strengthen would be that of adolescent health and one of the few new positions we created is in that area, because I believe firmly that attention to adolescents is a critical area for us. We have to work with them, we have to feel them, touch them, listen to them, hear them, and cooperate with them in attempts to influence their own health practices. In the area of Food and Nutrition we continued in 1995 to develop the conceptual underpinnings for that program which will focus on two broad areas: food security and the correction of malnutrition. There are few areas in which inequity is expressed more clearly than in the area of Environmental Protection and Development. The poor live in environmentally unsatisfactory conditions because they are poor and, therefore, they live in environmentally unsatisfactory conditions and therein lies the vicious spiral. You agreed that we would hold here in PAHO in 1995 the Pan American Conference on Health and Environment in Sustainable Human Development, which was a mandate of the Summit of Presidents held in Miami in 1994. That conference approved the Pan American Charter on Health and Environment in Sustainable Human Development and we are working with our Member States to make this Charter real; not just a bit of paper, but guidelines for action at individual country level.

In the area of Disease Prevention and Control I would only make mention very briefly of vaccine preventable diseases because we will be dealing with this as a specific item on the agenda. Our collaboration with UNICEF in this particular area was enhanced and we developed a joint strategy for integrated treatment of major childhood diseases. There was a lot of emphasis on acute respiratory

infections and on the issue of emerging and re-emerging diseases, so in June 1995 we began a sustained effort to examine strategies for the prevention and control of these new threats.

I would like to mention one specific problem that occurred in 1995 because is something that touched me deeply. There was an outbreak of plague in one of our Member States, and during 1995 we succeeded in mobilizing a not inconsiderable sum of money from the European Community Humanitarian Office to strengthen plague prevention and control activities. I had the opportunity to visit that very rural area and to me it was impressive to see how community participation really worked, and to see how the effort involved the whole family. We helped families to build silos to contain the grain so the rats could not get at it. I was impressed to hear of the women of the village doing the soldering of the silos while the men went to work. Houses were also sprayed, so whereas in 1994, well over 1200 cases of plague occurred, in 1995 this had dropped to well below 100, due to concentrated and concerted efforts at the local level with the support of our technical cooperation.

I will not mention the vaccine preventable diseases in detail because you will hear about them later; 1995 represented the fourth year of absence of poliomyelitis from the Americas, and the fourth year of absence of measles from countries of the Caribbean, and in the whole of 1995 not a single case of measles was imported into North America from the Latin American and the Caribbean Regions. In 1995 we created a new program of Non-Communicable Diseases because of the importance of this area.

We set out next the evaluation of technical cooperation in seven of our Member States, and we do this to show you one particular aspect of our evaluation work. We believe that our evaluation should not only be along the lines of fiscal transparency but also demonstrate programmatic transparency. We set out here in very succinct form what these evaluations showed to be the national priorities, what were the major accomplishments of the technical cooperation, and what were the recommendations for future technical cooperation of the Organization.

The area of management and administration is the next section of the report. The day before I took office, I tried to articulate a vision that I thought most of us shared for the Organization, and our vision was one of an organization that would live a fundamental principle, a principle that we represent a hemispheric cooperative health enterprise, and we have undertaken to work together to improve the health of all the people of the Americas in the spirit of panamericanism.

And a second great value principle within that vision was that we should be champions of the search for that equity and social justice that finds expression in Health for All. That vision is not enough, it has to be translated into what we do, our mission, and in a participatory exercise all of the staff of the Pan American Health Organization crafted what the mission of the Organization would be. They said, or we said, that the Pan American Sanitary Bureau is the Secretariat of the Pan American Health Organization, an international health agency, and its mission is to cooperate technically with the Member States, and to stimulate cooperation among them, in order that, while maintaining a healthy environment, and charting a course of sustainable human development, the people of the Americas may achieve health for all. Our vision is what we will be, our mission is what we will do. We restructured the Secretariat in 1995 along the lines of the Strategic and Programmatic Orientations, and we added a special program, the Special Program of Vaccines and Immunization, for reasons that I have explained to many of you before. We placed the Program on Women, Health, and Development in the Division of Health and Human Development. You will notice in the Report that there is no specific subheading of Women, Health, and Development. This was done deliberately because it is

important that issues related to women, health, and development, and more specifically those issues related to gender inequity and discrimination that find expression in ill health, should permeate much of what is in the Report. So you will find references to that issue throughout the whole Report and not in any single discreet place.

We introduced some different management practices and elements of due process in an attempt to flatten the Organization, we paid special attention to information and decided that our approach to information should be to determine why we needed information, and to organize our work to fulfill three needs: information for our corporate services, information for technical cooperation, and information on health by ourselves and others. We are convinced of the need to have the rest of the world know more about not only what the Organization did, but those things within the scientific literature that were important for the work of the countries. We established 56 publication centers in the countries, enhanced our text based GOFER service; and launched the English and Spanish versions of a media-rich interactive World Wide Web. We strengthened our planning and programming and made modifications to our AMPES system to make it more responsive. We are pleased that for the first time we presented our Program and Budget indicating the results we expect to get from our program. We began the arduous task of implementing a new personal evaluation system; streamlined our budget and finance; and we continue an aggressive policy towards enhancing the recruitment of women in the Organization. You will see on page 75 in the English text, some of the activities that have taken place. We have said at the Executive Committee, for example, that in the last four years, 48% of professionals incorporated into PAHO have been ladies.

I would be remiss if I did not mention the relations with the Staff Association. When I came to office there was some disquiet as whether we could maintain a professional relationship between ourselves and the Staff Association and not descend into adversarial conflict and confrontation. I am pleased with the responsible performance and behavior of our staff during this year, and our ability to discuss and negotiate, not necessarily agreeing on the different points of view that might exist between the Staff Association and myself.

Mr. Chairman, the last part of the Report summarizes the major accomplishments of PAHO's technical cooperation at the country level during 1995. If you view this as a whole, this highlights and depicts the scope of technical cooperation activities that the Organization has constructed in its Member States. The major accomplishments reported here were selected by the country office staff, and it is interesting that the selection criteria were remarkably uniform from country to country. They basically fall into the broad areas of the program's demonstration of the benefits of inter-sectoral, inter-programmatic, inter-institutional and inter-country cooperation, the program's benefit to the population's health or the health delivery system, the program's contribution to national institutional development through the dissemination of information or the enhancement of national capabilities, and the impact of our activities on national health policies. We also describe the effective mobilization of financial, human, technical and political resources, and the accomplishments that are congruent with the Strategic and Programmatic Orientations of the Pan American Health Organization.

Mr. Chairman, the cover of the Report has on it the faces of the people of our Region — that is why we are here. In spite of the problems that we encountered as a Secretariat during 1995, in spite of the difficulties that you as nations faced and overcame, I am convinced that the Organization as a whole, remained committed to working together so that all our people are indeed healthier because of our efforts.

Mr. Chairman, let me end where I began with gratitude to you, the Governments, and satisfaction and pride in our staff.

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