EIGHTH MEETING
OCTAVA REUNIÓN

Thursday, 30 September 2004, at 2:30 p.m.
Jueves, 30 de septiembre de 2004, a las 2.30 p.m.

President/Presidente: Dr. José Antonio Alvarado Nicaragua

SECOND REPORT OF THE GENERAL COMMITTEE
SEGUNDO INFORME DE LA COMISIÓN GENERAL

The PRESIDENT said that with the two Vice Presidents, the Rapporteur, and the Delegates of France, Mexico, and United Status, the General Committee had held its second meeting on Thursday, 30 September 2004, to consider the implementation of the Council's agenda. The Committee had recommended that the Council should work until 6:00 p.m. that day and begin work the next day, Friday, 1 October 2004, at 8:00 a.m. Following the closure of the Council, the 135th Session of the Executive Committee would be held on Friday, 1 October 2004, at 1:30 p.m., in Room B.

The second report of the General Committee was approved.
Se aprueba el segundo informe de la Comisión General.

ITEM 5.5: ACCESS TO MEDICINES (*cont*.)
PUNTO 5.5: ACCESO A LOS MEDICAMENTOS (*cont*.)

Dr. FITZGERALD (PAHO), responding to comments from the delegates, said that rational use considerations were seen as extremely important, not only in selecting medicines and providing the framework for defining formularies, but also as an element of cost containment. The comments relating to the use of International Nonproprietary Names for prescribing generic medicines had also been very useful, and all comments would be incorporated into the proposed resolution.

La DIRECTORA comunica que, a instancias del Delegado de Santa Lucía y habida cuenta de la importancia del tema para la Región, propondrá que el Comité Ejecutivo, en la reunión que celebrará inmediatamente después de la presente sesión del Consejo Directivo, considere la posibilidad de agregar a su agenda de trabajo para 2005 un punto relativo a la sangre segura.

In the interest of time, the Observer from the International Federation of Medical Students' Associations did not read his statement in extenso*, but asked that it be included in the record. This statement is appended as Annex A.*
Por razones de tiempo, el Observador de la Federación Internacional de Asociaciones de Estudiantes de Medicina no lee su declaración in extenso *y solicita que se incluya en el acta. Esa declaración figura en el Anexo A.*

ITEM 5.6: SCALING-UP OF TREATMENT WITHIN A COMPREHENSIVE RESPONSE TO HIV/AIDS
PUNTO 5.6: AMPLIACIÓN DEL TRATAMIENTO COMO PARTE DE LA RESPUESTA INTEGRAL A LA INFECCIÓN POR EL VIH/SIDA

Hon. Herbert SABAROCHE (President of the Executive Committee) said that the Executive Committee had examined the item at its 134th Session in June 2004.

The Executive Committee had welcomed PAHO's efforts to strengthen the regional response to HIV/AIDS and, particularly, the steps it was taking to increase access to antiretroviral therapy and make it more affordable for poor and vulnerable populations. At the same time, however, the Committee had stressed the need for continued emphasis on prevention and on promotion of healthy behaviors.

It had been pointed out that the need for treatment represented a failure of prevention, and that efforts to expand access to treatment had to be underpinned by vigorous prevention campaigns; otherwise, there was a risk that people might come to think of AIDS as a disease that was easily treatable and therefore become less careful about risk avoidance.

In that connection, PAHO had been strongly encouraged to incorporate promotion of abstinence into its advocacy strategy for youth. The Organization had also been encouraged to promote the integration of HIV/AIDS programs with sexual and reproductive health programs, including programs for the prevention of sexually transmitted infections.

The Committee had mentioned a number of roles for PAHO, including technical cooperation with countries to develop logistic and distribution systems for drugs and commodities, promotion of simplified treatment regimens using safe and effective drugs of high quality, and evaluation of actions and strategies to identify the best and most cost-effective practices. The Committee had also identified a number of challenges that needed to be overcome in order to strengthen health system response to the epidemic, including better training for health workers and strengthening of laboratories and other support services.

It had been pointed out that scaling up treatment was not just a question of improving access to drugs. It was also essential to ensure the necessary laboratory capabilities to monitor patients and measure viral load, provide patient education in order to promote better compliance with treatment regimens, provide psychological and social support services for patients and their families, and address the care needs of terminal patients. Another challenge was educating the population—particularly the population of persons living with HIV/AIDS—about when treatment was really necessary and beneficial, as there was a tendency to think that all HIV-infected individuals required treatment.

Delegates had underscored the need for cooperation between neighboring countries for HIV/AIDS prevention and treatment in mobile populations. The need for consistent attention to gender equity issues had also been highlighted.

One delegate had emphasized the importance of involving men and boys in the continuum of HIV/AIDS programs, including prevention, care, treatment, and support, while another had pointed to the need for a greater focus on and inclusion of women in the response to HIV/AIDS, particularly high-risk groups of women, such as sex workers, prisoners, and intravenous drug users. Citing the successes achieved in the prevention of vertical transmission in their countries, several delegates had stressed the importance of ensuring treatment for all HIV-positive pregnant women.

Resolution CE134.R4, adopted by the Executive Committee on the item, recommended that the Directing Council adopt a resolution urging Member States, among other things, to scale up efforts to treat HIV/AIDS and sexually transmitted infections within the context of a comprehensive response to the epidemic; ensure the effective, reliable supply of medicines, diagnostics, and other commodities necessary for scaling-up of treatment; sustain and reinforce prevention activities and the reduction of stigma within the health services; and strengthen the surveillance capacity of technical programs to monitor the trends in the epidemic and the impact of interventions, adjusting national responses and strategies accordingly.

The resolution called on the Director to continue to develop mechanisms to scale up treatment within a comprehensive response to HIV/AIDS in the Americas, including the expansion of the Regional Revolving Fund for Strategic Health Supplies, the application of tools and guidelines, human resource development and training, and other appropriate measures in support of health systems and services strengthening; to articulate and consolidate PAHO efforts for scaling-up treatment with the global “3 by 5” initiative; to continue to foster partnerships with the cosponsoring agencies of UNAIDS and other institutions and agencies in the fight against HIV/AIDS in the Americas; and to

continue to promote the sharing of regional and extraregional experiences and capacity development in prevention and control of HIV/AIDS and sexually transmitted infections.

Dr. VLASSOFF (PAHO) said that more than 2 million people were currently living with HIV/AIDS in the Region, and the spread of the HIV epidemic had increased steadily over the years from 1985 to 2003. It was well known that the Caribbean had the second highest prevalence rate in the world, although the true prevalence of HIV/AIDS in the Caribbean was masked by stigma and discrimination, particularly against vulnerable groups such as men who had sex with men. Half of the infections were acquired by young people, most of them between the ages of 15 and 24.

There was good news, however, with regard to evidence of the impact of treatment in the Region. In Brazil, deaths from AIDS had been significantly reduced through comprehensive treatment and prevention programs. Barbados, too, had achieved great advances in stemming the epidemic, thanks to its very enlightened program. Haiti, the poorest country in the Hemisphere, had also provided a very positive example of the impact of treatment. Partners in Health, an NGO working in Haiti, had taken an integrated prevention and treatment approach that was very decentralized and involved the community in supporting people living with AIDS. Such an approach was very effective in improving adherence to treatment and reducing stigma and discrimination.

WHO's "3 by 5" initiative, which had been endorsed by PAHO, provided a great opportunity for scaling-up the response to HIV/AIDS in the Region. Worldwide, the "3 by 5" initiative aimed to provide antiretroviral (ARV) therapy to 3 million people living with HIV and AIDS by the end of 2005.

At the regional level, the Declaration of Nuevo León, adopted by the Heads of State of the Americas in January 2004, had set the goal of treating 600,000 individuals requiring ARV therapy by the year 2005. While the challenge was daunting, it was far less so than in other Regions, because, at the end of 2003, WHO and UNAIDS had estimated that the Region had already achieved 55% coverage. Hence, universal treatment by the end of 2005 would mean a 45% increase in Latin America and the Caribbean.

With a view to implementing the "3 by 5" initiative in the Americas, PAHO had convened a task force, which had met in January 2004. It had agreed on a goal, strategic orientations, and strategies and activities. The goal was to work with PAHO partners to make the greatest possible contribution to prolonging survival and improving the quality of life for people living with HIV and AIDS in the Region, while advancing toward the ultimate goal of universal access to antiretroviral treatment for those in need, as a human right, as an effective prevention method, and as a measure against stigma and discrimination.

The strategic orientations developed to guide PAHO's technical cooperation were: (SO1) political commitment and leadership, partnerships, and community mobilization; (SO2) strengthening of health systems and services; (SO3) effective, reliable supply of drugs, diagnostics, and other commodities; (SO4) links with prevention services; and (SO5) dissemination of strategic information, research, monitoring, and evaluation. As shown in SO4, prevention was a major component of the orientations.

Some of the achievements of the "3 by 5" initiative thus far were the price negotiations conducted in collaboration with UNAIDS, WHO, and the countries of the Region, which had reduced costs for ARV therapy by 90%. PAHO and UNAIDS had prepared care and treatment fact sheets that would be used to monitor the "3 by 5" initiative and would also be useful for monitoring, program support, and advocacy at the country level.

PAHO had also been assessing countries' needs for technical cooperation, including technical cooperation between countries, based on the fact sheets and on consultations with the countries. Studies and workshops had been conducted on prevention among sex workers, blood infections among people suffering from hemophilia, and reduction of stigma and discrimination. Guidelines and manuals had been prepared on comprehensive care for TB and HIV, on working with injection drug users, and on reporting on AIDS in the media.

Meetings with UNAIDS regional cosponsors, known as the "Regional Director's Group," had already produced a number of outputs, including a regional calendar, a regional framework for working together, a website, and a joint advocacy strategy. A technical advisory committee on HIV/AIDS and STIs was being formed, the first meeting of which would be held in January 2005, with broad representation of countries, particularly the heads of AIDS programs, as well as representatives from PAHO offices and other development partners.

Although progress had been made, many challenges remained in the various areas covered by PAHO's strategic orientations. Under SO1, the reduction of stigma and discrimination was perhaps the single greatest challenge that countries had expressed with regard to scaling-up treatment and care. With regard to SO2, there was need for human resource development at the community level and for a larger number of highly trained specialists to back up the system, particularly in the Caribbean and Central America.

Under SO3, the challenges included prices for diagnostics and second-line medicines. There was also a need to work on capacity-building in the area of laboratories, quality control at all levels of the supply system, and monitoring tools for low-resource

settings. Under SO4, prevention services had to continue to receive high priority. It was essential to revitalize prevention efforts and public messages and programs to prevent the possible misconception that treatment was equal to a cure.

With regard to SO5, there was a need to develop better monitoring methods for measuring the impact of current treatment at all levels of the system. Priority areas for research included tools for rapid diagnosis of coinfection with HIV and other diseases and better combined treatments, pediatric formulations, and, of course, ongoing vaccine research and development of more simple therapeutic methods.

Dr. Vlassoff, in closing her presentation, briefly summarized the budgetary and human resource requirements for PAHO's work on HIV/AIDS. Existing resources and gaps across the Organization had been analyzed at the regional and country levels. It was estimated that a total amount of approximately $25 million was required to adequately address the many challenges involved in scaling-up treatment within a comprehensive response to HIV/AIDS.

The amount of regular budgetary resources allocated was $9 million, making the estimated funding gap $16.6 million, of which it was hoped that at least 75%, or $12.6 million, would come from WHO. The importance attached to prevention was evidenced by the fact that about 47% of the budget was devoted to preventive efforts.

With regard to human resource needs, it was estimated that an additional 15 staff members, including 7 fixed-term professionals, were required to optimize PAHO's response to HIV/AIDS work. The core group of representatives from a wide spectrum of PAHO units and areas, which had been formed early on in the "3 by 5" initiative and had played a central role in carrying it out, were not included in the human resource figures, but their financial requirements were reflected in the budget calculations.

Dr. CAREY (Bahamas), speaking on behalf of CARICOM, said that it had become widely known that the Caribbean region was the second worst affected region in the world for HIV/AIDS. The prevalence rate of about 2.8% obviously constituted a serious health threat, but it also had a significant socioeconomic impact. The region's health economists had estimated HIV/AIDS' current economic impact at 2% to 6% of gross domestic product, and that figure might increase to 20% if the epidemic was not reversed.

Even though it had been possible to slow the rate of increase of new infections, the total number of people living with HIV/AIDS was still increasing. Immediate acceleration of the multidisciplinary approach to HIV/AIDS was therefore a must. The Caribbean Community had consolidated its efforts in response to HIV/AIDS by establishing the Pan Caribbean Partnership against HIV/AIDS (PANCAB), which had

been entrusted with organization, mobilization of resources, coordination of the response, and advocacy for the region.

A conference on care, treatment, and support for the Caribbean had been organized in February 2005. Responses to a questionnaire distributed before the conference and surveillance results for the region had indicated a diagnosis gap of up to 90%, which meant that a large number of persons living with HIV/AIDS had not yet been diagnosed and did not know that they were infected. Of the diagnosed persons living with HIV/AIDS in the Caribbean, only 10% had access to treatment.

However, it had also become evident at the conference that the different programmatic approaches in the region had all resulted in success in the response to HIV/AIDS. The reduction in the prices of pharmaceuticals to treat HIV/AIDS had enabled several Caribbean countries to significantly increase the number of people receiving treatment.

The Bahamas had been able to achieve a fivefold increase in treatment, and had significantly reduced mother-to-child transmission, overall morbidity, and mortality. Data from the Bahamas and Barbados documented the fact that improved treatment had led to a significant reduction in hospital admissions and opportunistic infections, thus bringing down the overall cost of the response to HIV/AIDS.

Voluntary counseling and testing was seen as a key element in accelerating the response to HIV/AIDS in the region. However, test kits and an algorithm were not enough—trained counselors and a treatment program were also required. Furthermore, stigma and discrimination severely hampered the response to HIV/AIDS. There was a great need for politicians and other prominent individuals in society to publicly support efforts to increase awareness and reduce stigma and discrimination.

The CARICOM countries supported the proposed resolution on scaling-up of treatment within a comprehensive response to HIV/AIDS.

El Dr. BALAGUER CABRERA (Cuba) dice que la pandemia de VIH/SIDA se ha convertido en una verdadera catástrofe humana, social y económica, con implicaciones de gran alcance para los individuos, las comunidades y los países. Ninguna otra enfermedad ha puesto tan de relieve las disparidades y desigualdades en el acceso a la atención sanitaria, las oportunidades económicas y la protección de los derechos humanos básicos.

El acceso al tratamiento es un componente esencial de una respuesta integral a la epidemia de VIH/SIDA, pero debe acompañarse de esfuerzos eficaces en el área de la promoción y la prevención, en particular en lo que se refiere a la promoción de prácticas sexuales seguras y responsables. El acceso a servicios integrales de salud y a pruebas de

detección, a tratamientos adecuados de las infecciones de transmisión sexual y a medidas para prevenir la transmisión maternoinfantil del VIH son también elementos esenciales de los programas integrales de atención.

A los problemas que plantea para muchos países el costo de los tratamientos hay que agregar factores como la inexistencia de infraestructura sanitaria, las dificultades para capacitar al personal de salud, la carencia de laboratorios y la insuficiente capacidad de seguimiento de los pacientes en tratamiento. El orador manifiesta su apoyo a la iniciativa de la OMS "Tres millones para 2005", que para las Américas representa proporcionar tratamiento a 600.000 personas, y dice que en su país se cumplen las cinco orientaciones estratégicas identificadas por la OPS como parte de la respuesta integral a la infección por el VIH/SIDA.

Refiriéndose al llamamiento de la Directora para renovar los esfuerzos regionales para la eliminación de la sífilis congénita y el tratamiento de las infecciones de transmisión sexual, señala que Cuba participó en la reunión de expertos celebrada en mayo en la República Dominicana y trabajó en la elaboración de la propuesta de iniciativa regional. En ese marco se reconocieron los resultados obtenidos por su país en el manejo de las infecciones de transmisión sexual y en la eliminación de la sífilis congénita como problema de salud pública.

Cuba ha abordado la atención al VIH/SIDA a través de un programa integrado en los tres niveles de atención, en el que la mayoría de las acciones se ejecutan de forma descentralizada en la atención primaria de salud, con activa participación de la comunidad y de las personas que viven con VIH/SIDA. El programa cubano de prevención y control integra todos los componentes sugeridos por la OMS como estrategias claves para afrontar la epidemia, y satisface las necesidades nacionales identificadas de vigilancia epidemiológica, prevención, atención y cuidado (incluido el tratamiento antirretroviral), diagnóstico e investigaciones.

El orador se sorprende, por consiguiente, de que se hayan obviado los resultados de Cuba, siendo así que desde los inicios de la epidemia, en 1986, se han integrado las acciones de atención y prevención, como lo reconoce el ONUSIDA en su informe sobre la situación de la epidemia en 2004. Preocupa al orador la falta de coordinación entre copatrocinadores del ONUSIDA y otros socios, lo que ha provocado duplicidades y falta de sinergia en las acciones.

Como expresión de su espíritu solidario, Cuba ha manifestado ante las Naciones Unidas y la Comunidad de Estados del Caribe que está dispuesta a enviar médicos y otro personal de salud a África y el Caribe para luchar contra el SIDA, así como a crear facultades de medicina y de enfermería en África y el Caribe para dar sostenibilidad a la

colaboración. En efecto, miles de médicos y otros profesionales de la salud cubanos colaboran en estos momentos en 65 países.

El orador expresa su conformidad con el proyecto de resolución que se somete a la consideración del Consejo Directivo.

Dr. ZAND (Canada) noted the strong focus, in both the document and the proposed resolution, on the need for coordination at all levels, among programs, among national public health care systems at a regional level, and among national governments and donor agencies. She also acknowledged that effective scaling-up would require meaningful civil society involvement and mobilization to create the necessary social climate for testing and treatment.

To that end, Canada suggested that the proposed resolution (CD45/PR.6) be amended to include a statement at the end of paragraph 1d: . . . *working jointly with their international and national partners, including civil society organizations of people living with HIV/AIDS, to promote the Three Ones: one national HIV/AIDS action framework that provides the basics of coordinating the work of all partners, one national AIDS coordinating authority with a broad-based multisectoral mandate, and one country-level monitoring and evaluation system with one agreed-upon set of indicators.* She also suggested that the word *prisoners* be added to the list of vulnerable groups under paragraph 1e of the proposed resolution.

In the same vein, Canada encouraged PAHO to work with Members States to support the work of civil society organizations. Fostering and supporting such partnerships was pivotal to reducing stigma and discrimination within communities, building ARV treatment literacy, and developing life-long, home-based support for people on treatment.

Her Delegation greatly appreciated PAHO's work in training health professionals in key areas, particularly those focused on addressing the needs of youth. Canada applauded PAHO's plans to establish a reference laboratory in Central America and looked forward to continued collaboration with PAHO, CAREC, and other partners in strengthening the capacity for monitoring ARV treatment and ARV assistance surveillance, linking those initiatives to existing surveillance and monitoring systems.

PAHO's plans to improve the quality of information on girls aged 15 to 24 would be a step towards better understanding and towards addressing the gender dynamics of the HIV/AIDS epidemic. Canada encouraged PAHO also to work with Member States to ensure equitable access to treatment for males and females, and to collect sex-and-age-disaggregated data through all monitoring programs to allow national programs to be adjusted accordingly. Through its recently announced contribution of $100 million

towards the "3 by 5" initiative, as well as ongoing technical support, Canada would continue to play an active role in the Region's response to HIV/AIDS, working alongside and in coordination with PAHO, other Member States, and institutional partners.

O Dr. BARBOSA DA SILVA (Brasil) parabenizou o Secretariado e a Diretora pela apresentação e pela coordenação dos trabalhos na Região das Américas para atingir a meta de colocar 600.000 pessoas em tratamento com antirretrovirais. Além disto, pela apresentação de proposta de resolução, a qual apoiou, por apontar a necessidade de elaborar planos nacionais para enfrentar a AIDS envolvendo todos os seus componentes, como a luta contra o estigma, as ações preventivas, a ampliação do acesso a antirretrovirais, a rede de laboratórios, os sistemas de vigilância, etc.

Afirmou crer que essa abordagem ampla é o caminho mais seguro para obter uma boa resposta ao problema da AIDS na Região, mencionando que não há dúvidas que o êxito do programa brasileiro teve como elemento essencial a combinação de uma política de acesso aos antirretrovirais como direito social com ações preventivas em parceria com organizações da sociedade civil e com o respeito à diversidade cultural.

Informou que o Brasil tem cerca de 150.000 pessoas em tratamento com antirretrovirais e que apesar do êxito nas negociações para redução dos preços dos novos medicamentos, em especial os que ainda têm proteção de patente, três delas consomem um terço dos recursos gastos com medicamentos.

Tal situação, afirmou, requer que a OPAS, junto com outras agências, lidere um grande esforço mundial para que o Fundo Global possa suprir as lacunas no financiamento para poder atingir as metas do 3 por 5 até o próximo ano. Por outro lado, é necessário também utilizar todos os mecanismos e possibilidades legais para que o acesso a medicamentos essenciais para a preservação da vida nesse caso possam estar efetivamente disponíveis a todos os que dele necessitam.

Disse que também crê importante reforçar na resolução uma abordagem comum entre AIDS e tuberculose, ampliando-se igualmente para outras doenças sexualmente transmissíveis, especialmente a sífilis congênita, iniciativa a ser lançada em breve pela OPAS, a qual afirmou apoiar fortemente.

Referiu que no caso do Brasil, apesar do êxito do programa de AIDS, considera-se importante a iniciativa a ser lançada em breve pela OPAS que apoia fortemente. Considera que ainda que há uma resposta insuficiente para o problema da sífilis congênita, cuja atividade está sendo trabalhada em conjunto com a abordagem da transmissão vertical para AIDS.

Por último, anunciou que o Brasil deseja ampliar o trabalho de cooperação que já mantém com cinco países da Região e que no mês anterior em visita do Diretor da UNAIDS, Dr. Peter Piot, o mesmo anunciou, junto com o Ministro da Saúde, Humberto Costa, a criação de um Centro Internacional de Cooperação, com recursos iniciais de $1 milhão, e com funcionamento previsto para iniciar até o final de 2004, o que possibilitará um maior intercâmbio e maior compartilhamento da experiência brasileira com outros países da Região.

Le Prof. DRUCKER (France) souligne la qualité du rapport qui a été mis à la disposition du Conseil directeur sur le thème de l'intensification du traitement dans le cadre d'une réponse intégrée au VIH/SIDA.

La France souhaite rappeler son engagement politique volontariste dans le combat contre la pandémie de VIH/SIDA, engagement qui s'est traduit par un soutien technique et financier aux initiatives internationales de lutte contre le SIDA, notamment dans le domaine de la prévention et de l'accès au traitement. La France contribue ainsi à hauteur de €150 millions par an au financement du Fonds mondial de lutte contre le SIDA, le paludisme et la tuberculose, ce qui la place au deuxième rang des donateurs du fonds.

La France se réjouit du rôle moteur retrouvé par l'OMS dans la lutte contre le SIDA en lançant l'initiative « 3 millions d'ici 2005 » et adhère totalement aux principes qui sous-tendent cette initiative. Celle-ci constitue en effet un cadre conceptuel et un outil pratique pour faire face à une catastrophe humanitaire qui a un impact dévastateur sur les individus, les familles et les communautés et qui se révèlent également une menace à l'encontre du développement et de la sécurité mondiale. La France confirme donc son engagement à mettre à disposition de l'OPS son expertise pour renforcer l'action de l'Organisation dans la mise en œuvre de l'initiative « 3 millions d'ici 2005 ».

Le document de travail souligne par ailleurs, à juste titre, l'importance de rationaliser et de rendre plus cohérent le travail de la communauté internationale. La délégation française souscrit pleinement à cet objectif. Les institutions doivent en effet bâtir ensemble leur réponse en s'interdisant toute compétition entre elles.

L'action de l'OMS en appui aux pays est essentielle, notamment grâce au projet lancé à son initiative pour les achats, l'assurance de qualité et la recherche de sources d'approvisionnement pour donner aux pays en développement un accès plus facile aux meilleurs prix à des médicaments antirétroviraux de qualité. La France mettra également son expertise au service de l'initiative de l'OMS en matière de préqualification des antirétroviraux.

Le rapport met de façon pertinente l'accent sur la nécessité de nouvelles ressources financières. Il conviendrait, cependant, de s'assurer de l'efficience de

l'utilisation de ces fonds. Par ailleurs, les financements provenant des bailleurs de fonds étant destinés en grande partie à l'approvisionnement en antirétroviraux, des efforts doivent être consentis à court et à moyen termes à la formation des professionnels de santé qui en assurent la distribution et le suivi médical.

La problématique des capacités en ressources humaines constitue en effet un véritable obstacle à la mise en œuvre de stratégies cliniques complexes. À cet égard, les départements français des Amériques offrent de partager leur expérience et leur savoir-faire dans ce domaine, notamment dans la région des Caraïbes. La France encourage par ailleurs l'OPS à continuer à aider les pays dans l'élaboration de propositions réussies pour le fonds mondial.

Enfin, il conviendra de bien prendre en compte le problème des enfants orphelins, auxquels le document de travail fait référence et qui ne cesse de prendre de l'ampleur dans la région.

En conclusion, la délégation française soutient la résolution proposée au Conseil directeur relative à l'intensification du traitement dans le cadre d'une réponse intégrée au VIH/SIDA.

Mr. NEWTON (Saint Kitts and Nevis) said that his country endorsed the statement made by the Delegate of the Bahamas on behalf of CARICOM and supported the proposed resolution. He wished to acknowledge the support his country had received from PAHO and Health Canada, both of which had been providing ongoing assistance to its efforts to deal with issues pertaining to HIV and AIDS.

He also wished to highlight the efforts of the eight Member States of the Organization of Eastern Caribbean States (OECS) to engage in collective efforts to mitigate the negative impact of HIV and AIDS. They had successfully joined together to mobilize financial support from the Global Fund to implement several activities intended to focus on the provision of care, treatment, and support; prevention activities; and efforts to reduce and eliminate stigma and discrimination.

The collective efforts of the OECS countries complemented those made by national governments, mainly by raising additional financial resources. Challenges remained, however, and Saint Kitts and Nevis therefore requested continued support and assistance from PAHO and other agencies for Caribbean countries.

El Dr. RUÍZ MATUS (México) manifiesta el apoyo de su país a esta resolución. Es importante asegurar la disponibilidad de medicamentos, siempre que sean de alta calidad y garanticen la atención adecuada de los pacientes. Añade que México está en un proceso de acreditación y certificación de todas las unidades especializadas de atención

existentes. También debe garantizar la existencia de pruebas de laboratorio de calidad que permitan un seguimiento adecuado de estos tratamientos. Las acciones de prevención e información a la población y a los grupos de riesgo son un elemento importante y trascendente para tener éxito en el control de ese flagelo.

La participación de la sociedad civil es un elemento importante en esta lucha, por lo cual México se adhiere a la propuesta de modificación de la resolución hecha por Canadá para expresar explícitamente la necesidad de la participación de la sociedad civil.

El compromiso político es un elemento importante en esta lucha. En México existe el Consejo Nacional de Prevención y Control del VIH/SIDA, en el cual participan todas las instituciones oficiales y las principales instituciones privadas de salud, así como la sociedad civil. Los recursos financieros destinados al control de esta epidemia entre 2000 y 2004 han aumentado 15 veces, lo que representa el compromiso importante del Gobierno.

Finalmente, reitera la posición del Gobierno mexicano de apoyo a la resolución y al documento y las orientaciones estratégicas.

O Dr. STEIGER (Estados Unidos de América) disse que não iria repetir as palavras do Secretário Thompson, ditas na segunda-feira, porque todos perceberam a paixão e a dedicação pessoal que o mesmo coloca nessa luta. Afirmou que seu país respalda totalmente a ênfase na necessidade de ação urgente no Caribe e discutiu dois pontos adicionais:

Primeiro, disse que é amplamente conhecido que 20 países da Região das Américas têm recebido recursos do Fundo Global nos últimos três anos, além de cinco grupos de países do Caribe e da América Central, que também receberam recursos. Informou que existem dois representantes das Américas no Conselho Executivo desse Fundo—uma vaga ocupada pela Dra. Carol Jacob, de Barbados, e outra pelos Estados Unidos, que é considerado um representante da Região. O Dr. Steiger também informou, que o Secretário Thompson é o presidente deste Conselho mas também um aliado da Região no mesmo.

Afirmou que seu país está disponível e quer ajudar na implementação desses projetos nos países das Américas, em caso de os países terem problemas na implementação ou na negociação com o Secretariado em Genebra. Pediu que se faltar alguma coisa para assinar o acordo com o Fundo Global, favor informar ao Secretário—um amigo no Conselho, pois ele poderá ajudá-los no processo de concretização e implementação dos projetos do Fundo Global na Região.

Segundo, disse que gostaria de lembrar a todos países das Américas que, no último mês de maio, a *Food and Drug Administration* (do seu Departamento) criou, por liderança do Secretário Thompson, um novo caminho, um processo novo e acelerado para revisar e aprovar medicamentos antirretrovirais para uso tanto no Caribe como na África, segundo o plano americano—o Plano do Presidente Bush contra a AIDS.

Solicitou que se qualquer empresa estiver interessada poderá fazer uma aplicação para receber a licença e ser elegível para esse projeto americano contra a AIDS nos 15 países, África, o Caribe e agora no Vietnam (o novo país). Pediu que por favor divulgassem, que existe informação disponível para qualquer empresa das Américas que queira participar nesse novo processo de aprovação. O programa dispõe de $15 bilhões para os próximos cinco anos. Finalizou dando apoio à resolução apresentada ao Conselho Diretor.

El Dr. VIZZOTTI (Argentina) dice que en Argentina cada vez es mayor la transmisión sexual del VIH, especialmente en la población heterosexual. Ésta es la principal vía de transmisión y va disminuyendo la de usuarios de drogas. Recientemente se han adoptado numerosas medidas de prevención, promoción con entrega de preservativos y asistencia a los pacientes que viven con VIH/SIDA. También se realiza la cobertura de reactivos a 100% de las embarazadas al igual que de las madres VIH positivas y sus hijos.

El orador sugiere que en la resolución, donde dice *personas infectadas por el VIH/SIDA*, se diga *personas viviendo con VIH/SIDA*, y que se añada un artículo en el cual se diga que *la OPS continúe promoviendo el intercambio de información de los precios y facilitando entre los países el análisis de las diferentes estrategias conjuntas de negociación para aumentar la accesibilidad a los medicamentos antirretrovirales en los Estados Miembros*. Asimismo, la resolución debería hacer énfasis en las familias de las personas que viven con VIH/SIDA, en especial los niños.

El Dr. VILLACÍS (Ecuador) dice que su país respalda completamente el proyecto de resolución presentado. En este momento, en Ecuador hay 600 pacientes con VIH/SIDA que reciben tratamiento gratuito y exámenes de laboratorios; 5.000 pacientes diagnosticados; y 50.000 eventuales portadores no diagnosticados, lo cual es un riesgo y una preocupación constante. Se ha logrado reducir de $400 a $64 el precio del tratamiento que se proporciona gratuitamente.

Se está dedicando mensualmente 0,5% del presupuesto del Ministerio de Salud al programa de VIH/SIDA, y el Fondo Global, que asignará $7 millones durante tres años, servirá para iniciar actividades de promoción y prevención del ministerio y, como receptores secundarios, de las ONG especializadas en el tema. Se tiene la intención de desarrollar mecanismos legales, sociales y técnicos para diagnosticar a todas las personas

portadoras del virus y al mismo tiempo proteger sus derechos humanos en el proceso de identificación, y de desarrollar la promoción y prevención de esta enfermedad a través de un programa efectivo.

La Dra. ABREU CATALÁ (Venezuela) solicita que se agregue a las recomendaciones a la Directora un punto en el que se le pida que apoye a los países en la negociación e instrumentación de los derechos de propiedad intelectual en los tratados de libre comercio para garantizar el acceso de medicamentos antirretrovirales a la población. Esto enmarcado en los mismos principios que la OPS tiene reflejados en algunas de sus publicaciones y en declaraciones y leyes nacionales que de alguna manera apoyan las excepciones a esos tratados que los países están firmando. Esa es la propuesta específica.

Con respecto a las políticas de acceso a medicamentos antirretrovirales, desde 1998 Venezuela está trabajando intensamente en asegurar un suministro a toda su población, para lo que ha establecido mecanismos de negociación con empresas trasnacionales y negociaciones en conjunto a nivel de Sudamérica, la comunidad andina y otros países de América del Sur, que han logrado excelentes precios para la compra de medicamentos antirretrovirales y permitido sobre todo garantizar el acceso universal y gratuito a todas las personas que viven con VIH/SIDA, cuya cifra hoy se acerca a las 15.000. Sin embargo, ha habido algunos inconvenientes.

A raíz de que la OMS decidió ofrecer a los países medicamentos antirretrovirales precalificados, Venezuela decidió comprarlos, pero ha visto con desagrado y mucha sorpresa que en el transcurso de este último año varios medicamentos quedaban desprecalificados por la OMS. Propone que la reunión recomiende que los sistemas de precalificación sean más sostenibles, menos sensibles, menos lábiles, de forma tal que la precalificación perdure en el tiempo y los medicamentos no tengan que retirarse porque han sido desprecalificados con argumentos que no siempre son técnicamente sostenibles ni convincentes.

La Dra. SÁENZ MADRIGAL (Costa Rica) expresa su satisfacción a la Secretaría por haber retomado integralmente todas las recomendaciones.

A nivel de Centroamérica, destaca que algunos países han recibido financiamiento del Fondo Global, pero lo más importante es que se trata de la primera región que ha recibido fondos subregionales. Por otra parte, el Banco Mundial apoya un proyecto a nivel de la región centroamericana para fortalecer la capacidad de diagnóstico y la capacitación. En la próxima reunión de ministros de salud que se celebrará en El Salvador habrá oportunidad de ver los avances del proyecto a fin de que los ministros tomen decisiones para poder seguir contribuyendo a una atención integral del SIDA en Centroamérica.

En Costa Rica existe un consejo nacional del SIDA coordinado por el Ministerio de Salud, donde están integrados los diferentes grupos que trabajan en prevención, promoción, atención, etc., y desde hace dos años se ha incorporado este tema del SIDA en la agenda del Consejo Social donde están los ministros y los directores ejecutivos de organismos autónomos relacionados con el tema social, lo que ha permitido avanzar en los temas de educación, trabajo y vivienda.

Eso no quiere decir que se haya resuelto el problema ni mucho menos, pero esta experiencia podría ser un mecanismo importante para articular las acciones intersectoriales necesarias.

El Dr. ESTOL (Uruguay) apoya la resolución propuesta por el Comité Ejecutivo pero desea hacer algunas reflexiones. Uruguay es un país que tiene una muy baja prevalencia de SIDA, es el cuarto país en el mundo que ha integrado la terapia antirretroviral triple con gran éxito en la población. Aún así, en el futuro es preciso dar mensajes más convincentes y más claros para cambiar las conductas de la población.

Uruguay tiene una población con un 97% de alfabetización y, sin embargo, todavía persiste un 30-40% de población masculina que en sus relaciones ocasionales no usa preservativo. Por otra parte, 18% de los que utilizan drogas intravenosas son portadores del HIV, un 22% es portador de hepatitis B y un 23% de hepatitis C.

Todo esto lleva a una reflexión en cuanto al escenario futuro. Será preciso empezar a hablar a la población de forma mucho más clara, y en ese sentido tener modestia autocrítica y mirar la experiencia de algunos países africanos, como Uganda, con mensajes claros, elocuentes y directos, y decirles que si no hay cambio de conciencia, cambio de actitud, no habrá sostenibilidad de programas ni tratamientos posibles. Recomienda que esta cuestión se analice en el conjunto de la OPS para definir mensajes claros y directos destinados a toda la población.

La Dra. CUCHÍ (Observadora, Programa Conjunto de las Naciones Unidas sobre el VIH/SIDA (ONUSIDA)) dice que existe plena concordancia del ONUSIDA con la OPS sobre la necesidad de ampliar el tratamiento antirretroviral como parte de la respuesta integral a la infección del VIH en las Américas. El acceso a ARV no es solo una medida de salud pública, sino un derecho humano.

El Dr. Peter Piot, Director Ejecutivo de ONUSIDA, considera que el acceso al tratamiento de VIH es un reto que no es posible no afrontar. Asimismo, ha expresado en numerosas ocasiones la función crucial que desempeñan la OPS y la OMS en esta área.

La OPS y el ONUSIDA han caminado juntos desde el principio en el logro de la iniciativa “Tres millones para 2005”. La cooperación más reciente ha sido la reunión de

Jefes de Programa Nacional de VIH/SIDA y Sociedad Civil sobre ARV genéricos y TLC, en El Salvador este mes de septiembre. En la reunión participaron todos los países de Centroamérica, el Dr. Luiz Loures por parte del ONUSIDA, la OPS y varios representantes de otros organismos. Agradece a la OPS, y en especial al Dr. Eduardo Guerrero, Representante de OPS/OMS en El Salvador y Jefe del Grupo Temático de ONUSIDA, el excelente apoyo y coordinación de este evento.

La reunión se ocupó de la propiedad intelectual, los tratados de libre comercio y sus implicaciones en las compras futuras de insumos, y el tratamiento de VIH. La reunión de El Salvador marca el inicio del diálogo regional, donde en colaboración y coordinación con los países se busca lograr el marco legal necesario para que el acceso universal en la Región sea una realidad.

La Sra. CORONA (Observadora, Asociación Mundial de Sexología) felicita a toda la OPS por el enfoque integral adoptado en sus estrategias para enfrentar la pandemia del VIH/SIDA en la Región. Si bien el tratamiento en su eje principal, no soslaya y sí articula el papel fundamental de la prevención y la promoción de la salud, particularmente en los grupos más vulnerables.

La Asociación Mundial de Sexología reitera que la prevención y el tratamiento deben estar fundamentados por la visión integral de la salud sexual propuesta por la misma OPS, basada en el reconocimiento de los derechos sexuales de las personas y en los compromisos de los programas de acción de la Conferencia de El Cairo y de la Cuarta Conferencia de la Mujer. Estos compromisos incluyen pero no se limitan a la promoción de la abstinencia.

La Asociación reitera su voluntad de continuar colaborando con todos los países, ofreciendo su capacidad técnica y su experiencia programática, lo que también contribuye, como ya se ha dicho, al cumplimiento de uno de los Objetivos del Milenio propuestos por las Naciones Unidas. Finalmente, invita a todos los presentes al Congreso de la Asociación, que se celebrará en Montreal en julio del año próximo, uno de cuyo ejes temáticos será el de cuáles son los enfoques más adecuados para la pandemia del VIH/SIDA.

Dr. VLASSOF (PAHO), responding to comments made by delegates, pointed out that the important achievements in the Caribbean region were an excellent example of technical cooperation among countries. Delegates had mentioned a number of additional opportunities for such cooperation. Brazil was a very welcome partner, and PAHO was looking forward to working with the regional center that had just been established there to provide technical cooperation to countries in the Region. She had not mentioned the Three Ones in her presentation, but PAHO strongly supported that approach.

Several delegates had mentioned stigma and discrimination linked to HIV/AIDS. It was important to build on examples gathered from various parts of the world that had proven effective in breaking down stigma. Delegates had also underscored the importance of involving communities, and she agreed that more community involvement and pairing with volunteers would indeed be desirable.

Regarding the comments on the issue of prequalification of medicines and the removal of medicines from the prequalification list, PAHO recognized that the issue had caused real difficulties for some countries and had tried to respond individually to them, based on available information. Work was under way to produce a broader document dealing with issues of access to medicines, good manufacturing practices, and other issues of concern.

CONSIDERATION OF PROPOSED RESOLUTIONS PENDING ADOPTION
CONSIDERACIÓN DE LOS PROYECTOS DE RESOLUCIÓN PENDIENTES DE APROBACIÓN

Item 5.6: Scaling-Up the Treatment within a Comprehensive Response to HIV/AIDS
Punto 5.6: Ampliación del tratamiento como parte de la respuesta integral a la infección por el VIH/SIDA

The RAPPORTEUR presented proposed resolution CD45/PR.6, drawing attention to the amendments by Argentina, Canada, Dominica, and Venezuela.

Ms. VALDEZ (United States of America) said that as some of the changes were not only substantive but also referred to sectors beyond health, her Delegation would wish to discuss them overnight with the relevant departments within the United States Government.

Hon. Herbert SABAROCHE (Dominica) asked whether the reference to stigma should be understood as including the aspect of stigma and discrimination in the workplace. He pointed out that there had been no discussion of that aspect, or of its legal ramifications and implications.

Item 5.2: Regional Program Budget Policy
Punto 5.2: Política del Presupuesto Regional por Programas

Hon. John JUNOR (Jamaica), speaking as chair of the drafting group set up by the Council to examine the proposed resolution on Item 5.2, reported that the meeting of the group had been attended by representatives of 14 countries.

The group had studied three documents: the proposal made during the Council's sixth meeting by the Delegate of Trinidad and Tobago on behalf of CARICOM; the proposed resolution and the proposed amendments arising out of the comments received at the sixth meeting; and a revised table showing what the impact of the proposed changes would be, country by country, using the approved 2004-2005 budget as a basis. After reviewing the documents, the drafting group had offered additional amendments, which had resolved the concerns expressed by various countries.

In particular, a new preambular paragraph had been added: *Recognizing that countries that have achieved basic health indicators continue to be challenged and to require external assistance, yet notwithstanding, in the spirit of solidarity have agreed to the redistribution of resources to countries of greater need . . . .*

Operative paragraph 3 called for approval of the PAHO regional program budget policy as contained in Document CD45/7, but the words *with the following amendments* had been added, and then the four amendments were listed:

(a) In the reallocation of resources among countries, no country's core allocation should be reduced by more than 40% of its proportional allocation among countries as approved in the Biennial Program Budget, 2004-2005.

(b) The allocation to Key Countries, as identified in the Strategic Plan 2003-2007 for the Pan American Sanitary Bureau (Bolivia, Guyana, Haiti, Honduras, and Nicaragua), will be protected so that they do not experience reduction of their proportional share of the core budget with respect to the Biennial Program Budget, 2004-2005.

(c) The minimum level for the subregional component of the program budget is increased to 7%.

(d) The objectives for the use of the variable allocation among countries will be presented to the Subcommittee on Planning and Programming for approval at the time of presentation of the proposed Biennial Program Budget.

Additionally, operative paragraph 4 had been revised to read: *To ensure that the country allocations in the future PAHO program budgets, approved by the Council, are guided by the model approved in operative paragraph 3 above, to the phased in over three biennia in consultation with the countries, to ensure the least disruption to technical cooperation programs.*

Operative paragraph 6 had been deleted, and in the former operative paragraph 7, now 6, subparagraph (b) had been modified such that the evaluation of the Regional Program Budget Policy would be carried out after two biennia of implementation rather than three.

Finally, two additional subparagraphs had been added to operative paragraph 6:

(c) collaborate with Member States to promote more efficient modes of cooperation and to strengthen the capacity of those countries that will be receiving greater resources to ensure their effective and efficient use.

(d) ensure that the health information systems of all countries are improved to provide, among other things, reliable data that could be used for refining the model for allocation of resources among countries."

Decision: The proposed resolution, as amended, was adopted.[1]
Decisión: Se aprueba el proyecto de resolución así enmendado[1].

[1] Resolution CD45.R6
Resolución CD45.R6

ITEM 5.7: INTERNATIONAL HEALTH REGULATIONS: PERSPECTIVES FROM THE REGION OF THE AMERICAS
PUNTO 5.7: REGLAMENTO SANITARIO INTERNACIONAL: LAS PERSPECTIVAS DE LA REGIÓN DE LAS AMÉRICAS

Hon. Herbert SABAROCHE (President of the Executive Committee) reported that the Executive Committee had discussed the International Health Regulations in June 2004. The Committee had voiced strong support for the revision process, noting that the regulations adopted in 1951 were clearly insufficient in the current context of rapid, high-volume international migration, emerging infections, and increasing threats of bio-terrorism. It had stressed the need for regulations that were flexible but that clearly delineated the authorities and conditions under which WHO might recommend restrictions on travel or trade to contain the spread of disease.

The Committee had also emphasized the importance of active participation by Member States in the revision process and had commended PAHO for its role in facilitating that participation, which the Committee had seen as essential in order to arrive at a set of clear and balanced regulations that all Member States could embrace enthusiastically and implement fully.

It had been pointed out that the subregional consultations held in the Americas had not only produced helpful input that would assist WHO in redrafting the text of the regulations, but had also contributed to greater understanding among countries of the Region with respect to the challenges and opportunities for working together in response to public health emergencies of international concern.

The Committee had noted that the best way to prevent the international spread of diseases was to detect and contain them while they were still a local problem, which would require collaborative effort among countries. The Global Alert and Response Network (GOARN) had been cited as an excellent mechanism for effecting that collaboration.

It had been suggested that the next version of the document should contain a more detailed account of the recommendations that had emerged from the various subregional meetings. In particular, it had been felt that specific mention should be made of the recommendation from the North American consultation concerning the inclusion of a list of reportable diseases, which some countries in the Region believed was essential. The North American consultation had recommended that a list of specific diseases should be integrated with the algorithm that had been proposed for determining if an event constituted a public health emergency of international concern.

The Committee had not considered it necessary to adopt a resolution on the item; however, it had asked the Secretariat to take note of and transmit to WHO its comments on the revision of the International Health Regulations.

El Dr. LIBEL (OPS) dice que el SARS ha puesto de relieve que en el mundo se seguirán produciendo brotes de enfermedades graves inusuales y, por ello, es preciso disponer de un código de conducta para poder responder a situaciones de crisis. Este código debe proteger de la diseminación de enfermedades y del uso excesivo de medidas restrictivas no justificadas desde el punto de vista de salud pública.

El borrador del Reglamento Sanitario Internacional tiene, entre otros objetivos, la ampliación del número de enfermedades notificables, la posibilidad de trabajar con informaciones distintas de las oficiales, la inclusión en el marco del Reglamento de todas las acciones de preparación y respuesta a epidemias que se llevan a cabo en las Américas y en otras Regiones de la OMS, y la actualización de las medidas rutinarias que figuran en él, porque datan de 1951 y son obsoletas.

Entre los cambios sustanciales introducidos en el Reglamento destacan los siguientes. La ampliación del número de enfermedades notificables se vinculará con medidas de salud pública adecuadas al problema que se examina. Se han incluido puntos focales nacionales tanto para recibir información como para diseminarla en los países.

Es preciso que todos los países dispongan de las capacidades mínimas básicas de vigilancia y respuesta (detección y notificación, circulación de información entre las diversas instancias del país, infraestructura de los servicios de salud pública para dar una respuesta inmediata y eficaz a estos problemas, y relaciones nacionales e internacionales), así como de medidas sanitarias en puntos de entrada: puertos, aeropuertos y pasos de frontera.

Respecto a la colaboración de la OPS con los países en este ámbito, señala que desde 1998 la Organización disemina y promueve el intercambio de información con los países y entre ellos. Las redes que han establecido en cada una de las subregiones se dirigen a fortalecer las capacidades básicas señaladas, una actividad comparable con la llevada a cabo en el seno del CARICOM, MERCOSUR, el Organismo Andino de Salud y la Comunidad Andina de Naciones y la Reunión del Sector Salud de Centroamérica y la República Dominicana (RESSCAD) en Centroamérica. En las cuatro subregiones se han realizado consultas en busca de consenso político sobre el Reglamento y de la participación de otros sectores.

Por otra parte, se ha dado oportunidad a los Estados Miembros para que propongan cambios. Toda esta información aparece en el borrador final, disponible en seis

idiomas en la página web de la OMS, para que se revise en los países antes de la reunión del grupo intergubernamental, que se celebrará en noviembre en Ginebra.

Los puntos clave que los países han identificado como preocupación en el borrador anterior son la duda de que las capacidades básicas puedan estar disponibles en un plazo prudente y cómo lograr una amplia participación en las decisiones relativas a las medidas internaciones de salud pública, habida cuenta de que muchas de ellas habrán de tomarse en 48 horas. Por ello se han creado el comité de emergencia y el de revisión. Por último, caben dudas sobre el nivel jerárquico que deben ocupar los puntos focales y sobre el papel que han de desempeñar la OMS, las Oficinas Regionales y las Representaciones de la OPS en la implantación del Reglamento.

Por otra parte, en varios países de la Región se sugirió que en el instrumento de decisión propuesto —que funciona mediante un algoritmo de decisión— se incluyera un conjunto de enfermedades consideradas suficientemente graves para que constituyan por sí mismas una emergencia internacional, lo cual ha hecho ya la Secretaría.

Otro punto se refiere al uso de medidas máximas internacionales de salud pública, ante lo cual se ha manifestado la preocupación de que pueda entrar en conflicto con la soberanía nacional. Por consiguiente, ha de encontrarse un equilibrio entre lo que atañe al interés nacional y lo que constituyen responsabilidades solidarias internacionales.

La revisión del Reglamento está llegando a su término y el grupo intergubernamental de trabajo, que es un órgano de la Asamblea Mundial de la Salud, se reunirá dentro de dos semanas para preparar una propuesta final que presentará en la Asamblea Mundial de la Salud en mayo de 2005.

Dicho grupo de trabajo es la instancia que revisará por última vez el borrador para recomendarlo a la Asamblea Mundial de la Salud y, a diferencia de lo que tradicionalmente ocurre (sólo los países menos desarrollados reciben financiamiento de la OMS para su participación), en esta ocasión se financiará también la participación de un delegado de cada uno de los países que, de acuerdo con la clasificación económica de la Naciones Unidas, son de mediano-bajo desarrollo. Es importante resaltar también que a los Estados Miembros les compete aprobar y adoptar el Reglamento.

Con la introducción de algunos cambios en el Reglamento se intenta lograr que la importancia internacional que pueda alcanzar una notificación corresponda a una situación que realmente sea una emergencia y represente un riesgo internacional. Del mismo modo se prevé aceptar notificaciones confidenciales y que la OMS y la OPS retengan la información hasta que se confirme.

El tiempo para adoptar medidas será limitado y dependerá del riesgo de la circunstancia que las reclame, y se han actualizado las medidas aplicables en los puntos de entrada. En definitiva, el Reglamento será el marco que permitirá introducir ajustes a lo que ya se viene haciendo en el ámbito de la cooperación técnica.

Dr. NIGHTINGALE (United States of America) said that his Delegation strongly supported WHO's effort to revise the International Health Regulations in partnership with Member States. The current regulations were obviously insufficient in view of today's rapid, high-volume international migration, emerging infections, and the increasing threat of bioterrorism. The revised regulations would need to be flexible yet clarify the authorities and conditions under which WHO might recommend measures to contain the international spread of disease without placing unnecessary restrictions on the movement of humans, animals, and cargo.

A careful balance was needed between efforts to contain disease and the pursuit of international trade, commerce, and global migration. The revision process was complex, and the United States encouraged WHO to continue its leadership role to permit the adoption of clear and balanced IHRs that all Members States could enthusiastically embrace and fully implement. While his Delegation had found the first proposed revision of the IHRs to be a good initial effort, it had had a number of general and specific concerns which it had delineated in written submissions to the Director-General of WHO.

The major concern related to his country's firm belief that the IHRs must contain a list of specific diseases that had to be reported in their own right and not merely trigger the use of an algorithm. While the United States supported the use of an algorithm to determine certain public health emergencies of international concern, it strongly believed that the IHRs should also require reporting of a defined list of certain known serious communicable diseases that had the potential for creating a public health emergency of international concern. Although the algorithmic concept was a good one, relying solely on a nonspecific construct was insufficient. The United States believed that the list should be integrated as the first part of the first section of the algorithm.

Additionally, the United States believed that Member States should retain the right to impose measures in excess of those recommended by WHO for valid public health and scientific reasons, but should then be required to provide WHO with their rationale for so doing. It had prepared a "White Paper" listing a number of diseases that should be on the list because they fall within one or more specific categories, including communicable diseases that could be spread through the droplet or aerosol route and had life-threatening or severe consequences, or selected vector-borne diseases that could be translocated to nonendemic countries with comparable vectors.

Le Dr CORRIVEAU (Canada) indique que le Canada continue à appuyer fermement les modifications proposées au règlement sanitaire international. Le Canada avait accueilli avec plaisir la Consultation sous-régionale de l'Amérique du Nord à Ottawa, en juin 2004, à laquelle ont également assisté des représentants d'autres sous régions de l'OPS. Il prépare activement la réunion de l'OMS qui aura lieu à Genève du 1er au 12 novembre prochain.

Dans le cadre des préparations nationales, le Canada évalue actuellement ses capacités à se conformer aux dispositions du règlement et il a mis en place un comité /interministériel sur le règlement sanitaire international, composé de représentants des ministères gouvernementaux clés, notamment les Affaires étrangères, Citoyenneté et Immigration, Commerce international, ainsi que celui des Transports.

Des consultations sont également effectuées auprès des partenaires des gouvernements provinciaux et territoriaux qui sont responsables des activités courantes de la protection de la santé publique et de surveillance de la maladie.

Le Canada a également entrepris des consultations auprès des intervenants clés nationaux et régionaux du secteur privé et celui des organisations à but non lucratif, y compris les secteurs industriels de l'expédition, du transport et du voyage, les autorités aéroportuaires et portuaires et les groupes d'intérêt en matière de consommation et de santé.

La création récente de l'Agence de Santé publique du Canada constitue un développement nouveau concernant le développement révisé. Cette initiative découle des préoccupations soulevées par l'épidémie du SRAS à l'égard de la capacité du réseau de santé publique au Canada à prévoir les menaces à la santé publique et à y répondre efficacement. La nouvelle agence et l'administrateur en chef de la Santé publique du Canada permettront de focaliser le leadership et la responsabilisation du gouvernement fédéral en matière de gestion des urgences de santé publique au Canada.

Le Canada poursuivra sa participation active à la protection de la sécurité mondiale dans le cadre du Réseau mondial d'information sur la santé publique et du Réseau mondial de vigilance et d'interventions contre les flambées épidémiques. Ensemble ces entités fournissent de l'information clé sur la santé publique, concernant les risques sanitaires mondiaux et offrent des mécanismes de vérification et d'intervention d'urgence en cas d'éclosion.

Le document de discussion souligne adéquatement plusieurs enjeux révisés qui ont été soulevés au cours des consultations et qui devront être résolus avant l'adoption du nouveau règlement. Dans une perspective générale, il faut trouver un équilibre entre la souveraineté des États Membres et les mécanismes de coopération internationale

efficaces pour le Règlement sanitaire international (RSI), clarifier la portée et l'application des dispositions, surtout en ce qui concerne les autres accords internationaux et clarifier, également, les rôles et les fonctions dans la mise en œuvre du RSI; une démarche à laquelle collabore actuellement les divers gouvernements et agences du Canada.

Le souci du renforcement des capacités dans les pays en développement demeure un enjeu majeur, étant donné que certains pays ont exprimé leur préoccupation à l'égard du respect des exigences de base en matière de capacités. Il faut donc que l'OMS fournisse une assistance pour évaluer les ressources requises par les États Membres, leur permettant d'atteindre les capacités de base requises et mieux encadrer la mise en œuvre du règlement.

Enfin, le Canada s'inquiète du calendrier établi pour l'adoption des révisions du RSI. Tout en travaillant dans un esprit de coopération, compte tenu de la portée de ces révisions, il est d'avis qu'il y aurait lieu de prévoir une autre réunion intergouvernementale au printemps 2005 avant l'Assemblée mondiale de la Santé au mois de mai.

La Dra. PÉREZ XIQUES (Cuba) expresa su conformidad con el documento y dice que en él se han incluido las recomendaciones que Cuba, la República Dominicana y los países de Centroamérica acordaron hacer en una reunión celebrada en abril, así como las experiencias acumuladas por el sistema de alerta y respuesta y los laboratorios de Cuba.

Le Dr QUÉNEL (France) félicite le Secrétariat pour la qualité du document soumis au Conseil directeur et pour la richesse des échanges qui ont eu lieu lors des consultations régionales. Les évènements récents d'alerte mondiale, tel que la ré-émergence du SRAS ou le risque de survenance d'une pandémie de grippe aviaire, ont clairement démontré la nécessité d'une coordination internationale pour l'évaluation et la gestion de ces situations. Dans ce contexte, la délégation souhaite rappeler les principales positions de la France concernant la révision du règlement sanitaire international.

Premièrement, l'élargissement du champ d'application du règlement sanitaire international, et par corollaire du champ d'action de l'OMS, à toutes les urgences sanitaires de portée internationale quelle qu'en soit l'origine, biologique certes, mais aussi chimique ou radiologique, ainsi que les évènements d'origine à priori inconnue plutôt que de se limiter à une liste fermée de maladies infectieuses. Deuxièmement, la désignation au sein de chaque État d'un point de contact unique afin de faciliter l'interface avec l'OMS. Enfin, dans la mesure où certains États ne disposent pas toujours

des moyens nécessaires à l'application immédiate du RSI, la nécessité d'une assistance forte de l'OMS aux États afin de les aider à renforcer leurs capacités nationales.

Plus généralement, concernant la sécurité sanitaire mondiale, la France souhaite souligner trois points : 1) Premièrement, la nécessité d'un rôle moteur fort de l'OMS concernant les urgences sanitaires internationales, étant donné que la sécurité sanitaire mondiale représente l'une des missions essentielles de l'OMS. 2) Deuxièmement, la nécessité de renforcer la solidarité dans les pays, en particulier concernant la transparence et la réactivité dans la transmission des informations, notamment de nature épidémiologique et dans la circulation du matériel biologique. Ces principes de transparence et de réactivité sont au cœur de la problématique de l'alerte. 3) Troisièmement, l'importance d'élaborer des plans nationaux pour une gestion efficace des urgences sanitaire et l'importance de se préparer collectivement à l'éventualité d'une pandémie, notamment de type grippe aviaire.

En conclusion, la finalisation du processus de révision du règlement sanitaire international doit constituer une priorité pour les mois à venir. La France demeure attachée au respect du calendrier prévu, adopté lors du Conseil exécutif de janvier 2004.

Hon. Leslie RAMSAMMY (Guyana), speaking on behalf of CARICOM, said that globalization, with its phenomenal increase in international transportation of both people and cargo, had led to new threats. Outbreaks of disease, epidemics, and epizootics constituted a permanent threat in the globalized world. It was necessary, therefore, to have a good system of detecting such events promptly and implementing the appropriate control measures to counter the terrible speed with which those threats could spread.

The countries of CARICOM saw the IHR as the most effective vehicle to ensure partnership-based action to alleviate and prevent public health emergencies of international concern. CARICOM had supported WHO's initiative to enhance the International Health Regulations and continued to work within PAHO to ensure that the Region's input into their revision would be substantial. To that end a consultation meeting for the English-speaking Caribbean countries had been held in Grenada on 19 and 20 April 2004. At that meeting a number of concerns had been raised.

One such concern was that several of the countries in the Region and the regional epidemiological center still lacked the capacity to respond to disease outbreaks. In some cases, such capacities existed but needed enhancing. WHO and PAHO and regional and country partnerships would need to identify additional financial and technical resources if such capacities were to be attained rapidly enough.

In the CARICOM area, the Caribbean Epidemiology Center (CAREC) represented one initiative that the countries had undertaken to facilitate rapid response to

disease outbreaks. Through CAREC which was a source of collective core capacity, CARICOM hoped to build capacities in each country. In addition, with CAREC as a clearinghouse, and in collaboration with PAHO, a subregional surveillance network had been initiated.

The CARICOM countries suggested that a special fund should be established to support the development and enhancing of countries' surveillance and epidemiological capacities in order to permit their effective participation in the International Health Regulations. One important purpose of such a fund should be to offset economic losses during a public health emergency of international concern.

WHO should also consider establishing a deadline by which all countries should attain, at least, basic surveillance and epidemiological capacities. CARICOM urged caution in the management of the country focal point. The focal point was a facilitating position for local administration, and it needed to be ensured that its personnel reported to WHO only after obtaining approval of local authorities. WHO Regional Offices should serve as the conduit for information between countries.

The CARICOM countries supported the call for a list of diseases that were reportable. In addition, they believe that the IHR should focus more on disinfection and deinfestation of goods and materials being transported from one country to another. Moreover, WHO must vigorously pursue harmonization and standardization of IHR-related procedures. Greater clarity was required with respect to container-loading areas, as well as in the definition and identification of public emergencies of international concern. While countries were required to identify focal points, WHO was not required to do the same within the context of the IHR; that oversight should be corrected.

The IHR as they related to transport of biological materials, and indeed in all other aspects, must ensure compliance with the rules of the International Air Transport Association (IATA). The CARICOM countries stood ready to play a positive role in enhancing the International Health Regulations.

O Dr. BARBOSA DA SILVA (Brasil) parabenizou a OPAS por ter conduzido um processo extremamente aberto e amplo em toda a Região, com a realização das reuniões sub-regionais o que propiciará uma participação muito propositiva dos países da Região na reunião intergovernamental a ocorrer em novembro que provavelmente, se obtido um elevado grau de consenso, facilitará a aprovação do novo regulamento sanitário internacional na próxima Assembléia Mundial de Saúde.

Informou que o Brasil vem participando junto com a OPAS, desde 1999, envolvendo também os países que compõem o MERCOSUL, que testou e fez uma série de discussões pertinentes ao aperfeiçoamento das primeiras reações ao regulamento

sanitário internacional, particularmente no que diz respeito aos instrumentos de decisão para a definição de emergências sanitárias internacionais, procedimentos em portos, aeroportos e assim por diante.

Disse acreditar que é uma das mais importantes decisões que serão tomadas na próxima Assembléia Mundial de Saúde, a revisão do Regulamento Sanitário Internacional, pela completa incapacidade do atual Regulamento de detectar coerentemente os riscos existentes no cenário internacional, tendo em vista a emergência de doenças,entre outros, e também pela sua pouca possibilidade de ampliar a capacidade de resposta, tanto do nível nacional, com a definição de habilidades mínimas que todos os países devem ter para fazer frente a essas ameaças, como também o reforço do papel que a OMS e seus Escritórios Regionais devem ter na assessoria e na resposta que os países precisam diante de situações emergentes como essa.

Afirmou, mesmo sem ter visto ainda a nova versão do documento, crer que o mesmo tem incorporado vários questionamentos que os países fizeram sobre o problema do ponto focal, de maneira que o ponto focal garanta agilidade mas não retire a função de governo e a função de autoridade sanitária dos ministérios da saúde, nem sua responsabilidade; a combinação de uma lista ampliada de doenças também submetidas complementarmente ao próprio instrumento de decisão, algoritmo de decisão para emergência.

Disse ainda crer que todos esses melhoramentos farão com que a proposta apresentada e debatida em novembro aproximar-se-á muito de um Regulamento Sanitário Internacional capaz de fazer frente às ameaças do presente.

El Dr. PESQUEIRA (México) considera adecuada la decisión de la Asamblea de la Salud de que se prepare una revisión del Reglamento Sanitario Internacional, habida cuenta del contexto de riesgos prevalente. En México, ese contexto ha propiciado un proceso participativo encabezado por el sector de la salud, en el que participa también un amplio conjunto de sectores de la sociedad. Es necesario alcanzar un equilibrio entre la soberanía de los países y sus responsabilidades solidarias a escala internacional.

El orador subraya la necesidad de que en el texto del nuevo Reglamento se establezca con claridad la representatividad del punto de contacto nacional y la identidad del punto de contacto de la Organización, así como las funciones de las oficinas en los países y las Oficinas Regionales.

Coincide con el Delegado de Guyana en que se formulen reglas muy claras en cuanto al modo y a los plazos en que los países han de adquirir la capacidad necesaria para responsabilizarse del cumplimiento de las obligaciones que se deriven de este instrumento, y señala la importancia de que los países efectúen una revisión exhaustiva

de los instrumentos internacionales de los que sean signatarios, para determinar posibles contradicciones o contraindicaciones.

Hay que fijar reglas muy claras de discreción en el manejo de la información, puesto que cualquier error en ese sentido puede tener importantes consecuencias políticas, económicas y sociales. El orador se felicita por las valiosas aportaciones que han efec-tuado numerosos países de la Región.

El Dr. GARCÍA (Chile) considera de gran importancia que se respeten y se consideren permanentemente los intereses de los Estados Miembros, manteniendo el adecuado equilibrio con los intereses de las demás partes. En particular, el punto focal, o centro nacional, no debería notificar a la OMS sin autorización previa de la instancia nacional competente. La plena adhesión a los objetivos de los procedimientos de notificación sólo se logrará si los Estados son informados permanentemente en situaciones de alerta.

Del mismo modo, hay que prever sistemas de monitorización de público conocimiento sobre el grado con que los Estados colaboran y respetan la legislación acordada. El orador se felicita por esta iniciativa de construcción participativa que significará un gran adelanto para la salud mundial.

La Dra. ABREU CATALÁ (Venezuela) desea consignar un aspecto fundamental que tiene relación con la dinámica en relación con el Reglamento Sanitario Internacional. En ese sentido, felicita a la Secretaría porque ello ha permitido no solamente un trabajo interesante a nivel de todos los países sino también dentro de ellos sectorial y transectorialmente. En Venezuela, como en la mayoría de los países se desarrolló un amplio proceso de consulta y de consenso que puede ser muy valioso para otros temas en relación con la salud.

También felicita a la Secretaría porque reflejó en su exposición algunos de los aspectos fundamentales en cuanto a las dudas o a los aspectos que preocupan a los países en la aplicación del Reglamento. Se une a los comentarios que han hecho los países en relación con las competencias de los puntos focales de las Representaciones de la OPS en los países y con el papel de la OMS, y cree que se puede avanzar mucho en función de la dinámica que se ha establecido de amplios procesos de consulta.

Finalmente, destaca algunos comentarios que se han hecho en varios de los artículos, algunos básicamente de forma, probablemente producto de las traducciones, y otros que tienen que ver con elementos no incluidos como los casos de fronteras o los que tienen que ver con elementos químicos, físicos y ambientales que afectarían este debate.

El Dr. LIBEL (OPS) dice que los comentarios de los delegados reflejan la amplia participación que se ha producido en la revisión del Reglamento. Debe aún decidirse si, además de las enfermedades transmisibles, el Reglamento ha de englobar los riesgos químicos y las radiaciones, que por el momento forman parte de otros acuerdos de las Naciones Unidas.

Respecto a los puntos focales, señala que sus funciones deben estar claramente definidas y que la OPS ha propuesto que sean los ministros quienes deleguen directamente las responsabilidades, y añade que la OPS ha creado un grupo de trabajo para garantizar la participación de todas las unidades en la aplicación del Reglamento.

The meeting rose at 6:30 p.m.
Se levanta la reunión a las 6.30 p.m.

ANNEX A
ANEXO A

ITEM 5.5: ACCESS TO MEDICINES *(cont.)*
PUNTO 5.5: ACCESO A LOS MEDICAMENTOS *(cont.)*

Mr. LOH: As an international community of medical students hailing from all over the world, we are acutely aware of the problems of equal drug distribution and usage in different countries and the impact this has on the health care delivery and efficacy.

As Canadian medical students, we are constantly reminded that drugs we learn about in our curriculum that may seem ubiquitous to us are often times of a lesser quality or unavailable in the majority of countries in our region.

In the context of our organization, I am always impressed by the readiness with which our members attempt to redress this injustice. Many efforts are under way to educate our future colleagues worldwide about the basics of this challenge and to enlist their help in correcting this inequality.

In this regard, we commit ourselves to the collaboration with governments in our respective countries, with WHO and PAHO, and all those who are striving for the goal of access to medications that is on a need basis at reasonable cost and expense without toll upon the individual's freedom and health.

We would therefore like to stress the importance of involving young physicians in processes that provide the opportunity to redress these inequalities, either through public education, discussions with key players in this issue, and the like, in order to ensure that the future generation is fully aware of the differing opinions in the matter.

As future physicians and advocates for health and global equality, we resolve to ensure that:

1. Our colleagues and peers, juniors, and the public at large are informed about the issue surrounding access to medicines in their nations and the world as a whole.

2. We carefully discuss the issue surrounding sponsorship by pharmaceutical companies and the impact it has on access to medications.

3. We carefully consider the function, proper use, and abuse of patent laws with regard to medication research and delivery.

4. We challenge inequalities in distribution and delivery with internal and external programs from our collaborations designed to nullify the inequality as far as possible.

5. We develop young physicians and leaders who are sensitive to these issues and are able to critically assess the situations related to medication access as they arise, and who are able to apply this knowledge to their future practice in medicine.