ORGANIZACIÓN PANAMERICANA DE LA SALUD
ORGANIZACIÓN MUNDIAL DE LA SALUD

41.er CONSEJO DIRECTIVO

51.ª SESIÓN DEL COMITÉ REGIONAL

San Juan, Puerto Rico, 27 de septiembre al 1 de octubre de 1999

PRIMERA REUNIÓN
FIRST MEETING

Lunes, 27 de septiembre de 1999, a las 9.00 a.m.
Monday, 27 September 1999, at 9:00 a.m.

Presidente: *President*:	Dra. María Urbaneja	Venezuela
Después: *Later:*	Dra. Carmen Feliciano de Melecio	Puerto Rico

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ITEM 1: OPENING OF THE SESSION

A. Apertura de la sesión por la Presidenta saliente, Dra. María Urbaneja (Venezuela)
A. Opening of the Session by the Outgoing President, Dr. María Urbaneja (Venezuela)

The SECRETARY said that under the Rules of Procedure of the Council, the presence of at least 20 Members was required for a quorum. Thirty-five Members were present, and therefore a quorum had been established.

La PRESIDENTA pide disculpas a los delegados en nombre del Ministro de Salud y Desarrollo de Venezuela, que no ha podido estar presente en la sesión. Seguidamente saluda a todos los delegados y declara abierta la sesión.

B. Palabras de bienvenida de Sir George Alleyne, Director de la Oficina Sanitaria Panamericana
B. Welcoming Remarks by Sir George Alleyne, Director of the Pan American Sanitary Bureau

Sir George ALLEYNE (Director) welcomed the delegations to the Council and expressed sympathy to the Bahamas and the United States of America, which had been affected by Hurricane Floyd. He thanked the Government of Puerto Rico for its hospitality and noted that the Governor, who was himself a physician, had taken a special interest in health. The Directing Council was meeting outside of Washington for the first time in 21 years. In addition, the Pan American Health Organization was celebrating its fiftieth anniversary as the Regional Office for the Americas of the World Health Organization. All those circumstances augured well for the success of the current meeting.

C. Bienvenida en nombre del Miembro Asociado anfitrión por el Honorable Pedro Rosselló, Gobernador de Puerto Rico

C. *Welcome on Behalf of the Host Associate Member by the Honorable Pedro Rosselló, Governor of Puerto Rico*

El Dr. ROSSELLÓ (Gobernador de Puerto Rico) dice que es un triple privilegio para él recibir a los delegados con los brazos abiertos en tierra borincana. Primero, como Gobernador, se siente honrado por la selección de su isla para la celebración de tan importante reunión. Este hecho coloca a Puerto Rico en un lugar destacado en el continente, pues los asuntos que se han de tratar tienen una trascendencia que es vital para todas las sociedades.

También es un privilegio para él, como médico, darles la bienvenida a colegas y profesionales de la salud que tienen en su mente y en su corazón un ideal vibrante y continuo que alienta esfuerzos supremos por aliviar el sufrimiento humano. Cuando las personas que comparten ese mismo entusiasmo se reúnen para intercambiar ideas y/o experiencias, nada que no sea positivo y edificante ha de salir de esas deliberaciones.

Hay otra razón que lo lleva a sentirse honrado como puertorriqueño y orgulloso de formar parte del equipo que ha implantado en Puerto Rico una reforma de salud de amplio alcance, sobre la cual desea compartir algunas ideas. Dista de ser su intención dar a entender que el modelo que se ha desarrollado en la isla es perfecto y adaptable a todas las circunstancias. Por el contrario, la reforma implantada es un proceso activo y vibrante que representa una evolución clara y decisiva. Como premisa, parte de una base ya conocida: lograr un servicio de salud de calidad independiente de la capacidad económica del paciente, lo que equivale a lograr que la salud sea un derecho de todos y no un privilegio de algunos.

Por décadas el sistema implantado por los gobiernos locales adoleció de problemas familiares y recurrentes: falta de recursos, servicios de mala calidad, prevención casi inexistente, originalidad limitada, burocracia, falta de motivación. Por eso hizo falta un cambio radical, esencial y completo, desde la base y desde el principio.

El primer cambio de filosofía fue buscar que el Departamento de Salud cumpliera, primordialmente, una función preventiva y directriz en su objetivo de promover una mejor salud en todos los estratos de la ciudadanía. Para lograrlo debía liberarse de la pesada carga de prestar casi exclusivamente servicios de salud curativos, porque además de que lo hacía de manera deficiente y poco eficaz, dicha carga le restaba energía y enfoque a su labor fundamental: la prevención y la promoción de la salud pública. Se sabía, además, que aunque no se debía ni podía renunciar a la responsabilidad de lograr

que las personas recibieran servicios clínicos curativos de calidad, sí se podían buscar los medios e instrumentos para que estos fueran más efectivos y justos.

A principios de esta década, era fácil apreciar que en Puerto Rico existían dos sistemas paralelos que funcionaban simultáneamente pero que eran desiguales. El sistema privado, destinado a las personas de abundantes recursos económicos contaba con amplios servicios, permitía la libre selección de proveedores y tenía solvencia económica. El otro sistema, que estaba en manos del Gobierno y se destinaba a las personas de bajos ingresos, tenía una carencia relativa de recursos, un futuro incierto y un presente de dudosa calidad, además de limitaciones que iban en aumento, resultados poco satisfactorios y un descontento generalizado. De ahí que hubiera que realizar un cambio profundo que permitiera tomar un rumbo decididamente diferente.

Inspirados en los más altos principios salubristas se buscaba equidad —es decir, un sistema que fuera igual para todos— y también eficiencia, o un sistema que invirtiera los recursos disponibles para sacarles un máximo de utilidad y rendimiento. Es innegable que el concepto era arriesgado y debía estudiarse en detalle, pero a la vez no dejaba de ser fascinante.

Así, hace seis años ya, más de 400 expertos en salud —médicos, dentistas, farmacéuticos, gerentes, personal de enfermería, administradores, en fin, cientos de profesionales unidos por el único interés de reestructurar lo que no estaba funcionando bien— se unieron a un gobierno decidido a definir una fórmula de cambio que ofreciera más esperanzas de rehabilitación para el paciente y mejores perspectivas de salud para todo un pueblo.

La reforma de salud de Puerto Rico fue aprobada por mayoría legislativa en septiembre de 1993 y en diciembre del mismo año 48.200 personas antes denominadas "médico-indigentes" de la ciudad de Fajardo recibieron las primeras tarjetas de salud. Desde ese momento en adelante más de un millón y medio de puertorriqueños se han ido sumando a la gran masa de beneficiarios de esta reforma. Si se les pregunta qué sistema prefieren ahora, si el actual o el anterior, más del 94% declaran que prefieren el actual. Y ello no es una casualidad. Sus posibilidades de escoger han mejorado muy notablemente; hay 3,8 veces más centros de cuidados primarios; 4 veces más hospitales; 4,3 veces más médicos; 8 veces más farmacias y 8 veces más laboratorios.

Anteriormente, casi ningún hospital del Departamento de Salud contaba con dentistas, higienistas y asistentes dentales que velaran por la salud bucodental del pueblo. Hoy en día pueden escoger entre 1.082 profesionales en toda la isla. La población ya no tiene que mendigar medicinas en los municipios y ahora abundan los centros con servicios para atenderla.

Por su parte, el Departamento de Salud se ha podido dedicar más de lleno a su labor ministerial de velar por la salud general de la población y ahora rinde frutos impresionantes. En 1992 se notificaron 2.442 casos nuevos de infección por el virus de la inmunodeficiencia humana. En 1998, esta cifra se había reducido en 53%. La reducción de la infección en sus víctimas más inocentes, los recién nacidos, ha sido mayor aún. En 1992 se notificaron 49 casos en niños, pero en 1998 la cifra se redujo a solo dos casos y ese mismo año no se produjo una sola defunción en niños diagnosticados con el virus.

Otra estadística alarmante era la de 13 defunciones por cada 1.000 niños nacidos vivos en la isla que se observaron en 1992. En 1998 esta cifra de mortalidad infantil se había reducido a 9,5 defunciones por 1.000 nacidos vivos y todo parece indicar que se llegará al nuevo siglo habiendo logrado la meta definitiva de una tasa redondeada de 9 defunciones por 1.000 nacidos vivos.

Pero no son solamente estos resultados concretos los que revelan la nueva dirección eficiente del Departamento de Salud: esta también se manifiesta en el marcado adelanto de los servicios médicos avanzados, como el programa de trasplantes de corazón, que ya cuenta con sus primeras operaciones exitosas en la isla. Estas iniciativas se suman a los programas ya establecidos de trasplantes renales y de médula ósea. De igual manera se logró establecer un importante centro de tratamiento avanzado para la rehabilitación de pacientes que han sufrido accidentes graves y operaciones complejas.

Asimismo, la industria hospitalaria ha cobrado un auge sin precedente; ha ampliado sus instalaciones e incorporado nuevas tecnologías. Las camas de los hospitales han aumentado de 6.500 al comienzo de esta década a 9.200 en la actualidad, cifra que representa un incremento de más de 90%, y en el mismo período los empleados del sector hospitalario han aumentado de 18.000 a 31.000.

Como si todo lo antedicho fuera poco, el nuevo Departamento de Salud ha logrado que Puerto Rico sea reconocido como la jurisdicción de los Estados Unidos de América que ha alcanzado los avances más notables en el campo de la vacunación infantil, cuya cobertura ha aumentado de 38,4% en 1992 a 94% en 1999, y es la más alta que ha tenido la nación.

Estos logros se reflejan en la historia de la salud en Puerto Rico, donde el SIDA, que ocupaba el cuarto lugar entre las causas de defunción en 1992, ocupa actualmente el duodécimo lugar. Mientras que en 1990 se notificaron 1.890 casos de sarampión, en los últimos dos años no se ha notificado un solo caso. Y de 50.000 tratamientos preventivos que se ofrecieron en 1993 en el campo de la salud bucodental, en 1999 la cifra ha aumentado a más de 350.000.

Así de sencillos, claros e irrefutables son los resultados de la revolución que se ha producido en el campo de la salud en Puerto Rico. Surgen entonces algunas preguntas obvias: ¿Se ha encontrado la respuesta que se buscaba? ¿Es esta la panacea soñada? No lo parece aún. La reforma, como ya señaló al principio el orador, es un ente vivo con aspectos que aún deben mejorarse. Por ejemplo, la competitividad y eficiencia en la prestación de los servicios son factores importantes, pero no deben oponerse a la calidad de los servicios médicos. De ahí que hace unos años se haya ratificado en la legislatura un proyecto de ley que garantiza los derechos fundamentales del paciente, una carta de derechos que regirá el nuevo esquema de seguros de salud privados. Asimismo, este año se aumentará el número de personas con derecho a participar en el programa de seguros, incluidos los ciudadanos del último de los 78 municipios y los empleados públicos del gobierno central.

En nuestro desarrollo continuo también figura la oferta de incluir, a bajo costo en los planes de la reforma, a las pequeñas y medianas empresas privadas que voluntariamente deseen que sus empleados gocen de una amplia cobertura de servicios de salud. Como resultado de esta iniciativa, dentro de menos de un año Puerto Rico habrá logrado la soñada meta de los salubristas de proveer igual acceso a todo ciudadano por medio de seguros de salud que cubrirán a casi toda la población.

Hasta el momento y en los años venideros, la reforma de salud del Gobierno de Puerto Rico tiene sus ingresos fiscales asegurados y definidos. Pero habrá que evitar el aumento desmedido de los gastos y mantener los principios de una alta economía salubrista en constante escrutinio. Y es aquí donde entra en juego el segundo principio básico del modelo: la eficiencia en el uso de los recursos por medio de la competencia en el mercado.

Se está logrando la meta que se propuso hace seis años: cubrir a prácticamente toda la población de 3,8 millones de habitantes con un seguro de salud personal que permita la libre elección y que esté financiado por el sector público o privado, según el caso. Este modelo de salud está presente hoy y habrá oportunidad de evaluarlo más a fondo durante esta sesión. Ningún reconocimiento será mejor que el de saber que la experiencia y el esfuerzo de Puerto Rico sirvieron de base e inspiración para que los demás encuentren sus propias respuestas a algunos de los problemas que enfrentan en sus jurisdicciones.

Para terminar, el orador da la bienvenida a todos a Borinquen, tierra que el poeta bautizó “preciosa” y que Colón llamó “hija del mar y del sol”.

D. Palabras de la Dra. Gro Harlem Brundtland, Directora General de la Organización Mundial de la Salud

D. Address by Dr. Gro Harlem Brundtland, Director-General of the World Health Organization

Dr. BRUNDTLAND (Director-General, WHO): It gives me great pleasure to be with you here in San Juan, 35 years after I landed with my fellow students from Harvard School of Public Health for a one-week field trip to the exotic island of Puerto Rico. The beauty and serenity of this island belies the fury with which the natural elements can wreak havoc in this part of the world. While we can all enjoy our stay here, we should keep in mind the suffering and the tremendous damage caused by storms like Mitch and his siblings over the past few years. I would like to congratulate this Region on the tremendous effort it has made—and the solidarity it has shown—in building up health systems devastated by these recent and repeated major hurricanes.

Year 2000 is now only a few months away, and the world is taking stock. We who devote our work to health can celebrate many remarkable achievements. But there is also a legacy. More than a billion people who are poor—a substantial number of whom live in this Region—will enter the next century without having shared in the gains of the health revolution of the twentieth century.

That we have to change. With a combination of vision, commitment, effective organization, and working together, we can achieve notable accomplishments in the years ahead. The knowledge which produced the revolution of past decades can still bring the excluded billion into our midst.

Today I wish to take the opportunity to share with you how I see the role of the World Health Organization in this major transition. You know our mandate and I can assure you of our commitment: we are after a better deal for world health. A better deal with the prime purpose of delivering a better, healthier future to all, but especially to the poor.

As Director-General of WHO, I have seen it as one of my prime tasks to improve the effectiveness of our Organization's work. Working together more effectively, as one WHO, is key. We—WHO—cannot do everything, but what we decide to do, we must do well. It goes for all of us: in times of many conflicting challenges we must all learn to focus on the health issues that matter most—and we must reach out and convince our partners to do likewise. Reaching out to civil society, NGOs, our partners in the United Nations system, and to the private sector—as we do in this Region—increases the impact we can make.

Let me share with you today our assessment of our work with the American Region, based on four global strategic directions.

First, we have to reduce the burden of excess mortality, morbidity, and disability, especially that suffered by poor and marginalized populations.

On many fronts, the American Region can stand as an example for hope and optimism. Through systematic and effective intervention, this Region has achieved some impressive improvements in health over the past few years. These improvements show that what often seem like endless fights against diseases that constantly defeat us can be winnable battles, if we only take a systematic, result-oriented approach to them.

This Region has now been polio-free for five years, a real inspiration to the countries and regions of the world which still battle this crippling disease.

Although we have good reasons to celebrate, we must remember that this is a fragile victory as long as polio still is a problem in other parts of the world. We will urge countries not to let up on their surveillance efforts. In a global village, where any country can be reached in less than 24 hours, no country is safe from polio unless all countries are safe.

We may have reason to celebrate another great success and inspiration, as measles may be eliminated in this Region by next year.

Malaria continues to be a major health problem. In three weeks, many of you will meet in Lima to develop a common strategy to fight malaria in the Amazon basin. WHO will introduce its Roll Back Malaria Initiative at this meeting as a framework for a common strategy. We look forward to this meeting. I am confident it will pave the way a reduced economic, social, and health burden of malaria on the population.

Formidable long-term sustained efforts are needed in the global response to HIV/AIDS. WHO's commitment is unshakeable. We are addressing it on every front, from issues of blood safety and mother-to-child transmission, to the use of anti-retroviral treatments and the care of people living with HIV, and of course, the dual epidemics of HIV and tuberculosis. We will push for new drugs and eventually a vaccine against HIV. And we will push for every deal that can make these innovations available for all.

I am greatly encouraged by the fact that ministries of health in several countries in the Region are providing antiretroviral treatments free to people living with HIV. These bold initiatives should be widely applauded.

At the same time, intensive negotiations with industry need to continue to find ways to provide HIV drugs to all patients irrespective of where they live and what they can afford to pay. These mechanisms have to address the three basic strategic objectives, namely: affordability, reliable health systems, and adequate financing. PAHO's initiative to start a revolving fund for bulk purchase of antiretroviral drugs is an additional important option to improve access.

It is also encouraging to see the strong national sexually transmitted disease control programs that have been developed in the Region. One may consider the elimination of congenital syphilis as a feasible target for many countries in the Region in the next five years.

Two public health interventions need particular attention. The first is to develop voluntary HIV testing and counseling as an entry point for HIV prevention, for reduction of mother-to-child transmission, and for HIV care.

The second intervention is the urgent need to scale up sexually transmitted infections prevention and care through public and private outlets.

Even without HIV as its deadly ally, tuberculosis is a major global threat to health and demands an urgent and massive response. I have made the project against TB a priority. Last month, I moved all of WHO's TB control efforts under the single umbrella of the Stop TB Initiative. It will redouble its efforts to bring new partners into the coalition working to control TB and aims to double the worldwide expenditure on TB control within three years.

In many countries in this Region, the public sector is increasing case-finding and cure rates for TB. It is the private sector which is now lagging behind. Since the private sector often dominates health services for the poorest in many countries, too few people with TB are receiving proper care. We must bring the private sector and the voluntary agencies with us if we are going to succeed in our directly observed treatment short course (DOTS) strategy. We must all commit ourselves to achieving 100% coverage with the DOTS TB control strategy by the year 2005.

Progress in integrated management of childhood illness (IMCI) has been impressive in the Region, having been implemented in 19 countries. In Bolivia, the "Seguro Básico de Salud" includes free attention and treatment for children with IMCI classifications. This is the first country anywhere in the world to explicitly include IMCI in a health insurance scheme.

The Region has been so successful in building a network of skilled consultants that they are regularly used by other Regions and Headquarters, promoting the exchange

of experience across WHO Regions. This Region has also become a center for IMCI-related clinical research and development of educational material. These are great achievements which can be used as examples for other Regions to follow.

We will intensify our work on reducing maternal mortality. To push the agenda on reproductive health forward, WHO has developed a strategy to make pregnancy safer. The Making Pregnancy Safer Initiative will encourage governments and our international partners to ensure that safe motherhood is placed high on the political agenda, a matter of social responsibility and good economic sense.

Immunization remains one of the most cost-effective of public health interventions. Over the last year, the issue of vaccines and immunizations has been reviewed by WHO with the major partners—UNICEF, the World Bank, bilateral donors, and the private sector.

We have agreed to establish a Global Alliance for Vaccines and Immunization to push for a renewed effort to develop new vaccines and to help increase immunization rates all over the world. WHO will be chairing this Alliance in its first two years.

Let me move to the second strategic direction. Focusing on the things that matter does not just mean on diseases. There is also the need to counter potential threats to health that result from economic crises, unhealthy environments, and risky behavior.

We need to strengthen the focus on how sectors outside the health sector have a major impact on health. In the environmental field, air pollution is an ever-growing problem in cities in this Region. For the tens of millions who crowd into the slums of mega-cities, the effects of pollution, crowding, and lack of proper sanitation are the largest threats to their health. Neither health interventions nor economic growth will on their own solve these problems. It will take active government intervention—concerted policies towards sustainable development and vigorous enforcement—before we will see any meaningful improvements in the overall health situation for the urban poor.

On the subject of air pollution, there is another threat that is already with us in a big way—an emerging epidemic about to hit the developing world. I am referring to tobacco. The tobacco industry is conducting a major offensive. It is now focusing its attention and advertising power on the developing world—and especially on women and children. Young generations are lighting a fuse. The explosion will kill one out of two smokers and load new, expensive, and totally avoidable burdens on the health sector.

Let's be frank. Adolescents are being lured into tobacco addiction. In most countries, as many as 9 out of 10 addicted smokers say they started before the age of 18. We are not talking about free choice. We are talking about a violation of children's rights.

I am greatly encouraged by the suit launched by the United States Justice Department last week to seek compensation for the huge medical costs tobacco-related diseases place on federal health care. The way American states and now the Federal Government call a spade a spade is an inspiration to governments all over the world.

Yet, suing tobacco companies for the damage they cause is not enough. Strict tobacco advertising legislation and information campaigns are necessary if we want to reduce smoking prevalence among our populations.

In May, the World Health Assembly endorsed our work to create a WHO Framework Convention on Tobacco Control. We will welcome representatives from the Americas at the meeting in Geneva of the Working Group on the Convention in a few weeks. I especially welcome the recommendations from the meeting of the Working Group of Regional Lawmakers that took place in Chile a month ago. The three-year plan of action agreed on at this meeting will help the work on the Framework Convention considerably.

The third strategic focus concerns health systems to which WHO will give renewed priority.

Building on the impressive achievements of the last half century, health systems must assure protection for all within limits set by available resources. This is the key message of the New Universalism that WHO spelled out in this year's World Health Report. We must develop a process of priority-setting which is evidence-based, ethically grounded, and socially acceptable. Our best hope lies in a health system that makes the improvement of health status and the recognition of health inequalities its defining goal—a health system that responds to the legitimate needs of the population, a system that protects people from financial loss due to health care costs and that distributes such economic burdens fairly.

There will be tough choices, not just in deciding which services should be covered but in determining how health care should be financed. Health care has to be paid for but solidarity through some form of prepayment system places less of a burden on the poor than systems which rely on out-of-pocket payment. A growing body of evidence suggests that prepayment is an efficient as well as an equitable policy.

Countries are now looking to WHO for guidance on health sector reform. They want to engage us in how to handle the rapid growth of private medical care and to harness the energies of the private sector for public goals. We will respond to that call, and we are considerably expanding our capacity to do so.

We need to be able to understand why one country's health system performs better than another. A better understanding of success, failure, and best practice needs to underpin the new agenda for health system reform. To indicate the importance of this subject, the whole of the forthcoming World Health Report 2000 is being dedicated to it.

The fourth direction concerns the development agenda itself. I have pledged to do what I can to place health at the core of that agenda.

Research illustrates clearly how illness is not only a result of poverty, but can also cause it. What we are increasingly seeing is that improved health conditions can turn this vicious circle around. Healthier, better-fed people are more productive and can focus their resources on improving their livelihood.

You have to face many players in development—and we all are facing many players in international health. As the lead agency in health with a broad mandate, WHO needs to refine its role and see how we can best be of use to our Member States. Let me share with you some of the issues. They will indeed be brought to your attention as we start planning for the 2002-2003 budget.

In each area—be it HIV/AIDS or Making Pregnancy Safer—we need to ask ourselves where WHO's comparative advantage really lies. Which functions are we best equipped to perform? Which are better left to other organizations? Or where can we call on our collaborating centers?

WHO is a technical agency, not a major donor. We also need to think of ourselves as a catalyst forging alliances and building consensus in many different contexts at the national and international levels. This catalytic role lies at the heart of all our core functions and will be a dominant theme as we prepare our coming budget.

In too many countries our resources are divided among too many disparate activities, and there is not enough coordination of our activities. We are in the process of changing that, and I hope you will support this process.

I would like to conclude with some comments on the World Health Assembly budget resolution, and the work that is now under way in response to it. The Assembly

decided not to compensate us for cost increases. And, in addition, we were asked to shift resources from so-called low-priority areas to high-priority areas.

It has been a tough task, but I believe we have found a realistic way forward, one which avoids cutting our key activities.

You know where I stand: WHO's most important tasks lie in countries, and our budgets and joint efforts will reflect this. The efficiency shifts we have to make in the 2000-2001 budget will not lead to a reduction in spending at the country level. But throughout WHO, we can become more efficient.

In reviewing the options for efficiencies, I have looked first at measures that are applicable across the whole of WHO. We are concentrating on cutting our travel bill, for example, and taking a critical look at what we publish and what we procure.

Globally, I have decided on a figure for efficiency measures of around US$ 50 to 60 million at this stage, in line with what the World Health Assembly called for. I would ask for your cooperation as ministers when it comes to focusing the funding that this will free for priority health areas within your countries.

This is a Region of extreme contrasts, stretching from pole to pole, both geographically and when it comes to health. Highly equitable health systems neighbor some of high inequality. Poverty lives next door to tremendous wealth. Success stories in health abound, but so do failed policies.

Big or small, rich or poor, together you have achieved remarkable success. An important reason for this has been the last decade's renewed respect for human rights and popular democracy. These two basic institutions are crucial in improving health and reducing poverty. The progress over the past few years has proven that only when there is commitment among leaders to respect the will and the basic rights of their people can real development take place.

This Region has the human and financial resources to eradicate poverty and create a world where all its citizens enjoy the basic human rights of health and nourishment. The progress so far makes me optimistic. I am confident that you will succeed, and WHO stands ready to support you.

PUNTO 2.1: NOMBRAMIENTO DE LA COMISIÓN DE CREDENCIALES
ITEM 2.1: APPOINTMENT OF THE COMMITTEE ON CREDENTIALS

La PRESIDENTA SALIENTE anuncia que los países propuestos para constituir la Comisión de Credenciales son Colombia, Nicaragua y Uruguay y al no haber objeción, quedan nombrados Colombia, Nicaragua y Uruguay.

Así se acuerda.
It was so decided.

Se suspende la reunión mientras se reune la Comisión de Credenciales.
The meeting was suspended while the Committee on Credentials met.

PRIMER INFORME DE LA COMISIÓN DE CREDENCIALES
FIRST REPORT OF THE COMMITTEE ON CREDENTIALS

La representante de la COMISIÓN DE CREDENCIALES informa que dicha Comisión se reunió de acuerdo con el Artículo 31 del Reglamento Interno del Consejo Directivo. La Comisión, integrada por los Delegados de Colombia, Nicaragua y Uruguay, llevó a cabo su primera reunión el 27 de septiembre de 1999, a las 10.00 de la mañana, y eligió a Uruguay para ocupar la Presidencia. La Comisión procedió a examinar las credenciales entregadas al Director de la Oficina, de conformidad con el Artículo 4 del Reglamento Interno del Consejo, y observó que cuatro países no se han registrado. Asimismo, comprobó que las credenciales de los delegados de los Estados Miembros y Participantes, Miembros Asociados y Estados Observadores que se citan a continuación se presentaron en buena y debida forma, razón por la cual la Comisión propone que el

Consejo reconozca su validez: Estados Miembros y Participantes: Argentina, Bahamas, Barbados, Belice, Brasil, Canadá, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Estados Unidos de América, Francia, Guyana, Haití, Honduras, Jamaica, México, Nicaragua, Panamá, Paraguay, Perú, Reino de los Países Bajos, República Dominicana, Saint Kitts y Nevis, Santa Lucía, San Vicente y las Granadinas, Trinidad y Tabago, Uruguay y Venezuela; Miembro Asociado: Puerto Rico, y Estados Observadores: España y Portugal. La Comisión se reunirá nuevamente para examinar otras credenciales que se reciban.

Decisión: Se aprueba el primer informe de la Comisión de Credenciales.
Decision: The first report of the Committee on Credentials was approved.

PUNTO 2.2: ELECCIÓN DEL PRESIDENTE, LOS DOS VICEPRESIDENTES Y EL RELATOR
ITEM 2.2: ELECTION OF THE PRESIDENT, TWO VICE-PRESIDENTS, AND THE RAPPORTEUR

The SECRETARY stated that, under Rule 16 of the Rules of Procedure, the Directing Council was to elect Member States or Associate Members to the Presidency, the two Vice Presidencies, and the office of Rapporteur, who would hold office until their successors were elected.

La PRESIDENTA solicita la presentación de candidaturas para la Presidencia, las dos Vicepresidencias y la Relatoría.

El Delegado de CANADÁ propone a Puerto Rico, en la persona de su Secretaria de Salud, Dra. Carmen Feliciano de Melecio, para ocupar la Presidencia. Afirma que lo dicho por el Gobernador Rosselló ilustra las razones por las cuales Puerto Rico merece este honor, pues enseñar con el ejemplo es la mejor forma de ser líder.

El Delegado de CUBA apoya la candidatura de Puerto Rico.

Decisión: Puerto Rico es elegido por unanimidad para ocupar la Presidencia.
Decision: Puerto Rico was unanimously elected to the Presidency.

La Dra. Carmen Feliciano de Melecio pasa a ocupar la Presidencia.
Dr. Carmen Feliciano de Melecio took the Chair.

La PRESIDENTA da las gracias a los delegados por haber elegido a Puerto Rico y dice que esta designación es un honor y un privilegio para su país. Afirma que los temas que se van a abordar en esta sesión son vitales para la salud de los pueblos de las Américas, y el espíritu del panamericanismo debe guiar los pasos de todos los países en la erradicación de las desigualdades y las injusticias sociales que aún prevalecen.

El Delegado de COLOMBIA recuerda que la Dra. Brundtland se refirió anteriormente a la igualdad entre los sexos y por ello celebra que una mujer presida esta sesión, en lo cual cree interpretar el sentir de todos los hombres presentes.

La PRESIDENTA explica que, en el marco de conversaciones oficiosas que tuvieron lugar durante la mañana, los jefes de delegación han convenido que Canadá y Trinidad y Tabago ocupen las dos Vicepresidencias.

Decisión: Canadá y Trinidad y Tabago son elegidos para ocupar las Vicepresidencias.
Decision: Canada and Trinidad and Tobago are elected to the Vice Presidencies.

La PRESIDENTA explica que, en el marco de conversaciones oficiosas que tuvieron lugar durante la mañana, los jefes de delegación han convenido que México ocupe la Relatoría.

Decisión: México es elegido para ocupar la Relatoría.
Decision: Mexico was elected to the office of Rapporteur.

PUNTO 2.3: ESTABLECIMIENTO DE UN GRUPO DE TRABAJO PARA ESTUDIAR LA APLICACIÓN DEL ARTÍCULO 6.B DE LA CONSTITUCIÓN DE LA OPS

ITEM 2.3: ESTABLISHMENT OF A WORKING PARTY TO STUDY THE APPLICATION OF ARTICLE 6.B OF THE PAHO CONSTITUTION

The SECRETARY referred to the provisions of Article 6.B of the PAHO Constitution pertaining to the suspension of voting privileges of any Member State in arrears in an amount exceeding the sum of two full years' annual payments at the opening of a session of the Directing Council. In keeping with past practice, the Directing Council was asked to appoint a Working Party consisting of the delegates of three Member States to study the application of this article.

La PRESIDENTA explica que, en el marco de conversaciones oficiosas que tuvieron lugar durante la mañana, los jefes de delegación han convenido que Bolivia, Brasil y Dominica sean nombrados miembros del Grupo de Trabajo.

Decisión: Los Delegados de Bolivia, Brasil y Dominica quedan nombrados miembros del Grupo de Trabajo.
Decision: The Delegates of Bolivia, Brazil, and Dominica were appointed members of the Working Party.

PUNTO 2.4: ESTABLECIMIENTO DE LA COMISIÓN GENERAL
ITEM 2.4: ESTABLISHMENT OF THE GENERAL COMMITTEE

The SECRETARY indicated that, according to Rule 32 of the Rules of Procedure, the Directing Council was to establish a General Committee consisting of the President of the Council, the two Vice Presidents, the Rapporteur, and three delegates to be elected by the Council. The President of the Council would serve as President of the General Committee.

La PRESIDENTA explica que los jefes de delegación han convenido que los Delegados de Argentina, Cuba y Estados Unidos de América se incorporen a la Comisión General.

Decisión: Los Delegados de Argentina, Cuba y Estados Unidos de América quedan elegidos miembros de la Comisión General.
Decision: The Delegates of Argentina, Cuba, and the United States of America were elected members of the General Committee.

PUNTO 2.5: ADOPCIÓN DEL ORDEN DEL DÍA
ITEM 2.5: ADOPTION OF THE AGENDA

The SECRETARY explained that, pursuant to Rule 10 of the Rules of Procedure, it was incumbent on the Council to adopt its own agenda, and that in so doing it might make modifications or additions to the provisional agenda prepared by the Executive Committee and distributed in advance (Document CD41/1, Rev. 1).

La PRESIDENTA dice que, si no hay objeciones, da por aprobado el orden del día.

Decisión: Se aprueba el orden del día.
Decision: The agenda was adopted.

PUNTO 3.3: INFORME ANUAL DEL DIRECTOR DE LA OFICINA SANITARIA PANAMERICANA, 1998
ITEM 3.3: ANNUAL REPORT OF THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU, 1998

The DIRECTOR pointed out that the work of the Secretariat in 1998 had taken place in the context of the political, economic, and social realities not only in the Region but in the world at large. One of the major events had been the Asian crisis of 1997, which had adversely affected the flow of capital into the Region of the Americas. Whereas in 1997 its gross domestic product had grown by some 5.4%, in 1998 the level had dropped to 2.2%. However, by the end of that year the countries in Latin America and the Caribbean area with the largest economies had recovered remarkably. Other countries had adopted policies to keep the level of inflation constant because they believed that this approach was to the

benefit of the poorest sectors. In some cases, fiscal deficits had widened and export earnings had remained stagnant, or declined. Those problems due to the world economic situation had been of concern because they had represented a threat to various industries on which the Region's small economies depended.

Climatic phenomena such as El Niño and hurricanes Georges, Mitch, and Floyd had wreaked havoc. At the same time, for some of the small countries of the Region, tourism had continued to be a major engine of growth and had had important implications for the health sector.

Although poverty levels had fallen from about 41% to 36% between 1990 and 1997, some 200 million citizens of the Region were still living in poverty. However, in the last two years, 1997-1998, the actual numbers of poor people in the Region had remained steady. There had been a major reduction in urban poverty. In some countries—for example, Argentina, Chile, Costa Rica, and Uruguay—urban poverty had dropped to levels below 20%. Those developments had shown that there was not necessarily a direct correlation between economic growth and reductions in poverty, calling into question the assumptions underlying the methods traditionally applied to address poverty in the Region. The basic recipe had been accelerated economic growth, the provision of basic social services targeting the poor, and the creation of social safety nets. But that had proved not to be enough. It had been seen that the unequal distribution of assets, especially of human capital, affected overall growth, and that a better distribution of assets increased the income

of the poor and reduced poverty directly. The health sector had to bear in mind those inequalities that touched on areas that contributed basically to the formation of human capital. Inequality in access to health was one of the areas that had to be addressed in order to eliminate the scourge of poverty from the Region. The issue of income inequality was as important as that of absolute poverty. Income distribution had improved in the 1970s, then worsened considerably in the 1980s, and had remained stagnant at high levels in the 1990s. Addressing that phenomenon in the Region was important for social and political reasons, as well as for economic ones.

Much of the Region's inequality was associated with large wage differentials, particularly with respect to women. The standard belief was that economic development actually worsened income distribution, at least in its early stages. It was his opinion, however, that the countries of the Americas were close to achieving the kind of development that would reduce income inequality. Because fertility was falling, the proportion of people of working age was rising faster than that of children, and also, more adult women were working; in turn, fewer students per worker made it easier to finance a better education system. The issue of income inequality had been an important concern of the Secretariat in 1998, inasmuch as investment in health was a major contributor to the reduction of income inequality.

In synthesis, the panorama for 1998 had been one in which the Region as a whole had struggled against global forces. The year had seen the stabilization of poverty.

Democracy was finally entrenched in the countries. Social spending had remained a major concern of all the governments. Interaction at the political level had continued to be intense. CARICOM had celebrated 25 years of existence, and the political integration movements in Central America, the Andean subregion, and MERCOSUR had continued to be strengthened. At the Summit in Santiago, Chile, the heads of government had placed health on their agenda.

In view of the fact that information was a critical resource for the establishment of policies to deal with those inequities of income that were socially unjust, the Director's report for 1998 had been given the title "Information for Health." Referring to some of the major aspects of the report, he pointed out that the Pan American Sanitary Code had established that the Pan American Sanitary Bureau would be responsible for collecting and distributing sanitary information to and from the American republics. The 75th anniversary of the Pan American Sanitary Code would be celebrated in October. Only recently had information come to be regarded as a basic resource for economic growth—almost as another form of capital. It was incumbent on the Secretariat to manage information: to produce information about the health status of the population and the systems that the countries adopted to protect that status; to generate and disseminate scientific and technical information about health; and to share information about the Bureau itself and the extent to which its efforts helped to reduce the burden of ill health in the Region. Some minor changes had been made in the structure of the Secretariat in order to sharpen its work in the

area of information. The AMPES system had been modified to more clearly define what needed to be changed in the countries and the extent to which intervention by PAHO could facilitate such changes. It was important that the information from the countries be sufficiently disaggregated, both to single out the population groups that were disadvantaged and to relate the inequalities in health to other determinants of health such as gender, place of work, and geography. In addition, in the course of the year an effort had been made to engage other actors in the wider dissemination of information about health.

The rest of the report described what had happened in the five basic areas established in the strategic and programmatic orientations for the Pan American Sanitary Bureau. In the first area, health and human development, one of the aspects essential to that work was the search for equity, which offered a solid framework for cooperation among the Member States.

He noted that the Region had continued to experience demographic and epidemiological changes that were typical of societies in transition. The elderly population was increasing, and it was important to take account of its health. The health of the elderly was as deserving of attention as the health of other age groups.

In the environmental context, the report had looked at the situation of water and sanitation: 80% of the Region's population had household water connections or easy access to safe water, and some 70% of the population had access to disinfected water. These

figures had represented an enormous advance over the 20% who had access some 20 years ago.

In terms of the overall panorama of health as it appeared in 1998, infant mortality rates had continued to fall in every country—from 37 deaths per 1,000 live births in 1980-1985 to about 25 deaths per 1,000 live births in 1995. Noncommunicable diseases had accounted for roughly two-thirds of all the deaths in Latin America and the Caribbean area. Approximately one half of the 1.6 million cases of AIDS reported worldwide since the onset of the epidemic in the early 1980s had been found in the Americas. At the same time, the Region was still contending with some of the diseases that had been thought to be eliminated from the Americas. Dengue was still a problem, and it had not been possible to free the Region of its vector, the *Aedes aegypti* mosquito.

In 1998 many countries had determined that the prevalence of iodine and vitamin A deficiencies had decreased significantly. Iron deficiency—a problem that affected women of child-bearing age—had continued to be prevalent.

There had been little reduction in violence in its various forms, and the most pernicious form of violence that had been seen in the Region was the silent plague of domestic violence.

Morbidity from mental disorders had continued to increase, and mortality and morbidity associated with smoking unfortunately had not shown any significant decline.

In 1998 it had been possible to show that between 375 and 400 deaths occurred every single day from diseases associated with smoking.

The first chapter of the report presented various concrete measures of inequality and inequity in health, along with ways of relating them to other social parameters and various measures for reducing such inequality. It also indicated some of the measures that needed to be put in place for that purpose. Those activities were part of the Organization's mandate. They provided the basis for setting the priorities for technical cooperation in the Region of the Americas.

Studies undertaken during the year had made it possible to demonstrate that investment in health was good for business and could enhance a country's economic growth.

In 1998 the Secretariat had strengthened its activities in two aspects of the area of bioethics: the ethics of clinical practice and the ethics of clinical investigation. Also, during 1998 some of the health issues that dealt with gender-based social experiences had been addressed, including domestic violence, women's access to quality health care, and women's approach to reproductive health. Steps had been taken to systematize existing information in order to allow for a gender-based analysis of quality of care. Studies were also undertaken on socioeconomic indicators to guide policies to alleviate the impact of socioeconomic changes on the health of the poor. In addition, attention had been given to

the relationship between investment in health and the extent to which various forms of investment would be anti-poor or pro-poor. Through collaborative efforts with the Inter-American Development Bank (IDB) and the Economic Commission for Latin America and the Caribbean (ECLAC), research had been advanced in those particular areas. During 1998 some new priority areas for research had been identified, and one of those new priority areas was equity and human rights and the broader ethical issues related to such matters as reproductive health and access to medicines.

The Minister of Health of Brazil had suggested that PAHO might launch a program for getting graduate students to become involved in studies of the relative importance of economics and health that had actually been done. During 1998, PAHO had also discussed with several parliamentary bodies issues such as HIV/AIDS, reproductive health, disasters, tobacco, mental health, and the problems of the elderly. A mechanism was in place whereby the Collaborating Centers cooperated with one another. In 1998, BIREME, the PAHO Center in Brazil, had adopted a new technical cooperation strategy relating to the creation of a virtual library, so that all the reservoirs of scientific information in the countries of the Region would be available in virtual space.

In the area of health systems and services development, the major focus had been health sector reform. The emphasis on health sector reform came not only because of PAHO's conviction that it was a major concern for the Region, but also because in 1994, at the Summit of the Americas, the Presidents mandated the Organization to follow up on

developments in health sector reform in the countries of the Region. Many of the Organization's regional activities had been carried out under the aegis of a generous grant from the United States Agency for International Development (USAID) that had funded a project to produce a clearinghouse that would systematically describe and analyze the structure and dynamics of the health system and the health services in each country and provide a methodological tool for monitoring and evaluating reform processes. That was already in place.

There were three important aspects of the reform process that should always be borne in mind: the organization of health services, financing, and the role of the ministry of health in steering the process. He encouraged delegates to visit the PAHO clearinghouse on health sector reform on the Internet. PAHO had also established an observatory project for human resources in the health sector. Without adequately trained and prepared human resources, there would be no reform of any durability or worth.

In the area of health promotion and protection, PAHO had focused in 1998 on healthy municipios. It had participated in a major conference in Colombia on that subject. The Organization's message at the conference had been that not only was decentralization of authority for health in the municipios important, but attention to health in the municipios was also a mechanism for creating the social capital vital for the countries. He was pleased

to see the extent to which that movement had taken hold in all the countries of the Americas.

The Organization had worked intensely to revive its reproductive health information system. He thanked the Government of Uruguay for its efforts in the revitalization of the Center for Perinatology in Montevideo, which had taken on new life and was showing how various institutions involved in perinatology could work together to gather information.

In 1998, activities relating to adolescents had increased. Focusing on adolescents was important because that was an age group in which appropriate health behavior could be taught and inappropriate health behavior could be corrected. PAHO's focus was on getting teenagers to adopt healthy behavioral practices.

In 1998 PAHO had shown its concern for the health of the elderly by disseminating widely through the Region documents that should banish some of the myths associated with the elderly. The publications stressed the need to reduce the existing inequities between generations.

Also in 1998 the Organization had intensified its efforts in the area of mental health, which should come to fruition in 1999. A major initiative against depression had been put under way. There were some 24 million people in the Region who suffered from depression, and he believed that it was quite possible to institute programs to reduce the burden of illness. A major attempt must be made to address depression at the primary care

level. It did not need the careful attention of specialized psychiatrists and, in any case, there were not enough psychiatrists in the Region to deal with all those problems.

As far as prevention and control of tobacco use were concerned, he said that PAHO was focusing on the legislative approach and on the training of staff in charge of anti-smoking programs. It had expanded its efforts in anti-tobacco activities. The Government of Canada had strongly supported those efforts.

The press played a key role in fostering health, and in 1998 PAHO had worked to establish a closer relation with it. In several of the subregions, it had instituted prizes for health journalism, and that effort had resulted in increased attention by the media to health issues and to avoiding sensationalism.

In the area of environmental health, PAHO continued to attach importance to ensuring access to safe drinking water. The Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) had been revitalized, and he wished to thank the Government of Peru for its efforts to facilitate its growth and the expansion of its activities to other parts of the Region of the Americas. PAHO had contributed equipment, materials, and technical support to areas affected by El Niño and by hurricanes Georges and Mitch. Part of the reason why those who had prophesied that there would be major epidemics had been proven wrong was that the countries affected

had put in place simple environmental health technologies that had prevented the spread of waterborne diseases.

In collaboration with many other institutions, such as the United Nations Environmental Program, and with support from the United States Environmental Protection Agency (EPA), PAHO had conducted studies and organized seminars on persistent organic pollutants. There was no doubt that risk factors in the workplace and adverse working conditions were responsible for many health inequalities and inequities. Workers in the informal sector carried out many of their activities in settings that were not very healthy. One of the initiatives that had been started in 1998 was a study of ways to incorporate persons working in the informal sector into schemes that would provide them with some security. Work had begun in the area of microinsurance schemes especially directed to groups in the informal sector. With regard to activities in the areas of AIDS and immunization, which would be discussed in depth later in the week, he said that he wished to emphasize the area of emerging diseases, which had been a source of continuous concern.

Work had proceeded in 1998 on the provision of subregional laboratory networks to monitor emerging diseases in the Americas. The laboratories were important because without an accurate diagnosis of some of those emerging infections there was the possibility of spreading false rumors and giving false advice to Member States.

Dr. Brundtland had mentioned the area of tuberculosis. That continued to be a problem for the countries of the Region. The Director was encouraged, however, by the efforts that had been made by many countries. Dr. Brundtland had also mentioned the integrated management of childhood illness. The Director had promised that over the next four years, the Region would reduce the number of infant deaths by 100,000, at a rate of 25,000 a year. Part of the basis for that reduction rested on the expansion of the IMCI program.

In a few days, the wives of the presidents of the Hemisphere would be meeting in Ottawa, and one of the issues that PAHO would be presenting to that group was the possibility that they might take an active role in promoting the application of the IMCI approach to reducing infant mortality.

Noncommunicable diseases had also received attention in 1998. The Bill and Melinda Gates Foundation had donated $50 million to an alliance of five partners to deal with cervical cancer, $10 million of which would go to the Pan American Health Organization to strengthen the programs of the countries of the Americas. Given appropriate attention, that disease could be reduced or virtually eliminated. The high prevalence of that cancer in the Region was simply another manifestation of gender discrimination.

The Pan American Foot-and-Mouth Disease Center (PANAFTOSA)in Argentina had taken the lead in the area of food protection. Much of the gastrointestinal illness, including cholera, that occurred in the Region was caused by contaminated foods. The work done by PANAFTOSA in Rio de Janeiro was not sufficiently recognized. In 1998, the International Office for Epizootics in Paris had conferred disease-free status on the region comprising the Brazilian states of Rio Grande do Sul and Santa Catarina, where livestock was vaccinated against foot-and-mouth disease. The elimination of the disease represented millions and millions of dollars in terms of income, and keeping countries free of that disease also benefited countries that did not have it.

The Director would not elaborate on the part of the report that dealt with disasters. He merely wished to emphasize his appreciation for the support the countries had given each other. It was absolutely critical that the ministries of health maintain their disaster preparedness capability; the countries that had suffered the least from the disasters had had some degree of capacity in disaster preparedness.

With regard to the Secretariat, work was proceeding on improving the AMPES system for strategic planning. Every effort was being made to reduce costs. The Secretariat was increasingly involved in coordinating health initiatives from the Inter-American Summits, and would make a presentation at the forthcoming meeting of First Ladies. The processing of institutional information was being upgraded, and an institutional memory was being created. In order to improve the production of scientific

and technical information, as well as information for the general public, media training workshops had been set up. The technical units had been encouraged to include communication skills in their own activities. The Secretariat had published *PAHO Today* and *Perspectives in Health*, the latter a magazine highlighting positive experiences in the Region, which had won a prestigious award for excellence. A half-hour television show, *Perspectives in Health*, had also been produced, and had been aired on many stations throughout the Americas.

In conclusion, the Director stressed that one of the objects of the Pan American Sanitary Code was to stimulate the mutual interchange of information that could be of value in improving public health and combating the diseases of man.

O Delegado do Brasil manifesta que a Delegação do Brasil apóia os termos do relatório anual apresentado pelo Dr. George Alleyne, congratula-o pela eficiente gestão e expressa sua satisfação em constatar que as prioridades, estratégias e ações brasileiras estão perfeitamente consoantes aos diferentes temas nele abordados. Integram o compromisso solidário firmado entre o Governo e as 27 Secretarias Estaduais de Saúde para o quadriênio 1999-2002 e o plano plurianual do Governo para o período 2000-2003. Esse documento ressalta o papel e o compromisso solidário dessas instâncias de Governo na formulação das políticas de saúde, na gestão do sistema único de saúde e na implementação e coordenação dessas políticas em parceria com os gestores municipais, na busca de uma maior justiça social. O plano plurianual do Governo Brasileiro,

apresentado ao país e ao Congresso Nacional em 1º de setembro último, contém programas prioritários para o referido período, voltados para o atendimento das necessidades básicas da população brasileira: saúde, educação, moradia, segurança, transporte e saneamento básico. Praticamente 60% dos recursos do Governo Federal serão aplicados na área social. O Brasil também confere prioridade absoluta e aporte expressivo de recursos à assistência farmacêutica básica para garantir o acesso da população a medicamentos essenciais, inclusive aqueles usados na psiquiatria e no controle de doenças transmitidas por vetores, da hanseníase e da tuberculose. O Governo Federal e os Estados da Federação aportam anualmente recursos que atingem US$ 750 milhões, quando se inclui o programa de vacinação. Outra prioridade do Governo é a saúde da família, estratégia que contribui para a ampliação e universalização do atendimento básico e a organização dos serviços locais. Essa estratégia conta com agentes comunitários de saúde e equipes multiprofissionais de saúde que atuam nos domicílios, com o apoio da rede de serviços. Atualmente quase 102 mil agentes comunitários de saúde trabalham em 3.800 municípios brasileiros. Até o ano 2002 o total desses agentes deverá atingir 150.000. Há 4.501 equipes de saúde da família atuando em 1.533 municípios e a meta é aumentar esse número para 20.000 equipes até o ano de 2002. O Governo também promove junto à população a adoção de estilos de vida saudáveis, alimentação adequada, abandono do tabaco e a criação de ambientes favoráveis à saúde, tanto nos domicílios, como nas escolas, no trabalho e no lazer. Promove também a transformação de municípios em comunidades saudáveis, buscando a

efetiva participação da comunidade e a elaboração e implementação de políticas públicas salutares mediante o envolvimiento intersetorial. Este é um eixo estratégico e viabilizador da qualidade de vida das populações e por isto a promoção da saúde passou a ser componente essencial das políticas de saúde.

O Governo vem formulando políticas com a participação de diferentes segmentos sociais e, a partir de novembro próximo, lançará duas campanhas nacionais: a da prevenção da gravidez na adolescência e a da prevenção do câncer de mama. A expectativa é de que estes problemas de saúde pública que afligem uma parcela significativa da população feminina sejam partilhados por toda a sociedade.

Se levanta la reunión a las 12.30 p.m.
The meeting rose at 12:30 p.m.