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ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

This document is an updated version of the summary of the HIV/AIDS situation in the Americas presented at the 126th Session of the Executive Committee. Surveillance shows that the HIV/AIDS epidemic in the Americas consists of a mosaic of different epidemics, all of which will need to be addressed more forcefully to prevent a generalized epidemic in the Region.

Behavioral data indicate that known risk factors for HIV infection are present and well established in the Region. Data also show that while people have knowledge about AIDS, this is not being translated into action. More studies linking human behavior and HIV are crucial to fully understand the risks associated with transmission and to control the epidemic before it reaches more serious proportions.

The Directing Council is requested to review the document and provide comments to assist the Organization in terms of policy definition and implementation, in particular on the following issues: (a) building on existing surveillance systems to strengthen their capacity to explain the epidemic; (b) strengthening of primary prevention, including social communication and marketing strategies; (c) improving responses to increased demands for HIV/AIDS care by applying the "building blocks" approach, which brings a long-term vision and sustainability to health care; and (d) regional mechanisms to facilitate access to drug therapies, particularly regarding mother-to-child transmission of HIV prevention programs.

After discussing this subject, the Executive Committee adopted a resolution (see CE126.R5, annexed) for the consideration of the Directing Council.

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1. Current Situation of the HIV/AIDS Epidemic

The HIV/AIDS epidemic in the Americas has entered its third decade and continues to grow steadily. Currently, there are about 2.6 million people living with HIV in the Region: 1.3 million in Latin America, 360,000 in the Caribbean, and close to 1 million in North America. These figures continue to increase and it is estimated that between 600 and 700 people are newly infected with HIV every day in this Region. The death toll at the end of 1999 had reached more than half a million. On the other hand, the HIV epidemic in the Americas is still contained in the sense that it has not widely impacted the general population. However, there are some areas where the epidemic has reached worrisome proportions. A brief summary of the epidemic in the Region follows.

The Caribbean. The vast majority of HIV-positive people in the Caribbean were infected during unprotected heterosexual sex. Haiti is the most affected country in the subregion. In some studies, 13% of pregnant women tested positive for HIV in 1996. The country estimates that around 10% of adults in urban areas and 4% in rural areas are infected with HIV. Guyana, the Bahamas, and the Dominican Republic have also been hit hard by the epidemic. Guyana found close to 7.1% of pregnant women and 46% of female commercial sex workers in the capital city of Georgetown to be HIV-positive. The Bahamas showed a prevalence of 3.6% among pregnant women in 1995, and double that percentage (7.2%) in high-risk groups (patients with sexually transmitted infections [STI] nationwide). HIV prevalence among commercial sex workers averaged 5.5% in 1998 across the Dominican Republic, representing an increase from 3.3% observed only 2 to 3 years earlier.

In Puerto Rico, 24,352 cases of AIDS have been reported and 15,188 people have died from the disease. The main exposure categories are related to intravenous drug use in men (55% of cases) and heterosexual contact in women (59% of the cases).

Central America. Some of the countries of Central America are among the most affected by the epidemic in Latin America. In Honduras there are signs of the epidemic spreading to the general population (1.4% among pregnant women nationwide in 1998). Epidemiological studies of HIV infection among other groups, such as female sex workers in San Pedro Sula, showed that one in five was infected with HIV. In five other cities (1998) prevalence averaged 10% among sex workers. In Belize, El Salvador, and Guatemala the epidemic is already a cause for concern (1.4% HIV prevalence among pregnant women in Belize). Other populations registered figures considerably higher, for instance, in Puerto Barrios (Guatemala) 11% of sex workers tested HIV positive compared with 4.7% in Guatemala City. In El Salvador, 6% of STI patients tested HIV positive in 1995-1996. In Costa Rica and Panama, the epidemic is greatest in men who have unprotected sex with men.

Mexico. The National AIDS Program estimates that there were about 174,000 people living with HIV in Mexico at the end of 1999. The epidemic continues to be driven by men that have unprotected sex with men. In some studies 14.2% of this group were found to be infected with HIV, and probably act as a bridge to the general population. The epidemic is especially severe in the 25 to 44-year age group. At present, AIDS is the third most common cause of death in men and the sixth most common cause of death in women in Mexico.

Brazil has reported 170,078 AIDS cases and estimates that around 540,000 people were living with HIV and AIDS at the end of 1999. Most of the infections are concentrated in major urban areas and among men who have sex with men. Although the latter group continues to be important in transmitting HIV, in recent years injecting drug use has contributed significantly to the rising numbers of HIV-infected people. Among pregnant women aged 13 to 24 years, HIV prevalence rates varied between 1.7% in the southeast in early 1997 to 0.2% in the north a year later. In the country as a whole, HIV prevalence among 6,290 pregnant women aged 13 to 24 tested anonymously in March 1998 was 0.4%. In sexually transmitted diseases (STD) clinics, 3.7% of male and 1.7% of female clients tested HIV positive in the same month. Among patients in hospital emergency rooms, 1.7% of men and 1.2% of women tested HIV positive.

In the *Southern Cone*, men who have sex with men and injecting drug users (IDU) continue to be the main groups affected by the epidemic. It is believed that between 5% and 10% of adults are HIV-infected as a result of sharing of syringes or needles and other paraphernalia used by IDU. Injecting drug use is responsible for the shifting of the epidemic toward a younger age group (from 30-49 to 20-34 years), and for the growing numbers of women being infected, which increased from no cases in 1985 to more than 20% of cases in 1996. Particularly in Argentina, IDU has played a substantial role in the spread of the epidemic almost from its start, and since 1990 it is the most prevalent risk category. In the latest figures, IDU accounted for more than 40% of the reported AIDS cases. Chile has found only limited HIV infection in the general population in several areas of the country, including Santiago, the capital city, where risk behavior is thought to be highest. Among pregnant women between 1992 and 1997, HIV prevalence rates remained below 1 per 1,000. In Uruguay, similarly low rates were recorded among over 8,000 workers tested in 1997. Just 0.26% of samples tested were HIV positive.

The *Andean Area* seems to be relatively little affected by HIV to date, although there is no room for complacency since risk behavior is well established in several countries. Colombia estimated that 67,000 people were living with HIV in 1998. The overall seroprevalence rate was 0.24% in a large national campaign (130,000 people tested) to promote counseling and voluntary HIV testing in the mid 1990s. Since the beginning, the epidemic has affected mainly men. However, the male to female ratio

decreased from 37:1 in 1987 to 5:1 in 1998. In the highlands, HIV is spread principally through unprotected sex between men, while in coastal areas the epidemic is largely driven by unprotected heterosexual sex. In 1996, Bogota had a prevalence of 0.1% among pregnant women compared to 0.4% in Cali. In Peru, HIV prevalence among pregnant women was 0.23% and 0.07% among blood donors in 1998. Among high-risk groups, an ongoing study of sex workers found 1.6% HIV positive in Lima and 0.6% in the provinces. In all groups prevalences were higher in cities than in rural areas. In Bolivia, regular sentinel surveillance among pregnant women found little HIV infection. In 1997, just 0.5% of 980 pregnant women tested positive for HIV. Among female sex workers tested in Santa Cruz, only 0.3% were found to be HIV positive in 1998.

In *North America* the wide use of combination antirretroviral therapies has had a positive impact on mortality and in delaying the progression of HIV infection to AIDS. Of the more than 760,000 AIDS cases reported in the Unites States up to May 2000, almost 90% of cases were in men who had sex with men (MSM) and/or injecting drug users (IDU). Only 10% were attributed to heterosexual transmission. Recent trends of HIV infection have disclosed that both groups (MSM and IDU) continue to be the most affected groups, although heterosexual transmission among women has continued to increase. These trends are particularly noticeable in inner cities and among marginalized groups. In Canada, HIV prevalence is very low, but HIV transmission is increasingly related to heterosexual contact and injecting drug users as the principal sources of transmission. At the beginning of the epidemic (1985), sex between men used to account for most of the HIV cases (75%); 10 years later only 36.5% of cases continue to be related to this category. In contrast, injecting drug use, which in 1994 accounted for only 9% of the cases, is at present between 29% and 33.5% of all HIV infections. The sex ratio of newly reported HIV cases went from 9.4 infected men for every infected woman in 1985 to 1.5 by 1998.

In general the HIV/AIDS epidemic in the Americas continues to be a mosaic of different epidemics, all of which will need to be addressed more forcefully to prevent a generalized epidemic in the Region.

2. Strategies for Improving Surveillance Systems: A Link between Epidemiological and Behavioral Surveillance

Existing HIV/AIDS surveillance systems are ill equipped to capture the diversity or to explain changes over time of the mosaic of epidemics in Latin America and the Caribbean. Efforts are needed in the Region to build on existing systems, to strengthen their capacity to explain the epidemic and to make better use of the information they generate.

The second generation surveillance systems approach aims to concentrate resources where they will provide information that is the most useful in reducing the spread of HIV and in providing appropriate care for those affected (Annex I). The most efficient mix of data collection for surveillance will depend on nature of the epidemic in each country. The recommended choice of populations among whom data are collected will vary from epidemic to epidemic. So will the mix of behavioral and biomedical surveillance. Surveillance working plans and country efforts should be constructed with these principles in mind and the necessary human and financial resources should be allocated.

3. Strategies and Benefits of Primary Prevention

The need to provide quality care to people living with HIV/AIDS is unquestioned, but the emphasis on simplistic approaches that neglect the more basic and affordable interventions has created dilemmas of resource allocation to face the AIDS epidemic. There is a widespread belief that health care equals curative interventions. In addition, many people believe that AIDS has already become a chronic, manageable condition and that there is no longer a need to avoid high-risk sex and drug use. However, behavioral interventions continue to be the cornerstone for controlling the HIV/AIDS epidemic.

In recent years a special emphasis has been placed on educational interventions for the promotion of sexual and reproductive health in which, rather than focusing on disease and dysfunction, the value and advantages of healthy lifestyles are stressed. As examples, Colombia launched an initiative for the incorporation of sex education in school curricula, which puts the accent on the positive aspects of human sexuality and promotes the development of healthy sexual attitudes and behaviors. The Regional Program on AIDS has developed, in collaboration with a United States university, a model for promoting healthy sexual behaviors among men who have sex with men. This model ("Face to Face") has already been piloted among Latino men in the United States and participants from Latin American and Caribbean countries.

Behavioral interventions, which combine formal education strategies with social communication initiatives and face-to-face interactions such as counseling and peer education have proved to be most effective in preventing HIV/AIDS. A well-informed public has a greater probability of adopting preventive practices if the intervention is appropriate for that particular target group. Costa Rica, Jamaica, Mexico, Peru, and Venezuela have developed interventions in which the provision of factual information and face-to-face education are effectively combined to stimulate positive behavioral changes among groups of commercial sex workers, men who have sex with men, armed forces personnel, and youth on the streets. Awareness raising campaigns developed in Brazil are also good examples of how core messages can be tailored to specific situations

(e.g. Carnival, World AIDS Day, etc.) as well as target populations (e.g. youth, tourists, men who have sex with men).

In summary, prevention and comprehensive care should not be seen as competing areas but as vital parts of a health continuum that should serve to curb the further spread of HIV infection while meeting the needs of those already infected. Better integration of care and treatment services, including those for STI and substance abuse, would allow Member States to take advantage of multiple opportunities for prevention: first, to help the uninfected stay that way; second, to help infected people stay healthier; and third, to help those who are infected to initiate and sustain behaviors that will prevent further HIV transmission.

Finally, and as part of primary prevention, it is becoming increasingly evident that a vaccine would offer hope to control the pandemic in the future. Thus far, most HIV candidate vaccines have been based on the gp 120 or gp 160 proteins of subtype B HIV-1 strains, which are prevalent in the Americas and Western Europe. Candidate vaccines have also been developed based on subtype E strains, and these are being tested in Thailand, where this subtype affects most population groups. Other candidate vaccines are being designed to induce cell-mediated immunity (as opposed to producing antibodies) using live recombinant vectors (chiefly poxvirus-based vectors, such as complex multi-gene canary pox-vectors) and, more recently, naked DNA immunization. In the future, collaborative vaccine trials will have to be conducted in both industrialized and developing countries to assess the protective efficacy of different candidate vaccines. However, a future vaccine will not be the single solution to the HIV/AIDS pandemic. Even if effective and inexpensive HIV vaccines become widely available, these vaccines would have to be delivered as part of comprehensive HIV prevention packages, including other social/behavioral interventions.

4. Prevention of Mother-to-Child Transmission

Mother-to-child transmission (MTCT) is the most significant source of HIV infection in children below the age of 10 years. At the end of 1999, the ratio of HIV transmission between males and females in the Region was 2.2 males to every female. This is significant as it illustrates the increasing rate of heterosexual transmission of HIV and its subsequent impact on the number of pediatric AIDS cases through the concomitant increase in the transmission of HIV from mother to child. As of May 2000, 19,321 pediatric cases had been reported in the Region. This figure represents 1.8% of all reported AIDS cases. The situation is particularly worrisome in the Caribbean, where the magnitude of the epidemic is second only to sub-Saharan Africa. In the Caribbean, pediatric cases account for 5.8% of the total reported AIDS cases (May 2000). Data indicate that young mothers aged 15 to 24 years (Belize, Guyana, Jamaica, Trinidad and

Tobago) are particularly vulnerable to HIV infection, compared to older age groups. This is significant, as these women are also most likely to have multiple births.

Many studies conducted worldwide show the rate of MTCT of HIV, in the absence of preventive interventions, to be between 25% and 45% in developing regions (most estimates are between 30% and 35%). Two thirds of infants who contract HIV are infected in the prenatal or intrapartum period, and one third are infected postpartum due to breastfeeding. From experiences worldwide, we have learned that there are several interventions that are effective in reducing the rate of MTCT. These include the provision of voluntary and confidential counseling and testing, antiretroviral therapy (Zidovudine [AZT] or Nevirapine), proper nutrition, alternatives to breast-feeding, intrapartum management, management of sexually transmitted infections, elective cesarean section, and vaginal lavage. The opportune provision of these interventions has resulted in a dramatic reduction of perinatal transmission, from 25% to 8% or less.

The major challenge in curtailing HIV transmission from mother to child is not only providing a comprehensive package of interventions to all pregnant women, but also ensuring that those women present themselves for care prior to 36 weeks gestation in order to be offered a full range of preventive options (voluntary and confidential counseling and HIV testing, nutritional interventions, antiretroviral therapy). All pregnant women must be ensured of early access, preferably in the first trimester of pregnancy, to good quality antenatal care and to good intrapartum and postnatal care, as well as follow-up and support services for themselves and their children. At the present time, Argentina, Bahamas, Barbados, Belize, Bermuda, Brazil, Chile, Cuba, Dominican Republic, Jamaica, Mexico, and Uruguay, among other countries, are committing significant resources to successfully prevent MTCT of HIV. In many of these countries, AZT is provided to pregnant women free of charge, but is sometimes not provided after birth. Increased efforts are still needed to ensure the comprehensive and long-term care of women and children, especially in countries that have yet to implement this cost-effective and successful strategy.

5. Responding to the Challenge of Increasing Demands for Care

One of the goals of HIV/AIDS comprehensive care programs is to achieve equity in the provision of care. For this purpose the design of HIV/AIDS care programs and their monitoring and evaluation should be based on minimum standards.

The Pan American Health Organization convened a series of expert consultations to define what types of care interventions and responses can be provided in relation to resource availability. Three different scenarios were envisaged and the minimum standard of care that countries should strive to achieve was delineated within a scenario defined as

resource-limited setting, or Scenario I (Annex B) In this setting, testing and basic medications are available in a limited amount, at all levels of the health system. If more resources (physical infrastructure, financial and technical resources, support services) and skills (trained health providers and caregivers) become available, two improved scenarios are presented, namely *resource-competent settings* (Scenario II) and *resource-optimal settings* (Scenario III). Within these three scenarios, the wide range of activities necessary to meet the medical, social, and emotional needs of persons living with HIV/AIDS are incorporated as "building blocks" into the structure of comprehensive care programs. The "building blocks" approach intends to achieve equity, effectiveness, efficiency, and quality care for persons living with HIV/AIDS in the household and community and in the primary, secondary, and tertiary care levels of the health system. Also contemplated is the provision of necessary pharmaceuticals, including antiretroviral (ARV) drugs.

The building blocks approach to providing HIV/AIDS comprehensive care for persons living with HIV/AIDS was endorsed by the Executive Committee at its 126th Session in June. The Regional Program on AIDS/STI announced the Building Blocks Framework for HIV/AIDS Comprehensive Care as its new strategy to strengthen and improve care for persons living with HIV/AIDS in the Region of the Americas with the publication of the care guidelines on 5 July 2000. The Program will provide technical support to the countries for the implementation of these guidelines.

As a mechanism to facilitate access by Member States to state-of-the-art pharmaceutical products, a Regional Fund for Strategic Health Supplies will be established that includes antiretroviral drugs and reagents for monitoring antiretroviral treatments. The Regional Program on HIV/AIDS and STI has been responsible for preparing a detailed preliminary list of antiretroviral drugs, based on existing national lists and updated information about pharmaceutical products that should be incorporated into combined schemes of therapy. The Fund will be launched as a pilot in one country. If this is successful, the Fund will operate for a larger number of countries until it ultimately responds to the requests from all the countries in the Region that wish to participate.

6. Progress Report and Future Prospects

PAHO has continued to develop strategic alliances and work with key partners in the fight against HIV/AIDS/STI in the Region. Thus, in 1999 PAHO undertook a leading role in coordinating the United Nations System's (UNAIDS) integrated planning in support of national responses to HIV/AIDS. PAHO worked closely with governments (ministries of health) and key partners (international and bilateral agencies, universities, nongovernmental organizations, and community-based organizations) to promote consensus, active participation, and commitment to integrated planning. During 1999, integrated interagency planning took place in Central America, Chile, Colombia, Mexico

and Jamaica. Meetings of the Caribbean Task Force on HIV/AIDS were held in June 1999 (Antigua) and March 2000 (Trinidad) to develop the Pan-Caribbean Regional Strategic Plan for HIV/AIDS/STI (1999 to 2004). The Caribbean Regional Strategic Plan for HIV/AIDS/STI received full support by the Heads of Government of the Caribbean Community (CARICOM) at the 21st Meeting of the Conference of Heads of Government of the Caribbean Community held 2-5 July 2000.

In the area of epidemiology, efforts were concentrated on implementing second generation HIV/AIDS surveillance, which integrates a behavioral component as well as STIs and molecular surveillance to the already functioning AIDS case reporting and HIV sentinel surveillance. To disseminate the principles of second generation surveillance, PAHO helped establish and actively strengthened epidemiological networks, including a Latin American and Caribbean Surveillance Network (EpiNet). The EpiNet has proven a successful strategy to disseminate, adapt, and implement second generation surveillance in the Region while building capacity at the national level. By the end of 1999, all countries in the Region were members of the Latin American and Caribbean Surveillance Network (EpiNet). During 1999, subregional HIV/AIDS networks became functional in the Southern Cone, the Andean Area, and Central America and efforts were initiated to develop a Caribbean network. The Regional and subregional networks work together to improve the collection, analysis, and use of surveillance data. Members include representatives from countries and the many successes achieved from this experience support its use as a continued strategy in the Region. The V Regional meeting was held in Jamaica in September 2000.

As mentioned before, in 1999 the *Building Blocks Framework* (Annex B) for HIV/AIDS comprehensive care was finalized. This framework serves as another example of a successful joint planning effort and was developed in collaboration with WHO, UNAIDS, and the International Association of Physicians in AIDS Care (IAPAC).

By the end of 1999 regional training in the syndromic management of STIs had been completed, with all countries participating. Country-specific requests have also been addressed for training to be conducted at the primary health care level in Argentina, El Salvador, Haiti, and Paraguay. In addition, second generation STI surveillance guidelines were reviewed and endorsed at a Regional workshop in April 1999 and will serve as a practical tool to improve STI surveillance in the Americas. The PAHO/WHO Secretariat has also developed various documents based on WHO's STI-PAC strategy to ensure that prevention messages and practices are incorporated into comprehensive prevention and care initiatives.

During 1999, several countries began developing or were already implementing programs to reduce the transmission of HIV from mother to infant. These include Belize,

Dominican Republic, and Jamaica. Belize has developed a national strategy for MTCT and will pilot test interventions, including the provision of ARVs, before wider country implementation. Jamaica has initiated a pilot project to assess the feasibility of prevention of MTCT of HIV. Several countries in Central and South America are requesting technical guidance from PAHO in the planning, development, implementation, and evaluation of MTCT interventions.

In 1999, the Director made a special commitment to renew the regional efforts to promote social communication and marketing strategies to elicit behavioral changes conducive to the adoption of safer sex practices, especially among young people. The recruitment of a full-time professional is in process and PAHO is seeking the involvement and collaboration of UNAIDS, other institutions, and governments in Latin America and the Caribbean in supporting this renewed Regional effort. It is anticipated that a full-time professional will be part of the team by September 2000 to work in the area of social communication and marketing strategies to promote behavioral change.

Despite progress made by the countries, other institutions, and the PAHO Secretariat, more effort is needed to reduce the spread and impact of the HIV/AIDS epidemic in the Americas. Overall, there is a major need to strengthen the national and local capacity to better assess the HIV/AIDS/STI situation, the risk behaviors associated with their transmission, and the factors that hamper their prevention and control. Most importantly, the presence and further development of a strong national leadership, the ability to mobilize resources and establish multiple partnerships and alliances, and the broad-scale application of technically, ethically, and scientifically sound interventions remain as the most vital components of a successful fight against HIV/AIDS/STI in the Americas.

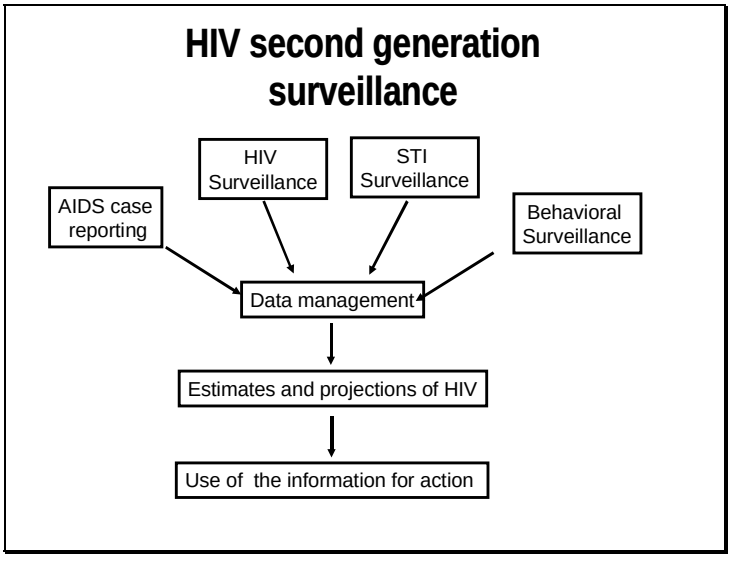
Annexes

Reaching Surveillance Goals through Epidemiological Networks:
Second Generation Surveillance

A Summary of Goals of Second Generation Surveillance Systems

- Better understanding of trends over time
- Better understanding of the behaviors driving the epidemic in a country
- Surveillance more focused on sub-populations at highest risk of infection
- Flexible surveillance that moves with the needs and state of the epidemic
- Better use of surveillance data to increase understanding and plan prevention and care

Second generation surveillance is based on the lessons learned during the first decade and a half of HIV/AIDS surveillance. Second generation surveillance focuses methods of data collection on appropriate populations and sub-populations and combine them (e.g., biological and behavioral data) in ways that have the greatest capacity to explain the factors underlying the epidemic. Data produced are used to increase and improve the national response. The methodology of second-generation surveillance integrates the surveillance of AIDS, HIV, STIs and the surveillance of risk behaviors (see diagram).



Building Blocks Framework

To determine the standards of care in any particular setting, three different dimensions that influence the choice of standards must be considered.

- The *first dimension* deals with the technical aspects of the intervention to be provided and is determined by the efficacy and effectiveness of the specific interventions.

- The *second dimension* is determined by the social and contextual factors that make efficacious interventions functional under operational conditions.

- The *third dimension* involves the setting of standards and is determined by the level of the health care system providing such interventions (e.g., home care, communities, health clinics, hospitals, tertiary referral centers).

The standards and norms of care should be defined in each country, for each level of service and for each population affected. Although there may be universal standards, it is important to emphasize that local standards should reflect the best care obtainable in current local circumstances.

Appropriate HIV/AIDS Care
❑ **Screening and diagnostic services**
❑ **Counseling and psychosocial support**
❑ **Community education and participation**
❑ **Prophylaxis and treatment of opportunistic infections and other infections**
❑ **Nutritional interventions**
❑ **Management of sexually transmitted infections**
❑ **Management of HIV in obstetrical/gynecological (Obs/Gyn) practice**
❑ **Management of pain and palliative care**
❑ **Antiretroviral therapy**
❑ **Antitumor therapy**
❑ **Neurological and psychiatric care**
❑ **Management of addictions**
❑ **Surgical procedures**
❑ **Management of sexual complaints and dysfunctions**

The proposed scenarios are:

Scenario I: In this setting, testing and basic medications (e.g., tuberculosis (TB) prophylaxis, palliative care) are available in a limited amount at all levels of the health system (primary, secondary, tertiary). Interventions are focused on *secondary prevention* activities (i.e., prophylaxis of opportunistic infections and avoidance of potentially harmful behaviors) to avoid further physical deterioration and provide symptomatic relief. Antiretroviral (ARV) therapy is available for the prevention of mother to child transmission (MTCT) at the secondary level of the health system.

Scenario II: In this setting, testing and drugs are available at all levels, including some ARVs at the secondary level of the health system. All Scenario I services are provided plus the etiologic treatment of opportunistic infections. Some excessively expensive drugs, such as antitumor medications, are not available at the primary and secondary levels of the health system.

Scenario III: In this setting, all of the above services are provided plus ARV therapies and specialized services, including antitumor medications.

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

126th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., 26-30 June 2000

CD42/7 (Eng.)
Annex C

RESOLUTION

CE126.R5

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

THE 126th SESSION OF THE EXECUTIVE COMMITTEE,

Having considered the report on acquired immunodeficiency syndrome (AIDS) in the Americas (Document CE126/9 and Add. I),

***RESOLVES*:**

To recommend to the Directing Council the adoption of a resolution along the following lines:

THE 42nd DIRECTING COUNCIL,

Having considered the report on acquired immunodeficiency syndrome (AIDS) in the Americas (Document CD42/___);

Acknowledging the strong relationship between the sexual and vertical transmission of HIV and the presence of other sexually transmitted infections (STI);

Cognizant of the evolution of the HIV/AIDS/STI epidemics in the Americas and of the challenges raised by the increasing numbers of people requiring comprehensive prevention and care services for HIV/AIDS/STI; and

Taking into account the technological developments and successful interventions and experiences in the Region and in the world to prevent and control the sexual, blood-borne, and mother-to-child transmission of HIV and other sexually transmitted infections,

***RESOLVES*:**

1. To urge Member States to:

(a) consolidate national HIV/AIDS/STI efforts and foster technical cooperation and maximize intercountry collaboration through regional, subregional, and national programs and initiatives;

(b) strengthen the surveillance capacity of the technical programs to better monitor the trends in the HIV/AIDS/STI epidemics and adjust national responses and strategies accordingly;

(c) continue to focus on prevention, especially the sexual and mother-to-child transmission of HIV, through voluntary counseling and testing and provision of appropriate preventive measures including drugs and breast-feeding policies based on scientific advances;

(d) consider prevention of HIV and care of people living with HIV/AIDS as a continuum requiring a comprehensive approach that responds to local needs and uses resources efficiently ("building blocks" approach).

2. To request the Director to:

(a) continue to facilitate a wider participation and collaboration with other institutions and agencies, particularly with UNAIDS, in the fight against HIV/AIDS/STI in the Americas;

(b) strengthen regional technical collaboration capacity, especially in the areas of social marketing and communication, promotion of healthy sexuality, and comprehensive prevention of HIV and care of people living with HIV/AIDS/STI;

(c) continue working toward the development of the Regional Revolving Fund for Strategic Public Health Supplies and mechanisms whereby Member States can access the Fund.

(Sixth meeting, 28 June 2000)