



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## 26<sup>th</sup> PAN AMERICAN SANITARY CONFERENCE 54<sup>th</sup> SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 23-27 September 2002

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### PROVISIONAL SUMMARY RECORD OF THE FIRST MEETING ACTA RESUMIDA PROVISIONAL DE LA PRIMERA REUNIÓN

Monday, 23 September 2002, at 9:00 a.m.  
Lunes, 23 de septiembre de 2002, a las 9.00 a.m.

*Outgoing President:* Dr. Ginés González García Argentina  
*Presidente saliente:*

*President:* Dr. Patricio Jamriska Ecuador  
*Presidente:*

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Note: This record is only provisional. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted. Delegates are requested to notify the Conference Documents Center (Room 215), in writing, of any changes they wish to have made in the text. Alternatively, they may forward them to the Chief, Conference Services, Pan American Health Organization, 525 - 23rd Street, N.W., Washington, D.C., 20037, USA, by 31 October 2002. The final text will be published in the *Proceedings* of the Conference.

Nota: Esta acta es solamente provisional. Las intervenciones resumidas no han sido aún aprobadas por los oradores y el texto no debe citarse. Se ruega a los Delegados tengan a bien comunicar al Centro de Documentación de Conferencias (Oficina 215), por escrito, las modificaciones que deseen ver introducidas en el texto. Como alternativa, pueden enviarlas a la Jefa del Servicio de Conferencias, Organización Panamericana de la Salud, 525 - 23rd Street, N.W., Washington, D.C., 20037, EUA, antes del 31 de octubre de 2002. El texto definitivo se publicará en las *Actas* resumidas de la Conferencia.

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Se abre la sesión a las 9.00 a.m.*

ITEM 1: OPENING OF THE CONFERENCE  
PUNTO 1: APERTURA DE LA CONFERENCIA

- A. Opening of the session by the Outgoing President, Dr. Ginés González García (Argentina)*
- A. Apertura de la sesión por el Presidente saliente, Dr. Ginés González García (Argentina)*

El PRESIDENTE SALIENTE declara oficialmente abierta la sesión y da la bienvenida a todos los ministros de salud y demás delegados, y en especial al Hon. Tommy Thompson, Secretario de Salud y Servicios Sociales del país anfitrión. También da la bienvenida a la Dra. Gro Harlem Brundtland, Directora General de la Organización Mundial de la Salud, y a los doctores Carlyle Guerra de Macedo y Héctor Acuña, ex directores de la Oficina Sanitaria Panamericana.

The SECRETARY said that under the Rules of Procedure of the Conference, the presence of at least 17 Members and Associate Members was required for a quorum. All Members were present, and therefore a quorum had been established.

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

Sir GEORGE ALLEYNE (Director): "First of all, let me give you a warm welcome: Secretary Thompson, Dr. Brundtland, distinguished colleagues, ladies and gentlemen. I know there are some among you who are new and there will be a few

veterans among you, but even those who are new, I hope you are conscious that you are all inheritors of a long tradition that stretches back in time for 100 years. You will see around you many visual symbols of the achievements of a hundred years of your Organization. As we go through our deliberations this week, I hope that you will all be conscious of the responsibility that devolves upon us as inheritors of that long and grand tradition. I am sure that this will be a week of debate, discussion and differences, but I have every confidence that this debate, this discussion, these differences will be in the same spirit of gentleness and fraternity that it has been my pleasure to observe in my 21 years in this Organization.

It is a long agenda, but you have shown over the years that you have the capability to discharge these matters with dispatch, and I have no doubt that you will display the same capacity as your predecessors. I trust that the arrangements that we have made are to your liking and that you will find in the Secretariat a ready response to any request that you might have. All you have to do is ask us: if we don't know, at least we will say that we don't know and we will try to find an answer.

I am pleased to see not only the Ministers of Health, but many members of the diplomatic corps, many ambassadors. This is a great pleasure for me because it gives an indication that interest in what we do is not only in the sector that we love so much, the sector of health, but spreads beyond that sector.

Once again, let me thank you very much for your presence and give you the warmest possible welcome to Washington and to your house.”

- C. *Welcome on Behalf of the Host Country by the Honorable Tommy G. Thompson, Secretary of Health and Human Services of the United States of America*
- C. *Bienvenida en nombre del país anfitrión por el Honorable Tommy G. Thompson, Secretario de Salud y Servicios Sociales de los Estados Unidos de América*

The Hon. TOMMY G. THOMPSON (United States of America): “First of all, let me thank you, Dr. González, for your leadership of this Organization as President, and you, David Brandling-Bennett, for your great work as Deputy Director of PAHO. Sir George, it is always a privilege and a pleasure to be with you and to be able to thank you once again for the great job you have done in leading this wonderful Organization. Your welcoming remarks this morning were very well thought out. Dr. Brundtland, thank you also for coming. It is always a privilege to be with you and have the opportunity to discuss health issues with you. You have done a tremendous job as head of WHO. It is always a pleasure when you bring my friend from Madison, Dr. Tom Loftus, with you: it is always good to see Tom, and again, I thank you very much.

All of you, honorable Ministers of Health, distinguished members, delegations, colleagues and friends, welcome to the United States, welcome to Washington, D.C. On behalf of my President, George W. Bush, let me take this opportunity to welcome you to the 26<sup>th</sup> Pan American Sanitary Conference and to the capital of the United States, the city of Washington, D.C.

It was 100 years ago that a hero of mine, President Teddy Roosevelt, came to this Organization and welcomed PAHO to this great city. The issues facing our hemisphere at that time were diseases like yellow fever and malaria. In large measure, we have conquered those diseases or at least found some cures for them, but now we are struggling with new diseases, new threats and new challenges.

For my country, one of the greatest of those challenges over the past year has been international terrorism. I discussed this with all of you last year when I addressed this august body, and I thank you, the members of delegations, and the constituencies in your countries, who stood with us, giving us your prayers, your support and above all your friendship as we have dealt with our loss and our pain for the past 12 months.

My country was struck by ruthless enemies. In the name of security, justice and freedom, we struck back, and we will continue to carry this battle to our adversaries until victory is assured and international terrorism is abated. The reality of war has introduced a brand new dynamic in American lives and one of the constants of our public policy is our dedication to joining with all of you as we address issues of regional concern. After all, ladies and gentlemen, the region of the Americas, both North and South, is our mutual neighborhood, and as good neighbors, we need to renew regularly the friendships and relationships, and share our perspectives on issues of common interest and need. Over the past 12 months, the governments of our nations have rededicated our leadership, our expertise and our resources to the full range of issues important to us, regionally and globally.

Several of these issues come to mind immediately. First, the focus on investments in health and education at the International Conference on Financing for Development, held in Monterrey, Mexico from 18-22 March 2001; second, the critical role of parents and families in the health, development and wellbeing of children, which the United States highlighted at the United Nations General Assembly Special Session on Children, held in May 2002, where I had the privilege to meet some of you and discuss with you how we can further our agenda in promoting good health conditions for all of our children; third, using the Global Fund to Fight AIDS, Tuberculosis and Malaria, provide innovative ways of fighting these diseases; fourth, President Bush's, and my Department's, initiative on preventing mother-to-child HIV transmission. And, finally, an issue that I wanted to raise this morning and that I hope we will discuss through the course of the meetings: I believe that PAHO should have an annual meeting in the Caribbean dealing directly with HIV/AIDS. We had a very positive and constructive

meeting, in Guyana last year, but I believe passionately that we can do a lot more. PAHO can lead in this effort. The Caribbean is our second great hotspot for HIV/AIDS transmission and infection, and I believe it is our mission to do more to curtail, reduce and eliminate this scourge in our Region. I therefore call upon all of you in PAHO to set aside some time this coming spring so that we can go back to the Caribbean, to discuss how we can do a better job and use our resources more effectively to help all the countries and all the people in this Region to fight this terrible disease. Through collaboration and joint commitment, I believe we in the Americas can accomplish that objective, learn from each other and evaluate our progress.

The Pan American Sanitary Conference provides us with another opportunity to renew our partnership on important public health issues, including the one that I think is the most prevalent and most dominant right now for all of us, and that is HIV/AIDS; but also chronic diseases, women's health, immunizations, and how to create better health conditions for our children.

At this Conference, we are also commemorating the 100<sup>th</sup> anniversary of the Pan American Health Organization. I believe we can redirect, reenergize and reignite PAHO's commitment to better health conditions for the Region. PAHO has been and remains my country's steadfast partner in advancing science and improving public health. I believe we are all very grateful –I know I am– for all that PAHO has done to improve the health and wellbeing of everyone in our hemisphere.

In particular, over the last eight years we have been led by a dynamic individual, Sir George Alleyne, who has brought a new level of quality and integration to PAHO's technical cooperation. I would like personally to thank you, Sir George, and your staff for your commitment to all of the Americas. Sir George, you have helped to make a difference in the lives of so many individuals. I know you have done a lot for me and for my Department and I applaud and thank you.

I also want to recognize the great talents and abilities of Dr. Gro Harlem Brundtland, Director-General of the World Health Organization. Under Dr. Brundtland's leadership, public health issues have become an intrinsic part of the international policy agenda. Dr. Brundtland recently announced, despite our objections, that she will not seek a second term. Dr. Brundtland, your expertise, your passion, your compassion, and above all your energy, will be sorely missed.

My friends, our Region has achieved a great deal in improving the lives and the quality of life of our citizens. We can be particularly proud of the cooperation that has become essential in the way many public health challenges in North and South America are addressed. Joint action is imperative, as we work to ensure that our overall accomplishments are greater than the sum of activities in our individual countries. Thus it is vital that Members States, all of us, should be actively consulted and involved to

ensure that policy actions are embraced and sustained at the country level. The election of a new Director is particularly important in that regard. A new vision and new ideas are of course essential in a new Director. But it is also vital to continue to expand the vital coordinating role that PAHO has played for the past 100 years.

I believe we have the opportunity, ladies and gentlemen, to expand the scope, the abilities, the need and the responsibilities of PAHO in the coming years. And I believe that this meeting, this 100<sup>th</sup> anniversary, gives us many opportunities to accomplish that. This session of the Conference also gives us the opportunity to guide the Pan American Health Organization, because here we can reflect on our collective commitment to improving the health of our people and preserving the dignity of human life.

PAHO exists because our nations affirm that human dignity –the value of every individual person– is the unique inheritance of every individual whatever his or her income, heritage, ethnicity, race, religion, or political allegiance. One of my country's greatest statesmen, Alexander Hamilton, affirmed this principle in an article that he wrote in 1775. As he put it then, and I quote, 'The sacred rights of mankind are written ... as with a sunbeam, and the whole volume of human nature, by the hand of the Divinity itself, and can never be erased or obscured by mortal power.'

In other words, every life in our hemisphere is sacred, every person has innate God-given value, no one is unimportant, insignificant, or forgettable. That's why all of us are here. Because every citizen of every nation represented here deserves a government that is committed to fighting and, ultimately, eradicating threats to public health.

And that is why I believe we, as delegates and ministers to this wonderful Organization, have a tremendous opportunity over the course of the next few days to be able to give it some more direction, more opportunities to represent this hemisphere better in the future. We have a chance to build on the successes Sir George has given us, for the next hundred years, starting today. We have an opportunity to expand and excel in providing good quality health to every individual in our hemisphere.

It is in that effort that the President of the United States and I stand proudly with you today. We welcome you to this city, we thank you for coming, but more than that, I thank you for your passion and dedication to providing quality health for all of your citizens. May God bless you all, and thank you for giving me this opportunity.”



- D. *Address by Dr. Gro Harlem Brundtland, Director-General of the World Health Organization*
- D. *Alocución de la Dra. Gro Harlem Brundtland, Directora General de la Organización Mundial de la Salud*

Dr. BRUNDTLAND: “Mr. President, Secretary Thompson, Regional Director, honorable ministers, ambassadors, distinguished delegates, ladies and gentlemen. I bring with me the congratulations of all of WHO for this centenary year of the Pan American Health Organization.

The Health Assembly in May celebrated the spirit of unity that has characterized health work in this Region over the past century. Experience shared among countries has led to the development of regional solidarity and concerted action to find solutions. PAHO has played a path-finding role and has been a champion of key public health issues. Its work is an example to us all. Let me congratulate all of the staff who have worked for PAHO and for WHO in the Americas, and first and foremost its outstanding leader Sir George Alleyne.

It is less than two weeks since the world marked the anniversary of the September 11<sup>th</sup> attack last year on the United States. Within days of that outrage, we saw signs of powerful solidarity both in the Region and globally. Over time we have seen how those tragic events shaped so much of what has happened in subsequent months. Global interdependence has become even clearer. We have become aware of the potential for threats to health used deliberately, to cause alarm, provoke suffering, and undermine our security. Nations have acted in solidarity to counter these threats. WHO Member States have worked with the Secretariat to examine the possible public health consequences of incidents due to biological, chemical, and radio-nuclear material. We have all recognized the importance of sharing information, of better surveillance and preparedness. We have acted together.

This September for me started just after I worked with southern Africa’s Health Ministers in Harare in late August as they focused on reducing the region’s humanitarian crisis. I then joined the Heads of State gathered in Johannesburg to focus on the critical sequel to the Rio summit, making hard-fought commitments to a common future for people and planet. I traveled to Lesotho for a close-up review of responses to suffering. I then moved on to WHO’s committees for the South East Asia Region in Jakarta and, last week, the Western Pacific Region in Kyoto and the European Region in Copenhagen.

The themes are consistent in all of these meetings. Ten years on from Rio, the world accepts that health is a key element in securing our common future. Expectations are higher than ever, for efficient health systems that work and tangible reductions in ill-health. So we have to focus on the issues that matter the most, and find better ways of

working to achieve the best possible results. Two years ago, world leaders agreed to focus on the Millennium Development Goals. Many of these are concerned with health. They help us all to coordinate our actions. International agencies including WHO are analyzing the cost of achieving them, and identifying and monitoring indicators of progress.

Last year I received the report of the Commission on Macroeconomics and Health. The Commissioners showed the benefits of investing in health. They advocated focused investments in cost-effective interventions, in systems and people who are committed to results and in measurements of progress. They called for further reform to health systems so that they pursue health equity.

That is why health has been so prominent in recent international conferences—particularly when we discussed financing for development in Monterrey, Mexico, at the start of the new trade round in Doha and during the Sustainable Development Summit in Johannesburg earlier this month.

Investing in health means making additional resources available through alliances working together for common goals. We must find ways to make these alliances work really well. Only then can we break down the barriers which prevent people accessing the health systems and commodities they need. Only then can we respond properly to environmental risks.

New international agreements do help. Three years ago we began to negotiate the Framework Convention on Tobacco Control. I hope that the Health Assembly next year adopts a strong convention: when it comes into force we must implement it with all speed.

But on most occasions we will need to establish and sustain more informal partnerships. The challenge is for governments, civil society, and private entities to respond within this spirit. There are many good examples within this Region. WHO helps to ensure that the outstanding achievements of a few are the new paradigms that inspire action from us all.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a bold response to the extraordinary impact of these illnesses. Countries from this Region have made substantial resources available to the Fund for investing in effective programs. And everywhere I go there is great anticipation for its success in moving real action forward. Countries have asked WHO for help. We are working with countries as they try to access funds, and, if they are successful, turn them into concrete action. We want to see effective mechanisms for handling funds and for monitoring results. We will encourage further contributions so that the Fund has enough resources to respond to country needs.

We have all worked hard for reductions in the price of essential health commodities – including medicines. After intense efforts over the last four years, differential pricing is now commonly used to widen poor people’s access to medicines. The prices of some anti-retroviral drugs dropped by 80 to 90 percent and TB medicine prices by a third. Nevirapine is available free of charge for preventing mother-to-child transmission of HIV, as is multi-drug therapy for leprosy.

New partnerships have been established to develop medicines for neglected diseases. And at Doha, safeguards in the TRIPS Agreement were strengthened with respect to essential medicines. Governments, nongovernmental organizations, researchers, companies, the media, and the United Nations should all take credit for these achievements. The mold has been broken. Access to medicines is now at the center of the Global Agenda with the insistence that people’s health be given highest emphasis in trade debates.

I take the view that no clause in any trade agreement should work in a way that denies –to those who need them– access to life saving medicines for common diseases. This applies wherever they live and whatever their ability to pay.

Most health systems need more funds to provide essential care for all. If care is to be effective, both governments and private groups need to be ruthless in their commitment to making a difference to changing people’s lives. For example, governments in this Region have highlighted mental illness, generating interest in the issues, bringing in new players, and defining a vibrant and vivid agenda for us all. The world has taken notice: together we have put mental health on the map.

Governments have also shown the importance of building consensus –not just within the health sectors but across other sectors. Then the efforts of all bring benefits to many. For years this Region’s politicians have known that without careful attention, people’s environment can undermine their health. Since my time in government in Norway, I have seen how environment and health ministers, by working together, can blaze a trail for environmental health. It is a demanding process that starts from an analysis of evidence and consensus building, to political agreements, then codes of conduct, joint planning and common programs, then measuring results and comparing them to expected indicators. This joint work inspired much of the emphasis on healthy environments at the Johannesburg Summit. Children’s environmental health issues now bring together the peoples of the Americas. WHO’s American regional team has shown the value of focusing on evidence for action and on cost-effective interventions, fostering alliances that involve groups within and outside government.

Too many children are made ill by their surroundings –where they live, work and play. In 2000, nearly 5 million child deaths resulted from unhealthy environments. Most commonly the children developed acute respiratory infections and diarrhea. We know

how unsafe environments make children sick. Human waste finds its way into water and food. Water is further contaminated with pathogens and chemicals. Air is polluted by smoke from indoor cooking or tobacco use. All the toxins get into the air and soil. Disease-carrying insects bite children. Too many children are injured at home or on the road.

We know how to help alliances to work in practice. Three weeks ago in Johannesburg, the WHO team worked with UNICEF and UNEP, together with key nongovernmental organizations to expand the circle, starting to build a global alliance to promote healthier environments for children.

The time is right for governments and NGOs, scientists and politicians, private entities and campaigners to work together to this end. To put children first. To tackle environmental health risks with cost-effective interventions. To agree strategies and use precise indicators. By working together we will make a difference to public health and to our children's future.

I do not want to omit a reference to the important resolution on dengue and dengue hemorrhagic fever that was adopted at the Health Assembly in May. The growing burden of the disease is worrying. Given that prevention and reduction of the virus transmission depends at present entirely on controlling the mosquito vectors, we have to encourage the widest possible participation of local communities and health systems both in planning and in intervention strategies.

But much more remains to be done. You have exposed the AIDS crisis in the Americas and the Caribbean. Demands for prevention programs are on the increase. Resources are needed but they are not always easily mobilized. And the many thousands of people living with AIDS need effective care –including anti-retroviral drugs. They wonder why they cannot yet access the cheaper medicines. We have to continue searching for ways to get them what they need, in the long term, even though the challenges in some areas may seem enormous.

Nations in the Americas and the Caribbean are reforming their health systems. Ministers and senior officials have worked hard to do this in a way that responds to people's needs. Yet for many, the never ending reforms are frustrating. This is not surprising. The negotiations to agree standards for health systems staffing, financing and performance among the different interested parties are extraordinarily complex.

I want WHO to offer the right support to national reforms. I know, from my own experience, that the process of health system reform is not simple. But the stakes are high: we need to secure public support for our health systems, and we need to be credible. This means focusing our collective efforts on health outcomes, service quality and patient safety.

Life would be so easy if health systems could be reformed as a direct result of something said by Health Ministers, the WHO's Director-General or the PAHO Director, but that is not how it works. Action for health involves interplay among professionals, backed by evidence from research, and interactions which involve professional associations, politicians, the media and other campaigners.

Whether we like it or not, the achievement of health equity calls for effective and principled action by those who can access the levers of change. Effective advocates find ways to pull these levers, working both inside and outside institutions. They can draw on WHO for help –using our standards as a point of reference, using our technical materials to exercise influence. Sometimes we will go out in front, acting as pathfinders. More often, though, we are both the supporters' club and the training staff. We offer guidance and encouragement, and, I would hope, we are there when we are needed.

WHO should be in a position to help countries obtain information about their people's health, options for preventing or tackling illness, and tools for accessing the performance of health systems. We learn from your experiences and we share examples of best practice. Working with partners like the World Bank, regional banks and the OECD, we seek to help you compare your experiences with others.

To get the best out of investments in health we need to know the important health risks, and then tackle them with cost-effective interventions. What are the most important risks? This year's *World Health Report* to be issued in October, will provide some answers. It will remind us that the risks associated with underdevelopment are still exerting a high toll. They include unsafe water, poor sanitation and hygiene, unsafe sex (particularly related to HIV/AIDS), iron and other nutrient deficiency and indoor smoke from solid fuels. Other enemies of health are more associated with unhealthy consumption patterns. They include high blood pressure and blood cholesterol, tobacco use, excessive alcohol consumption, obesity and physical inactivity. These risks and the diseases they cause are dominant in all middle and high income countries.

Throughout the world, unhealthy consumption factors are replacing healthier ways of eating. Sedentary life has replaced regular activity. These changes are now starting to affect the health of all –young and old, rich and poor. We know that some cardiovascular conditions, types of diabetes and cancers can be prevented through dietary change and increasing exercise. WHO is now responding to a Health Assembly resolution with a global strategy on diet, physical activity and health. Member States will discuss these at six regional consultations during the next year. I know that countries in this Region will set the right tone for this work. Indeed I was particularly pleased to spend World Health Day in the Region, in Brazil, and see how physical fitness is such an important part of health promotion in São Paulo and beyond. In the *World Health Report 2002*, results from our analysis of the costs and effects of potential interventions to

reduce blood pressure and blood cholesterol send a very clear message: we can expect major reductions in the incidence of stroke and ischemic heart disease also through the more systematic use of antihypertensives, statins and aspirin. Luckily, there are effective medicines within these categories no longer on patent, making these strategies realistic globally.

Your experience shows the value of working together on key issues. Why else have we fought so hard to get concerted action against the product that kills half of its regular users? For decades we have known how to prevent each of the 4 million annual deaths caused by tobacco consumption. It is not difficult really: tax increases, advertising bans and regulations to keep indoor air clean.

In 1998, convinced that we must act, we examined Article 19 of WHO's Constitution, which can be used by Member States to negotiate global standards, and decided to use the Organization's treaty-making power to prevent tobacco-related diseases. By setting in motion the negotiations for the Framework Convention on Tobacco Control (FCTC) we were making history. The FCTC negotiations have reminded us about the critical role of the State in public health –particularly in setting norms and standards and ensuring that others adhere to them.

But such efforts encounter opposition. In all regions we find tobacco companies continuing to act solely in their own interests –safeguarding market share and profits, luring ever younger women and men into the smoking habit. Why? And how? With flawed science and false propaganda, often disguised as so-called corporate citizenship.

The first draft of the FCTC is now ready for the next round of negotiations in October. It spells out possible agreements on tobacco advertising, promotion, sponsorship, illicit trade in tobacco products, taxes and international corporations. I want to thank our host government here today for also hosting an International Conference on Tobacco Smuggling here this summer.

If countries want it badly enough, FCTC can become real and workable. But this means political determination in the final, crucial stages to determine the strength of WHO's first international treaty. Our target date for finishing is the Health Assembly in May 2003. The FCTC will then come into force. It will bring benefits to countries and to their people. It will help safeguard important public health policies, in a way that is tailored to national needs. I know that you are better prepared than ever before, and are committed to make the FCTC a treaty in the service of public health.

In early October we will focus on the public health consequences of violence. In 2000, 1.6 million people died as a result of violence. Half were suicides, one third were homicides and one fifth were due to war. Millions more are scarred for life by violence, for many the scars are locked away. Many of those affected are women. We need to break the silence and confront violence. That is why, early next month, I will launch the first World Report on Violence and Health. We want to raise the problem of violence as a public health issue and provide Member States with the tools to address it.

For me, WHO is a vibrant network of many parts with a very long reach. It touches the lives of billions of people in many different ways. It links –in a particular way– with each of its Member States. WHO’s skeleton is its regional structure: the regions are the bare bones on which our country action depends. The regions give WHO a unique strength. The diversity of countries’ needs is reflected within the regions, and this feeds through to our WHO-wide programs of work. In these ways regional perspectives influence the positions that WHO takes on all global issues. I want to express my thanks and appreciation to the staff of our country offices. But I also want to pay a special tribute to our dedicated staff in the Regional offices. The demands on them are many and –generally– they respond well.

Our performance within countries should be stronger. The Regional Directors and I are now looking at ways to improve our country operations. That is why we have launched the Country Focus Initiative. Remember, you may feel that in many areas of the Americas you have a strong country office system but globally this is still a considerable weakness.

WHO is present in 147 countries around the world. Within this Region we are working hard to build up our presence within countries. The Country Focus Initiative is particularly important. It will help to focus on countries’ needs, supporting effective health action through both standard-setting and technical cooperation. We will build on strategies for cooperation and memoranda of understanding between individual countries and WHO. With much of this, there is a lot of experience within PAHO. The whole Organization worldwide will respond to the strategic agenda for health in each country. We will build up the competencies of our country teams so that they are able to lead this response. We will do our best to transform WHO’s administrative systems so that WHO country offices operate more effectively, whether they are using regular or extra-budgetary funding. And we will encourage WHO country teams to work better with UN system agencies, World Bank and other development partners.

Friends and colleagues, when I started my term in 1998, I committed WHO to making a difference. Our analysis of the Global Burden of Disease encouraged us to set clear priorities, and I believe we have done so. We now have a focused approach to world-wide improvements in health that reflects our corporate strategy. We build on our regional perspectives and solidarity and we work with partners at all times. Together, we

are confronting the risks that contribute to ill-health world wide; we are scaling up action to address the health conditions that drive and are driven by poverty; we are making sure that the health sector plays a central role in curbing the pandemic of HIV/AIDS as well as non-communicable diseases and the tobacco menace; we are helping to establish health systems that are effective, fair and responsive to people's needs; and to underpin all these efforts, we are doing everything we can to put health at the very core and center of political attention. It is a challenging agenda and one which we can tackle only if we continue this focused effort together. Thank you."

The DIRECTOR presented Dr. Brundtland with a gift as a token of the affection and appreciation of the Conference.

Dr. BRUNDTLAND expressed her thanks to the Director and the Conference.

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

The SECRETARY recalled that under Rule 32 of the Rules of Procedure, a Committee on Credentials consisting of three delegates of Members or Associate Members was to be appointed by the Conference at the beginning of its first meeting to examine the credentials of the delegates of Members and Associate Members and representatives of Observer States and report to the Conference thereon without delay.

El PRESIDENTE SALIENTE señala que en la reunión de jefes de delegación efectuada en la mañana se propuso que Costa Rica, Guyana y Perú formasen la Comisión de Credenciales. Si no hay objeciones, Costa Rica, Guyana y Perú pasarán a integrar la Comisión de Credenciales.



The SECRETARY proposed that the meeting should be suspended to allow the Committee to meet and prepare its report.

*It was so decided.  
Así se acuerda.*

*The meeting was suspended at 10:05 a.m. and resumed at 10:45 a.m.  
Se suspende la reunión a las 10.05 a.m. y se reanuda a las 10.45 a.m.*

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

Dr. RAMSAMMY (Guyana) said that in accordance with the Rules of the Procedures of the Conference, the Committee on Credentials, appointed at the first plenary meeting and consisting of the delegates of Costa Rica, Guyana and Peru, had held its first session on 23 September 2002 at 10:00 a.m. and elected the delegate of Guyana as President. It had examined the credentials delivered to the Director of the Bureau in accordance with Rule 5 of the Rules of Procedure of the Conference, and had determined that the credentials of the delegates of the Member States and Participating and Associate Member States listed below were in order. It therefore proposed that the Conference recognize their validity. The accredited members were Antigua and Barbuda, Argentina, Barbados, Bolivia, Canada, Costa Rica, Cuba, Dominica, Dominican Republic, El Salvador, France, Guyana, Haiti, Jamaica, Mexico, Panama, Peru, Saint Kitts and Nevis, Trinidad and Tobago, the United States of America, and Uruguay. The accredited Associate Member was Puerto Rico. Member States that had not yet

presented their credentials were urged to do so as soon as possible so that they could be examined at the Committees' next meeting.

*Decision:* The first report of the Committee on Credentials was approved.

*Decisión:* Se aprueba el primer informe de la Comisión de Credenciales.

ITEM 2.2: ELECTION OF THE PRESIDENT, TWO VICE PRESIDENTS, AND  
THE RAPPORTEUR

PUNTO 2.2 ELECCIÓN DEL PRESIDENTE, LOS DOS VICEPRESIDENTES Y EL  
RELATOR

The SECRETARY said that under Rule 17 of the Rules of Procedure, the Conference was to elect a Member or Associate Member to the Presidency, the two Vice Presidencies, and the office of Rapporteur, respectively, who would hold office until their successors were elected. Each elected member or associate member should designate a person on its delegation to serve in that office for the duration of the session.

El PRESIDENTE explica que en la reunión de los jefes de delegación realizada en la mañana se acordó postular a Ecuador para la Presidencia.

*Decision:* Ecuador was unanimously elected to the Presidency.

*Decisión:* Ecuador es elegido por unanimidad para ocupar la Presidencia.

*Dr. Patricio Jamriska took the Chair.*  
*El Dr. Patricio Jamriska pasa a ocupar la Presidencia.*

El PRESIDENTE agradece la elección de su país para ocupar la Presidencia de la 26ª Conferencia Sanitaria Panamericana.

Seguidamente, dice que procede elegir a los dos vicepresidentes. Indica que por la mañana los jefes de delegación propusieron a Antigua y Barbuda y a Panamá.

*Decision:* Antigua and Barbuda and Panama were elected to the Vice Presidencies.  
*Decisión:* Antigua y Barbuda y Panamá son elegidos para ocupar las Vicepresidencias.

El PRESIDENTE informa que por la mañana se propuso a Uruguay para ocupar la Relatoría.

*Decision:* Uruguay was elected to the Office of Rapporteur.  
*Decisión:* Uruguay es elegido para ocupar la Relatoría.

ITEM 2.3: ESTABLISHMENT OF A WORKING PARTY TO STUDY THE APPLICATION OF ARTICLE 6.B OF THE PAHO CONSTITUTION  
PUNTO 2.3: ESTABLECIMIENTO DE UN GRUPO DE TRABAJO PARA ESTUDIAR LA APLICACIÓN DEL ARTÍCULO 6.B DE LA CONSTITUCIÓN DE LA OPS

The SECRETARY, recalling Article 6.B of the PAHO Constitution, pertaining to the suspension of the voting privileges of any Member State in arrears in an amount exceeding the sum of its annual payments of contributions for two full years, unless the Conference was satisfied that failure of the Government to pay was due to conditions beyond its control, said that it had been the practice of the Conference to appoint a working party made up of delegates of three Member States to study the application of the article.

El PRESIDENTE señala que en la reunión de los jefes de delegación celebrada en la mañana se propuso a Bahamas, Canadá y Chile para formar el grupo de trabajo.

*Decision:* The Delegates of Bahamas, Canada, and Chile were appointed members of the working party.

*Decisión:* Los Delegados de Bahamas, Canadá y Chile quedan nombrados miembros del grupo de trabajo.

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

The SECRETARY indicated that, according to Rule 33 of the Rules of Procedure, the Conference was to establish a General Committee consisting of the President of the Conference, the two Vice Presidents, the Rapporteur, and three delegates elected by the Conference. The President of the Conference would serve as President of the General Committee.

El PRESIDENTE dice que, en el marco de las conversaciones habidas en la mañana, los jefes de delegación han convenido en que Cuba, Estados Unidos de América y México integren la Comisión General.

*Decision:* The Delegates of Cuba, Mexico, and the United States of America were elected members of the General Committee

*Decisión:* Los Delegados de Cuba, Estados Unidos de América y México quedan elegidos miembros de la Comisión General.

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

The SECRETARY invited the Conference to consider the provisional agenda contained in document CSP26/1, Rev.1 in the light of Rule 11 of the Rules of Procedure.

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

ITEM 3.2: REPORTS OF THE PAN AMERICAN SANITARY BUREAU  
PUNTO 3.2 INFORMES DE LA OFICINA SANITARIA PANAMERICANA

- a) Annual Report, 2001, and Quadrennial Report 1998-2001, of the Director of the Pan American Sanitary Bureau*  
*a) Informe Anual, 2001, e Informe Cuadrienal 1998 - 2001 del Director de la Oficina Sanitaria Panamericana*

The DIRECTOR: “Mr. President, Dr. Brundtland, distinguished delegates, ladies and gentlemen: It is a constitutional responsibility that once a year the Director of the Organization should set before its Members those items which he considers to merit special attention or to reflect most faithfully the work of the Organization during that period. In previous years I have begun with an analysis of the social and economic context in which the technical cooperation was developed, but I am not going to do that this year, first of all because I think the events of recent years are well known to most of you and because this report is both annual and quadrennial. But, in addition to focusing on the last four years, I will attempt to give a flavor of the 100 years of our existence. It is obviously not possible to review the social panorama of the Americas over the past 100 years, so I will strive to set before you some of the events that have been the rivets of our 100 years of history. The report has two basic parts: I will speak about some of the activities of the Secretariat and the Member States which I think merit your attention, and then I will have my colleagues describe two of our publications, *Health in the Americas* and *Public Health in the Americas*. After the presentation of the second, I hope you will permit our Director Emeritus, Dr. Carlyle Guerra de Macedo, the opportunity to make some comments.

I began the report that you have before you, *Charting a Future for Health in the Americas*, with an essay. I thank Dr. Julio Frenk from Mexico for reviewing this essay in its draft form and Dr. Judith Navarro for editing it and for the preparation of most of the report. My essay begins with a quotation from Psalm 107: “They that go down to the sea

in ships, that do business in great waters: these see the works of the Lord and his wonders of the deep.” This nautical flavor, which will permeate much of what I have to say, derives from my upbringing. I was born in Barbados, an island, and things of the sea have always been near and dear to us. I remember being taught very, very young the lines of John Masefield’s “Sea Fever”: “I must go down to the seas again, to the lonely sea and the sky,” and having to learn word for word Samuel Coleridge’s “Rime of the Ancient Mariner,” with its memorable verse, “Water, water every where/ And all the boards did shrink/ Water, water every where/ Ne any drop to drink.” And this last report as Director of the Pan American Sanitary Bureau allows me to envision the Bureau as the “Good Ship PAHO” and reflect on where we have voyaged in the past and what course we might chart for the future.

This is the year of our Centennial, and much has been written of this institutional odyssey of 100 years. All countries have chronicled experiences in health as they bear witness to, and celebrate, the history of the Organization. We remember with affection the previous directors who have guided this ship: Drs. Soper and Horwitz, and Drs. Acuña and Guerra de Macedo, whom we have the pleasure of having with us here today. I owe a debt of gratitude to them all. I never tire of speaking not only of our directors but of the health workers in countries, who are the true heroes of health in the Americas.

In the essay, I refer to the various strong currents that I think will guide or direct the work of the Organization. I refer to them as transitions—the demographic and epidemiological transitions, together with transitions caused by exposure to ever-changing environmental risks—that will determine what we are and what we do. All the countries in the Americas are contending with an epidemiological mosaic comprising a wide array of diseases and health problems. It is not a question of one stage of the transition ending and one beginning. It is a mosaic in which we have to deal with all the problems at the same time. A major contributor to the most fundamental demographic shift in the Americas has been the conquest of the main causes of childhood mortality. But another aspect of the health transition that has not been given sufficient prominence is the change in the determinants or vectors of the various diseases or health problems that confront us. Pasteur made it easy for us to understand the microbial causes of disease. Less discernible is the insidious role of propaganda as a vector or agent of modern diseases across borders. As Dr. Brundtland pointed out this morning, the three most egregious examples are modern epidemics related to changes in behavior, such as smoking, alcoholism, and obesity.

The aim of much of our work over the past 100 years has been to reduce the threat of infectious diseases through attention to environmental factors. In the course of the next 100 years, undoubtedly new tools will be found, and new tools will be needed to cope with new epidemics and new vectors. I hope and pray there will be more emphasis on health promotion and health promotion strategies, which I think are essential for dealing

with the new transitions. I continue to believe that information is critical to stopping the spread of the new pandemics, whether infectious or non-infectious in origin.

We are fond of referring to our age as the “Information Age” and tend to forget that every age has been one of information. The changes wrought by Gutenberg’s movable-type printing press in the spread and use of information may have been every bit as profound as the changes we are witnessing now. In this sense, one could trace a direct line from Gutenberg to Gates. However, what is different today is not only the speed at which information is transmitted, but the reduced cost of its transmission. The modern epidemics I mentioned before—those of tobacco, alcohol, and obesity—were spread across borders by the facile dissemination of information in the form of advertisements.

The concept of global public goods has become popular. PAHO has managed information as a global public good from the beginning. Information is a critical aspect of what we do, and the challenge for us in the next 100 years will be to continue to produce and use information as a global public good.

Another of the great changes that has influenced us and will continue to do so is a transition in relations between our member countries. On 2 December 1902, the President of the first meeting of the Bureau, Dr. Walter Wyman, said: “We have come together to give one another interesting and necessary information about ourselves, to give encouragement by telling of the good work that is going on in each Republic, and at the same time, in a fraternal manner, to confess the shortcomings of each, with the confident assurance of that sympathy and aid which one member expects confidently of the other members of the family.” We are a family, as Secretary Thompson pointed out this morning.

I think when we look at our history, the institutional emphasis at the start was very much on preventing disease within the borders of individual countries. The second half of the century witnessed a great change, in which countries of the Americas began to appreciate and realize that it was possible to target the prevention and control of diseases in the Americas as a whole and not restrict themselves to one particular country. This transition, from within country to multi- and intercountry, has challenged the Organization to adapt the form and focus of its technical cooperation.

Another transition under way in the political world—one aggravated by the events of 11 September 2001—could also be expected to affect our work. This is the transition in the concept of the nation state. The nation state took shape after the Thirty Years’ War and the signing of the Treaty of Westphalia in 1648. This saw the end of the feudal system, the decline of the Holy Roman Empire, and the development of the concept of a nation state. That unitary state has been the dominant paradigm for some 300 years. The multilateral system, with the United Nations at its epicenter, was an arrangement among sovereign states.

However, over the last century we have seen growth in the pluralism that was evidenced before the Treaty of Westphalia. We have seen the growth of the kind of pluralism that Peter Drucker called “a congeries of autonomous and semiautonomous institutions,” each concerned with its own cause, its own values, its own welfare, and, unfortunately, its own aggrandizement. This political transition towards greater pluralism is going to have an impact on the governance of our Organization in years to come, because the day will surely come when the governmental structure of our Organization will have to address the claims of other legitimate actors to participate in its governance.

The formation of the United Nations in 1945 represents the hope of the world for a multilateral system that puts the common interest and welfare of mankind to the fore. However, we have sometimes seen a tendency towards unilateralism. The undisputed dominance of the United States in so many fields has led inevitably to the perception of a predilection for unilateral action. However, it has been a matter of great pride and satisfaction to us that the United States has been a genuine partner and champion of the Pan American approach to the health problems of our Region. As an example, I have only to cite the participation of the many agencies of the United States: the Centers for Disease Control and Prevention, the National Institutes of Health, the Fogarty International Center, and others.

There is general agreement, however, that the horrible and nefarious terrorist attacks of September 11th have thrown into sharp relief the concept and need for the multilateral approach. I am very fond of the recent publication by Joseph Nye, *The Paradox of American Power—Why the World’s Only Superpower Can’t Go It Alone*. In an interesting analogy Nye posits that the interrelationships between nations can be viewed as a chess board with three-levels. On the top level is the dominant military power; on the second level relationships among those nations with economic importance and economic power. On the bottom level of the chess board is the realm of transnational relations that cross borders, outside of government control. At this bottom level, power is widely dispersed. It is at this third level that influence is wielded through what he calls “soft power,” and I have always been grateful to a former Minister of External Affairs of Canada for articulating so clearly the importance of “soft power” in international relations. International order is one of those global public goods that are of critical importance for all nations, and this is assured in large measure by the exercise of “soft power.” In our Organization, perhaps that is the only power we have. The growth of pluralism within the nation states must never blind us to the fact that there are certain responsibilities that devolve on the state and cannot be avoided or delegated.



The last of the great transitions through which our Good Ship PAHO will have to chart a course is the social transition, which will come in many forms. One of the most important transitions will be the ever-changing role of women. We will see greater attention paid to discrimination against women—to the gender discrimination that is nefarious by being so insidious. The changing role of women will have positive implications for the Organization. We are proud that in PAHO 45% of our professional staff are female.

But the most significant of the social transitions taking place results from the almost inexorable drift towards a liberal market economy—driven in part by economic globalization. Some would contend that globalization is not a new phenomenon, that it existed in the early part of the previous century. And they will say that many of the problems that beset the world at the beginning of the last century were caused by globalization. It is our hope that the social safety nets developed as a result of the last period of globalization will assuage any possible negative effects of this new wave of globalization.

A fundamental aspect of our work is assessment of the population's health. Presenting to the countries information about the state of health is the bedrock of our work, the nub and pith of what we do. You will hear more about this when Dr. Castillo presents *Health in the Americas*. I take some satisfaction in the restructuring of the Secretariat to create the Special Program for Health Analysis, which reports to me on the health situation and trends. Dr. Castillo will also tell you more about what has been achieved in that regard and about the establishment of the Core Health Data Initiative, which has five basic components: the Basic Indicators brochure, with which many of you are familiar and which has now been seen in many other parts of the world; our web-based table generator system; an indicators glossary; country profiles, which you will find on our Internet site; and a geographic information system that is in development.

In the document are references to measured inequalities in health, and you will find many examples of the use of data to demonstrate health inequalities. Indeed, before one can speak of inequity one must have the basic data to demonstrate where the disparities are and where they exist. You will see mention of the strategic use of epidemiology and you will see mention of our countries establishing “situation rooms.” Many of these situation rooms came into play during conditions of emergency, as in Venezuela when that country suffered from floods. But it is not only in situations of emergency that these situation rooms have become important; they allow the ministers to see the state of health in their countries at the peripheral as well as the central level and what can be done and is being done about it.

Moving on to health and human development, whenever I speak of this area I have to go back to our founding, because when our Organization was founded it was envisaged that what we did in health would contribute to the promotion of trade and

commerce—trade and commerce being then one of the essential aspects of the economic development of our Region. And we would like to think that we have kept faith with our founders in that we have tried to posit the importance of health and human development, as you have heard Dr. Brundtland so elegantly put it this morning. Dr. Horwitz and Dr. Guerra de Macedo have been in their times champions of the idea that health is an intrinsic part of our human development. You will also find reference to our advocacy of health being a means—not only a good in itself, not only a constrictive good, but health also as a means for ensuring the acquisition of other aspects of human development.

The report describes the coordination of a new approach to health research, and this is based, obviously, on strengthening our ability for data collection and provision of information. It also refers to the development of several multi-centric studies. I refer here specifically to the support of agencies like the Fogarty International Center that has been a champion of this approach to health research. And when we speak of mediating evidence, measuring evidence, action for health, and the use of health information, we can never forget what has been done in the last couple of years: the creation of the Virtual Health Library, and I am grateful to the government of Brazil for its support for BIREME, our center there. That center has developed the concept that you might have a virtual library in which all the health resources, the information resources of all the continent, might be available to anyone who has the possibility of accessing the Internet. I have said, and not only in jest, that the Virtual Health Library would become the “yahoo.com” of health information in the Region of the Americas.

The Regional Program on Bioethics is also discussed, and I would like to thank the Government of Chile for hosting the Pan American Center on Bioethics and for being so generous in contributing to its maintenance, because there is no doubt that as we move forward, ethics has to be an important part of what we do.

The report speaks of mainstreaming gender. One of the areas of great satisfaction to me has been the growth of the Program on Women, Health, and Development and the affirmation that the importance of gender lies not in mere rhetoric but in demonstrating that one can determine and detect those differences that are based on gender discrimination and show what can be done to correct them.

In the area of preventing and controlling disease, as I have said, this was at the core of our beginning. The Organization was set up to gather information about the control and spread of infectious diseases so that there should be better movement of commerce in our countries. Today, the successes in eliminating such diseases as smallpox and poliomyelitis are well known, and soon measles will be nothing more than a mere memory. You will hear from Dr. de Quadros later what has been done in the Region of the Americas in the area of immunization, and I am sure he will make you proud of the leadership this Region has given to the world as a whole in terms of immunization. Measles, no doubt, will be history, as I said. There is documentation to

show that 30 million measles cases and 800,000 measles deaths occurred in the world in the year 2001. There is also documentation that in the Region of the Americas there were only 537 cases of measles in that year. This is a tribute to what our countries have done to maintain vaccination and to maintain the Vaccines and Immunization Program high on the list of things that they wish to emphasize.

When I was reelected, I said that we should try to save another 100,000 children's lives, and the basic instrument for that was the Program on Integrated Management of Childhood Illness (IMCI). I am pleased that there has been progress in that regard, and I am pleased that, if we look at the period between 1998 and 1999, there has been an overall reduction in child mortality of over 7.3%. Mortality from diseases targeted under the IMCI initiative has declined by about 15%, and there have been some 22,000 fewer deaths of children from those diseases.

We must not forget, however, that part of our remit is to attend to the preventable diseases that are more evident among the poor—diseases like malaria. When we look at such diseases it brings back to us quite clearly why we in public health have to be modest and not exhibit the hubris that will bring nemesis in its train because we have failed in some areas. One of the areas in which we have failed is that of dengue. I feel badly that, in this day and age, dengue is still a scourge upon us. Neither have we done as well as we had hoped in the area of tuberculosis, although let me pay tribute here to the Government of Peru for its magnificent attempt to mount an exemplary program in the area of tuberculosis.

You will hear more about attempts to combat HIV/AIDS, and I am sure you were warmed by Secretary Thompson's words on the subject. But, I would like to emphasize the optimism that must go along with the concern for AIDS, because in this Region, there are clear examples of what can be done—examples from Brazil, with its efforts to make treatment available to large numbers of people, and examples from the Bahamas, which is one of the best kept secrets of what a small country can do to confront the AIDS epidemic with few resources.

The report discusses reducing the risk of noncommunicable diseases and shows what has happened in the various countries of the Americas to do just that.

We must not forget that some of our programs deal with veterinary public health and how we can protect food and safeguard the public's health. I always recall with affection the meeting we held last year in São Paulo, when the ministers of health and ministers of agriculture got together and signed an agreement that would allow us to work to advance the cause of eliminating those problems that come from infected food.

We must not forget the eradication of foot-and-mouth disease and the tremendous work that is being done in our center PANAFTOSA, which is supported by the Government of Brazil in the same way that the Government of Argentina supports our center INPPAZ, which deals with food protection. In spite of an outbreak of foot-and-mouth disease in the second semester of 2000, we think that the countries of the Americas have taken the appropriate steps and are on track to have themselves declared free of foot-and-mouth disease in the not too distant future.

The issue of promoting and protecting health is next dealt with, and this is one of the divisions which I created, the Division of Health Promotion and Protection, to demonstrate that the basic strategies of health promotion are not merely things on paper, but can produce actual results. Today we recognize the active application of the strategies of health promotion—these are essential in preventing much of the disease that still burdens the Americas as well as maintaining *mens sana in corpore sano*.

When we speak of enhancing families' and the population's health, I am cheered by the advances that we have seen in the whole movement towards healthy municipalities. The Minister of Health of Paraguay invited me to visit the border with Argentina, and there we met the Minister of Health of Argentina and saw a number of Healthy Municipalities where the children were setting out to demonstrate that their communities could be made healthy. In Uruguay I have seen what has been done, what is being done, to bring all sectors together with the sole purpose of creating healthy communities, demonstrating how a hospital can be more efficient, how it can reduce its number of beds and attend more people; how the community can be involved from the children of the first generation to the older generation, how they can all be involved in creating healthy communities. These are some of the experiences that warm our hearts, that show that the issues of healthy communities and of health promotion are alive and real.

In the area of adolescent health, we are happy to present progress. One of the first new appointments I made on assuming the directorship was an appointment in adolescent health and I have always been pleased that I did that, because in recent years, modesty apart, we have become pioneers in adolescent health, helping adolescents to avoid behaviors that lead to unfortunate events later in their lives. We must not forget, however, that health is not a province only of the young: on page 90 of the report, you will find a picture of which I am very proud. It is my meeting with the world's oldest lady, Elizabeth "Pampo" Israel, born in 1875 in Dominica and at 127 reputedly the oldest living person in the world. And, I must tell you, the interview with her was very interesting because she quizzed me more than I quizzed her. She is still very alive and still very vibrant, this good lady of 127. I asked her what her secret was— and at some other time I will tell you what she said.

I must mention our activities in food and nutrition, one aspect of which is micronutrients and the concern that iron-deficiency anemia still is a major scourge in our countries, especially in women. I must thank the Government of Canada for its initiative to support the micronutrient initiative, for which I have great hope.

Dr. Brundtland mentioned physical activity this morning, and I take up her challenge to continue our work in this regard. We promise you, Dr. Brundtland, that we will carry out regional consultations which will help to strengthen our capacity in this particular area. Right from the beginning, from the time of Hippocrates, it was known that the environment was important to human health. The report illustrates some of the work that we have done in this area, including how we have struck alliances between the health and environmental sectors. We were pleased to be able to go to Toronto, Ottawa, for the meeting of health ministers and environmental ministers in which they found so many points in common and agreed to work together in so many critical areas, such as the elimination of pesticides. On that topic, I was intrigued by the demonstration by Mexico of how it was possible to eliminate the use of DDT and still have adequate vector control.

During the course of the last four years, an evaluation of the regional water supply and sanitation services was conducted. It was a genuine *tour de force* which has produced a tremendous amount of data on the environmental health situation in our Region. Primary environmental care is always important, but it takes center stage when we deal with disasters. Since 1976 the Organization has had a program for reducing countries' vulnerability in the face of disaster. We say, not in jest, that a disaster is really a situation in which we as human beings have not been competent enough to avoid the impacts of hazards. In a real sense, there is no such thing as "natural disasters"; disasters take place when we do not put in place the mechanisms for avoiding the deleterious effects of those hazards.

In describing health systems and services development, it is pointed out that they are the basis on which much of what we do will be supported. We have had the mandate from the First Summit of the Americas, held in 1994 in Miami, to move forward in that regard. Later on, Dr. López-Acuña will make a presentation on *Public Health in the Americas*, which will be commented on by Dr. Macedo. That publication is the culmination of a large amount of work in the last four years to present a panoramic view of what public health is like in the countries of the Americas. It also points out the need to extend social protection in health. A couple of years ago, I signed an agreement with the Director-General of the International Labour Organization, Juan Somavía, in which both organizations agreed to work together to reduce social exclusion in health. But we also have to strengthen the delivery of health services. We all know the contribution of health services to overall health outcomes, and it behoves us to make our health services as efficient as possible. The report describes the work we do in trying to improve these health services. I must mention here one area that is sometimes forgotten, namely, oral

health. I am pleased about the progress in the last few years in oral health and that our goal that all the children of the Americas should have healthy smiles is coming to fruition. The wide acceptance of fluoridation is really making a difference, as we are seeing a dramatic decline in dental caries in many parts of our countries.

One of my commitments when I was reelected was to try to ensure the safety of the blood supply. Not all the blood is safe, but the report records what has been done to promote non-remunerated blood donation and other work in this area with partners such as the American Red Cross and the International Federation of Red Cross Societies.

However, it is not only in these technical areas that we have seen progress. Subregional integration has also been strengthened. It has been a part of my philosophy that we should seek to strengthen the subregional movements, and there is no contradiction between doing so and strengthening the Pan American Health Organization as such. We believe also that it is not enough for PAHO to provide technical cooperation to the countries; we should also encourage technical cooperation among countries. The report mentions the increase in funds allocated for that purpose, along with some examples of what has happened over the last four years in terms of relationships between countries.

We have been pleased that many of our partners have seen fit to have us execute funding for them, and we would like to thank our partners for helping us mobilize resources. For us, 2000-2001 was a banner biennium in that we significantly increased our extrabudgetary resources. From 1998 to 2001, we have seen a 28% increase in the extra-budgetary resources that have been mobilized. This is one area where we have to thank all of our staff and, most especially, the Office of External Relations. I include here the work of our Pan American Health and Education Foundation (PAHEF), a creation of Dr. Horwitz, which has been a mechanism through which we have been able to mobilize significant additional resources. I would like to thank the last two chairpersons of this Foundation for the work they have done.

Dr. Brundtland put the issue of health on the political agenda, and we are pleased that in the Region of the Americas, health has a strong place on the agenda of our hemispheric summits. In every one of these summits, health has been prominent in the discussions of presidents, and we have been proud partners in trying to follow up on some of the changes and some of the charges issuing from these summits.

It was four years ago this week, in discussions with the Inter-American Bank, that I presented to President Iglesias the possibility of having a shared agenda for health in the Americas. Today, we have an arrangement between the Inter-American Bank, PAHO, and the World Bank that we should put our heads together and not try to duplicate one another's efforts, but rather to complement them in a "shared agenda for health in the Americas." I am pleased at the way that initiative has developed. Another area with

which I am pleased is our work with religious groups, where we have promoted the idea that various religious faiths share much common ground with us in health.

I have said on many occasions that we are proud of our continued transparency, in both a fiscal and a programmatic sense, and you will find in this report a transparent account of our budget as well as developments in other areas. You will also find clear demonstrations of the slow but steady increase in the resources allocated to our country offices. If we add together all resources allocated to country offices, we see that around 85% of our spending goes directly or indirectly to these offices. In this regard, our Department of Finance provides sterling support. One of the best encomiums of this department came from a bank which looked at our investment guidelines, considered the current interest rate environment, and concluded that the Organization is clearly maximizing the returns on its investment. This is your money. We are very cautious about what we do with your money, and are very pleased that we have been considered careful stewards of your money.

The honor roll of our partners is a long list that always carries the risk of omitting someone. We refer here to our personnel, because in the final analysis, our personnel make or break the Organization.

Finally, I want to deal with an area which, though mentioned previously, is of fundamental importance. This is the management of information. We have seen the growth of connectivity in the Organization. The bandwidth available to the Organization and its offices has increased almost ten-fold in the last four years, and we have seen more of our offices being able to interconnect with each other as a result. We have also seen our communications system improve significantly.

If you are pleased with the way this building is kept, I think we must give thanks and praise to our General Services. In certain specific areas, such as how we service our countries by procuring supplies, service has tripled from the last quadrennium to this one. In the area of machine translation, where we have been the pioneers, service has likewise increased considerably.

In the area of public information, you are surrounded by evidence of the information we have produced for our publics. In addition to this information, we think it is a part of our mandate to produce and disseminate scientific and technical information. Since our Organization was founded in 1930, the first journal, the *Pan American Sanitary Journal*, has continued publication without interruption, though its name is now the *Pan American Journal of Public Health*. Throughout these years, it has served as a showcase of health work in the Americas. I believe PAHO remains today the premier publisher of information about health in the Americas. I am particularly pleased that effort has been devoted not only to the production of scientific and technical information, but also to its marketing, as information that remains on a shelf does little good. As you will hear later

when we discuss the relevant document, strategic planning has been a tremendous exercise that has probably involved the greatest participation in planning for this Organization that I have ever witnessed.

This brings me to the end. I could not end without thanking all of the staff of the Pan American Health Organization. I like to think that we are few, and a happy few. I would like to think that we are a family. I remain eternally grateful to the 2,400 members of PAHO who have contributed in every great way to what has been achieved over these four years.

Let me read, if you permit, the last lines of my report, with its nautical flavor: ‘I have outlined some of the major transitions that I regard as the currents that the Good Ship PAHO must note and log as it charts its course for the future. The Organization will not be able to avoid them and, indeed, must even take advantage of those that are favorable. Unfortunately, as is the nature of currents, they do not necessarily flow together or in the same direction nor with the same force. The transitions that are driven by technology and many of the aspects of globalization are evolving much more rapidly than the social transitions. Such is their nature. In addition, we often observe a “concertina effect” with many of these changes, as they are apt to be squeezed together and compressed because of other transitions acting upon them.

I have no doubt, however, that the ship will be steady and that those who come after me will do business in great waters, and the wonder they will see will be the ever-improving health of the people of the Americas.’

And I will leave you with an old Latin quotation. “*Ave et vale*—hail and farewell!”

El PRESIDENTE dice que sobran las palabras ante el aplauso otorgado al Director en reconocimiento del informe que ha presentado sobre los últimos cuatro años de su administración.



- B. *Health in the Americas*
- B. *Salud en las Américas*

El Dr. CASTILLO SALGADO (Jefe, Programa Especial de Análisis de Salud) presenta la publicación titulada *La salud en las Américas 2002* ayudándose de la proyección de una serie de transparencias. Destaca que, desde 1954, este informe ha presentado cada cuatro años una evaluación de las tendencias en las condiciones de salud en la Región. Miles de profesionales de la salud y autoridades nacionales de salud, así como el personal de las representaciones, centros y unidades técnicas, participan en la producción de esta importante publicación, que ha tenido y tendrá un impacto primordial. Por ejemplo, durante los últimos tres años se han descargado 500.000 copias de estos informes en la Internet. El volumen I ofrece la perspectiva regional de los aspectos más destacados de la salud pública y el volumen II presenta los perfiles de salud de cada uno de los países.

Es importante mencionar los cambios fundamentales que se han registrado en las tendencias en la Región de las Américas. En 2000, la población llegó a 833 millones de habitantes, lo que significa que ha habido un gran incremento demográfico con respecto a 1950, cuando había 331 millones. La población mayor de 64 años está creciendo a un ritmo superior al 2% anual, y el 78% de la población de las Américas vive en zonas urbanas. Observando las pirámides demográficas y las diferencias entre los años 1950, 1980 y 2000, se puede percibir el gran incremento de la población de personas mayores, así como las diferencias entre los países y las subregiones. A este respecto, América Latina y el Caribe tienen un perfil distinto de América del Norte.

También es importante destacar que el crecimiento económico de los países ha tenido un incremento desafortunado de las brechas entre los ricos y los pobres. Ha habido un crecimiento económico muy pequeño de los países pobres y es importante valorar la brecha que existe, puesto que el 20% de la población más rica tiene el 58% del ingreso, mientras que el 20% más pobre solo tiene el 4%. Estas diferencias en la equidad tienen un gran impacto en las condiciones de salud en los países.

A pesar de esas diferencias económicas, el sector de la salud en las Américas ha tenido un enorme impacto poblacional, como puede verse en el crecimiento de la tendencia de la esperanza de vida para el año 2000, que es de un promedio de 72,4 años. La diferencia entre el país que tiene la esperanza más baja (53 años) y la más alta (79 años) es de 26 años.

También es importante destacar el impacto del acceso al agua potable. En Centroamérica, por ejemplo, por cada 1% de la población con acceso a agua potable, la mortalidad infantil pudo reducirse en 1,4 muertes por 1.000 nacidos vivos, puesto que hay una tremenda relación entre la falta de acceso al agua y la mortalidad infantil. Por otro lado, cuando se revisan las principales causas de muerte por grupos de causas se puede observar las diferencias en la reducción que ha habido entre 1980 y el 2000, particularmente en las enfermedades del aparato circulatorio.

Seguidamente el orador hace mención a muchas de las acciones que los países han realizado en los últimos 20 años y que han tenido un gran impacto en los niveles de salud de la población. Se refiere concretamente a la atención primaria. Las acciones que los países han realizado en este campo han logrado un gran impacto en la esperanza de vida y los años de vida ganados en la población. La esperanza de vida ganada de 1980 al 2000 ha sido gracias al control de las enfermedades transmisibles y cardiovasculares. La gran parte del aumento de la esperanza de vida se ha producido en menores de un año y en menores de cinco años. En esos grupos de edad, los programas de atención primaria, de sales de rehidratación oral y fundamentalmente también de inmunización han tenido un impacto primordial. Para poder mostrar estas tendencias se ha presentado también en el informe los máximos aportes de ganancias atribuibles al control de enfermedades prioritarias, por ejemplo, diarreas agudas y enfermedades respiratorias, y a las vacunas. Es importante mencionar asimismo la reducción del tabaquismo en los varones, que ha contribuido a aumentar la esperanza de vida. No puede decirse lo mismo con respecto a las mujeres, para quienes el impacto del tabaquismo es negativo.

El riesgo absoluto de mortalidad de los años ochenta a los noventa ha disminuido en un 25%, es decir se obtuvo una ganancia de seis años en la esperanza de vida. El 50% de este aumento se debe a los programas que más impacto han tenido, particularmente en los niños. Se han ganado dos años en la esperanza de vida básicamente por el trabajo realizado en la población de menores de un año. Pero existe una disparidad enorme en la esperanza de vida de los países con una gran brecha en los ingresos, y no solo porque sean pobres o ricos. Hay países ricos con grandes diferencias económicas que tienen

peores condiciones de salud que algunos países pobres pero con una mejor distribución del ingreso.

La OPS ha desarrollado una metodología que permite identificar cuántos años de vida perdidos se pueden evitar y el gran trabajo que falta por hacer en el campo de las enfermedades transmisibles, fundamentalmente las cardiovasculares, las perinatales, en algunos países la diabetes, la violencia y los homicidios. También es importante la carga de tres enfermedades en los varones: el SIDA, que es una de las enfermedades infecciosas que tiene mayor impacto en la población relativamente joven; la violencia, que tiene el pico más elevado, y la diabetes. En las mujeres, destacan el SIDA, la diabetes, y el cáncer pulmonar.

Hay que reconocer que las diferencias regionales y las tendencias exigen una caracterización en forma individual debido a las disparidades y brechas que presenta cada país.

Finalmente, dice el orador que como ha señalado el Dr. Alleyne es apropiado recordar uno de los objetivos del Código Sanitario: “El estímulo del intercambio mutuo de información, que ha de ser valioso para mejorar la salud pública y combatir las enfermedades del hombre. Así fue en el principio. Así debe ser por siempre”.

- C. *Public Health in the Americas*
- C. *Salud pública en las Américas*

El Dr. LOPEZ ACUÑA (Director, División de Desarrollo de Sistemas y Servicios de Salud) dice que la iniciativa denominada “La salud pública en las Américas” fue alentada por el Dr. Alleyne al inicio de su segundo mandato como Director de la Oficina Sanitaria Panamericana. Hace dos años, el Consejo Directivo, en su 42.<sup>a</sup> sesión, solicitó que la iniciativa se emprendiese en todos los países con el apoyo de la OPS. En esta iniciativa se ha tenido permanentemente la asesoría, el compromiso y el trabajo intenso del Director Emérito de la Oficina, Dr. Carlyle Guerra de Macedo. También ha habido una colaboración estrecha con los Centros para el Control y la Prevención de Enfermedades de los Estados Unidos. La razón de ser fundamental de la iniciativa es la de facilitar una base conceptual y operativa para fortalecer la práctica de la salud pública de los países de las Américas; al mismo tiempo, se confía que esto constituya un elemento fundamental para promover la salud pública como un componente importante y muchas veces olvidado de los procesos de reforma del sector de la salud. Uno de los objetivos de la iniciativa ha sido elaborar una definición consensuada en toda la Región de las 11 funciones esenciales de salud pública que tienen que desempeñar las autoridades sanitarias; esto se ha hecho a lo largo de los últimos tres años mediante una amplia consulta con los medios académicos y profesionales. Además, fue necesario elaborar una metodología y unos instrumentos para medir el desempeño de estas 11 funciones esenciales, con el objeto de que ello sirva de base para mejorar el ejercicio de la práctica de la salud pública. Una vez hecha la radiografía de la situación de las 11

funciones esenciales en cada país, en las subregiones y en la Región en su conjunto, el siguiente paso consistirá en formular marcos de análisis y de referencia para elaborar planes de acción para el desarrollo de la práctica de la salud pública, la creación de la fuerza de trabajo correspondiente y el auspicio de esquemas y mecanismos de cooperación internacional en este campo.

A continuación, el orador presenta el libro en el que se resumen las actividades mencionadas, titulado *La salud pública en las Américas*, y reseña sucintamente su contenido. En su primera parte, el libro plantea las razones por las cuales hay que fortalecer la práctica de la salud pública en la Región, que muchas veces ha quedado rezagada en el enorme vértigo de las reformas sectoriales. De manera complementaria, se abordan los desafíos que se plantean para reforzar la función rectora de las autoridades sanitarias, uno de cuyos pilares fundamentales es precisamente el desempeño adecuado de las funciones esenciales de salud pública. En la segunda parte del libro se examina la renovación conceptual necesaria para mejorar la práctica de la salud pública, y se hace un resumen de la historia de la salud pública, con miras a identificar algunos de los factores básicos que van a seguir definiendo su evolución. Se abordan también los elementos centrales de la salud pública, como son sus objetivos, los actores que intervienen, así como los elementos necesarios para su promoción y su práctica dentro de los sistemas de salud. Se establece que la salud pública debe ser un quehacer de la sociedad en su conjunto para mejorar y proteger la salud de la población, pero bajo la responsabilidad fundamental del Estado. A propósito de esto último, en el capítulo 5 se establece un aporte innovador por el cual se pretende definir mejor las prácticas sociales que tienen

una relación estrecha con la salud pública. Finalmente, se discute lo que es necesario hacer para impulsar una mejora en la práctica de la salud pública, con el objetivo último de mejorar la salud de la población.

En la tercera parte del libro se presentan las bases utilizadas para medir el desempeño de las funciones esenciales de salud pública y el resultado de su aplicación en 41 países y territorios de la Región. Se muestra el fundamento lógico de la medición, el desarrollo del instrumento y el proceso mismo de medición. Los resultados se presentan en forma de tendencias regionales y subregionales, y cada país cuenta con su informe propio.

En el capítulo 12, se presenta un estudio de caso de la experiencia de los Estados Unidos de América en la medición a nivel subnacional. Se pretende desglosar el quehacer de las autoridades sanitarias nacionales a los niveles subnacionales hasta el punto que permita identificar las áreas prioritarias en el punto más cercano a la toma de decisiones locales y para propósitos de asignación de recursos. Esto es sólo una muestra del perfil de las 11 funciones esenciales de salud pública trazado en los países con respecto a un patrón óptimo posible que fue predefinido y que supondría una puntuación de uno para cada una de las 11 funciones que están siendo desempeñadas. En la Región en su conjunto hay funciones que, en términos generales, requieren un fortalecimiento mucho mayor, como la función de garantía de calidad de la atención de salud, la del desarrollo de recursos humanos o la de gestión y planificación de la salud pública. Con todo, el orador señala que la función 11, que se refiere a los preparativos para desastres y situaciones de emergencia, fue la que tuvo el máximo desempeño en toda la Región. Esto

guarda una gran relación con lo que menciona el Dr. Alleyne en su informe cuatrienal, es decir, el hecho de que durante prácticamente dos décadas ha habido un esfuerzo continental concertado con una cooperación intensa de la Organización, los Estados Miembros y otros socios para fortalecer la capacidad institucional para los preparativos de desastres. Por último, en la cuarta parte del libro se intenta entreabrir algunas puertas para el futuro y plantear algunas rutas que habrán de recorrerse, sobre todo a partir de las enseñanzas extraídas de la medición del desempeño. En este sentido, se plantea la imperiosa necesidad de actuar de una manera mucho más decidida y concertada para el fortalecimiento institucional del desempeño de las 11 funciones en un marco integral que esté ligado a los procesos nacionales de planificación. También es necesario mejorar la estimación del gasto y el financiamiento relativos al cumplimiento de las funciones esenciales de salud pública y de establecer bases para el cálculo de costo y la presupuestación que, entre otras cosas, ayude a las autoridades sanitarias a gestionar y hacer la promoción necesaria para la asignación de recursos que se requiere para sostener estas funciones esenciales del Estado. Un tema crítico es la necesidad de poner un gran énfasis en el desarrollo de la fuerza de trabajo en salud pública, todo lo que supone el desarrollo de competencias de los profesionales de salud pública para poder llevar a cabo estas 11 funciones esenciales. Finalmente, el último capítulo aborda todas las posibilidades que la OPS ofrece a los países de la Región en su conjunto, como organismo internacional especializado en salud, trabajando con los países y con otros socios de la cooperación internacional que puedan sumarse al esfuerzo para poder concertar la acción para mejorar la práctica de la salud pública a partir de la evidencia



general de una medición del desempeño que permita entender dónde están las debilidades y dónde están las fortalezas en la operación institucional para llevar a cabo estas funciones.

*The session rose at 12:30 p.m.  
Se levanta la sesión a las 12.30 p.m.*