PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

26th PAN AMERICAN SANITARY CONFERENCE
54th SESSION OF THE REGIONAL COMMITTEE

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PROVISIONAL SUMMARY RECORD OF THE FOURTH MEETING
ACTA RESUMIDA PROVISIONAL DE LA CUARTA REUNIÓN

Tuesday, 24 September 2002, at 2:30 p.m.
Martes, 24 de septiembre de 2002, a las 2.30 p.m.

President:		
Presidente:	Dr. Fernando Gracia García	Panamá
Later:		
Después:	Dr. Patricio Jamriska	Ecuador

(continued overleaf)
(continúa al dorso)

CONTENTS
CONTENIDO

The meeting was called to order at 2:45 p.m.
Se abre la reunión a las 2:45 p.m.

ITEM 4.5: STRATEGIC PLAN FOR THE PAN AMERICAN SANITARY BUREAU FOR THE PERIOD 2003–2007
PUNTO 4.5: PLAN ESTRATÉGICO PARA LA OFICINA SANITARIA PANAMERICANA PARA EL PERÍODO 2003-2007

The Hon. Dr. RAMSAMMY (Representative of the Executive Committee) reported that the Executive Committee had discussed the Strategic Plan in June 2002, and that an earlier version had been discussed by the Subcommittee on Planning and Programming (SPP) in March 2002. The Executive Committee had felt that the Strategic Plan represented a great improvement over previous planning documents and a good start to strategic planning for the new millennium. It had commended the Secretariat for its efforts to seek maximum input from Member States and other stakeholders in the process of formulating the plan.

The Committee had welcomed the changes made following the SPP's consideration of the Strategic Plan, in particular the addition of specific mentions of indigenous groups and children among the special groups to be targeted. However, some of the recommendations made during the SPP session had not been incorporated, notably those concerning globalization and the vision of the Pan American Sanitary Bureau.

In relation to globalization, the Secretariat had been asked to try to present a more balanced view, acknowledging some of the potential opportunities that globalization might afford for health development as well as its adverse effects. As for the vision statement, the Secretariat had again been asked to consider changing the wording to

"PASB will be *a* major catalyst for ensuring that all peoples of the Americas enjoy optimal health," rather than "PASB will be *the* major catalyst," recognizing that numerous other agencies and organizations were working to improve health in the Americas.

Some concern had been expressed as to whether the document correctly portrayed PAHO's role vis-à-vis the countries. One delegate had felt that some of the language in the document needed to be adjusted to make it clear that PAHO was not a supranational organization, but an organization that reflected the interests of and collaborated with its Member States. However, other delegates believed that the document clearly stated that PASB helped the countries to help themselves and carried out its functions in collaboration with Member States. Moreover, the priorities for 2003–2007 had been identified in consultation with the countries and reflected the priorities they had established for improving the health of their populations.

The Committee had felt that the eight priority technical areas in the Strategic Plan accurately reflected the major regional priorities for health development. However, some delegates had cautioned that the plan might identify too many priorities and urged that the objectives defined under each priority be stated in more precise and measurable terms in order to facilitate monitoring and evaluation. In addition, delegates had called attention to the need to ensure sufficient financial and human resources to carry out and evaluate the plan. The need to clearly link the regional priorities with global priorities established by WHO and with other international goals and mandates had also been emphasized. Some delegates thought that the classification of the countries according to their stage of

demographic transition and the plan's focus on a very limited number of countries, might raise questions of fairness and equity.

A number of other specific suggestions for further refining the document had been made including addition of a discussion of the assumptions on which the Strategic Plan was based, the risks that might affect its implementation, and strategies for dealing with those risks, and changing the phrase "reproductive health services" to "reproductive health care," as that term was more inclusive and more closely aligned with the terminology currently in use in other international forums. Delegates had also submitted additional proposed changes in writing.

Resolution CE130.R1 adopted by the Committee anticipated that the Secretariat would take into account the Committee's suggestions in finalizing the Strategic Plan and recommended that the Pan American Sanitary Conference approve the final, revised version as it appeared in Document CSP26/10.

Dr. SEALEY (Chief, Analysis and Strategic Planning, PAHO), presenting the Strategic Plan for the period 2003-2007, said the Secretariat shared the pride felt by countries over the celebration of 100 years of progress in health and of the public health heroes that had contributed to that success. The goal of the Pan American Health Organization had remained unchanged: to achieve health for all, by all, throughout the Americas. It was that clear vision, together with the Director's desire for the Organization to improve its strategic planning, that had motivated the design of a

strategic planning process that would be more responsive to the needs of countries and have the impact that countries desired in a short space of time.

For the Secretariat, the planning process meant determining what to focus on and how to do so. First, regional priorities were set to guide the technical cooperation programs, the programming process at the country level, and, most importantly, resource allocation. Then, ideas for improving the Secretariat's performance were developed. Strategic planning was thus a continuous process, centered on the future, with emphasis on inclusive participation and leadership— an enabling tool to turn mandates and insights into actions.

During the most recent planning process, the Secretariat's vision had been made explicit and shared, the Organization's values had been clarified and reconciled with the vision, and scenarios had been incorporated to help to envision what the future might be and, more importantly, to test the robustness of strategies and policies in various areas. In addition to the traditional analysis of the external environment, the Secretariat had carried out an analysis of the internal environment, to identify Organization-wide issues. Objectives had been identified, together with strategies for achieving them, thereby setting up a new approach of integrating organizational development into the strategic planning process.

The Secretariat's analysis of the external environment and its decision-making regarding technical cooperation priorities had included a detailed analysis of mandates emanating from the United Nations (the millennium goals, for example), from the Organization's Governing Bodies, and from WHO, from international forums, such as the

Summits of the Americas. Both staff of the Organization and the countries had participated in the planning process. The Secretariat had drawn on experts in social development planning and had held consultation meetings with representatives of 13 governments to get feedback before the plan was finalized.

The resulting vision was of a Secretariat that would be the major catalyst for ensuring that all the peoples of the Americas enjoyed optimal health and contributed to the well-being of their families and communities. Its mission would be to lead strategic collaborative efforts among Member States and other partners to promote equity in health, combat disease, and improve the quality and length of the lives of the peoples of the Americas.

An important aspect of developing that vision was to explicitly recognize the values of the Secretariat, starting from those inherent in the goal of health for all. The first was equity: striving for fairness and justice by eliminating differences that were unnecessary and avoidable. The second was excellence: achieving the highest quality. The third was solidarity: promoting shared interest and responsibilities and collective efforts to achieve common goals. The fourth was respect: embracing the dignity and diversity of individuals, groups, and countries. The fifth was integrity: assuring transparent, ethical, and accountable performance. Those five values, combined with the Secretariat's vision and mission, set a compass for the period 2003-2007.

In the external analysis, the Secretariat had identified three forces of change outside the health sector that shaped the nature and quality of human interactions and defined beliefs and attitudes. Globalization, environmental change, and science and

technology all had public health implications. Despite some improvements in the physical environment, the needs of millions of persons in the Americas for safe water and proper sanitation remained unfilled. Problems connected with pollution, urbanization, industrialization, and natural disasters continued to plague the Region. On the positive side, however, the focus on the health-in-development agenda at the regional and international level had led to greater recognition of the inequities in health and the need to regard health as both a resource and a goal.

As part of the internal analysis undertaken, an effort had been made to determine PAHO's weaknesses and strengths. Specific areas on which work was needed had then been identified and incorporated into the plan.

The Strategic Plan not only set priorities for technical cooperation but also addressed critical Organization-wide issues going beyond technical aspects of PAHO's work. Priorities had been identified in terms of special population groups and key countries, as well as technical areas.

The special population groups identified included low income and poor populations; ethnic and racial groups; and women, children, and the elderly. The addition of the elderly to that list had resulted from recent internal reviews that recognized the growing need of countries to address their problems. While the Secretariat would continue to work with all of the countries of the Americas, it had recognized the need to work in a different or more intense way with five countries that had been identified as highly indebted poor countries (HIPC) or as having an intolerable state of health: Bolivia, Guyana, Haiti, Honduras and Nicaragua.

The Secretariat had identified eight priority technical areas: prevention, control, and reduction of communicable diseases; prevention, control, and reduction of noncommunicable diseases; promotion of healthy lifestyles and social environments; healthy growth and development; promotion of safe physical environments; disaster management; assurance of universal access to integrated and sustainable health systems for individual and public health; and promotion of effective health input into social, economic, cultural, and development policies. For each area, the plan outlined key issues and objectives and identified strategies. Ways of tracking the Secretariat's performance were being developed.

The Plan recognized the overriding importance of the collection, analysis, and dissemination of information on and about health in the Americas. That consideration would be reflected in program areas throughout the Organization and in special programs as and when necessary.

There were six critical issues that the Secretariat must address in the period 2003-2007. They were called "cross-cutting" because while some might seem to be technical, their implementation would require modifications in administrative areas, and while some appeared to be purely administrative, they would be affected by technical programs and the selection of human resources. All units would accordingly be required to incorporate strategies to address those critical issues. The first was bridging the information divide so that those who lived without technology were not necessarily at a disadvantage and maximizing information and communication technology so that the right information was provided to policy-makers at the time of decision-making. The

second critical issue was the need for foresight to anticipate what would happen in the future and also in places where one did not normally look. The third was the need to influence the development of research in science and technology and to harness the results thereof to aid in reducing inequities in health. The fourth was positioning the Secretariat to influence transnational and global issues that are decided in forums outside the health sector but affect international health. The fifth critical issue was attracting and retaining a creative, competent, and committed workforce. Finally, the sixth was making PAHO a high-performance organization.

The challenges ahead included internalization of the Strategic Plan within the Secretariat, with adequate participation by staff; implementation of priority-driven programming and strategic budgeting; and the use of monitoring and evaluation by management.

The Conference was requested to agree that the objectives of technical cooperation in the document reflected the collective priorities to be pursued by Member States and to approve the Strategic Plan for the work of the Pan American Sanitary Bureau for the period 2003-2007.

El Dr. ARTAZA (Chile) aprecia la exposición hecha por la Dra. Sealy, pero echa en falta una mayor reflexión estratégica en torno a la propia Organización. A este respecto, se hace eco de las palabras del Director sobre si el cambio ha de venir dado por revolución o por evolución y estima que hace falta un debate sobre el particular porque, si bien la Organización tiene 100 años de experiencia, las conversaciones sobre ella, que debieran producir cambios en la conducta y en los paradigmas, quizá hayan sido insuficientes.

La 26ª. Conferencia debiera preguntarse urgentemente en qué debe cambiar la Organización para apoyar los procesos de los países. Ello resulta pertinente por la responsabilidad derivada de sus cien años de existencia, la responsabilidad respecto del futuro y las tensiones que se viven en los Estados Miembros. Lo es también porque las conversaciones sobre estrategia coinciden con un momento clave, marcado por un centenario y por un proceso de elecciones particularmente intenso. Esto último dice cosas importantes, en particular sobre la voluntad y la audacia requeridas para mejorar la labor de la Organización, que la Conferencia tiene el deber de escuchar.

Mr. SHEIKH (Canada) said that Canada viewed the Strategic Plan as an important tool for helping to set the direction of the Organization and as a substantial improvement over past efforts. A new Director would bring a new reality to the strategic planning process and might have views on the program and the agenda. It would be unfortunate if the new Director did not have an input into the delivery of the Plan. Canada requested

that the Plan be approved, but that its ratification be deferred until the new Director had had the time to consider it fully.

With respect to the substance, Canada fully endorsed the emphasis on key countries. His country looked forward to seeing concrete strategies and budget allocations to eliminate inequities. It was somewhat disappointed with the lack of specificity regarding the promotion of healthy lifestyles, more emphasis should be placed on tobacco control. In the area of healthy growth and development, PAHO should become much more active in assisting governments in developing strategies for family planning and affordable access to contraception. Improvements in those areas would do much to reduce mortality and morbidity, especially in connection with unsafe abortions. In addition to those communicable diseases already identified as priorities, the Organization needed to prepare for the next influenza epidemic.

El Dr. LÓPEZ BELTRÁN (El Salvador) dice que en vista de las tendencias a la globalización, caracterizadas por brechas cada vez mayores entre los ricos y los pobres y el aumento de la desigualdad, la vulnerabilidad y la exclusión, si no se crean programas de integración y apoyo a escala regional, podrían aumentar también las desigualdades en la salud pública, sobre todo en los países con subdesarrollo o con crecimiento insuficiente.

El Plan Estratégico es fruto de una planificación sistemática, se basa en los mandatos y compromisos regionales, así como en las conferencias mundiales y cumbres de las Américas, y es coherente con las prioridades de los Estados Miembros y con las

estrategias dirigidas a resolver los problemas existentes en cada país; establece ámbitos de trabajo institucionales, y ofrece una visión amplia de los puntos fuertes y débiles, así como de las funciones y los compromisos de la OSP. Por esos motivos El Salvador se compromete a contribuir al logro de sus objetivos.

El Dr. FRENK (México) felicita a la Secretaría de la Organización por la elaboración del plan y suscribe las recomendaciones de la reunión del Comité Ejecutivo. Asimismo, considera un paso adelante el esfuerzo realizado para establecer prioridades, analizar el entorno y recoger la reforma constitucional interna en el plan estratégico.

Las funciones de un organismo de cooperación técnica merecen un debate más profundo, y a este respecto debe tenerse en cuenta el documento *La Salud Pública en las Américas*. La primera función consistiría en la producción de bienes públicos regionales, como información, vigilancia epidemiológica y acción colectiva regional. La segunda sería la cooperación técnica con los países. En este caso, habría que establecer prioridades a tenor de la gravedad de la situación sanitaria de cada país. La tercera y última función consistiría en la evaluación de los indicadores de equidad. A este respecto, sería conveniente definir los criterios y los indicadores de la evaluación.

El orador suscribe la sugerencia del Ministro del Canadá de aprobar el plan estratégico y dar la oportunidad al nuevo Director de proponer en la próxima reunión del Consejo un nuevo enfoque para el documento, así como las medidas que deben tomarse para convertirlo en una estrategia de implantación.

Ms. BLACKWOOD (United States of America) said that overall, the draft Strategic Plan was a great improvement over the past document. The process that had sought to increase foresight, creativity, and strategic thinking in the Secretariat was evident. PAHO's strategy must be linked to WHO global priorities and other appropriate regional and global goals.

While many of her country's comments had been included in the report of the Executive Committee, they had not been incorporated in the final version of the Strategic Plan. One remaining concern was that the document cast globalization in a very negative light, even though substantial debate remained about the role of globalization in relation to potential adverse effects. Her delegation again recommended a more balanced view. It also urged that under section 6.3.4, Healthy growth and development, the words "reproductive health services" be changed to "reproductive health care" to be consistent with similar language used in the document of the Special Session of the General Assembly on Children and the World Health Assembly resolution on WHO's contribution to fulfillment of the goals contained in the Millennium Declaration. In addition, the section lacked recognition of the need for greater parental involvement in the development of children. The United States again recommended expanding the first bullet in the square box entitled "Strategies" to include the promotion of appropriate parenting skills as part of any model exercise.

Addressing the bioterrorism threat should be a priority for every country in the Region and the world. Dramatic new steps had been taken to increase preparedness for bioterrorism, including the creation of a new Office of Public Health Preparedness,

procurement of more than a billion doses of antibiotics and 150 million doses of smallpox vaccine, expansion of the national pharmaceutical stockpile and initial new funding of US$ 1.1 billion to help states better prepare for bioterrorism attacks. PAHO had been a leader in the hemisphere in emergency preparedness and mitigation, and the United States looked to the Organization for appropriate leadership in preparing for and responding to bioterrorism and national disasters.

With the comments already noted, the United States supported adoption of the Plan, but with the understanding that it should remain flexible, particularly since it did not take into account the vision of the new Director. The United States remained eager to work with the Secretariat to review and revise the Plan so that the concerns of countries could be addressed.

The Hon. Dr. SABAROCHE (Dominica) said that the Strategic Plan represented a new direction and should be commended. The inclusion of promotion of a healthy lifestyle and social and physical environment as priority areas was welcome, because the need for people to take full responsibility for the own health was increasingly being recognized and advocated. He noted that the term "quality of life" [p. 7] was not defined.

At that very moment, hurricanes were threatening the Region, and many more might occur in the next few years. The Plan therefore had to be dynamic in terms of disaster preparedness and disaster management. Planning efforts must take into account that resources must to be available to address the priorities that are set.

El Dr. ARMADA (Venezuela) reconoce el esfuerzo que ha supuesto la elaboración del documento, con el que coincide en líneas generales. No obstante, en el párrafo dedicado a los grupos especiales podría hablarse explícitamente de la importancia de disminuir las desigualdades, así como de las brechas existentes entre el hombre y la mujer. Asimismo, considera importante establecer un espacio y una metodología para la evaluación del Plan, por lo que pide que se agreguen los siguientes acápites al párrafo 2 de la parte dispositiva:

"d) presente informes anuales de evaluación y seguimiento de la implementación del plan estratégico, particularmente en lo referente al impacto de la cooperación técnica;

e) presente un análisis de las características organizacionales existentes y requeridas para la implementación del plan."

La Dra. SÁENZ MADRIGAL (Costa Rica) felicita a la Secretaría por la excelente labor realizada, pero opina que sería preciso retomar el tema de la rectoría de la autoridad sanitaria, que no queda claramente recogido en las siete áreas prioritarias. También cabría replantear la estrategia para abordar la cooperación técnica con los países que, como Costa Rica, han logrado mejorar sus índices de salud, pues no se debe tratar de igual modo a países que son desiguales. Por otra parte, como la complejidad de los procesos de salud y el avance de las reformas introducidas se traducen en zonas grises entre las rectorías de las distintas instituciones, y como además la agenda ambiental tiene su propia dinámica, sería importante velar por que se tuvieran debidamente en cuenta las

necesidades de la población en este sentido, en particular las relacionadas con el tema del agua potable y de los desechos sólidos.

El Dr. PEÑA PENTÓN (Cuba) expresa su satisfacción por el Plan Estratégico para el período 2004–2007, pues recoge los problemas actuales de la Organización y de los países, y señala la manera de enfrentarlos, pero se hace eco de la opinión de que deberá ser perfeccionado, en particular escuchando las voces de los pueblos de la Región, sobre todo las que reclaman que se reconozca que la salud es un derecho fundamental. En lo que atañe al papel del Director de la OPS, Cuba considera que éste es imprescindible. Con todo, el Plan Estratégico responde a las decisiones de la Conferencia. Por tanto, deberá ejecutarse teniendo en cuenta los intereses y el mandato establecido por cada una de las delegaciones al respecto.

Mr. SHEIKH (Canada) said that his delegation was happy with the document as it stood and would be very uncomfortable with any substantive changes such as the replacement of the phrase “reproductive health services” with “reproductive health care.”

El Dr. ACUÑA (ex Director) dice que la planificación estratégica, aunque quizá no en forma tan detallada, se viene realizando en la Oficina Sanitaria Panamericana desde hace cien años. El documento elaborado por el Director y la Secretaría resulta sumamente valioso como guía y referencia indispensable para que los Cuerpos Directivos lo utilicen en beneficio de los países de la Región, dirigiendo la cooperación técnica a las áreas que esos países consideren prioritarias.

Ahora bien, las prioridades las establecen los partidos, de acuerdo con lo que consideran que la mayoría de la población quiere. En esta Conferencia están representados muchos gobiernos cuyos puntos de vista pueden ser diferentes, pero todos convergen en el sentido de que desean para sus pueblos la mejor salud y la mayor longevidad posibles. Se trata de planes, no de estrategias.

Las estrategias se definen luego para acoplarlas, modificarlas y adaptarlas a las posibilidades reales, económicas y políticas, y a lo que desean todos los que trabajan en el sector salud. Por ello, el documento presentado supone un gran avance. En otros tiempos, sólo se podía enumerar los problemas y enunciar posibles estrategias para resolverlos. Había que recurrir a instituciones privadas, que no podían considerar tanto la importancia del problema como las posibilidades de financiación. Así, por ejemplo, gracias a "Rotary Internacional", se consiguió erradicar la poliomielitis, primero en la Región y luego en el mundo entero. También hoy existen, por fortuna, organizaciones y gobiernos interesados en participar activamente y financiar programas específicos para problemas determinados.

El plan estratégico presentado por el Director se adapta muy bien a las necesidades actuales, y las observaciones de algunos delegados, muy atinadas e importantes, podrían recogerse en una pequeña adición.

Dr. SEALEY (Chief, Analysis and Strategic Planning, PAHO) thanked delegates for their support for the Strategic Plan and comments on how to improve the document in the future. In terms of participation, the Secretariat had indeed focused on key

participation, not only internally but externally. The points made about widening the circle would have been taken very seriously, not only at the planning stage, but also during implementation and monitoring. As to the inclusion in the Plan of certain topics such as an influenza epidemic, she said the Plan did not list all of the things that had to be done but that the Secretariat recognized that there would be new areas, if not new diseases, that required more attention. As for the key countries, they constituted an initial list to which others might need to be added.

The Secretariat would try to continue monitoring the situation and the environment to ensure that through the Plan it remained responsive.

With respect to the idea that there was less cooperation with some countries, she pointed out that programming at the country level remains flexible, adaptive, and responsive to particular needs. The Organization did not have the same type of program in each of the countries, since completely different approaches were required to different health status situations. Thus, the Organization was trying to set a regional, collective agenda and then to respond flexibly in terms of bilateral technical cooperation programs.

The DIRECTOR was pleased that member governments had appreciated the participative nature of what had been a long, but worthwhile, process. In its several iterations before the Governing Bodies, the Strategic Plan had been improved every time.

He wished to remove any impression he might have given to the Delegate of Chile that he was somehow against change: in fact, he agreed with him completely. In his introductory essay, he spoke of the great transitions that the Organization would have

to face. Discovering how to effect such change would come from internal reflection and external support, and it had to be a collective effort.

If the Plan was approved as it stood, the new Director should be given the essence of the comments just made. He agreed with the comments by the Delegate of Mexico, about global public goods and believed that a fundamental basis for the existence of international organizations was to make investments in regional public goods. Information was probably the most important of the essential regional public goods, and that too was one of the bases for organizations like PAHO. Any ways in which the Organization could highlight the use of information as a genuine regional or global public good should be discussed.

Regarding globalization, he had thought that the Organization had put forward a neutral point of view rather than referring to globalization as negative or positive, but the issue should be revisited. Instead of agonizing over whether globalization was bad or good, it was necessary for PAHO to adapt to the globalization process, and its inevitable consequences.

He asked for the guidance of the Conference on the disagreement between the United States and Canada on the reproductive health terminology. A solution had to be found. One approach would be for the delegations to come together and arrive at language to be incorporated in the document. The other approach would be simply to ignore the problem. He asked the delegations to reflect on the problem and how to address it. That particular issue had already come up on several occasions and the time had come to do something about it.

El PRESIDENTE pide a las delegaciones que han hecho importantes contribuciones al tema del plan estratégico que remitan a la Secretaría sus comentarios, a fin de elaborar un nuevo proyecto.

The meeting was suspended at 4:15 and resumed at 4:50 p.m.
Se suspende la reunión a las 4:15 y se reanuda a las 4.50 p.m.

ITEM 4.2: ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS
PUNTO 4.2: SÍNDROME DE INMUNODEFICIENCIA ADQUIRIDA (SIDA) EN LAS AMERICAS

The Hon. Dr. RAMSAMMY, Representative of the Executive Committee, said that the Executive Committee had applauded PAHO's comprehensive regional response to HIV/AIDS and endorsed the "building blocks" approach, which highlighted the need to strengthen health systems and viewed prevention and care not as competing priorities, but as part of the health care continuum. Delegates had underscored the need to improve the accessibility and affordability of antiretroviral drugs, since it was essential to provide treatment to the millions of people in the Region who were already infected with the virus. Treatment and care were also seen as key strategies for preventing transmission.

The Committee had further commended PAHO on its efforts to promote and implement the declaration of the United Nations General Assembly Special Session on HIV/AIDS and had stressed the need for ongoing monitoring and reporting on the achievement of the goals established by the countries at that session. With regard to the Global Fund to Fight AIDS, Tuberculosis, and Malaria, delegates had expressed the hope

that the secretariat being created to manage the Fund would be kept as small as possible so that the funds mobilized would not be unnecessarily expended on administrative costs.

Several possible improvements to the document had been proposed, for example, the placement of greater emphasis on the role that communities and community-based organizations could play in reducing the spread of HIV and providing support for infected individuals and their families. Various delegates had noted that the document did not address the role of research as a basis for development of policies and interventions. The Committee had underscored the need for a coordinated international and intersectoral response to the AIDS epidemic and had pointed out that the unprecedented levels of international and intersectoral collaboration inspired by HIV/AIDS could be expected to translate into gains in other areas, such as poverty alleviation and improvement in overall health conditions. The Committee had also highlighted the need for broader health promotion and education efforts that focused on cultural attitudes and practices that were at the root of individual behaviors.

In Resolution CE130.R6 the Committee had recommended that the Conference adopt the resolution that was presented in Document CSP26/7. In addition to thanking the Director for the annual reports on HIV/AIDS presented since 1987 in compliance with Resolution CD32.R12, the proposed resolution requested that the report to the Governing Bodies in the future only when he considered developments in HIV/AIDS in the Region or in approaches to its prevention or control to be significant.

El Dr. ZACARÍAS (OPS), haciendo uso de diapositivas, dice que en las Américas hay casi 3 millones de personas infectadas por VIH y que el año pasado se produjeron casi un cuarto de millón de nuevas infecciones por este virus y alrededor de 40 millones de otras infecciones de transmisión sexual. Cabe destacar que cualquier persona puede formar parte de poblaciones puente o comportarse como transmisor principal.

En los países de la Región se ha avanzado mucho en las áreas de los bancos de sangre, de la prevención de la transmisión del virus de madre a hijo y de la transmisión sexual. Como ilustra un estudio llevado a cabo en Bolivia, entre 1992 y 1995 se produjo un descenso marcado de la gonorrea, la sífilis y la úlcera genital en las trabajadoras sexuales de La Paz —un grupo de población muy vulnerable— que coincidió con el inicio del uso del preservativo, fenómeno también observado en Barbados y Guyana. No obstante, y a pesar de la insistencia en el uso del preservativo, en algunos países se sigue promoviendo la abstinencia, la fidelidad mutua, las relaciones sin penetración o sin intercambio de fluidos y el uso de medidas químicas y físicas de barrera. Si solamente se promueve la abstinencia como única medida preventiva, debe recordarse que los votos de fidelidad mutua se rompen más fácilmente que el preservativo.

Por otra parte, es preciso recordar que la atención y la prevención han de estar integradas y que un reto muy importante de la atención es conseguir que la mayoría de las personas infectadas tengan acceso a medicamentos antirretrovirales. En cuanto a la atención integral, la Organización, con el apoyo de expertos de los países y de otras organizaciones, desarrolló el modelo *paso a paso* (en inglés, *building blocks*), que contempla tres escenarios, atendiendo al nivel de recursos disponibles para la atención de

personas infectadas por VIH o con SIDA. Un mínimo nivel de acceso a los antirretrovirales debe garantizarse con independencia de los recursos disponibles y en todos los niveles de la atención de salud, y esta medida ha de acompañarse de acciones como el asesoramiento, la provisión de pruebas de detección, y diagnósticas, y medidas nutritivas, salvaguardando la equidad y el respeto a los derechos de las personas.

Otro punto que cabe destacar es la gran diferencia observada en el costo anual de un tratamiento con antirretrovirales, según los países. Por ejemplo, en el Brasil el costo anual de un tratamiento es de $ 635, en Jamaica, de $ 1.200, mientras que en los Estados Unidos de América asciende a $ 10.000.

Uno de los avances más notables en la lucha contra la epidemia por VIH y el SIDA ha sido la movilización política, económica y social directa o por medio de iniciativas y foros específicos, como la sesión extraordinaria de la Asamblea General de las Naciones Unidas celebrada en junio de 2001 y los acuerdos alcanzados en ella por más de 170 líderes de países. Además, las agencias de financiamiento multilateral y las bilaterales están interesándose cada vez más en apoyar iniciativas de los países. Existe una agenda compartida por la OPS, el Banco Mundial y el Banco Interamericano de Desarrollo, y cada vez se observan más proyectos de cooperación entre países y alianzas subregionales y regionales para prestar cooperación técnica en esta área. Entre ellos valga citar la Alianza Pancaribeña, las actividades emprendidas en países de Centroamérica, el MERCOSUR, Mesoamérica y el Área Andina, así como las propuestas presentadas al Fondo Mundial contra el SIDA, la Tuberculosis y la Malaria.

Otros avances recientes, además de las mejoras en la calidad de la atención, han sido la articulación de mecanismos funcionales de coordinación en los países, el aumento de la participación de la comunidad y de la sociedad civil, el establecimiento de mecanismos de control financiero y, finalmente, mejoras en la eficiencia en la gestión. En un análisis realizado recientemente en un encuentro transamazónico se puso de manifiesto que tanto el apoyo político, como la capacidad técnica, la experiencia y el apoyo financiero pueden constituir debilidades, fortalezas, amenazas u oportunidades en los países de la Región y que la capacidad gerencial se contempla en todos ellos como una debilidad.

Por último, indica que, si bien en 1989 la prevalencia de infección por VIH en la Región se acercaba al 1%, en 1999 ya superaba el 2% en la población sexualmente activa. La pregunta que puede formularse ahora es cuál será dicha prevalencia en 2010.

El Dr. ARTAZA (Chile) reconoce el avance que significa el informe presentado sobre el control del VIH y el SIDA en la Región, lo cual se aprecia fundamentalmente en su carácter técnico y político. El informe pone de manifiesto la necesidad de abordar los obstáculos que dificultan el acceso al tratamiento efectivo en la Región y reafirma la necesidad de mejorar la prevención de la infección. El tema tiene gran calado político y económico, como demuestra el hecho de que, en los últimos dos años, con el apoyo del ONUSIDA y del Programa de las Naciones Unidas para el Desarrollo y por medio de la negociación de precios y la adquisición centralizada de fármacos antirretrovirales e insumos de diagnóstico de alto costo, se ha logrado que en Chile el 90% de las personas

infectadas tengan acceso a tratamientos simultáneos con tres fármacos efectivos. La negociación, unida al acceso reciente de Chile a recursos procedentes del Fondo Mundial contra el SIDA, la Tuberculosis y la Malaria, permitirá alcanzar a muy corto plazo la cobertura total. Por añadidura, la reforma del sector salud de Chile contempla explícitamente que el tratamiento de la infección por VIH y el SIDA esté garantizado para todas las personas que coticen en el seguro público o privado.

Está convencido de que la actitud de la industria farmacéutica ha experimentado un cambio significativo en los últimos años, gracias a la postura del Ministerio de Salud y del Gobierno del Brasil a la que todos debemos estar agradecidos. Por su parte, el Gobierno de Chile ha ofrecido su colaboración a todos aquellos países que aspiren a aumentar el acceso a los medicamentos antirretrovirales. A este respecto cabe mencionar algunas estrategias subregionales exitosas que no se mencionan en el informe presentado, como la desarrollada por el grupo de cooperación técnica horizontal de los programas VIH/SIDA y ETS de la Región de las Américas, así como la de la coordinación entre las redes de personas afectadas por el VIH y organizaciones no gubernamentales.

Es preciso que los esfuerzos actuales se basen en estudios rigurosos del comportamiento de las personas, con o sin conductas preventivas. El conocimiento que se obtenga sólo puede proceder de estudios cualitativos que aborden las distintas realidades de la Región. En este sentido, la próxima campaña nacional de educación en Chile para el control del VIH se basa tanto en este tipo de estudios como en la experiencia acumulada en el análisis de campañas anteriores y en el desarrollo de estudios nacionales del comportamiento sexual, que han recibido el apoyo del Gobierno de Francia.

Para finalizar, subraya la necesidad de que algún organismo de las Naciones Unidas, como la OPS, desarrolle un plan de seguimiento y apoyo concreto para que se emprendan acciones destinadas a alcanzar las metas definidas en la reciente conferencia de las Naciones Unidas sobre el SIDA.

O Dr. MERCADANTE (Brasil) ressaltou que, de acordo com os últimos dados anunciados pelo UNAIDS, as Américas contam com 2,8 milhões de portadores do vírus, número esse que esconde dados vitais para compreensão da dinâmica e do impacto da epidemia na Região. Disse que o Caribe é a segunda área mais afetada do planeta, depois da África subsaariana, com taxa média de prevalência superior a 2% na população adulta e aumento relativo de 16% no número de novas infecções, em 2001. Entretanto, continuou, é possível modificar profundamente esse quadro adverso, sendo de importância fundamental o envolvimento e trabalho conjunto de autoridades governamentais e de outras esferas e de atores sociais, bem como a aplicação de um conjunto de políticas tecnicamente consistentes e de eficácia comprovada.

Manifestou que o Brasil tem obtido vitórias importantes a partir de sua experiência com uma abordagem integral à epidemia do HIV/AIDS e que não se deveria desperdiçar tempo e recursos escassos com mensagem ambíguas. A vasta maioria dos novos casos ocorrem pela via sexual e a prevenção é feita com uso de preservativo; é portanto, o pretenso caráter ético ou religioso de outras iniciativas constitui um dos mais poderosos inimigos da prevenção efetiva.

Informou que a redução da transmissão vertical do HIV tem merecido particular atenção do Governo brasileiro. O número de gestantes que recebem anti-retrovirais passou de 1.364, em 1997, para 5.577, no ano passado, embora esse número ainda esteja aquém do desejado. Para solucionar esse problema, o Governo brasileiro está lançando o "Projeto Nascer-Maternidade", que pretende ampliar a cobertura para 100% das parturientes com HIV, fornecendo aconselhamento, testes rápidos e medicamentos adequados ao controle de infecção para a redução da transmissão dos vírus para os bebês.

Esse avanço só pode ser obtido com a existência do programa de distribuição universal e gratuita de anti-retrovirais, os quais além de catalisar esforços de prevenção por seu impacto na testagem voluntária, possui um impacto crucial na manutenção da auto-estima dos portadores do vírus, colaborando para que continuem em seus empregos e junto de suas famílias.

De acordo com ele, articulação bastante próxima do Governo brasileiro com a sociedade civil era fator essencial e indispensável deste processo e que organizações não-governamentais participam não somente da elaboração como da implementação de políticas públicas de combate à AIDS no Brasil. Ressaltou a estreita colaboração com agremiações religiosas e Igrejas, particularmente com a Igreja Católica.

Acrescentou que o Grupo de Cooperação Técnica Horizontal, do qual o Brasil faz parte, junto com outros 20 países, tem atuado constantemente na busca de soluções e ações concentradas para o controle da epidemia na América Latina e Caribe e, de acordo com esse espírito de cooperação, o grupo realizaria o Forum 2003, em Cuba, em abril de 2003 próximo. O Brasil, apesar de seus limitados recursos financeiros, tem procurado

apoiar países da Região, com a criação do "Programa de Cooperação Internacional para outros Países em Desenvolvimento", o qual possibilitará o tratamento de até cerca de 100 pacientes de AIDS por projeto, com medicamentos anti-retrovirais produzidos no País.

Recordou que uma das mais importantes conquistas, pela qual o seu País havia lutado com grande afinco, havia sido a compreensão da Organização Mundial do Comércio de que os medicamentos para o combate à AIDS devem ter seu acesso facilitado e que, por esse motivo, achava que uma referência à "Declaração de Doha" deveria ser incluída em documentos pertinentes aprovados pelos Estados Membros. Assim, julgava também oportuno que a OPAS iniciasse estudos de viabilidade para a criação de um centro de controle de qualidade de medicamentos genéricos, que viria favorecer grande quantidade de países do Continente.

Concluiu sua exposição solicitando as seguintes correções:

No documento CSP26/7:

Item 2.1.2, último parágrafo, modificar a redação para: (ex: no Brasil, o aumento do uso da camisinha entre jovens, na primeira relação sexual, foi de 4%, em 1986, para 48%, em 1999)".

Item 2.1.4, segundo parágrafo, "o mesmo ocorrendo com 20,6% dos casos no Brasil".

Então, levando em consideração a declaração da resolução ora apresentada, de inclusão, de uma referência à declaração sobre o Acordo TRIPS e Saúde Pública da Reunião de Doha, bem como de um terceiro sub-item do item 2, que reza: "estudos de

viabilidade para criação de um Centro de Controle de Qualidade de Medicamentos Genéricos"

The Hon. Senator WALCOTT (Barbados), speaking on behalf of the Caribbean Community (CARICOM) noted that as the HIV/AIDS pandemic entered its third decade, it was clear that no country had been left untouched. Many, particularly those in the developing world, had already been devastated, and the epidemic had not yet reached its peak. Unless swift and decisive actions were taken, figures were projected to double by 2010.

The prevalence rate of HIV/AIDS in the Caribbean, ranged from an estimated 5% in Haiti, to 3.6% in the Bahamas, to 1.75% in Barbados. The estimated overall rate of 2.3% of the adult population ranked below that of sub-Saharan Africa, but was four times that of the next most affected region.

The epidemic continued to spread, with devastating social and economic consequences. An estimated 500,000 persons were presently living with HIV/AIDS in the wider Caribbean, with 387,000 of that total in the CARICOM countries. The disease was the leading cause of death in the age group 15-44 years, the most productive social group.

Caribbean governments had demonstrated political will and a sustained commitment in responding to the growing problem. They had identified as priorities the interruption of mother-to-child transmission, change of sexual behavior among youth, treatment and support for people living with HIV/AIDS, and establishment of programs in the workplace. The regional approach to the epidemic had three fundamental

components: the Pan-Caribbean Partnership, launched in February 2001, which was a broad coalition of institutions and groups with a shared vision and common strategic agenda; the Regional Strategic Plan, which recognized the wider developmental aspects of the epidemic and set out a strategic Plan of Action focused on shared opportunities and challenges and encompassing priorities that could best be addressed collectively at a regional level; and the Regional Strategy for Care and Treatment, which identified a core set of activities, together with financing mechanisms, aimed at accelerating access to care and treatment.

The majority of persons living with HIV/AIDS in the Caribbean had very little access to adequate care and treatment. The high cost of the drugs was a major factor limiting access to antiretroviral therapy to those who could afford to pay. Stigma and discrimination associated with HIV/AIDS hindered contact with the health system, and treatment offered in the public sector to HIV/AIDS patients mainly dealt with opportunistic infections.

Four countries (the Bahamas, Barbados, Jamaica, and Trinidad and Tobago) had developed comprehensive treatment programs. In Barbados, people living with HIV/AIDS received antiretroviral drugs and other pharmaceutical products at no cost at the point of delivery. The “building blocks” model was being used to ensure that all elements required for the efficient and effective delivery of highly active antiretroviral therapy were in place. All countries had programs for short-term antiretroviral use, but coverage varied widely.

National and regional efforts were now focused on accelerating access to care, including antiretroviral therapy. A single regional price for antiretrovirals for all participating countries was a fundamental objective of the regional approach. CARICOM countries held a firm view that prices should be negotiated, taking into consideration HIV/AIDS prevalence rates, unemployment levels, the poverty index, and economic vulnerability as well as the human development index. Questions of sustainability, universal access, and compliance should also be considered when determining the price of antiretroviral drugs and other pharmaceuticals used to fight the epidemic.

A phased approach to increased use of antiretrovirals was recommended to allow for improvements in resource mobilization, infrastructure, procurement and distribution systems, and training to ensure that lessons were learned and shared. To this end, both individual countries and the subregion as a whole had been negotiating with pharmaceutical companies, and prices for antiretrovirals in the Bahamas, Barbados, Jamaica, and Trinidad and Tobago had fallen from $ 13,000-$15,000 per patient per year to $ 1,200-$2,400. However, some countries could not provide universal access to those drugs if the price, rose above $ 350 per patient per year.

Discussions and negotiations begun in February 2002 had resulted in an agreement in principle with leading pharmaceutical companies on reduced prices for antiretrovirals signed during the 14th International Conference on HIV/AIDS in Barcelona, Spain, in July 2002. However, because of some dissatisfaction with the agreement, CARICOM governments had agreed to resume discussion with pharmaceutical companies aimed at securing further price reductions.

Looking toward the future, health workers would need training to ensure full compliance with treatment regimens, and laboratory capacity for basic screening and diagnostic testing would need to be enhanced. Use of a regional framework to accelerate access to care and treatment had been given the highest priority by governments of the Region. A "building block" approach that included affordable and continued access to antiretrovirals was a key component of the Accelerated Access Initiative. Success would depend on the extent to which a mutually beneficial and sustainable partnership involving national, regional, hemispheric, and global actors could be established.

El Dr. LÓPEZ BELTRÁN (El Salvador) dice que, en sus observaciones, El Salvador ha manifestado su total respaldo al documento presentado a la Conferencia Sanitaria Panamericana, ya que sus resoluciones son congruentes con los objetivos y prioridades nacionales del programa, puesto que se está trabajando en el acceso a los medicamentos antirretroavirales a un costo menor. Hay que destacar la importancia que tiene la formación y capacitación de los recursos humanos para combatir la epidemia, y el apoyo a las investigaciones operativas para caracterizarla y enfocar así las acciones de prevención dirigidas a la población en general, enfatizando en los grupos de riesgo.

El Dr. BOLAÑOS (Guatemala) manifiesta que le Gobierno de Guatemala tiene un Compromiso político importante en el tema del SIDA, que se refleja en el Decreto 27–2000, que declara el VIH/SIDA problema social de urgencia nacional, integra una comisión multisectorial de lucha contra él y establece el mandato de defender los derechos humanos de las personas que viven con el SIDA. Se refleja también en el

otorgamiento de partidas presupuestarias para el Programa Nacional del SIDA, del Ministerio de Salud, el Ministerio de Educación y las fundaciones que trabajan para enfermos terminales. En conjunto, aproximadamente, $ 2 millones.

Se refleja asimismo en el cumplimiento de algunos acuerdos como el programa de prevención de la transmisión vertical mediante el otorgamiento de antirretrovirales específicos a las mujeres embarazadas con el VIH, a partir de la 14ª semana, y al niño al momento de nacer; el Convenio suscrito con ONG de personas que viven con el SIDA, para proveerles de tratamiento antirretroviral y fortalecimiento institucional; la elaboración del protocolo nacional para el tratamiento antirretroviral del VIH/SIDA, de común acuerdo con la sociedad civil, personas que viven con el VIH/SIDA, infectólogos, organismos internacionales y organismos bilaterales; y la elaboración del plan estratégico nacional para ITS/VIH/SIDA 2002-2003, de común acuerdo con todos los actores; la realización del Segundo Congreso Centroamericano de SIDA en noviembre de 2001 en la ciudad de Guatemala, el proyecto para la prevención de la transmisión vertical en colaboración con UNICEF, el Hospital Roosevelt de Guatemala y maternidades cantonales, la elaboración de un manual de asesoría y consejería para el sistema nacional de salud y usuarios, la de un documento en coordinación con ONUSIDA para participar en el proyecto de acceso acelerado a medicamentos antirretrovirales, y la presentación de una propuesta al Fondo Mundial de Lucha contra el SIDA, la Tuberculosis y la Malaria.

Se refleja igualmente en algunos convenios suscritos, como el convenio de asistencia técnica en el Programa Nacional de SIDA del Brasil, el intercambio entre hospitales de Guatemala y España, además de la asistencia técnica, el proyecto para

fortalecer el sistema de vigilancia epidemiológica entre el Gobierno de los Estados Unidos a través de AID, el CDC de Atlanta y el Ministerio de Salud de Guatemala a través del programa nacional, y el proyecto SIDA y Migración en el que se trabaja con México, Centroamérica y los Estados Unidos. Y finalmente, mediante el proyecto multicéntrico para ITS/VIH en trabajadoras comerciales del sexo y hombres que tienen relaciones sexuales con hombres.

Ms. DABBS (United States of America) said that her country considered HIV/AIDS a health, development, and security issue and a priority for both national and global action. PAHO was urged to consider emphasizing the links between HIV/AIDS and economic growth and development as a framework for mobilizing resources to address the issue.

The United States had been the first and, with $ 500 million, the largest contributor to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In June 2002, President Bush had announced the establishment of the $ 500 million International Mother and Child HIV Prevention Initiative, which focused on increasing the availability of preventive care, including drug treatment, and building health care delivery systems to reach as many women as possible. In the hemisphere the initiative targeted Guyana, Haiti, and the Caribbean region through the Caribbean Epidemiology Center. The yearly multilateral and bilateral contribution of the United States to HIV/AIDS research, prevention, and care and treatment activities, amounted to more than $ 1 billion.

The United States Government reiterated the need for political and social commitment, as embodied in the UN Declaration of Commitment on HIV/AIDS (27 June 2001). It had convened a Caribbean Ministerial Consultation on HIV/AIDS in April 2002 in Georgetown, Guyana, and was a signatory in the Pan-Caribbean Partnership against HIV/AIDS.

The United States was pleased that the report described prevention and treatment as complementary and not competing priorities. However, several topics in the discussion paper seemed too general for use in a strategy and should be expanded in future documents. Information that should be added included lessons learned on use of antiretrovirals; a description of how PAHO was promoting abstinence and healthy choices for young people in its HIV prevention activities; examples of how the comprehensive care model worked in community-based settings and how Ministries of Health were managing or supporting comprehensive care programs; examples of approaches to incorporate prevention of mother-to-child transmission into prenatal and delivery care; and information on care and treatment activities in general, on the Regional Revolving Fund for Strategic Public Health Supplies in particular, and on how PAHO planned to use WHO's pre-qualification program.

The United States believed that nongovernmental organizations and faith-based organizations were essential partners, especially for care and support programs. Working with key stakeholders, religious leaders, and faith-based organizations represented excellent opportunities to help overcome some of the daunting challenges of HIV/AIDS.

Resource limitations currently forced a rationing of services for people living with HIV/AIDS and would continue to do so in the medium term. A major challenge of the future would be to ensure effective implementation of national strategies or policies for allocating resources to those who can least afford treatment. With that in mind, the United States wished to introduce an additional operative paragraph to the draft resolution. Paragraph 1(d) would read: "to explore and develop strategies and/or policies for more efficiently and effectively targeting scare public resources for HIV/AIDS to those most in need."

Mr. SHEIKH (Canada) pointed out that the regional response to HIV/AIDS was more complex than the response to other diseases in that all sectors of society needed to participate. His country was pleased that PAHO was increasingly involving multisectorial partners and advocating a unified response to the epidemic. The Organization should not only continue those efforts but also pay greater attention to the social, economic, and development issues associated with the spread of HIV and incorporate gender empowerment as an integral component of the regional response.

Canada supported the proposed resolution and applauded PAHO's efforts to promote and implement the United Nations Declaration of Commitment on HIV/AIDS. The Declaration should be used to guide HIV/AIDS prevention efforts at home and abroad.

Through PAHO, Health Canada had worked with the Ministry of Health of St. Kitts and Nevis to strengthen that country's capacity to respond to HIV/AIDS.

Canada had recently increased its support for PAHO's efforts in HIV/AIDS prevention and care and would be working on specific projects in Ecuador and Paraguay. The Canadian International Development Agency (CIDA) would provide increased funding for CAREC in order to broaden its scope to include Dominican Republic and the Haiti and in support of the Caribbean Community Secretariat. In addition, CDN$ 50 million had recently been pledged to support the work of the International AIDS Vaccine Initiative and the African AIDS Vaccine Partnership. Canada pledged its continued cooperation with other concerned actors in the fight against HIV/AIDS in the Americas.

El Dr. PEÑA PENTÓN (Cuba) suscribe los elogios al Dr. Zacarías y afirma que el documento contiene los puntos más destacados de la lucha contra la pandemia, es decir, la disponibilidad y asequibilidad de los medicamentos indispensables para salvar vidas; la intensificación de las actividades de promoción y prevención; y la imperiosa necesidad de contar con servicios de salud y de laboratorio satisfactorios. Asimismo, es imprescindible que el Fondo Mundial de Lucha contra el SIDA apoye debidamente a los países que más lo precisen y que se disponga de fondos para intervenciones adecuadas a las realidades de los Estados Miembros. Por su parte, los ministerios de salud deben incorporar a sus políticas los objetivos de la declaración de compromisos del XXVI periodo extraordinario de sesiones de la Asamblea General de las Naciones Unidas.

El crecimiento de la epidemia en Cuba es bajo, y la tasa de prevalencia de la infección entre la población de entre 15 y 49 años es la más baja de América Latina y una de las más bajas del mundo. El Gobierno de Cuba ha creado un grupo operativo integrado

por representantes de organizaciones y organismos públicos, y presidido por el Ministerio de Salud Pública, que evalúa periódica y cabalmente las estrategias de prevención y control. Por su parte, el Centro de Prevención ITS, VIH, SIDA dirige sus principales actividades educativas a los grupos más afectados por la epidemia. Las campañas de prevención nacionales se están extendiendo a todo el país a través de las escuelas, los medios de comunicación y otras vías. Asimismo, los pacientes que lo precisan reciben gratuitamente antirretrovirales de producción nacional.

Ante los alarmantes indicadores de África, Cuba planteó durante el XXVI periodo extraordinario de sesiones de las Naciones Unidas que está dispuesta a enviar a ese continente 4.000 médicos y profesionales de la salud; profesores para la creación de 20 facultades de medicina para la formación de 1.000 médicos todos los años en los países más necesitados; otros especialistas para las campañas de prevención de las enfermedades de transmisión sexual; equipos para la prevención y el diagnóstico; y antirretrovirales cubanos para el tratamiento de 30.000 pacientes. El orador pide a los países desarrollados que aporten los insumos necesarios para la acción del personal profesional y técnico.

Invita a los presentes a participar en la III Conferencia de Cooperación Técnica Horizontal en América Latina y el Caribe sobre VIH y ETS, que se celebrará en cumplimiento de la declaración de compromisos sobre la lucha contra el VIH/SIDA aprobada por la Asamblea General de las Naciones Unidas.

Por último, suscribe la opinión de que la resolución requerirá un análisis posterior, debido a la presentación de propuestas de modificaciones.

Dr. COLEMAN (World Association for Sexology) thanked Dr. Zacarías for his excellent report, which pointed out that the HIV/AIDS epidemic was still growing rapidly rather than ebbing. He was puzzled, given the severity of the health problem and the apparent interest of the health ministers, that the Executive Committee had recommended eliminating the yearly report to the Governing Bodies on HIV/AIDS.

Sexual health promotion was seen as one of the most important strategies for preventing transmission of HIV, but it would also address numerous other sexual health problems facing the Region of the Americas, including sexually transmitted infections (STIs), unwanted pregnancies, unsafe abortions, infertility, sexual dysfunction among men and women, sexual violence, and gender inequity and discrimination based upon gender and sexual orientation. It was a public health imperative to address those problems—which disproportionately affected individuals and countries with few financial resources—in a scientific and evidence-based manner.

He applauded PAHO's efforts to provide information on the promotion of sexual health to the Region's ministries of health. An example was the document "Promotion of Sexual Health: Recommendations for Action", which his association had helped PAHO to develop. Next month, the World Association for Sexology would be working again with PAHO on an initiative to address the sexual health problems on indigenous populations in the Americas. The project would culminate in a technical document to be unveiled at a subsequent meeting of the Governing Bodies. With WHO, his association was jointly sponsoring the World Congress of Sexology, to be held in Havana, Cuba,

next March. It would be glad to work with any of the health ministries, through its member organizations in the Region, to promote sexual health.

El Sr. GONZÁLEZ (Unión Latinoamericana contra las Enfermedades de Transmisión Sexual) dice que la lucha contra las enfermedades de transmisión sexual es importante en sí, porque traen consigo severas complicaciones y secuelas, como infertilidad, aborto, muerte neonatal y varios tipos de cáncer.

En cuanto a la importancia de estas enfermedades en lo referente a la transmisión del virus de inmunodeficiencia humana, si bien hay un control común a todas ellas, compartido con el VIH, no es menos cierto que, como pone de manifiesto el marco teórico concebido por la ULACETS para el tratamiento de las infecciones de transmisión sexual, hay elementos permanentes olvidados que imposibilitan dicho control.

Algunas enfermedades, como la hepatitis B (cuya prevalencia va en aumento), se pueden eliminar con una simple vacuna. Otras, como las infecciones por gonococo y clamidia, cuyas complicaciones causan problemas permanentes en el recién nacido y esterilidad y otras secuelas en el adulto, se pueden controlar mediante el simple empleo de condones antibióticos. Respecto de otras, como el virus del papiloma humano, no queda más recurso que invertir en investigación. En cualquier caso, hay enfermedades de transmisión sexual que además de representar un problema en sí mismas, multiplican de tres a cinco veces la probabilidad de transmisión del VIH. Todavía otras, como la sífilis y las úlceras de origen viral, pueden multiplicar hasta por veinte la posibilidad de contraer el SIDA.

Todos aspiran a un mundo libre del VIH donde reine la salud sexual y reproductiva. La ULACETS pide pues que los recursos no se distribuyan políticamente, sino sobre la base de pruebas científicas, y que las siempre olvidadas enfermedades de transmisión sexual vuelvan a ser consideradas en los programas políticos nacionales de una forma que corresponda a la importancia que tienen.

El Dr. ZACARÍAS (OPS) agradece los comentarios de los delegados, el apoyo financiero y técnico brindado por el Canadá, los Estados Unidos de América, Francia, los Países Bajos, el Reino Unido, España, Alemania, Noruega y Suecia, así como la cooperación prestada, entre otros países, por el Brasil, México y Chile.

El PRESIDENTE dice que el proyecto de resolución se revisará a la luz de las enmiendas y los comentarios presentados.

The meeting rose at 6:00 p.m.
Se levanta la reunión a las 6.00 p.m.