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PROVISIONAL SUMMARY RECORD OF THE SEVENTH PLENARY SESSION
ACTA RESUMIDA PROVISIONAL DE LA SEPTIMA SESION PLENARIA

Thursday, 24 September 1987, at 9:00 a.m.
Martes, 24 de septiembre de 1987, a las 9:00 a.m.

President: Dra. Ilda María Urizar de Arias — Peru
Presidente:

Later: Dr. Guillermo Soberón Acevedo — Mexico
Después:

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ITEM 5.6: ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS
TEMA 5.6: SINDROME DE LA INMUNODEFICIENCIA ADQUIRIDA (SIDA) EN LAS AMERICAS

La PRESIDENTA llama la atención al Documento CD32/10 y ADD. I sobre el tema, y solicita al Representante del Comité Ejecutivo que presente su informe.

El Dr. QUIJANO (Representante del Comité Ejecutivo) manifiesta que este tema se examinó con gran interés en la 99a Reunión del Comité Ejecutivo. En esa ocasión el Dr. St. John señaló que la infección con el virus de la inmunodeficiencia humana adopta la forma de una epidemia que hace pesar una grave amenaza sobre todos los países, tanto desarrollados como en desarrollo. Ciento doce países han comunicado oficialmente a la OMS más de 50.000 casos de SIDA, pero la Organización calcula que el número de infectados asintomáticos debe ocilar entre 5 y 10 millones de personas. La epidemia del SIDA está en sus comienzos, es difícil prever qué magnitud alcanzará y será necesario que todos los países de la Región movilicen sus energías y recursos, tomando una serie de medidas contra la enfermedad y adoptando estrategias para poner coto a su difusión, sin perder por ello el respeto a la dignidad humana. En el Comité se reconoció, sin embargo, que el control del SIDA es difícil y costoso, puesto que por ahora no hay ninguna vacuna ni tratamiento eficaces. Se dieron numerosos detalles sobre la magnitud de la infección en las diferentes Regiones de la OMS y especialmente en las Américas.

La OPS cree que el número real de casos debe ser de dos a cuatro veces superior al notificado y las previsiones para el futuro son

alarmantes, ya que la enfermedad tiene un período de incubación de cinco a diez años durante los cuales no se detecta a los portadores asintomáticos del virus. El impacto económico del SIDA puede ser gravísimo, pues amenaza directamente a la población adulta de 20 a 50 años. Se calculó que para 1991 el SIDA acarrearía unos $16.000 millones de gastos de atención tan solo en los Estados Unidos de América.

Se dijo también que, a pesar de todo, cabe cierto optimismo si se piensa en los enormes progresos científicos realizados en poco tiempo: aislamiento del virus, el conocimiento de su estructura genética, de sus principales proteínas y de su forma de actuar en la célula. Ya existe un medicamento, la AZT, aunque todavía imperfecto, y se están investigando posibles vacunas.

El programa especial de la OMS contra el SIDA, que ha movilizado recursos y voluntades en el mundo entero, tiene dos objetivos: prevenir la transmisión de virus y reducir las consecuencias de la infección. Sus componentes principales son la formación de comités nacionales para dirigir los programas, la evaluación inicial de la difusión del SIDA mediante encuestas de seroprevalencia en grupos seleccionados de la población, el desarrollo de la vigilancia intensiva, el adiestramiento a todos los niveles del personal de salud, la adopción de medidas preventivas, como la educación sanitaria, y un plan para el cuidado de las personas infectadas y de los pacientes.

La Organización Panamericana de la Salud se encarga del programa especial de la OMS en lo que respecta a las Américas. Se han destinado ya $1,1 millones de fondos extraordinarios para las actividades y se da asistencia y apoyo financiero a los programas nacionales. Ahora se trata

de conseguir otros $5 millones para investigaciones en América Latina y el Caribe. Se comunicó además al Comité Ejecutivo el incremento del programa especial de la OMS, que movilizó para el SIDA $6 millones en 1986, $36 millones en 1987 y piensa destinar $80 millones en 1988.

El debate en el Comité Ejecutivo sobre este tema fue largo y animado, refiriéndose no solo a problemas técnicas, epidemiológicos, económicos y organizativos, sino también a educación para la salud, formación de personal, relaciones con los medios de comunicación y necesidad de conjugar el respeto a los derechos y a la dignidad del hombre con las obligaciones y deberes que le incumben como ser social.

Cerró el debate con una intervención del Director, que señaló la nueva crisis que plantea el SIDA a los servicios de salud y lo delicada que resulta la actuación de estos en tal contexto. A continuación el Comité Ejecutivo aprobó la Resolución XII en la que se propone al Consejo Directivo la adopción de una pormenorizada resolución para que los Países Miembros, con el apoyo de la OPS, puedan poner en marcha programas de prevención y control del SIDA.

Dr. ST. JOHN (PASB) said that the epidemic of infection with the human immunodeficiency virus (HIV) had now become global in scope. Both industrialized and developing countries were affected. Since PAHO's report to the Executive Committee in June, 11 more countries had reported cases of AIDS to WHO, so that now 123 countries in all had officially reported more than 60,000 cases of AIDS.

On a worldwide basis the relatively small number of reported cases of AIDS had resulted in a certain degree of complacency when the AIDS situation was compared to the magnitude of other long-standing health

problems. But those cases represented only a small fraction of the large number of infected but currently asymptomatic people. WHO estimated that there were at present between 5 and 10 million infected persons in the world. The epidemic was an unprecedented threat to global health. It was just beginning and its ultimate magnitude and impact were difficult to estimate.

The epidemic curves of reported AIDS cases from different regions of the world for the period 1978 through 1986 showed that in Europe over 7,000 cases had now been reported. The spread of the disease was identical to that in the Americas. There had been a delay between the onset of the disease in the United States of America and the its onset in Europe. In Oceania, the curve was also similar: of the 634 reported cases, the vast majority had occurred in Australia and New Zealand. Asia remained relatively untouched, with a total of 182 cases reported in Japan, Thailand and some other countries. In Africa it was estimated that over 50,000 cases had occurred, though only 5,800 had been officially reported. The most affected area was Central Africa.

In the Americas, the Andean group had reported a total of 352 cases. The total for the Southern Cone had now reached 181 cases and Brazil had reported a total of 2,013. In Central America the total stood at 142 cases, while Mexico had reached 534. The Latin Caribbean had now reached 1,116 cases, and the non-Latin Caribbean had reported 628 cases. North America had reported a total of 43,138 cases. Thus, since the initiation of surveillance in 1983, a total of 48,104 cases and 26,512 deaths had been reported. The overall case-fatality rate was 55%.

The United States of America, Brazil, Canada and Haiti alone accounted for 96% of the total for the Region. Excluding North America, there had been 4,966 cases in all the remaining 40 countries and territories of the Americas. That represented a net increase of 1,894 persons in the first eight and a half months of 1987. The Latin Caribbean subregion had contributed approximately 33% of those cases, but had only 7% of the population of Latin America and the Caribbean. The entire non-Latin, English-speaking Caribbean had contributed 10% of the total from a population base of only 6.5 million; that 10% corresponded to only 2% of the population. AIDS in the entire Caribbean basin was a matter of urgent concern.

To date, the world had tracked the course of the epidemic by monitoring the total number of accumulated cases since 1981, when the epidemic had started. The total number of cases was used in many circles to make comparisons between countries, and undue attention was attracted by those countries reporting a large number of cases, for example, the United States of America, Brazil, France and Haiti. The comparisons were invalid and misleading because they did not consider the size of the population which gave rise to the AIDS cases. A variety of approaches to facilitate comparisons had been considered in the PAHO/WHO AIDS program. No ideal approach had been developed as yet, but one method of approximating incidence estimates involved the calculation of the ratio of reported cases for a given count in the year to the mid-year population estimate for that year.

If one considered the case ratios for the major subregions of the Americas, the ratio for the North American grouping was 62.6 cases per million population. The Caribbean subregion was second only to the North

American region, with 38.8 cases per million population, while the Latin American region had a rate of 2.8 cases per million. Yet those averages also obscured significant differences between countries.

Taking the case ratios for individual countries reporting 10 or more cases in 1986, several Caribbean countries were contributing a disproportionate number of cases for their population size. Those numbers were all obviously influenced by the degree of completeness of the reporting, the relative population size, and other complex factors, yet PAHO felt that they were important far identifying countries where more detailed investigation of the AIDS situation should be undertaken at once.

There was severe under-reporting due to failure to detect cases, and problems arose in meeting the fairly strict case definition criteria established by WHO, which had been revised at least three times in the past four years. There was also some confusion of cases of AIDS with persons infected by the AIDS virus. Those differences might explain some of the discrepancies in the data now available throughout the world.

PAHO now estimated that there might be two to four actual cases for every one reported and that there might be more than 500,000 infected persons in Latin America and the Caribbean. How far had the virus penetrated the general population? The answer was unknown. Seroprevalence studies were incomplete and somewhat fragmentary. Nevertheless, scattered evidence indicated that the problem might be severe in many countries. In Haiti, approximately 50% of the prostitutes were now infected. In the Dominican Republic, 3% of the blood donors were

infected. In Mexico, the problems of infection of paid donors recruited in some private blood banks reached nearly 50%. In the Dominican Republic in 1983 and 1984 there had not been a single case reported in women, but in 1987, 45% of the cases were in women.

Unlike Africa, where the male to female ratio was one to one, indicating heterosexual transmission, the disease profile in the Americas for the most part was dominated by homosexual and by bisexual transmission. However, two countries, Haiti and the Dominican Republic, had male to female ratios of four to one, which was intermediate between the African and the American ratios and suggested that the pattern of transmission might be shifting towards a heterosexual one. Since the initiation of reporting of cases by sex in January 1987 in the non-Latin and Latin Caribbean, 15 and 22% respectively of the reported cases were now in women, while only zero to 9% were in women in the rest of the Region.

The epidemic curve for the United States of America was well known, but in country after country of the Americas the curve was beginning to resemble it.

Thus the curve for Brazil showed an initial slow rise in the number of reported cases followed by a rapid, dramatic and sudden increase as the epidemic had become established. A further spread was to be expected.

Infection with AIDS was for life. A long incubation period which might last for 5 to 10 years created an asymptomatic but infectious carrier state. The disease was spread sexually and from mother to

child. Those modes of transmission involved some of the most fundamental aspects of human behavior, aspects that were essential to life itself. Transmission through blood and blood products further guaranteed that nearly all segments of society might experience some risk to exposure during a lifetime.

In the short space of one year, WHO had mobilized funds, people and, most importantly, the will to confront the problem. The special program on AIDS had two major objectives. The first was to prevent the transmission of the AIDS virus wherever and however possible. The second was to reduce the impact associated with HIV infections. The key strategy of the special program on AIDS was collaboration with Member Countries for the development of national AIDS prevention and control programs. PAHO had now mobilized over $1.3 million for national programs in Brazil, Argentina, Haiti, Mexico and, through the Caribbean Epidemiology Center, for 19 English-speaking countries of the Caribbean. Financing had recently been secured for the Dominican Republic, and national plans for Chile, Ecuador, El Salvador, Suriname, Jamaica and Uruguay were being discussed. By the end of 1988, all countries in the Region should have national programs for AIDS prevention and control.

To promote the development of national plans, PAHO had organized the first Pan American Teleconference on AIDS from Quito, Ecuador. Through satellite television that conference had reached an audience estimated at 50,000 health-care workers in over 650 sites, from Chile to Canada, in four languages. That unique event had brought a major PAHO/WHO conference directly to health care workers, on whom it would depend to carry out the public health program.

In summary, the problem continued to spread. Much had been learned but much remained to be learned. A common effort by all countries would be required to deal with this major threat to the health of all.

Dr. SOBERON (México) informa que hasta el 14 de septiembre de 1987 se habían registrado en México 713 casos de SIDA, con lo cual se calcula que el período de duplicación del número de casos es ahora de siete a ocho meses. Se ha constituido un Comité Nacional con seis subcomités: vigi- lancia epidemiológica, educación para la salud, control sanitario de la transfusión sanguínea, investigación química y terapéutica, legislación y participación comunitaria. Desde el año pasado el SIDA figura entre las enfermedades de notificación obligatoria, con sanciones específicas cuando no se proceda en esta forma. Se ha prohibido la comercialización de sangre y ahora en el país no puede haber donadores remunerados.

Hay un programa muy activo de educación para la salud dirigido sobre todo a las personas que pertenecen a los grupos denominados de alto riesgo, pero también hay mensajes dirigidos a la población en general y al personal de salud. Una de las formas de evitar la diseminación es la práctica del sexo seguro, y señala la resistencia que se ha encontrado en ciertos grupos conservadores en cuanto a la recomendación del uso del preservativo, siempre que no se mantenga una relación estrictamente monogámica.

Se ha hecho una erogación extraordinaria a favor del programa de educación para la salud y de la expansión de las instalaciones hospitalarias del Instituto Nacional de Nutrición. Se han establecido

contactos con los Institutos Nacionales de Salud de los Estados Unidos de América para proponer proyectos de investigación en diferentes campos. Hasta ahora no se ha estructurado un programa de pruebas de identificación del virus en la población en general o en grandes grupos, aunque no faltan las presiones a este respecto, sobre todo en lo que se refiere a los trabajadores inmigrantes. Desearía conocer la opinión del Dr. St. John sobre este asunto. Señala que ya hay casos comprobados en heterosexuales y que aumenta la incidencia en niños.

El Dr. GODOY (Paraguay) dice que hace una semana el Paraguay participó en la teleconferencia que tuvo lugar en la Región con varios centenares de profesionales, con lo que ha obtenido informaciones muy actualizadas. Conoce, pues, el explosivo crecimiento de la pandemia de la infección por el virus de la inmunodeficiencia humana y del síndrome de inmunodeficiencia adquirida, así como la extrema gravedad de esta enfermedad. La única medida actualmente eficaz es la educación sanitaria y es urgente la necesidad de desarrollar otros instrumentos eficaces de prevención y control. Aunque en el Paraguay solo se han detectado hasta la fecha seis casos de SIDA y nueve personas infectadas, una vez introducido el virus es fácil su propagación, primero, entre las personas de alto riesgo y, después, en otros grupos sociales, incluidos los recién nacidos, por lo cual las medidas de prevención y control deben ser tomadas de inmediato.

Después de haber analizado el proyecto de resolución presentado y teniendo en cuenta la creciente amenaza que supone el SIDA, expresa su firme apoyo al mismo, por considerarlo un instrumento apropiado para oponer una barrera a la transmisión de tan temible enemigo de la humanidad.

Además, ante la gran amenaza del SIDA y la difícil situación económica que sufre la Región de las Américas, propone que se establezca un sistema de compra mancomunada de reactivos y que se promueva el desarrollo de tecnologías más sencillas para la detección y el diagnóstico oportuno de las infecciones.

El Dr. ANTELO (Cuba) dice que su país ha tomado plena conciencia de la amenaza que representa el SIDA para la humanidad, que su magnitud en el orden epidémico no se puede predecir en el momento actual y que ha considerado necesario tomar una serie de medidas inmediatas y a largo plazo para asegurar que esta enfermedad no se convierta allí en un problema de salud. Entre estas medidas, cabe mencionar que ya en 1983 se empezó a elaborar un programa de control, organizado mediante un sistema de vigilancia nacional de la enfermedad, que se creó una comisión multisectorial para establecer la estrategia nacional en la prevención y control del SIDA en el país y que se prohibió la importación de hemoderivados, dejando así el terreno preparado para establecer en 1985 un programa bien estructurado.

La vigilancia epidemiológica ha constituido desde 1983 el pilar fundamental de este programa. Como parte de él, se ha desarrollado un plan de educación en salud de la población y de divulgación de los conocimientos que se tiene sobre la enfermedad, y se ha adiestrado al personal de salud en las técnicas de diagnóstico del SIDA, el tratamiento de los pacientes y la investigación epidemiológica.

Refiriéndose a las medidas que se califica de "desacertadas o ineficientes" en el Documento CD32/10 y ADD. I, el orador considera que

se ha emitido un juicio prematuro porque aun no ha habido tiempo de valorar los resultados.

En Cuba, que tiene una situación epidemiológica privilegiada, se han realizado 1.100.000 pruebas de detección del VIH en grupos de riesgo y donantes de sangre, lo que representa el 10% de la población, y se han detectado 147 portadores del virus. A partir del 1 de octubre se iniciarán las pruebas a todos los pacientes mayores de 14 años que ingresen en los hospitales. Asimismo, a todas las personas que deseen residir en Cuba, fundamentalmente estudiantes procedentes de varios países que se benefician de la cooperación internacional, se les realiza una prueba de detección que se repite a los seis meses de haber llegado al país.

Mientras que de cada 100 portadores del virus VIH sometidos a tratamiento médico en cualquier lugar del mundo se ha notificado que enferman aproximadamente entre 30 y 50 en un tiempo relativamente corto, en Cuba han enfermado seis, para un 4%, por lo que estos resultados aun no se pueden considerar ineficaces o desacertados.

Observa el orador que cuando se masifica el número de portadores del VIH se hace difícil tomar medidas de protección, no solo de la población sana, sino de las personas enfermas, debido a las condiciones especiales de atención médica, nutricional y psicológica que requieren. No se trata, como se señala en el documento presentado, de un problema de temor, sino de una situación muy particular de su país, que tiene la decisión política de dedicar todos los recursos humanos y materiales necesarios para que enferme el menor número posible de portadores y para protegar a su familia y la sociedad.

Considera el orador que, tal como se establece en el documento, "cualquier medida tomada ahora tendrá mayores repercusiones que las que se adopten más tarde", y que los programas nacionales de prevención y control deben seguir el modelo recomendado por el Programa Especial de la OMS sobre el SIDA, adaptado al contexto de cada país. Finalmente, señala que algunos países no pueden implantar materialmente, aunque quisieran, la política de salud establecida en Cuba, de modo que no la preconiza como modelo, pero sí deben medirse sus resultados y condiciones antes de ser absolutos en los calificativos que se utilicen en un documento de la Organización.

Dr. SANTOS (Brasil) observa inicialmente que, em termos absolutos, o Brasil tem figurado em segundo ou terceiro lugar nas estatísticas mundiais sobre a SIDA, com um número muito elevado de casos, o que levou o Governo a sociedade em geral a dar atenção muito especial às campanhas de informação, esclarecimento e orientação. Acrescenta, porém, que essas cifras, da maneira como foram apresentadas, merecem algumas considerações.

Em primeiro lugar, do total de 1.480 casos notificados, 1.400 resultavam de contacto homossexual e apenas 80 de contacto heterossexual. Esses dados são de evidente importância, tendo em vista a crescente preocupação no mundo com a participação dos contactos heterossexuais exclusivos na transmissão da SIDA. A transmissão sanguínea vem merecendo atenção muito especial dado que, tal como em outros países, o uso ilegal de drogas injetadas é o mais difícil de conter.

No Brasil, também como em outros países, a campanha de esclarecimento e informação sobre a transmissão da doença tem sido a providência mais eficaz até que venha a ser descoberta alguma forma de vacina ou tratamento. E essa campanha tem sido inovadora e até ousada diante das tradições do país, mas a reação dos setores mais conservadores da sociedade não atingiu as domensões que se poderia esperar.

Mas, a classificação do Brasil em relação aos demais países do mundo quanto ao número absoluto de casos de SIDA altera-se completamente ao se levar em conta a grande população do país. Um exame do relacionamento entre esses números absolutos e as dimensões da população brasileira situa o Brasil no 35o. lugar entre os demais países, em matéria de casos notificados dessa doença.

Mais recentemente, a campanha de informação e esclarecimento está sendo orientada intensamente para as escolas a fim de motivar a adolescência no sentido de adotar atitudes mais correctas do ponto de vista do comportamento sexual. Também tem sido intensa a preocupação com os aspectos trabalhistas e legais relativos ao diagnóstico e à transmissão da SIDA, questão que está sendo examinada a nível técnico como forma preliminar de sua discussão ao nível legislativo.

Finaliza expressando a esperanza de que todos esses números se estarão reduzindo no futuro, quando os efeitos da campanha se fizerem sentir.

Le Dr. DEMEULEMEESTER (France) rapporte qu'à la Martinique, à la Guadeloupe et en Guyanne, au 30 juin 1987, 160 cas de SIDA avaient été repertoriés pour l'ensemble des trois départements d'une population d'environ 250 000 habitants. De ce nombre de cas, on comptait 109 hommes

et 55 femmes, soit une proportion extrêment importante d'une femme pour deux hommes. En ce qui concerne les groupes à risques, 7% seulement figuraient parmi les homosexuels ou les bisexuels; 1% parmi les toxicomanes et 6% parmi ceux ayant reçu une transfusion de sang d'un suget infecté par le virus. 10% provenaient de meres infectées et 65% n'étaient classés dans aucun groupe, ce qui fait penser à la transmission hétérosexuelle comme la plus probable pour ce groupe.

En ce qui concerne l'infection par le virus d'immuno-déficience humaine, en 1986, pour les trois départements, deux dons de sang sur 1000 étaient positivement confirmés. Des études effectuées dans d'autres types de population indiquaient au début de 1987 qu'entre 0,5% et 1% de la population adulte était infecté.

Un programme national comportant trois volets a été mis sur pied. Le premier volet porte sur l'amélioration des connaissances du problème grâce a un relevé trimestriel des cas dans l'ensemble des établissements hospitaliers par les services de santé, un relevé trismestriel d'examens positifs dans l'ensemble des laboratoires et enfin, la réalisation d'enquêtes épidémiologiques en cours dans plusieurs catégories de populations.

Le deuxieme volet consiste en une tentative de contrâler l'expansion du virus dans la population. A cet égard, une importante campagne de sensibilisation a été entamée en juillet 1987 sous le theme SIDA - Alerte No. 1, par analogie avec l'alerte en cas de cyclone a laquelle les gens réagissent favorablement. De nombreuses interventions dans les media ainsi qu'une information réguliere des profesionnels de santé ont été três bien reÜues par le public, compte tenu de ce que,

étant donné le schéma particulier des groupes à risques, le principal but était d'encourager un comportement sexuel moins risqué. De surcroit, depuis aout 1985, le dépistage des dons de sang est systématiquement effectué.

Le troisieme volet touche la prise en charge des personnes atteintes de SIDA. Des consultations se font dans plusieurs hopitaux entre les consultants séro-positifs et les autres consultants. Aucune discrimination n'est practiquée entre les patients atteints de SIDA et les autres.

La délégation francaise souhaite d'une part que tous les pays de la région agissent avec la meme rigueur et la même franchise en ce qui a trait aux activités de recensement et de déclaration des cas et d'autre part que l'éducation du public en matiere de SIDA soit généralisée dans la région. A titre indicatif, l'importante campagne menée en juillet à la Martinique, à la Guadeloupe et en Guyanne n'a pas eu de retombées négatives sur le tourisme comme on l'avait craint. Finalment, le Dr. Demeulemeester réaffirme que les moyens de lutte contre le SIDA devraient respecter les droits de l'homme et la libre circulation des personnes et surtout, que les sujets positifs ne fassent l'objet d'aucune discrimination.

Le Dr. Demeulemeester annonce que la France est prête à coopérer à la réalisation de programmes nationaux de trois manieres: soit par l'envoi d'experts tes qu'épidémiologistes, spécialistes en transfusion, immunologistes ou cliniciens; soit en aidant au dévelopement d'équipes

compétentes ou soit éventuellement en finançant dans un cadre multilatéral ou bilatéral des actions de prévention, des activités de formation ou de recherche.

M. CARON (Canada) déclare que les points de vue du Canada ayant déja été énoncés à la 40eme Assemblée mondiale de la Santé, il se contentera de faire quelques commentaires additionels.

Le Canada appuie la résolution proposée par le Comité exécutif à la 99eme réunion. Il estime que tous les pays doivent prendre une part active à la lutte contre le SIDA. Au Canada, plus de 1200 cas ont été diagnostiqués et plus de 50% des personnes atteintes sont déjà mortes.

A titre de sa contribution, le Canada a appuyé le programme international de lutte contre le SIDA et a établi en juillet dernier un centre national de SIDA que sera chargé de coordonner les efforts canadiens dans cette lutte. Les provinces mettent sur pied plusieurs programmes et des équipes spécialisées d'intervention dépistage et les traitements. Des unités de recherche ont été chargées d'entreprendre entre autres, la recherche épidémiologique clinique et évaluative.

Finalement, M. Caron félicite l'Organisation d'avoir organisé la premiere conférence interaméricaine sur le SIDA et souhaite voir cette expérience renouvelée.

Mr. TAITT (Barbados) said that the first confirmed case of AIDS in Barbados had been reported in December 1984 and that up to June 1987 there had been 44 cases, with 27 deaths. Of that total, 37 had been males and 7 females. The first case among females had been reported in 1985.

Most of the cases in Barbados had occurred in the 20-39 years age group, but there had been four cases among children under 5 years of age. Among the adult males for whom the risk group had been assessed, 15 or 40%, had admitted to being homosexual or bisexual. Only one case in Barbados to date had been associated with transfusion of blood and none with intravenous drug abuse. In all the pediatric cases, one or both parents had had a confirmed HIV infection.

Since 1985, blood transfusions had been routinely screened for HIV antibodies. All the reported cases of AIDS had presented one or more opportunistic infections. The only malignancy had been reported in one of the pediatric cases.

In 1985, the Government of Barbados had established in the Ministry of Health a technical committee comprising professionals who were responsible for educating the public about measures to contain the spread of the disease while examining its effects in more detail. But by June 1987 it had become apparent that a national committee was necessary and, as a result, the Ministry of Health had appointed in August 1987 a national advisory committee whose recommendations would form the basis for all policy on AIDS throughout the country.

It might be of interest to Members of PAHO to know that, although world statistics indicated that children who became ill died early, there were in Barbados two children affected by HIV who had reached the age of 6. The prognosis for those two children was of course still guarded, but the need for arrangements to take care of children with AIDS was being given substantial attention, since such care was going to be important in a community the size of Barbados.

There was one matter relating to AIDS which deserved attention. It was no secret that a substantial number of countries in the Caribbean subregion depended to a considerable extent for their economic survival on the vagaries of the tourist industry. It was therefore a matter of concern to those countries that the manner in which the statistics on AIDS were being reported continued to suggest that the disease was more prevalent in those countries than in the rest of the world, and gave a disproportionate and possibly incorrect image of the incidence of the disease in the Caribbean. In any event, the reporting methods used by WHO and PAHO could have unforeseen and unintended economic repercussions on Caribbean countries which depended for their livelihood on tourism.

His Government believed that PAHO might consider a more realistic approach to the reporting of the AIDS statistics and the incidence of the disease. While Barbados did not wish to suggest that the well-known procedures for the gathering of statistics should be modified, it did believe that a systematic approach to a different, or at least ancillary form of reporting would go a long way towards alleviating the situation to which he had referred.

His Government wished to thank PAHO for its continuing work on AIDS and for the assistance it was giving to Barbados and other Caribbean countries in their attempts to fight the disease.

El Dr. UGARTE (Uruguay) dice que en el momento actual en su país el SIDA no es un problema grave de salud. Desde 1983 se han declarado 112 casos de personas portadoras del VIH. De ellas, ha habido 13 casos de SIDA, ocho de los cuales fueron mortales; seis de estos casos correspondieron a hemofílicos que habían contraído el virus como consecuencia de transfusiones sanguíneas.

No obstante, no se puede permanecer ajeno a la evolución que tiene la enfermedad en el mundo. Siguiendo las recomendaciones de la OPS, el Uruguay ha elaborado un programa de control y prevención del SIDA basado en una intensa campaña educativa que se ha realizado en diferentes niveles. El primer nivel es el de los docentes, escolares y universitarios, que se considera que actúan como elementos multiplicadores. El segundo nivel es el de una campaña de educación del personal de salud, que en una primera instancia tenía un verdadero temor de tratar a los enfermos del SIDA. Actualmente se está desarrollando una campaña de información de la población por medio de los medios de comunicación. Se considera fundamental instruir al público en general sobre cómo se contagia el SIDA y en qué condiciones no existe peligro de contagio. Por otro lado, hay que subrayar la influencia nefasta que tiene esa enfermedad sobre los derechos individuales de los enfermos, que tienen derecho a vivir como seres humanos, a trabajar y a vivir en familia y en el seno de la comunidad. La sociedad debe ser educada para convivir con estos enfermos, debe admitirlos en su seno y asumir conjuntamente con ellos la responsabilidad de evitar la propagación del SIDA.

El Dr. AHUMADA (Argentina) informa que, de los 95 casos notificados en este país hasta julio de 1987, el 100% eran personas del sexo masculino, todos ellos homosexuales o bisexuales, y que se ha comprobado que el 80% de esos casos contrajeron la enfermedad en el extranjero.

A través de los estudios de vigilancia epidemiológica que se han hecho en la Argentina, se perciben algunos elementos que no coinciden con la tendencia en otros países. Se están realizando determinaciones serológicas en grupos de personas en riesgo, y hasta el presente el grupo

que ha presentado una mayor incidencia del VIH es el de los toxicómanos endovenosos, con un 56% de los casos identificados. La legislación del país proscribe y penaliza la venta de la sangre. Entre los donantes voluntarios solamente se ha encontrado un 0,5 por 1.000 casos de infección, y entre los homosexuales que se han sometido voluntariamente a las pruebas del VIH, se ha hallado un 8% de casos positivos. En cuanto al grupo de prostitutas examinado hasta el momento, la infección es del 0%.

El programa contra el SIDA en la Argentina consta de diversos elementos. Uno de ellos es la prevención, a través de la información y la educación de los profesionales y trabajadores de salud y de la población, así como la educación sexual y para la salud. Otro elemento es la vigilancia epidemiológica a través del análisis de los grupos en riesgo, de las comunidades recluídas o confinadas, de los bancos de sangre, etc. Se ha constituido una red de laboratorios de investigación cuyo laboratorio central se encuentra en la Facultad de Medicina de la Universidad de Buenos Aires. Este laboratorio es de alta seguridad y permite el estudio de virus. También hay un laboratorio de referencia. La red de laboratorios es capaz de operar en la detección de casos y cuenta con no menos de dos laboratorios en cada una de las provincias. Asimismo, se está preparando una red de asistencia de los pacientes para evitar su marginación, es decir, que cada enfermo deberá ser atendido por el servicio correspondiente de su lugar de residencia.

Finalmente, se destaca el efecto sociocultural cada vez mayor que está produciendo la enfermedad en la sociedad, con conductas a veces totalmente irracionales. En la Argentina se ha formado un grupo para

investigar este efecto. Otro tema importante de investigación es el jurídico, sobre todo referido a aquellos pacientes que están bajo custodia legal, como psicópatas y psicóticos, para lo cual se ha constituido una comisión especializada con la que se está trabajando para actualizar la legislación al respecto.

A pesar de su tremendo efecto sobre la salud y las aterradoras posibilidades de propagación que presenta, el SIDA ha tenido un aspecto positivo, que es el de poner al descubierto las carencias de los sistemas de atención de la salud. Esto obliga a replantear las estructuras de estos servicios. El orador propone al Director de la OSP que se efectúe la actualización de la información sobre las distintas consideraciones legales que existen con respecto a la enfermedad en los distintos países de la Región.

Ms. KEFAUVER (United States of America) thanked Dr. St. John for his presentation and for the report before the Council, and congratulated PAHO for the AIDS teleconference which had taken place in Quito, Ecuador. Not only had the program been well carried out, but the conference had demonstrated the advantage of telecommunications in bringing important messages to a huge and geographically scattered audience.

As the document before the Council stated, AIDS constituted an urgent an unprecedented threat to global health and, since there was no cure, education and prevention activities were indeed critical. The recent teleconference was a good example of the education process. Educating health professionals around the world about the disease was certainly a major component of the education process.

As it had done at the Meeting of the Executive Committee in June, her Delegation wished to reaffirm its support for the comprehensive and reasonable plans for AIDS prevention and control in the Americas which had been presented and to reiterate her Government's offer to provide the Organization with technical experts in support of program activities related to AIDS.

Two distinct areas of activity had recently emerged in the United States of America. In August 1987, the United States Assistant Secretary of Health had announced the first clinical study of an AIDS vaccine to be approved by the Food and Drug Administration and to be conducted in the United States. The study would be carried out at the clinical center of the National Institutes of Health by a senior investigator in the Laboratory of Immunoregulation of the National Institute of Allergic and Infectious Diseases. The vaccine was manufactured by Microgenesis Inc., a biopharmaceutical firm in Westhaven, Connecticut. The study was designed to assess the vaccine's safety and its ability to produce an immune response, and to determine proper dosage. The vaccine consisted of purified protein from HIV and not the virus itself, so no one could contract AIDS from it. It was too early to predict whether the vaccine would undergo widespread efficacy trials, but her Government was quite hopeful about it. In addition, several candidate AIDS vaccines developed by research teams in academic institutions and in industry were in various stages of pre-clinical testing. When they were ready for Phase I and Phase II clinical testing, facilities called "vaccine evaluation units" supported by the National Institutes of Health at medical institutions around the country, would be offered as a national resource.

Another event that was worthy of note was that the United States Centers for Disease Control had issued, also in August 1987, a revised case definition for AIDS.

Over the past several years a large number of guidelines dealing with various aspects of AIDS had been developed, including recommendations and guidelines for health care workers and laboratory personnel, for hemophilia patients, patients with special disease conditions, donors of body fluids and tissues, vaccines, etc. The revised definition was expected to increase the number of AIDS cases reported. The old definition had been developed before there had been definitive testing procedures. The new definition not only took into consideration the availability of definitive testing but also provided for the inclusion of a number of disabling and fatal conditions not covered by the previous definition. The revisions added to the definition most of the severe, non-infectious, non-cancerous, HIV-associated conditions that were categorized in the clinical classification systems for HIV infection.

Her Delegation considered that it was of value to present both those pieces of information to the Council. It would be happy to make details information available to any interested Delegation.

Dr. HOSEIN (Trinidad and Tobago) thanked Dr. St. John and the Secretariat for the report now before the Council.

Trinidad and Tobago was one of the 39 countries in the Americas reporting cases of AIDS, and one of those with the largest number of cases in relation to population size. The first confirmed cases had appeared in 1983 and had all been in homosexual or bisexual men. The

situation as of 30 June 1987 was as follows: number of cases, 165; number of fatalities, 122, representing a fatality rate of 73.9%. The distribution of AIDS cases was: males, 83%, 47% of whom were between 20 and 34 years old; females, 16%, all recorded since 1985. Fourteen of the cases had been among children under 15 years of age and 10 in children under one. The risk factors were: homosexual males, 33%; bisexual males, 24.9%; heterosexual contacts, 12.1%; children born to infected mothers, 8.5%; cases due to blood transfusion, 1.2%; and four drug users, all of whom had acquired the infection abroad, 0.6%.

The screening of blood donors for HIV had begun in Trinidad in June 1985 and high-risk groups had been eliminated by interview; 0.4% of the screened blood donors had been found positive. The needed ad hoc AIDS committee had been galvanized into action in 1983. Earlier in the current year, the Cabinet of Trinidad and Tobago had approved a program which recognized the need for new drugs and the development of new strategies to educate and motivate the whole population to make the necessary changes in human sexual behavior. The goals of the recently approved national plan of action were similar to those of WHO, and the main components of the program included, first of all, establishing a national focus for the AIDS prevention and control program; strengthening and maintaining surveillance of the AIDS problem; educating and training health care personnel; prevention of transmission, primarily through public education; screening for blood transfusions; counseling of infected males and females; and, of course, research. A number of measures had been taken to ensure the effective implementation of the

program. They included, first, amendment of legislation to designate AIDS a notifiable disease, to control and ensure safe practices in blood transfusion and to regulate laboratories; second, the establishment of a national blood transfusion service; and third, the provision of funds for personnel to support diagnostic and educational services and activities and for supplies to protect health workers.

PAHO was to be commended for its informative background paper on the present item and especially for the information on the history of the disease and the status of AID in the Americas. A review of the table of cumulative reported AIDS cases tended to indicate, however, that several countries might well be remiss in submitting current an up-to-date reports. Countries should work with the Organization to eliminate that information gap and facilitate the monitoring of the AIDS problem, since the incidence of the disease could increase by leaps and bounds within a short period.

As stated in the report, the situation in the Caribbean was one of grave concern. It was to be noted, however, that it had been difficult to compare the exact extent of the problem in the English-speaking and in the Latin Caribbean because of the way in which the categories had been presented. Nevertheless, it was evident that resources must be identified to assist the smaller States to define the epidemiological pattern of AIDS with the characteristics peculiar to each individual country.

If the WHO estimates of the global situation were applied, it could be estimated that there were 16,500 HIV-infected persons in Trinidad and Tobago, giving a potential of nearly 5,000 future AIDS cases

within five years. However, to date there had been no epidemiologically acceptable approximation of the extent of the HIV infection in the general population, which made realistic programming difficult.

Trinidad and Tobago had found that the guidelines developed by WHO provided a simple methodology for the development and strengthening of national AIDS programs, and they had been used since 1983 to establish a coordinated national program with goals similar to those of WHO. The national AIDS prevention and control program in his country was now monitored by a national AIDS committee under the chairmanship of the Chief Medical Officer. The committee was responsible for developing comprehensive education, training and treatment components, and for promoting the amendment of legislation to ensure safe practices with respect to blood and blood products in hospitals and laboratories in both the public and the private sectors.

His Government was in agreement with the innovative approach of the PAHO programs and felt that an appropriate role had been identified for the Organization. Within one of the components, he would urge PAHO to accord priority to assisting countries in developing effective national educational programs, which must be targeted to the different sections of the population as well as to the wide range of health and security personnel that encountered AIDS patients, and utilizing appropriate communications technologies to promote life-style changes. Trinidad and Tobago recognized, however, that individual country efforts would be maximized if the problem was viewed as a regional one. Each country must place its AIDS program among its public health priorities, yet care must be taken to integrate the new approaches with existing

programs and to ensure that progress made in vital programs was not jeopardized.

Trinidad and Tobago supported the proposed resolution in the report, which so clearly outlined the roles of the Member Countries and of the Organization in dealing with AIDS, the number one problem of the twenty-first century.

The session rose at 10:35 a.m. and resumed at 11:00 a.m.
Se levanta la sesión a las 10:35 a.m. y se reanuda a las 11:00 a.m.

El Dr. MOHS (Costa Rica) desea llamar la atención acerca de dos aspectos relacionados con el SIDA. El primero es que el término "viajeros" debe ser revisado, ya que resulta un término muy amplio que incluye a cualquier persona que pueda viajar de un país a otro. Es improcedente realizar cualquier tipo de exámenes de detección de anticuerpos en estas personas. El orador considera, en cambio, que sí deben realizarse en el caso de los marineros. A Costa Rica llegan cada año 2.000 barcos con una población de marineros de 200.000 a 300.000 personas, que desembarcan durante una o dos semanas y conviven o tienen relaciones sexuales con aproximadamente 1.000 personas, de ellas unas 700 mujeres y unos 300 hombres. Esta población de marineros es un grupo de alto riesgo en cuanto a enfermedades de transmisión sexual, puesto que, según un estudio realizado en 290 marineros, el 3% tenía anticuerpos contra la sífilis y, algunos, anticuerpos contra el virus del SIDA. Por esta razón, Costa Rica ha decidido que estas personas, para bajar al puerto, deben presentar un certificado reconocido estableciendo que la prueba de anticuerpos contra el SIDA ha sido negativa.

El segundo aspecto que el orador desea señalar es el de las iniciativas seudocientíficas que ofrecen un tratamiento contra el SIDA, con lo que se pretende atraer a personas desesperadas que se convierten en víctimas de este tipo de charlatanería. Mientras no se diga que no existe ninguna vacuna y que no hay ningún tratamiento contra el SIDA, se abrirá el paso a este tipo de iniciativas deshonestas. La OPS debe expresar claramente en un manifiesto que no existe un tratamiento efectivo de momento, y condenar este tipo de iniciativas que constituyen un atentado contra la legitimidad de las acciones auspiciadas por ella y representan un grave peligro para personas inocentes.

El Dr. SAMPSON (Nicaragua) se felicita de la excelente calidad técnica y científica de las medidas con que la OPS y la OMS están abordando los problemas relacionados con el SIDA. Nicaragua ha elaborado un programa nacional de prevención y control del SIDA que se encuentra en fase de aplicación. Se ha establecido una Comisión Nacional, se ha iniciado una labor de detección de portadores entre los donantes de sangre y otros grupos de riesgo, y se ha puesto en marcha una campaña de educación dirigida a la población en general y a los trabajadores de salud.

En los países que se enfrentan con una grave crisis económica, el SIDA supone una carga adicional para los servicios de salud. Pese a los esfuerzos realizados por la Organización para abaratar los costos de los reactivos y del equipo de diagnóstico, este esfuerzo adicional representa una gran carga financiera.

El orador hace un llamamiento para que se busquen formas más económicas de promover la cooperación entre los países y canalizar la ayuda internacional hacia los países menos favorecidos económicamente.

Dr. BLACKMAN (Guyana) said that Guyana had begun an active surveillance program for AIDS in 1987, following the formation of a national AIDS committee. An epidemiological survey to determine the incidence of the disease was currently being conducted according to the guidelines recommended by WHO, with the assistance of the Caribbean Epidemiology Center in Trinidad. Five positive cases had been identified out of over 200 persons tested in various high risk groups. All five cases involved homosexual men; none had resulted from blood transfusions. The identification of AIDS cases in Guyana confirmed that the disease was indeed a global problem and that no country would be spared.

Guyana had established a national education program for AIDS, but it urgently needed laboratory facilities for testing and screening in order to prevent the transmission of the disease. Blood samples were currently being sent to CAREC in Trinidad for those purposes, resulting in delays in diagnoses and problems in transporting specimens. In addition, it did not allow for the screening of blood donors.

Guyana appreciated the support PAHO had offered in the past and looked forward to continued cooperation in the prevention and control of AIDS.

Dr. SMITH (United Kingdom) said that his Government strongly supported WHO/PAHO's immediate plans for developing AIDS control programs

in the Region, and had contributed to date 3.25 million pounds, channeled primarily through the WHO Special Program on AIDS. It was expected that any bilateral assistance would be provided within the framework of national AIDS programs developed with WHO assistance. The United Kingdom also supported CAREC as the WHO/PAHO agency responsible for assisting its 19 member countries in the English-speaking Caribbean region to develop national plans for AIDS control, and urged those countries to make full use of the Center's expertise and resources.

The Director of PAHO was also requested to ensure good donor coordination in any bilateral assistance being given to AIDS programs in the Region and close coordination of all regional programs with WHO.

The United Kingdom and WHO were organizing a world summit of Ministers of Health on programs for AIDS prevention, to be held in London from 26 to 28 January 1988. Its main aim was to provide Ministers of Health and their senior policy advisers with a forum for considering the prevention and control of AIDS, particularly the strategies needed in public information and health education which, many present would recall, the resolution on AIDS adopted unanimously at the 1987 World Health Assembly had identified as essential elements in controling the spread of the disease. Invitations to the summit had been sent to Ministers of Health throughout the world, and to relevant international agencies and to nongovernmental organizations, and the initial response had been very favorable. If further information was needed about the summit meeting, he would be happy to provide it.

Mr. SAMUDA (Jamaica) said it was clear from Dr. St. John's presentation that AIDS was the most serious epidemic facing mankind in

recent history. The impact of action taken now to reduce the number of new cases would be felt only in five years. There was no place for complacency, even among countries having few cases, as they were certain to have many more over the next few years.

Jamaica appreciated the initiatives of WHO/PAHO with respect to the Special Program on AIDS, and urged that no effort be spared in mobilizing the necessary expertise, support and funding to ensure that every country in the Region developed and implemented an effective AIDS control program.

Every country must define its own epidemiological patterns of AIDS and the spread of the HIV infection. In some countries, homosexuals, bisexuals and intravenous drug abusers were the largest groups affected, but in Jamaica the highest incidence (56% of the total cases to date) was to be found among heterosexuals. As of September 14, 30 cases of AIDS had been identified; 19 (63%) were male, 8 (27%) female, and 3 (10%) children, including two under 1 year old.

The first case had been diagnosed in 1982 and the second not until 1984. Prior to 1987 there had been 11 cases, all imported, but that year had seen a very sharp increase, with 19 cases, including the first local one. So in less than three years, between 1985 and the present date, 28 cases, or 93% of the total, had been diagnosed, and 63% of the total had emerged in the present year alone.

As a result, Jamaica had a national plan of action and was taking measures to fully define the pattern of spread of the disease. AIDS had been identified as a reportable disease, and the necessary steps were being taken to make such reporting mandatory. All blood donors were

screened, and a comprehensive health education program was underway to include community leaders, health professionals and teachers, especially in remote rural areas with low literacy rates.

Referring to the cost implications of AIDS, he said that if the number of cases doubled yearly, the costs of medical care and prevention programs and the losses in wages of AIDS victims by 1992 in Jamaica alone would total about $1.5 billion Jamaican dollars or US$273 million. The entire national health budget was only 30% of that amount. In addition, if misperceptions regarding the risk of contracting AIDS in Jamaica persisted, particularly among tourists from the United States of America, it would result in a possible loss of some $1.4 million Jamaican dollars, or US$255 million, by 1992. Such misperceptions could have vast and devastating implications on the Jamaican economy. Therefore, programs being undertaken by the Pan American Health Organization and allied agencies should make every effort to ensure that the information disseminated throughout the Region and the world presented accurate facts about the likelihood of acquiring AIDS. A reduction in tourism was unthinkable, as it was vital to the survival of the Caribbean islands.

Jamaica was taking all necessary steps to acquaint its people with the dangers involved in the spread of AIDS, and sincerely looked forward to continued cooperation and support in terms both of technical expertise and the necessary funding to help in its efforts to at least contain the spread of the disease.

Mr. WILLIAMS (Grenada) said that six cases of AIDS, resulting in four deaths, had been reported in Grenada as of 18 September. All six cases had been imported. Grenada was more vulnerable to AIDS than many

other countries, because of certain additional exposure factors: most of its advanced students studied abroad; a certain sector of its population was engaged in trafficking between Grenada and other countries; it had emigrant workers working abroad seasonally; and of course, there were all the risks faced by a country dependent on tourism. An AIDS task force, set up in February 1986, regularly monitored trends in AIDS and kept the Ministry of Health informed. Grenada accepted that the approach was prevention. It made full use of all the facilities available to disseminate information. In addition to the mass media and public address systems, health workers had held question-and-answer sessions with villagers.

Grenada reported quarterly on AIDS to WHO via CAREC. It appreciated the efforts made by WHO and PAHO, and would collaborate fully with them to promote the AIDS prevention campaign. Lastly, if PAHO agreed that some countries were more vulnerable than others, it might be prepared to give extra attention to those countries.

El Dr. VANZIE (Belice) se hace eco del problema expuesto por los Representantes de Barbados y de Jamaica. En efecto, una impresión distorsionada por parte de la comunidad internacional puede ser nefasta para los países del Caribe. Estos países, que tienen una población pequeña y una cobertura de servicios de salud relativamente buena, pueden llevar un registro aceptable de morbilidad y mortalidad, incluyendo los casos de SIDA.

Considera que la presentación de tablas comparativas sin un sistema normalizado de registro de información puede ofrecer una imagen

distorsionada de la distribución real de casos en la Región, con los consecuentes efectos negativos para estos países. Por ello, el orador insta a la Secretaría a que revise el problema de la presentación de datos a fin de evitar efectos negativos no intencionados en una subregión o un país determinados.

El Dr. VILLEDA (Honduras) desea señalar a la atención cuatro temas que apenas han sido mencionados: 1) la necesidad de introducir cambios en las legislaciones en función de los conocimientos actualizados; 2) las estrategias para neutralizar las actitudes negativas que produce el periodismo; 3) el problema del SIDA y los bancos de leche materna, y 4) la conveniencia de proceder a una síntesis periódica actualizada de la información entre países.

Le Dr. DUPERVAL (Haiti) rappelle que les Haitiens ont été, sans preuve scientifique, tenus pour responsables de l'épidémie du SIDA, ce dont ils en ont beaucoup souffert moralement et économiquement.

Cependant, les recherches cliniques et épidémiologiques ainsi que l'histoire naturelle de la maladie ont porté les accusateurs à revenir sur leur erreur.

Le gouvernement haitien a pris d'importantes mesures pour affronter le SIDA, à savoir: un décret confiant le prélevement, la conservation et la distribution du sang et de ses dérivés à la Croix-Rouge; un mémorandum aux termes duquel le SIDA est ajouté à la liste des maladies qui doivent être déclarés et enfin la création de la Commission nationale du lutte contre le SIDA, selon la recommandation de

l'OMS-OPS. Cette commision vient de recevoir une aide susbtantielle de l'OMS-OPS qui lui permettra d'accélérer la réalisation de son programme de surveillance épidémiologique, d'information, d'education, de mesures préventives spécifiques et d'activités de support.

En attendant un vaccin efficace, le Gouvernement haitien compte prendre des mesures préventives en vue de réduire à l'avenir le nombre de cas de SIDA. Il pense aussi offrir aux malades des conditions médico-sanitaires psychologiques propres à leur permettre vivre le reste de leurs jours.

El Dr. SCHUSTER (Chile) felicita a la OPS y en particular al Dr. St. John por la forma en que ha enfocado el problema del SIDA en la Región. Se trata en efecto de apoyar a los Países Miembros no solo con asesoramiento técnico y recursos extrapresupuestarios, sino también con información útil actualizada permanentemente. Chile figura entre los países que están incorporando aceleradamente todas las medidas que permitan reducir la incidencia y prevalencia del SIDA, y también disminuir las consecuencias económicas y sociales de esta enfermedad sobre la población. Solo un efectivo sistema de vigilancia y control y un programa educativo amplio y permanente a todos los niveles de la población, que modifique su estilo de vida sexual, permitirá reducir el incontenible avance de esta dramática enfermedad, que en Chile ha aumentado en los últimos nueve meses en un 72%.

Dr. LANSIQUOT (Saint Lucia) said that the fight against AIDS was well under way. However, while some Member Countries had the human and

financial resources to fight the disease, Saint Lucia, like other Caribbean Islands, was a small, poor Third World country, unable to generate the necessary resources. For that reason, PAHO and its Member Countries should spare no effort to assist them with additional human resources and financial support.

The Caribbean countries had to coordinate their various activities in the fight against AIDS. He hoped that PAHO would assist them in organizing a meeting of Caribbean Ministers of Health in Saint Lucia, before the year's end so that together they could devise mechanisms and strategies which might lead to a Caribbean plan of action. He trusted that PAHO would participate in such a meeting and that other friendly territories such as the United States of America and Canada would also lend support.

Lastly, he drew attention to the need for informational support, for example in the form of television documentaries. He suggested that the United States of America could distribute copies of such documentaries aired on its television stations to the territories in the Caribbean. In addition, PAHO could distribute a summarized version of its recent AIDS teleconference throughout the Caribbean islands, so that the small countries could also benefit from it.

El Dr. PADILLA (Venezuela) felicita a la OPS y al Dr. St. John por la presentación del tema y manifiesta su satisfacción por dos anuncios importantes que ha hecho el Representante de los Estados Unidos de America esta mañana. El primero se refiere a la iniciación por el

Instituto Nacional de Alergias y Enfermedades Infecciones de los Estados Unidos de los primeros ensayos en voluntarios humanos de una vacuna experimental contra el SIDA. El segundo anuncio se refiere a los estudios realizados para precisar los criterios sobre la definición del síndrome de inmunodeficiencia adquirida. Es posible que estos nuevos criterios incrementen en un futuro próximo el número de casos identificados de la enfermedad, lo que abre perspectivas esperanzadoras.

Dr. BALLANTYNE (St. Vincent and the Grenadines) said that as of September 1987 six AIDS cases resulting in four deaths had been reported in St. Vincent and the Grenadines. Five of those cases had involved migrant farm workers who traveled annually to the United States of America. Perhaps PAHO might consider some special program to reach out to such migrant farm laborers in their workplaces.

Dr. HEINRICH (Observer for the International Council of Nurses) said that the International Council of Nurses represented several million nurses in 97 countries who accepted their ethical responsibility to provide compassionate care for people infected with the HIV virus. Nurses were called upon to safeguard the confidentiality of the patients and to assist their family and friends in coping with the complex problems surrounding AIDS. Public health education and clear, specific information were of paramount importance if people were to change their behavior. Moreover, health care providers who were constantly working with blood, body fluids and needles must be educated in basic hygienic methods so as to protect themselves and their patients. Energetic work

was needed to develop ways of caring for patients once they are infected, which usually called for intensive nursing and counseling. Her organization was indeed committed to working with WHO and PAHO in those efforts and in developing joint guidelines for nurses in the prevention of AIDS and the care of AIDS patients.

Dr. ST. JOHN (PASB), replying to points raised, observed that there had been in fact three AIDS epidemics. The first, in the 1970s, had been a silent one during which the virus had been moving throughout the world unbeknownst to everyone. The second had been the epidemic of infected people; the third, just beginning, was the epidemic of fear and irrational response. The global response to the 60,000 AIDS cases had been generally positive. Countries pulled together and made plans. However, at times, it had been astounding and frightening. It would be interesting to know what the world's response would be when there were a million reported cases. Some of the negative responses had been fear and stigmatization. Asians stigmatized Westerners as importing the disease into their countries. Africans were stigmatized as being the source of the disease. Homosexuals, prostitutes, and ordinary people who happened to have been infected by chance through a transfusion had likewise been stigmatized, denied work, expelled from families and so forth. Massive education was of paramount importance in combating the third epidemic. People must be informed that personal conduct was the key factor in contacting AIDS.

Referring to PAHO's education policy on AIDS, he noted that there were at least five major language groups and five major cultures in the Region. The scientific message concerning AIDS prevention must be highly

individualized on a country-by-country basis, taking account of each country's special considerations and cultural values. PAHO planned to assist countries in developing their own messages and to establish a series of educational information exchange centers throughout the Region, so that materials might be shared among countries.

A WHO group of experts had established 12 questions to be answered by a country contemplating the screening of any particular group of people. Those guidelines had been distributed to every Ministry of Health. The issue of screening really had to do with how the information would be used. Screening for its own sake was not particularly useful.

Referring to comments made by the Representative of Costa Rica regarding pseudo-scientific treatments, he said that anyone professing to have a cure must submit his evidence to scientific scrutiny. Such control was absolutely essential, otherwise large numbers of desperate people would rush to seek the magic treatment.

WHO had established guidelines for carrying out either vaccine trials or therapy trials for AIDS. He would make sure that they were made available to the Member Countries.

The teleconference, to which many representatives had referred with appreciation, had been a unique event in the history of WHO and PAHO. For the first time it had not been necessary for large numbers of people to travel in order to attend a conference. More than 350 questions from almost every country in the Region had been received. Regrettably, it had not been possible to answer them all on the air. Moreover, it had not been possible to bring the teleconference to every country in the Region, given current technology costs. Nevertheless, a

series of follow-up measures had been planned, including the production of eight video tapes, one forty-four minute tape summarizing the highlights of the entire conference, four twenty-two minute tapes summarizing each of the major plenary sessions, a special tape on AIDS in children, as it had not been fully covered by the Conference, and health education documentaries presented during the conference which would be expanded to twenty-two minutes in order to include material originally deleted for lack of time. In addition, the entire conference was recorded on 20 tapes, which were being condensed and would be available shortly to any country desiring the complete, unedited version of the conference.

Lastly, referring to the welcome news from the United States of America regarding vaccine development, he said that PAHO was closely following the developments in vaccines and in therapies. However, to sound a note of caution, the best scientists in the United States of America estimated that a vaccine would not be available for general use for at least five years, barring some spectacular, truly lucky, scientific breakthrough.

El Dr. GUERRA DE MACEDO (Director, OSP) dice que no es necesario insistir en la importancia del tema del SIDA. Se trata de un problema que, por sus extraordinarias proporciones, preocupa no solo desde el punto de vista de la salud, sino también por sus profundas implicaciones económicas, culturales y políticas.

Muchos sectores de opinión, sobre todo sectores técnicos en el área de la salud, mantienen posiciones un tanto contradictorias en cuanto a la prioridad que se está dando al SIDA. Es evidente que con la

aparición del SIDA no ha disminuido la importancia de otros muchos problemas sumamente graves para la salud de las poblaciones, como son el de la mortalidad evitable, que todavía representa por lo menos 700.000 defunciones al año en la Región, el de las grandes endemias, el de las diarreas y el de otras enfermedades evitables con las vacunas disponibles. Pese a todo, no puede olvidarse la importancia extraordinaria del SIDA. La OPS y la OMS se han comprometido a hacer todo lo posible para ayudar a los países a poner en práctica sus planes de acción y a coordinar sus esfuerzos conjuntos. Como dice el lema del programa aprobado por la 40a Asamblea Mundial de lá Salud, solo un esfuerzo global detendrá al SIDA.

El orador repite que no existe todavía ningún instrumento eficaz comprobado contra el SIDA, y que el desarrollo de las terapias adecuadas llevará un tiempo: cinco años por lo menos para hallar una vacuna, probablemente algo menos para encontrar una terapia efectiva. La única posibilidad por el momento consiste en cambiar el comportamiento de las personas y los sistemas de control y prevención destinados a frenar la enfermedad. Como ha dicho el Dr. St. John, el SIDA se transmite solamente por tres vías, y se requiere un esfuerzo casi determinado de las personas, a través de un intercambio de fluídos corporales, para que la transmisión sea efectiva. Sin embargo, esto es lo que está ocurriendo y el número de los casos aumentará en un futuro próximo. Las estimaciones más conservadoras para América Latina y el Caribe indican que en los próximos cinco años habrá cerca de 150.000 nuevos casos del SIDA, lo que significa que para 1992 habrá que gastar casi $2.000

millones solo en actividades de tratamiento y prevención específica, y ello con unos recursos que ya no son suficientes para responder a los problemas actuales.

El Director está convencido de que el esfuerzo para combatir el SIDA ha de ser un esfuerzo común e integrado en el desarrollo de los sistemas de salud. Sin unos servicios de salud adecuados, la batalla del SIDA se perderá aunque se esté en condiciones de realizar actividades específicas muy concretas.

Insiste en la necesidad del trabajo conjunto y de la cooperación entre la Organización, los países, los Gobiernos y las instituciones nacionales para responder a este desafío fortaleciendo la cooperación como mejor camino del éxito.

Por lo que respecta a los países del Caribe, dice que se están considerando y desarrollando medidas adicionales para fortalecer y apoyar los esfuerzos que realiza cada uno de los países de la subregión, dada su relativa vulnerabilidad. Una de las actividades que se está considerando es la realización de una reunión de organismos de colaboración, probablemente en noviembre, con el fin de definir un plan subregional y presentar propuestas concretas para la movilización de recursos externos en apoyo de los esfuerzos nacionales.

El PRESIDENTE pide a la Relatora que dé lectura al proyecto de resolución que figura en el Documento CD32/10.

The RAPPORTEUR read out the following proposed resolution:

THE XXXII MEETING OF THE DIRECTING COUNCIL,

Having reviewed Document CD32/10 on acquired immunodeficiency syndrome (AIDS) in the Americas and Resolution WHA40.26 of the World Health Assembly;

Recognizing that the AIDS epidemic presents an unprecedented, immediate, and long-term threat to public health in the Region of the Americas, requiring urgent, coordinated action;

Aware that, under these conditions, special efforts must be made to prevent and control the spread of the disease, yet concerned that these efforts reaffirm human dignity, protect human rights while stressing the social responsibilities of individuals, foster political commitment to health, strengthen health systems based on the primary care approach, and protect freedom of travel, interpersonal communication and international commerce;

Fully supporting the global response to this problem which is being implemented through the WHO Special Program on AIDS, and recognizing its responsibilities as Regional Committee for the Americas to review annually the situation in the Americas, to monitor the use of regional resources, and to report annually to the Director-General of WHO; and

Aware of the impact AIDS has on health services,

RESOLVES:

1. To urge Member Countries:

   a) To develop, implement and sustain strong national AIDS prevention and control programs along the model recommended by the WHO Special Program on AIDS, adapted to individual national contexts;

   b) To strengthen national epidemiologic surveillance activities in order to improve national programs;

   c) To mobilize and coordinate the use of national and international resources for the prevention and control of AIDS while assuring that national health systems are maintained and strengthened in order to combat this epidemic;

   d) To provide accurate information to their citizens about AIDS, strengthening health information through all mass media and health promotion activities and promoting responsible, appropriate public action to reduce the transmission of the virus and to provide compassionate responses to those with the disease;

e) To continue permitting freedom of international travel, without restrictions based on human immunodeficiency virus (HIV) infection status;

f) To provide periodic situation and progress reports to PAHO/WHO, as requested; and

g) To make every effort to develop the Special Program on AIDS within the framework of the policy for health system development and strengthening, making use of the AIDS crisis to promote the needed changes in health services.

2. To request the Director, within available resources:

a) To coordinate regional AIDS prevention and control activities with the global program in the establishment of a PAHO/WHO Special Program on AIDS;

b) Urgently to provide technical support to national AIDS prevention and control programs, including support for implementing, strengthening and maintaining surveillance systems with appropriate laboratory support services; transmission prevention and control programs; health professional training programs; and research activities needed to define the epidemiology of AIDS;

c) To develop AIDS control activities, especially those related to health care, together with the development and strengthening of health systems;

d) To promote, coordinate and conduct epidemiologic studies and related research in order to support regional control efforts;

e) To disseminate information to the Member Countries concerning technological advances in combating AIDS, epidemiological information about the regional situation, and other information vital for the conduct of national AIDS prevention and control programs;

f) To develop mechanisms to facilitate the interinstitutional exchange of technical and resource information at the operational level;

g) To provide annual reports on the regional situation and the use of regional resources to the Regional Committee for the Americas; and

h) To take further steps as may be needed, within his authority, to combat this epidemic.

LA XXXII REUNION DEL CONSEJO DIRECTIVO,

Habiendo examinado el Documento CD32/10 sobre el síndrome de la inmunodeficiencia adquirida (SIDA) en las Américas y la Resolución WHA40.26 de la Asamblea Mundial de la Salud;

Reconociendo que el SIDA constituye una amenaza sin precedentes, inmediata y a largo plazo, para la salud pública en la Región de las Américas, que requiere una urgente acción coordinada;

Consciente de que, en esas condiciones, hay que hacer esfuerzos especiales para prevenir y controlar la difusión de la enfermedad, pero preocupada por que esos esfuerzos reafirmen la dignidad humana, protejan los derechos humanos resaltando las responsabilidades sociales de las personas, promuevan el compromiso político con la salud, refuercen los sistemas de salud basados en el enfoque de la atención primaria y protejan la libertad de los viajes, la comunicación entre las personas y el comercio internacional;

Dando pleno apoyo a la respuesta mundial a este problema que se realiza por medio del Programa Especial de la OMS sobre el SIDA y reconociendo sus responsabilidades como Comité Regional de la OMS para las Américas, a fin de revisar anualmente la situación regional, vigilar la utilización de los recursos regionales e informar anualmente al Director General de la OMS, y

Consciente de la repercusión que tiene el SIDA sobre los servicios de salud,

RESUELVE:

1. Instar a los Países Miembros a que:

   a) Desarrollen, pongan en práctica y mantengan fuertes programas nacionales de prevención y control del SIDA conforme al modelo recomendado por el Programa Especial de la OMS sobre el SIDA, adaptado al contexto nacional individual;

   b) Refuercen las actividades nacionales de vigilancia epidemiológica con el fin de mejorar los programas nacionales;

   c) Movilicen y coordinen la utilización de recursos nacionales e internacionales para la prevención y el control del SIDA asegurándose al mismo tiempo de que se mantienen y se refuerzan los sistemas sanitarios nacionales para combatir esta epidemia;

d) Proporcionen información exacta sobre el SIDA a sus ciudadanos, reforzando la información sanitaria a través de todos los medios de comunicación y las actividades de fomento de la salud y promoviendo una acción pública responsable y adecuada para reducir la transmisión del virus y dar respuestas adecuadas para los que tienen la enfermedad;

e) Sigan dejando libertad para los viajes internacionales, sin restricciones a causa del estado de infección por el virus de inmunodeficiencia humana (VIH);

f) Proporcionen los informes periódicos sobre la situación y la evolución que la OPS/OMS pueda necesitar, y

g) Hagan todos los esfuerzos posibles por desarrollar el Programa Especial sobre el SIDA dentro del marco de la política de desarrollo y fortalecimiento del sistema de salud, aprovechando la crisis del SIDA para promover los cambios que hagan falta en los servicios de salud.

2. Pedir al Director que, con los recursos disponibles:

a) Coordine las actividades regionales de prevención y control del SIDA con el programa mundial en el establecimiento de un Programa Especial OPS/OMS sobre el SIDA;

b) Proporcione urgentemente apoyo técnico a los programas nacionales de prevención y control del SIDA, incluido el apoyo para poner en práctica, reforzar y mantener sistemas de vigilancia con ayuda de servicios adecuados de laboratorio; programas de prevención y control de la transmisión; programas de formación sanitaria profesional, y las actividades de investigación necesarias para definir la epidemiología del SIDA;

c) Organice actividades de control del SIDA, especialmente las relacionadas con la atención de salud, juntamente con el establecimiento y el fortalecimiento de los sistemas de salud;

d) Promueva, coordine y lleve a cabo estudios epidemiológicos y las correspondientes investigaciones con el fin de dar apoyo a los esfuerzos regionales de control;

e) Difunda información entre los Países Miembros sobre los avances tecnológicos en la lucha contra el SIDA, información epidemiológica sobre la situación regional y otra información vital para la marcha de los programas nacionales de prevención y control del SIDA;

f) Establezca mecanismos para facilitar el intercambio interinstitucional de información y recursos técnicos a nivel operativo;

g) Facilite informes anuales sobre la situación regional y la utilización de los recursos regionales al Comité Regional para las Américas, y

h) Adopte otras disposiciones que hagan falta y sean de su competencia para combatir esta epidemia.

El Dr. LUNA (Panamá) estima que la parte dispositiva del proyecto de resolución queda un poco fría, en cuanto que se dirige exclusivamente a los Países Miembros y al Director. Propone que se incluyan tres puntos: uno recordando al hombre su deber de buscar información; otro instándole a proteger a sus amigos, a su familia y a la sociedad, y un tercero, indicando que su conducta y su actitud es lo que permitirá hacer frente a esa terrible enfermedad.

El Dr. GUERRA DE MACEDO (Director, OSP) dice que, desde el punto de vista del procedimiento, no sería posible incluir en el texto de un proyecto de resolución al Consejo un llamamiento a la población, ya que es preciso dirigirse a los Gobiernos Miembros o al Director en representación de la Oficina. Pero la Secretaría podría preparar una declaración o un documento de información, a través del cual se transmita a la población esta preocupación del Consejo en representación de todos los Gobiernos de las Américas.

Decision: The proposed resolution was unanimously adopted.
Decisión: Se aprueba por unanimidad el proyecto de resolución.

CANDIDACY OF THE DIRECTOR OF PASB FOR THE POST OF DIRECTOR GENERAL OF WHO
CANDIDATURA DEL DIRECTOR DE LA OSP PARA EL CARGO DE DIRECTOR GENERAL DE LA OMS

El PRESIDENTE comunica que ha recibio información oficial de que el Gobierno del Brasil ha presentado la candidatura del Dr. Guerra de Macedo para el cargo de Director General de la Organización Mundial de la Salud. Esta información le produce sentimientos ambivalentes. Por una parte, los méritos personales del Dr. Guerra de Macedo son ampliamente conocidos. Su talento, su inteligencia y su liderazgo al frente de la Organización le han encumbrado en estos años y reúne méritos suficientes para asumir esta responsabilidad. Por otra, habría que lamentar el verse privado de su dirección y liderazgo. El Presidente desea pleno éxito al Dr. Guerra de Macedo, ya que desearía compartir con los países de otros continentes uno de los productos de la Región y de la Organización.

The session rose at 12:15 p.m.
Se levanta la sesión a las 12:15 p.m.