

**FIFTH MEETING  
QUINTA REUNIÓN**

Wednesday, 24 September 2003, at 9:00 a.m.  
Miércoles, 24 de septiembre de 2003, a las 9.00 a.m.

*President/Presidente:*

Hon. Senator Marcus Bethel

Bahamas

ADDRESS BY DR. LEE JONG-WOOK, DIRECTOR-GENERAL OF THE WORLD  
HEALTH ORGANIZATION  
ALOCUCIÓN DEL DR. LEE JONG-WOOK, DIRECTOR GENERAL DE LA  
ORGANIZACIÓN MUNDIAL DE LA SALUD

Dr. LEE: Thank you for inviting me to be here with you and for the support you have given me in recent months. I look forward very much to continuing our work together. We live in times of great challenges. I feel a great personal responsibility being in charge of WHO, an important part of the UN system, and I am grateful for your expressions of good wishes.

As you know, the United Nations system is going through a very testing time. We were profoundly shocked by the bombing of the United Nations premises in Baghdad and by the deaths and injuries of so many of our colleagues. The impact of a deliberate attack on the United Nations system is still being felt and we are working hard to see how we can continue our work in Iraq despite this new threat. In Iraq, as elsewhere, despite terrible losses and great difficulties, we continue our missions with determination. On this continent, you too have faced the shock of terrorism and the terrible feelings of vulnerability it leaves in its wake. We continue our work to ensure that the world is ready to deal with outbreaks of infectious diseases, whether they are naturally occurring or deliberately caused.

On this 25th anniversary year of the Alma-Ata Declaration on Primary Health Care, it is good to remind ourselves that health is for all. Everyone equally needs health, and, when society fails massively through negligence to meet that need, it is in very serious trouble. I am looking forward to going to Alma-Ata at the end of next month and to Brazil in December to mark the anniversary.

“Unequal development in different countries in the promotion of health and the control of disease . . . is a common danger,” our Constitution says. In some countries, conditions associated with poverty are bringing life expectancy down to 40 years, while in others, wealth and health technology are enabling it to rise towards 80. Inequalities of this magnitude are not just a danger but an injustice which itself undermines human well-being.

The greatest challenge facing us now is the catastrophe of HIV/AIDS. More than 42 million people in the world are HIV-positive. Each of those infected urgently needs treatment. At a special session on HIV/AIDS at the UN General Assembly in New York on Monday, this week, I said that the lack of access to treatment for millions of people in developing countries is a global health emergency.

I pledged WHO to respond rapidly and urgently to these needs. We are preparing to make available emergency response teams at the request of countries with high HIV/AIDS burdens. The teams will work with those countries to find ways to deliver antiretroviral medicines to many, many more of the people who need them. WHO is working to produce much simpler treatment guidelines and training materials. We are committed to providing all the support we can to countries in their struggle to respond to AIDS. We must deliver an integrated global HIV/AIDS strategy linking prevention, care, and treatment.

We are working with local, national, and international partners to design the necessary programs to treat 3 million people with antiretrovirals by the end of 2005. "Three by five" will not solve the problem but it will mark the beginning of a solution, and be proof that it is possible. A comprehensive strategy for making this happen will be announced on 1 December, World AIDS Day, three months from now, and our work with countries will be initiated immediately.

We are working with many partners, including UNAIDS and the Global Fund, to mobilize the resources to put these plans into action. Overall success will require the commitment of civil society, United Nations agencies, the private sector, and above all Member States. It will require the commitment of each one of us here today.

We must also not lose sight of other infectious diseases. Dengue is on your agenda this week for a very good reason. TB is a serious problem still in parts of this continent. Rapid expansion of DOTS and a more aggressive management of drug resistance is essential.

Our struggle to eradicate polio is entering its final stages. The financial support pledged by the G8 and other key donors will greatly help us to press home our hard-won advantage on this front to complete eradication during this year and the next.

The need for health care starts at birth. Protection during pregnancy, childbearing, and motherhood forms the core of the health system. Half a million women die every year from giving birth. Skilled attendants are needed in pregnancy and childbirth, with access to emergency obstetrics care when complications arise.

Despite the struggle of parents for their children's survival, 10 million children in low and middle income countries die every year before reaching the age of 5. Seven million of those deaths are from five preventable and treatable conditions: pneumonia, diarrhea, malaria, measles, and malnutrition. We can reduce this toll substantially by working with countries to build up strategies such as Making Pregnancy Safer and Integrated Management of Childhood Illnesses. Reducing child mortality worldwide by two-thirds by 2015 is probably achievable. But it will not happen without major rethinking and commitment.

A vitally important part of this entails making the health system work as an integrated whole. Many of the problems that beset adolescence in particular, such as teenage pregnancy, injecting drug use, and violence, are inseparable from maternal and child health. Low birth-weight babies are one outcome, rapid transmission of HIV is another. A high prevalence of violence, alcohol abuse, and mental disorders is also associated with this age group.

All of this shows the need for integrated health systems at the heart of any viable society—not just as an investment but as recognition of the value of human life and health in their own right.

In addition, good health care calls for good surveillance systems in WHO and our Member States. These showed their effectiveness in the eradication of smallpox and, earlier this year, in stopping the SARS epidemic. They are a key to success now, both for the eradication of polio and for the control of new and reemerging infections. We also need to finalize the important work on the revision of the international health regulations.

Meanwhile, noncommunicable diseases and injuries account for a growing share—now about 60%—of the burden of disease worldwide. In May, the World Health Assembly adopted the Framework Convention on Tobacco Control. This was a global achievement in the fight against the tobacco-related diseases. The convention has now been signed by over 50 countries and ratified by one, Norway. I urge you all to follow suit without delay. This will give the world the means to protect people from tobacco harm by banning advertising, preventing smuggling, raising tobacco taxes, and enforcing more visible warning notice on packages. We must do everything we can to speed the process to the ratification by 40 countries that will bring the Convention into force.

The unbalanced nutrition, now affecting all societies, rich and poor, poses a major challenge for health. Our objective is integrated approaches that work against malnutrition from deficiencies and from excesses. WHO's Global Strategy on Diet, Physical Activity, and Health will be presented to the World Health Assembly next May.

This year's Health Assembly reviewed the work of the Codex Alimentarius and concluded that the health sector should play a more prominent role in setting safety standards for food. The Health Assembly stressed that developing countries should be given more support to participate fully in the process of international food standard-setting. In many cases, this is a matter not just of food safety but also of food security—of ensuring the intake of the minimum calories essential for survival and health.

Every year, more than a million people die in traffic accidents in the world, making it a leading cause of death in all Regions. What is needed is to raise awareness and strengthen our response. World Health Day 2004 will be dedicated to road safety.

All that we are doing has to do with reinforcing national health systems. Our work everywhere is important, but the real center of it has to be the countries. We have to give our country offices more people, more realistic budgets, and more authority. At the same time, we also have to ensure sound management and financial practices as well as transparent budgeting.

At Headquarters, all the Assistant Directors-General are now looking at the global issues under their responsibility, to see which of the activities could be better carried out in regional and country offices.

Overall, I want to see these changes completed for the 2006-2007 budget. Strengthening country offices is a major objective for me because having worked for 20 years in WHO, I can see very clearly that strengthening our work in countries is by far the most effective way to help achieve the goals of our Member States. We will work in close partnership with the Regions towards this goal.

Health systems depend most of all on skilled and dedicated personnel, and here, we face a major challenge: the brain drain. It is above all good staff that will enable us to reach "3 by 5" and achieve the Millennium Development Goals, and everyone is short on human resources. We will be working closely with the countries on innovating methods to train, deploy, and supervise health workers, with particular emphasis on the community and the primary health care level. That is where we can make the swiftest progress in getting results.

In most countries, the system for providing reliable health information is also inadequate. This is one area in which the trend is on our side: the means for building effective information systems are becoming more powerful and more affordable all the time. I believe this problem can be effectively addressed with the health metrics network

being formed by WHO's information partnership with the Member States, foundations, the World Bank, and UNICEF.

Over the years, WHO has built strong and effective working relationships with Member States, foundations, nongovernmental organizations, the private sector, and fellow multilateral organizations. Our work depends on partnerships, some long-standing and some more recent. By combining our strengths, we can do so much more. We in WHO and PAHO/AMRO, know what working together can produce and have shown it.

There is a commitment to partnership by global leaders on a scale we have never seen before. At the United Nations Millennium Summit in September 2000, the global community committed itself to eight goals. Three of them were directly about health: to reduce child mortality, improve maternal health, and control major infectious diseases. The five others are about poverty, education, gender equality, the environment, and global partnership. All these, as we have seen, have a direct bearing on health.

Better health for all is our common goal, let's work together to achieve this in the Americas and globally.

ITEM 4.2: A PAHO FOR THE 21st CENTURY  
PUNTO 4.2: UNA OPS PARA EL SIGLO XXI

El Dr. FRENK (México) evoca la conmemoración del primer siglo de vida de la OPS en diciembre del año pasado y subraya el valioso legado recibido de sus fundadores. Al respecto, desea formular algunos comentarios en relación con el documento CD44/6 que su país ha presentado sobre el presente punto. Indica que la globalización está cambiando la naturaleza de los retos sanitarios y que los sistemas de salud deben atender problemas tanto locales como internacionales; ello está en estrecha relación con los cambios en materia medioambiental, los movimientos de población, la difusión de tecnología médica y el comercio de productos perjudiciales legales e ilegales, como el tabaco o las drogas.

No hay duda de que se necesitan nuevas formas de cooperación internacional, y de que es preciso revisar el papel de las organizaciones internacionales de salud, que han de adaptar sus funciones y sus estructuras a un nuevo entorno; el propio Secretario General de las Naciones Unidas así lo ha sugerido recientemente. Otros aspectos que se han de tener en cuenta son la multiplicación y diversificación de los actores públicos y privados del campo de la salud internacional, el avance de la democratización en las Américas y la necesidad de que la transparencia y la rendición de cuentas sean los principios rectores de las instituciones financiadas con el dinero de los ciudadanos.

A pesar de los logros de la OPS a lo largo del último siglo, México considera que es preciso transformarla para enfrentar mejor los retos del nuevo siglo y cumplir su misión con efectividad, eficiencia y transparencia. Asimismo, los Estados Miembros deben mantener un diálogo constructivo con el objetivo central de mejorar la salud de las diversas poblaciones del continente y para ello los anima la preocupación constante de lograr que el sistema multilateral responda a los intereses de los Estados que lo componen.

México ha participado activamente en la introducción de cambios en diversos organismos internacionales y sólo pretende estimular el debate y plantear algunas de las inquietudes que comparte con otros países acerca de los objetivos y el funcionamiento de la OPS. El orador invita a otras delegaciones a que aporten ideas al respecto y aclara que si bien inicialmente se creía idóneo la creación de un grupo de trabajo ad hoc, en la actualidad pareciera que sería preferible organizar un foro de debate abierto y plural, no atado a la estructura formal de la Organización. Seguidamente enumera los posibles temas para la discusión en un foro de ese tipo y añade que el foro no debería burocratizarse, debería tener una duración de unos dos años y celebrar reuniones periódicas abiertas a la participación de todos.

Por último, expresa su deseo de que su propuesta prospere y señala la necesidad de trabajar con celeridad, si bien con cuidado, en el diseño de una nueva OPS que responda a la realidad del nuevo siglo para que se convierta en un paradigma de relevancia, modernidad, eficiencia y adherencia a los valores de servicio y equidad que le dieron origen.

Hon. John JUNOR (Jamaica) agreed that every organization needed from time to time to reexamine its mandate, its operation, its goals, and whether those goals were being achieved, but pointed out that reexamination had to be informed by an analysis of the present situation. If such an analysis gave a satisfactory result, then the well-worn catchphrase would apply: "If it ain't broke, don't fix it."

While appreciating the initiative from Mexico, he considered that it would have been preferable to consider the strategic objectives and performance of the Organization beforehand. If there was agreement that the Organization was substantially meeting its challenges, then the debate could move to the stage that Mexico proposed. The first step, therefore, should be evaluation of the strategic objectives.

Mr. GREEN (Canada) commended Mexico for initiating discussions between Member States on how collectively to better guide and support PAHO to ensure preparedness for future health challenges. Suggesting that the present moment might be the time for Member States to review what they wanted from PAHO and to recommit their collective will to improve health throughout the Organization, he pointed out that

the Organization could not achieve its goals of improving health in the Americas without the full and active participation of all of its Members.

He acknowledged that the Director, had recently initiated a significant restructuring of PAHO, with some of the changes introduced being specifically targeted to address the changing dynamics of the Hemisphere.

Canada believed that the document presented by Mexico provided an insightful and helpful overview of the challenges and opportunities for health in the Americas, with interesting suggestions for actions to improve the Organization. As it pointed out, international health was becoming increasingly complex, and there was a need to assess strategic approaches. The paper was an important starting point in that process.

El Dr. GARCÍA (Chile) destaca la importancia de la OPS, que ha cumplido y cumple una labor fundamental en el desarrollo de la salud de las Américas. En la Región y en el mundo en su totalidad se están produciendo cambios sustanciales, tanto en las relaciones entre países como en la aparición de actores mundiales que no necesariamente se ajustan a la lógica de los países y están interviniendo e influyendo para bien o para mal en el estado de salud de las poblaciones. Por otra parte, las realidades entre los países, al igual que como dentro de ellos, son distintas y deben ser reconocidas para que todos se sientan permanentemente vinculados a esta noble e importante institución que es la OPS.

En este sentido, son extraordinariamente valiosas las voluntades de intervención y de cambio planteadas por la Secretaría y por la Dirección actual de la OPS, como también lo que plantea el documento de México para establecer un diálogo más abierto y decidido con los Estados Miembros. Habría que crear herramientas, tales como discusiones en la Internet, en las que los actores políticos de los países, no necesariamente los técnicos, estén más involucrados en las relaciones en formas más permanentes. Esto podría ser un aliciente para una mayor participación de los países en la gestión de la OPS y para crear un mayor vínculo con ella.

Asimismo, se deberían buscar situaciones en las que se analizaran las estrategias a nivel local, sobre todo de las oficinas locales, con respecto a los diferentes niveles de desarrollo para que los países pudieran estar más articulados y más cercanos, tanto en los aspectos de colaboración como de recepción de información por parte de la OPS.

El Dr. PEDROZA (Perú) pone de relieve el persistente esfuerzo realizado por la Delegación de México para generar propuestas que permitan mejorar la gestión y las orientaciones estratégicas de una OPS capaz de enfrentar los retos de este nuevo siglo. Apoya la iniciativa de crear un foro que trabaje intensa y conjuntamente con la Secretaría

en la definición de esta nueva estrategia. Son los Estados Miembros los que deben marcar el rumbo y tomar las decisiones respecto a la OPS.

Para terminar, reconoce los logros sustanciales alcanzados por la OPS, fruto del trabajo de los países y la Secretaría, y propone incorporar en el documento que una de las funciones primordiales que debería tener un organismo internacional de salud, eso es la promoción del acceso universal a la atención de salud, debería ser un elemento de intervención prioritaria.

El Sr. ARMADA (Venezuela) agradece el esfuerzo de México por mantener viva la reflexión acerca del destino de la OPS y el papel que debe desempeñar en estos momentos. Su país ha expresado reiteradamente el reconocimiento de los avances importantes que ha hecho la OPS, pero también ha señalado algunas insatisfacciones con respecto a la forma en que está organizada y cómo se abordan algunos problemas. Se hace eco de los comentarios de la Delegación de Perú acerca del enfoque de la salud como un derecho, como un aspecto primordial de lo que debe ser la participación de la OPS.

Considera asimismo importante resaltar el esfuerzo importantísimo que se ha hecho y el que lidera la Directora para tener una Organización que responda a los retos y aspiraciones referentes a la promoción de la salud y a la disminución de las inequidades.

El Dr. BOSHELL (Colombia) se congratula por la propuesta de México, que complementa las iniciativas de cambio manifestadas por la Directora, si bien representa el clamor y el deseo de participación de los países en los cambios encaminados a que la OPS continúe siendo la magnífica institución de siempre. Agrega que no los mueve el deseo de coadministrar la institución sino de participar. Asimismo, estima que los cambios estructurales propuestos por la Directora son oportunos pero insiste en la necesidad de que se permita la participación de los países.

Mr. STEIGER (United States of America) found the timing of the discussion propitious in the overall context of changes in international public health in general and in the Pan American Health Organization in particular, together with the opportunity of new leadership both in Washington, D.C., and in Geneva.

He agreed with the main elements identified in the paper presented by Mexico, as challenges that the Organization would have to face in the years ahead, which differed from the challenges of the past. Noting that PAHO was the leading edge of the world health system, he said that it was essential that the Organization should continue on its innovative path. He found timely Dr. Lee's challenge to focus on concrete and measurable goals both in the Organization and within governments, to reinvigorate PAHO/WHO's country presence and health ministries' presence at local levels, and to



streamline administration. He added that the Director had already taken steps in those directions but that much more needed to be done before the 2006 biannual budget that the Director-General had set as his target for completion of his change agenda.

He suggested that Member States as shareholders had to be full participants in the discussions about changes in PAHO and WHO, and reminded them that the broader best interests of the Region and of the Organization were sometimes forgotten. Thus, the United States applauded the effort by Mexico, looking forward to continuing the dialogue both in formal settings and informally with the Director and other senior staff in order to ensure that PAHO's vision was in concert with that of the Director-General and that PAHO should continue its sterling record of success into the future.

El Dr. GUTIÉRREZ (Ecuador) dice que su país considera muy válida la propuesta de México, pero que también coincide con las apreciaciones vertidas en la presentación de la Directora el día de ayer. Indica que su país se encuentra en pleno proceso de búsqueda de la equidad y de solidaridad para garantizar el acceso universal a la salud y comparte el deseo de una amplia participación en la discusión de las estrategias y objetivos de la OPS.

El Dr. ALVARADO CORREA (Nicaragua) concuerda con el Delegado de México en la necesidad de realizar un análisis profundo de la nueva visión que ha de compartirse y considera que en la presentación de la visión estratégica de la Directora también quedaban claros los cambios que es preciso introducir. El mundo cambia constantemente y las organizaciones deben adaptarse, adelantándose a las crisis; es necesario conocer la propia ubicación y la orientación que se tiene, la visión, las metas y los métodos para alcanzarlas. Es necesario reconocer los objetivos logrados, no hay que negar la existencia de situaciones nuevas que surgen y que confirman la idea planteada por México, que cuenta con el apoyo de su país por ser precisamente un complemento de la visión estratégica que presentara la Directora en cuanto a una estrategia común y un análisis profundo de la propia institución y de su misión en el ámbito mundial.

Le Dr VOLTAIRE (Haïti) accueille favorablement la proposition du Ministre de la Santé du Mexique et estime que cette initiative d'une réflexion stratégique pourrait imprimer un nouveau leadership aux États Membres en renforçant le dialogue entre les pays, en affrontant un nouveau défi sanitaire lié notamment à la globalisation et en posant la contradiction au sein de l'Organisation, la contradiction entre les pays et la contradiction à l'intérieur d'un pays.

Toutefois, cette approche proposée par le Ministre du Mexique pourrait être confrontée à une autre allant plutôt de bas en haut et permettant de déterminer quel type d'adéquation existe, d'une part, entre les bureaux locaux de l'Organisation et les besoins des pays et, d'autre part, quel type de mécanismes actuels pourrait faciliter un meilleur

appui et une meilleure collaboration entre chaque pays et l'Organisation. Il serait alors possible d'établir, au niveau des différents pays, les types de contradictions à souligner en vue de décider à ce moment-là des ajustements à introduire à l'Organisation.

Le Dr Voltaire ajoute qu'il faut également penser à préserver les acquis réalisés durant ces 100 ans, à savoir l'élimination de la poliomyélite, de la rougeole et bientôt, espère-t-il, dans les différents pays, du tétanos néonatal ainsi que d'autres maladies. Il faudrait aussi penser à améliorer les instruments disponibles comme, par exemple, le Plan stratégique de gestion proposé par le Dr Mirta Roses. Il s'agit d'un instrument de changement nouveau appelé à créer une nouvelle dynamique au sein de l'Organisation et il faudrait peut-être renforcer cette approche soutenue dans le Plan stratégique du Dr Roses de façon à déterminer comment rendre l'Organisation plus performante et plus efficace, au bénéfice de tous les États Membres.

El Lic. LIZARDO (Honduras) dice que la propuesta de México es interesante y subraya la importancia de valorar debidamente el trabajo que se ha realizado en el área de planificación estratégica hasta el presente. A los Cuerpos Directivos conformados por los delegados corresponde decidir cómo actuar ante las inquietudes planteadas por México e indicar si algunas ya tienen una respuesta, en qué caso correspondería actuar y a través de qué mecanismo, o si correspondería emprender un esfuerzo concertado.

Considera oportuna la creación de un foro a fin de conocer las inquietudes de otros países en relación con la función de la OPS. Al despuntar un nuevo siglo y una nueva gestión institucional es preciso estar de acuerdo en cuanto a un mapa de indicadores, armonizar las prioridades de los Estados Miembros y las de la Organización, puesto que suponen la inversión de valiosos y escasos recursos, y establecer metas regionales y por país, para luego trazar las estrategias y fijar el tiempo que se prevé invertir para lograr los cambios. Si la creación del foro fuera inmediata, el grupo debería ser cerrado y plantearse tareas concretas. El orador cree que ya existe espacio para el debate en el seno de la Oficina y que es necesario prever la rotación de los cargos públicos en el área de salud y saber transferir los proyectos y funciones a los reemplazantes a fin de garantizar la continuidad de las acciones que se emprendan. Destaca la repercusión financiera de la celebración de reuniones, tanto en los respectivos países como en la OPS, y recuerda la falta de acuerdo que aún impera en relación con el tema de los recursos.

El Dr. ESTOL (Uruguay) dice que la inquietud manifestada en el documento que ha presentado México es una reflexión que deben hacerse los propios países internamente. Los ministerios de los países de la Región tienen unas estructuras que no se ha podido adaptar a las circunstancias y dilemas que implica la mundialización, ni a los nuevos movimientos sociales producto de los distintos escenarios de crisis regionales o mundiales en lo que se refiere a la economía. Será preciso reestructurar tales

ministerios para que sean verdaderas estructuras al servicio de sus comunidades y aprovechen de una forma mucho más eficiente los escasos recursos disponibles para la atención de dichas comunidades.

La Directora ha iniciado unos procesos de cambio importantes en la OPS, que también afectan a los países, no son fáciles, y adaptarlos a los nuevos dilemas implica unas estructuras que a veces son burocráticas. El orador expresa su deseo de que el documento presentado por México sea integrado como un documento fundamental en el planteamiento estratégico de las funciones de la OPS con miras al futuro. Fundamentalmente, el espíritu del documento de México es que sea una herramienta de fortalecimiento de la OPS como organización.

El Dr. HECHAVARRÍA (Cuba) felicita a México por proponer esta iniciativa, que se corresponde con el deseo de los Estados Miembros expresados en las intervenciones anteriores y con los planteamientos hechos por la Directora. Los cambios deben producirse, es evidente, pero de lo que se trata es de saber cómo y dónde deben hacerse. La OPS tiene una vasta experiencia de 100 años que hay que aprovechar, y también hay que romper esquemas, pero siendo flexibles y utilizando los medios y vías que corresponden. Para hacer estos cambios se han planteado algunas iniciativas, mientras que otras se generan dentro de la propia OPS y tienen que ver con los métodos y estilos de trabajo que se impongan en cada lugar y en los países. Se ha considerado igualmente la eventualidad de realizar un foro, pero deberían evaluarse sus costos de financiamiento y sus posibilidades de realización.

El Dr. GONZÁLEZ GARCÍA (Argentina) hace referencia a lo que dijo el Secretario de Salud de México, que representa un poco el pensamiento de todos los presentes, no sólo como Miembros de la OPS sino como responsables en los países de organizaciones verdaderamente muy grandes, importantes y a veces no estrictamente adecuadas a las necesidades de los pueblos a los que sirven. Citando al filósofo griego Heráclito, dice que “sólo el cambio es permanente”, de tal manera que cambiar es parte de las necesidades de las personas y las instituciones para ajustarse a los nuevos desafíos del mundo, que como bien se sabe son cada vez más rápidos y superan a veces la capacidad de respuesta. La cuestión es saber cómo se hace este cambio, sin diluir la intención original. Hay que concretar y escribir las propuestas, lo cual es siempre un esfuerzo intelectual y de tiempo importante, y consolidar así rápidamente la opinión de los países en los Cuerpos Directivos, estableciendo incluso algún método, alguna estructura matricial, de modo que pasen a ser propuestas de mediano y largo plazo que obliguen a todos a hacer un ejercicio de reflexión sistemático.

The PRESIDENT suspended the meeting so that the Working Party on the budget could start its deliberations. He noted that the Working Party would be open-ended, and would be electing its own chair.

ITEM 4.6: PRIMARY HEALTH CARE IN THE AMERICAS: LESSONS  
LEARNED OVER 25 YEARS AND FUTURE CHALLENGES  
PUNTO 4.6: ATENCIÓN PRIMARIA DE SALUD EN LAS AMÉRICAS: LAS  
ENSEÑANZAS EXTRAÍDAS A LO LARGO DE 25 AÑOS Y LOS  
RETOS FUTUROS

El Dr. VIDAL RIVADENEIRA (Presidente del Comité Ejecutivo) dice que en la sesión de junio del Comité, el Dr. Pedro Brito, Gerente interino del Área de Desarrollo Estratégico de la Salud, reseñó la historia de la estrategia de atención primaria, haciendo hincapié en sus repercusiones y en las lecciones aprendidas en las Américas, así como en la necesidad de renovar el compromiso con ella. Señaló que en Alma-Ata la atención primaria se definió como la principal estrategia para alcanzar la meta de salud para todos en el año y en las Américas se convirtió en la plataforma principal de la política sanitaria. En la mayoría de los países, la estrategia dio lugar a una ampliación de los servicios de salud a las zonas rurales y periurbanas y a la elaboración de programas prioritarios, así como a cambios en la capacitación del personal, en el ejercicio de la medicina y la salud pública, y en la participación comunitaria. También dio origen a reducciones notables de la mortalidad y a aumentos de la esperanza de vida.

Se consideró que los principios en que se apoyan la atención primaria y la meta de salud para todos siguen siendo válidos para afrontar los retos del siglo XXI y alcanzar las metas establecidas por varias cumbres internacionales recientes. Para conmemorar los logros de los últimos 25 años y reflexionar acerca de su futuro, la Oficina ha propuesto celebrar una serie de actividades durante el año siguiente y redactar una declaración regional donde se establezcan políticas y estrategias encaminadas a mejorar la situación sanitaria de los pueblos y a reafirmar el compromiso con la atención primaria, la promoción de la salud y los objetivos de desarrollo del milenio.

El Comité Ejecutivo consideró oportuno evaluar los logros de los 25 años anteriores y reflexionar sobre cómo adaptar la atención primaria a los nuevos retos enfrentados por los países. Expresó su apoyo a la estrategia de atención primaria y reafirmó la validez de sus principios básicos. Asimismo, subrayó el valor de dicha atención para mejorar la equidad, la calidad y el acceso a los servicios de salud. Entre los logros de la atención primaria se destacaron la ampliación de los servicios de salud a zonas subatendidas; una mayor participación de la comunidad; el adiestramiento de agentes comunitarios; mejores condiciones ambientales; una mayor cobertura de vacunación; un mejor control de las enfermedades, y una menor morbilidad y mortalidad.

No obstante, reconocieron que era preciso orientarla a superar los retos planteados por las actuales tendencias demográficas y epidemiológicas y por los cambios tecnológicos propios de la globalización. Por otra parte, la estrategia debía adaptarse a la carga cada vez mayor de enfermedades no transmisibles y a la formación de personal experto.

El Comité subrayó asimismo la necesidad de elaborar indicadores para determinar en qué medida se habían logrado los objetivos de desarrollo del milenio y vincular ese progreso a las actividades de atención primaria y salud pública.

En mayo pasado la Asamblea Mundial de la Salud definió cuatro necesidades fundamentales para renovar el compromiso con la atención primaria de salud: asignar los recursos suficientes para su desarrollo; fortalecer los recursos humanos dedicados a ella; apoyar la participación de las comunidades locales en la atención primaria, y respaldar la investigación en torno a ella. La Asamblea también exhortó a la OMS a convocar una reunión para examinar las enseñanzas de los primeros 25 años de la estrategia de la atención primaria y decidir cómo avanzar.

El Comité aprobó la resolución CE132.R5, donde se recomienda que el Consejo apruebe una resolución instando a los Estados Miembros a conseguir los recursos necesarios para la atención primaria; a procurar encaminarla a reducir las desigualdades de salud; a reorientar los servicios sanitarios hacia la promoción de la salud; a mantener y fortalecer los sistemas de información y vigilancia en el ámbito de la atención primaria de salud; y a respaldar la participación activa de las comunidades locales en dicha atención.

También se solicita a la Directora que se evalúen los sistemas basados en la atención primaria y que se difunda información sobre cómo mejorarla. Asimismo, se le pide que siga apoyando a los países en la capacitación del personal de salud dedicado a la atención primaria; que organice una celebración en reconocimiento de los 25 años de experiencia acumulada en este campo en las Américas, y que convoque a una consulta regional para definir futuras orientaciones estratégicas y programáticas al respecto.

The PRESIDENT said that it gave him great pleasure to welcome the distinguished group of panelists who were to speak on the item: Dr. LEE Jong-wook, Director-General of the World Health Organization; Mr. K. Gautam, Deputy Executive Director of UNICEF; Mr. Roy Romanow, who had had a long and distinguished career in public service in Canada, including as Premier of the Province of Saskatchewan; and Dr. Torres-Goitia, a Bolivian pediatrician and public health expert who had twice been Minister of Health of that country.

Dr. LEE (Director-General, WHO) said that primary health care had become a core policy of Member States in 1978, after the Declaration of Alma-Ata. Two years ago, WHO had initiated a review of PHC and what people in the health world thought about it. The result showed that despite all of the changes in the health landscape over the last quarter of a century, many in the global health community considered PHC still to be crucial to their work. That message was an important one in the process of reflecting on the way ahead.

There were many different ideas about what PHC actually was, and the support that people gave to it was often based on their own interpretations. After Alma-Ata, there had been two mainstreams of thought: PHC had sometimes been viewed as a level of care, and sometimes as an overall approach to health policy and services provision. In the rich countries, it had been and was still looked on as the first level of care. In the developing countries, where access challenges persisted, it was seen more as a system-wide strategy. There was a need to see for the future whether there was value in bringing the two strands together.

How had PHC affected WHO's work? Simply put, very profoundly. When he had joined WHO 20 years before, every staff member was supposed to work for PHC. That arrangement had changed over the years, but the spirit in which they had worked 20 years ago was still very much a part of WHO's culture. The value base of equity that was the core of WHO's Constitution, and the core of PHC, had guided much of WHO's thinking. The Organization had tried to incorporate community participation and a sectoral approach into all of its programs. In the 1980s there had been a move to more "selective" PHC, with the delivery of limited basic interventions in poor areas. Who was to say if this had been right? It had delivered gains in immunization or reductions in childhood mortality, but it had not been a comprehensive approach. By the 1990s the talk had been of investing in health, core public health interventions and essential clinical services. That too had delivered positive results in some countries but had left out much of the community participation envisaged in Alma-Ata.

As 2000 approached, it was found that the motto of health for all by the year 2000 had in fact not been fulfilled. Nevertheless, it was unrealistic to think that the Organization could deliver its current health goals, including the Millennium Development Goals, without functioning health systems based on primary health care. PHC principles could be integrated into a country's health systems, which would hopefully avoid worries about a clash between PHC and secondary and tertiary care.

But for health systems based on primary health care, there was a need to keep working on the two key subjects of financing and the workforce. In 1978, the same basic group of financing sources had been under discussion as today: general and earmarked taxation, social security, community-based financing fees, and external assistance. Not

much progress had been made in working out how an individual country should approach the right mix. PHC was undermined by too much expenditure on tertiary care or limited funding for prevention. With regard to the workforce, there had been a huge transformation over the past 25 years. Traditional models under which the government provided training, recruiting, and deployment had broken down. Now, decentralization, expansion of NGOs, and the private sector all impacted on the workforce. And there was a brain drain out of many of the poorest countries.

PHC required that a way be found to keep health workers delivering services at the community level in the poorest countries. Health systems and primary health care were not very interesting or exciting. It was far more interesting to talk about vaccinations, AIDS, SARS, or bioterrorism. There was a need to work out ways in which to ensure that national and international support was available to strengthen PHC. There was a need to explain that sustainability required a basic foundation. He said that he was committed to ensuring that national and international support for those high-profile issues strengthened PHC. Functioning health systems that could deliver PHC were essential for the delivery of all the other interventions that were needed. The task was now to ensure that all the attention to global health issues was translated into measurable improvements in health systems that would deliver PHC to all.

Mr. GAUTAM (Executive Deputy Director, United Nations Children's Fund) said that the health challenges that the Region had faced during the first decade following the Declaration of Alma-Ata had been very difficult indeed. Many remembered the difficult economic context, with the debt crisis and hyperinflation, turning the 1980s into a lost decade for development in Latin America. But there had also been some shining moments. UNICEF and PAHO had worked together to develop health as a bridge to peace in conflict-ridden Central America. They had been great partners in the polio eradication campaign that had made the Americas the first polio-free Region in the world a decade earlier. The child survival revolution that UNICEF had promoted as the cutting edge of primary health care had originated in the Region, with national immunization days in Colombia, the Pastoral do Criança in Brazil, the pioneering work in nutrition in Guatemala, the days of tranquility that had literally stopped the war in El Salvador to allow children to be immunized.

The world had been a very different place in 1978, when 134 ministers of health and the leaders of WHO and UNICEF had met in Alma-Ata and launched the revolutionary concept of primary health care.

Looking back, the concept that came out of Alma-Ata had been a bold attempt to redefine health *by* the people and *for* the people. Its aim had been to transform "medical treatment for some" into "health for all." Alma-Ata had sought to bring the benefits of modern medicine, science, and technology to the doorsteps of even the poorest families

in the poorest countries of the world. It had set the stage for what today was called the rights-based approach to health care: “the people have the right and duty to participate individually and collectively in the planning and implementation of their health care,” as the Declaration of Alma-Ata had said. Primary health care, it argued, was essential health care made universally available to individuals and families in the communities by means acceptable to them, through their full participation, and at a cost that the community and the country could afford. That had been the Alma-Ata vision.

Some of the intellectual contributions to the founding principles of primary health care had been inspired by experiences in the Region, especially those of health care systems in Chile, Cuba, and Venezuela in the 1970s. The concept of primary health care had paved the way for many other revolutionary ideas that had later become common wisdom in international development, including basic services, education for all, and health for all. But after a very promising start, PHC had lost some momentum at the beginning of the 1980s, when the debt crisis and the onset of structural adjustment programs had begun to sap the vitality of the Region’s health and social development.

It had taken the child survival and development revolution promoted by UNICEF’s Jim Grant and later embraced by Halfdan Mahler of WHO and leaders like Carlyle Guerra de Macedo and Ciro de Quadros, here at PAHO, to give a new boost to primary health care. Though meant to be multisectoral, in the early years after Alma-Ata primary health care had still been generally viewed as a health sector concern. What the child survival and development revolution had done in the 1990s was to put health issues firmly on the world’s political and social agenda, cultivating ownership by mayors and governors, parliamentarians, civil society activists, the media, and academia. It had really inverted the “health for all” motto into “all for health,” and it had mobilized everyone— film stars and schoolteachers, heads of religious organizations, heads of State—in promoting oral rehydration therapy, immunization, and many other health and nutrition interventions.

Inspired by some of the early successes in those areas, in 1990 UNICEF had helped convene the historic World Summit for Children, which had adopted an ambitious agenda for accelerated child survival and development, with public health and nutrition at its very core. In the true spirit of primary health care, it had called for active participation by all key sectors and actors of society. It had adopted a goal-oriented approach and had brought the international community to agreement on a common development agenda, with clear targets and milestones, especially in the area of health. Indeed, many of the Millennium Development Goals had their origins in the health-related goals of the World Summit for Children.



Although there was still much to be done to realize the vision of Alma-Ata, the Region of the Americas had reason to be proud of many achievements in reducing infant mortality, maternal mortality, and malnutrition, and in increasing life expectancy, literacy, access to water and sanitation, all very tangible measures of improved health.

Looking ahead, he said that he could see five challenges if the vision of primary health care from Alma-Ata was to be fully realized in the Americas and in the world. The first was the challenge of mobilizing all for health. It was often said that health was too important to be left entirely to the care of medical professionals. Health establishments played an important role in combating diseases and promoting health. But their effectiveness was greatly enhanced if support could be mobilized from sectors outside health.

From the point of view of child health, the number one health worker was the mother. The more that could be done to empower the mother with basic knowledge about good infant-feeding practices, care, and stimulation of the young child, hygiene and sanitation, and better birth spacing, the better the health outcomes. One of the best ways to promote this was through investing in education. Girls' education was probably the most effective of all health interventions. Why? Because an educated girl married later, was better able to protect herself from disease, had reduced fertility, her children were likely to be better nourished and healthier, and as they became adults, they helped to break the intergenerational cycle of ill-health and poverty. Schoolteachers were potentially great health workers. Most children spent many years as a captive audience of their teachers. Why weren't teachers acting as important health workers?

It was often said that the greatest reductions in infant and child mortality in the nineteenth century in Europe had been attributable, not to medical breakthroughs, but to dramatic progress in water and sanitation. Collaboration with the water, sanitation, and other sectors could have a tremendous impact on health. And in today's world, the mass media could be a provider of good health information or a promoter of unhealthy lifestyles. He called for mobilization of all of those other sectors for health.

The second challenge was that of global interdependence. It was not possible to be healthy in an unhealthy world. Unlike people, diseases needed no passport or visa to travel. Therefore international cooperation had to be fostered to combat diseases and to promote health as a global, public good. Programs to eradicate or eliminate polio or measles, to fight HIV/AIDS, malaria, or tuberculosis, and to promote epidemiological surveillance had increasingly to be considered global, public goods. In the age of globalization and massive population movements, diseases could be weapons of mass destruction. But health could be a bridge to peace.

The third challenge was to scale up the actions. The health development map of the world was littered with too many small-scale demonstration projects. To be really effective, health programs should attempt to take action on a scale commensurate with the problems they were trying to tackle. For most of the major causes of mortality and morbidity affecting children and women in developing countries, there were proven and low-cost interventions. The challenge was to scale those actions up with simple and focused plans, strong partnerships, competent and motivated human resources, essential supplies, strong monitoring and evaluation, and sufficient funds.

The fourth challenge was that of mobilizing resources. The WHO Commission on Microeconomics and Health estimated that the financial resources required for a set of interventions against infectious diseases and nutritional deficiencies, that could save 8 million lives a year in low-income countries, would cost about \$34 per capita per year. The total additional resources needed for low-income countries would amount to an additional 1% to 2% of GNP, and for the donors, an additional 0.1% of their GNP in the form of overseas development assistance (ODA). These amounts were certainly affordable for both developing countries and donors. In addition, the public sector alone did not need to bear the burden of investment in health. Recent years had seen wonderful examples of generous corporate contributions, and more could be done. The pharmaceutical industry could also be a more enlightened partner in public health efforts. The public sector could encourage this by providing tax and other incentives.

Finally, there was the challenge of leadership. Strong leadership was needed at the local, national, and international levels to promote health for all. Health issues were now commanding the interest and support of many world leaders. If, collectively, leadership could be mobilized at the highest levels of government, civil society, and the private sector, health for all need not be a dream delayed for far too long. And given its past record and future potential, PAHO was looked to provide strong leadership in pursuing the vision of Alma-Ata, and the Region of the Americas was counted on to once again set an example for the rest of the world to follow.

Mr. ROMANOW (Canada) began by saying that the primary health care strategy, with its complementary “health for all” concept, today remained essentially as valid and as relevant and organized a construct for improving human health, as it had been 25 years before. The choices a society made about how to organize its health care system, how and by whom the priorities within it were established, timely access to care, quality of care, the weight given to prevention and health promotion, and a whole host of other concerns, spoke volumes about its values and social cohesion. Health care was not an abstraction, it did not exist in isolation, it was not just another government program or bureaucratic imperative. It was a defining aspect of the nation’s identity.

If social cohesion was an essential ingredient in achieving the vision of health for all, what then was the role of civil society and of the private sector? Trade unions, religious organizations, professional associations, academic institutions, and NGOs in the environmental, cultural, and social fields had each in their own ways made important contributions to primary health care, contributions that had ranged from advocacy to research, financial support to leveraging, public awareness and educational efforts in support of disease prevention, and health promotion to the direct delivery of community health programs and services. There had been a welcome development, indeed a growing trend of governments effectively transferring to civil society some of their traditional service-delivery responsibilities.

While there was nothing inherently wrong with that development of a partnership between the public sector and civil society, a cautionary note needed to be injected. Organizations independent from government whose legitimacy evolved from their autonomy were one of the key building blocks of any civil society, and when such groups placed their resources, networks, expertise, or capacities at the service of the State, they had to be exceedingly vigilant to preserve their integrity and freedom to maneuver and act.

When NGOs simply substituted for, rather than complemented governmental programs, when they became overly dependent upon government support to maintain their capacity to do good, there was a risk that they would lose their flexibility and discretion and, more importantly, their direct connection with the grassroots. The potential contribution of civil society in advancing the cause of primary health care could not and should not be excluded, but there was a need also to be very careful to avoid creating dependencies or taking that contribution as a given.

Secondly, what was the role of the private sector in primary health care? In some ways, he thought that the distinction between civil society and the private sector was really an arbitrary one. Companies that adopted sustainable development practices, provided safe and healthy working environments, paid decent wages, and provided employees and their families with access to good health care services, played an important and positive role. Some of the larger employers in southern Africa were developing strategies to combat HIV/AIDS and improve access by their employees and families to affordable drug therapies. That was another highly commendable, worthy development.

But good citizenship aside, the private sector could make its influence felt in primary health care in a variety of ways: for example, through advances in health informatics and telecommunications systems, particularly those that allowed primary health care providers in distant or remote areas to access up-to-date knowledge or expertise. The advances in management sciences in relation to systems design, data

management, and the use of incentives to affect behavioral changes, found application also at the primary care level. Multilateral agencies, academic research institutions, and pharmaceutical companies had to work together to provide incentives for developing new treatments and therapies to cope with some of the unique health problems afflicting the developing world and the globalization of disease. Indeed, with the advances in genomics and biotech fast making so-called designer drugs more than just a theoretical possibility, there was a need to ensure that research and development was not carried out exclusively to create products to meet the health needs of the wealthy few at the expense of the health needs of the many that could not pay.

Above all, looking back 25 years ago, health for all and primary health care were good ideas that needed to be refined and expanded in order to involve the community on a wider basis in promoting the values of wellness, and health in a very, very careful balance of community with government.

El Dr. TORRES-GOITIA (Bolivia) está de acuerdo con la Directora en que la salud pública internacional tiene una deuda pendiente hasta ver cumplida la meta de salud para todos.

La estrategia de la atención primaria busca planteamientos integrales y hace hincapié en la salud como derecho fundamental y responsabilidad de los gobiernos, como se afirma en la Declaración de Alma-Ata. Pero la falta de comprensión en torno a estos postulados dio origen a dos vertientes aún vigentes: 1) cambios limitados al primer nivel de atención y expresados en una medicina comunitaria orientada a resolver los problemas de salud en zonas urbanomarginales o rurales, sin afectar a los niveles superiores de atención; 2) la defensa, en función de una nueva filosofía, de un cambio en todos los niveles del sistema de salud.

La participación popular se convirtió en una forma de reducir los costos de los servicios y de simplificar el primer nivel de atención con miras a ampliar su cobertura. La colaboración gratuita de la comunidad se impuso y los servicios médicos fueron sustituidos por precarias organizaciones comunitarias en las que se delegaban las obligaciones estatales. En otras palabras, la medicina comunitaria llegó a convertirse en una medicina de tercera clase para ciudadanos de segunda.

Bolivia fue de los pocos países donde la participación popular se desarrolló en el contexto doctrinario de la atención primaria. Dicha participación fue impulsada sobre la base de nuevos conceptos y la medicina social vino a enseñar que la salud y enfermedad no son estados diferentes, sino parte de un mismo proceso arraigado no sólo en lo biológico, sino también en lo económico y social. Se hizo evidente que defender el derecho a la salud no compete sólo a los médicos sino a los seres humanos en general, y

que los sectores pobres de la sociedad son los más propensos a enfermar y los que más necesitan que se defiendan su salud y calidad de vida.

Bolivia no buscó, por ende, que la comunidad aportara mano de obra barata o gratuita, sino que los servicios de salud ayudaran a la comunidad a mejorar sus condiciones de vida y, como resultado, su salud. Los Comités Populares de Salud fueron los protagonistas de una política de salud participativa y descentralizada. Se logró una activa movilización social gracias a la cual se eliminó la poliomielitis, desaparecieron las epidemias de sarampión y se combatió el bocio mediante el uso de sal yodada. También, gracias a la iniciativa popular, se formaron guarderías en casas particulares, donde madres de familia atendían voluntariamente a niños de su vecindad. La mortalidad infantil bajó más de 50% en menos de 10 años.

Hay que reconocer que 25 años después de aprobada la estrategia de atención primaria, sus postulados han sufrido diferentes embates. No obstante, se ha producido paralelamente un mayor reconocimiento de los derechos humanos, civiles, políticos y sociales, valorándose al ser humano como beneficiario de la libertad de competir y no como simple mercancía en competencia por sobrevivir. También se ha producido una renovación conceptual de la salud pública según la cual la salud no es sólo de la población, sino también un producto generado por ella.

La sociedad moderna está recuperando los postulados de la atención primaria, que constituyen la expresión de una nueva sociedad solidaria que da vigor a una democracia participativa. Bolivia asume el desafío de mejorar sus condiciones de salud mediante una gestión compartida entre el Estado y los municipios descentralizados y una activa participación popular para encarar el futuro con optimismo.

*The meeting rose at 12:40 p.m.  
Se levanta la reunión a las 12.40 p.m.*