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A. REGIONAL STRATEGY AND PLAN OF ACTION FOR NEONATAL HEALTH WITHIN THE CONTINUUM OF MATERNAL, NEWBORN, AND CHILD CARE (2008-2015): MIDTERM EVALUATION

Background

1. In October 2008, the 48th Directing Council of the Pan American Health Organization (PAHO) adopted, through Resolution CD48.R4, Rev. 1, the *Regional strategy and plan of action for neonatal health within the continuum of maternal, newborn, and child care (I)*. This resolution urges Member States to take into account this strategy and plan of action when formulating national plans aimed at reducing neonatal mortality in the context of the continuum of maternal, newborn, and child care. Monitoring of the strategy and plan of action, which is also included in the resolution, is an essential component for assessing the status of implementation and results, which will make it possible in turn to determine if it is necessary to adopt corrective measures to achieve the expected results.

Evaluation Scope and Methodology

2. This document provides a consolidation of the results of the midterm evaluation of the strategy and plan of action for the purpose of determining progress and achievements in the first phase of implementation (2008-2012), and of setting priorities and making recommendations for the 2013-2015 period. It analyzes processes and results at both the regional and country level.

3. The evaluation was based on the guidelines in the plan of action. Qualitative and quantitative methods were used to evaluate processes carried out at regional, subregional, and national levels, as well as their achievements and results. A participatory approach was used, with contributions from those responsible for the development and implementation of plans and measures in the ministries of health, scientific and academic associations, experts, cooperation agencies, collaborating centers, and relevant stakeholders.

4. The evaluation included four main components:

- (a) Review of plans and technical documents with relevant information related to strategies, goals, or expected results.
- (b) Data analysis from primary and secondary sources to respond to the indicators.
- (c) Promotion of a process in the countries of the Region to review implementation of the plan and its adaptation to national situations, as well as its results and lessons

- learned. Conclusions from this process were consolidated and analyzed at two subregional meetings.
- (d) Consultations with technical groups and groups of experts, such as the Regional Partnership for Neonatal Health and Technical Advisory Group on IMCI (IMCI-TAG)-Comprehensive Child Health, as well as with PAHO/WHO collaborating centers. A similar participatory consultation mechanism was encouraged with partners and other relevant organizations in the analysis and discussion process in the countries.

Situation Update

5. The following are among the most important achievements, in line with the plan's Strategic Areas:

- (a) The creation of an enabling environment for the promotion of neonatal health, development of national plans, and promotion of alliances in countries are essential strategies that have been implemented in the Region. Of the 29 countries that have reported results¹ (83% of the Region's countries), 72% has a national plan that includes maternal and neonatal health within the framework of the continuum of care, and three countries of the Region are in the process of developing a national plan. For the most part, the approved national plans that are underway include a monitoring system; approximately half of them have allocated a specific budget, and a large proportion of countries have neonatal health alliances or technical groups.
- (b) In general, a high proportion of births in the Region are attended by skilled personnel. However, in 20% of countries, the proportion of deliveries attended by skilled personnel is lower than 90%. It is primarily within countries where the most significant differences are found, both in terms of the proportion of births attended by skilled personnel and with regard to the proportion of institutional deliveries. In some geographical areas, fewer than 50% of births are institutional births; in many cases these are areas with a high indigenous population. Practically all countries (96%) report that they have guidelines, standards, or protocols for newborn care in health services, approved by national authorities. Home visits or other community interventions tied to newborn health are highly constrained in the countries of the Region.
- (c) The countries of the Region have functioning information systems, although with considerable variability in coverage and type of information. They also have systems aimed at assessing vital events (88.5%) as well as information systems in

¹ Information from an online survey developed for this purpose.

- health services (77%). Countries have made progress with formation of committees to analyze the cause of neonatal deaths (70% indicated that they have a committee of this type). Less frequent are community-based information systems (50%).
6. The Region of the Americas experienced a 55.6% reduction in the estimated neonatal mortality rate from 1990 to 2010 (from 18 to 8 per 1000 live births).² However, there is wide intercountry variability, with rates ranging from 2.8 to 27.3 per 1000 live births.
 7. In the same period, a 50% reduction in the estimated neonatal mortality rate was seen in Latin America and the Caribbean. In this case, neonatal mortality for the years 1990 and 2010 showed a reduction from 22 to 11 per 1000 life births.² It is calculated that neonatal mortality declined 4% from 2008 to 2010.³
 8. Neonatal mortality (<28 days of age) is the principal component of under-1 and under-5 mortality, and has increased in the Region since 1990. Neonatal mortality accounts for 57.1% of under-1 mortality and 44.4% of under-5 mortality in the Region of the Americas. In the case of Latin America and the Caribbean, these proportions are 61.1% and 47.8%, respectively. Neonatal mortality tends to be slightly higher for males, with an estimated median of 54.6%, although rates range from 45.2% to 61.1%.
 9. There have been no major changes in neonatal mortality disaggregated by cause: prematurity (35.2%), birth defects (20%), asphyxia (15.2%), and infectious processes such as sepsis, meningitis, and tetanus (12.2%) account for over 85% of neonatal deaths, all of which are problems that can be prevented to a great extent with specific control measures and timely and quality treatment.
 10. Other disorders that affect newborn health and that have an impact throughout life are considered equally high priorities and need to be addressed. Among them, prematurity (2) and low birth weight (3, 4, and 5), retinopathy of prematurity (6), congenital malformations, and specific metabolic or sensory problems contribute to varying degrees to the development of different disabilities and chronic diseases that considerably affect quality of life and social capital in the countries of the Region (7).

² The data are estimates by the United Nations Inter-agency Group for Child Mortality Estimation (IGME). Levels and Trends in Child Mortality. Report 2012 (August 2012 update available from: <http://www.childmortality.org>).

³ The data are the most recent estimates by the Institute for Health Metrics and Evaluation. Infant and Child Mortality Estimates by Country 1970-2010 (July 2012 update available from: <http://www.healthmetricsandevaluation.org>).

Measures to Improve the Situation

11. In view of the analysis regarding implementation at both the Region and country levels, the following are some measures to improve the situation in the 2013-2015 period:

- (a) Continue with implementation of the plan in the Region and promote development of national plans and strategic partnerships where they still do not exist.
- (b) Boost reduction of neonatal mortality, aiming measures specifically at the principal causes detected. Furthermore, countries should outline strategies that make it possible to intervene more intensively in geographical areas where access is more critical, as well as in areas with conditions causing greater vulnerability and exclusion (socioeconomic, ethnic, or other types of factors that are considered relevant).
- (c) Strengthen work in health services and at the community level. It is indispensable for Member States to strengthen these services, promoting universal access to good quality care and implementation of effective interventions, in the framework of inclusive, equitable, and high-quality health systems.
- (d) Boost newborn care within the framework of the continuum of care, involving stakeholders and linking measures to those proposed in the *Plan of action to accelerate the reduction of maternal mortality and severe maternal morbidity (8)* and the *Strategy and plan of action for integrated child health (9)*.
- (e) Further strengthen information systems for the purpose of making timely information available, both aggregated at the national level and disaggregated by geographical area and by the problems that make it possible to identify inequity, to contribute to the creation of surveillance and monitoring systems that provide the basis for measures that should be taken and that evaluate results.

Conclusions

12. Progress has been seen in implementation of the regional plan as well as in the achievement of results. However, it is indispensable to strengthen measures aimed at addressing those determinants that have an influence on both neonatal mortality and the development of diseases that will affect the quality of life of children and, consequently, that of their families and the community.

13. In this regard, it is necessary to strengthen healthcare networks to advance toward inclusive, equitable, and good-quality health systems within the framework of the

continuum of care, prioritizing, especially, work in the most vulnerable geographical areas and population groups.

14. Training of health professionals and improving quality of care are priority issues. The use of modern communication and training strategies that help to facilitate access to new knowledge that is transferred to practices and skills should be especially promoted.

15. It is indispensable to strengthen community-based work, furthering access to health care and the identification of risk factors, and promoting healthy habits and practices, particularly breastfeeding and growth and development monitoring.

16. Inequity is a persistent issue in the Region and requires a specific approach. To this end, it is indispensable to focus work within countries, particularly in those areas where the population is the most vulnerable.

17. It is indispensable to continue to strengthen information systems to make good quality information available, in a timely fashion and with the greatest possible degree of disaggregation, which will make it possible to detect inequity.

18. Strengthening alliances at both the regional level and in countries has proven to be a fundamental means for implementation of the plan, because it encourages visibility of the problem and advocacy for addressing it, an aspect that should also be strengthened in the countries of the Region.

19. PAHO should continue to promote and implement measures for technical cooperation among countries, to strengthen achievements made thus far.

Action by the Executive Committee

20. The Executive Committee is invited to take note of this report and offer any recommendations it may have.

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B. STRATEGY AND PLAN OF ACTION FOR THE ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND CONGENITAL SYPHILIS: MID-TERM EVALUATION

Background

1. In 2010, the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis was approved by Pan American Health Organization (PAHO) Member States (Resolution CD50.R12) (1). The objective of the strategy is to eliminate congenital syphilis and mother-to-child transmission of HIV in the Americas by the year 2015 through: (a) reduction of mother-to-child HIV transmission to 2% or less; (b) reduction of the incidence of mother-to-child transmission of HIV to 0.3 cases or fewer per 1,000 live births; and (c) reduction of the incidence of congenital syphilis to 0.5 cases or fewer (including stillborn infants) per 1,000 live births. The resolution requests the PAHO Director to promote coordination and implementation of the Strategy and Plan of Action, promote partnerships and technical cooperation among countries, and report periodically to the Governing Bodies on the progress and obstacles identified during execution of the Strategy and Plan of Action.

PAHO Support for Implementation of the Strategy and Plan of Action

2. The PAHO HIV/STI Project, the Latin American Center for Perinatology and Women and Reproductive Health (CLAP/WR), and the United Nations Children's Fund (UNICEF) are leading the support for implementation of the Strategy and Plan of Action. Other supporting partners include: the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), and the Centers for Disease Control and Prevention (CDC). Tools developed include a concept document (2), integrated clinical guidelines (3), a monitoring strategy (4), a costing tool (5), a field guide (6), and a validation methodology (7). Various capacity-building activities were also conducted in collaboration with the partners, and direct support was provided to priority countries. The HIV project is implementing an innovative strategy for more sustainable treatment programs in line with the UNAIDS/WHO Treatment 2.0 Initiative, which supports elimination efforts in the countries. In response to the resolution, PAHO also initiated reporting on the elimination targets in 2010, aligned with Universal Access reporting, based upon which two regional progress reports were prepared (8, 9). A mid-term evaluation of the implementation of the Strategy and Plan of Action was conducted in 2013.

Purpose of the Mid-term Evaluation

3. The mid-term evaluation aimed to: (a) assess progress and identify challenges related to implementation of the Strategy and Plan of Action, and (b) identify priority

countries and actions to accelerate progress towards achievement of the elimination targets by the year 2015.

Scope and Methodology

4. The mid-term evaluation covered the first three implementation years of the resolution (2010-2012). The evaluation accounted for a regional perspective with country-level outcomes and issues being the top priority. The following sources of information were consulted: (a) the global UNAIDS report (10); (b) regional reports (8, 9); (c) reports of three sub-regional stakeholder meetings held in 2012; and (d) a mid-term evaluation questionnaire sent to all countries and completed by 30.

Key Findings

Progress

- (a) Most of the countries (33 of them) have developed strategic and/or operational plans, and 30 countries have developed or updated their national guidelines.
- (b) Regional coverage of HIV testing among pregnant women increased from 29% in 2008 to approximately 66% in 2011. The estimated coverage of antiretroviral treatment for pregnant women living with HIV increased from 55% in 2008 to 70% in 2011 (67% in Latin America and 79% in the Caribbean). Consequently, new cases of HIV infection among children dropped by 24% in Latin America and by 32% in the Caribbean between 2009 and 2011.
- (c) The HIV mother-to-child transmission rate in Latin America and the Caribbean for 2011 is estimated to be 14.2% (5.8%–18.5%), a decline from 18.6% (10.5%-22.9%) in 2010.
- (d) Data reported by the countries in 2011 and 2012 indicate the following:
 - i. Eight countries achieved coverage of 90% or greater for HIV testing of pregnant women, and 10 countries reported antenatal syphilis screening at close to 90% or greater.
 - ii. Among the 15 countries reporting on syphilis treatment of pregnant women in 2011, the coverage ranged from 23% to over 95%, with nine countries reporting coverage of 90% or greater.
 - iii. Virological testing of HIV-exposed infants within two months of birth was low in the Region, with only three countries reporting levels close to 90% or greater. Country capacity to report and monitor these data needs to be strengthened. Significant loss to follow-up of infants prior to definitive diagnosis was noted by some of the countries.

- iv. Fourteen countries with antenatal care (ANC) coverage and syphilis testing greater than 80% reported congenital syphilis rates of less than 0.5 per 1,000 live births.
- v. Five countries with ANC coverage and HIV testing greater than 80% reported HIV vertical transmission rates of 2% or less, and an additional 10 countries had rates close to 2%.

Challenges

- (a) The available data indicate significant variances in progress. Some countries are still showing very low coverage of essential services.
- (b) Key challenges include:
 - i. need to strengthen health systems, health information and data collection systems and service delivery models that integrate ANC, HIV, and sexual and reproductive health (SRH);
 - ii. need for the promotion of early initiation of antenatal care and improvement of the quality of ANC;
 - iii. need for the strengthening of strategies to reach young women and other vulnerable groups with SRH and primary prevention interventions.

Conclusions

- (a) The mid-term evaluation indicates significant progress in implementation of the Strategy and Plan of Action for the elimination of mother-to-child transmission of HIV and congenital syphilis. However, intensified action is needed in order to address the low coverage of services in some countries.
- (b) The countries for which PAHO recommends intensified action are:
 - i. Those with HIV or syphilis testing of pregnant women under 50% in 2011: Dominican Republic, Guatemala, Mexico, Nicaragua, Panama, and Paraguay.
 - ii. Those with HIV or syphilis testing of pregnant women between 50% and 70% in 2011: Antigua and Barbuda, Barbados, Bolivia, Colombia, Dominica, Honduras, Jamaica, Montserrat, Saint Lucia, and Turks and Caicos Islands.
- (c) The programmatic priorities for the second phase of the implementation period are: strengthening of the health information systems, development and sharing of models and best practices for HIV/SRH/MCH integration, and laboratory strengthening.
- (d) Continued emphasis on a health systems approach is essential in order to address the health systems barriers.

Action by the Executive Committee

5. The Committee is requested to take note of this mid-term evaluation and offer any recommendations it may have.

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C. MILLENNIUM DEVELOPMENT GOALS AND HEALTH TARGETS IN THE REGION OF THE AMERICAS

Introduction

1. The Member States of the Pan American Health Organization (PAHO) have expressed a clear commitment to achieving the Millennium Development Goals ([MDGs](#)), in the conviction that health plays a crucial role in social, economic, and political development. The MDGs and their related targets are key to PAHO's commitment to health policies with quantifiable results. The Organization believes that the best way to address the MDGs is by strengthening equity in health through technical cooperation in priority countries and in the interior of middle-income countries, based on comprehensive, integrated interventions that prioritize vulnerable areas and groups and populations living in poverty.

2. This report responds to the commitment made in 2011 to report on the Region's progress and challenges in achieving MDGs directly related to health.

3. The report also includes some lines of discussion on health-related areas of the Post-2015 Development Agenda stemming from the international meeting organized by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) that took place in Botswana in early March and from the regional consultations to address the commitments included on the United Nations Agenda.

Background

4. 2013 offers a two-year margin to support the countries through intersectoral and interinstitutional strategies aimed at stepping up the pace of progress towards the MDGs for 2015. The Region of the Americas is on the path to achieving MDGs related to health, which includes progress in water and sanitation services and in health determinants. These advances, however, occur at the national level and are not comparable to advances at the subnational level.

5. According to data from the Economic Commission for Latin America and the Caribbean (ECLAC), while poverty and extreme poverty levels are lower than ever in the Region, they are still a problem that must be tackled as a critical health determinant at the regional and national levels. ECLAC estimates that 167 million Latin Americans were living in poverty in 2012. Of these, 66 million were living in extreme poverty, with

incomes insufficient to ensure an adequate diet. Reducing chronic malnutrition therefore continues to be a priority.⁴

Current Situation Analysis

6. Progress towards the MDGs varies from country to country in relation to every goal. In its analysis of the period from 1990 to 2011, this report uses information provided by the countries (referred to as PAHO), including routine registries and estimates generated by each country, and also draws on estimates provided by the Economic Commission for Latin America and the Caribbean (ECLAC/CELADE), which heads the inter-Agency group (1, 2).

7. MDG 4 is evaluated based on mortality in children under one year of age, since this group accounts for over 60% of deaths in children under five in the Region of the Americas. This analysis draws on estimates generated by the Inter-Agency Group. UNICEF is responsible for monitoring and evaluation of this indicator.

8. **Infant mortality** continues to decline in the Region. In Latin America and the Caribbean, the infant mortality rate (IMR) was 42 per 1,000 live births in 1990 compared to 16 per 1,000 live births in 2011, representing a -62.0% reduction (3).

9. An estimated 170,000 childhood deaths occurred in the Americas in 2011. Barbados, Canada, Chile, Costa Rica, Cuba, the United States of America, and Uruguay registered the lowest IMR (5 to 12 per 1,000 live births), while Bolivia and Haiti presented the highest levels (40 to 45 per 1,000 live births).

10. The series are more unstable in Caribbean countries (English and French-speaking) due to their small populations; the situation in these countries is more homogeneous compared to Latin American countries. The French Departments of the Americas (French Guiana, Guadeloupe, and Martinique) and Anguilla present the lowest IMR (under 12 per 1,000 live births), while Guyana and Suriname have the highest rates in the subregion, with 39 and 26 per 1,000 live births, respectively.

11. Public health interventions that have contributed to reductions in infant mortality include: *a*) advances in high-impact, low-cost primary care; *b*) mass immunization programs; *c*) oral rehydration therapy; *d*) well-child check-ups; *e*) expanded coverage of basic services, especially drinking water and sanitation; *f*) higher levels of schooling among the population, declines in fertility, and poverty reduction.

⁴ Hacia el desarrollo Sostenible: América Latina y el Caribe en la Agenda Post 2015. Draft for discussion. Feb 2013. Inter-Agency Report coordinated by ECLAC.

12. **Maternal mortality** has declined in the Region, although the trends vary among countries. The maternal mortality ratio (MMR) in Latin America and the Caribbean was 140 per 100,000 live births in 1990, and 80 in 2010 (9,726 deaths in the Americas), a -41% reduction, with an annual average decline of -2.6% (4). Based on data from 33 countries and territories in the Region, the MMR declined in 25 countries. The Central American Isthmus showed reductions in the MMR ranging from -8.0% and -54.5%. In the Spanish-speaking Caribbean (Dominican Republic and Cuba) reductions in the maternal mortality ratios ranged from -9.6% to -57.5% in some countries, while increases of between 15.9% and 86.4% were observed in others. Nearly all the countries in the Andean Area and Southern Cone show reductions in the MMR ranging from -2.1% to -66.5%. Significantly, in several countries strategies such as expanded prenatal care coverage, deliveries attended by trained staff, and access to and use of contraceptives are helping to reduce maternal mortality. Currently, reported increases in the MMR may be due to improved monitoring and reporting of events, rather than an actual increase in mortality.

13. Estimates of new **HIV** infections in the countries of the Region (5) reflect a reduction in morbidity and mortality. In 2011, the Region accounted for nearly 6% of all new HIV infections worldwide (147,000 cases): 83,000 in Latin America, 51,000 in North America, and 13,000 in the Caribbean (5). The Caribbean is among the subregions that present the greatest decline in new infections relative to 2001 figures (42% fewer new infections). Moreover, the number of children who contracted HIV dropped by 24% in Latin America and 32% in the Caribbean in a two years period (2009-2011). The Joint United Nations Program on HIV/AIDS (UNAIDS) is responsible for monitoring goals 6A and 6B. While still not halted, the epidemic is starting to be reversed (5). As of the end of 2011, 68% of HIV-positive people in Latin America and the Caribbean had received treatment. This percentage surpassed the world average of 54%. Moreover, the percentage of HIV-positive pregnant women that had received antiretroviral medications in Latin America and the Caribbean rose from 36% to 70%.

14. For the 2000-2011 period, the Region reported a 58% reduction in morbidity, and a 70% reduction in mortality from **malaria**. Seventeen of the 21 malaria endemic countries had successfully reduced this disease in 2011, with 12 of those countries registering reductions of over 75% and the other five, over 50%. Of the four countries that presented increases, only one has shown a downward trend (with reductions beginning in 2005) and is on track to achieving the goal (6).

15. All 35 Member States have made progress in **tuberculosis** control, with a detection rate of 84% of the cases that WHO estimated for the Region of the Americas in 2011. Despite progress in control of this disease, however, multidrug resistance and coinfection with HIV (TB/HIV) still pose a significant challenge that must be addressed. According to the WHO Global Tuberculosis Report 2012 (which compiles data reported by the countries of the Region), the incidence of tuberculosis in the Americas is declining

at a rate of 4% annually, making it the region with the fastest rate of decline in the world. Moreover, the Region of the Americas has already reached and surpassed the goals proposed for 2015 of reducing tuberculosis prevalence and mortality by 50%.⁵

16. According to the data reported on **sustainable access to safe water**, access to improved water sources was 96% (99% in urban areas and 86% in rural areas) in the Region of the Americas (2010). The same figure for Latin America and the Caribbean was 94% (98% in urban areas and 81% in rural areas) (7, 8). It should be noted that no systematized information is available on water quality for the 86% of homes with access to piped water (1, 2), despite the known presence of contaminants that pose a health risk. In addition, increased use of bottled water has been observed (4), which threatens the human right to access to water (6) and poses an environmental challenge that requires further study.

17. Coverage levels of improved **basic sanitation** are at 88% in the Region of the Americas (91% in urban areas and 74% in rural areas). The same figure for Latin America and the Caribbean is 80% (84% in urban areas and 60% in rural areas). In addition to continuing to promote this service in rural and peri-urban areas, it is also necessary to make progress in the quality of this service, in reducing unimproved sanitation services and defecation in the open, and in urban wastewater treatment. The lower income quintiles pose the greatest challenge in this regard (8). It is important to point out that 25 million people in Latin America and the Caribbean still defecate in the open.

Progress in the commitments made in 2011

18. Work will continue along the strategic lines proposed in 2011 for achieving the MDGs: *a)* Review and consolidation of information systems; *b)* Strengthening of systems based on Primary Health Care (PHC); it is proposed that the health systems of municipalities in more highly vulnerable situations be strengthened with the renewed PHC framework; *c)* Reduction of inequity within countries, giving priority to the most vulnerable municipalities and excluded population groups, as a response to the Social Determinants of Health (DSS). It is proposed that initiatives targeting such municipalities and groups, such as “Faces, Voices and Places,” Healthy Municipalities, the Alliance on Nutrition and Development, and Safe Motherhood be strengthened; *d)* Public policy-making to ensure the sustainability of achievements and reaffirm “health in all policies.”

19. As for the Post-2015 Development Agenda **on the health issue**, following WHO indications, PAHO has carried out regional consultations with the heads of health systems and services and with key stakeholders who are not always included in decision-

⁵ World Health Organization. Global tuberculosis control 2010. Geneva (Switzerland): WHO; 2010.

making, such as mayors, indigenous and Afro-descendant leaders, and civil society organizations. There is consensus on the need to prioritize universal access to health care, understood as guaranteeing enjoyment of the right to health, by supporting health services coverage as well as interventions that act on social determinants of health as the priority objective to be presented on the Post-2015 Development Agenda. It also proposes to examine the conclusions and outcomes of the meeting held in Botswana; continue to make progress in the MDGs directly related to health; optimize a healthy life throughout the life cycle as an overarching objective; take into account the rise in noncommunicable diseases (NCD); and promote universal coverage that should include, the goals of access to all key interventions and strengthening health systems. It will be necessary to ensure that all the countries study these results and to obtain a commitment to advance in access to health for all the inhabitants of the Americas.

Action by the Executive Committee

1. The Executive Committee is requested to take note of this report and make any observations and recommendations it deems pertinent.

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D. IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Background

1. This is a progress report on tobacco control in the Region of the Americas, as of 31 December 2012, in the framework of two resolutions, CD48.R2 (2008) adopted by the 48th Directing Council (1) and CD50.R6 (2010) adopted by the 50th Directing Council of the Pan American Health Organization (PAHO). (2)

Progress Report

2. The number of States Parties to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) that have ratified the Convention is 29 and remains unchanged since the last report was submitted (document CD51/INF/5). Although there have been certain advances in implementation of the “best buys” (3) (smoke-free places; health warnings; bans on tobacco advertising, promotion, and sponsorship; and tax increases), these have been slow and uneven both among the different measures and among countries.

3. The countries that have moved forward with the most comprehensive implementation of the Convention have begun to see results. Brazil and Uruguay show a substantial reduction in tobacco consumption in adults (4, 5) and other studies have found reductions in hospital admissions for myocardial infarction. (6, 7)

4. In general, there is a trend toward the feminization of tobacco use in the Region, with a reduction in the consumption gap between adult women and men (8), which is even more pronounced in adolescents (prevalence in male adolescents 12.3%, in female adolescents 11.3%). (9)

5. The Global Tobacco Surveillance System furnishes information disaggregated by sex for both adults and adolescents. However, many countries in the Region still do not have a national tobacco surveillance system set up. In this period, there has been a noteworthy increase in the number of countries that have comparable and nationally representative adolescent surveys; additionally noteworthy is the case of Panama, which will obtain representative data for its indigenous population in the Global Adult Tobacco Survey.

6. Brazil, Costa Rica, and Ecuador adopted measures intended to increase tobacco taxes. Furthermore, for the first time, governmental delegates of tax-related administrations and ministries of health in the Region met to discuss effective tobacco tax and contraband control policies.

7. In fourteen countries, all indoor public places and workplaces and public transportation are 100% smoke-free. Brazil,⁶ Costa Rica, and Ecuador are recent additions.

8. Nineteen countries have legislation on tobacco product packaging and labeling that is consistent with the FCTC, although two of them do not include pictures and four have not still implemented the law. At the end of this biennium, 12 countries will have missed the deadline for implementation of this article.

9. Brazil⁷ has joined Colombia and Panama with a total ban on tobacco advertising, promotion, and sponsorship, while five more countries have broad restrictions that are not total. At the conclusion of this biennium, 22 countries that have still not complied with this article will have missed the FCTC deadline for its implementation.

10. Intense interference by the tobacco industry against tobacco control policies persists, which includes national and international lobbying and lawsuits. World Trade Organization (WTO) measures have now been added.

11. The Pan American Sanitary Bureau has kept in continuous contact with the countries to provide technical support for both the drafting and the approval and implementation process for tobacco control legislation, as well as in defending it against industry attacks. A manual was written about development of tobacco control laws, including fundamental human rights underlying tobacco control as well as lessons learned at the country level, which will be published in mid-2013. Furthermore, regional forums are being encouraged for discussion of supranational issues (such as interactions with trade agreements and contraband control) and to facilitate exchange of information and experiences, not only among countries, but within them among sectors other than the health sector.

Recommended Measures to Improve the Situation

12. It is recommended that States Parties consider signing and subsequent ratification of the new Protocol to Eliminate Illicit Trade in Tobacco Products, adopted by the Fifth Session of the Conference of the Parties to the WHO FCTC.

13. It would be important for Member States to consider ratification of the WHO FCTC if they have still not done so, as well as the possibility of implementing the four tobacco control “best buys.”

14. The establishment and strengthening, as well as allocation of resources for, coordinating units or technical units responsible for tobacco control continue to be a

⁶ Regulation and implementation of the law are pending.

⁷ *Idem*.

challenge. The specific allocation of funds from tobacco taxes can be one of the sources of financing for this purpose.

15. Member States should consider the possibility of establishing national surveillance systems with data disaggregated by sex and, if possible, by socioeconomic status, as well as representative of minority populations, among others, indigenous populations. A standardized module of questions on tobacco is currently available. This module can be included in national surveys on broader topics, as a way to ensure international comparability of data with data from tobacco surveys in other countries, without creating an additional burden on national surveillance systems. (10)

16. It is recommended that Member States consider inclusion of tobacco use detection and brief advice on smoking cessation in their primary health care systems, as well as higher complexity services at other levels, for people with serious addiction.

17. Regarding the existence of dissimilar positions in different international forums, for example, in WTO and WHO, Member States are reminded that there is no incompatibility between implementation of the FCTC and trade agreements. (11) Furthermore, it is recommended that they consider the possibility of not including tobacco in future trade agreements.

18. Taking into account the impact that tobacco control will have on chronic noncommunicable diseases,⁸ it is recommended that Member States consider inclusion of the issue of tobacco control in the agenda of all United Nations agencies at the country level, as well as in all United Nations Development Assistance Framework (UNDAF) projects. (12, 13)

Action by the Executive Committee

19. The Executive Committee is requested to take note of this progress report.

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E. REGIONAL PLAN ON WORKERS' HEALTH

Introduction

1. The Regional Plan on Workers' Health ([Resolution CD41.R13, 1999](#)) was designed to respond to the challenges that political, social, economic, and labor development imposed on the workforce in the 1990s. Its implementation at the national level has produced multiple outcomes with many ups and downs due to the lack of recognition of the important role that the workforce plays as a key driver of sustainable human development. Today, the challenge is to prioritize the protection of workers' health in recognition of the fact that when working people are in good health and enjoy good employment and job conditions they tend to be highly productive at the social, economic, and individual level (1). Although the Plan has been reviewed and adjusted by the Pan American Sanitary Bureau (the Bureau) during its 13 years of existence, it is now imperative to explore and devise new ways to address the complex problems that the Region's workforce confronts today. Accordingly, this report presents the background, summarizes the results obtained to date, explains the realities and the gaps facing workers' health today, and requests the Executive Committee's support in reconsidering the issue.

Background

2. The Plan came into being after the launch of the concept of "sustainable development" at the 1992 Earth Summit, which included the need to protect workers' health and safety ([UNCED, 1992](#)), and the Pan American Conference on Health and Environment in Sustainable Human Development ([PAHO, 1995](#)). The Plan was based on the mandates of the Governing Bodies of the Pan American Health Organization (PAHO) regarding workers' health ([Resolution CSP23.R14, 1990](#)) the Declaration on Occupational Health for All ([WHO, 1994](#)), and the Global Strategy on Occupational Health for All ([WHO, 1995](#); Resolution [WHA49.12](#)).

3. With the formulation of "Workers' Health: Global Plan of Action" ([Resolution WHA60.26, 2007](#)) and the determinations of the WHO Secretariat and the World Network of Collaborating Centers ([WHO/CC](#)), agreements were reached in 2012 to focus work on seven global priorities (2, 3) to which PAHO contributes in accordance with the Region's needs. Appendix 1 presents the milestones marking the Plan's origin and development.

4. The Plan's objectives were achieved by implementing actions in four programmatic areas: (a) quality of work environments, (b) policies and legislation, (c) promotion of workers' health, and (d) comprehensive health services for workers (4). Focusing on these four areas, the Bureau provided technical cooperation to the countries,

with the support of the Network of Collaborating Centers in Occupational Health, and established strategic alliances with the Inter-American Conference of Ministers of Labor of the Organization of American States ([ICML/OAS](#)), the International Labor Organization (ILO), the International Commission on Occupational Health ([ICOH](#)), and the United States National Alliance for Hispanic Workers, among others.

5. The Plan's results were evaluated in 2006 by means of a survey designed for this purpose and other sources of information available in the countries (5) and partially published in the report Health in the Americas 2007 ([PAHO, 2007](#)).

Update on the Situation

6. The Region's population and the economically active population (i.e., people between 15 and 65 years old) rose from 781 million to 954 million and from 351 million to 468 million, respectively, between 1996 and 2011 (6, 7). Around 60.2% (283 million) of the active population is in Latin America and the Caribbean, and 39.5% (185 million) is in North America. The employment conditions (salary, unemployment, and social protection among others) and working conditions (workplace hazards and risks) considered to be social determinants of health (8) have been transformed in the last 15 years because of the processes of change occurring in the working world (9) creating many inequities with regard to workers' health.

7. According to the ILO (10), for 2011 the highest rates of informal employment and people working in the informal sector were present in Bolivia, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, and Peru. Precarious work expanded in the Region, making employment relationships more fragile, affecting daily work life (11), and potentially affecting workers' health (12).

8. Other serious problems are: (a) child labor (13), which is mainly present in its most dangerous forms in informal employment (agriculture 60%, services 26%, and industry 7%, as well as in mining, fishing, and street work (14); (b) forced labor, perceived as abusive practices of semi-slavery, servitude, or work exploitation, and which increased from 1.3 to 1.8 million people for 2012 in Latin America and the Caribbean (15, 16); (c) inequities for working women (17); and (d) excluded population groups such as indigenous people, the elderly, and rural populations that in general have not been covered by social security (18).

9. Inadequate working conditions were detected through an analysis done by PAHO, based on a series of surveys carried out in Argentina, Chile, Colombia, Guatemala, and Nicaragua, indicating that uncontrolled exposure to work hazards persisted, with different levels of frequency and intensity (19), causing avoidable harm to workers' health. Estimates made on the basis of figures from 16 countries in the Region, based on working

populations covered by workers' compensation systems, indicated that in 2007 there were at least 7.6 million occupational accidents, with an approximate frequency of about 20,825 occupational injuries per day (19). For 2009, it is estimated that around 11,343 fatal occupational accidents occurred, among them 5,232 in Latin America and the Caribbean and 6,107 in the United States and Canada. Nevertheless, these figures do not reflect the complete regional picture, for two reasons: both exclude people who are not affiliated with social security systems, and there is significant under-recording of cases.

10. The ILO estimates that 2.34 million work-related deaths occur (20), but among them only 321,000 are caused by occupational injuries. The rest (86%) are attributable to occupational diseases. WHO estimates that the annual toll of nonfatal occupational diseases is around 160 million cases (21). PAHO estimates, based on information on insured populations in nine countries in the Region (19), indicate that in 2009 there was an estimated average of 281,389 cases. In the Region, only 1% to 5% of occupational diseases are effectively reported (19). This underreporting is due to the limited coverage (< 30%) of the health systems and services, and occupational risk management systems; the growth of the informal sector and the invisibility of rural workers; and the countries' deficiencies with regard to monitoring, detecting, and registering occupational diseases, among others.

11. The Global Burden of Disease Study 2010 (22) shows that the greatest risk for occupational mortality in age groups from 15 to more than 80 years old continues to be occupational injuries (higher in young men, although still noteworthy in people over age 65) and exposure to asthmogenic agents in men and women from 15 to 35 years old. Deaths from exposure to occupational carcinogens and particulates occur in both sexes and at both ends of the age spectrum, while deaths from exposure to particulates occur mainly in men and women over age 40: figures that show the long latency period of chronic illnesses caused by prolonged occupational exposures to hazards present in the workplace. The Global Estimates of Occupational Burden of Disease compiled by WHO's Global Health Observatory (23) considered the most frequent risk factors for occupational diseases to be airborne particulates, carcinogens, ergonomic stressors, noise, and risk factors for injuries.

12. The current situation indicates that despite the successes that the Plan has achieved during its years of existence, gaps persist that impose large and worrisome challenges if the countries are to overcome inequities in workers' health. Health systems are assuming the burden and the costs of providing health services to workers in the formal and informal sectors.

13. In light of the situation described above, a call is needed to position and prioritize the subject of workers' health on the governmental agenda of the Member States and, in particular, of the health ministries. It is necessary to strengthen their leadership to

generate policies and programs aimed at prevention and at protecting workers' health, increasing the provision of health services, and providing universal coverage to workers through the primary health care services. Capacity-building will lead the Ministries to better meet people's needs and close the gaps in workers' health to achieve healthy, safe, dignified, and productive work.

Measures to Improve the Situation

14. Given that the Plan's is not uniform in scope and has not reached all of the countries in the Region, it is necessary to create and develop new initiatives to work with the Member States and redefine priorities for action, so that the health sector assumes leadership in providing preventive and treatment services, and can be strengthened and equipped with state-of-the-art tools, methods, and knowledge to meet the objective of protecting workers' lives and health.

15. All of this points to the need to reconsider the Plan so that the Pan American Sanitary Bureau can respond effectively to help Member States find solutions to occupational health inequities and meet the countries' needs for technical assistance.

Action by the Executive Committee

16. The Executive Committee is requested to take note of this report and consider the option to present a new Plan on workers' health for the consideration of the Governing Bodies for the period 2014–2019, so as to respond to the new global, regional, and national challenges, in accordance with PAHO's 2014–2019 Strategic Plan.

Annex

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Annex: Milestones in the evolution of the PAHO Regional Plan of Action on Workers' Health



F. TOWARDS THE ELIMINATION OF ONCHOCERCIASIS (RIVER BLINDNESS) IN THE AMERICAS

Background

1. Onchocerciasis is an infection produced by the parasite *Onchocerca volvulus* that is transmitted to humans by bites from flies of the genus *Simulium*. The disease causes itching, dermatological deformations, loss of vision, and blindness. The prevalence and the intensity of microfilaraemia significantly increases with age, but no association has been found in terms of the gender of those affected (1, 2).

2. Onchocerciasis is endemic in 13 foci located in six countries of the Americas (Brazil, Colombia, Ecuador, Guatemala, Mexico, and Venezuela). The number of people exposed to the risk of infection and blindness has gone from more than 550,000 to only 376,601 in 2012 (see Annex A).

3. In 1991, the Directing Council of the Pan American Health Organization (PAHO) adopted Resolution [CD35.R14](#) related to the elimination of onchocerciasis in the Americas. The donation of medicines, carried out through the [Ivermectin Donation Program](#) since 1987, was designed to contribute to the elimination of the disease. In 1992, with the support of PAHO, the [Onchocerciasis Elimination Program for the Americas](#) (OEPA) was created to unite the efforts of associates and partners with a view to achieving the goal of elimination and providing technical and financial assistance to national programs. The goal was reaffirmed in Resolutions [CD48.R12 \(2008\)](#) and [CD49.R19 \(2009\)](#), which set 2012 as the year to achieve the goal of eliminating ocular morbidity and interrupting transmission of the disease in the Region.

4. This Progress Report submitted to the Governing Bodies of PAHO in 2013 sets forth the challenges that must be overcome to attain the goal set for the Region and to sustain the accomplishments achieved to date.

Achievements

5. Blindness caused by onchocerciasis has been considered to be eliminated in the Region of the Americas since 1995, as no new cases have been reported since that year. As a result of the regional initiative, 184,310 persons (33%) are no longer at risk of contracting onchocerciasis, and the eligible population for treatment is 19,133 persons (Annex B). The transmission of onchocerciasis has been eliminated in seven foci and interrupted in four, which means that in these 11 foci, mass drug administration has been suspended (Annexes A, B, and C), and thus the goal established in Resolution CD48.R12 has been reached.

6. Colombia is the first country of the Americas to have eliminated the transmission of onchocerciasis, and it will receive official verification from PAHO/WHO to that effect in 2013. Ecuador confirmed that transmission was eliminated, and it can be the next country in 2013 to formally request verification from PAHO/WHO.

7. Guatemala and Mexico will complete three years of post-treatment epidemiological surveillance in all of their foci in 2014, and could then request verification from PAHO/WHO.

8. In its focus in the Amazon, Brazil has increased the number of treatment rounds in meso-endemic and highly-endemic communities since 2010 in order to accelerate the process of elimination (4x/year) (3), while continuing the traditional regimen (2x/year) in the rest of the communities, which are near the goal of elimination.

9. Venezuela interrupted the transmission in two of its three foci. It will complete three years of post-treatment epidemiological surveillance in its North-Central focus in 2013 and could achieve elimination. Venezuela initiated post-treatment epidemiological surveillance in the Northeastern focus in 2013. In the Southern focus, 185 new endemic Yanomami indigenous communities were identified along the border with Brazil, with 8,591 eligible people for treatment.

10. Through scientific articles published in indexed journals (3-12), the countries moved forward with the dissemination of scientific evidence that supports the achievements attained. In addition, since 1996, corresponding data are published annually in WHO's [*Weekly Epidemiological Record*](#).

11. The guidelines and procedures developed by OEPA with the participation of PAHO were adopted by WHO and used in the countries where onchocerciasis is endemic.

Challenges

12. The Yanomami focus, shared between Brazil (Amazon focus) and Venezuela (Southern focus), is the last obstacle to overcome in order to eliminate onchocerciasis from the Region. It presents particular difficulties: (a) It is divided by a border between nations; (b) It is a geographic area of difficult access (jungle area); and (c) the affected communities are nomadic. Accordingly, the logistics required to reach persons at risk make it difficult to provide them care and involve high operational costs.

13. Another challenge is to ensure that once transmission of the disease has been interrupted, the countries (a) continue activities to detect potential recrudescence (13); (b) once they reach the elimination that they document the process and request verification

from PAHO/WHO, as was done by Colombia; and (c) address the challenges of the post-elimination period.

Next Steps

14. In view of the current situation analyzed in this report, the following steps are recommended going forward:

- (a) Issue a firm call for coordinated action in the Yanomami area (Southern focus in Venezuela and the Amazon focus in Brazil) in terms of decision-making at the political level. Furthermore, a plan of operation should be defined for the next five years, and treatment and comprehensive care should be provided in order to meet the goal to interrupt transmission in 2015 and eliminate onchocerciasis in 2019 (Annex C). This should be carried out within the framework of protecting Yanomami territories and employing an intercultural approach (14, 15).
- (b) During the three years of post-treatment epidemiological surveillance, promote the adoption of education and community participation methodologies through the integration of other public health programs and the maintenance of monitoring and evaluation in order to sustain the goal of elimination.
- (c) During the phase of onchocerciasis elimination, maintain an ecosystems approach in terms of health determinants and epidemiological surveillance activities through the integration of activities to address other neglected infectious diseases, and continue to strengthen primary care services and the integrated sectoral and intersectoral approach (access to health services, education, housing, safe water, and basic sanitation).
- (d) Recommend that OEPA, with support from PAHO/WHO and in coordination with the six endemic countries, associates, and partners, lead the impact assessment of elimination of onchocerciasis from the Region of the Americas and promote the publication of lessons learned so that they can support the elimination of other diseases.

Action by the Executive Committee

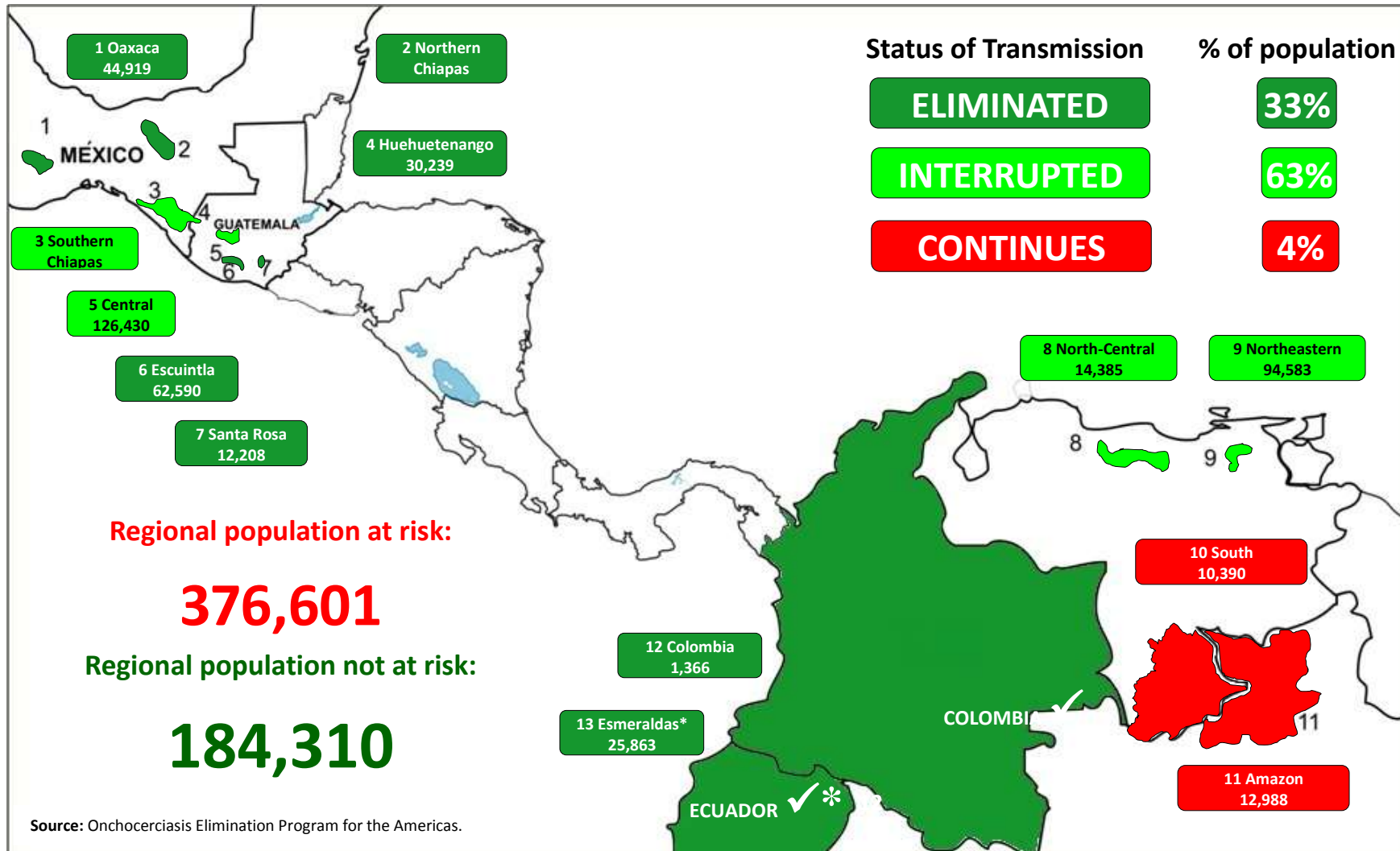
15. It is requested that the Executive Committee take note of this Progress Report and formulate additional recommendations that it considers pertinent.

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Annex A. Geographical Distribution of Onchocerciasis and the Status of its Transmission in the Americas, December 2012



*Pending acceptance by governmental authorities of Ecuador.



Annex B. Current Status of Ocular Morbidity and Its Transmission in the Region of the Americas, 2013

Focus	Endemic communities	Population at risk	Population not at risk	Population under post-treatment epidemiological surveillance	Population eligible for treatment	Status of transmission
Escuintla—GUA	117		62,590			Eliminated
Santa Rosa—GUA	37		12,208			Eliminated
Northern Chiapas—MEX	13		7,125			Eliminated
López de Micay—COL	1		1,366			Eliminated
Huehuetenango—GUA	43		30,239			Eliminated
Oaxaca—MEX	98		44,919			Eliminated
Esmeraldas—ECU	119		25,863*			Eliminated*
Central—GUA	321	126,430		126,430		Interrupted
Southern Chiapas—MEX	559	117,825		117,825		Interrupted
North-Central—VEN	45	14,385		14,385		Interrupted
Northeastern—VEN	465	94,583		94,583		Interrupted
South—VEN	10	10,390			8,591	Continues
Amazon—BRA	22	12,988			10,542	Continues
Total	1,850	376,601	184,310	353,223	19,133	

*Pending acceptance by governmental authorities of Ecuador.

Source: Onchocerciasis Elimination Program for the Americas

Annex C. Expected Timetable to Achieve the Elimination of Onchocerciasis Transmission in the Endemic Countries in the Americas

Country	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Colombia		VEPT			2011	 The international team designated by PAHO/WHO for verification of onchocerciasis elimination visited Colombia in November 2012.							
Ecuador				VEPT			2013	 The Program Coordinating Committee recommended that Ecuador formally request verification of elimination from PAHO/WHO.					
Guatemala						VEPT			2015				
Mexico						VEPT			2015				
Brazil										VEPT			2019
Venezuela	Yanomami Area									VEPT			2019
	Last year of massive drug administration.												
	Post-treatment epidemiological surveillance phase.												
	Year in which the country could request verification of onchocerciasis elimination from PAHO/WHO.												

Source: Onchocerciasis Elimination Program for the Americas (OEPA).

G. REGIONAL PLAN OF ACTION FOR STRENGTHENING VITAL AND HEALTH STATISTICS

Background

1. This is a progress report to the Governing Bodies of the Pan American Health Organization (PAHO) on the status of the targets in the *Regional Plan of Action for Strengthening Vital and Health Statistics* (PEVS), (CD48.R6 [2008])⁹ (1).

Progress Report

2. With regard to birth coverage (Table 1), by the middle of the last quinquennium (2005-2010),¹⁰ 17 of 25 countries would have reached the coverage target: Argentina, Bahamas, Barbados, Belize, Brazil, Chile, Costa Rica, Cuba, United States of America, Honduras, Mexico, Nicaragua, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, and Venezuela (12 would have surpassed it). Three countries (Ecuador, Panama, and Paraguay) would have increased coverage levels during that quinquennium and could reach the projected target if they maintain strengthening plans in effect. Bolivia Colombia, El Salvador, Guatemala, and the Dominican Republic would have decreased their level compared to the previous period and should make a special effort to reach the target.

3. With regard to death coverage (Table 2), by the middle of the last quinquennium (2005-2010), 11 of 25 countries would have reached the target: Argentina, Barbados, Belize, Chile, Cuba, Ecuador, United States of America, Mexico, Saint Vincent and the Grenadines, Trinidad and Tobago, and Uruguay (the last four would have surpassed it). Bahamas, Brazil, El Salvador, Nicaragua, Panama, Paraguay, and Peru would have increased their coverage during that quinquennium and could reach the target if they maintain processes for strengthening health information systems. The slight decline in Costa Rica, a country with almost complete coverage, and the declines in Colombia, Guatemala, the Dominican Republic, and Venezuela may be associated (particularly in Costa Rica and Venezuela) with the use of estimates that have not yet been adjusted in

⁹ This document only reports on birth and death coverage. For both events, the PEVS contains the following targets for 2005 to 2013: countries with >90% coverage should at least maintain it; countries with 80-90% should reach at least 90%; countries with 61-79% should improve coverage by at least 10%; and countries with ≤60% should improve coverage by at least 20%. The other indicators mentioned in the Annex of Resolution CD48.R6 (2008) are currently being evaluated.

¹⁰ Since uniform information is only available from routine birth and death records through 2011 and from current estimates for quinquennia (2000-2005 and 2005-2010) from ECLAC/CELADE, this report analyzes changes in coverage between averages for those quinquennia. In the next two years (2014/2015) it is expected that routine data up to 2013 will become available for numerators of the rates and up-to-date country projections based on the last censuses in the 2010 round for denominators of those rates. Thus, more realistic values will be available to evaluate changes in coverage rates.

light of their new census. Finally, no data are available for Bolivia and Honduras for the last period.

Proposal

4. Submitted for consideration by the Governing Bodies is the importance of having a progress report that uses routine data and up-to-date estimates by 2015 and ensuring the sustainability and necessary adjustments of the PEVS for the period 2013-2017, so that without neglecting the achievements of many of the countries, it efforts target technical cooperation so that countries where the situation is more critical can move forward in improving the coverage and quality of vital statistics.

5. Strengthen horizontal cooperation and the exchange of good practices, strengthening the role of the Latin American and Caribbean Network for Strengthening Health Information Systems (RELAC SIS), to foster its expansion to the countries of the English-speaking Caribbean and maintain the alliance with international technical and financing agencies.

Action by the Executive Committee

6. The Executive Committee is invited to take note of this progress report and offer any recommendations it deems necessary for ensuring attainment of the Plan of Action.

Annex

References

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Annex. Birth and Death Coverage. 2000-2005 and 2005-2010. PEVS 2013 Targets.

Table 1. BIRTHS. Progress in coverage between quinquennia 2000-2005 and 2005-2010

Selected countries of the Americas							
Group by coverage at baseline	Country	2000-2005	CD48.R6 Target	2013 Target (%Coverag	2005-2010	Progredds by 2010	Effort to make by 2013
1 ≥91%	USA	100,0	Maintain level	100,0	100,0	Reached	
	Mexico*	100,0	Maintain level	100,0	100,0	Reached	
	Argentina**	100,0	Maintain level	100,0	100,0	Reached	
	Bahamas	100,0	Maintain level	100,0	100,0	Reached	
	Barbados#	97,0	Maintain level	97,0	100,0	Reached and Improved	
	Cuba**	96,8	Maintain level	96,8	96,8	Reached	
	Uruguay**	96,2	Maintain level	96,2	100,0	Reached and Improved	
	Venezuela**	96,5	Maintain level	96,5	100,0	Reached and Improved	
	Chile**	95,1	Maintain level	95,1	98,3	Reached and Improved	
	St Vicent	94,8	Maintain level	94,8	95,4	Reached and Improved	
	Costa Rica**	94,6	Maintain level	94,6	99,8	Reached and Improved	
	Trinidad and Tobago	92,9	Maintain level	92,9	93,6	Reached and Improved	
	Guatemala	91,8	Maintain level	91,8	81,6	Declined (10.2 points)	10,2
	El Salvador	91,2	Maintain level	91,2	82,8	Declined (8.4 points)	8,4
2 80-90%	Panama*	84,6	Reach 90%	90,0	88,4	Improved w/o reaching	1,6
	Ecuador*	83,0	Reach 90%	90,0	84,6	Improved w/o reaching	5,4
3 61-79.9%	Nicaragua	79,6	Improve 10%	87,6	89,3	Reached and Improved	
	Bolivia**	79,2	Improve 10%	87,1	52,9	Declined (26.3 points)	34,2
	Colombia	78,7	Improve 10%	86,6	76,4	Declined (2.3 points)	10,2
	Brazil**	74,1	Improve 10%	81,5	90,8	Reached and Improved	
	Dom. Rep.**	69,3	Improve 10%	76,2	62,9	Declined (6.4 points)	13,3
	Honduras#	68,0	Improve 10%	74,8	100,0	Reached and Improved	
	Peru	62,3	Improve 10%	68,5	100,0	Reached and Improved	
4 ≤60%	Paraguay**#	60,1	Improve 20%	72,1	65,0	Improved w/o reaching	7,1
	Belize#	50,00	Improve 20%	60,00	96,4	Reached and Improved	

* Countries with adjusted estimates based on circa-2010 censuses.

** Countries with circa-2010 censuses that have not yet released adjusted estimates. Current United Nations estimates are used.

Countries with registry data in PAHO.

Table 2. DEATHS. Progress in coverage between quinquennia 2000-2005 and 2005-2010

Selected countries of the Americas								
Group by coverage at baseline	Country	2000-2005	CD48.R6 Target	2013 Target (%Coverag	2005-2010	Progress by 2010	Effort to make by 2013	
1 ≥91%	USA	100,0	Maintain level	100,0	100,0	Reached		
	Cuba**	100,0	Maintain level	100,0	100,0	Reached		
	Uruguay**	100,0	Maintain level	100,0	100,0	Reached		
	Chile**	100,0	Maintain level	100,0	100,0	Reached		
	Argentina**	99,0	Maintain level	99,0	99,0	Reached		
	St Vicent	100,0	Maintain level	100,0	100,0	Reached		
	Barbados	100,0	Maintain level	100,0	100,0	Reached		
	Costa Rica**	97,3	Maintain level	97,3	93,5	Declined (3.8 points)		
	Trinidad and	99,4	Maintain level	99,4	100	Reached and Improved		
	Mexico*	94,9	Maintain level	94,9	100,0	Reached and Improved		
	Ecuador*	93,5	Maintain level	93,5	94,6	Reached and Improved		
	Guatemala	93,2	Maintain level	93,2	89,5	Declined (3.7 points)	3,7	
	2 80-90%	Venezuela**	89,1	Reach 90%	90,0	71,1	Declined (18.0 points)	18,9
		Brazil**	86,4	Reach 90%	90,0	87,0	Improved w/o reaching	3,0
Panama*		84,4	Reach 90%	90,0	85,8	Improved w/o reaching	4,2	
Colombia		81,6	Reach 90%	90,0	78,0	Declined (3.6 points)	12,0	
3 61-79.9%	Bahamas	75,6	Improve 10%	83,2	76,9	Improved w/o reaching	6,3	
	El Salvador	75,6	Improve 10%	83,2	79,0	Improved w/o reaching	4,2	
	Honduras	68,0	Improve 10%	74,8	nd			
	Paraguay**	62,4	Improve 10%	68,6	67,9	Improved w/o reaching	0,7	
	Nicaragua	57,4	Improve 20%	68,9	62,0	Improved w/o reaching	6,9	
4 ≤60%	Dom. Rep.**	50,4	Improve 20%	60,5	49,9	Declined (0.5 points)	10,6	
	Peru	57,1	Improve 20%	68,5	58,8	Improved w/o reaching	9,7	
	Belize	50,0	Improve 20%	60,0	80,5	Reached and Improved		
	Bolivia**	31,1	Improve 20%	37,3	nd			

* Countries with adjusted estimates based on circa-2010 censuses.

** Countries with circa-2010 censuses that have not yet released adjusted estimates. Current United Nations estimates are used.

nd: No data.

H. IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS

1. The purpose of this report is to provide an update on the status of the implementation of the International Health Regulations (IHR, hereafter also referred to as the “Regulations”). It also highlights issues deserving concerted action by States Parties in the Region for the future implementation of the Regulations.
2. The Pan American Health Organization (PAHO) serves as the World Health Organization (WHO) IHR Contact Point for the Region of the Americas and facilitates the management of public health events. In the period from 1 January to 31 December 2012, a total of 122 public health events of potential international concern were identified and assessed. For 63 of the 122 events (52%), national health authorities (through the National IHR Focal Points, NFP) were the initial source of information. Verification was requested for 31 events identified through informal or unofficial sources, and it was obtained from the NFP for all but one event. Of the 122 events considered, 56 (46%) were of substantiated international public health concern, affecting 20 States Parties in the Region. The largest proportion of these events was attributed to infectious hazards (34 events or 61%), and the etiologies most frequently recorded were dengue viruses (8) and influenza viruses (4). The remaining 22 events of substantiated international public health concern were attributed to the following hazards: food safety (11), zoonosis-related (5), product-related (3), undetermined origin (2), and radiation (1). It may be noted that, in 2012, 32 of the 35 States Parties in the Region (91%) submitted an annual confirmation or update of their NFP contact details.
3. Subsequent to the request for extension and the submission of National IHR Extension Action Plan 2012-2014 in June 2012, 29 of the 35 States Parties of the Americas (83%) were granted an extension until June 2014 to establish core capacities.¹¹
4. As of 15 May 2013, 31 of 35 State Parties of the Americas (89%) had submitted a State Party Annual Report to the Sixty-sixth World Health Assembly (WHA). This information is presented in the Report by the Director-General entitled “Implementation of the International Health Regulations (2005)”¹². The most critical weaknesses observed in the Americas (capacities with a score below 60%) were: human resources (57%), preparedness (55%), management of events related to chemical hazards (48%), and management of events related to radiation hazards (41%).

¹¹Resolution WHA58.3 (2005). Revision of the International Health Regulations. Available from: <http://www.who.int/csr/ihr/WHA58-en.pdf>

¹²World Health Organization. Implementation of the International Health Regulations (2005) Report by the Director-General [Internet]. 66th World Health Assembly; 2013 May 20-28; Geneva (Switzerland). Geneva: WHO; 2013 [cited 2013 May 2]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_16-en.pdf

5. Compared to the States Parties Annual Reports submitted to the Sixty-fifth WHA, the data showed States Parties making progress in a number of core capacities. The most significant progress was in capacity at designated points of entry (+8%), followed by laboratory capacity and the capacities to manage events related to zoonotic and food safety hazards (+6%), surveillance (+5%), the capacity to manage events related to chemical hazards (+4%), human resources and the capacity to manage events related to radiation hazards (+3%), and response capacity (+2%). No substantial changes were reported for the following capacities: legislation and policy (-1%), preparedness (-1%), and coordination (-4%). The most noticeable regression was observed for risk communication capacity (-6%). A summary table on the States Parties Reports of the Region of the Americas to the 66th WHA is provided in the Annex.

6. Thirty-one of the 35 States Parties indicated their designated ports (64 in total); 34 States Parties indicated their designated airports (77 in total), and nine States Parties provided a list of their designated ground crossings (22 in total). In addition, as of 31 March 2013, 457 ports in 23 States Parties in the Region of the Americas were authorized to issue Ship Sanitation Certificates.¹³

7. Together with sub-regional integration mechanisms¹⁴, international organizations (such as the International Civil Aviation Organization and the International Atomic Energy Agency), and WHO Collaborating Centers,¹⁵ PAHO continues to support the efforts of States Parties in the Region to attain and maintain their core capacities.

8. Meeting the June 2014 deadline for establishing core capacities poses substantial challenges to the States Parties and to PAHO/WHO. Anticipating that a significant

¹³ List of ports authorized to issue Ship Sanitation Certificates available from:

http://www.who.int/ihr/ports_airports/ihr_authorized_ports_list.pdf [Consulted 2013 April 4].

¹⁴ The Southern Common Market (MERCOSUR), through the Intergovernmental Commission for the International Health Regulations (CIRSI) of the Working Group on Health (SGT-11); the Andean Community (CAN), through the Andean Network for Epidemiological Surveillance (RAVE) of the Andean Regional Health Agency-Hipólito Unanue Agreement (ORAS-CONHU); the Union of South American Nations (UNASUR), through its Technical Working Group for Surveillance and Response (GTVR); the Central American Integration System (SICA), through the Executive Secretariat of the Council of Ministers of Health of Central America and the Dominican Republic (SE-COMISCA); and the Caribbean Community (CARICOM).

¹⁵ WHO Collaboration Center (CC) for the Implementation of IHR National Surveillance and Response Capacity at the United States Centers for Disease Control and Prevention (CDC), Atlanta, GA: http://apps.who.int/whocc/Detail.aspx?cc_ref=USA-359&cc_ref=usa-359&; WHO CC on Public Health Law and Human Rights at the Center for Law and the Public's Health, Washington, D.C., United States, WHO CC USA-311: http://apps.who.int/whocc/Detail.aspx?cc_ref=USA-311&cc_ref=usa-311&; WHO CC for Prevention, Preparedness, and Response to Chemical Emergencies at the Environmental Agency of São Paulo State (Companhia Ambiental do Estado de São Paulo - CETESB), Sao Paulo, Brazil, WHO CC BRA-46: http://apps.who.int/whocc/Detail.aspx?cc_ref=BRA-46&cc_ref=bra-46&; WHO CC for Travelers' Health at the CDC, Atlanta, GA, United States, WHO CC USA-387: http://apps.who.int/whocc/Detail.aspx?cc_ref=USA-387&cc_ref=usa-387&

number of States Parties would seek an additional two-year extension until 15 June 2016, the WHO Secretariat proposed that the 132nd Session of the WHO Executive Board adopt criteria to be used when considering future requests for extension.¹⁶ While the Executive Board did not object to the proposed criteria, it determined that the criteria would benefit from further consideration by the Member States at forthcoming meetings of the Regional Committees in 2013. This would allow the final criteria to be provided to the 134th Session of the Executive Board in January 2014.

Action by the Executive Committee

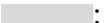
9. The 152nd Session of the Executive Committee is invited to take note of this report and provide recommendations it may have. The Committee is also invited to approve the inclusion of the IHR as a program policy item on the agenda of the 52nd Directing Council, 65th Session of the Regional Committee of WHO for the Americas in order to consolidate the position of States Parties in the Region regarding criteria to grant the additional two years' extension, as well as procedures and methods to monitor the status of implementation of the Regulations beyond 2016.


Annex

¹⁶ World Health Organization. Implementation of the International Health Regulations (2005). Report by the Director-General. [Internet]. 132nd Session of the Executive Board. 2013 January 21-29. Geneva (Switzerland). Geneva: WHO; 2013 [cited 2013 May 9]. Available from: http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_15Add1-en.pdf

Summary table: State Party Annual Report to 66th World Health Assembly and National IHR Extension Action Plan, Region of the Americas, 2012-2014

State Party	Requested and obtained 2012-2014 extension	Submitted State Party Annual Report to 66th WHA	Legislation/Policy	Coordination	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Antigua and Barbuda	Yes	Yes	100	66	95	70	60	43	100	66	77	89	80	62	29
Argentina ¹	Yes	Yes	50	73	80	83	100	86	100	73	NA ²	67	60	69	86
Bahamas	Yes	No													
Barbados	Yes	Yes	50	40	95	66	40	86	80	96	97	100	93	54	0
Belize	Yes	Yes	25	36	85	76	10	71	40	77	58	78	67	8	0
Bolivia (Plurinational State of)	Yes	Yes	50	56	75	83	60	43	0	86	51	78	60	31	71
Brazil	No	No													
Canada	No	Yes	100	83	100	100	100	100	100	100	94	100	100	100	100
Chile	No	Yes	50	46	85	94	70	57	20	67	87	89	93	23	79
Colombia	No	Yes	100	73	70	65	50	86	80	90	97	33	80	62	21
Costa Rica	No	Yes	100	100	95	94	60	86	100	80	91	100	100	38	21
Cuba	Yes	Yes	100	100	100	100	100	100	100	96	97	100	100	100	93
Dominica	Yes	Yes	75	100	85	65	50	29	0	71	87	78	73	31	0
Dominican Republic	Yes	Yes	75	90	80	48	70	86	40	39	21	44	27	23	57
Ecuador	Yes	Yes	0	56	35	47	20	43	20	35	45	56	60	38	71
El Salvador	Yes	Yes	75	90	100	100	50	71	100	100	97	67	73	46	86
Grenada	Yes	Yes	50	83	90	52	0	57	0	41	64	100	67	23	0
Guatemala	Yes	Yes	75	66	85	76	20	86	100	91	38	89	47	62	29
Guyana	Yes	Yes	100	83	80	94	90	71	80	100	50	100	67	62	7
Haiti	Yes	No													
Honduras	Yes	Yes	50	26	90	71	20	29	60	91	22	100	67	0	7
Jamaica	Yes	Yes	50	73	100	100	90	86	100	90	91	100	93	54	0
Mexico	Yes	Yes	100	53	80	89	60	43	80	96	54	89	87	69	86
Nicaragua	Yes	Yes	25	100	95	87	80	100	20	81	62	100	80	92	71
Panama	Yes	Yes	100	73	90	89	50	43	100	96	77	100	93	54	43
Paraguay	Yes	Yes	50	80	55	82	10	100	60	96	37	33	60	46	71
Peru	Yes	Yes	100	50	100	87	50	57	80	77	27	78	93	8	0
Saint Kitts and Nevis	Yes	Yes	100	66	60	52	40	29	20	59	97	78	93	31	14
Saint Lucia	Yes	Yes	0	73	80	65	50	29	20	43	12	67	40	15	0
Saint Vincent and the Grenadines	Yes	Yes	0	46	75	60	10	0	0	81	41	100	40	0	0
Suriname	Yes	Yes	50	66	35	66	50	43	0	90	51	56	67	54	0
Trinidad and Tobago	Yes	Yes	50	56	80	76	50	71	0	77	74	89	87	46	57
United States of America	No	Yes	100	100	100	100	100	100	100	60	100	100	100	100	93
Uruguay	Yes	No													
Venezuela (Bolivarian Republic of)	Yes	Yes	25	73	80	94	80	86	80	90	50	100	87	85	86
Core capacity score (%) - Regional average			64	70	82	78	55	65	57	79	65	83	75	48	41
States Parties that identified need for action to attain core capacity in IHR Extension Action Plans 2012-2014			26	26	25	27	21	20	25	24	25	16	16	21	21

Legend: : Actions to be taken to attain the core capacity indicated in the National IHR Extension Action Plan 2012-2014.

: Actions needed in order to attain the core capacity, but not considered a priority for the National IHR Extension Action Plan 2012-2014.

¹ Argentina submitted the report using the MERCOSUR tool and subsequently migrated data from the relevant sections to the format proposed by WHO, pursuant to agreement with UNASUR-GTVR.

² Information related to points of entry from Argentina was submitted in a format that could

I. STATUS OF THE PAN AMERICAN CENTERS

Introduction

1. This document was prepared in response to the mandate of the Governing Bodies of the Pan American Health Organization (PAHO) to conduct periodic evaluations and reviews of the Pan American Centers.

Background

2. The Pan American Centers have been an important modality of PAHO technical cooperation for almost 60 years. In that period, PAHO has created or administered 13 centers¹⁷, eliminated nine, and transferred the administration of one of them to its own governing bodies. This document presents up-to-date information on the Pan American Foot-and-Mouth Disease Center (PANAFTOSA), the Latin American and Caribbean Center on Health Sciences Information (BIREME), the Latin American Center for Perinatology and Human Development/Women's and Reproductive Health (CLAP/SMR); and the two Subregional Centers, the Caribbean Epidemiology Center (CAREC) and the Caribbean Food and Nutrition Institute (CFNI), which were transferred at the end of 2012 to the Caribbean Public Health Agency (CARPHA).

Pan American Foot-and-Mouth Disease Center (PANAFTOSA)

3. In view of the convergence of human health and animal health, there is an ever-growing need for PAHO to exercise leadership in the sphere of zoonoses, food safety, and food security. The articulation between health, agriculture, and the environment constituted the main theme of the 16th Inter-American meeting, at the Ministerial Level, in Health and Agriculture (RIMSA 16): *Agriculture, Health, and Environment: joining efforts for the well-being of the Americas*, which was held in Santiago, Chile, on 26-27 July 2012, under the coordination of PANAFTOSA. There were three technical events held preceding RIMSA 16: the 12th Meeting of the Hemispheric Committee for the Eradication of Foot-and-mouth Disease in the Americas (COHEFA 12); the 6th Meeting of the Pan American Commission for Food Safety (COPAIA 6); and the Interagency Forum "Toward integrated epidemiological surveillance." RIMSA 16 and these three technical events had technical and financial support from the Government of Chile, through the ministries of health and agriculture. The final report of RIMSA 16, which culminated in the Consensus of Santiago, will be submitted to the Governing

¹⁷ CLATES, ECO, PASCAP, CEPANZO, INPPAZ, INCAP, CEPIS, Regional Program on Bioethics in Chile, CAREC, CFNI, CLAP, PANAFTOSA, and BIREME.

Bodies this year. The final reports on the technical events preceding RIMSA 16 and on the Consensus of Santiago are available on the Web page of PANAFTOSA.¹⁸

Recent Progress

4. Within the framework of the institutional development project for PANAFTOSA which began in 2010, the financial contributions from sources specifically interested in foot-and-mouth disease eradication in South America are supporting technical cooperation of the Center in relation to regional coordination of the 2011-2020 Action Plan of the Hemispheric Program for Eradication of Foot-and-mouth Disease (PHEFA). Accordingly, it has been possible to channel a significant proportion of the regular financial resources of the Center toward technical cooperation in the areas of zoonosis and food safety. The generous contribution from the Ministry of Agriculture, Livestock, and Food Supply of Brazil continues to provide full support for the maintenance costs of the Center.
5. At the end of 2012, PAHO, through PANAFTOSA, and the Secretariat for Health Surveillance of the Ministry of Health of Brazil signed an Annex to the Technical Cooperation Agreement for contributing to the strengthening of the National Health Surveillance System and the management capacity of the Unified Health System of Brazil, to reduce the burden on the human population of zoonoses, vector-borne, waterborne, and foodborne diseases. This agreement and its Annex also include activities for knowledge management and South-South cooperation, in addition to the valuable sustained collaboration for more than 60 years with the Ministry of Agriculture, Livestock, and Food Supply of Brazil. These collaborative activities reinforce the important function of PANAFTOSA as a center of intersectoral technical cooperation on animal health and public health.
6. At the beginning of this year a new Technical Cooperation Agreement was signed with the Latin American Development Bank (CAF) for foot-and-mouth disease control in the border areas of the Andean countries. In addition, technical cooperation agreements are being negotiated with public organizations of other Member States, on activities in all the spheres of activity of PANAFTOSA: zoonosis, food safety, and foot-and-mouth disease.
7. Within the framework of the Action Plan for Elimination of Human Rabies Transmitted by Dogs, which lays out the actions for the last stage of elimination to be reached in 2015, diagnostic laboratories are being strengthened through training of professionals and review of the national plans for elimination in priority countries through evaluation missions. Technical cooperation was provided for a wildlife rabies

¹⁸ <http://ww2.panaftosa.org.br/rimsa16/>

outbreak in Ecuador, through training of field and laboratory professionals. Support is being provided for laboratories in Central America and Colombia for diagnosis of equine encephalitis and preparation of the intersectoral national plan for surveillance, prevention, and control of echinococcosis/hydatidosis in Peru.

8. Country programs for food safety have been strengthened through direct technical cooperation and organization of in-person intersectoral workshops in collaboration with other international and regional organizations. These included workshops on the following subjects: food safety in emergencies and response to outbreaks; integrated surveillance of foodborne diseases; integrated monitoring of antimicrobial agents in the primary animal chain of production, and risk analysis and modernization of food protection services. A workshop on risk management was organized during the regional meeting of Codex Alimentarius, with participants of all the countries of the Region. Six interactive virtual seminars were organized with more than 1,500 participants on quality management from the laboratories of the Inter-American Network of Food Analysis (INFAL).

9. Since January 2012 there have been no cases of foot-and-mouth disease recorded in the countries of South America. The subregions of North America, Central America, and the Caribbean are free of this disease. Within the framework of the 2011-2020 Action Plan of PHEFA, technical cooperation and training were provided in the area of surveillance, laboratory work, and program management to Bolivia, Brazil, Colombia, Ecuador, Guyana, Panama, Paraguay, Peru, Uruguay, and Venezuela. Technical cooperation was provided to Paraguay in response to foci in 2011 and 2012, for preparation of a national study of circulation of the foot-and-mouth disease virus.

10. In 2012, Panama was accepted as a full member of the South American Commission for the Control of Foot-and-Mouth Disease (COSALFA), which held its 40th regular meeting in that country in April 2013.

Latin American and Caribbean Center on Health Sciences Information (BIREME)

11. BIREME is a specialized center of PAHO founded in 1967 to administer the supply of technical cooperation that the Organization provides to the countries of the Region in scientific and technical information on health. On 1 January 2010 the new BIREME Statute went into effect, and on 31 August of the same year the Advisory Committee of BIREME was established.

12. The 28th Pan American Sanitary Conference selected Cuba, Ecuador, and Puerto Rico for the Advisory Committee of BIREME, with a mandate of three years, replacing Argentina, Chile, and Dominican Republic, the mandates of which expired in 2012.

Recent Progress

13. The third meeting of the Advisory Committee of BIREME took place on 5 December 2012, in the offices of BIREME in São Paulo (Brazil). The members of the Advisory Committee reaffirmed their continued support for the institutional development of the Center, including the implementation of the new institutional framework, the drafting and signing of the Headquarters Agreement, and the financing of its work plans, in addition to the setup of the Scientific Committee, the organization of the IX Regional Congress on Information in Health Sciences (CRICS9), and the holding of the the VI Meeting of Regional Coordination of the Virtual Health Library (BVS6) in Washington, D.C., from 20 to 24 October 2012. At its third meeting, the Advisory Committee of BIREME approved the appointment of the members of the Scientific Committee, according to the criteria defined by PAHO. The specialists in this committee come from five countries: Brazil, Canada, United States, Honduras, and Trinidad and Tobago.

14. In the context of the lines of action for implementing the new institutional framework of BIREME, the following points should be noted:

- (a) Headquarters Agreement for BIREME. PAHO and the Ministry of Health of Brazil prepared a headquarters agreement, which was submitted for approval on 6 August 2010. After a series of negotiations that took place during the year 2012, on 4 October of the same year the Executive Secretariat of the Ministry of Health of Brazil, through the PAHO/WHO Representative Office in Brazil, presented a new version of the *Agreement between the Federative Republic of Brazil and the Pan American Health Organization on the installation of the Latin American and Caribbean Health Sciences Information Center*, as proposed by the Government of Brazil. This new version was reviewed in PAHO Headquarters and referred to the Ministry of Health of Brazil with observations, since it involved substantive changes from the previous proposal, particularly regarding the privileges and immunities to be accorded to PAHO.
- (b) Agreement on the installations and operation of BIREME on the São Paulo Campus of UNIFESP. The terms of this agreement are currently being negotiated with UNIFESP, and its signing will take place once the Headquarters Agreement with the Government of Brazil, cited in the previous paragraph, is signed.
- (c) Definition of the financing mechanism for BIREME based on the contributions of PAHO and of the Government of Brazil, stipulated in the article 6 of the Statute. Regular contributions will be defined by mutual consent to support the approved biennial work plans, in accordance with the provisions in the Statute. At the first meeting in 2012 of the National Advisory Committee of BIREME, held on 1 June, the Ministry of Health of Brazil approved a contribution of 3.8 million reais (approximately 1.8 million dollars) to finance the BIREME work plan for 2012. This sum will be transferred to PAHO through Annex No. 20 to the Agreement on

- Maintenance and Development of BIREME, that is in the process of being approved at the date of publication of this document.
- (d) Establishment of the Scientific Committee in coordination with the Advisory Committee of BIREME. The process for presentation of candidacies for members of Scientific Committee was carried out took place in the first half of 2012. Proposals were received from thirteen Member States and presented to the Advisory Committee of BIREME during the second half of the year, for appointment of the members according to the approved Terms of Reference for the Committee.
15. The biennial work plan for 2012-2013 of BIREME as a entity under the PAHO Knowledge Management and Communication Area was prepared together with the Area, with which it continues to coordinate its elaboration and articulation.

Latin American Center for Perinatology and Human Development/Women's Reproductive Health (CLAP/SMR)

16. The Latin American Center for Perinatology (CLAP) was created in 1970, through an agreement between the Government of the Eastern Republic of Uruguay, the University of the Republic of Uruguay, and PAHO, which is renewed periodically and the last extension of which is in effect until 28 February, 2016. The general objective of CLAP is to promote, strengthen, and raise the capacities of the countries of the Region of the Americas with regard to health care for womens, mothers, and newborns.

Recent Progress

17. The Baseline Plan was prepared for stepping up reduction in maternal mortality and severe maternal morbidity. A complementary form on Perinatal Clinical History was developed, jointly with WHO and experts of the Region, for registering cases of extremely serious maternal morbidity in the Perinatal Information System (SIP). Implementation of the project for technical cooperation among countries in Central America (El Salvador, Honduras, Nicaragua, Panama) was finalized, and a new proposal was prepared with the same purposes incorporating Belize, Costa Rica, and the Dominican Republic. Within the framework of the strategy for Elimination of Vertical Transmission of the Maternal Syphilis and HIV, the tool for certification and its field testing was implemented for the certification of Chile as a country that has achieved the goal of elimination of congenital syphilis. CLAP/SMR assumed responsibility for implementation of the neonatal component of health and proceeded to a mid-term evaluation of the Regional Plan for Newborn Health. CLAP/SMR was accepted as a member of the executive committee of the LAC Forum on family planning. Education for

midwifery educators was promoted through the “Caribbean Regional Midwives Association,” given the need for strengthening midwifery in the Region.

18. The search continued for a site for the offices of CLAP and the PAHO/WHO Representative Office in Uruguay. At the end of 2011, five sites were visited, but did not meet the necessary requirements. In the first semester of 2012 the search was resumed with a visit to five private properties and to a governmental site the School of Veterinary Medicine. The latter was ruled out since it will not be available until two years from now, and the other properties did not meet the physical and economic requirements.

Subregional centers (CAREC and CFNI)

19. On 31 December 2012 the transition from CAREC and CFNI to the Caribbean Public Health Agency (CARPHA) became effective, in accordance with the provisions in the Agreement between PAHO and CARPHA for the transfer of CAREC and CFNI to CARPHA. Previously, on 13 December, a special ceremony of closure for CAREC and CFNI was held with the participation of staff members of the Ministry of Health of Trinidad and Tobago, CARICOM, the Interim Director of the CARPHA, and PAHO staff members. The Transfer Document was signed by the Interim Director of CARPHA and the Chief of Administration of the Pan American Sanitary Bureau on the same date. As a consequence of these steps, information on CAREC and CFNI will no longer be included in the context of evaluations of the Pan American centers.

Caribbean Epidemiology Center (CAREC)

20. In 2012, CAREC concentrated in maintaining its normal services, while preparing for the transition. To this end, PAHO constituted a working group for implementing a plan on the technical, administrative, and laboratory products and services to be transferred to CARPHA. Furthermore, several subcommittees were formed to support the transition in the areas of information, finances, and human resources.

21. At the same time, CAREC collaborated actively with the Executive Committee of CARPHA in the approval of its organization chart, policies, procedures, and processes, including the Staff Regulations. In addition, it supported contracting staff members for key posts, including the first Director of CARPHA, the Director of Institutional Services, and the Director of Surveillance and Research.

22. The other missions CAREC programmed for the fourth quarter of 2012 were carried out in accordance with the transition plan. This made it possible for the transition to take place efficiently and in an orderly manner without interruptions to the services CAREC has provided to its Member States.

Caribbean Food and Nutrition Institute (CFNI)

23. CFNI maintained its technical support for the member countries in 2012, while at the same time it worked with CARICOM on the various subjects and processes necessary for an efficient and orderly transition to CARPHA. As noted in previous paragraphs, the transition from CFNI to CARPHA took place on 31 December 2012.

24. PAHO will continue to offer technical cooperation to the Member States in accordance with its mandates and regional and subregional commitments, but some cooperation functions will be transferred to other entities of the Region, for example, universities, United Nations agencies, nongovernmental organizations, and collaborating centers. In this regard, PAHO will promote partnership and network consolidation.

25. The technical documents of CFNI were transferred to the library of the University of the West Indies (UWI) and digitized in order to make them available to the countries.

26. The office of the PAHO/WHO Representative Office in Jamaica was transferred to the CFNI building on the UWI campus.

Action by the Executive Committee

27. The Executive Committee is asked to take note of this progress report and to make the additional recommendations that it considers pertinent.

References

1. Pan American Health Organization—Pan American Foot-and-Mouth Disease Center. Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA) – Action Plan 2011-2020. PANAFTOSA; Rio de Janeiro (Brazil): PAHO; 2011 [consulted 9 March 2012]. Available at: <http://bvs1.panaftosa.org.br/local/File/textoc/PHEFA-PlanAccion-2011-2020ing.pdf>.