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PROGRESS REPORTS ON TECHNICAL MATTERS

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A. STRATEGY AND PLAN OF ACTION ON CLIMATE CHANGE

Background

1. This report provides an update on the progress made during the first two years of the implementation of the Strategy and Plan of Action on Climate Change *(1).* The report focuses on the progress achieved towards the four overall objectives: evidence; awareness raising and education; partnerships; and adaptation. The report is based on the findings of two key workshops that addressed implementation of the Strategy and Plan of Action at the end of 2013: one held in Mexico for all countries in the Region, with 24 participating countries; and the other in Barbados for the Caribbean, with 14 participating countries. The report also draws on information from a questionnaire sent to countries regarding their implementation of actions (18 responses to date). All combined, this includes input received from 33 countries.

Update on Progress Achieved

2. The Strategy provides an agreed set of common activities needed to advance work on climate change. The Strategy has motivated countries where no or very few activities were being carried out. Table 1 shows factors that are facilitating implementation of the plan of work, factors that are hindering progress, and factors required to overcome difficulties, as identified by the countries (not all factors apply to all countries).

3. ***Evidence*** *(Promote and support the generation and dissemination of knowledge to facilitate evidence-based actions to reduce health risks associated with climate change)*: Guides on vulnerability assessment and adaptation have been developed and disseminated widely in English, Spanish, and Portuguese. Ten countries in the Region submitted national communications to the United Nations Framework Convention on Climate Change (UNFCCC) during 2012-2013; all of them included reports on health, some with detailed analyses *(2)*. There has been limited progress on the evaluation of greenhouse gas emissions in the health sector. However, the Smart Health Facilities Initiative includes the reduction of carbon emissions in its aims for safe and green facilities.

4. ***Awareness Raising and Education*** *(Raise awareness and increase knowledge of the effects of climate change on health in order to facilitate public health interventions)*: Several courses and awareness-raising activities were supported, including a course for MERCOSUR countries in Uruguay and one for Andean countries in Ecuador; a module in the Pan American Health Organization's (PAHO) Edmundo Granda Ugalde Leaders in International Health Program; as well as many national courses. Several countries have developed awareness-raising campaigns aimed at the general population. The workshops in Mexico and Barbados were useful in increasing knowledge and awareness among key participants from ministries of health. A community of practice on health and climate change was launched in partnership with the United Nations Environment Programme

(UNEP) and the National Institute of Public Health in Mexico, and work started with online seminars.

5. ***Partnerships*** *(Promote policies and interventions in and between countries in coordination with other agencies and sectors)*: PAHO collaborated effectively with other UN partners, including UNEP in a workshop in Mexico. Activities were developed and implemented with national agencies (e.g. a multi-country training workshop in Ecuador); with Collaborating Centers (e.g. with NIEHS at a side event during the UNFCCC Conference of the Parties in 2013); with the Amazon Cooperation Treaty Organization (e.g. an ACTO workshop on climate change and health in Manaus); and with the Convention on Biological Diversity regarding the interlinkages between climate change, biodiversity, and health (e.g. two Regional workshops, one for the Americas and one in collaboration with AFRO). PAHO also contributed to the reports submitted by the World Health Organization (WHO) to the UNFCCC. Continuing work with partners includes development of instruments to compile and disseminate information as well as networks for information exchange.

6. ***Adaptation*** *(Support the evaluation of the population's vulnerability to climate change and identify adaptation interventions)*: PAHO supported countries in their vulnerability assessments under different projects and with other partners. Several countries include health in their national adaptation plans, and some have completed or started health sector-specific adaptation plans. PAHO is contributing to the work of the newly created WHO/World Meteorological Organization joint office for climate and health with regional pilot projects.

Action Necessary to Improve the Situation

7. Based on the consultations, PAHO will continue to work to identify success factors and best practices as highlighted in Table 1, in particular during the next biennium. This work will focus on implementing feasible actions required for success under: *a)* evidence, the development of vulnerability indicators and vulnerability assessments; *b)* awareness Raising and Education, supporting national and regional capacity-building efforts; *c)* partnerships, strengthening newly established networks; and *d)* adaptation, continuing the support for national adaptation plans.

Action by the Directing Council

8. The Directing Council is requested to take note of this progress report and make any observations it considers pertinent.

Table 1. Summary factors influencing progress in implementing the Strategy and Plan of Action in the Region

	Facilitating factors	Hindering factors	Factors required for success
Evidence	Increasing scientific evidence on climate change and health links. Increased understanding of the concepts of social and environmental determinants.	Insufficient country-level evidence. Current evidence not fully utilized in the health sector. Insufficient involvement of government institutions.	Health vulnerability indicators and vulnerability assessments to guide actions. Strengthening of norms to reduce vulnerability and risks. Public health-based criteria to guide investments.
Awareness raising and education	Increasing political will. Increased information and outputs by scientific groups. Actions led by international agencies, including limited but targeted funding.	Insufficient human resources and frequent movement of personnel. Lack of appropriate information dissemination. Limited participation of youth and of social networks. Lack of leading institutions in the topic area.	Regional human resource development. Educational programs tailored to decision makers, children, and the community at large. Regional seminars on the topic. Empower the health sector to be more inclusive and proactive.
Partnerships	Increased national interagency activities. Increased activities of current international alliances.	Population not involved in the issues. Delay in policy implementation. Lobbying by greenhouse gas producers.	Health in all policies. Improve intersectoral participation. Local government involvement, with community participation. Networks to facilitate action.
Adaptation	National adaptation plans increasingly include health. Some countries are developing health sector-specific action plans.	Some countries stress mitigation over adaptation. Plans lack funding. Lack of a sector approach. Low budgets for health.	Stress preventive action. A health agenda included in climate change policies. Develop action plans based on successful examples.

References

1. Pan American Health Organization. Strategy and plan of action on climate change [Internet]. 51st Directing Council of PAHO, 63rd Session of the WHO Regional Committee for the Americas; 2011 Sep 26-30; Washington (DC), US (Document CD51/6) [cited 2014 April 14]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=14471&Itemid

2. United Nations Framework Convention on Climate Change. Non-Annex 1 national communications [Internet]. Bonn (Germany): UNFCCC; 2014 [cited 2014 Apr 14]. Available from: https://unfccc.int/national_reports/non-annex_i_natcom/items/2979.php

B. PLAN OF ACTION FOR MAINTAINING MEASLES, RUBELLA, AND CONGENITAL RUBELLA SYNDROME ELIMINATION IN THE REGION OF THE AMERICAS

Introduction

1. This report presents the Governing Bodies of the Pan American Health Organization/World Health Organization (PAHO/WHO) with the evidence related to the interruption of endemic circulation of the measles and rubella viruses in the countries of the Americas. This report also discusses the progress made in the implementation of the Plan of Action for maintaining elimination in the Americas.

Background

2. The 27th Pan American Sanitary Conference (2007) adopted Resolution CSP27.R2, which urged the Member States to establish national commissions in each country to document and verify measles, rubella, and congenital rubella syndrome (CRS) elimination. Creation of an International Expert Committee (IEC) was also requested in order to document and verify regional elimination.

3. Furthermore, in order to maintain measles, rubella, and CRS elimination, the 28th Pan American Sanitary Conference (2012) adopted Resolution CSP28.R14 for implementation of an emergency plan of action for the next two years.

Situation Analysis

4. Measles and rubella elimination is defined by PAHO/WHO as the interruption of endemic transmission of these viruses for a period of at least 12 months, in the presence of high-quality surveillance. To confirm elimination of these diseases and sustainability of the elimination, countries had to document interruption for a period of at least three years from the last known endemic case. In order to verify the elimination, an independent International Expert Committee (IEC) along with 23 national commissions were established, including one for the French Overseas Departments of the Americas and one subregional commission for English-speaking and Dutch-speaking Caribbean countries and territories, including Suriname.

5. Each national commission reviewed and approved the reports on elimination, which were submitted to the IEC through PAHO/WHO. These reports were reviewed by the IEC and countries received feedback for improvement of the final version.

6. IEC members visited eight countries to assess the progress made and to identify any challenges faced in maintaining the elimination. In addition, countries that presented sustained outbreaks of measles in the period 2011-2014 or that identified sporadic cases

of rubella during retrospective searches, received special monitoring with national authorities.

7. No fewer than five meetings were organized between the IEC and all the national commissions to analyze the epidemiological trends of measles and rubella and to monitor advances toward verifying their elimination. These meetings were also used to continue advocating for maintaining elimination.

8. In their reports on elimination, the national commissions and the sub regional commission presented evidence indicating the interruption of endemic transmission of the measles and rubella viruses in their countries and territories. The evidence—studied by the IEC at its fifth meeting, held in April 2014—is the following:

a) Member States documented the last case of endemic transmission of measles and rubella in their countries and territories. No endemic measles cases were reported between 2002-2013 in countries and territories. The last endemic cases of rubella and CRS were on 3 February 2009 and 26 August 2009, respectively.

b) From 2003 to 2013, low numbers of measles cases associated with importations were reported in the Americas. These imported cases were associated with widespread measles outbreaks in Europe and Africa.

c) There have been few rubella cases reported associated with importations for the period 2009–2013. In 2012, three import-associated cases of CRS were reported.

d) In the period 2009-2013, the Region, on average, met the targets for four of the five epidemiological surveillance indicators[1] (>80%) on a continuous basis (83-91%).

e) Given the differences among and within countries in terms of sustained achievement of surveillance indicators, 16 of 23 countries with national commissions carried out active institutional and community case-finding in the period 2010-2013, to document the absence of measles and rubella cases in their territories. No case of measles and rubella was confirmed.

f) For the same period, and with the purpose of documenting the absence of CRS cases, 16 of 23 countries with national commissions carried out retrospective searches for suspected cases, using several sources of information. No case of CRS was confirmed.

g) Genotype D9 was isolated in the last endemic outbreak of measles reported in Colombia and Venezuela in 2002. For the period 2009-2013, genotypes D4 and D8, which mainly circulate in Europe, have been found in 88% of outbreaks; while genotype B3, which circulates mainly in Africa, was identified in the longest outbreak (Ecuador 2011-2012).

[1] The indicators are: % sites reporting weekly; % of cases with adequate investigation (indicator made up of % of cases with household visit within 48 hours following reporting, and % of cases with the following eight data points); % of cases with adequate blood specimen; % of blood specimens received in laboratory in ≤5 days; and % of laboratory results reported in <4 days.

h) Rubella virus genotype 2B was identified in the last endemic outbreaks reported in Chile and Argentina in 2008-09. For the period 2009-2013, reported genotypes 1E, 1G, 1J, and 2B have been linked to imported cases.

i) The countries presented an analysis showing that all cohorts aged ≤40 years were vaccinated against measles and rubella. From 1994 to 2013, nearly 500 million people were vaccinated in catch-up campaigns (<15 years), follow-up campaigns (in general, for children aged 1–4), and speed-up campaigns (in general, for people aged 20–39).

9. The most recent epidemiological data indicates reintroduction of measles virus in two states of Brazil, which has been circulating for more than 1 year (2013-2014). **The IEC awaits the control of this outbreak, to declare the elimination of measles in the Americas**. Rubella and CRS elimination has been sustained in the Americas.

10. Brazil has conducted a measles vaccination campaign aimed at children under 5 and intensified vaccination activities among vulnerable groups in the affected states, and has increased the epidemiological surveillance. Further activities are planned and PAHO will be supporting efforts to halt the outbreak.

Sustainability of Measles, Rubella, and CRS Elimination

11. In compliance with Resolution CSP28.R14 (2012), 20 national commissions presented an elimination sustainability plan for the period 2013-2015, to address challenges identified in their epidemiological surveillance systems and routine vaccination programs.

12. Maintaining elimination requires ≥95% coverage with two doses of MMR or MR[2] at the municipal level. In order to achieve the highest possible coverage with MMR2, in 2013, the **Technical Advisory Group (TAG)** on Vaccine-preventable Diseases recommended administering MMR2 at 15-18 months, simultaneously with other vaccines in the regular program. The follow-up campaigns should be waived only where ≥95% coverage with each of the two MMR doses is guaranteed for all municipalities. Five countries implemented follow-up campaigns in 2012 and 2013, while eight countries will do so in 2014 and 2015.

13. The IEC recognizes the efforts of Member States to strengthen surveillance systems to minimize importation of measles and rubella virus, while sustaining the elimination status. As evidenced by the lack of measles transmission following major international events, such as the Soccer World Cup 2014 in Brazil and the U-20 World Cup in Colombia.

[2] MMR: measles-, mumps-, and rubella-containing vaccine.
MR: measles- and rubella-containing vaccine.

Call to Action (Next Steps)

14. The IEC recognizes the success of measles and rubella elimination in the Americas and calls upon the Member States and strategic partners to continue their efforts to sustain elimination. To this end and in light of recent outbreak experiences, the Member States are requested to:

a) Ensure the implementation of actions aimed at maintaining elimination and progressively integrate them into their annual immunization plans.

b) Continue to support the implementation of vaccination strategies (routine program and follow-up campaigns as indicated) to ensure high and uniform population immunity levels, as outlined in the annual plans.

c) Maintain a high-quality epidemiological surveillance system, including early case detection, data analysis, monitoring coverage and rapid response to measles and rubella importation.

d) Strengthen epidemiological and programmatic capacity at the local levels.

e) Improve risk communication activities to promote the benefits of vaccination.

15. The IEC recommends that the Brazilian national authorities implement all necessary measures to immediately stop the current measles outbreak. The IEC and PAHO stand ready to offer any type of assistance, if needed.

Action by the Directing Council

The Directing Council is invited to take note of this IEC report and support the recommendations contained therein.

C. PLAN OF ACTION TO ACCELERATE THE REDUCTION IN MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY

Background

1. In 2011, the 51st Directing Council of the Pan American Health Organization adopted resolution CD51.R12 “Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity” (referred to in this document as “the Plan”). The Plan was intended to help the Member States achieve three main objectives: *a)* helping to accelerate the reduction in maternal mortality; *b)* preventing severe maternal morbidity; and *c)* strengthening the surveillance of maternal morbidity and mortality *(1)*.

2. Monitoring and evaluation will make it possible to identify the corrective measures needed to achieve the expected outcomes; furthermore, it will be a relevant input for other global and regional strategies, such as monitoring Millennium Development Goal 5 and the issues under consideration by the Commission on Information and Accountability for Women’s and Children’s Health 2011 *(1, 2)*.

Progress Report

3. This progress report presents the regional trends of three impact indicators and 19 process or outcome indicators in Member States with at least 7,000 annual births (27 countries) *(1–4)*.

4. The data used to develop the baseline were obtained between January and December 2012; and the data for measuring the trends of these indicators were obtained between December 2013 and March 2014.

5. Information was obtained from 26 of the 27 countries; however, to measure the trend of the maternal mortality ratio (MMR), information was available from only 23 countries (Annex A).

6. Between the date of approval of the Plan and this report, the impact indicators indicated the following:

a) The regional MMR (data from 23 countries) has fallen from 67.9 per 100,000 live births to 56.6, a reduction of 21.4%. One country presented data from sentinel institutions instead of national data.

b) With regard to identifying inequities within countries, half of the countries (11 out of 23) reported MMR figures equal to or above 125 per 100,000 live births in different subnational areas; seven countries reported that mortality in ethnic populations was higher than the national level; 12 countries reported lower mortality than the reference value; and seven did not have data.

c) The other impact indicator is for severe maternal morbidity (SMM). On the baseline, 10 countries reported monitoring SMM; today, 14 countries have

national data. However, for nine of these countries the data does not appear to be coherent, based on the expected frequency of this event in relation to maternal mortality *(5)* (Annex B).

7. None of the countries is in a position to give a full report on all 19 process and outcome indicators. Since the beginning of the plan, only four of 24 countries gave responses concerning 80% or more of the requested indicators (Annex C). The indicators with the lowest response levels are: *i)* use of magnesium sulfate in cases of severe preeclampsia (12%); *ii)* screening for family violence in institutional childbirth (27%); *iii)* proportion of use of oxytocics during the third stage of labor (35%); and *iv)* postpartum care (44%). Of these indicators, *i* and *iii* are highly important, since they are related to the two leading causes of maternal mortality (hypertensive disorders in pregnancy and hemorrhages). Monitoring of the rate of use of modern contraceptive methods was available in only 58% of the countries; many countries take this information from demographic and health surveys which, due to their frequency, have not been updated since the Plan began. These indicators are based solely on national information, in some cases broken down by age groups and in others by ethnic factors or by area of residence *(3, 4)*.

Recommended Measures to Improve the Situation

8. Take action to improve health care access and quality in health systems serving populations in conditions of vulnerability. Breaking down the information as outlined in the Plan will make it possible to evaluate trends and make adjustments to actions, if necessary.

9. It is essential to systematically improve the analysis of severe maternal morbidity in order to increase the quality of maternal health care. Monitoring this will make it possible to determine the number of women who have been on the verge of dying and to implement the necessary improvements.

10. By monitoring the process indicators at their health institutions, Member States will be able to evaluate universal access to life-saving interventions of proven effectiveness, and ensure that this access is provided.

11. Countries should consider routinely collecting process indicators that measure inequities in the delivery of quality services, in order to uniformly measure the degree of progress made and to facilitate comparability among and within countries.

Action by the Directing Council

12. The Directing Council is requested to take note of this progress report and to formulate the relevant recommendations.

Annexes

References

1. Pan American Health Organization. Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity [Internet]. 51st PAHO Directing Council, 63rd session of the WHO Regional Committee for the Americas; 2011 Sep 26-30; Washington (DC), USA. Washington (DC): PAHO; 2011 (Resolution CD51.R12] [cited 2014 Feb 13]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=15033&Itemid=

2. Centro Latinoamericano de Perinatología, Salud de la Mujer y Reproductiva. Plan de acción para acelerar la reducción de la mortalidad materna y la morbilidad materna grave: estrategia de monitoreo y evaluación [Internet]. Montevideo: CLAP/SMR; 2010 (CLAP/SMR. Publicación Científica 1593) [consulted 13 February 2014]. Available from: http://www.paho.org/clap/index.php?option=com_content&view=article&id=174&Itemid=1

3. Centro Latinoamericano de Perinatología, Salud de la Mujer y Reproductiva. Plan de acción para acelerar la reducción de la mortalidad materna y la morbilidad materna grave: línea de base del plan en países con más de 7000 nacimientos anuales. Montevideo: CLAP/SMR; 2012 (unpublished material, available on request).

4. Centro Latinoamericano de Perinatología, Salud de la Mujer y Reproductiva. Plan de acción para acelerar la reducción de la mortalidad materna y la morbilidad materna grave: datos en países con más de 7000 nacimientos anuales a dos años de lanzado el plan. Montevideo: CLAP/SMR, 2014. (unpublished material, available on request).

5. Tunçalp O, Hindin MJ, Souza JP, Chou D, Say L., The prevalence of maternal near miss: asystematic review. *BJOG* 2012 May;119(6):653-661.

Annex A

Mortality ratios reported in baseline and monitoring reports, by country, year, and source

Countries	Maternal Mortality Ratio (100,000)	Absolute No. Maternal Deaths	Year	Maternal Mortality Ratio (100,000)	Absolute No. Maternal Deaths	Year
Argentina	39.8	302	2011	34.9	258	2013
Belize	41.8	3	2012	0.0	0	2013
Bolivia	229.0	627	2003			
Brazil	67.4	2025	2012	60.9	1850	2013
Canada	4.8	18	2011			
Colombia	68.8	458	2011	53.6	348	2013
Costa Rica	29.9	22	2012	15.6	11	2013
Cuba	33.4	42	2012	38.9	49	2013
Chile	18.3	45	2012	22.6	57	2013
Ecuador **	60.2	205	2012	40.0	135	2013
El Salvador	50.8	53	2011	38.0	48	2013
United States of America	16.9	677	2010			
Guatemala	123.5	449	2012	118.5	445	2013
Guyana	143.9	21	2012	111.1	18	2013
Haiti *	1,084.4	751	2012	211.8	151	2013
Honduras	82.3	73	2010	66.1	146	2013
Jamaica	95.7	37	2011	91.1	36	2013
Mexico	42.3	960	2012	39.9	910	2013
Nicaragua	61.9	84	2011	51.0	71	2013
Panama	80.5	59	2011	64.9	49	2012
Paraguay	88.7	93	2011	95.3	101	2013
Peru	93.4	445	2011	63.4	379	2013
Dominican Republic	106.3	231	2011	113.0	236	2012
Suriname	39.4	4	2012	39.2	128	2013
Uruguay	10.4	5	2012	16.4	8	2013
Venezuela	68.3	401	2012	66.1	387	2013

* Reports only selected institutions; does not correspond to population data

** Year 2012 data on reported MM + active searches - year 2013 reported only

Legend	
(pink)	Countries that did not have data
(yellow)	Countries where MMR increased
(green)	Countries where MMR decreased

Annex B

Availability of impact indicators and of a monitoring and follow-up report on the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity

Country	MMR	MM by cause	MM by age	Severe Maternal Morbidity (SMM)	SMM by cause	SMM by age	MMR by subnational level	Urban/ rural MMR	MMR by ethnic group	Reporting rate
Argentina	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Belize	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Bolivia	NO	YES †	YES ‡	YES *	YES **	NO	NO	NO	NO	44%
Brazil	YES	YES	YES	NO	NO	NO	YES	NO	YES	56%
Canada	YES	YES	YES	YES *	YES	YES	YES	YES	NO	89%
Colombia	YES	YES	YES	YES	YES	YES	YES	YES	YES	100%
Costa Rica	YES	YES	YES	YES	YES	YES	YES	YES	YES	100%
Cuba	YES	YES	YES	YES	YES * **	YES * **	YES	YES	YES	100%
Chile	YES	YES	YES	YES *	YES **	YES	YES	YES	YES	100%
Ecuador	YES	YES	YES	NO	NO	NO	YES	NO	NO	44%
El Salvador	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
United States of America	NO	NO	NO	NO	NO	NO	YES	YES	YES	33%
Guatemala	YES	YES	YES	YES *	YES	YES	YES	NO	YES	89%
Guyana	NO	YES	YES	YES *	NO	NO	YES	YES	YES	67%
Haiti	YES §	NO	NO	YES	YES **	NO	YES	YES	YES	67%
Honduras	YES	YES	YES	YES *	YES **	YES	YES	NO	NO	78%
Jamaica	YES	YES †	YES	YES	YES **	NO	YES	YES	YES	89%
Mexico	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Nicaragua	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Panama	YES	YES	YES	NO	NO	NO	YES	NO	YES	56%
Paraguay	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Peru	YES	YES †	YES ‡	NO	YES **	NO	NO	NO	NO	44%
Dominican Republic	YES	YES	YES	NO	NO	NO	YES	NO	NO	44%
Suriname	YES	YES	YES	YES	YES	YES	NO	NO	NO	67%
Uruguay	YES	YES	YES	YES	YES **	YES	YES	YES	YES	100%
Venezuela	YES	YES	YES	YES *	YES **	NO	YES	NO	YES	78%
Reporting rate	88%	92%	92%	54%	54%	35%	88%	62%	73%	
Number of countries	23	24	24	14	14	9	23	16	19	

MM= Maternal Mortality, MMR= Maternal Mortality Ratio, SMM= Severe Maternal Morbidity.

§ Reports only selected institutions; does not correspond to population data.

† Causes of MM are reported, but with differences from the requested classification.

‡ MM by age is reported, but with differences from the requested classification.

* SMM data are reported, but more or less frequently than the expected interval (1).

** Causes of SMM are reported, but with differences from the requested classification.

***Data reported, but not available.

(1) Tunçalp O, Hindin MJ, Souza JP, Chou D, Say L., The prevalence of maternal near miss: a systematic review. BJOG. 2012 May;119(6):653-61.

Annex C: Availability of process indicators and of a monitoring and follow-up report on the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity

Summary table

COUNTRY	Number of indicators reported by country	%
Argentina	18	95%
Belize	15	79%
Bolivia	11	58%
Brazil	14	74%
Canada	12	63%
Colombia	10	53%
Costa Rica	16	84%
Cuba	16	84%
Chile	11	58%
Ecuador	9	47%
El Salvador	15	79%
United States of America	8	42%
Guatemala	8	42%
Guyana	12	63%
Haiti	9	47%
Honduras	15	79%
Jamaica	14	74%
Mexico	11	58%
Nicaragua	19	100%
Panama	13	68%
Paraguay	11	58%
Peru	12	63%
Dominican Republic	12	63%
Suriname	13	68%
Uruguay	16	84%
Venezuela	13	68%

Table on Strategic area 1

COUNTRY	Rate of use of contraceptive methods	Postpartum and/or post-abortion contraceptive counseling and provision of contraceptives by health services	Percentage of maternal deaths due to abortion	Prenatal coverage with four or more check-ups	Institutional coverage of deliveries
Argentina	X	X	X	X	X
Belize	X	X	X	-	X
Bolivia	-	X	X	X	X
Brazil	X	-	-	X	-
Canada	-	-	X	-	X
Colombia	-	-	X	X	X
Costa Rica	X	-	X	X	X
Cuba	X	X	X	X	X
Chile	X	X	X	-	X
Ecuador	-	-	X	-	X
El Salvador	-	X	X	-	X
United States of America	-	-	-	X	-
Guatemala	X	-	X	X	X
Guyana	X	-	-	X	-
Haiti	X	-	-	X	X
Honduras	X	X	X	X	X
Jamaica	X	X	X	X	X
Mexico	-	-	X	X	X
Nicaragua	X	X	X	X	X
Panama	X	X	X	X	X
Paraguay	-	X	X	-	X
Peru	X	-	X	X	X
Dominican Republic	-	X	X	-	X
Suriname	-	X	X	X	X
Uruguay	-	X	X	X	X
Venezuela	X	-	X	-	X
# countries that report	**15**	**14**	**22**	**18**	**23**
%	**58%**	**54%**	**85%**	**69%**	**88%**

Annex C *(cont.)*

Table on Strategic area 2

COUNTRY	Post-partum check-up 7 days after delivery	Use of oxytocics during the third stage of labor in institutional births	Use of magnesium sulfate in cases of severe preeclampsia/eclampsia in health facilities	Use of magnesium sulfate in cases of severe preeclampsia/eclampsia in health facilities	Screening for family violence during pregnancy (in institutional childbirth)
Argentina	-	X	X	X	X
Belize	-	X	-	X	-
Bolivia	X	-	-	-	-
Brazil	X	X	-	X	X
Canada	-	X	X	-	X
Colombia	-	-	-	-	-
Costa Rica	X	X	-	X	-
Cuba	X	-	-	X	-
Chile	X	-	-	-	-
Ecuador	-	-	-	-	-
El Salvador	X	X	-	X	-
United States of America	-	-	-	X	-
Guatemala	-	-	-	-	-
Guyana	-	-	-	X	-
Haiti	X	-	-	X	-
Honduras	X	-	-	X	-
Jamaica	-	X	-	X	-
Mexico	-	-	-	X	-
Nicaragua	X	X	X	X	X
Panama	-	-	-	-	-
Paraguay	-	-	-	-	X
Peru	X	-	-	X	X
Dominican Republic	X	-	-	-	-
Suriname	-	-	-	X	-
Uruguay	-	X	-	X	X
Venezuela	X	-	-	X	-
# countries that report	12	9	3	17	7
%	46%	35%	12%	65%	27%

Indicator available in less than half of countries

Table on Strategic area 3

COUNTRY	Caesarean section rate	Maternal deaths due to obstructed labor	Coverage of childbirth care provided by skilled personnel, as defined by WHO	Coverage of postpartum care provided by skilled personnel, as defined by WHO	Emergency obstetric care facilities that perform an audit of all maternal deaths
Argentina	X	X	X	X	X
Belize	X	X	X	X	X
Bolivia	X	X	X	-	-
Brazil	X	X	X	-	X
Canada	X	X	X	-	-
Colombia	X	X	X	-	-
Costa Rica	X	X	X	X	X
Cuba	X	X	X	X	X
Chile	X	X	-	-	-
Ecuador	X	X	X	-	-
El Salvador	X	X	X	X	X
United States of America	X	-	X	-	-
Guatemala	X	X	X	-	-
Guyana	X	X	X	X	X
Haiti	X	-	-	-	-
Honduras	X	-	X	X	X
Jamaica	X	X	-	-	X
Mexico	X	X	-	-	X
Nicaragua	X	X	X	X	X
Panama	X	X	X	X	X
Paraguay	X	X	X	-	-
Peru	X	-	X	-	-
Dominican Republic	X	X	X	-	X
Suriname	X	X	X	-	X
Uruguay	X	X	X	X	X
Venezuela	-	X	X	X	X
# countries that report	25	22	22	11	16
%	96%	88%	88%	44%	64%

Indicator available in less than half of countries

Annex C *(cont.)*
Table on Strategic area 4

COUNTRY	Public reports on maternal health that include national statistics on maternal mortality and MMR	Health system has a functioning perinatal information system	Health system keeps records of severe maternal morbidity	Over 90% coverage of maternal deaths in the vital records system	Number of indicators per country	%
Argentina	X	X	X	X	**18**	**95%**
Belize	X	X	X	X	**15**	**79%**
Bolivia	X	X	X	-	**11**	**58%**
Brazil	X	X	X	X	**14**	**74%**
Canada	X	X	X	X	**12**	**63%**
Colombia	X	X	X	X	**10**	**53%**
Costa Rica	X	X	X	X	**16**	**84%**
Cuba	X	X	X	X	**16**	**84%**
Chile	X	X	X	X	**11**	**58%**
Ecuador	X	X	X	X	**9**	**47%**
El Salvador	X	X	X	X	**15**	**79%**
United States of America	X	X	X	X	**8**	**42%**
Guatemala	-	-	X	-	**8**	**42%**
Guyana	X	X	X	X	**12**	**63%**
Haiti	X	X	X	-	**9**	**47%**
Honduras	X	X	X	X	**15**	**79%**
Jamaica	X	X	X	X	**14**	**74%**
Mexico	X	X	X	X	**11**	**58%**
Nicaragua	X	X	X	X	**19**	**100%**
Panama	X	X	-	X	**13**	**68%**
Paraguay	X	X	X	X	**11**	**58%**
Peru	X	X	X	-	**12**	**63%**
Dominican Republic	X	X	X	X	**12**	**63%**
Suriname	X	X	X	X	**13**	**68%**
Uruguay	X	X	X	X	**16**	**84%**
Venezuela	X	X	X	X	**13**	**68%**
# countries that report	**25**	**25**	**25**	**22**		
%	**100%**	**100%**	**100%**	**88%**		

D. STATUS OF THE MILLENNIUM DEVELOPMENT GOALS

1. In 2000, the 189 member countries of the United Nations signed the Millennium Declaration, which set eight Millennium Development Goals (MDGs); these goals were reaffirmed in 2010 at the United Nations Summit on the Millennium Development Goals. These goals refer to the eradication of poverty; universal primary education; gender equality; reduction of child mortality; improvement of maternal health; combating HIV/AIDS, malaria, and other diseases; environmental stability; and development of a global partnership for development.

2. This report covers progress in achieving the health-related MDGs and the latest advances toward meeting the commitments assumed during the 45th Directing Council in 2004, which adopted Resolution CD45.R3 on the MDGs and health targets (CD45/8); the report of the World Health Assembly (A63/7 and WHA63.15 [2010]); and the Millennium Summit resolution (A/65/L.1 [2010]) as it pertains to the Region of the Americas.

3. In response to requests in resolutions, the progress and milestones attained toward meeting the MDGs vary from one country to another, within each country, and from one goal to another. The analysis of the global and regional picture is based on country data available to WHO, complemented by statistical modeling to fill the data gaps. There is an urgent need to strengthen country health information systems in order to accurately monitor progress towards achieving the targets at global, national, and subnational levels.

Background

4. Although the Region of the Americas is well on its way to attaining the health-related MDGs, which include drinking water and sanitation as health determinants, these advances have been made at the national level and do not necessarily correspond to the progress made at the subnational level, since there are still areas and municipalities that remain completely outside the achievements of MDGs. The reasons is that the national averages tend to conceal major intra-country and inter-country disparities and that varying paces in progress toward meeting the goals continue to be characteristic of our Region.

5. In 2012, the Economic Commission for Latin America and the Caribbean (ECLAC) reported that an estimated 167 million Latin Americans live in poverty. Of this total, 66 million people live in conditions of extreme poverty with insufficient income for an adequate diet. As a result, eradication of chronic malnutrition continues to be unmet goal in some countries; chronic malnutrition tends to be concentrated in the interior municipalities and areas of countries *(1).*

6. With the adoption of Resolution CD45.R3 in 2004, the countries have implemented activities with support from the Organization's different technical areas, emphasizing measurement, quality, and monitoring of the progress made toward meeting the goals.

7. This progress report is based on data provided by the Member States and published annually by PAHO in the framework of the *Regional Core Health Data and Country Profile Initiative* (CD40/19 [1997], CD45/14 [2004] and CD50/INF/6 [2010]).

Analysis of the Current Situation

8. The analysis of the current status of the MDGs was based on the best official and reliable information in the Region from 1990 to 2013, which covers 92% of the time period allotted for achievement of the MDGs.

9. When routine data was not available, country estimates and international organization calculations had to be used, which do not always coincide. This progress report is based on data provided by the Member States and published annually by PAHO within the framework of the Regional Core Health Data and Country Profile Initiative (CD40/19 [1997]), inter-agency groups such as the UN Inter-agency Group for Child Mortality Estimation (coordinated by UNICEF), the Maternal Mortality Estimation Inter-Agency Group (coordinated by WHO), the WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation, and estimates from the Economic Commission for Latin America and the Caribbean (ECLAC/CELADE).

10. PAHO is implementing a strategy to strengthen vital statistics and health statistics (CD48/9 [2008]) with three components: *a)* work with countries to strengthen and improve data generation; *b)* coordinate with international agencies to avoid duplication; and c) apply different techniques or hypotheses to calculate indicators.

11. In 1990, the Latin American and Caribbean (LAC) **infant mortality** rate was 43 per 1,000 live births, and in 2012, 16 per 1,000, a reduction of 63%. MDG 4 is analyzed by mortality of children <1 year of age, since in the Region of the Americas this age group accounts for more than 70% of the deaths in children under 5.

12. According to estimates by the interagency group[1], the **maternal mortality** rate (MMR), which was 110 per 100,000 live births in the Americas in 1990, fell to 68 per 100,000 in 2013, for an overall reduction of 37%, or an annual average of -2.0%. Latin America, not including the Caribbean subregion, saw a 40% reduction in its MMR in the same period, while the reduction for the Caribbean was 36%. The data available show that maternal mortality continues to decline, but the magnitude of the changes in the last eight-year period (2005–2013) has not been as great as in previous periods. If the countries continue to accelerate their efforts at the same pace, 17 of the 31 countries in the Region are on track to meet the MMR commitment for 2015; 11 are making progress; two have failed to make sufficient progress; and one has made no progress. In 2012, a regional plan to accelerate the reduction of maternal mortality was approved and a strategy was adopted to incorporate the surveillance of severe maternal mortality.

[1] The study is based on statistics from: the Maternal Mortality Estimation Inter-Agency Group (MMEIG), "Trends in Maternal Mortality 1990-2013," coordinated by the World Health Organization and published in 2014.

13. Strategies contributing to decline in MMR include: expanded prenatal care coverage, delivery by skilled birth attendants, and access to and use of contraceptives. In countries where mortality rates are reported to be rising, increased rates could be due to improved monitoring and reporting of events and not necessarily to a real increase in number of deaths. The WHO is responsible for monitoring this indicator. (See footnote.)

14. Estimates of new **HIV infections** in the countries in the Region reflect a reduction in morbidity and mortality in the last decade. In 2012, about 6% of the total new HIV infections worldwide—that is, 146,000 cases—were reported in the Region. Of these, 86,000 occurred in Latin America, 48,000 in North America and 12,000 in the Caribbean. The Caribbean shows one of the biggest drops in new infections (down 52%) compared with 2001. The number of new infections in Latin America fell 11% in the same period while in North America they increased by 4%.

15. New infections in children show one of the greatest declines, supported by the commitment of countries to the Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. Coverage of pregnant women who receive antiretroviral drugs for preventing mother-to-child transmission reached 95% in the Caribbean and North America and 83% in Latin America in 2012, leading to reductions in the number of children with HIV, which between 2009 and 2012 dropped by 71% in the Caribbean and 29% in Latin America. North America maintained low stable levels.

16. Latin America and the Caribbean coverage in **antiretroviral treatment** was 75% in 2012. The goal is universal access to antiretroviral treatment (defined as 80% or more of those in need of treatment actually receiving it). The treatment coverage for children under 15 years old was 67% in 2012. However, the new treatment eligibility criteria for antiretroviral treatment published by WHO in 2013 recommend an earlier start of antiretroviral treatment, implying that a larger number of persons living with HIV are in immediate need of treatment. Further efforts to expand access to antiretroviral treatment are necessary, since the coverage rate drops to 48% under the new criteria. The countries of Latin America and the Caribbean are taking steps toward intensified action and expansion of successful approaches, with focus on the HIV care continuum. New targets have been set for the year 2020, pushing for earlier diagnosis (90% of persons living with HIV having received a diagnosis), earlier treatment of HIV (90% of persons eligible for treatment receiving ART) and effective viral suppression (90% of persons in treatment virally suppressed).

17. During 2000-2013, the Region reported a 59% reduction in **malaria** morbidity and a 72% reduction in malaria-related mortality. Of the 21 countries in which malaria is endemic, 18 reported a reduction by 2013, and of those, 13 registered reductions of over 75% and two others, reductions of over 50%. As of 2011, two countries, Argentina and Paraguay, reported that they had no cases of autochthonous malaria. In 2014 Argentina sent a request to the Director-General of the World Health Organization to initiate the process leading to certification of the elimination of malaria from the country. The countries in Central America and on the Island of Hispaniola adopted a resolution to eliminate malaria from their territories by 2020. This work is being

supported by a project financed by the Global Fund. At the same time, three countries in the Region—Guyana, Haiti, and Venezuela—reported increases in the number of cases during the period.

18. With respect to **tuberculosis**, according to WHO estimates for the Region of the Americas in 2012, the 35 Member States reported 79% of estimated TB cases. Nevertheless, multidrug resistance (MDR) and tuberculosis/HIV co-infection still pose a challenge, despite progress made toward their control. For the Region, the rate of reduction of TB incidence from 1990 to 2012 was 52%, with a 3.6% reduction between 2011 and 2012. In recent years the Region has been facing difficulties in reaching populations vulnerable to the disease, in the poor and marginal neighborhoods of large cities. As a result, in 2013, PAHO began application of a working framework for the control of tuberculosis in large cities to improve these populations' access to quality care. The Region of the Americas has already met and surpassed the targets of a 50% reduction in TB prevalence and mortality rates by 2015.

19. With respect to **sustainable access to safe water** in the Region of the Americas, in 2010, it was reported that 96% of the total population had access to improved water sources (99% in urban areas and 86% in rural areas). However, when only the LAC region is considered, access drops to 94% (98% in urban areas and 81% in rural areas). Of the 86% of households with access to piped water, there is no systematized data on water quality. In spite of this high percentage of coverage, many disparities persist, especially in suburban and dispersed rural areas, as well as among indigenous and African–descent populations.

20. The inter-agency group is responsible for measuring these two indicators, specific responsibility rests with UNICEF and WHO, which, through the WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation, utilize data from household surveys and censuses, with standardized definitions to ensure comparability over time and between countries.

21. The global MDG target for **sanitation** will likely be missed in the Region, despite the advancement of several countries. For the entire Region of the Americas, coverage with improved basic sanitation is 88% (91% in urban areas and 74% in rural areas), and for Latin America and the Caribbean alone the percentage is 80% (84% in urban areas and 60% in rural areas). Some 109 million people in Latin America and the Caribbean have no access to improved sanitation, and of these, 30.4 million still have no access to a toilet or latrine.

22. Many people continue to face a scarcity of **medicines** in the public sector, forcing them to the private sector where prices can be substantially higher. In the Region of the Americas, only 22 countries (71%) have adopted a pharmaceutical policy, and implementation plans are under way in 66% of these countries. Countries have made important strides in improving regulatory frameworks and developing regulatory systems to ensure the quality, safety and efficacy of medicines and other health technologies. Countries are strengthening national processes to assess medicines and medical products and define mechanisms for the systematic incorporation of health technologies in health systems, thus supporting progress towards

universal health coverage. Out-of-pocket expenditure remains high; 78% represents private out-of-pocket cost, while moneys spent on pharmaceutical products by public institutions correspond to approximately 22% of this category. Annual per capita expenditure on medicines in the countries in the Region varies considerably, from an estimated US$ 7.50[2] in Bolivia to more than $160 in Argentina. Lack of reliable information on effective access to medicines remains a challenge because it is difficult measure.

Progress in the Commitments

23. The following strategic lines for MDG achievement, established in 2011, continued to be pursued: *a)* Review and consolidation of information systems; special attention has been given to improving data production and collection among the Caribbean's English-speaking countries; *b)* Strengthening of systems based on primary health care (PHC), giving priority to the most vulnerable municipalities 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; and *d)* Public policy-making to ensure the achievements' sustainability and reaffirm "health in all policies."

24. In addition, the following actions continue to be promoted*: a)* joint efforts among countries in the Region; considering that some must speed up activities underway particularly for the targets that lag behind, such as the safe motherhood initiative, and progress to achieve water as a universal human right; *b)* continue PAHO's leadership role in monitoring and technical cooperation to improve performance of PHC-based health systems and promote water and sanitation systems; and *c)* strengthening of health information systems to make increasingly valid, reliable and real-time data available through routine systems.

Action by the Directing Council

25. The Directing Council is requested to take note of this status report at 15 months before the target date for the MDGs, and it is asked to give its comments and suggestions so that the work of PAHO in this line of technical cooperation can proceed and further promote achievement of the health-related MDGs.

26. The Member States are requested to intensify and scale up their efforts to decrease the existing gaps in achieving the MDGs through pointed actions and the intensification of national and subnational initiatives to comply with the accelerated plans already approved (CD51.R12 [2011], CD48.R10 [2009]).

27. The Ministries of Health of the Region are called upon to consolidate information systems through the Basic Health Indicators initiative, with emphasis on data at the subnational level and from the perspective of social determinants. At the same time, it is important to focus on monitoring the indicators of equity in order to better understand and address the MDG

[2] Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

challenges at the subnational level and move forward with strategies aimed at universal health coverage in order to guarantee the right to health.

28. It is recommended that the final report on MDG achievement in the Region be submitted in 2015 as well as a continuation strategy for post-2015 at the regional, national and subnational levels in order to continue advancing the targets, goals and indicators that have lagged behind.

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E. ELIMINATION OF NEGLECTED DISEASES AND OTHER POVERTY-RELATED INFECTIONS

Background

1. Since the adoption of PAHO Resolution CD49.R19 on the elimination of neglected diseases and other poverty-related diseases in 2009**,** there has been a growing global and regional commitment to the control and elimination of many neglected diseases and other poverty-related infections (in this report, referred to as NIDs). New partnerships have been formed, such as the PAHO/UNICEF Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Syphilis in Latin America and the Caribbean (2009) and the London Declaration on Neglected Tropical Diseases (2012), which supports the elimination of 10 of these diseases globally by 2020. In 2010, the PAHO Directing Council passed Resolution CD50.R17, a Strategy and Plan of Action for Chagas' Disease Prevention, Control and Care, providing a framework to prevent transmission, improve patient care, and reach the elimination goal. In that same year, the PAHO Directing Council approved Resolution CD50.R12, the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis, with a goal to reduce the incidence of congenital syphilis to ≤ 0.5 cases per 1,000 live births by 2015.

2. In 2011, PAHO Resolution CD51.R9, Strategy and Plan of Action for Malaria, was approved. In the meantime, efforts to reduce the burden of malaria and promote its elimination in parts of the Region have principally been financed by national governments, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the United States Agency for International Development, with support by the endemic countries. In addition, PAHO developed a plan of action 2014-2018 for the elimination of dog-transmitted human rabies *(1)*, which has been supported by the 14th Meeting of Directors of National Programs for Rabies Control in Latin America (REDIPRA-14) of the Ministries of Health and Agriculture of the Americas (Lima, 20-22 August 2013).

3. The political commitment to NID elimination has also increased in AMRO and other WHO regions, accompanied by reassignment or commitment of resources to scale up control, elimination, and monitoring of impacts. The development and availability of new tools and methods to combat and monitor NIDs, the improvement of health service infrastructure, and the implementation of primary care strategies have made it possible to improve surveillance, treatment, prevention and control of NIDs. Selected diseases have now even become targets for elimination.

Update on Progress Achieved

Progress

4. In our Region, WHO verified the elimination of onchocerciasis in Colombia in 2013, and the same is anticipated for Ecuador in 2014. The number of people needing

treatment for onchocerciasis in the Region has dropped from over 336,000 in 2009 to just over 20,000 in 2013. The number of onchocerciasis foci with active transmission has dropped from 7 to 2 foci in the same period (PAHO NID program data as of 2014, CHA/VT/NID). Mexico is expecting to request verification of elimination of blindness due to trachoma in the near future, while Colombia recently confirmed that it is endemic for blinding trachoma and is treating patients. Since 2009 three countries have been removed from the WHO map of lymphatic filariasis-endemic countries (Costa Rica, Suriname, and Trinidad and Tobago), and three countries have significantly reduced areas of transmission (Brazil, Haiti, and the Dominican Republic), bringing them closer to elimination. Several countries in Central and South America have eliminated transmission of Chagas' disease by the principal domestic vector, and 20 of 21 endemic countries have 100% screening of blood banks (PAHO NID program data as of 2014, CHA/VT/NID).

5. The areas of malaria transmission in several countries have been reduced in size, with a 58% drop in malaria cases reported in 2012 compared with 2000. Seven[1] of the 21 endemic countries are now classified as being in the WHO pre-elimination phase *(2)* (PAHO regional malaria program data as of 2014, CHA/VT/MAL*)*. Of the seven, four are in Central and North America; and the others are in South America. As a result, in 2013 an initiative to eliminate malaria by 2020 in Mesoamerica and Hispaniola was publicly announced. The Regional Coordination Mechanism for HIV/AIDS was amplified to include malaria and tuberculosis as part of developing a Global Fund proposal for malaria elimination in Central America and Hispaniola.

6. Though still varying from year to year, reports on the numbers of at-risk children treated for control of soil-transmitted helminth infections has grown in several countries, and about 26.9 million children were reported treated in 2012 *(3)*.

7. Integrated plans of action for the control and elimination of multiple NIDs have been prepared by 17 countries (PAHO NID program data as of 2014, CHA/VT/NID). Specific plans for the elimination of certain NIDs in multicountry subregions (e.g., malaria in Mesoamerica and malaria and lymphatic filariasis in Hispaniola) have also been developed.

8. Cases of dog-transmitted rabies are delimited to a small number of well-defined geographic areas in a few countries. Since 1982, when the Regional Program for the Elimination of Human Rabies began, reported cases of rabies transmitted by dogs have decreased by ~95% (from 355 in 1982 to 10 in 2012) *(1).* Though only six countries reported cases between 2009 and 2012, and although the number of annual human fatalities remains low *(1)*, persistent pockets of transmission remain, leading to a sustained risk of infection for people in the Region. In Latin America, prevention of domiciliary transmission and prevention of human deaths from plague have been strengthened in the four countries with human cases and natural foci. Between 2010 and 2012, in Latin America only Peru reported confirmed cases of human plague (24 cases

[1] Argentina, Belize, Costa Rica, Ecuador, El Salvador, México, and Paraguay.

with some fatalities). A few suspect cases were reported in Bolivia *(4)*; and sporadic cases were reported in the USA through 2013.

9. With respect to infectious diseases of poverty affecting newborns, two are approaching elimination. As of 2013, 14 countries report having achieved the congenital syphilis target *(5)*. Reported cases of neonatal tetanus declined from 22 in 2011 to 11 in 2012 *(6)*.

10. The successes in this Region, such as onchocerciasis elimination, are being taken as learning models by WHO Headquarters and other WHO regional offices, following in the footsteps of success in eliminating smallpox, polio, measles, and rubella in the Americas. Our Region's remaining challenges are shared with other WHO regions.

Lessons Learned:

11. Among the principal lessons learned, we note:

a) Political/government support reflected in national budget increases for the health sector targeting the increased control and elimination of NIDs is the most important single factor for achieving public health goals.

b) Advocacy and technical cooperation provided by PAHO have been important in supporting countries to prioritize NIDs in national health agendas. Mobilization of seed funds was critical in supporting scale-up or expansion of control and elimination of NIDs (e.g., national surveys, plan of action design and implementation, dossiers for verification of elimination, advocacy with donors, and health sector staff training).

c) Development of regional guidelines for integrated control and elimination of NIDs, including malaria, accompanied by health worker training, have led to integrated implementation of actions to reduce the burden of these diseases.

d) Existing and new tools for monitoring and evaluation and for identification of financial gaps in national NIDs programs have facilitated the capacity of countries to plan and improve their control and elimination efforts.

e) New resolutions from the World Health Assembly and the Organization of American States on NIDs, coupled with expanded commitment by numerous partners in the donor and pharmaceutical communities, have facilitated advocacy efforts with decision-makers and strengthened national control and elimination efforts.

f) Development of integrated plans of action for NIDs has been facilitated by multidisease surveys—for example, combined field surveys for soil-transmitted helminths together with malaria, schistosomiasis, or lymphatic filariasis, or collective treatment of school-age children combined with mass screening for leprosy and blinding trachoma.

g) Prevention of new cases of dog-transmitted human rabies is best achieved by increasing the dog vaccination rate to reach the high coverage targets necessary for every high-risk community.

h) Elimination of congenital syphilis depends upon strengthened health promotion; early detection in pregnant women, their partners, and children, particularly in key populations; increased screening with rapid tests in primary health care settings; increased availability of supplies and medications (syphilis tests and penicillin) and timely treatment; intensified case surveillance; and reduction of the high burden of syphilis overall.

i) For the vaccine-preventable infectious diseases of poverty, elimination of neonatal tetanus depends principally on immunization (with tetanus toxoid) of women of child-bearing age.

Action Necessary to Improve the Situation

12. Countries need to make the final push to eliminate the NIDs as a public health problem in the Americas, taking every last step to reach the "endgame" of elimination to protect the health of the most vulnerable populations, among them the indigenous and Afro-descendent communities. It is important to continue to scale up actions to eliminate and control NIDs in target countries through development of integrated multidisease plans of action for the health sector and to strengthen political commitment to increase access to treatment and morbidity management in order to reach the "endgame." Progress will be made when authorities develop and implement integrated intersectoral programs, policies, and plans for NIDs at national and local levels in every endemic country or area, and by collaborating and developing agreements with key stakeholders and partners.

13. Authorities will need to facilitate the donation, importation, and access to (distribution of) medicines and improve case management for NIDs based on the best available science. In countries with migrant labor populations, there is need for increased cross-border (binational) collaboration on surveillance and elimination efforts for blinding trachoma, lymphatic filariasis, onchocerciasis, and malaria based on a gender and intercultural approach. In areas at risk for NIDs, appropriate authorities will need to address the environmental and social determinants of health as they relate to NIDs, including safe water and basic sanitation, drainage, health education, housing, and integrated vector management. Sustainability of resources and personnel is needed in order to accomplish reduction targets and elimination efforts and to prevent reintroduction in areas free of malaria and other NIDs.

14. Full coverage for early prenatal care, high maternal and neonatal immunization coverage, and safe birthing practices, accessed through integrated community health and reproductive services, are needed to eliminate neonatal tetanus. Intensified action is necessary for those countries where syphilis testing among pregnant women is under 70%. All countries require a continued emphasis on a health systems approach including

integration of prevention and control actions for congenital syphilis elimination with sexual and reproductive health interventions.

15. To prevent new human cases of dog-transmitted rabies, annual dog vaccination must reach the necessary vaccination coverage targets in all at-risk communities. In addition, postexposure prophylaxis must be available, particularly in high-risk areas, accompanied by intensified surveillance and training, together with improved communication and rapid action at all levels of the health system and with the animal health sector, thus promoting an intersectoral approach. Prevention of deaths from human plague depends on rapid case detection in the community, local capacity of health care personnel in the diagnosis, and proper hospital case management procedures, including the use of personal protective equipment by health staff.

16. Reaching our Region's goals for the control and elimination of neglected diseases and other poverty-related infections remains a priority for the Organization and the endemic countries through 2015 and beyond. Accompanying the countries' successes since 2009, as universal health care expands in the Region, more people will have access to prevention and treatment services for these diseases. Working inter-programmatically within the Ministries of Health and with the key stakeholders and partners, and with the support of adequate financing, the Region will continue to advance in the control and elimination of these diseases that affect millions of poor and underserved families.

Action by the Directing Council

17. The Directing Council is requested to take note of this progress report and make any observations it considers pertinent.

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F. PLAN OF ACTION ON SAFE HOSPITALS

Background

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on the progress made in implementing Resolution CD50.R15, Plan of Action on Safe Hospitals, adopted in October 2010. The Plan of Action seeks to facilitate Member States' adoption of "Hospitals Safe from Disaster" as a national risk reduction policy and urges them to work toward the goal of building all new hospitals with a level of protection that better guarantees that they will remain functional in disaster situations. It also calls for appropriate mitigation measures in existing health facilities.

2. Resolution CD50.R15 also requested the Pan American Sanitary Bureau (PASB) to submit periodic progress reports to the Governing Bodies on the implementation of the Plan of Action, which has six objectives, each with defined goals.

Update on Progress Achieved

Progress toward the goals

Objective	*Goals*	*Status*
1	By 2011, 80% of the countries will have established a national safe hospitals program.	24 countries (69%) have a formal safe hospitals program; 33 countries (94%) include disaster risk reduction in the health sector; 20 countries (57%) have a national safe hospitals policy.
2	By 2013, 90% of the countries will have an information system on the construction of new hospitals or the improvement of existing hospitals.	31 countries (89%) have a database of the hospitals assessed using the Hospital Safety Index.
3	By 2013, at least 80% of the countries in the Region will have established mechanisms for the supervision of hospital construction work and other investments in health facilities.	15 countries (43%) have formally established independent supervision mechanisms for hospital construction.
4	By 2015, all countries will have included measures that guarantee the operation of health facilities in the event of a disaster in all new health investment projects.	18 countries (51%) with new health investment projects have included safe hospital concepts in them.

Objective	*Goals*	*Status*
5	By 2015, 90% of the countries will have up-to-date standards for the design, construction, and operation of new, safe health facilities.	18 countries (51%) have up-to-date standards for the design of safe health facilities.
6	By 2015, at least 90% of the countries will have improved the safety of the existing health facilities in disasters.	34 countries (97%) are improving the safety of their health facilities by implementing disaster reduction interventions.

Challenges and Lessons Learned

a) The development and use of the Hospital Safety Index tool has enabled countries to transition from a purely qualitative system to a standardized scoring system. It provides national authorities with comprehensive information on the level of safety of their health services so that they can prioritize and implement interventions.

b) Even though many countries are allocating substantial funds for the implementation of corrective measures to improve the safety of health facilities, it is still a challenge to convey these priorities to the financial sector and to higher political and decision-making levels.

c) Despite the progress made, ensuring that all new health facilities are safe from disasters and improving the safety of existing facilities remains a major challenge.

d) Strengthening multisectoral participation of stakeholders both within and outside the health sector is critical for achieving success. For example, the countries with greater success in implementing the Safe Hospitals Initiative[1] are those where the national disaster management organization assumed an active role along with the health sector.

Action Necessary to Improve the Situation

a) Foster and guarantee inclusion of the provisions of the Safe Hospitals Initiative and Plan of Action into government policies.

b) Promote the strengthening of the health services network and the development of disaster response plans for the health sector and hospitals.

c) Strengthen capacities and certification of hospital safety assessment teams.

d) Create awareness within civil society on the importance of having hospitals and health centers that continue operating at their maximum capacity during

[1] PAHO Resolution CSP27.R14, Safe Hospitals: Regional Initiative on Disaster Resilient health Facilities (2007).

emergencies and disasters.

Action by the Directing Council

The Directing Council is invited to take note of this progress report and offer any recommendations it deems necessary.

G. 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 centers,[1] eliminated nine, and transferred the administration of one 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); and the Latin American Center for Perinatology/Women's and Reproductive Health (CLAP/WR).

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

3. To address the convergence of human, animal and environmental health, PAHO has been exercising hemispheric leadership in the sphere of zoonosis, food safety, and food security. The political and strategic directives for the Organization's technical cooperation in veterinary public health were defined by the 16th Inter-American Meeting at the Ministerial Level on Health and Agriculture (RIMSA 16), held in Chile in July 2012 with the theme "Agriculture, Health, and Environment: Joining efforts for the well-being of the Americas." RIMSA 16 approved the "Consensus of Santiago, Chile" which urged countries, among other things, to set up permanent mechanisms and platforms for intersectoral coordination and communication, as part of their efforts to manage risks to public health arising at the human-animal-environment interface, within the framework of the International Health Regulations and World Organisation for Animal Health (OIE) norms. Other important goals included the elimination of human rabies transmitted by dogs, and the eradication of foot-and-mouth disease from the Americas by 2020, within the framework of the Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA). RIMSA 16 also called on the countries to step up efforts and join forces to guarantee the production of safe and healthy food (which is essential for the prevention and control of both communicable and noncommunicable diseases), including the establishment of public-private partnerships. The importance of technical cooperation initiatives for national capacity-building was emphasized, and it was urged that such initiatives be implemented with improved interagency cooperation

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

and with the coverage and continuity required to achieve their objectives, targets, and results.[2]

Recent Progress

4. PANAFTOSA's technical cooperation is being implemented, as part of the work of the Department of Communicable Diseases and Health Analysis, by a technical team based in Duque de Caxias, Rio de Janeiro, and by three veterinary public health advisors based in the Andean, Central American, and Caribbean subregions. There have been important achievements in this biennium in the areas of food safety, foot-and-mouth disease, and other zoonosis.

5. With regard to food safety, a growing number of institutions in the Region are now contributing to regional intersectoral food safety networks for the prevention of foodborne diseases (e.g. the Inter-American Network of Food Analysis Laboratories (INFAL), the Global Foodborne Infections Network (GFN) and the PulseNet Latin America and Caribbean network); in particular, they are addressing the impact of antimicrobial resistance and promoting an integrated approach involving different actors and sectors (e.g. human and veterinary medicine, agriculture, and environmental and consumer sectors). The PulseNet Latin America and Caribbean network received the IHRC[3] PulseNet Innovations Award in 2013 "in recognition of [the] innovative use of instructional technology with the potential to significantly enhance the functionality of PulseNet in outbreak investigations". The challenge is now to maintain PAHO's excellence and relevance within the context of budgetary reductions in this area, while continuing to innovate and mobilize new resources. In addition, PANAFTOSA has been leveraging its unique technical capacity within PAHO to strengthen the collaboration between the World Health Organization (WHO), the Food and Agriculture Organization of the United Nations (FAO), and OIE for combatting antimicrobial resistance, in the spirit of the "One Health" approach.

6. Regarding zoonosis, the Center worked with experts from the Member States in establishing an action plan to eliminate dog-transmitted human rabies in the Americas (Clavijo et al., 2013), which was endorsed by the rabies program managers during the 14th Meeting of Directors of National Programs for Rabies Control in Latin America (REDIPRA 14) held in Lima, Peru, in August 2013. The follow-up to REDIPRA 14's recommendations includes, among other measures, a laboratory proficiency exercise (including the national reference laboratories), and the addition of the dog rabies vaccine in the PAHO revolving fund. The Center, in collaboration with the office of Procurement and Supply Management, is now collecting information on future vaccine demand. With respect to other zoonosis, the Center provided technical cooperation and capacity

[2] Pan American Foot-and-Mouth Disease Center of the Pan American Health Organization. Consensus of Santiago of Chile [sic] [Internet]. 16th Meeting at the Ministerial Level on Health and Agriculture; 26-27 July 2012; Santiago, Chile. Rio de Janeiro (Brazil): PAHO/PANAFTOSA; 2012 [accessed on 14 February 2014]. Available at: http://ww2.panaftosa.org.br/rimsa16/dmdocuments/RIMSA16(INF5)%20Consensus%20ingles.pdf

[3] International Health Resources Consulting, Inc.

building on leptospirosis, leishmaniasis, sylvatic rabies, and surveillance of the animal and vector reservoirs of yellow fever. The Center is also leading technical cooperation activities on the surveillance and control of hydatidosis in six countries.

7. With regard to foot-and-mouth disease (FMD), for the first time since the Center was established in 1951 there has been a 25-month period without any reported cases of FMD. This is a historic achievement for all the countries of the Hemisphere and for PANAFTOSA and PAHO/WHO. The challenges now faced are to maintain this accomplishment by moving forward towards an FMD-free Hemisphere without vaccination; to continue supporting the countries, particularly by introducing new surveillance and emergency response tools and mechanisms in order to address the growing susceptibility of the population to the FMD virus; and to strengthen Venezuela's national policy, strategy, and plan for FMD eradication.

Cooperation Agreements and Resource Mobilization

8. The Center has been able to mobilize voluntary contributions from sources specifically interested in foot-and-mouth disease eradication in South America and these contributions are supporting the Center's technical cooperation for regional coordination of PHEFA. An example is the National Animal Health Coordinating Association (ACONASA) of Paraguay, which has renewed its financial support to the trust fund established to facilitate financial contributions. In addition, other cooperation agreements are being negotiated with public entities in other Member States (e.g. Ecuador) in PANAFTOSA's areas of activity. Accordingly, the regular financial resources provided by the Organization to the Center have been channeled 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 (MAPA) continues to fully support the Center's maintenance costs. This contribution has been significantly increased in the last five years to offset a reduction in the Organization's contribution since the implementation of the Center's institutional development process began in 2010.

9. PAHO, through PANAFTOSA and the Secretariat for Health Surveillance of the Ministry of Health of Brazil, signed an annex to the technical cooperation agreement in 2012, contributing US$ 1,618,914[4] to strengthen the National Health Surveillance System and the management capacity of Brazil's Unified Health System in order to reduce the burden of zoonosis and of vector-borne, waterborne, and foodborne diseases on the human population. The technical cooperation agreement was renewed in 2013 and the amount of US$ 4,918,409 was added—a threefold increase since 2012. Other technical cooperation and financial agreements have been established with the Wellcome Trust (Sanger Institute) to build the professional capacity of health workers, and faculty and students of health-related professions such as medicine, microbiology, veterinary medicine, and nursing; with the Joint Institute for Food Safety and Applied Nutrition (JIFSAN) for cooperation on food safety; and with the Association of American Veterinary Medical Colleges (AAVMC) to build professional capacity in faculty and

[4] Unless otherwise indicated, all the monetary figures of this report are expressed in United States dollars.

students of health-related professions such as medicine, veterinary medicine, and nursing. A three-year project to build One Health leadership and develop the capacity of Caribbean veterinary diagnostic laboratories, funded by the European Union, is being implemented in partnership with the University of the West Indies, Trinidad and Tobago, and FAO. Collaboration has been strengthened with the veterinary public health working group of the Caribbean Animal Health Network (CaribVET) for the surveillance, prevention, and control of rabies, leptospirosis, and salmonellosis in the Caribbean following the One Health approach.

Review of PANAFTOSA Governance

10. During the 154th Session of the Executive Committee, the delegation of the Government of Brazil suggested studying the possibility of creating a governance mechanism for PANAFTOSA that would allow greater participation by the Member States: for example, the creation of an collegiate body with equal representation by the different subregions of the Organization, similar to the governance mechanisms in effect in BIREME. In response to this request, PAHO will initiate a process of consultations with Brazil and other Member States in order to study this proposal, and will report to the Governing Bodies on the progress and results of this process.

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

11. BIREME is a specialized center of PAHO founded in 1967 to channel the technical cooperation that the Organization provides to the countries of the Region in scientific and technical information on health.

12. BIREME's current institutional structure is characterized by the coexistence of the previous institutional framework (Agreement on Maintenance and Development of BIREME, in effect until 31 December 2014) and the new framework (Statute of BIREME, approved by the 49th Directing Council, in effect since 1 January 2010).

13. The Statute of BIREME calls for the establishment of a BIREME Headquarters Agreement, to be signed with the Government of Brazil, and an agreement on BIREME's facilities and operations, to be signed with the *Universidade Federal de São Paulo* (UNIFESP). Both agreements continue to be negotiated.

14. BIREME's governance structures currently include the Advisory Committee and the Scientific Committee (new framework), in addition to the National Advisory Committee (CAN) (previous framework). The three committees are operating efficiently.

15. PAHO and Brazil are permanent members of the BIREME Advisory Committee, which also comprises five nonpermanent members. The 28th Pan American Sanitary Conference selected Cuba, Ecuador, and Puerto Rico for the BIREME Advisory Committee, with a three-year mandate (2013-2015), replacing Argentina, Chile, and the Dominican Republic, whose mandates ended in 2012. The 51st Directing Council selected Bolivia and Suriname (2012-2014), replacing Jamaica and Mexico, whose

mandates ended in 2011. The 53rd Directing Council will select two members for a two-year mandate (2015-2016) to replace Bolivia and Suriname. The members of the Advisory Committee have held four working sessions since it was established. The fifth session is scheduled for the end of the second semester of 2014.

16. The Scientific Committee was established in July 2013 and is made up of five health information experts from Brazil, Canada, Honduras, and Trinidad and Tobago, as well as a representative of the National Library of Medicine (NLM) of the United States. The members of the Scientific Committee have held two working sessions since it was established. In the context of the objectives and expected results of the Committee, a virtual meeting was also held to strengthen communication among the members. The second session of the Committee was held on 14 August 2014.

Recent Progress

17. The fourth session of the BIREME Advisory Committee was held in BIREME's offices on 26 November 2013. The members of the Advisory Committee reaffirmed their ongoing support for the institutional development of the Center, which includes implementing the new institutional framework, establishing and signing the Headquarters Agreement, financing the work plans, and integrating the new Scientific Committee. Among the achievements of the 2012-2013 biennium, special emphasis was put on the results of the IX Regional Congress on Health Sciences Information (CRICS9) and the VI Coordination Meeting of the Virtual Health Library (BVS6), both events held at PAHO/WHO Headquarters in Washington, D.C. between 20 and 24 October 2012.

18. The following are the most significant components of the lines of action to finalize the implementation of BIREME's new institutional framework:

a) BIREME Headquarters Agreement: PAHO and the Ministry of Health of Brazil continued negotiations on the new Headquarters Agreement proposal presented by the Executive Secretariat of the Ministry of Health, until an agreement on a final draft was reached with the legal advisory service (CONJUR) of the Ministry of Health of Brazil at the meeting on 22 January 2014. It was agreed to send this version to the Ministry of Foreign Affairs of Brazil for approval, and to the National Congress of Brazil for final approval.

b) Agreement on BIREME's facilities and operations on the UNIFESP campus: Meetings continue to be held with the president of the university and designated authorities. Initially, the subject of these meetings was the institutional relationship between BIREME and UNIFESP, and the terms of the agreement; the meetings held in 2014 focused on a detailed review of the mutual responsibilities of BIREME and UNIFESP.

c) Definition of the financing mechanism for BIREME based on the contributions from PAHO and the Government of Brazil, stipulated in 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 of the Statute. The results

obtained by the Center in the last 18 months were presented at the second meeting of the National Advisory Committee (CAN) on the BIREME Maintenance and Development Agreement, held on 23 January 2014 at PAHO/WHO Brazil. The corresponding report was approved by representatives of the Ministry of Health of Brazil, the Secretariat of Health of the State of São Paulo (SES-SP), and UNIFESP. The Ministry's contribution to the maintenance and financing of the BIREME work plan for 2014 will be the same amount as in 2013: $3.8 million reais (approximately $1.7 million at UN dollar exchange rate in July 2014). This sum has been transferred to PAHO through a supplementary agreement to the BIREME Maintenance and Development Agreement, which has been signed by the parties (PAHO and the Ministry of Health of Brazil).

d) The BIREME biennial work plan (BWP) for 2014-2015, which is integrated into the BWP of PAHO's Department of Knowledge Management and Communication (restructured in 2014 as Knowledge Management, Bioethics, and Research), was prepared in coordination with this department, with which it coordinates its ongoing development and implementation.

e) In order to strengthen implementation of the new Statute of BIREME, approved by the Member States, PAHO is conducting an external evaluation of the Center, in which recommendations will be presented to the Director of the Bureau in late 2014.

Challenges

19. The upcoming challenges in this period include:

a) Completely implementing BIREME's new institutional framework in 2014, including the signing of the two main agreements that constitute it: *i)* the Headquarters Agreement with Brazil; and *ii)* the agreement with UNIFESP on BIREME's facilities and operations.

b) Updating the terms of the BIREME Maintenance and Development Agreement if the new institutional framework is not completely implemented in 2014; i.e. establishing a new agreement if so requested by the signatories (Ministry of Health of Brazil, SES-SP, and UNIFESP).

c) Adapting BIREME's cash flow needs to the goal of maintaining the Center's financial sustainability, given its two coexisting institutional frameworks—in particular, until its new institutional framework is completely implemented.

d) Holding negotiations for the prompt signing of the agreements to transfer the corresponding contributions for the maintenance of BIREME in the 2014-2015 biennium—in particular, the contributions from the Ministry of Health of Brazil.

Latin American Center for Perinatology/Women's and Reproductive Health (CLAP/WR)

20. 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. This agreement is renewed periodically and its latest extension is in effect until 28 February 2016. In a process of decentralization, the Center merged with the Women's Health unit in 2005, when it became the Latin American Center for Perinatology/Women's and Reproductive Health (CLAP/WR), and also began operating as a decentralized unit linked to the Family, Gender and Life Course (FGL) unit. The general objective of CLAP/WR is to promote, strengthen, and improve the capacities of the countries of the Region of the Americas with regard to health care for woman, mothers, and newborns.

Recent Progress

21. On 10 January 2014 the new Director/Unit Chief of CLAP/WR assumed her functions. The new management analyzed the available resources and implemented changes to reduce costs and favor a more efficient use of resources. Arrangements were also made to generate additional resources with extrabudgetary funds.

22. From the standpoint of the lines of work, the activities linked to the specific technical areas for which CLAP/WR is responsible have continued. The Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity is in the mid-term evaluation process, the baseline having been prepared and the state of the indicators evaluated two years after approval of the Plan. The complementary Perinatal Clinical History form for registering cases of extremely severe maternal morbidity in the Perinatal Information System (IAPA) has been validated, jointly with WHO and experts from 23 institutions in 12 countries of the Region. Ongoing support has been provided to the Latin American Federation of Societies of Gynecology and Obstetrics (FLASOG) for the promotion of human resources training in obstetric emergencies, in addition to collaboration with the International Confederation of Midwives (ICM) to support the training of educators in midwifery throughout the Caribbean.

23. CLAP/WR has participated in regional conferences in order to examine the progress made toward achieving the objectives of the International Conference on Population and Development, held in Montevideo in August 2013. As a part of technical support to the countries in the implementation of the reproductive health strategy, CLAP/WR, in collaboration with UNFPA, organized a regional meeting of 15 countries in El Salvador in October 2013: "Repositioning family planning in the context of universal access to sexual and reproductive health: MDG 5b." As a result, the two agencies will implement a work plan in the participating countries. Also, in May 2014, a "Family planning in the Caribbean" workshop was held in Grenada in collaboration with UNFPA and WHO.

24. The WHO publication "Safe abortion: technical and policy guidance for health systems" was translated into Spanish[5] and Portuguese[6] and disseminated in the countries of the Region (20,000 copies).

25. Within the framework of the strategy for the Elimination of Mother-to-child Transmission of HIV and Congenital Syphilis, information was consolidated and a scientific report was prepared on the relationship between congenital syphilis and the number of stillborn infants. The information contributed by the countries and other sources is currently being consolidated in order to update the situation map of syphilis in the Region of the Americas. The use of the rapid tests to diagnose syphilis using different algorithms has been discussed with the countries.

26. Based on the input from the mid-term evaluation of the Regional Plan for Newborn Health, progress was made in the preparation of instruments and technical guidelines to improve the quality of neonatal care associated with the main causes of mortality. A process was also initiated to generate information that will make the burden of prematurity more visible on the political agenda, and to prepare a regional map of the status of legislation and programs for neonatal screening. Finally, an instrument was developed to evaluate the implementation of evidence-based interventions to enable countries to assess improvements in practices associated with neonatal care.

27. With regard to the initiative to join the Center's facilities with the Representative Office in Uruguay, a floor is now being rented in the building where the PAHO/WHO Representative Office is currently located, so that both units can operate from there. The paperwork for the move is underway and studies of the financial cost of the physical merger are being carried out.

Action by the Directing Council

28. The Directing Council is requested to take note of this progress report and to formulate the relevant recommendations.

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[5] http://www.clap.ops-oms.org/web_2005/BOLETINES%20Y%20NOVEDADES/EDICIONES%20DEL%20CLAP/CLAP-Trad04.pdf

[6] http://www.clap.ops-oms.org/web_2005/BOLETINES%20Y%20NOVEDADES/EDICIONES%20DEL%20CLAP/CLAP-Trad04pt.pdf