



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



146th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 21-25 June 2010

Provisional Agenda Item 7.6

CE146/INF/6, Rev. 1 (Eng.)
11 May 2010
ORIGINAL: ENGLISH

PROGRESS REPORTS ON TECHNICAL MATTERS

CONTENTS

A	Implementation of the International Health Regulations (2005).....2 <i>Resolutions CSP27.R13 (2007) and WHA58.3 (2005)</i>
B	Update on the Pandemic (H1N1) 20097 <i>Document CD49/INF/2, Rev.1 (2009)</i>
C	Plan of Action for Strengthening Vital and Health Statistics11 <i>Resolution CD48.R6 (2008)</i>
D	Regional Core Health Data Initiative and Country Profiles16 <i>Resolution CD40.R10 (1997)</i>
E	WHO Framework Convention on Tobacco Control: Opportunities and Challenges for its Implementation in the Region of the Americas.....19 <i>Resolution CD48.R2 (2008)</i>
F	Implementation of the Regional Strategy and Plan of Action for an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet, Physical Activity and Health24 <i>Resolution CD47.R9 (2006)</i>
G	Elimination of Rubella and Congenital Rubella Syndrome.....35 <i>Resolutions CD44.R1 (2003), CD47.R10 (2006), and CSP27.R2 (2007)</i>

A. IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

Introduction

1. With the declaration of the 2009 (H1N1) pandemic as a public health emergency of international concern (PHEIC), implementation of the International Health Regulations (2005) (IHR) at the global level was put to the test. This action required concerted efforts on the part of the World Health Organization (WHO) and its Member States toward a common objective. Moreover, it showed the value of having a legal framework that facilitates the coordination of communications and response, as well as the need for continued progress in strengthening the ability to apply the IHR (2005) ever more effectively.

2. The purpose of this report is to give an account of the progress made by the Member States and PAHO toward fulfilling the commitments made in resolution WHA58.3 (2005) of the World Health Assembly. This resolution outlines the IHR (2005) implementation process. This report is divided into the seven areas of work¹ defined by WHO for implementation of the IHR (2005).

Promote Regional Partnerships

3. Through regional integration systems, the Member States have taken on a shared responsibility and play an active role in the implementation of the IHR (2005). In order to promote compliance with this commitment, support continues to be provided to Working Subgroup 11 (SGT-11) of the Southern Common Market (MERCOSUR), the Andean Regional Health Agency-Hipólito Unanue Agreement (ORAS-CONHU), the Special Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD), and the Caribbean countries through the Caribbean Epidemiology Center (CAREC).

¹ (i) Promote global partnerships; (ii) Strengthen national disease prevention, surveillance, control, and response systems; (iii) Strengthen public health security in travel and transport; (iv) Strengthen PAHO/WHO global alert and response systems; (v) Strengthen the management of specific risks; (vi) Sustain rights, obligations, and procedures; and (vii) Conduct studies and monitor progress.

4. Technical support for Working Subgroup 11 (SGT-11)² of MERCOSUR and ORAS-CONHU has focused on standardizing procedures for the implementation of IHR (2005), harmonizing the list of events considered to be of public health concern, and training rapid response teams. In Central America, implementation of the technical cooperation among countries (TCC) project agreed on by the Member States during HON-XXIV-RESSCAD-3 as a means of assessing basic surveillance and response capacities was completed, and strengthening of these capacities was included in the Agenda and 2010-2015 Health Plan approved by the Council of Central American Health Ministers (COMISCA). Countries and territories in the English- French- and Dutch-speaking Caribbean agreed to continue activities for effective implementation of the IHR (2005), with support from CAREC.

Strengthen National Disease Prevention, Surveillance, Control, and Response Systems

5. During this period, PAHO continued to support its Member States in assessing the capacity of their structures and resources and in developing action plans in line with those already in place in each country and with regional plans already in execution. The information available to date shows that 34 of the 35 Member States have completed the assessment of their surveillance and response capacities at the national level; 28 have prepared nationwide plans for strengthening these capacities; and 18 have assessed their capacities in points of entry.

6. The Member States have begun executing action plans for strengthening their capacities. In order to identify technical cooperation needs in this regard, a meeting of the heads of the national surveillance services of the Latin American countries was held in Lima, Peru. This led to the development of a list of technical support priorities, which were assessed and included in the 2010-2012 Biennial Work Plan for PAHO's project on prevention and control of communicable diseases. Furthermore, for the purpose of preparing a document on the guiding principles to make traditional national surveillance systems compatible with information searches to detect and respond to public health risks, as required in the IHR (2005), a workshop attended by 16 surveillance experts from various institutions³ was held at PAHO Headquarters in Washington, D.C.

² The Common Market Group (CMG) is divided into 15 Sub-working Groups (SWG) in order to meet the objectives of MERCOSUR. Within these SWGs, number 11 corresponds to the Health Subgroup, which was created by CMG Resolution 151 in 1996. SWGs prepare their negotiating agendas and send them to the CMG, which sets the priorities and prepares a timetable for their fulfillment.

³ The Public Health Agency of Canada; the U.S. Centers for Disease Control and Prevention; the European Center for Disease Prevention and Control; the heads of the national surveillance services of Chile, Costa Rica, El Salvador, and Mexico; as well as staff members from PAHO, the WHO Regional Office for Europe, and WHO headquarters in Geneva.

7. In order to support the strengthening of IHR National Focal Points (NFPs), and through collaboration with the Ministries of Health of Brazil and Chile, operating guidelines for the work of the NFPs were prepared, and a computerized tool was adapted to improve event-based surveillance. The results of the assessments showed that 14 Member States had been offered support to strengthen their NFP, whose proposals are under review and pending final approval. Finally, and with the same objective, a system for internships was planned, with implementation beginning in March 2010. The IHR internships are for NFP staff who take part in the activities of the Alert and Response Team at PAHO Headquarters in Washington, D.C. At the time of this writing, the first intern from the Dominican Republic had been welcomed.

8. As part of strengthening their response capacities, countries must also strengthen their rapid response teams (RRTs). With this objective, the RRT training program has been updated and expanded. Support has been provided for training activities in Bolivia, Chile, and Costa Rica, training 89 professionals from different disciplines. Furthermore, to foster implementation of the field epidemiology program, support was provided to Paraguay to prepare a proposal for its implementation, which was approved and is currently in the early stages of execution.

Strengthen Public Health Security in Travel and Transport

9. Regarding initiatives related to points of entry, collaboration with the Organization of American States' Technical Advisory Group on Port Security has continued for the purpose of strengthening even further the basic capacities required at designated ports. Furthermore, to facilitate guidance and development of point of entry tools, PAHO has a new Advisor in this area to buttress supervision of and support for IHR implementation.

Strengthen PAHO Alert and Response Systems

10. During 2009, the IHR (2005) Regional Contact Point maintained its routine and emergency response activities, ensuring 24/7 availability. Communication tests with Member States' NFPs were also conducted. Out of 35 NFPs, 25 responded in a timely fashion to the electronic message that was sent, and telephone contact was established with 22.

11. Regarding the detection and assessment of risks: 166 public health events of international concern were reported in 2009, 39 of which were related to the 2009 (H1N1) pandemic. Thirty-four percent of events were reported by NFPs, 14% by other government institutions, and 52% through PAHO's routine surveillance activities. Information was made available to the Member States on the Event Information Site (EIS), providing 539 updates on 49 public health events of international concern.

12. As part of its response to the 2009 (H1N1) pandemic, WHO activated the Global Outbreak Alert and Response Network (GOARN). Between April and November 2009, 17 PAHO Member States⁴ benefited from the technical support of experts mobilized by it. A total of 77 experts from 17 institutions and agencies,⁵ as well as PAHO/WHO experts, were deployed to work with the national response teams. This process culminated in a meeting in Panama to analyze the response.

Strengthen the Management of Specific Risks

13. In the context of the response to the 2009 (H1N1) pandemic, national influenza surveillance systems have been strengthened with equipment, reagents, training, and the setting up of laboratories. The information produced by these laboratories has been integrated into national surveillance systems and is used in monitoring the pandemic.

14. During the period of this report, 112 bulletins and alerts were issued, 87 of which concerned the 2009 (H1N1) pandemic. Furthermore, in order to improve analysis of the risk of the spread of disease and ensure proper monitoring of events, risk maps for yellow fever and dengue and qualitative indicators of the pandemic were prepared and kept up to date.

15. A lessons-learned exercise on the response to pandemic (H1N1) 2009 in the Americas was carried out for a critical analysis of the countries' experiences and to generate knowledge capable of improving the response.

Sustain Rights, Obligations, and Procedures and Conduct Studies and Monitor Progress

16. The IHR (2005) have still not been completely implemented in all the Member States of the Region. In order to facilitate a review of the legislation in the Member States, a framework for IHR (2005) implementation has been developed and is currently being printed.

⁴ Argentina, Belize, Bolivia, Chile, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Suriname, and Uruguay.

⁵ The Public Health Agency of Canada; the U.S. Centers for Disease Control and Prevention; Doctor Ricardo Jorge National Health Institute of Portugal; the Pasteur Institute of French Guiana; the Ministries of Health of Argentina, Brazil, Chile, and Peru; the Ministry of Health and Social Policy of Spain; the Secretariat of Health of Mexico; the Andean Regional Health Agency-Hipólito Unanue Agreement; Program for Appropriate Health Technology (PATH), a nongovernmental organization; the Caribbean Office of the French Institute for Public Health Surveillance; the European Field Epidemiology Training Program; the University of Valparaiso, Chile, and the University of Texas.

17. The Member States have named 72 experts to the IHR (2005) Roster of Experts. The Director-General of WHO has called on experts from this Region to participate in the Emergency and Review Committees. These experts came together for the first time from 12 to 14 April 2010.

18. The Region of the Americas has taken part in WHO studies to evaluate the performance of the decision instrument described in Annex 2 of the IHR (2005)⁶; in the concordance study to examine the reliability of evaluation and notification; in a qualitative study that consisted of an in-depth survey with questions on the use of the decision instrument; and in a survey to assess its use. The results of these studies will be divulged during the course of the year.

19. Finally, the first regional joint meeting of National Focal Points, heads of national surveillance services, and national authorities responsible for points of entry will be held this year.

⁶ A preliminary report on the results of the concordance study conducted by the University of Geneva was made available to the countries on 22 March 2010 through the WHO IHR Contact Point for the Region of the Americas (ihr@paho.org).

B. UPDATE ON THE PANDEMIC (H1N1) 2009

Background

20. The purpose of this document is to examine the pre-pandemic efforts and the response to the new influenza A (H1N1) virus since April 2009.

21. In late April 2009, a novel influenza A virus capable of infecting humans was detected in North America. From its initial focus in Mexico, the virus spread worldwide, yielding hundreds of thousands of confirmed cases and greater than 16,000 deaths as of March 2010. Based on the available evidence and on the guidance of the Emergency Committee established under the International Health Regulations (IHR-2005), the Director General of the World Health Organization (WHO) determined that the scientific criteria for an influenza pandemic had been met and declared the first pandemic of the 21st century.

22. Since 2002, the technical cooperation of the Pan American Health Organization (PAHO) has promoted countries development of National Influenza Pandemic Preparedness Plans (NIPPPs) developed through an intersectoral planning process. In addition to the development of NIPPPs, the goal was to strengthen countries generic core capacities for surveillance and response, as required by the IHR-2005.

23. In support of strengthening countries' capacity to detect influenza viruses with pandemic potential, PAHO technical cooperation efforts focused on implementation of Generic Protocol for Influenza Surveillance developed by PAHO and the U.S. Centers for Disease Control and Prevention. As a complement to an integrated virological and epidemiological surveillance system, the countries' laboratory capacity was enhanced through training in laboratory techniques, provision of reagents and supplies, and purchase of equipment. For most countries in the Region, training focused on antigenic techniques which allowed for the detection of seven respiratory viruses, including influenza. Over the past five years, these efforts contributed to the establishment in Central America of five new National Influenza Centers, which are WHO-recognized laboratories with proven capacity to safely and effectively diagnose influenza viruses. Prior to these recently designated centers, only one National Influenza Center in Central America had been operating.

24. Support was also provided to establish rapid response teams to investigate possible outbreaks. In addition to providing tools for field investigation, training included the implementation of effective strategies for infection control, safe handling of clinical samples, stress management, and crisis and mass fatality management. Capacity building was also provided on risk and outbreak communication to train senior communication

staff, those who influence and make communication policies, and those responsible for messages and commentaries to the public and the media.

Update

25. The emergence of a pandemic influenza in April 2009 sparked an overwhelming demand from the countries for direct technical support. The pandemic forced a shift from preparedness activities to mitigation efforts. The threat of a potential pandemic caused by the highly pathogenic avian influenza A H5N1 (“avian flu”) had resulted in the development of NIPPPs in most countries. The Region of the Americas was the only WHO Region that had not been affected by the H5N1 virus, and as such, the pandemic preparedness process had been waning in many countries due to a low perceived risk. Countries responding to the H1N1 pandemic often found that their NIPPPs lacked the operational details necessary for effective operational implementation. While national plans lacked operational details, the preparedness process over the past few years had served to lay the groundwork for coordination mechanisms and bring together the necessary stakeholders.

26. In response to the initial outbreak, PAHO activated its alert and response mechanisms with the deployment of rapid response teams and the activation of its Emergency Operations Center at (EOC) PAHO Headquarters. The EOC served as a point of contact for communication between technical areas and countries’ ministries of health. Through coordination with WHO’s Global Alert and Response Network (GOARN), PAHO deployed intersectoral delegations to most countries. Such teams included specialists in surveillance, laboratory diagnosis, infection control, response to emergencies, and risk communications. In the absence of antiviral medications and vaccines, health officials faced anxious communities demanding quick information. Risk communication training in many cases led to more coordinated messages with transparency and compliance to public health measures.

27. The capacity of national public health laboratories was stretched to the limit because laboratories were used for diagnostic purposes and not to meet the recommended public health surveillance goals. Even so, laboratories produced timely, accurate results on the excess of samples that were submitted. Most countries were able to identify influenza and other respiratory viruses through antigenic techniques. The identification of the new virus was only possible through more sophisticated, polymerase chain reaction (PCR) which had not been established in every country in the Region. Within the first four weeks of the start of the pandemic, PAHO coordinated the provision of training, equipment, materials and reagents for this technique in order to respond to this immediate gap. Realtime PCR equipment was provided to Brazil, Chile, Colombia, Cuba, Dominican Republic, Ecuador, El Salvador, Haiti, Honduras, Jamaica, Paraguay, and Uruguay. PAHO also purchased and distributed reagents, additional equipment, and

supplies. As a result, every country in Latin America is now able to diagnose the novel H1N1 virus.⁷

28. Support for epidemiological surveillance included the development of national protocols based on PAHO/WHO guidelines for the enhanced surveillance of acute respiratory infections. Throughout the pandemic an obvious gap and time lag existed in the epidemiological information generated by countries. The gains that had been achieved with the years of technical cooperation in implementation of influenza surveillance were not completely apparent during the pandemic. Now that the pandemic has subsided in the Southern Hemisphere, there is an opportunity to strengthen sentinel surveillance systems in the affected countries, which are now more receptive to such activities.

29. PAHO convened a group of experts for development of a guideline for clinical management of pandemic (H1N1) 2009 in children and adults, in collaboration with the Pan American Association of Infectology.⁸ Clinical characteristics of the severe cases were monitored in close communication with country specialists. These efforts allowed the early identification of pregnancy and obesity as risk factors for severe forms of the disease. Technical support was provided to Argentina, Bolivia, El Salvador, Honduras, Peru, and Trinidad and Tobago for the revision of national protocols on clinical management and infection control. Through experts in the field, PAHO provided guidance on clinical management of severe cases, cases among children, and infection control measures in Belize, Dominican Republic, El Salvador, Guatemala, Mexico, Nicaragua, and Paraguay. In conjunction with the Pan American Association of Infectology, a meeting was convened to collect the main lessons learned on clinical management in intensive care units (São Paulo, 26 August 2009). PAHO also collaborated with WHO Headquarters in the development of a global consultation on the management of severe cases of pandemic (H1N1) (Washington, D.C., 14-16 October 2009).

30. Through its emergency mechanisms, PAHO was able to coordinate many of the donations and purchases for countries. Over 50,000 personal protective equipment kits were purchased and delivered to countries, as well as over 589,000 treatments of oseltamivir.

31. PAHO developed technical guidelines for vaccine use and supported countries in Latin America and the Caribbean in the introduction of the pandemic influenza vaccine. Three subregional workshops were conducted, using these guidelines to support countries in developing their national plans. PAHO sent risk communication teams to work directly

⁷ CAREC member countries, except Jamaica, sent suspect pandemic (H1N1) 2009 samples to CAREC for confirmation by *realtime* PCR.

⁸ Available at:
http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=2163&Itemid=

with the ministries of health to prepare for vaccine introduction. In the Americas, different mechanisms exist for countries to access pandemic influenza vaccines. Twenty-seven countries and territories purchased this vaccine through PAHO's Revolving Fund. Ten countries in the Region were eligible to receive WHO-donated vaccine to cover up to 10% of their population. Two countries purchased vaccine directly from manufacturers. As of 23 March 2010, 22 countries and territories had received pandemic influenza vaccine, and approximately 14 million doses had been applied. PAHO will continue to support countries in the surveillance of vaccine adverse events and in the evaluation of vaccine impact.

32. PAHO produced and translated guidelines and made them available in the influenza portal⁹ in Spanish and English. A weekly pandemic monitoring report was produced describing the evolution of the pandemic in the Region, and is still published every week. PAHO also held weekly virtual meetings with ministries of health to disseminate the latest available information and evidence. PAHO made available a secure virtual site for information sharing for the use of Canada, Mexico, and the United States. In order to disseminate knowledge and information on infection control, PAHO designed a virtual course in clinical management and infection control for healthcare workers.

33. Support was also provided to countries in the development of appropriate messages and the evaluation of the effectiveness of these messages through knowledge, attitudes, and practice studies. Based on informal feedback from countries in the Region, these results helped programs determine whether their message contributed to the public's compliance with social distancing recommendations and when necessary to make subsequent adaptations.

34. At the regional level, PAHO convened a working meeting of all Member States in September 2009 to analyze the experiences of the countries, share lessons, and examine the challenges facing the Region. With the severe season in the Southern Hemisphere past, and the Northern Hemisphere influenza season arriving, the countries addressed seven themes: coordination and management, epidemiological surveillance, IHR, health services response, risk communications, non-pharmaceutical measures, and vaccination.

35. While still supporting efforts to mitigate the effects of the current pandemic, PAHO intends to continue to strengthen the pandemic response strategy. The goal now is to move away from the reactive mode required by the initial months of the pandemic. Technical cooperation will continue to promote integrated strategies of capacity building, planning tools, and simulation exercises involving the active participation and ownership of governments at all levels.

⁹ Available at:
http://new.paho.org/hq/index.php?option=com_content&task=blogcategory&id=805&Itemid=569&lang=en.

C. PLAN OF ACTION FOR STRENGTHENING VITAL AND HEALTH STATISTICS

Introduction

36. 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 CD48.R6 (2008) *Regional Plan of Action for Strengthening Vital and Health Statistics* (PEVS for its acronym in Spanish), adopted in October 2008.¹⁰

Background

37. The aforementioned resolution urges Member States to promote the participation and coordination of different agencies and actors (national and sectoral statistics offices, epidemiology departments of the ministries of health, civil registries, and other public and private actors) in the situation analysis and preparation of national plans of action. It also urges them to approve the PEVS, which would provide indicators with sufficient coverage and quality for the design, monitoring, and evaluation of health policies.

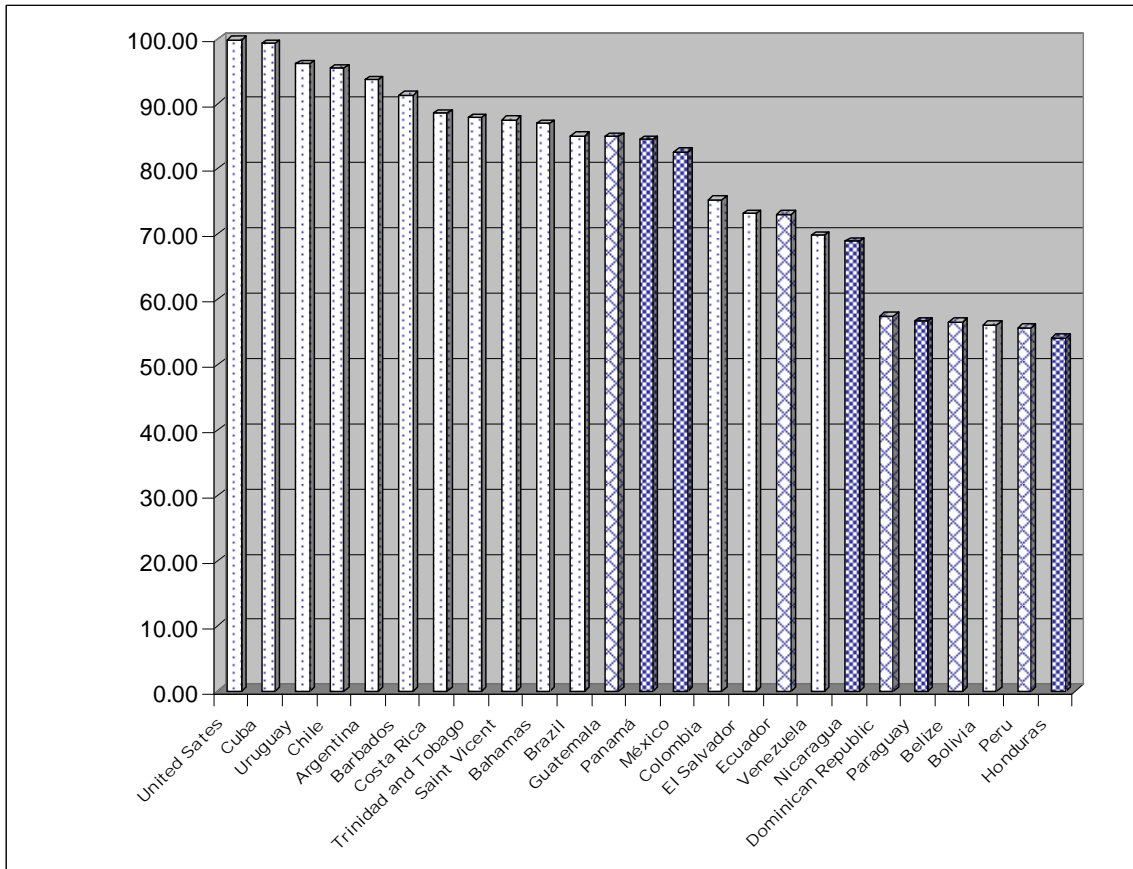
38. The resolution also requests the Director to work with Member States to develop their national plans of action and improve coordination between the PEVS and initiatives of the same nature undertaken by other international technical cooperation and financing agencies, as well as global initiatives to strengthen health statistics in the countries.

Situation Analysis

39. Analyses of the statistics situation, performed using PAHO tools, are available for 25 countries. In partnership with the U.S. Agency for International Development (USAID) and initiatives such as the Health Metrics Network (HMN) and the Performance of Routine Information System Management (PRISM) framework, strategic plans have been drafted in 10 of the priority countries. The figure and tables below describe the situation as it stands.

¹⁰ Pan American Health Organization. Regional Plan of Action for Strengthening Vital and Health Statistics (Resolution CD48.R6) [online] 48th Directing Council, 60th Session of the Regional Committee of WHO for the Americas; 29 September-3 October 2008; Washington (DC), USA. [Accessed 15 April 2010].
<http://www.paho.org/english/gov/cd/cd48.r6-e.pdf>

Figure 1: Countries by index of coverage of vital events (PAHO assessment) for which there is an assessment and/or strategic plan (SP) using tools of PAHO, HMN, and PRISM (circa 2005)



 **SP with HMN and/or PRISM**  **SP with HMN and/or PRISM in preparation**  **Only PAHO assessment**

Table 1. Countries with a strategic plan (SP)

Country	Study	SP	Remarks
Belize	Yes	Yes	
Bolivia	Yes	No	Not yet initiated
Costa Rica	Yes	Yes	
Dominican Republic	Yes	No	Is developing a plan within the framework of PAHO/WHO
Ecuador	Yes	No	Is developing a plan within the framework of PAHO/WHO
El Salvador	Yes	Yes	
Guatemala	Yes	No	Is developing a plan within the framework of PAHO/WHO
Honduras	Yes	Yes	
Mexico	Yes	Yes	
Nicaragua	Yes	Yes	
Panama	Yes	Yes	
Paraguay	Yes	Yes	
Peru	Yes	No	Is developing a plan within the framework of PAHO/WHO

* The priority countries for statistics are in boldface.

Table 2. Countries with a situation analysis and strategic plan (SP) with a framework different from that of PAHO/WHO. 2010.

Country	Assessment	SP
Argentina	Yes	No
Brazil	Yes	No
Chile	Yes	No
Colombia	Yes	No
Cuba	Yes	No
Uruguay	Yes	No
Venezuela	Yes	No

40. Every country in the Region has aligned itself with Strategic Objective 11¹¹ of the Strategic Plan 2008-2012 for PAHO, Amended (2009). The PEVS is included in the subregional biennial work plans of the Andean countries and MERCOSUR, and a comprehensive plan for the countries of the English-speaking Caribbean is being discussed.

41. PEVS activities are complementary and in sync with other Organization activities such as the Regional Core Health Data Initiative (RCHDI) and the strategies on the gender and ethnic approach, which provide the conceptual framework for the core health indicators, making it possible to monitor the Organization's mandates, such as the Millennium Development Goals (MDG). Better health information is expected to result in the dissemination of better quality indicators and, thus, better monitoring of the policies implemented to meet the Millennium Development Goals.

42. A list of strengthening activities, based on the common needs of groups of countries or subregions, is available.

43. Agreements have been entered into, and there has been success in coordinating the countries' work with international technical organizations and agencies such as the Economic Commission for Latin America and the Caribbean (ECLAC); ECLAC's Population Division (ECLAC/CELADE); ECLAC's Statistical Conference of the Americas (SCA-ECLAC); the United Nations Children's Fund (UNICEF); the United Nations Population fund (UNFPA); the World Health Organization (WHO); and the United Nations Statistics Division (UNSD), and financing agencies such as the Inter-American Development Bank (IDB) and the World Bank.

Proposal

44. A workplan has been developed for the biennium 2010-2011, coordinated with the Regional Core Health Data Initiative (RCHDI), that will make it possible to evaluate the coverage and quality of the data toward the end of 2011. The focus will be on monitoring the countries' progress toward the achievement of MDGs 4 and 5.

45. The plan, however, requires the mobilization of extrabudgetary resources (estimated cost: US\$ 8 million for three years) to finance implementation and technical cooperation in at least 15 countries whose situation is critical, and the design and implementation of subregional activities based on horizontal cooperation among countries.

¹¹ Pan American Health Organization. Strategic Plan 2008-2012 for PAHO, Amended (Official Document 328), pg. 93. Strategic Objective 11: To strengthen leadership, governance, and the evidence base of health systems.

46. The PEVS seeks to strengthen the recently created Latin American and Caribbean Network for Strengthening Health Information Systems (RELACISIS), with a view to implementing strengthening practices at the regional and subregional level, based on horizontal cooperation and the support of regional and national collaborating centers working in the field of health information.

D. REGIONAL CORE HEALTH DATA INITIATIVE AND COUNTRY PROFILES

Introduction

47. In 1997, the Directing Council of the Pan American Health Organization (PAHO) approved Resolution CD40.R10, "Collection and Use of Core Health Data," (1) to monitor the implementation of mandates adopted by the Member States. In 2004, the ten-year Evaluation of the Regional Core Health Data Initiative (2) was presented to the Directing Council. The current report presents the progress made since 2004.

Background

48. Between 1995 and 1998, the Organization's technical programs, working in close collaboration with Member States and its Country Offices, developed the Regional Core Health Data Initiative (RCHDI). The Initiative was crafted within the context of PAHO's strategic and programmatic orientations and is designed to improve the Organization's ability to describe, analyze, and explain the Region's health situation and trends that it must address.

Update on the Current Situation

49. The Basic Indicators Health Information System¹² is being modified. The compilation of data and its validation at Country Offices and technical programs will be done through an inhouse-developed web application, a new approach that will replace the current excel sheet compilation. This application allows for the various databases to be merged and supports the validation of data at the country and regional levels. The new information system includes a metadata repository and data visualization.

50. Both the statistical pamphlet and the online database (table generator system) have been updated yearly and are widely disseminated. The online database with 117 indicators allows for annual trend analysis dating back to 1995.

51. The Basic Indicators Health Information System is part of PAHO's Regional Health Observatory. The Observatory facilitates access to all health data generated by the Member States and collected by PAHO's technical areas.

¹² The Basic Indicators Health Information System can be consulted at:
http://new.paho.org/hq/index.php?option=com_content&task=blogcategory&id=1775&Itemid=1866.

52. In an effort to systematically update the Country Health Profiles, the project “Analysis of the Health Situation in the Countries of the Americas” was carried out in 2009. As a result of this effort, the methodology of the analysis was revised. The analysis allows for the observation of temporal trends in strategic health indicators during recent years. Health profiles have been prepared for 35 countries and Puerto Rico.

53. Most countries in the Region have adopted the Core Health Data Initiative by establishing a set of basic national indicators. Roughly half of the countries and territories consulted (19 of 39¹³) have regularly updated and disseminated a set of basic indicators for more than a decade. Of the Spanish speaking countries, only Venezuela and Uruguay are currently not on the list. Belize is the only English-speaking country that regularly updates and shares basic indicators, whereas Bahamas, Antigua and Barbuda, Jamaica, and Saint Vincent and the Grenadines could not sustain their efforts in consolidating and disseminating their basic national indicators. The remaining 13 other English-speaking countries or territories have not yet established national basic indicators.

54. The quality of the data reported to PAHO (regional basic indicators) needs to improve. Based on the latest information reported to PAHO by 48 countries or territories, selected basic mortality indicators were evaluated (3). Highlights of this analysis are presented in the following paragraphs.

55. According to the Organization, the under-registration of mortality in Latin America and the Caribbean is 16.1%. Ten countries have under-registration levels higher than 20% and six have levels 10%-20%.

56. The countries with the highest proportion of ill-defined and unknown causes of death are Bolivia (2003 data) and Haiti (2004 data), followed by Ecuador, El Salvador, French Guiana, and Paraguay, the latter four falling between 10% and 15%.

57. The timeliness of mortality data shows that nine countries submitted their mortality data with a four-to-five year delay. Honduras only reports public hospital mortality. Jamaica is not part of the database.

58. Some countries do not report the maternal mortality ratio and the infant mortality rate periodically to PAHO, even though these indicators are part of the Millennium Development Goals.

¹³ Updates on 39 countries and territories who responded to the consultation. Excluded from analysis are: French Overseas Territories, Netherlands Antilles and Aruba, Bermuda, USA, US Virgin Islands, and Canada.

59. Most countries and technical programs update their disease surveillance systems for their specific program objectives on a timely basis. However, data consistency is often poor, which affects comparability over time.

Action to Improve the Situation

60. Many countries clearly have made progress in the collection of national basic indicators and in the sustained efforts to count on periodic indicator updates. However, improvements in data quality, and timeliness, need to be emphasized. In addition, data is often not analyzed for program monitoring. At national and regional levels, data collection, data validation and information generation need to be institutionalized. Advocacy at the highest policy making level is needed to institutionalize these initiatives.

61. Technical assistance must be increased to help produce reliable and timely health information. Technical assistance must also strengthen the data validation process in each technical program. Improved data analysis will help programs more accurately determine health inequities and better allocate resources.

62. The highest political commitment is essential for implementing this Initiative requested by countries.

References

1. Pan American Health Organization. Collection and Use of Core Health Data (document CD40/19). 40th Directing Council, 49th Session of the Regional Committee of WHO for the Americas; 1997 September; Washington (DC). Washington (DC): PAHO; 2010 [cited 14 July 1997].
2. Pan American Health Organization. ten-year Evaluation of the Regional Core Health Data Initiative (document CD45/14) [online]. 45th Directing Council, 56th Session of the Regional Committee of WHO for the Americas; 2004 Sep 27-Oct 2; Washington (DC). Washington (DC): PAHO; 2010 [cited 29 July 2004]. Available at: <http://www.paho.org/english/gov/cd/CD45-14-e.pdf>.
3. Pan American Health Organization, Health Information Analysis Project. Health Situation in the Americas: Basic Indicators 2009. Washington (DC). Washington (DC): PAHO; 2009.

E WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL: OPPORTUNITIES AND CHALLENGES FOR ITS IMPLEMENTATION IN THE REGION OF THE AMERICAS

Background

63. In September 2008, the PAHO Directing Council recognized that, notwithstanding some successful experiences in the Region in the area of tobacco control, progress has been uneven and it adopted [Resolution CD48.R2](#) (1). The following is a progress report:

Regarding point 1(a) of the resolution

Ratification of the Framework Convention on Tobacco Control (FCTC)¹⁴

64. Suriname and Bahamas ratified the Convention, bringing the number of States Parties to 27 (77% of the total PAHO Member States).

Implementation of FCTC Measures

Price- and tax-related measures to reduce the demand for tobacco – Article 6

65. Although several countries (Bahamas, Brazil, Colombia, Guyana, Jamaica, Nicaragua, Suriname, Trinidad and Tobago, and Uruguay) increased tobacco taxes, none ensured that they represent 75% of the retail price of tobacco products. At present, only three countries in the Region (Chile, Cuba, and Venezuela) have achieved this goal.

Protection from exposure to tobacco smoke – Article 8

66. Six countries (Canada, Colombia, Guatemala, Paraguay, Peru, and Trinidad and Tobago) joined the nations that have national or subnational legislation banning smoking, in all enclosed public areas and work places, without exception. With Uruguay and Panama, this brings the total number of countries in the Region that are 100% smoke-free to eight. Conference of the Parties (COP) guidelines recommend that Article 8 be implemented within five years of the Convention's entry into force for each Party; in six States Parties, this deadline will come and go without their having met this goal.

¹⁴ Table 1 shows the status of ratification in the Americas of the Framework Convention on Tobacco Control (FCTC).

Packaging and labeling of tobacco products – Article 11

67. Five countries in the Region (Bolivia, Colombia, Mexico, Paraguay and Peru) passed regulations banning the use of misleading labeling and requiring the use of pictorial warnings that occupy more than 30% of the main surfaces of tobacco product packaging. These five countries join the six pioneers (Brazil, Canada, Chile, Panama, Uruguay, and Venezuela), and Jamaica and Cuba (this last country is not a Party to the FCTC, therefore is not legally bound by it) that do not include images but meet the basic requirements of the FCTC, for a total of 13 countries that already comply with this measure. Furthermore, the Convention establishes a three-year period from the date the Convention enters into force for each Party as the deadline for compliance with this article. For 10 States Parties, this period will expire in September 2010 without their having met the article's minimum requirements.

Tobacco advertising, promotion, and sponsorship – Article 13

68. Colombia became the second country in the Region, after Panama, to pass a comprehensive law banning all forms of tobacco advertising, promotion, and sponsorship. Again, the Convention establishes a period of five years from the date the Convention enters into force for each State Party for implementation of this article. For 7 States Parties, this period will expire in September 2010 without their having fully complied with the provisions of this article.

**Table 1: Status of WHO Framework Convention on Tobacco Control (FCTC)
Ratification in the Americas**

Member State (or Country)	Ratification Date	Member State (or Country)	Ratification Date	Member State (or Country)	Ratification Date
Mexico	28 May 2004	Brazil	3 November 2005	Costa Rica	21 August 2008
Panama	16 August 2004	Saint Lucia	7 November 2005	Suriname	16 December 2008
Canada	26 November 2004	Guatemala	16 November 2005	Bahamas	3 November 2009
Trinidad and Tobago	19 August 2004	Belize	15 December 2005	Argentina	Not a Party
Uruguay	9 September 2004	Antigua and Barbuda	5 June 2006	Cuba	Not a Party
Peru	30 November 2004	Venezuela (Bolivarian Republic of)	27 June 2006	Dominican Republic	Not a Party
Honduras	16 February 2005	Dominica	24 July 2006	El Salvador	Not a Party
Chile	13 June 2005	Ecuador	25 July 2006	Haiti	Not a Party
Jamaica	7 July 2005	Paraguay	26 September 2006	Saint Kitts and Nevis	Not a Party
Bolivia	15 September 2005	Grenada	14 August 2007	Saint Vincent and the Grenadines	Not a Party
Guyana	15 September 2005	Nicaragua	9 April 2008	United States of America	Not a Party
Barbados	3 November 2005	Colombia	10 April 2008		

Regarding point 1(b) of the resolution

69. PAHO has facilitated the sharing of experiences among countries to achieve implementation of the provisions of the Convention and facilitated technical cooperation agreements among countries.

Regarding point 1(c) of the resolution

70. There has been no significant progress on this point. In the vast majority of countries, there is still no intra- and interministerial unit to coordinate implementation of the FCTC, and when one does exist, it is rather weak. PAHO should play a more active role at the national level in helping the Region's ministries of health create or strengthen their coordinating units and in getting other relevant players involved.

Regarding point 1(d) of the resolution

71. Some subregional integration bodies, such as MERCOSUR and CARICOM, have made considerable progress by putting the issue of tobacco control—specifically, discussions on the Convention and its effective implementation in their subregions of influence—on their agendas.

Regarding point 1(e) of the resolution

72. There has been no significant progress on this point. PAHO should play a more active role at both the regional and national level in efforts to fund opportunities and support the preparation of proposals toward this end.

Regarding point 2 of the resolution

73. Seeking to make technical and financial support for Member States more effective and efficient, PAHO has promoted the articulation of partnerships and engaged in a coordinated effort with international and regional partners in the field of tobacco control. One example of this is the joint work with the Campaign for Tobacco-free Kids (CTFK) in Costa Rica, Guatemala, and Peru to push for the passage of tobacco control legislation and with the Inter-American Heart Foundation in El Salvador to promote ratification by that country of the Framework Convention on Tobacco Control (FCTC).

74. Furthermore, within the context of negotiations for the drafting of a Protocol on Illicit Trade in Tobacco Products (established within the framework of the FCTC), PAHO has worked with the FCTC Secretariat in fostering coordination between the health sector and sectors such as the economy, finance, and customs in the States Parties.

75. It is important to point out that tobacco industry opposition is what is behind the slow progress. This opposition hinders all processes before, during and even after legislation has been passed. It bears noting that, in order to achieve significant progress in the Region, in addition to political will in the Member States, it will be necessary to join forces with civil society and other partners to take the appropriate action to curb the influence of the tobacco industry in the Region. To this end, the recommendations of Article 5(3) of the FCTC should be taken into account.

Reference

1. Pan American Health Organization. WHO Framework Convention on Tobacco Control: Opportunities and Challenges for Its Implementation in the Region of the Americas (Resolution CD48.R2) [online], 48th Directing Council, 60th Session of the WHO Regional Committee for the Americas; 2008 29 Sept.-Oct.. 3; Washington, D.C.: PAHO; 2008 [cited 16 April 2010]. Available at: <http://www.paho.org/english/gov/cd/cd48.r2-e.pdf>.

F IMPLEMENTATION OF THE REGIONAL STRATEGY AND PLAN OF ACTION FOR AN INTEGRATED APPROACH TO THE PREVENTION AND CONTROL OF CHRONIC DISEASES, INCLUDING DIET, PHYSICAL ACTIVITY AND HEALTH

Background

76. In 2006, the Directing Council adopted Resolution CD47.R9, *Regional Strategy and Plan of Action for an Integrated Approach to the Prevention and Control of Chronic Diseases, Including Diet and Physical Activity*. The resolution urges Member States to implement integrated policies and plans, guided by the Regional Strategy, and requests the Director of the Pan American Sanitary Bureau (PASB) to strengthen Member States' capacity to implement comprehensive, multi-sectoral approaches and strengthen or establish new partnerships. The Regional Strategy follows four lines of action: policy and advocacy, surveillance, health promotion and disease prevention, and integrated management of chronic diseases.

Update on Current Situation

77. Chronic diseases are now the leading cause of premature mortality and disability in the vast majority of countries in the Americas. About 250 million people of a total of 890 million (in 2005) in the Region suffer from chronic diseases, mainly cardiovascular diseases, cancer, obesity and diabetes. These particularly affect low- and middle-income populations, with an estimated 139 million (25%) of persons >15 years of age being obese (BMI>30) in 2005, and rapidly increasing to reach an estimated 289 million (39%) by 2015.¹⁵ There is also a growing concern over the rapid increase of obesity in children and adolescents. The toll in human suffering and economic cost from chronic diseases is enormous. Yet, these diseases are preventable and can be controlled through public policies, risk factor reduction, and the provision of health services for screening, early detection, and disease management. For example, the implementation of basic strategies to reduce tobacco use by 20%; salt intake by 15%; and to use simple multidrug regimens for patients with high-risk cardiovascular disease, could prevent more than 3.4 million deaths from chronic diseases in the Region over 10 years at reasonable cost.¹⁶

78. Since the Directing Council adopted the resolution on chronic diseases in 2006, almost all Member States have made substantial progress in implementing national plans for their national chronic disease programs as noted in the End-of-biennium Report

¹⁵ Estimated from WHO Info Base. It can be consulted at <https://apps.who.int/infobase/report.aspx>.

¹⁶ Gaziano T, et al. Scaling-up interventions for chronic disease prevention: the evidence. *Lancet*, 2007, 370: 1939-46; extrapolated to countries of Latin America and Caribbean countries.

presented to the Executive Committee (see Table 1). In most cases, countries reported exceeding the Regional Expected Result indicators of the Strategic Plan related to chronic diseases.

79. During the 2008-2009 biennium, PAHO mobilized approximately US\$ 21 million of the \$28 million budgeted to support Strategic Objective 3¹⁷ (non-communicable diseases (NCDs)). At the international level, the resource picture for (NCDs) is at best mixed.¹⁸ For example, in 2008 the Bill and Melinda Gates Foundation and Bloomberg Philanthropies committed \$500 million to help countries improve tobacco control. World Bank lending between 1995 and 2005 was more than \$300 million for NCDs and injuries. The level of Official Development Assistance (ODA) commitment to NCDs is unknown, but preliminary estimates are 1-2% of total. Most international development agencies find it difficult to support NCDs because they are not included in the Millennium Development Goals (MDGs). At the same time, some bilateral technical or donor agencies are investing, such as the Spanish International Cooperation Agency for Development (AECID), Centers for Disease Control and Prevention (CDC), and Public Health Agency of Canada (PHAC). However, efforts to increase the level of attention current resources are needed, given the huge burden.

Policy and Advocacy

80. An assessment of the status of chronic disease responses in the Region shows that 26 countries in Latin America and the Caribbean reported making program-related investments in chronic diseases, including having a national focal point in the ministry of health, training personnel, and creating intersectoral partnerships. Compared to 2005, when 63% of countries had a national focal point/unit and budget, all countries now report having such. However, more efforts are needed since only 29 countries are implementing a national plan for NCDs. In 2008, resolutions on diabetes and obesity, and on cervical cancer prevention and control, were also approved by the Directing Council. Many countries have also taken important steps to include NCDs in social protection packages, including medicines.

81. The CARMEN Policy Observatory is a joint initiative between PAHO and the PAHO/WHO Collaborating Center on Non-communicable Disease Policy of Public Health Agency of Canada (PHAC). The Observatory is a platform for the network of American countries and institutions engaged in the systematic analysis and monitoring of chronic disease policies

¹⁷ Strategic Objective 3: To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.

¹⁸ WHO. NCDnet Working Group on Innovative Resourcing Background Paper. Geneva 24 February 2010. www.who.int/ncdnet.

82. A compilation of Latin American legislation on prevention and control of obesity, diabetes and cardiovascular diseases was produced in 2009 followed by an electronic publication. A similar compilation is under way for the English-speaking Caribbean countries and territories, as well as the drafting of guidelines to help in the up-grading of legislation when needed. A plan of work for the upgrading of legislation on the prevention and control of obesity in Latin America and Caribbean countries will begin in the second semester of 2010 with a regional meeting of legislators.

83. The economic, fiscal and welfare implications of the obesity epidemic were analyzed in a regional workshop held in 2009 with 10 countries and representatives from the Inter-American Development Bank and the World Development Bank. A regional study on economic burden was also started. The output will be used to engage policy makers from ministries of health and finance in a meeting in 2011 to increase support to address NCDs.

84. At the subregional level a special summit of the Heads of State of the Caribbean Community (CARICOM) on chronic diseases was conducted in 2007. This summit generated high-level commitment to advance policies and monitor implementation of the summit's declaration. CARICOM countries have also formally proposed a United Nations General Assembly Special Session (UNGASS) on chronic diseases for September 2011. RESSCAD/COMISCA¹⁹ adopted resolutions on chronic diseases and cancer, and developed an annual operation plan that encompasses seven activities on chronic diseases. MERCOSUR²⁰ has made the surveillance of chronic diseases a priority to guide policy and decision makers. Courses were conducted on policy analysis and development, with special reference to chronic diseases, in the Caribbean and Central America.

Surveillance

85. PAHO/WHO supports Member States in their efforts to strengthen their health information systems to monitor chronic diseases by providing guidance and tools for implementing the PanAm STEPS²¹ methodology; for the surveillance of risk factors; as well as with a standardized list of minimum indicators. Twenty seven target countries in

¹⁹ RESSCAD/COMISCA: *Reunión del Sector Salud de Centroamérica y República Dominicana/Consejo de Ministros de Salud de Centroamérica* (Meeting of the Health Sector of Central America and the Dominican Republic/Council of Ministers of Health of Central America).

²⁰ MERCOSUR: *Mercado Común del Sur* (Southern Common Market).

²¹ The PanAm STEPS approach to chronic disease adult risk factors surveillance was designed to help countries build and strengthen their capacity to conduct surveillance. It provides an entry point for low and middle-income countries of the Region to get started on chronic noncommunicable diseases surveillance. Similarly, Pan AM STEPS serves as a harmonizing tool to collect and display data throughout the Region in a unifying way.

the Region have defined the set of NCD core indicators. Thirteen target countries have established a system to collect these data using PAHO methodology and analyzing these data from the social determinants and gender perspectives. Discussion forums on NCD surveillance have been established through technical groups of the Common Market of the Southern Cone (MERCOSUR), through the Caribbean epidemiologists' network coordinated by CAREC, and for Andean countries with the support of the Andean Health Agency (ORAS). Twenty seven target countries have produced at least one report on the situation of NCDs or included it in the report of the health situation of the country. PAHO/WHO supports the collection and analysis of data disaggregated by sex, age, and ethnic origin, including the participation of users and producers from governments and civil society.

Health Promotion and Disease Prevention

86. Healthy diet, the promotion of physical activity, and tobacco control continue to be the pillars of the regional strategy. Most of these programs lack the needed human and financial resources. Ten countries report implementing multi-sector, population-wide approaches to promote risk factor reduction for chronic diseases.

87. A Trans-fat Free Americas Initiative was launched by PAHO in 2007 in collaboration with the private sector, which promotes regulations, guidelines and voluntary actions to eliminate trans-fats from processed foods. Such an initiative has the potential to reduce the population's risk for cardiovascular diseases.

88. The Dietary Salt Reduction Initiative with a target to reach 5g/person/day by 2020 to prevent cardiovascular disease in the Americas was launched in 2009. An expert group on salt reduction was created, outlining actions for governments, industry and civil society, while preserving the benefits of salt fortification programs. Argentina, Barbados, Canada, Chile, and the United States are among the countries that have put dietary salt reduction high on the agenda.

89. The creation, in July 2008, of the Pan American Alliance for Nutrition and Development makes it possible to implement comprehensive, intersectoral programs that are both sustainable and coordinated, within the framework of the MDGs. The Alliance addresses social determinants such as malnutrition and poverty as a way to prevent obesity and NCDs. The participation of civil society in issues such as food marketing to children and child obesity has increased significantly over the past five years, notably in Brazil, Canada, Chile, Mexico, and the United States.²²

²² Data was obtained during the AMRO consultation (Marketing of Food and Beverages to Children) and is based on country responses. No document has been released to the public on this consultation as yet.

90. Seventy-six cities of 14 countries²³ across the Americas have established *Ciclovias Recreativas*. Nine countries²⁴ have developed programs on Bus Rapid Transit, which contribute to reduce traffic congestion, reduce road-accidents and facilitate utilitarian and recreational physical activities. The Caribbean countries have all implemented Caribbean Wellness Day, emphasizing mass physical activity.

91. Twenty-seven countries have ratified the Framework Convention on Tobacco Control.²⁵ Ten countries have increased taxes on tobacco (Bahamas, Brazil, Colombia, Guyana, Jamaica, Nicaragua, Suriname, Trinidad and Tobago, and Uruguay). Six countries have national or subnational legislation banning smoking in public places and indoor workplaces.

92. PAHO is also promoting the concept of urban health as a means to address the needs of the most vulnerable, through urban planning that promotes safe spaces for physical activity and healthy eating habits, two important protective factors for the prevention of chronic diseases. World Health Day 2010 stimulated all the countries of the Region of the Americas to promote activities related to physical activity and healthy lifestyles. PAHO's programs on healthy schools and on healthy workplaces include attention to healthy diet, physical activity and other measures which support chronic disease prevention. A major objective of the WHO workers' health plan is healthy workplaces.

Integrated Management of Chronic Diseases and Risk Factors

93. PAHO, working closely with Member States, professional associations, and other partners has supported the development and implementation of evidence-based guidelines and protocols on the integrated management of chronic diseases, targeting cervical cancer, breast cancer, diabetes, and cardiovascular diseases. Currently, 18 countries report implementing integrated primary health care strategies to improve quality of care for persons living with chronic diseases. The Chronic Care Model to improve the quality of care delivered through primary health services for persons with chronic conditions has been promoted by PAHO and is being applied in 15 countries. A rapid assessment in 24 countries on disease management capacity showed the availability of guidelines or protocols for hypertension and diabetes in 23 countries (97%). Twenty (86%) have protocols for cancer, but a very low proportion have guidelines and protocols for weight control and physical activity. There are no policies for the access to some medications

²³ Argentina, Brazil, Chile, Colombia, Costa Rica, El Salvador, Canada, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Peru, United States.

²⁴ Brazil, Chile, Colombia, Canada, Ecuador, Guatemala, Mexico, Peru, United States.

²⁵ PAHO. WHO Framework Convention on Tobacco Control: Opportunities and Challenges for its Implementation in the Region of the Americas (Document CE146/INF/6-E) 2 May 2010).

and services, particularly for low-income groups. All countries in the Region have a list of essential medicines for chronic diseases.

94. The Central American subregion, through the support of AECID, has developed a list of essential medicines, mainly on cancer, for consolidated subregional procurement. Chronic diseases are associated with catastrophic family expenditure, which sharpens and deepens poverty. Access to treatment for low-income persons is hindered by 39-63% of the population having to pay full cost of basic medications for diabetes and hypertension.²⁶ Between 25-75% of basic procedures/tests, including blood glucose monitor, x-rays, mammography, cervical cancer smears, colonoscopy, lipid profile, and dialysis, are not mentioned in guidelines to address NCDs. They are available however in about 85% of the countries of the Region. Dialysis services are accessible in 83% of countries. It is estimated that around 40% of the population have to pay from their pocket an average of \$99 per dialysis session, or \$15,500 a year.

Strengthening Networks and Partnerships

95. The CARMEN network of national chronic disease program managers, WHO Collaborating Centers, and nongovernmental organizations, has been strengthened and expanded to 32 countries. Regional courses have been conducted under the CARMEN school, in collaboration with academic and technical institutions in evidence-based public health practice, social marketing, physical activity, and chronic disease care. In 2009, PAHO a multi-stakeholder Partners' Forum for Action on Chronic Diseases was established to serve as an instrument to engage the private sector and the civil society together with Member States, given that no one sector can solve the problem alone. This novel mechanism aims to leverage unique roles and capacities of each sector to take joint action to accomplish policy and environmental change to promote health and prevent chronic disease. Future meetings and activation are planned for 2010.

Actions for Improvement

96. Despite the major gains made by Member States on their national chronic disease programs, the attention and resources devoted to this public health issue are severely lacking, despite the enormous disease burden and economic costs. Member States, with PAHO's collaboration, should support a major effort to build competencies and capacity for all aspects of prevention and control of chronic diseases, including surveillance, policy analysis and development, tobacco control, healthy diets and physical activity, improved quality of disease management, and multi-stakeholder engagement and coordination mechanisms. Support from PAHO, its partners, and other sectors must be

²⁶ PAHO, National Capacity for the Management of Chronic Diseases in Latin America and the Caribbean. 2009.

harnessed to increase Member States' capacity to adopt evidence-based policy actions that can have the greatest impact, such as tobacco control, salt reduction, and policies that support healthy eating and physical activity. These interventions also involve scaling up access to medicines and quality health services for screening, early detection, and control of chronic diseases, especially cardiovascular disease and low-income populations. Member States and PAHO should continue to strengthen the capacity and competencies of health systems for integrated management of chronic diseases and risk factors, including patient self-care, with a focus on primary health care.

97. Efforts are needed to improve the quality and timeliness of health information to guide policy, planning and evaluation, especially risk factor information. Such efforts should be directed to gender-based analysis, and leveraging novel approaches/technologies to increase participation. PAHO and Member States should advocate for and support the UNGASS on NCDs. Technical cooperation between countries on successful practices and sharing of experiences on NCDs should continue to be actively pursued. No single institution or sector can tackle chronic diseases. Therefore, establishment of national intersectoral efforts, and partnerships and alliances is encouraged as a key strategy. The CARMEN Network and the Partners Forum can be an innovative resource to support this effort. Increase efforts to support Member States to review their legislation and norms for addressing chronic diseases, tobacco control, measures when necessary, including legislation on food marketing to children and child obesity with participation of the civil society.

**Table 1: Region-wide Expected Results (RER) Indicators
Target and List of Countries and Territories
Reporting Progress ²⁷**

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
3.1.3	Number of countries whose health ministries have a unit or department for chronic noncommunicable conditions with its own budget	26	Argentina, Bahamas, Barbados, Bolivia, Brazil, Colombia, Costa Rica, Cuba, Chile, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, Venezuela
3.1.4	Number of countries where an integrated chronic disease and health promotion	10	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, British Virgin Islands,

²⁷ PAHO Strategic Plan 2008-2012 (October 2007 version).

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
	advocacy campaign has been undertaken		Dominica, Dominican Republic, Grenada, Guyana, Montserrat, Panama, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago
3.2.4	Number of countries that are implementing a national policy and plan for the prevention and control of chronic non-communicable conditions	32 (not achieved)	Anguilla, Argentina, Barbados, Belize, Bermuda, Bolivia, British Virgin Islands, Canada, Cayman Islands, Chile, Colombia, Cuba, Dominica, Ecuador, Grenada, Guyana, Haiti, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States, Uruguay, Venezuela
3.2.5	Number of countries in the CARMEN network (an Initiative for integrated Prevention and Control of Noncommunicable Diseases in the Americas)	27	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Brazil, British Virgin Islands, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Jamaica, Mexico, Montserrat, Netherlands Antilles, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay
3.3.4	Number of countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions and their risk factors	28	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Barbuda, Belize, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, Grenada, Guyana, Haiti, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Uruguay, Venezuela
3.5.4	Number of countries implementing the Regional Strategy on an Integrated approach to prevention and	10 (not achieved)	Ecuador, Guatemala, Honduras, Jamaica, Trinidad and Tobago

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
	control of Chronic Diseases, including Diet and Physical Activity		
3.6.4	Number of countries implementing integrated primary health-care strategies recommended by WHO in the management of chronic noncommunicable conditions	17	Anguilla, Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, British Islands, Chile, Costa Rica, Cuba, Dominica, El Salvador, Guatemala, Jamaica, Montserrat, Nicaragua, Peru, Saint Kitts and Nevis, Suriname, Trinidad and Tobago, Venezuela,
3.6.5	Number of countries with strengthened health-system services for the treatment of tobacco dependence as a result of using WHO's policy recommendations.	12	Argentina, Bolivia, Brazil, Chile, Cuba, Guatemala, Guyana, Jamaica, Mexico, Panama, Trinidad and Tobago, Uruguay, Venezuela
6.2.1	Number of countries that have developed a functioning national surveillance system using Pan Am STEPS (Pan American Stepwise approach to chronic disease risk factor surveillance) methodology for regular reports on major health risk factors in adults	10	Anguilla, Argentina, Bahamas, Barbados, Belize, Brazil, British Virgin Islands, Chile, Costa Rica, Dominica, Grenada, Guyana, Montserrat, Netherlands Antilles, Panama, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Uruguay
6.2.3	Number of countries generating information on risk factors (through registers and population studies); to be included in the Regional Non-communicable Disease and Risk Factor information database (NCD INFO base)	15	Argentina, Barbados, Belize, Bolivia, Brazil, Canada Chile, Colombia, Costa Rica, Guyana, Mexico, Peru, Trinidad and Tobago, United States of America, Uruguay
6.3.1	Number of countries that have adopted smoking bans in health care and educational facilities consistent with the Framework Convention on Tobacco Control	10	Anguilla, Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia, Brazil, British Islands, Chile, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago,

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
			Uruguay, Venezuela
6.4.1	Number of countries that have implemented policies, plans, or programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use	13	Argentina, Barbados, Belize, Bolivia, Brazil, Chile, Costa Rica, Cuba, Dominica, Dominican Republic, Honduras, Mexico, Nicaragua, Panama, Peru, Uruguay
6.5.1	Number of countries that have developed national guidelines to promote healthy diet and physical activity including DPAS (Diet and Physical Activity Strategy)	10	Argentina, Barbados, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, El Salvador, Guatemala, Jamaica, Mexico, Panama, United States of America, Uruguay
6.5.2	Number of countries that have initiated or established rapid mass transportation systems in at least one of their major cities	10	Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guatemala, Mexico, Panama, Uruguay, Venezuela
6.5.4	Number of countries that have created pedestrian and bike-friendly environments, physical activity promotion programs and crime control initiatives, in at least one of their major cities	7 (not achieved)	Brazil, Canada, Chile, Mexico, United States of America
7.2.3	Number of countries which have implemented the Faces, Voices and Places initiative	12	Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela
7.5.1	Number of PAHO publications that contribute to building evidence on the impact of gender inequalities in health	12 (not achieved)	Chile, Cuba, Dominican Republic, Nicaragua, Panama
9.4.3	Number of countries that have developed national programs that implement strategies for promotion of healthy dietary practices in order to prevent diet-related	16	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Belize, Brazil, British Virgin Islands, Chile, Colombia, Costa Rica, Dominica, El Salvador, Grenada, Guatemala, Honduras, Jamaica, Montserrat,

RER Indicator No.	RER Indicator Text	Target 2009	Countries and Territories Reporting Progress
	chronic diseases		Nicaragua, Panama, Peru, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Uruguay
12.3.2	Number of countries with a national list of essential medical products and technologies updated within the last five years and used for public procurement and/or re-imbursement	31	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, British Virgin Islands, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Montserrat, Nicaragua, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Venezuela
	Member States that have ratified the WHO Framework Convention on Tobacco Control ²⁸		Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Ecuador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, Venezuela

²⁸ For further information please see Information Document CE146/INF/6-E.

G. ELIMINATION OF RUBELLA AND CONGENITAL RUBELLA SYNDROME

Background

98. The Member States of the Pan American Health Organization have a long-standing commitment to the eradication and elimination of vaccine-preventable diseases. This pledge began with the eradication of smallpox and polio, and more recently targeted the elimination of measles by 2000, rubella, and congenital rubella syndrome (CRS) by 2010.

99. The countries of the Americas, working with strategic partners²⁹ and health care workers in all levels of the system, have made extraordinary progress in fulfilling the commitments outlined in Resolutions CD44.R1 (2003) and CD47.R10 (2006) to eliminate rubella and CRS by 2010. As highlighted in Resolution CSP27.R2 (2007), the Region is implementing the necessary measures to document and verify the interruption of the endemic transmission of the rubella virus.

Situational Analysis

100. Rubella, usually a mild rash illness, can produce devastating consequences when a woman becomes infected during the first trimester of pregnancy. The sequelae of infection during pregnancy include a series of birth defects—blindness, deafness, and cardiac defects—known as CRS. Before wide-scale rubella vaccination, an estimated 20,000 CRS-affected children were born each year in the Americas.

101. All countries and territories of the Region of the Americas administer rubella-containing vaccine to their populations through their routine childhood vaccination programs. In addition, by December 2009, nearly 445 million people had been protected against measles and rubella through the administration of measles-rubella combined vaccine during “catch-up,” “follow-up” (to maintain measles and rubella elimination), and “speed-up” campaigns designed to eliminate rubella and CRS and strengthen measles elimination efforts. The commitment of the countries to conduct “speed-up” campaigns in adolescent and adult men and women has ultimately prevented the reestablishment of endemic measles virus transmission in the Region.

²⁹ The American Red Cross, the U.S. Department of Health and Human Services’ Centers for Disease Control and Prevention, the Canadian International Development Agency, the GAVI Alliance, the Inter-American Development Bank, the International Federation of Red Cross and Red Crescent Societies, the Japanese International Cooperation Agency, the March of Dimes, the Sabin Vaccine Institute, the United Nations Children’s Fund, the United States Agency for International Development, and the Church of Jesus Christ of Latter-day Saints.

102. In 2007, the Americas experienced a resurgence of rubella cases due to importations of rubella virus into countries that initially vaccinated only females during mass vaccination campaigns. Confirmed rubella cases increased from 2,998 in 2006 to 13,246 in 2007, as a result of outbreaks in Argentina, Brazil, and Chile. A total of 4,532 confirmed rubella cases were reported in the Region in 2008, of which Argentina and Brazil accounted for 98%. These countries intensified vaccination and surveillance efforts. Chile implemented a “speed-up” campaign targeting men in 2007. Argentina (men only) and Brazil (men and women) conducted campaigns in 2008. Vaccination activities were also implemented within the framework of the first South American Technical Cooperation among Countries (TCC) project intended to immunize populations against measles and rubella along border areas of all countries that shared a border with Argentina and Brazil. In 2009, endemic rubella virus transmission was limited to only Argentina, where the last reported confirmed endemic rubella case had a date of rash onset of 3 February 2009. In addition, eight imported/import-related rubella cases were confirmed in Canada (four cases), and the United States (four cases).³⁰

103. As an unfortunate consequence of the rubella outbreaks, in 2009² the Americas reported 15 CRS cases in Argentina (3 cases) and Brazil (12 cases). The dates of birth of the last confirmed CRS cases were 24 June 2009 and 6 July 2009 for Brazil and Argentina, respectively. Since CRS cases can excrete virus for up to 12 months, it is essential that countries that reported the last CRS cases intensify surveillance and monitor virus excretion from confirmed CRS cases until two viral negative cultures are obtained at least one month apart. This will help ensure no additional spread of endemic rubella virus.

104. Integrated case-based measles and rubella surveillance is carried out in all countries. Cases are reported weekly to the regional level. The continuous monitoring of recommended standardized measles/rubella surveillance indicators ensures high-quality surveillance in the Region. In an effort to further strengthen surveillance, countries are improving coordination with the private sector to rapidly detect and respond to outbreaks.

105. During 1997-2005, wild-type rubella virus genotype 1C was isolated from previous outbreaks in the Region; the last occurrence of 1C virus transmission was in Chile and Peru. Beginning in 2006, genotype 2B was introduced in the Region and linked to imported cases. Following virus transmission for more than a year it was considered endemic in the Americas. The last confirmed endemic rubella genotype 2B case was reported in the Region in February 2009; suggesting that the countries of the Americas have achieved the elimination goal set for 2010.

³⁰ Data up to EW 52/2009.

106. More than 112,500 CRS cases have been prevented over an analytic horizon of 15 years³¹ in Latin America and the Caribbean as a result of the success of the rubella and CRS elimination initiative.

107. Many useful lessons are currently being shared with other Regions, including the vaccination beyond childhood, the importance of political support, the development of social communication strategies targeting nontraditional groups, the value of alliances to respond to crisis situations, to name a few.

108. The initiative has also contributed to the development of the fundamental pillars of primary health care, including the expansion of health services, an emphasis on community participation and solidarity, a sense of empowerment for making informed health related decisions, and intersectorial cooperation. Elimination strategies have also promoted the strengthening of health systems through improvements in information systems, management and supervision, development of human resources, standard of care newborn hearing screening, and related research.

Call to Action

109. Follow-up to Resolution CSP27.R2 (2007), a regional Plan of Action for documenting and verifying measles, rubella, and CRS elimination has been finalized. The Plan has an overarching goal of guiding countries and their national commissions in preparing the necessary evidence that supports the interruption of wild virus transmission. The plan was formally endorsed by the Technical Advisory Group on Vaccine-preventable Diseases (TAG) during its XVIII Meeting in August 2009. The following components are included in the regional plan: epidemiology of measles, rubella, and CRS; quality of surveillance; molecular epidemiology and laboratory activities; molecular epidemiology of the virus; analysis of vaccinated population cohorts; sustainability of the National Immunization Program; and the correlation and integration of evidence.

110. Currently, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, Guatemala, Mexico, Nicaragua, Paraguay, and Uruguay have formed national commissions. Sixteen additional countries have begun the process to establish commissions and the remaining eight countries³² are encouraged to initiate the process in 2010.

³¹ Estimated for each country beginning with the implementation of interventions to interrupt rubella virus transmission.

³² In 2005 the United States declared endemic rubella virus transmission eliminated.

111. The International Expert Committee (IEC) will evaluate the documentation submitted by national health authorities, in collaboration with national commissions, to verify elimination at the regional level. The data must demonstrate that endemic measles and rubella virus transmission has been interrupted for at least three continuous years in the Americas. Documentation of the interruption of endemic virus transmission should be concluded by countries by the first quarter of 2012. The final presentation on the verification of elimination in the Region of the Americas will be presented to the Pan American Sanitary Conference in 2012.

112. Many challenges remain to sustain elimination, including the inevitable risk of importations due to ongoing measles and rubella virus circulation in other regions of the world. It is imperative that countries do not become complacent. Otherwise, they risk losing all the remarkable success achieved in measles, rubella, and CRS elimination in the Region. Consequently, they must sustain a high level of preparedness to quickly and adequately respond to importations. Sustained commitment of Member States and PAHO strategic partners will also be necessary. Finally, it is vital that the Member States of the Pan American Health Organization continue to advocate that other regions also eliminate endemic measles and rubella, particularly in light of the request of the Executive Board of the World Health Organization in May 2008³³ to report on the feasibility of global measles elimination.

Action by the Executive Committee

113. The Executive Committee is invited to take note of these progress reports.

- - -

³³ See document EB123/2008/REC/1, summary record of the second meeting, section 1.