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CONTENTS

A.	Social Determinants of Health**	2
B.	Plan of Action for Implementing the Gender Equality Policy	7
C.	Elimination of Measles, Rubella, and Congenital Rubella Syndrome in the Region of the Americas.....	12
D.	Regional Strategy and Plan of Action on Nutrition in Health and Development, 2006–2015: Mid-term Review	20
E.	Regional Strategic Plan for HIV/AIDS/STI, 2006-2015: Mid-term Evaluation	27
F.	Current Dengue Situation.....	31
G.	Implementation of the International Health Regulations	34
H.	Regional Goals for Human Resources for Health 2007–2015	43
I.	Status of the Pan American Centers	47

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A. SOCIAL DETERMINANTS OF HEALTH

Introduction

1. World Health Assembly (WHA) Resolution WHA62.14 (2009), Reducing health inequities through action on the social determinants of health, urges Member States to “tackle the health inequities within and across countries through political commitment” (1). In line with this resolution, the objective of this progress report is to provide an update on the World Conference on Social Determinants of Health (hereafter referred to as the “World Conference”) and its outcomes. This also entails an assessment of current regional achievements and efforts made in enhancing health equity through a social determinants of health (SDH) approach.

Background

2. The World Health Organization (WHO) convened the World Conference on 19–21 October 2011 in Rio de Janeiro, Brazil. Its purpose was to build support for implementing actions aimed at dealing with social determinants of health. The World Conference was organized in accordance with Resolution WHA62.14 (2009) and hosted by the Government of Brazil. To organize this worldwide event, the Brazilian Ministry of Health, the Oswaldo Cruz Foundation (FIOCRUZ), and the Brazilian Ministry of Foreign Affairs worked closely with WHO and its Regional Office for the Americas, the Pan American Health Organization (PAHO).

3. The World Conference brought together Member States and stakeholders to share experiences on policies and strategies aimed at reducing health inequities. More than one thousand participants attended the World Conference, while 19,000 people followed the event via webcast. The key objective was to draw lessons learned and catalyze coordinated global action in five key areas, namely:

- (a) governance to tackle the root causes of health inequities: implementing action on social determinants of health;
- (b) promotion of participation: community leadership for action on social determinants of health;
- (c) the role of the health sector, including public health programs, in reducing health inequities;
- (d) global action on social determinants of health: aligning priorities and stakeholders; and
- (e) monitoring progress: measurement and analysis for informed policy-making that will build accountability for the social determinants of health.

4. In preparation for the World Conference, PAHO held three regional consultations:
 - (a) A face-to face meeting with Member States with the objective of formulating regional recommendations on the social determinants of health in line with the five themes identified by WHO (2).
 - (b) A virtual consultation with 300 civil society organizations (CSOs), as well as a face-to-face meeting with 25 CSOs, with the latter aimed at synthesizing the results of the previous consultation and formulating recommendations to inform policy-makers on what would become the Rio Political Declaration on Social Determinants of Health.
 - (c) A virtual consultation with members of the Equity, Health and Human Development listserv aimed at reaching additional stakeholders. The recommendations that emerged from these consultations were documented and distributed accordingly.
5. A total of seven case studies from the Region of the Americas were documented and published on the WHO Conference website as background material. These case studies formed the basis of the evidence used in the World Conference to illustrate the systematic and practical aspects of implementing the SDH approach at the country level.
6. The Rio Political Declaration on Social Determinants of Health (hereafter referred to as the “Rio Declaration”) was adopted on 21 October 2011 during the World Conference (3). It expresses worldwide political commitment to implement an approach geared toward the social determinants of health, with a view to reducing health inequities. This will allow countries to build momentum for developing their own national action plans and strategies dedicated to reaching this goal within their borders.
7. The Rio Declaration recommends that the SDH approach be duly considered in WHO’s reform process, and that the Sixty-fifth World Health Assembly adopt a resolution incorporating its text. The outcome of the Rio Declaration was discussed at the 130th session of the WHO Executive Board (EB130). A Draft Resolution was proposed by Brazil, Chile, and Ecuador to be presented at the Sixty-fifth World Health Assembly, scheduled to meet in Geneva on 21–26 May 2012.

Update on the Current Situation

8. The SDH approach was included in the noncommunicable diseases (NCDs) outcome document (UN Resolution A/RES/66/2 [2012]) (4) as a result of efforts to include this model. Similarly, PAHO is working to ensure that the approach to health inequity and the social determinants of health will be addressed in the agenda of the

United Nations Conference on Sustainable Development (hereafter referred to as the “Rio+20 Conference”).

9. Also concerning the Rio+20 Conference, a meeting was held with 54 PAHO/WHO Collaborating Centers to discuss how best to use the recommendations from the World Conference on Social Determinants of Health in preparing for the Rio+20 Conference, which will tackle the issue of sustainable development (5).

10. PAHO has launched and established a Cross-Organizational Team (COT) on the Determinants of Health and Risks, which promotes interprogrammatic and intersectoral work—including the concept of “Health in All Policies” (HiAP).

11. In collaboration with University of New South Wales, Australia, and the Kobe Center, Japan, a total of 23 Country Delegations in the Region have received training on two tools:

- (a) Health Impact Assessment; and
- (b) Urban Health Equity Assessment and Response Tool (Urban HEART).¹

12. Both of these tools specifically address inequities within local and national contexts.

13. Efforts to build intersectoral and interagency collaboration are made through PAHO’s *Faces, Voices and Places* initiative. The goal is to build political will at the highest level while at the same time providing technical assistance to address the social and economic determinants of health at the local level in the most vulnerable communities. This is done through partnerships with mayors, nongovernmental organizations and other development agencies. To date the initiative has grown to include over 50 communities in 23 countries and four territories.

14. The overarching theme of the 2012 edition *Health in the Americas* is inequities and determinants of health².

15. A five-year WHO Strategy and Global Plan of Action (2012–2017) to implement the Rio Declaration is currently being drafted and will be reviewed in a number of consultations.

16. PAHO has been supporting the preparation of the Strategy and Global Plan of Action, convening meetings and discussions.

¹ For more information, see http://www.who.int/kobe_centre/measuring/urbanheart/en/index.html

² A preliminary draft of *Health in the Americas* has been written with Sir/Professor Michael Marmot as an External Advisor.

17. The SDH approach is being addressed and promoted in preparation for the 8th Global Conference on Health Promotion, to be held in Helsinki in 2013. Its central theme will be “Health in All Policies.”

Action to Improve the Situation

18. In line with the recommendations that emerged during the Regional Consultation on the Social Determinants of Health, PAHO will do the following:

- (a) Enhance and strengthen intersectoral action through the *Faces, Voices and Places* initiative.
- (b) Collect disaggregated data improving both the analysis and understanding of inequities and social gradients in health within the Region, as well as within countries.
- (c) Include the topic “Social Determinants of Health” when formulating the post-2015 Millennium Development Goals (MDGs).
- (d) Work with and extend PAHO’s networks, with the goal of strengthening technical cooperation on the social determinants of health.

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B. PLAN OF ACTION FOR IMPLEMENTING THE GENDER EQUALITY POLICY

Background

1. Member States approved the Pan American Health Organization's (PAHO) Gender Equality Policy during the 46th Directing Council (Resolution CD46.R16, [2005]). The resolution requested of the Director "...within the available financial means, as mandated within the various processes of institutional strengthening, to develop an action plan for the implementation of the Gender Equality Policy, including a performance monitoring and accountability system" (1).

2. The requested Plan of Action was approved by Member States in 2009 (Resolution CD49.R12) (2). It provides a roadmap with monitoring indicators for the Pan American Sanitary Bureau (PASB) and the Member States to implement the Gender Equality Policy. The plan requires the Director to report on progress of its implementation. This is the first such report presented to the Governing Bodies.

Methodology

3. PASB's Gender, Diversity and Human Rights Office (GDR) developed a monitoring framework (three questionnaires) to solicit information on progress of PASB technical areas, PAHO/WHO Country Offices (PWRs), Member States, and GDR itself. During 2011, the monitoring framework was presented at three subregional PASB Managers' Meetings, as well as at the Technical Advisory Group on Gender Equality and Health (TAG/GEH), the PASB Gender Focal Point (GFP) network, and to other partners. The four strategic areas reviewed in the framework are (a) data disaggregation, analysis and use; (b) capacity building to integrate gender in health; (c) civil society participation in gender equality plans; and (d) monitoring gender equality advances.

Update

4. Information was self-reported by four technical areas of PASB, GDR, and 36 countries and territories, including Barbados and nine Eastern Caribbean countries. Haiti, Jamaica, Puerto Rico, and the United States of America did not provide results. Some of the consultations included the participation of all partners, including civil society, others included only ministry of health and PASB colleagues, and still others included other ministries and United Nations (UN) partners. Two reports were provided without consultations.

Results in Desaggregating Health Information

PASB Gender, Diversity and Human Rights Office

5. GDR has developed a number of tools for training producers and users of health information on how to integrate a gender and intercultural perspective in the use of health information and in health information systems. To strengthen the capacity of countries to produce, analyze, and use health information that includes gender indicators, GDR has developed (with UN partners): the third biennial statistical brochure “Gender, Health and Development in the Americas: Basic Indicators 2009;” “Health of Women and Men in the Americas: Profile 2009;” and other documents¹

Technical Areas: Number and Percentage of Guidelines with Disaggregated Data by Sex, Age, and Ethnicity, 2005–2010

Project ²	Total Guidelines	Disaggregated by:					
		Sex		Age		Ethnicity	
		Number	%	Number	%	Number	%
SDE	9	9	100	8	89	3	33
FCH	20	14	70	16	80	6	30
HSD	13	11	85	10	77	9	69
HSS	8	5	63	6	75	4	50
TOTAL	50	39	78	40	80	22	44

6. As the table above shows, between 63% and 100%, of the guidelines and publications produced by the technical areas disaggregated information by sex, but considerably fewer did so by ethnicity. Disaggregation is a necessary step for identifying health disparities, but it alone is not sufficient for understanding why these disparities exist. A gender and equity analysis can complement disaggregated information by indicating how to address inequalities in health.

Countries with Guidelines/Publications with Data Disaggregated by Sex and Age, 2005–2010

7. Countries reported having between 1 and 19 guidelines for integrating gender in health information, policies, and programming (with Bolivia reporting the highest number), and between 1 and 20 publications (with both Peru and Uruguay reporting the highest number). Countries that disaggregated information by sex predominantly reported

¹ All publications, including the complete monitoring report, are available from: <http://www.paho.org/gdr/publications>.

² The acronyms in this column refer to the following PASB areas: Sustainable Development and Health (SDE), Family and Community Health (FCH), Health Surveillance, Disease Prevention and Control (HSD), and Health Systems based on Primary Health Care (HSS).

that they had included a gender analysis and used information for decision making, advocacy, monitoring, and training. The countries that published gender and health profiles were Bolivia, Costa Rica, Honduras, Mexico, Panama, Peru, and Uruguay. Colombia, Nicaragua, and Trinidad and Tobago reported that gender analysis was included in their country's health situation reports.

Results in Capacity-Building on Gender and Health

PASB Staff Training on Gender and Health

8. The GDR Senior Advisor is part of the PASB management team that determines staff training opportunities. In 2008 and 2009, GDR trained the Country Offices' GFPs, the Ministries of Health, and partners from national women's agencies and civil society organizations during four-day subregional workshops. As a result, more than 100 people at the country level and 30 PASB headquarters staff were trained. Since then, GDR has developed a virtual course on "Gender and Health with a Human Rights and Cultural Diversity Perspective" to train intersectoral country teams. In 2011, 58 persons, including 16 from PASB, were trained from five priority countries.

Gender and Health Training in Member States

9. More than half of Member States reported having received training on gender to implement their national plans on gender and health. It was commonly noted that this training should be more consistent and focused on specific health issues. Trainings often were provided by the country's ministry of health, as in the exemplary case of Mexico, whose Secretariat of Health gender trainers provide ongoing support for capacity-building and offer a gender and health diploma course to health workers.

Results of Gender and Health Plans and Participation of Civil Society

Technical Advisory Group on Gender and Health (TAG/GEH)

10. The PASB Director's TAG/GEH consists of gender experts and representatives of UN sister agencies, government (MOH leaders or Gender Offices), and regional civil society organizations that promote gender equality in health. The TAG/GEH met three times from 2008 to 2011 to assist the Director and PASB with concrete recommendations for the development, consultation, implementation, and monitoring of the Plan of Action for Implementing the Gender Equality Policy.

Gender Equality Policies and Budgets

11. Most countries have passed national gender equality or equal opportunity laws that also apply to the health sector. Nine countries reported having specific health and

gender policies and eight have specific units. Only Honduras, Mexico, Peru, and Venezuela reported budgets assigned by law. Many countries noted that their gender activities were mostly donor supported.

Results in Gender Equality in Health Monitoring Mechanisms

12. PASB has developed and implemented gender tools and checklists for reviewing Biennial Work Plans, Country Collaboration Strategies, and Governing Body documents and resolutions. These tools, which also measure the integration of human rights and cultural diversity, have been included in the PASB's operation, planning, and training manuals.

Intersectoral Participation in MOH Advisory Groups

13. The participation of many different stakeholders in integrating gender in health is vital because trained partners can support their MOH's efforts with respect to gender.

Actions to Improve the Situation

Conclusion

14. PAHO's technical areas, Country Offices, and Member States are in general agreement that an understanding of the causes of women's and men's health disparities requires an equity and social determinant perspective. The monitoring exercise reveals that the greatest challenge to gender integration in health is insufficient political support. Even with challenges, the results also show progress in implementation of the Plan of Action for PAHO's Gender Equality Policy.

Recommendations

15. Ministries of Health should clearly position the integration of gender in their national health plans. This requires a specific gender policy and plan of action that includes indicators, an allocated budget, and trained staff. Many countries recommend that the ministries of health should create a coordinating unit at the senior level to carry out this responsibility.

16. PAHO's Gender Equality Policy should include other important components related to gender equality and health, including health issues related to men; unpaid health care in the household and equal compensation of health workers; the participation of women in leadership; and sexual harassment policies.

References

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C. ELIMINATION OF MEASLES, RUBELLA, AND CONGENITAL RUBELLA SYNDROME IN THE REGION OF THE AMERICAS

Introduction

1. In 1994, during the 24th Pan American Sanitary Conference, ministers of health adopted Resolution CSP24.R16, setting a goal to eliminate measles from the Region of the Americas by 2000. Approval of the resolution was based on the impressive and rapid reduction in measles demonstrated by countries that pioneered the use of immunization strategies for elimination. The measles elimination goal was reaffirmed by subsequent Resolutions CD38.R6 (1995), which approved a Plan of Action for Measles Elimination in the Americas,¹ and CE118.R14 (1996), which urged all countries to allocate the necessary human and financial resources to fully implement the strategies outlined in the Regional plan. The Region of the Americas achieved the goal of measles elimination in November 2002.

2. The strengthening of measles surveillance also revealed that rubella and congenital rubella syndrome (CRS) had emerged as significant public health problems in the Region. In 1999, the Pan American Health Organization's (PAHO) Technical Advisory Group on Vaccine-Preventable Diseases (TAG) recommended accelerated rubella control and CRS prevention with campaigns targeting a wide age range, including young adults. In light of the lessons learned from vaccinating large and heterogeneous populations with measles-rubella vaccine, as well as the documented cost-effectiveness of rubella vaccination, in 2003 the 44th Directing Council adopted Resolution CD44.R1, calling on Member States to eliminate rubella and congenital rubella syndrome from their countries by 2010. Toward this end, the countries were requested to draft national plans of action within one year. In addition, the resolution called on the Director to "elaborate a regional plan of action and mobilize resources in support of a rubella/CRS elimination goal for 2010." The last endemic rubella and CRS cases in the Region were reported in 2009.

3. In October 2007, considering the elimination of measles in 2002 and the progress achieved toward the rubella and CRS elimination goals, the 27th Pan American Sanitary Conference approved Resolution CSP27.R2. This resolution urged Member States to establish National Commissions to document and verify measles, rubella, and CRS elimination in each country, and it authorized the formation of an International Expert Committee (IEC) to document and verify the interruption of transmission of endemic measles and rubella viruses in the Region of the Americas. To ensure a standardized

¹ The Plan of Action (contained in Document CD38/15) targets achievement and maintenance of at least 95% measles vaccination coverage in all municipalities or districts in every country of the Region. This is to be done by supplementing routine vaccination activities with periodic follow-up campaigns aimed at preventing the accumulation of susceptible preschool-aged children.

approach to documentation and verification, PAHO developed a regional plan of action that was endorsed by the TAG and approved by the IEC. The plan was created to guide countries and their National Commissions in compiling and analyzing evidence that endemic measles and rubella transmission has been interrupted.

4. This document summarizes the progress to date in documenting the elimination of measles, rubella, and CRS in the Region of the Americas and the remaining challenges and risks to maintaining the Region free of endemic measles, rubella, and CRS. It also proposes an emergency plan of action to ensure the maintenance of elimination of these diseases in the Region.

Progress to Date

5. In accord with Resolution CSP27.R2 of the Pan American Sanitary Conference, an International Expert Committee has been formed and 23 National Commissions have been established, including a Commission for the French Overseas Departments in the Americas. In addition, a Subregional Commission was established for the English-speaking and Dutch-speaking Caribbean countries and territories, including Suriname.

6. As of April 2012, 19 commissions, including those for the French Departments and the English/Dutch-speaking Caribbean, have submitted their final elimination reports to PAHO for review and comment by the International Expert Committee. The remaining countries (Brazil, Colombia, Ecuador, Haiti, and Peru) will submit their reports by the end of June, or after the countries ensure that measles transmission has been interrupted by completing active and retrospective searches, implementing outbreak response vaccination, and implementing successful vaccination campaigns to close immunity gaps.

7. After careful analysis of the reports submitted by the National Commissions and Subregional Commission, it appears that the interruption of endemic measles and rubella virus transmission has been achieved. However, countries that reported sustained measles outbreaks in 2011 will need to provide evidence that virus transmission did not extend over a period of 12 months or more. For rubella, a country with unknown source cases identified through the documentation process will need to conduct careful investigation to ensure that the cases are not due to endemic circulation.

8. As part of the documentation and verification process, several PAHO Member States have identified challenges in maintaining elimination of measles, rubella, and CRS. Moreover, some of the countries have reported weaknesses and failures in national surveillance systems and routine immunization programs, which need to be addressed.

Challenges to Maintaining Elimination

9. Between 2003 and 2010, historically low numbers of measles cases were reported in the Americas. During this eight-year period, 34 of 45 countries and territories (76%)

reported no measles cases, and another 5 countries (11%) together reported 10 confirmed measles cases. The remaining 6 countries (13%) reported a total of 1,239 cases, 99% of the 1,249 confirmed cases in the Region during this period. The occurrence of measles was mainly limited to cases that were internationally imported or import-linked. Moreover, all the genotypes identified from outbreaks occurring in the Americas since 2003 have been imported to the Region.

10. In 2011, however, 1,379 measles cases were reported in the Americas, an eightfold increase over the previous annual average of 156 cases between 2003 and 2010. This increase coincided with several large outbreaks in Europe and Africa. Of the 45 countries and territories, 33 (73.3%) reported no measles cases, and 9 (20%) reported 14 confirmed measles cases. Three countries—Canada, Ecuador, and the United States (6.7%)—reported a total of 1,290 cases, 93% of the 1,379 confirmed cases in the Region (unconfirmed data for 2011, as of EW18/2012). The most commonly identified genotypes in these three countries include D4, which is circulating on the European continent; B3, from Africa; and D8 and D9, from Southeast Asia and the Pacific.

11. The most recent measles outbreaks, with several secondary transmissions, have similar characteristics. The vast majority of cases have occurred in specific groups of unvaccinated persons (religious groups or other groups that reject vaccination) or in specific geographic areas, such as in indigenous communities, in large cities (especially on the peripheries), and in rural and border areas with limited access to health care. Almost all measles cases are import-associated.

12. The current outbreaks in the Region put measles elimination at risk. In 2011, 171 outbreaks due to imported measles viruses were documented, and the imported viruses have caused persistent transmissions in at least three countries. To highlight the challenges, the three largest outbreaks are summarized below.

13. The largest outbreak, with a duration of seven months (EW14/2011–EW40/2011), occurred in Canada and resulted from an importation of D4 measles virus from Europe. It accounted for 803 cases, 61% of all reported cases in the Region in 2011. A large proportion of these cases (70%) were centered in a single province, Quebec, where 79% of the cases detected were not vaccinated or had no proof of vaccination. The authorities implemented a province-wide school-based vaccination activity, targeting children who were not fully immunized against measles with the recommended two doses of measles-mumps-rubella vaccine.

14. The second-largest outbreak in the Region occurred in Ecuador, where it appears that children in some rural indigenous localities have continued to be missed during routine and supplementary immunization activities, thus creating pockets of susceptible population. The outbreak spread to nine different provinces across the country. A total of 265 confirmed measles cases occurred in six provinces in 2011 and 53 additional cases among children in three provinces in 2012 (data as of May 2012). The most affected age

group has been children under five years old. Cases with genotype B3, which is commonly found in Africa, have been identified along with one case of D4. To ensure rapid response to this measles outbreak, a follow-up campaign targeting children up to 15 years of age was rescheduled to start early. According to the Ministry of Health, vaccination coverage among children up to 5 years of age was $\geq 95\%$ in the majority of the provinces. Ecuador has also completed vaccination activities for the age group from 5 to 14 years. The last measles case was reported in EW16/2012 (data as of May 2, 2012). After the country has not reported any new measles case for a 12-week period, health authorities will implement three main activities to verify the interruption of measles virus circulation: (a) rapid coverage monitoring; (b) active case searches for measles; and (c) retesting negative dengue specimens for measles. Once these activities are concluded, the National Commission will submit the final report on the interruption of endemic transmission of measles, rubella, and CRS in Ecuador.

15. The state of São Paulo (Brazil) reported the third-largest outbreak, with six isolated cases and three chains of transmissions, resulting in 27 confirmed cases in seven municipalities. Only two of the six isolated cases reported previous travel abroad. In two cases, genotype D4 was isolated. Additionally, a 7-month-old infant was reported to have a rash with an onset date of 24 December 2011, which was eventually confirmed as measles with genotype D4. Despite complete epidemiological investigations, it was not possible to identify the source of infection for any case or to link any of the confirmed cases to importations. The National Commission for documenting/verifying measles and rubella elimination will review the epidemiology and results of the retrospective case searches at the end of April 2012 to either rule out or confirm circulation of measles virus in the area.

16. During 1998–2006, confirmed rubella cases in the Americas decreased by 98%, from 135,947 to 3,005. In 2007, however, the Americas experienced a resurgence of rubella cases due to importations of rubella virus into countries that initially targeted only females during mass vaccination campaigns. Confirmed rubella cases increased from 3,005 in 2006 to 13,187 in 2007 as a result of outbreaks in three countries. A total of 4,536 confirmed rubella cases were reported in the Region in 2008; cases in two countries accounted for 98% of them. As an unfortunate consequence of the rubella outbreaks of 2008–2009, a total of 27 CRS cases were reported in these two countries. The last confirmed CRS case was a child born on 26 August 2009. In response to these outbreaks, countries intensified surveillance activities and vaccination interventions by conducting supplementary immunization activities among adolescents and adults. Countries that completed campaigns for adolescent and adult males and females have not reported any endemic rubella cases. The last confirmed endemic rubella case was reported in February 2009. In 2009, two countries reported 7 import-associated rubella cases; in 2010, the Regional total was 15 import-associated rubella cases; and in 2011, it was again 7 import-associated rubella cases (provisional data as of April 2012). No endemic CRS cases were reported in 2010 or 2011.

17. Despite limited molecular epidemiology information, the rubella virus genotype 1C has been identified as endemic only in the Americas, as it has not been identified in other regions of the world. The last occurrence of 1C virus transmission was in 2005. Between 2006 and 2009, the genotype 2B was isolated from the outbreaks reported in three countries and was considered to be endemic to the Americas, but endemic transmission was interrupted in 2009. Since 2009, viruses of genotypes 1E, 1G, 1J, and 2B have been linked to imported cases.

18. During the process of verifying measles, rubella, and CRS elimination, Colombia identified several cases of clinical and laboratory-confirmed rubella in 2008, 2009, and 2011. The first detected case was a laboratory-confirmed rubella case from 2011, without genotype information available. Retrospective investigations in the same department of Colombia revealed eight more rubella cases with laboratory or clinical confirmation between 2008 and 2009. The majority of affected people had no vaccination history. Retrospective and active case searches were conducted to complement the epidemiological investigation, but they were not able to identify the source of infection of all these cases. Colombia will need to implement active case searches in the epidemiologically silent areas of the country.

19. Although progress toward the goal of documenting and verifying the elimination of measles, rubella, and CRS was on track by the end of 2011, some of the National Commissions have concluded that the epidemiological surveillance is not sufficiently robust to ensure maintenance of the elimination of rubella and CRS. Nevertheless, the Commissions state that documentation to verify the absence of the endemic diseases in the Region can be achieved if the weaknesses identified are corrected promptly. Toward this end, countries are urged to take prompt actions to correct challenges identified during the verification process to ensure that the achievements in eliminating endemic diseases will be maintained.

20. Ensuring timely vaccination responses to imported measles and rubella viruses has become increasingly important as progress is made toward documenting and verifying elimination of the endemic viruses. Member States have taken costly additional measures to reduce the risk of new outbreaks caused by the international spread of measles and rubella viruses. These measures include supplementary and routine immunization activities to close gaps in population immunity, rapid coverage monitoring, vaccination of vulnerable populations, and timely investigations of each imported case. In the supplementary campaigns for measles and rubella elimination in the Region, 485 million people have been vaccinated, often with simultaneous campaigns taking place in border areas of neighboring countries. Actions to contain outbreaks pose substantial direct costs to public health and the health care system, with a net public

sector cost of as much as US\$ 10,000 per case.²

21. The Region of the Americas continues to be at risk of importations, given continuing circulation of measles and rubella viruses in other regions of the world. Also, announcing the elimination of endemic measles and rubella may be misinterpreted by the general public or by people who are not familiar with the technical distinctions between imported and endemic cases.

22. In light of the remaining challenges for maintaining elimination of measles and rubella in the Region of the Americas, it is proposed the 150th Session of the Executive Committee recommend that the 28th Pan American Sanitary Conference adopt a resolution on an emergency plan of action. This resolution should urge Member States to strengthen active surveillance of these diseases and to maintain high population immunity through vaccination.

Regional Emergency Plan of Action 2012–2014 for Maintaining Measles and Rubella Elimination

23. With a view to maintaining the Regional goal of elimination of measles, rubella, and congenital rubella syndrome, and following guidance from TAG, the IEC, and PAHO, an emergency action plan was formulated for the next two years to address weaknesses identified in the immunization and surveillance programs for measles, rubella, and CRS.

24. Member States were requested to verify the interruption of endemic measles, rubella, and CRS cases in all the countries of the Americas for a period of at least three years from the last known endemic case, in the presence of high-quality surveillance and with coordination and guidance from PAHO. Elimination means the interruption of endemic disease transmission for a period of at least 12 months under high-quality surveillance. To sustain and build on this elimination achievement, PAHO urges Member States to implement the following actions, which are highly recommended by the IEC:

- (a) Maintain high-quality, elimination-standard surveillance in all Member States and ensure timely and effective outbreak response measures to any wild virus importation. To ensure high-quality surveillance, the following activities should be conducted:
 - i. Implement external rapid assessments of measles, rubella, and CRS surveillance systems to increase robustness and quality of case detection and reporting and strengthen registries of congenital anomalies.
 - ii. Conduct active case searches and review the sensitivity of surveillance

² Sugerman DE, Barskey AE, Delea MG, et al. Measles outbreak in a highly vaccinated population, San Diego, 2008: Role of the intentionally undervaccinated. *Pediatrics* 2010;125(4):747–55.

- systems in epidemiologically silent areas.
- iii. Issue health alerts for mass-gathering events (such as the Olympic Games and the FIFA World Cup).
 - iv. Involve the private sector in disease surveillance with a special focus on inclusion of private laboratories in the Regional Measles and Rubella Laboratory Network.
 - v. Enhance collaboration between epidemiological and laboratory teams to improve measles and rubella surveillance and the final classification of suspected cases.
 - vi. Improve molecular genotyping of the confirmed cases throughout outbreaks.
 - vii. Address gaps and failures in surveillance systems, as identified by the National Commissions.
- (b) Maintain high population immunization coverage against measles and rubella ($\geq 95\%$) in all Member States. Toward this end, the following activities are recommended:
- i. Implement rapid coverage monitoring to identify populations susceptible to measles and rubella, focusing particularly on high-risk populations with any of the following characteristics:
 - Live in high-traffic border areas.
 - Live in densely populated areas such as urban fringe settlements.
 - Live in areas with low vaccination coverage or high vaccination dropout rates.
 - Live in areas not reporting suspected cases (epidemiologically silent).
 - Live in areas with a high density of tourists.
 - Are geographically, culturally, or socioeconomically difficult to reach.
 - Are dedicated to commerce/trade (e.g., through fairs, markets) or live in highly industrialized areas.
 - ii. Implement immediate vaccination activities in the areas where rapid coverage monitoring finds coverage to be under the recommended threshold of 95%.
 - iii. Implement high-quality follow-up vaccination campaigns. To ensure high levels of immunity, countries have made commitments to implement such

campaigns while the Region is in the process of verifying its status as free of endemic transmission of measles and rubella (2008–2014).

25. Full implementation of intensified vaccination activities to maintain elimination status will be essential to ensure high immunization coverage, especially in areas that have susceptible populations. In the areas where measles and rubella viruses are still circulating, further efforts to interrupt virus transmission and conduct epidemiological investigations should focus on unvaccinated vulnerable population groups and on high-risk areas.

26. Countries should integrate the proposed activities for maintaining measles, rubella, and CRS elimination in their annual plans of action for national immunization programs, which will reflect an ongoing political commitment and sufficient financing.

27. To ensure implementation of the emergency plan of action 2012–2014 for maintaining the Region free of measles, rubella, and CRS, the budget of US\$ 1.5 million must be fully financed.

Action by the Executive Committee

28. The Executive Committee is invited to review the information provided in this document and to consider whether it is appropriate to move this item from “Matters of Information” to “Program Policy Matters,” in order to adopt a resolution during the 28th Pan American Sanitary Conference.

D. REGIONAL STRATEGY AND PLAN OF ACTION ON NUTRITION IN HEALTH AND DEVELOPMENT, 2006–2015: MID-TERM REVIEW

Introduction

1. There is no good health without good nutrition. Many of the most effective policies and programs for promoting good nutrition fall outside the health sector. Yet the burden of poor nutrition, with an array of health outcomes related to both undernutrition and overweight, has a direct impact on the health sector. The dual burden of malnutrition is increasing, including undernutrition (primarily chronic malnutrition among young children and micronutrient deficiencies among children and other age groups), and in contrast, overweight and obesity. These two forms of malnutrition can coexist within the same country or community, and even within a single household. Food and nutrition insecurity, inadequate water and sanitation, poverty, and gaps in access to health services and education are all determinants of malnutrition, which puts at risk the achievement of the Millennium Development Goals and other global and regional health goals.

2. In the Americas in 2007, 77% of total deaths (3.9 million) were due to noncommunicable chronic diseases (NCDs) (1). Of these deaths, 76% (2.95 million) resulted from four diseases: cardiovascular diseases (1.5 million), cancer (1 million), diabetes (232,000), and chronic obstructive pulmonary disease (219,000). Three of these (all but cancer) have poor nutrition as a risk factor. Approximately 44% of deaths from all causes occurred before 70 years of age; these premature deaths are associated with significant social, health, and economic costs to families and countries, and to the health sector in particular.

3. NCDs are a problem in all countries. Like undernutrition, however, the burden of NCDs affects the poor far more than the wealthy, in both relative and absolute terms, globally and in the Region of the Americas. The extent of child malnutrition varies among countries in the Region, depending on their poverty levels, relative income equity, and safety nets. It also varies within countries because of inequities. Micronutrient deficiencies are widespread.

4. Addressing underlying determinants and improving the quality of diet and physical activity throughout the life course is critical to reducing both undernutrition and nutrition-related chronic diseases. This requires specific policies to increase agricultural production of and broad access to quality foods; improved initiatives to promote consumer information, school nutrition, general nutrition, and physical education; and implementation and monitoring of the International Code of Marketing of Breast-milk Substitutes and guidelines on the marketing of foods and beverages to children.

Background

5. At the 47th Directing Council in September 2006, Member States approved the Strategy and Plan of Action on Nutrition in Health and Development, 2006–2015 (Document CD47/18) by Resolution CD47.R8. This includes five interdependent strategies: Development and Dissemination of Macropolicies Targeting the Most Critical Nutrition-related Issues; Strengthening Resource Capacity through the Health and Nonhealth Sectors Based on Standards; Information, Knowledge Management and Evaluation Systems; Development and Dissemination of Guidelines, Tools, and Effective Models; and Mobilizing Partnerships, Networks, and a Regional Forum in Food and Nutrition. It also includes one line of action and two sublines: Food and Nutrition in Health and Development; Suboptimal Nutrition and Nutritional Deficiencies; and Nutrition and Physical Activity in Obesity and Nutrition-related Chronic Diseases.

6. The Strategy and Plan of Action contributes to the Health Agenda for the Americas and to PAHO's Strategic Plan 2008–2012. To carry out the five strategies, Member States, with the support of the Pan American Sanitary Bureau, have made progress in developing multisectoral strategies and integrating interventions throughout the life course. This approach has contributed to the prevention of malnutrition in all its forms.

Progress and Early Results

7. With respect to “Development and Dissemination of Macropolicies Targeting the Most Critical Nutrition-related Issues,” in 2006 few countries had policies related to food and nutrition security and reduction of chronic malnutrition and obesity. As of 2012, nearly every country has a national policy addressing one or more of these issues. Many have also established high-level intersectoral and/or interministerial committees at the national, subregional, and municipal levels. Some are also acting to ensure national food production sufficient to meet population requirements. A key achievement in Central America was the recently approved Regional Agenda for Food and Nutrition Security. In South America, Mercosur is working on a similar agenda. At the 50th Directing Council in September 2010, Member States approved the Strategy and Plan of Action for the Reduction of Chronic Malnutrition (Document CD50/13) by Resolution CD50.R11. This Strategy and Plan of Action recognizes that underlying factors cause malnutrition and proposes interventions to address its determinants, using an intersectoral approach and involving different levels of government. It also promotes national alliances and monitoring and evaluation.

8. With respect to “Strengthening Resource Capacity through the Health and Nonhealth Sectors Based on Standards,” PAHO has held regional and national trainings in coordination with partners on the World Health Organization (WHO) Child Growth

Standards and Baby-Friendly Hospital Initiative, as well as on design of food fortification programs and quality assurance involving both the public sector and food producers.

9. In the area of “Information, Knowledge Management and Evaluation Systems,” PAHO has promoted the use of nutrition indicators in national health surveillance systems. This has proved challenging and requires additional work. A number of countries have implemented nationally representative nutrition surveys that provide updated information on nutrition indicators. Some countries still lack such surveys, particularly those in the Caribbean. PAHO has used these surveys to develop reports on anemia, iodine deficiency, child growth, and breastfeeding, describing national and regional trends and numbers of persons affected. A cross-organizational technical team in nutrition for health and development has been formed at PAHO to promote coordination of activities across different technical areas.

10. On the “Development and Dissemination of Guidelines, Tools, and Effective Models,” PAHO, in coordination with other stakeholders, has developed regional guidelines, translated guidelines from WHO, and supported adaptation of guidelines to national contexts. Examples include updated materials and reactivation of the Baby-Friendly Hospital Initiative, indicators for assessing infant and young child feeding practices, guidelines for vitamin A supplementation, and guidelines for implementing quality control, quality assurance, and regulatory monitoring of staple food fortification. These actions have resulted in updated national policies and norms in Member States, measurement of indicators using global and/or regional standards, and improved nutrition training for health professionals. A key challenge is to ensure broad coverage and high-quality implementation of these norms and guidelines.

11. Regarding “Mobilizing Partnerships, Networks, and a Regional Forum in Food and Nutrition,” in July 2008 the Regional Directors of the United Nations (UN) established the Pan American Alliance for Nutrition and Development (2). This interagency initiative, made up of 15 UN agencies, facilitates the coordination of international cooperation efforts and resources to promote effective, evidence-based multisectoral and inter-programmatic interventions to respond to the multiple causes of malnutrition. The agency directors established a Regional Technical Team to develop a conceptual framework and plan of action. The Alliance’s conceptual framework has been disseminated throughout the Region through workshops with UN Country Teams in Argentina, Bolivia, El Salvador, Guatemala, Paraguay, and Peru, as well as through a number of political, technical, and academic seminars. A next step is the development of national alliances along the same lines.

12. With respect to the subline of action on “Suboptimal Nutrition and Nutritional Deficiencies,” data show that among children in the Region, chronic malnutrition is the most prevalent form of growth failure. However, overweight and obesity is also a growing problem: 7% to 12% of children under 5 years of age are obese, six times the

percentage of children who are currently underweight (3). Although the prevalence of chronic malnutrition is declining, about one-third of children are stunted in Bolivia and Ecuador, and about half in Guatemala. National data mask increasingly wide disparities within countries based on income, rural or urban residence, and ethnicity. Because stunting starts during the prenatal period and is transmitted intergenerationally, its eradication requires health-service and intersectoral approaches, using a life-course framework. In the health sector, PAHO promotes policies and programs to support optimal breastfeeding and complementary feeding, growth assessment, treatment of severe acute malnutrition, micronutrient supplementation, and food fortification, as well as measures to increase access to health services. PAHO also advocates approaches across a range of other sectors, including housing and environment, water and sanitation, education, food security, employment and family income, and social protection, targeted to areas where nutritional deficiencies are most prevalent. Moreover, PAHO has learned from successful experiences in reducing chronic malnutrition in Brazil, Mexico, and Peru and has shared these with other countries. Other examples include Chile's *Crece Contigo* program and conditional cash transfers in several countries.

13. Globally, suboptimal breastfeeding is the third-greatest risk factor for global morbidity and mortality, according to the most recent estimates from the Global Burden of Disease Project.¹ Both breastfeeding and complementary feeding practices, essential for healthy growth and development, are far from universal. In the Region, only 58% of newborns are put to the breast within the first hour of birth, and only 44% of infants less than six months of age benefit from exclusive breastfeeding, dropping to only 25% among those four to five months old (4). About 30% of children do not receive minimum dietary diversity, and only 43% receive a minimum meal frequency. Although most countries have implemented the International Code of Marketing of Breast-milk Substitutes, only five countries have regulations in place for its effective enforcement (5). Certification of hospitals for the Baby-Friendly Hospital Initiative has lagged.

14. Micronutrient deficiencies have a significant impact on human development and economic productivity. In the Region, the prevalence of anemia is 44.5% in young children (22.5 million), 30.9% in pregnant women (3.5 million), and 22.5% in women of reproductive age (31.7 million) (6). Over the past 10 years, only the prevalence of anemia among pregnant women has declined, illustrating the failure of most micronutrient supplementation programs as well as the need to better integrate actions against anemia with Integrated Management of Childhood Illness (IMCI), maternity care, and other programs that deliver health services. Most countries have implemented folic acid supplementation or fortification programs to prevent neural tube defects. Argentina, Brazil, Canada, Chile, Costa Rica, and the United States have nationally representative information showing reduction in neural tube defects as evidence of the effectiveness of

¹ Presented at PAHO in January 2012 by Christopher Murray, Institute for Health Metrics and Evaluation; publication pending.

these programs. Efforts are being made in Central American countries to implement a neural tube defects surveillance system. Universal salt iodization to prevent iodine deficiency disorders has been adopted, and 90% of the population in the Region has adequate iodine intake. Challenges persist in countries with low quality salt production and in communities with no access to fortified food. It is estimated that vitamin A deficiency is mild to moderate in the Region, although for some countries available information is more than 10 years old. Vitamin A supplementation has been the main strategy for preventing this deficiency; however, only countries with national demographic and health surveys have information on program coverage. Sugar fortification with vitamin A has been successful in Central America. Deficiencies of zinc, vitamin B12, and more recently vitamin D have been reported by nonrepresentative small surveys in Central America. Although most countries of the Region have national policies and plans of actions for micronutrient supplementation or staple food fortification, surveillance systems to guide these policies are weak.

15. With respect to the subline of action on “Nutrition and Physical Activity,” overweight and obese children are likely to remain obese into adulthood and to develop NCDs at a younger age than average. For most NCD conditions associated with obesity, the risks depend partly on the age of onset and the duration of obesity. Policies and programs are needed to provide environments conducive to healthy eating and an active life, so that the healthy choice becomes the easy choice. Because children are especially vulnerable to the influence of advertising, they must be protected through effective public health action. To this end, PAHO convened an Expert Consultation on the Marketing of Food and Non-Alcoholic Beverages to Children in the Americas to make recommendations on the subject (7). Coordinated and focused actions with Member States are needed to implement these recommendations and evaluate their impact. Progress has also been made in developing bicycle paths and limiting traffic on main roads on weekends to facilitate recreation. Regional meetings on obesity have been held in Aruba and Mexico and among the presidents of Central America. The Chilean Senate also organized a conference in Valparaíso, supported by PAHO, to discuss improved food supply.

16. During the Sixty-third World Health Assembly in 2010, Resolution WHA63.23 was approved. It mandates WHO to support Member States in expanding their nutritional interventions related to the dual burden of malnutrition, in monitoring and evaluation of these interventions, in strengthening or establishing effective nutrition surveillance systems, and in implementing the WHO Child Growth Standards and Baby-Friendly Hospital Initiative. The resolution also charged WHO with developing an implementation plan for these measures to be presented at the WHA in 2012. To receive input from Member States on the draft implementation strategy, PAHO and the Food and Agriculture Organization convened a regional meeting in 2011, which involved teams from 17 countries.

Conclusion

17. At the midpoint of the Nutrition Strategy and Plan of Action, Member States have made important advances in addressing the determinants of malnutrition and its effects on health, with the participation of many sectors and stakeholders. In addition, there is an increased awareness and integration of nutrition interventions in primary health care, using a life-course approach. Notable reductions in chronic malnutrition have occurred in Brazil, Mexico, and Peru, and many other countries show some extent of reduction.

18. This mid-term review highlights the many challenges in the Region related to the dual burden of undernutrition and overweight/obesity. While much of the burden of poor nutrition in terms of its myriad health outcomes affects the health sector, many of the solutions to its underlying determinants lie outside the sector. Ministries of health therefore must play a catalyzing role in promoting a multisector and comprehensive approach, ideally led at the highest levels of government. A well-established set of effective interventions, if implemented, could prevent 35% of the mortality from maternal and child undernutrition (8). Ministries of health must take the lead in improving the coverage and quality of these interventions.

19. A key requirement for PAHO's technical cooperation is to identify those actions that are likely to have the greatest impact in reducing morbidity and mortality caused by malnutrition. In addition, knowledge dissemination throughout PAHO's technical areas must be strengthened so that those interventions known to be effective in reducing malnutrition are implemented in the context of primary health care.

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E. REGIONAL STRATEGIC PLAN FOR HIV/AIDS/STI, 2006-2015: MID-TERM EVALUATION

Background

1. The Regional Strategic Plan for HIV/AIDS/STI, 2006-2015 was approved by PAHO Member States in September 2005 (Resolution CD46.R15). It calls for a mid-term evaluation, which is being conducted during the period March-July 2012, to inform, revise, and update the targets, priorities, and strategies for the remaining years of the Plan.

2. The objective of the Plan is to provide guidelines for the countries of the Americas to respond more effectively to the HIV epidemic and to prevent and control sexually transmitted infection (STI). It aims to strengthen national plans in all countries of the Region as well as to encourage international and national planners to consider long-term impacts, sustainability, and the trajectory of the disease in relation to other long-term economic and human development goals.

3. The Plan has five critical lines of action:

- (a) strengthening health sector leadership and stewardship and fostering the engagement of civil society;
- (b) designing and implementing effective, sustainable HIV/AIDS/STI programs and building human resource capacity;
- (c) strengthening, expanding, and reorienting health services;
- (d) improving access to medicines, diagnostics, and other commodities; and
- (e) improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination.

4. For each line of action, specific strategies, targets, milestones, and indicators are defined in the Plan, which also establishes the role of the Pan American Sanitary Bureau (PASB) in support of the Plan, including its oversight and management.

Subregional Plans

5. Building on the Plan, subregional plans were developed for the Caribbean, Central America, and the Andean regions. The Andean Plan ended in 2010 and was evaluated in 2011. The findings of that process are being incorporated into the mid-term review process. The other subregional plans will be evaluated using a methodology fully aligned with that of the Regional Plan.

Purpose of the Mid-term Evaluation

6. The mid-term evaluation aims to:
 - (a) identify key achievements and challenges related to the regional HIV/STI health sector response and the implementation of the Plan; and
 - (b) update targets, priorities, and strategies for the health sector response as well as for PAHO's technical cooperation strategy for the period 2012-2015.

Scope of the Evaluation

7. The mid-term evaluation covers the period 2006-2011 and has a regional scope, with specific attention to subregional processes, issues, and outcomes. There is a strong focus on the updating of health sector strategies based on new evidence and recent initiatives, events, and commitments related to HIV, including but not limited to:
 - (a) New evidence regarding HIV treatment as prevention.
 - (b) WHO/UNAIDS Treatment 2.0, for optimization of HIV treatment.
 - (c) Regional Initiative for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in Latin America and the Caribbean.
 - (d) WHO Global Health Sector Strategy on HIV/AIDS, 2011-2015.
 - (e) Changes in the global financial situation related to HIV, including eligibility criteria for the Global Fund to Fight AIDS, Tuberculosis and Malaria and their consequences for the Region.

Methodology

8. Within the parameters of limited resources, the mid-term evaluation applies a mix of approaches to allow for the highest possible level of stakeholder consultation and involvement and to generate a high level of ownership of the outcomes of the process.
9. The methodology has five main components:
 - (a) Desk review of regional and subregional plans, reports, and recent regional and global technical guidance documents.
 - (b) Consultations with stakeholders at regional and subregional events.

- (c) Stakeholder surveys administered via e-mail to national program managers, laboratory directors, people living with HIV, civil society organizations, advocates, and PAHO technical staff. Two different survey forms were designed for stakeholders and PAHO staff.
- (d) In-depth interviews with selected stakeholders, including UN partners, relevant regional and subregional organizations, chief medical officers, national program managers, representatives from subregional entities (such as the Pan Caribbean Partnership against HIV and AIDS, and the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA), and PAHO regional, subregional and country staff.
- (e) Consultation with the PAHO Technical Advisory Committee (TAC) on HIV/STI through review and discussion of preliminary findings and recommendations, and joint formulation of final recommendations.

Implementation Process

10. The implementation process includes:
- (a) Two consultants have been contracted to support the mid-term evaluation, one for the Caribbean process and another for Latin America. These consultants are working closely with the PAHO team to identify and collect relevant documents, develop data collection tools, and identify stakeholders to interview.
 - (b) In the Caribbean, a Steering Committee chaired by the Minister of Health from Grenada was established to provide input into the evaluation process. At the regional level, the TAC will assume this role.
 - (c) Based on analysis of the collected data, two reports will be produced. The first will be a detailed report on the evaluation process and outcomes. The second will be a summary report with critical conclusions and recommendations for realignment and updating of the HIV/STI Health Sector Response for the remaining period of the Regional HIV/STI Plan, to be submitted to the 28th Pan American Sanitary Conference in September 2012.

Implementation Schedule

Dates	Activity
March 2012	Contracting of consultants; development of evaluation methodology and tools
April-May 2012	Stakeholder consultations, surveys interviews, drafting of reports
4-5 June 2012	Meeting of the Caribbean Steering Committee for review of findings in the Caribbean process
11-13 June 2012	Meeting of the TAC on HIV/STI for review of findings in the regional process and draft reports
14-30 June 2012	Preparation of final reports

Expected Outcome

11. The expected outcome of the mid-term evaluation is a collection of data and other relevant information for obtaining the guidance of the Governing Bodies on areas of emphasis for the implementation of the strategy for the remaining period of the Plan.

F. CURRENT DENGUE SITUATION

Introduction

1. Dengue, an endemic disease with epidemic cycles, continues to be a significant public health problem in the Region. Its persistence is associated with the presence of social determinants, or macrodeterminants, such as population growth, migration, uncontrolled or unplanned urbanization, poverty belts in cities, and the lack of basic services such as water supply and liquid and solid waste disposal.
2. This report presents an update on the situation of this disease and progress in the activities promoted by the Member States for its prevention and control.

Background

3. During the 27th Pan American Sanitary Conference in 2007, the countries recognized the problems posed by increasingly frequent dengue outbreaks and the complexity of the epidemiological situation for its prevention and control. Considering dengue to be a problem that goes beyond the health sector, the Conference set a course for the identification of public policies to control the macrodeterminants of its transmission and to strengthen national integrated management strategies for the prevention and control of dengue (IMS-dengue).

Situation analysis

4. The dengue epidemiological situation in the Americas continues to be highly complex, with all four serotypes of the disease in circulation and conditions that are very propitious for their transmission. The number of reported cases peaked in 2010 at 1.6 million, 50,235 of them severe, and 1,185 deaths. In 2011, morbidity declined by 39% and the number of deaths by 40%, with 1,044,279 cases and 719 deaths. It appears that this trend will continue in 2012. There was also a 39.1% reduction in the percentage of severe cases in 2011 with respect to the preceding four years, which may be related to the application of the new case management guidelines that recommend timely care of warning signs indicating severity at the primary care level.
5. Currently, 22 countries and territories of the Americas have prepared a national IMS-dengue. In addition, four subregional IMS-dengue have been prepared (Andean subregion, Southern Cone, Central America, and the English-speaking Caribbean).
6. The IMS-dengue evaluation process began in Mexico in 2008. Since then, 16 countries and territories have been evaluated. The Dengue International Task Force (GTI-dengue for its Spanish acronym) and the national technical groups carried out all of the evaluations jointly. Since 2003, GTI-dengue has provided technical support during

outbreaks and epidemics and has strengthened the capacity of technical personnel in the countries. Today, the Group promotes the use of new tools such as the Larval Index Rapid Assay of *Aedes aegypti*, (known as LIRAA, by its Portuguese acronym), Geographic Information Systems (GIS), new diagnostic tests, and the new dengue classification.

7. During the 2009-2010 biennium, important outbreaks were reported in Argentina, Colombia, Brazil, Bolivia, Guadeloupe, Honduras, Martinique, Paraguay, Puerto Rico, Dominican Republic, and Venezuela. The response to the problem has been tangibly more comprehensive with the participation of municipalities, the private sector, the community, and the media, in addition to the health sector. The outbreaks in Santa Cruz de la Sierra in Bolivia, the Chaco in Argentina, and Honduras are examples of this.

8. The Dengue Laboratory Network of the Americas (RELDA) was consolidated, comprising the national reference laboratories and the four PAHO/WHO collaborating centers for dengue. The quality control process and the use of molecular diagnostic techniques were strengthened.

9. Training continues to be provided to the countries on the Communication for Behavioral Impact methodology (COMBI) for dengue and on risk communication. In 2011, a publication systematizing this process was prepared and distributed to all the countries.

10. IMS-dengue is influencing the development of public policy, laws, and ordinances to improve the environment and tackle the macrodeterminants that cause dengue. Greater extrasectoral impetus is needed, however, and the social determinants of transmission must be addressed in order to ensure the sustainability of current efforts.

11. Dissemination of the new guides on dengue prepared by PAHO/WHO began in 2010, with their translation, publication, and distribution. Experts from the Region adapted the patient care component during 2011 and training covered all the countries of South America, Central America, and the Spanish-speaking Caribbean.

12. In terms of combating the vector, inappropriate insecticide use compromises the durability of the main active ingredients currently in use and evidences the growing resistance of *Aedes aegypti* to insecticides. At the same time, few countries in the Region are conducting research on susceptibility and resistance. For this reason, PAHO/WHO is working on a regional project to monitor insecticide resistance in collaboration with the Latin American Network for Vector Control (RELCOV) and with the support of the four reference centers.

13. Several vaccines against dengue are currently in the clinical development phases and it is possible that at least one safe and effective vaccine will be available in the near

future (5 to 10 years). The more advanced of these, a live attenuated vaccine against the four serotypes, is currently in phase III clinical trials, the results of which should be available in 2013. There is an incentive for Member States and PAHO/WHO to prepare for the timely and evidence-based introduction of the vaccine against dengue, which will be one more tool for dengue control within an integrated approach. Significantly, ProVac¹ has signaled its intention to include the dengue vaccine in its future activities.

14. Cooperation from the Spanish and Canadian governments played a critical role in the progress made in the last two biennia. The Meso-America Project for dengue will be a source of support for the countries of that subregion in the coming years.

15. Major challenges remain for dengue prevention and control in the Region. Countries still face serious problems in addressing social determinants, compounded by other external factors such as climate change that benefit the life cycle of the mosquito transmitter.

Proposal

16. This progress report presents the accomplishments and work of the Pan American Sanitary Bureau for the prevention and control of dengue in the Region. It proposes to continue to support the integrated management response, strengthen national capabilities, and step up efforts by the Member States to implement public policies that influence the social determinants or macrodeterminants related to the disease.

¹ The ProVac initiative was created by PAHO/WHO's Immunization Project to strengthen national capacity to make evidence-based decisions on new vaccines introduction. It is made up of high-level scientific institutions and organizations.

G. IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS

Introduction

1. The purpose of this report is to provide an update on the progress made by Member States in the Region of the Americas and by the Pan American Health Organization (PAHO) towards fulfilling their obligations and commitments to implementing the International Health Regulations (IHR; hereafter also referred to as the “Regulations”). It updates the last report presented in 2011 to the 51st Directing Council (1).
2. Additionally, this report is intended to encourage States Parties to use the IHR not only as a framework for ensuring global health security. The IHR are also an opportunity and a tool to institutionalize essential public health functions¹ through the mobilization of sustainable resources to support efficient mechanisms for intersectoral collaboration and multi-hazard public health preparedness.
3. This report is structured around selected strategic areas of work as defined in the WHO document *International Health Regulations (2005): Areas of work for implementation* (2). It focuses on the status of national core capacities as detailed in Annex 1 of the Regulations, due to be present by 15 June 2012.

Promote Regional and Global Partnerships

4. PAHO continues to collaborate with subregional integration mechanisms and initiatives.² The most important objective in this regard is to promote the ownership and leadership of States Parties in their IHR implementation efforts. Other objectives are to optimize the use of technical and financial resources and to increase awareness with respect to rights and obligations stipulated by the Regulations among partners and States Parties.

¹ Document *La Salud Pública en las Américas – Instrumento para la Medición del Desempeño de las Funciones Esenciales de Salud Pública* (PAHO 2001) is available from: http://new.paho.org/hq/dmdocuments/2010/FESP_Instrumento_Medicion_Desempeno.pdf.

² These subregional integration mechanisms and initiatives include the Southern Common Market (MERCOSUR), through its Working Group on Health (SGT-11) in charge of the Intergovernmental Commission for the International Health Regulations (CIRSI); the Andean Community (CAN), through the Andean Network for Epidemiological Surveillance (RAVE) coordinated by the Andean Regional Health Agency-Hipólito Unanue Agreement (ORAS-CONHU); the Union of South American Countries (UNASUR), through its Technical Working Group for Surveillance and Response (GTVR); the Central America Integration System (SICA), through the Executive Secretariat of the Council of Central American Health Ministers (SE-COMISCA); and the Caribbean Community (CARICOM), through the PAHO/WHO's Caribbean Epidemiology Centre (CAREC).

5. Although the implementation of the IHR is reflected in the programmatic and strategic documents of the subregional initiatives, and is supported by PAHO/WHO through dedicated subregional work plans,³ the diverse governance mechanisms, organizational structures, and technical expertise of the subregional initiatives continue to be characterized by lack of clarity as for their roles and responsibilities vis-à-vis the IHR. These, among others, include: the perception that subregional initiatives can be delegated responsibilities that are States Parties' prerogatives (e.g. management of public health events of potential international concern); being driven by the agendas of donors that is resulting in the diversion of attention from the implementation of National IHR Action Plans; sub-optimally exploiting their potential to secure political commitment and intersectoral coordination needed for the implementation of the National IHR Action Plans.

6. Mechanisms to maximize the contribution of existing networks for technical cooperation need to be further explored and developed by the Organization. The results of such an evaluation should be used by national authorities to strengthen existing efforts.⁴

7. PAHO/WHO and the International Civil Aviation Organization (ICAO) have conducted joint assessments of international airports in 15 countries of the Region, as part of the *Cooperative Arrangement for the Prevention of Spread of Communicable Disease through Air Travel* (CAPSCA).⁵

8. As a result of PAHO's partnership with the International Atomic Energy Agency (IAEA), a unique project will be launched in June 2012 to strengthen national

³ Southern Common Market (MERCOSUR), Andean Regional Health Agency-Hipólito Unzué Agreement (ORAS-CONHU), Executive Secretariat of the Council of Central American Health Ministers (SE-COMISCA), Caribbean Epidemiology Centre (CAREC).

⁴ Information available from the following sources:

- International Food Safety Authorities Network (INFOSAN):
http://www.who.int/foodsafety/fs_management/infosan/en/index.html.
- Global Foodborne Infections Network (GFN):
http://thor.dfvf.dk/portal/page?_pageid=53,1&_dad=portal&_schema=PORTAL
- PulseNet: <http://www.pulsenetinternational.org/networks/Pages/latinamerica.aspx>
- Poison Centres Network:
http://www.who.int/gho/phe/chemical_safety/phe_poison_centres_20110701.xls
- Strategic Approach to International Chemicals Management (SAICM) of the United Nations Environment Programme:
<http://www.saicm.org/documents/List%20of%20SAICM%20National%20Focal%20Points%20web.doc>
- *Red de Emergencias Químicas de Latinoamérica y el Caribe (REQUILAC)*:
<http://www.bvsde.paho.org/requilac/e/miembros.html>
- *Red de Toxicología de Latinoamérica y el Caribe (RETOXLAC)*:
<http://www.bvsde.paho.org/bvstox/e/retoxlac/review.html>
- Radiation Emergency Medical Preparedness and Assistance Network (REMPAN):
http://www.who.int/ionizing_radiation/a_e/rempan/REMPAN_directory_2007.pdf

⁵ For information on the CAPSCA country visits, see <http://www.capsca.org/AmericasEventsRefs.html>.

infrastructure for radiation safety and the security of radioactive sources in Member Countries of the Caribbean Community (CARICOM).

9. During the session on integrated surveillance at the 16th Inter-American Meeting, at Ministerial Level, on Health and Agriculture (RIMSA)—which PAHO will convene in Chile in July 2012—the Organization will be using the IHR framework to further foster intersectoral collaboration with international agencies and organizations. The meeting will focus on the animal-human interface and raise awareness of national obligations vis-à-vis the IHR among sectors other than health.⁶

10. PAHO continues to strengthen partnerships with the WHO Collaborating Centre (WHO CC) for the Implementation of IHR National Surveillance and Response Capacity, at the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Additional efforts made by PAHO to grant access to the highest level of technical expertise include the involvement of WHO CC during the management of specific events and during the decision making process related to the extension of the 2012 deadline.

11. In June 2011, PAHO played a facilitating role in establishing the Regional component of WHO's Global Outbreak Alert and Response Network (GOARN).

12. In order to promote the exchange of experiences and best practices among States Parties in the Region—as well as to identify common challenges and common solutions—PAHO organized the *Second Regional Meeting on the Implementation of the International Health Regulations (IHR) in the Americas*, held in Cancún, Mexico, on 1–2 September 2011.

13. The FIFA World Football Cup and Summer Olympics that Brazil will be hosting in 2014 and 2016, respectively, will constitute additional opportunities to forge partnerships, and accelerate public health preparedness in the Region. To this end, on 12–13 December 2011 PAHO and the Ministry of Health of Brazil organized the *First Meeting in Latin America on Actions of the Health Sector for Mass Gathering Events / Fifth Meeting of the Health Task Force for the FIFA World Football Cup 2014* in Brasilia, Brazil.

Strengthen National Disease Prevention, Surveillance, Control and Response Systems, and Public Health Security in Travel and Transport

14. In the Regulations, according to the provisions of Articles 5 and 13 as well as Annex 1, States Parties should have assessed their core capacities for surveillance and response, including at designated points of entry, by 15 June 2009. In addition, they

⁶ For example, the Food and Agriculture Organization of the United Nations (FAO), Inter-American Institute for Cooperation on Agriculture (IICA), International Regional Organization for Plant and Animal Health (OIRSA), and World Organisation for Animal Health (OIE).

should have developed a National IHR Action Plan for attaining core capacities by 15 June 2012 and have institutionalized the mechanisms to maintain them after that date.

15. The deadlines stipulated in the Regulations should be regarded more as milestones in an ongoing public health preparedness process. Nevertheless, the target dates are challenging to meet. Therefore, in compliance with the above-mentioned provisions that allow the target date to be extended to 15 June 2014 in a first instance, in September 2011 both WHO and PAHO informed States Parties about the procedures to request the extension.

16. To this effect, starting in February 2012, PAHO has been holding meetings with national authorities, both virtual and face-to-face. For purposes of transparency and accountability during these sessions, all States Parties were invited to communicate to PAHO/WHO their respective position about any possible extension prior to the 65th World Health Assembly (WHA)—but no later than 15 June 2012. Similarly, in a first attempt to compile the list of designated points of entry meant to have a response function, States Parties were invited to explicitly communicate the list of designated points of entry that have either attained the core capacities or need an extension.

17. As anticipated in the *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009*, which was submitted to the 64th WHA, “many States Parties lack core capacities to detect, assess, and report potential health threats and are not on a path to complete their obligations for plans and infrastructure by the 2012 deadline specified in the IHR” (3). Globally, it is estimated that approximately 70% of the 194 States Parties will request an extension of the 2012 deadline. As of 15 April 2012 PAHO/WHO had received from five States Parties in the Region an official communication of their position about the extension. Based on communications with national authorities, PAHO anticipates that about 28 (~80%) of the 35 States Parties in the Americas will request an extension of the 2012 deadline.

18. The status of core capacities in the Region is rather heterogeneous across the subregions, as can be seen from the picture emerging from direct interactions with national authorities as well as from the *State Party Annual Report* submitted to the 65th WHA by 31 of the 35 States Parties (89%).⁷ The table in the annex shows the average

⁷ Submission status by country of the *State Party Annual Report* (hereafter referred to as “the Report”) to the 65th World Health Assembly as of 15 April 2012 is as follows:

- The Dominican Republic, Peru, Uruguay, and Venezuela had not yet submitted the Report.
- Argentina, Bolivia, Brazil, Chile, Colombia, and Paraguay had submitted the Report using the MERCOSUR tool, subsequently migrating data from the relevant sections to the format proposed by WHO as per the agreement with the UNASUR Technical Working Group for Surveillance and Response.
- Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago had submitted the Report using modified versions of the format proposed by WHO.

core capacities score by subregion (in percent)—as defined in the WHO document *IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties (4)*, which constitutes the basis of the format proposed by WHO for reporting to the WHA. The current situation at global level and in other Regions is being presented at the 65th WHA (2012) in *Implementation of the International Health Regulations (2005): Report by the Director-General (5)*.

19. The most critical weaknesses identified included the following areas: radiation emergencies, chemical events, points of entry, human resources, and preparedness. These areas are expected to be addressed in the action plan(s) due to be submitted by States Parties, together with their requests to extend the 2012 deadline. These areas will require resource mobilization efforts at the international level.

20. The following must be taken into account: the substantial variance in capacity and quality observed across States Parties as to their approach adopted for the planning process in terms of degree of intersectoral involvement and commitment; the comprehensiveness of the capacities addressed in the plan(s); priority setting for the components aimed at ensuring the sustainability of the capacities attained; the status and integration of the plan(s) within the context of the national health strategy, planning processes, financial cycles, and monitoring and evaluation mechanisms; anticipated strategies on the use the plan(s) as a resource mobilization tool; and the role of monitoring and evaluation for the implementation of said plan(s).

21. High staff turnover within the health sector, which extends to the institutions of the National Focal Points (NFPs), hampers the sector's ability to build sustained human resource capacity. In some countries with small populations and limited government capacity, it is common for one person to be responsible for a range of duties. Such challenges impede the efforts and investments being made both by the Organization and by other partners since the Regulations entered into force. The *PAHO Regional Plan for Training in Epidemiology in the Americas, 2010*, should be revitalized as an attempt to establish and maintain competencies in field epidemiology according to models that best fit each national context.

22. In compliance with the recommendations formulated by the *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009*, and following the request made by various WHO Member States during the 130th Session of the Executive Board, WHO headquarters and its Regional Offices carried out an analysis of factors that limit country progress towards achieving national core capacities, as well as any possible actions that the Organization should take to overcome these obstacles. The full analysis will be presented to the 65th WHA.

23. WHO is currently considering convening an IHR Review Committee to advise on monitoring and evaluation methods related to the implementation of the Regulations, including core capacities. The prospective scope of the IHR Review Committee's work may include those aspects related to a potential additional extension period of 2014–2016, as well as the feasibility of assessing the impact of the Regulations in terms of both health and economics.

Strengthen PAHO/WHO Regional and Global Alert and Response Systems

24. PAHO serves as the WHO IHR Contact Point for the Region of the Americas by facilitating the process of managing public health events: this includes risk detection, risk assessment, response, and risk communication. In the period from 1 January to 31 December 2011, a total of 196 public health events of potential international concern were detected and assessed. For 94 of the 196 events considered (48%), national health authorities—via the NFP—were the initial source of information. For the remaining 102 events, verification was requested and obtained from the NFP for all but 2. Of the events considered, 82 (42%) were of actual international public health concern, affecting 22 States Parties in the Region. The largest proportion of these events was attributed to infectious hazards (52 events, 63%): the etiologies most frequently recorded were imported measles (10), influenza viruses (9), and dengue (6). These were followed by events related to food safety (11), zoonosis-related events (8), events of undetermined origin (5), product-related events (3), events occurring in a disaster context (2), and a single event related to a radionuclear hazard.

25. PAHO continues to support the authorities in Haiti and the Dominican Republic in their efforts to control the cholera outbreak. On 11 January 2012, the Presidents of Haiti and the Dominican Republic—together with PAHO/WHO, UNICEF, and CDC—called for major international investments in water and sanitation infrastructure to eliminate cholera from the island of Hispaniola.⁸ This was followed by a binational meeting, attended by PAHO Assistant Director and held in Haiti in March 2012, aiming at harmonizing the cholera national action plans of Haiti and the Dominican Republic.

26. During the period considered, PAHO supported national authorities in their efforts to respond to several outbreaks in the Region, mobilizing experts from institutions that are members of the Regional GOARN network.

27. Within the framework of regionalizing the GOARN network, an exercise aimed at drawing lessons from joint CDC-PAHO responses was held in Atlanta, Georgia, United States, in May 2012.

⁸ *Call to Action: A Cholera-Free Hispaniola*; see <http://new.paho.org/colera/>.

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

28. Several countries reviewed the provisions of the Regulations and harmonized national provisions accordingly within the legal and normative framework. Nevertheless, a challenge remains for the countries in approving and enforcing the revised norms and laws. To that end, PAHO organized an *IHR Legislation Workshop for Eastern Caribbean Countries* in Bridgetown, Barbados, on 22–23 November 2011.

29. In 2011, all 35 States Parties in the Region either submitted their annual NFP confirmation or updated their NFP contact details. As of 31 March 2012, the IHR Roster of Experts includes 309 experts, 71 of whom were from the Region of the Americas. In 2011, procedures for the renewal or discontinuation of membership in the Roster—which is valid for four years—were activated and are currently ongoing.

30. As of 31 March 2012, 412 ports in 19 States Parties of the Region of the Americas were authorized to issue Ship Sanitation Certificates. The list of authorized ports is being regularly updated and posted online.⁹

31. In 2011, 15 States Parties from the Region informed WHO of their vaccine requirements for travelers. This information has been included in the 2012 edition of the WHO publication *International Travel and Health (ITH)*, currently available in English (6). PAHO has taken action to increase the transparency of procedures and participation related to the definition of areas at risk for yellow fever transmission. A two-step approach for updating yellow fever vaccination requirements for travelers should be introduced at global level and should be reflected in the 2013 edition of the ITH.

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Annex

**CORE CAPACITIES
AVERAGE SCORE (%) BY SUBREGION**

Capacity	Subregion				Americas ⁵
	<i>North America¹</i>	<i>Caribbean²</i>	<i>Central America³</i>	<i>South America⁴</i>	
National legislation, policy, and financing	92%	36%	80%	84%	65%
Coordination and communications with NFPs	82%	62%	90%	73%	74%
Surveillance	90%	77%	76%	73%	77%
Response	88%	73%	72%	80%	75%
Preparedness	68%	49%	53%	63%	58%
Risk communication	76%	71%	68%	69%	72%
Human resources	100%	39%	50%	66%	57%
Laboratory	80%	63%	76%	86%	73%
Points of entry	85%	50%	58%	48%	51%
Zoonotic events	81%	74%	73%	80%	77%
Food Safety	91%	64%	56%	71%	69%
Chemical events	75%	29%	23%	59%	41%
Radiation emergencies	86%	15%	46%	40%	35%

¹ The subregion of North America includes Canada, Mexico, and the United States; the response rate was 3 out of 3 States Parties (3/3, or 100%). The table reflects information provided by 3 States Parties.

² The Caribbean subregion includes Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Haiti, Jamaica, Saint Lucia, Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago; the response rate was 13 out of 13 States Parties (13/13, or 100%). The table reflects information provided by 11 States Parties.

³ The Central American subregion includes Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Panama; the response rate was 6 out of 7 States Parties (6/7, or 86%). The table reflects information provided by 6 States Parties.

⁴ The South American subregion includes Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay, and Venezuela; the response rate was 9 out of 12 States Parties (9/12, or 75%). The table reflects information provided by 8 States Parties.

⁵ For the Region of the Americas, the response rate was 31 out of 35 States Parties (31/35, or 89%). The table reflects information provided by 28 States Parties.

H. REGIONAL GOALS FOR HUMAN RESOURCES FOR HEALTH 2007–2015

Introduction

1. In September 2007, the 27th Pan American Sanitary Conference (PASC) ratified Resolution CSP27.R7, Regional Goals for Human Resources for Health 2007–2015 (1). Its goal is to support the development of national action plans for human resources for health (HRH) aimed at strengthening primary health care (PHC). A series of 20 Regional Goals for Human Resources for Health 2007 was organized under the five principal challenges identified in the *Toronto Call to Action 2006–2015: Towards a Decade of Human Resources in Health for the Americas* (2) and later on in the *Health Agenda for the Americas 2008–2017*.

2. This progress report provides information on key findings from the baseline measurements taken in 23 countries for the 20 Regional Goals.¹ It identifies areas in need of renewed attention and offers recommendations to ensure the achievement of these goals by 2015.

Update on the Current Situation

3. Following the adoption of the above-mentioned Resolution CSP27.R7 (2007), a set of indicators and a methodology were developed to establish a baseline assessment and to enable further monitoring. Training and technical support were provided to the ministries of health in the countries that showed interest. The process was first completed in selected countries of the Andean Region, followed by the Southern Cone, the English-speaking Caribbean and—more recently—Central America and the Spanish-speaking Caribbean.

4. The most relevant findings, as presented under the five challenges,² were as follows:

Challenge 1: Build long-range human resources policies and plans

5. For Challenge 1, three goals (numbers 1, 2, and 5)³ showed severe problems in achieving both a minimum density of health workers and proper composition of the

¹ Detailed information on the baseline for measuring the 20 Regional Goals for Human Resources 2007–2015 can be found at the following website: <http://www.paho.org/baseline20goalshrh>

² A report on the baseline assessment of the 20 Regional Goals will be published in 2012.

³ Goal 1: All countries of the Region will have achieved a human resources density ratio level of 25 per 10,000.

Goal 2: The regional and sub-regional proportions of primary health care physicians will exceed 40% of the total medical workforce.

medical workforce. Limited national capacity to manage human resources in health (HRH) remains an issue.

6. With regard to Goal 1, only 12 out of the 23 countries where baseline measurements were taken have achieved the minimum WHO-recommended density ratio of 25 health professionals (doctors/nurses/midwives) per 10,000 inhabitants. With respect to Goal 2, only 6 countries reported that over 40% of the total medical workforce is considered to be primary health care physicians. For Goal 5, only 3 countries scored 100%, meaning that they have established an HRH unit with comprehensive capacities for strategic planning, management, monitoring, and evaluation.

Challenge 2: Put the right people in the right places

7. The four goals outlined in Challenge 2 focus on expanding national access to primary health care. Many of the countries had insufficient data to adequately evaluate these goals. However, whenever information was available on these specific points, Goal 7⁴ revealed that access to primary care has not been developed adequately and that immediate attention is needed to ensure universal access.

8. *Goal 7:* This requires that at least 70% of primary health care workers have demonstrable public health skills and intercultural competencies. Nine countries scored under 50% on this indicator, while two countries had no data. Barbados, Dominica, Jamaica, and St. Lucia scored 100%—thus having fully achieved Goal 7.

Challenge 3: Ensure an adequate level of staffing for health personnel, according to country needs

9. The countries of the Region have not attained self-sufficiency in filling their HRH gaps and meeting their national needs. Most countries have made strides towards managing migration through bilateral and multilateral agreements aimed at recognizing licenses and at cooperative reporting. However, Goal 10⁵ shows that few countries have made a commitment to adhering to any ethical code of practice on the international migration of health workers and the protection of source countries from aggressive recruitment practices by other countries.

10. *Goal 10:* Regarding the international recruitment of health care workers, only 2 out of the 23 countries (less than 10%) reported having adopted an international code of

Goal 5: All countries of the Region will have established a unit of human resources for health responsible for the development of human resources policies and plans, the definition of strategic directions and the negotiation with other sectors, levels of government, and stakeholders.

⁴ Goal 7: At least 70% of the primary health care workers will have demonstrable public health and intercultural competencies.

⁵ Goal 10: All countries of the Region will have adopted a global code of practice or developed ethical norms on the international recruitment of health care workers.

practice or having developed ethical norms related to such recruitment. Those countries are Barbados and Jamaica.

Challenge 4: Promote healthy work environments and foster commitment to the institutional mission to guarantee quality health services for all the population

11. Studies have shown that supportive workplaces lead to higher productivity, better quality of care, and reduced emigration. Under Challenge 4, Goals 13⁶ and 16⁷ were the most striking, revealing that many countries do indeed have mechanisms for managing labor conflicts. However, they have not regularized the practice of written contracts, nor have they created guidelines for normalizing posts—even though such standard practices alleviate the causes of labor disputes.

12. *Goal 13:* Most countries have a high proportion of unprotected and precarious employment contracts for health workers. Five countries scored 0% or ‘not applicable,’ with no strategy in place to normalize contracts offering social protection to workers. Seven other countries scored less than 50%. Only four countries scored 100%, meaning that they have defined strategies for protecting contractual workers and normalizing precarious posts.

13. *Goal 16:* Sixteen countries scored 100%, meaning that more than two-thirds of the countries have put into place mechanisms for resolving conflicts and ensure continuity of care during labor disputes, and four of the seven remaining countries are half way towards achieving this goal.

Challenge 5: Develop cooperation between institutions that offer training and those that deliver health services

14. Because most ministries of health in the participating countries do not have authority over educational institutions in the health sciences, problems emerged in attempts to assess related goals—thus providing evidence of a lack of coordination.

15. *Goal 17:* Only one country (Jamaica) reached Goal 17,⁸ which requires that education be aimed at primary health care in 80% of the country’s health science schools and also that interdisciplinary training strategies be adopted. Most of the countries scored quite low on this indicator, with 15 countries—more than half of those measured—scoring 50% or below.

⁶ Goal 13: The proportion of precarious, unprotected employment for health service providers will have been reduced by half in all countries.

⁷ Goal 16: 100% of the countries of the Region will have in place effective negotiation mechanisms and legislations to prevent, mitigate or resolve labor conflicts and ensure essential services if they happen.

⁸ Goal 17: 80% of schools of clinical health sciences will have reoriented their education towards primary health care and community health needs and adopted inter professional training strategies.

16. Approaches aimed at addressing specific national priorities differed among countries; however, there was a consensus on the need to (a) improve monitoring and evaluation capacity within the ministries; and (b) refine and adjust the Regional Goals based on country-specific needs.

17. Based on key findings from the baseline assessment of the 20 Regional Goals, Member States are invited to consider the following lines of action:

- (a) Intensify both their efforts and investments in planning and scaling-up appropriate HRH, as an essential requirement to achieve universal access to quality health care services and implement the primary health care strategy.
- (b) Increase efforts aimed at equitable distribution of health personnel, particularly in terms of their recruitment and retention in underserved, rural, and indigenous areas.
- (c) Put into place systems to deliver continued education and programs for in-service training for HRH managers and health workers; and partner with academic institutions.
- (d) Strengthen their Observatory of Human Resources in Health as a strategy to involve relevant sectors and social stakeholders, as well as to ensure quality information on HRH for both decision- and policy-making.
- (e) Make a commitment to a conducting a second assessment of the 20 Regional Goals for HRH in 2013.

18. The Organization reiterates its commitment to working with the ministries of health and Regional entities as well as to supporting their efforts to achieve the Regional Goals for strengthening HRH capacity in the Region.

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I. STATUS OF THE PAN AMERICAN CENTERS

Introduction

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

Background

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

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

3. In view of the convergence of human health and animal health, there is an ever-growing need for PAHO to exercise leadership in the sphere of zoonoses, food safety, and food security.

Recent Progress

4. In the framework of the PANAFTOSA institutional development project, a Trust Fund was created to facilitate financial contributions from public and private sectors interested in the eradication of foot-and-mouth disease. The Fund received its initial funding from the National Animal Health Coordinating Association (ACONASA) of Paraguay, while other donors are studying the feasibility of using it. Thus, an adequate proportion of the Center's regular financial resources has been channeled to technical cooperation in the areas of zoonosis and food safety. The financial resources mobilized for foot-and-mouth disease are supporting technical cooperation related to the regional coordination of the Action Plan 2011-2020 of the Hemispheric Program for the Eradication of Foot-and-mouth Disease (PHEFA), which was adopted in a special meeting of the Hemispheric Committee for the Eradication of Foot-and-Mouth Disease (COHEFA) in December 2010 (1).

5. In December 2011, the first stage concluded of the transfer of the PANAFTOSA reference laboratory to the facilities of the National Agricultural Laboratory of the Ministry of Agriculture, Livestock, and Supply of Brazil, located in Pedro Leopoldo in the State of Minas Gerais. At present, remodeling of the laboratory is being completed, which will have a biosafety level of 4, according to the standards of the World Organization for Animal Health (OIE).

6. In December 2011, PAHO, through PANAFTOSA, and the Secretariat of Health Surveillance of the Ministry of Health of Brazil signed a technical cooperation agreement to contribute to strengthening the National Health Surveillance System and the management capacity of the Unified Health System of Brazil to reduce the burden of zoonoses, vector-borne diseases, and water- and food-borne diseases on the human population. The agreement also includes actions regarding knowledge management and South-South cooperation, and builds on the 60 years of prolonged and valuable collaboration with the Ministry of Agriculture, Livestock, and Supply of Brazil, highlighting the important role of PANAFTOSA as a center for intersectoral technical cooperation between animal health and public health. It is worth underscoring that the linkage among health, agriculture, and the environment will be the main theme of the next Inter-American Meeting, at the Ministerial Level, on Health and Agriculture, which will be held in Santiago (Chile), on 26-27 July 2012. PANAFTOSA is coordinating the organization and preparation of this meeting.

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

7. BIREME is a PAHO specialized center that was established in 1967 to channel the technical cooperation provided by the Organization to the Region with regard to scientific and technical information on health. On 1 January 2010, the new Statute of BIREME became effective and, subsequently, the BIREME Advisory Committee was formed.

8. The 51st Directing Council elected two new members, Bolivia and Suriname, to the BIREME Advisory Committee, with the finalization of the terms of Jamaica and Mexico. The 28th Pan American Sanitary Conference will select three new Member States to the BIREME Advisory Committee for a three-year term, to replace Argentina, Chile, and Dominican Republic, whose terms will end in 2012.

Recent Progress

9. In the context of the lines of action for implementing BIREME's new institutional framework, the following aspects should be pointed out:

- (a) BIREME headquarters agreement: PAHO/WHO and the Ministry of Health of Brazil prepared a headquarters agreement, which has been in the pipeline for

approval since 6 August 2010. Following the change in government in Brazil, contacts with the Executive Secretariat of the Ministry of Health have been maintained. The Executive Secretariat of the Ministry of Health of Brazil invited the Director of BIREME to a meeting in late February 2012 to consider the status of the adoption of BIREME's new institutional framework. The discussion was broadened at a meeting on 21 March 2012 with the participation of: the Executive Secretariat; two other Ministry of Health Secretaries; representatives from FIOCRUZ (Oswaldo Cruz Foundation), UNIFESP (Federal University of São Paulo), ABRASCO (Brazilian Association of Collective Health), the Health Secretariat of São Paulo State, the PAHO/WHO Representative Office in Brazil; the Manager of the Area of Knowledge Management and Communication of PAHO, and the Director of BIREME.

- (b) Agreement for BIREME facilities and operation on the UNIFESP campus: the negotiation and signing of this document will begin once the Headquarters Agreement with the Government of Brazil, cited in the previous paragraph, has been signed.
- (c) Determination of the financing mechanism for BIREME in the coming years based on the PAHO and Government of Brazil contributions stipulated in Article 6 of the Statute. Regular contributions will be determined by mutual consent to support the biennial work plans approved in accordance with the Statute's provisions. As signing of the new Headquarters Agreement is still pending, in 2011 it was necessary to extend the BIREME Maintenance and Development Agreement once more. A budget was approved based on a detailed work plan for that year, through Additional Term No. 18¹ to the BIREME Maintenance and Development Agreement, for an approximate amount of US\$ 2,300,000, on the basis of the new BIREME institutional framework.
- (d) Establishment of the Scientific Committee in 2011 in coordination with the BIREME Advisory Committee. The process for submission of nominations to elect members of the Scientific Committee has begun, in accordance with the approved Terms of Reference. These Terms were annexed to a letter that asks the countries to send their proposals by the end of May 2012 in order to fulfill the plan to establish the Scientific Committee in the first half of 2012.

10. The second meeting of the BIREME Advisory Committee was held on 25 October 2011 in the BIREME offices in São Paulo (Brazil). The members reaffirmed

¹ Additional Term No. 18 to Agreement No. 007/2004 (Grant 063004), entered into by the Government of the Federative Republic of Brazil, through its Ministries of Health and Education; the Secretariat of Health of the State of São Paulo; and PAHO/WHO, seeks the maintenance and development of BIREME, through the assignment of financial resources and goals by the Ministry of Health, in accordance with the provisions in the second paragraph of clause 14 of Agreement No. 007/2004.

their support for the Center's institutional development, which encompasses implementation of the new institutional framework, the establishment and signing of the Headquarters Agreement, and financing of its work plans, in addition to the formation of the Scientific Committee in the first half of 2012 and organization of the 9th Regional Congress on Health Sciences Information (CRICS), to be held in Washington, D.C. in the second half of 2012.

11. Preparation of the biennial work plan (2012-2013) in the form of a sub-entity of the Area of Knowledge Management and Communication (KMC) of PAHO. The 2012-2013 biennial work plan with PAHO was prepared in an integrated manner with KMC and communication has continued to enhance and consolidate it.

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

12. The Latin American Center for Perinatology (CLAP) was created in 1970, through an agreement between the Government of the Eastern Republic of Uruguay, the University of the Republic of Uruguay, and PAHO, which is renewed periodically and whose most recent extension expires on 28 February 2016. The general objective of CLAP is to promote, strengthen, and boost the capacities of the countries of the Region of the Americas with regard to health care for women, mothers, and newborns.

Recent Progress

13. The search continues to find a site for the offices of CLAP and of the PAHO/WHO Representative Office in Uruguay. In late 2011, five sites were visited that did not meet the necessary requirements. In the first half of 2012, the search has been resumed with visits to five private properties and to a governmental property belonging to the School of Veterinary Medicine.

Subregional Centers (CAREC and CFNI)

Caribbean Epidemiology Center (CAREC)

14. The transition of CAREC to the Caribbean Public Health Agency (CARPHA) has been scheduled for the end of 2012. CAREC has focused its work on maintaining its current services, expanding them as appropriate, and preparing for the transition. As part of the strengthening of its current capacity, in September 2011 it filled the post of laboratory director, and in the final quarter of 2011 it completed an analysis and reorganization of its human resources.

15. CAREC has received considerable support from Headquarters for all activities related to the transition. In preparation for this process, a working group was formed that

is in charge of implementing a plan with respect to the products and the technical, administrative, and laboratory services that will be transferred to CARPHA.

16. Additional missions to CAREC have been programmed, which will be carried out during the rest of 2012. In accordance with the transition plan, it is expected that it will be carried out in an efficient and orderly manner to keep interruptions from occurring in the services that CAREC provides to its Member States.

Caribbean Food and Nutrition Institute (CFNI)

17. The transition of CFNI to CARPHA has been programmed for the end of 2012. In preparation for the transition, the personnel from the CFNI subsidiary office in Trinidad and Tobago were relocated to CAREC headquarters. Furthermore, the surveillance functions of CFNI and CAREC are being evaluated to merge them, when possible, to achieve greater effectiveness. This process will conclude in December 2012.

18. Plans have gone ahead to relocate the PAHO/WHO Representative Office in Jamaica to the CFNI building and it is expected that the process will conclude during the second half of 2012.

19. CFNI continues to provide technical support to the member countries while at the same time it continues to work with CARICOM on the various issues and processes necessary for an efficient and orderly transition to CARPHA.

References

1. Pan American Health Organization—Pan American Foot-and-Mouth Disease Center. Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA) – Action Plan 2011-2020. PANAFTOSA; Rio de Janeiro (Brazil): PAHO; 2011 [consulted 9 March 2012]. Available at:
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