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A. IMMUNIZATION: CHALLENGES AND OUTLOOK

Background

1. At the 50th Directing Council of the Pan American Health Organization (PAHO), the concept paper *Strengthening Immunization Programs* (Document CD50/14 (2010)) was submitted and adopted through Resolution CD50.R5. This resolution recognizes the great strides made in this area in the Region and urges the Member States to endorse national vaccination programs as a public good, while reiterating its support for the Regional Strategy for Immunization and its vision to sustain the achievements, complete the unfinished agenda, and tackle new challenges. It also calls for continued support for PAHO's Revolving Fund for Vaccine Procurement.

Progress

2. Vaccination coverage in the Region is among the highest in the world. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) estimated coverage for the Region of the Americas in 2009 at 94% for BCG, 91% for VOP3, and 92% for DTP3 in children under 1 year of age, and 93% for the MMR vaccine in children aged 1. However, 10 countries reported national coverage of less than 90% for DTP3, while 43% of municipalities in Latin America and the Caribbean reported coverage of under 95%.

Sustain the achievements

3. Since 1991, our Region has been free of polio cases caused by wild poliovirus. There have been no indigenous cases of measles since 2002 or indigenous rubella or congenital rubella syndrome since 2009. In 2010, 63 cases of measles imported from other regions of the world were reported, along with 190 cases connected with imports. Measles outbreaks in Argentina and Brazil in 2010 involved people who had attended the Soccer World Cup in South Africa.

4. Given the reintroduction of polio in disease-free countries in other regions of the world and the imported cases of measles, in 2010 all the Member States analyzed the risk of the reintroduction of these diseases, the capacity for timely detection of cases or of the reintroduction of the viruses, and the capacity for timely and definitive prevention of secondary cases.

5. *Haemophilus influenzae* type b (Hib) vaccination has resulted in a dramatic reduction in the number of cases and hospitalizations from this cause, and measures to

assess the impact of the vaccine are being strengthened. It is possible that many countries have already eliminated the invasive diseases caused by Hib.

Complete the unfinished agenda

6. Use of the vaccine against seasonal flu in the vaccination programs of the Member States has been on the rise; 36 countries and territories now include the vaccine in their immunization scheme. Based on the lessons learned from the vaccination efforts to combat pandemic influenza H1N1 2009, the vaccination approach targeting at-risk groups, especially pregnant women, has proven to be very important.

7. Yellow fever vaccination has remained a priority in Member States where the disease is enzootic. In 2010, vaccination efforts were compromised by a drop in the supply of vaccines from producers. The situation has begun to correct itself in 2011, and it is anticipated that Member States will catch up on the vaccination of their at-risk populations.

8. Each Member State has prepared a plan of action to achieve or maintain municipal vaccination coverage of 95% or higher and to strengthen epidemiological surveillance. In this effort, the technical and financial support of the Canadian International Development Agency (CIDA) and the U.S. Centers for Disease Control and Prevention (CDC) has been key.

9. Vaccination Week in the Americas (VWA) represents an opportunity to keep vaccination on the countries' political and social agenda and to connect with vulnerable or hard-to-reach populations. In 2011, the theme of the ninth VWA is "Vaccinate your family. Protect your community." Four other regions of WHO are holding their own Vaccination Week in 2011: the European Region is holding its sixth, the Eastern Mediterranean Region, its second; and, the African and Western Pacific Regions are holding their very first. PAHO has provided technical support to the other regions through workshops, teleconferences, and field visits to share materials and information on experiences and lessons learned. The South-East Asia Region has committed to launching its own initiative in 2012, bringing us close to the goal of declaring a World Vaccination Week.

10. Haiti is at risk for the reintroduction or reemergence of vaccine-preventable diseases, especially given the fragility of its health situation following the earthquake and cholera outbreak of 2010 and the number of susceptibles that have accumulated. In light of this, PAHO, under the coordination of Haiti's Ministry of Public Health and Population, has called on other institutions and partners to work together to strengthen the country's vaccination program.

Tackle new challenges

11. Extraordinary progress has been made in the introduction of new vaccines, which will save lives and avert expenditures. By 2010, 15 countries and territories had added the rotavirus vaccine to their regular series, 18 had the pneumococcal vaccine and 5, the human papillomavirus vaccine. Sixteen countries have sentinel surveillance centers that will enable them to assess the impact of vaccination and detect changes in the epidemiological patterns of diseases in a timely manner.

12. Through the ProVac Initiative, PAHO has continued its technical assistance to the member States in all the aspects of decision-making in connection with new vaccines and support for the aspects related to economic studies.

13. Studies have been conducted with the member States and technical partners to consolidate the lessons learned from the introduction of new vaccines in terms of cost-effectiveness, epidemiological impact, and the cost and surveillance of adverse events. These studies have served as a global reference.

14. Ensuring timely and adequate information on the vaccinated population, coverage, and vaccine and supply needs for the development of strategies and planning operations is one of the major challenges for vaccination programs. With support from PAHO, the member States have promoted the creation of digital vaccination records. Some countries have had records of this type for years, and others are well into the development and execution stage. The member States have made a commitment to sharing experiences and working together, which means that the use of digital vaccination records is likely to spread in the Region in the short term.

PAHO Revolving Fund for Vaccine Procurement

15. At the close of 2010, 40 Member States had purchased vaccines, syringes, and supplies through the Revolving Fund for Vaccine Procurement (RF). In 2010, the RF offered 45 different biologicals, with purchases totaling US\$ 510 million.

Next steps

- (a) Sustain vaccination as a public good.
- (b) Strengthen epidemiological surveillance measures and vaccination at all levels in response to the risk that vaccine-preventable diseases already or eliminated in our Region could be reintroduced.
- (c) Strengthen communication, information, and education for the population about the benefits of vaccines and immunization.

- (d) Continue providing technical support to the Member States through the Pan American Sanitary Bureau.

Action by the Executive Committee

16. The Executive Committee is requested to take note of this progress report and offer recommendations in this regard.

B. IMPLEMENTATION OF THE GLOBAL STRATEGY AND PLAN OF ACTION ON PUBLIC HEALTH, INNOVATION, AND INTELLECTUAL PROPERTY

17. The purpose of this progress report is to provide a comprehensive overview of the way in which the *Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property* (Resolution WHA61.21 [2008]) is being adapted to the Region of the Americas by employing a regional perspective (Resolution CD48.R15 [2008]), mentioning the principal lines of action, access, innovation, and management of intellectual property rights from a public health perspective.

18. The guiding principles of public health, innovation, and intellectual property rights expressed in the global strategy are gradually becoming an integral part of national pharmaceutical, research, and innovation policies. Subregional integration mechanisms such as the Union of South American Nations (UNASUR), the Andean Health Agency (ORAS), and MERCOSUR (and Associated States) have adopted elements of the global strategy.

19. The Member States continue to exercise leadership in the worldwide discussions on the global strategy. Especially important in this regard is the Consultative Expert Working Group on Research and Development: Financing and Coordination. In January 2011, the WHO Executive Board selected four representatives (Argentina, Brazil, Canada, and the United States of America) out of the 13 candidacies presented by the Member States of the Region of the Americas to form part of the Consultative Expert Working Group.

20. The political will and desire of the Member States and principal regional actors to cooperate has resulted in concrete cooperation activities—in particular, the modality of working in a network. The recently created Health Technology Assessment Network of the Americas, headed by the national health authorities, consists of experts from the Region's collaborating centers and reference institutions to improve the countries' ability to justify decisions on innovation and the adoption, development, and use of health technologies in health systems Through ECONMED, a bilingual electronic listserv,¹ health authorities access key information for health technology management. The Pan American Network for Drug Regulatory Harmonization (PANDRH) brings national regulatory authorities together to facilitate the drafting of regulatory standards and guidelines.² These networks address highly diverse matters and reflect different priorities

¹ To access the documents, communications, and public materials distributed by ECONMED, visit: www.paho.org/econmed.

² To learn about the current situation, historical trajectory, and groups currently active in the network, visit: http://new.paho.org/hq/index.php?option=com_content&task=view&id=1054&Itemid=513&lang=en.

ranging from the use of medicinal³ plants to biotechnology,⁴ from health and innovation in the Pan-Amazon region⁵ to the conducting of major clinical trials.

21. In the Region, managing intellectual property rights from a public health perspective remains a priority. Since June 2010, Mexico has had a mechanism in place to evaluate patent applications (Federal Commission for Protection against Sanitary Risk, COFEPRIS), while Bolivia and Paraguay have adopted a similar instrument known as “advance consent.” A major development has been the ceding by the U.S. National Institutes of Health of an antiretroviral drug patent to the patent pool created by the International Drug Purchase Facility (UNITAID). The flexibilities provided in the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) have been used in the Region: in Ecuador, with the use of mandatory licenses by the national authorities, and in Colombia, with the government’s announcement of its decision to use the parallel import mechanism.

22. Eleven member States have begun analyzing the legal and institutional health frameworks connected with the management of intellectual property rights. The information gathered is being analyzed in each country under the aegis of the health authorities to improve coordination between health and other sectors in the management of intellectual property rights with a view to improving access and health.⁶

23. In response to the official request from the countries of the Region, PAHO has offered assistance through a range of activities in the areas of trade and access to essential medicines, supporting training workshops in Central America and the Caribbean attended by representatives of the ministries of health and other national actors. It has provided support to Argentina’s Ministry of Health in offering a course on public health and intellectual property to train public officials from the ministries, regulatory agencies, and other entities. It has also provided assistance for a study on pharmaceutical policies, the regulation of intellectual property, and access to drugs, in collaboration with CARICOM and other Caribbean countries.⁷

³ Information available at:

http://new.paho.org/hq/index.php?option=com_content&task=view&id=1587&Itemid=513.

⁴ To view the work plan, members of the Group, and latest publications, visit: http://new.paho.org/hq/index.php?option=com_content&task=view&id=1587&Itemid=513.

⁵ To view the network’s objectives and mission, visit:

<http://panamazonica.bvsalud.org/php/index.php?lang=en>.

⁶ Brazil, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, and Peru. Information on the project and its scope can be found at:

http://new.paho.org/hq/index.php?option=com_content&task=view&id=2781&Itemid=1178&limit=1&limitstart=2&lang=en.

⁷ The report on the regulatory situation, management of intellectual property, and access to medicines in the CARICOM countries (and the Dominican Republic) is under review by the pertinent CARICOM bodies.

24. The renewed interest in promoting the creation of national innovation systems has led the countries and principal actors in the consultative processes to actively participate in aspects key to the implementation of the global strategy. The meeting on innovation to fight neglected diseases, which was part of the Global Forum for Health held in Cuba in November 2009, and the consultation on promoting research and development for health products, held in Panama in September 2009⁸, are clear examples of that interest.

25. The regulatory framework and capacity building to facilitate technology transfer were topics also addressed during a consultation held in Uruguay in October 2010,⁹ and another in Mexico in May 2011 on the production of influenza vaccines. Finding the right incentives to bridge the innovation gaps that impact the most vulnerable sectors of the population has also been a matter of concern. PAHO's proposal to create an incentive for innovation to fight neglected and priority diseases has sparked the countries' interest.

26. Country activities to improve access to health technology are grounded in the principle of integrating interventions in access and innovation; they include:

- integrating supply systems in El Salvador and the Dominican Republic;
- increasing and improving the efficiency of public drug financing through the People's Pharmacy Program in Brazil;
- increasing the transparency of pharmaceutical markets through the creation and use of price banks to support public procurement of medicines in MERCOSUR, Central America, Peru, and Colombia;
- promoting rational use by creating multidisciplinary national programs in Bahamas, Bolivia, Nicaragua, and Paraguay;
- assisting the Central American countries in the negotiation and joint procurement of costly drugs, with support from the Regional Revolving Fund for Strategic Public Health Supplies, to improve access to these supplies; and
- strengthening regulatory capacity to guarantee the safety, efficacy, and quality of drugs in the Caribbean countries, Colombia, Cuba, Honduras, Panama, and Peru.

27. Today, the Region has four regulatory authorities for regional reference (Resolution CD50.R9 [2010]) to strengthen capacity and regulatory functions in the Member States.

⁸ A summary of the meeting can be accessed at http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=8796&Itemid=.
(Spanish only)

⁹ A summary of the events at the International meeting on technology transfer and health innovation in the Americas can be accessed at: http://new.paho.org/uru/index.php?option=com_content&task=view&id=245&Itemid=230.
(Spanish only)

28. Integrating the multiple initiatives and work areas of the global strategy implies major challenges. In addition to improving access, having a participatory space with reliable and pertinent information will help to strengthen the capacities necessary to implement all the activities required for innovation in health. Therefore, PAHO, in collaboration with the Member States, international organizations, and key actors, is developing a Regional Platform for Access and Innovation for Health.¹⁰ This platform will serve as an integrating instrument and channel for promoting the cooperation, work in networks, transparency, and information flows necessary for promoting leadership, innovation, access, and rational use in the field of health technology, as well as the sharing of information on the initiatives included in the global strategy.

29. The member States of PAHO have displayed a serious commitment to comprehensive implementation of the strategy. The 49th Directing Council of PAHO provided complementary tools with its adoption of the *Policy on Research for Health* (Resolution CD49.R10 [2009])¹¹ and Resolution CD49.R19¹² (2009) on the elimination of neglected diseases and other poverty-related infections.

Action by the Executive Committee

30. The Executive Committee is requested to take note of this progress report and offer its recommendations in this regard.

¹⁰ Available from:

http://new.paho.org/hq/index.php?option=com_content&task=view&id=2168&Itemid=1178&lang=en.

¹¹ Resolution CD49.R10 (2009), *Policy on Research for Health*, [online] is available at:

http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=3093&Itemid=.

¹² Resolution CD49.R19 (2009), *Elimination of Neglected Diseases and Other Poverty-related Infections* [online] is available at: [http://new.paho.org/hq/dmdocuments/2009/CD49.R19%20\(Eng.\).pdf](http://new.paho.org/hq/dmdocuments/2009/CD49.R19%20(Eng.).pdf).

C. ADVANCES IN THE IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Background

31. The objective of this report is to provide an update on the progress made with respect to tobacco control measures in the Region of the Americas pursuant to Resolutions CD48.R2 (2008) of the 48th Directing Council of the Pan American Health Organization (PAHO) (1) and CD50.R6 (2010) of the 50th Directing Council of PAHO (2).

Progress Report

32. Saint Vincent and the Grenadines ratified the Framework Convention on Tobacco Control (FCTC), bringing the number of Parties to 28 (80% of all PAHO Member States).

33. Mexico and Panama raised taxes on tobacco products; however, these levies still fail to represent 75% of the retail price, which means that only three countries have reached that goal (Chile, Cuba, and Venezuela).

34. Ten countries have national or subnational legislation covering more than 90% of the population that bans smoking in all indoor public places and workplaces, without exception. Barbados, Honduras, and Venezuela are the three new countries that joined Canada, Colombia, Guatemala, Panama, Peru, Trinidad and Tobago, and Uruguay. One country, Paraguay, suffered a setback with the repeal of a decree that addressed this issue, due to a lawsuit filed by the tobacco industry.

35. Fifteen countries have regulations governing the packaging and labeling of tobacco products that are consistent with the FCTC, although two of them do not require images in the warnings. Honduras and Nicaragua are the new countries that have joined this group. Paraguay suffered a setback with the repeal of the decree that addressed this issue, due to a lawsuit filed by the tobacco industry. For 12 countries, the deadline for application of the pertinent article of the FCTC is the end of 2011.

36. Although Honduras and Nicaragua have adopted partial restrictions on tobacco advertisement, promotion and sponsorship, and other countries have broad restrictions, the two only countries with a total ban continue to be Colombia and Panama. For 20 countries, the deadline for application of the pertinent article of the FCTC is the end of 2011.

37. Recent years have witnessed an increase in the number and aggressiveness of measures adopted by the tobacco industry to fight tobacco control policies. PAHO is collaborating closely with civil society organizations to provide immediate and appropriate technical assistance to the Member States in this area under Article 5(3) of the FCTC.

38. With respect to the cross-cutting issues of gender and human rights, PAHO, in collaboration with the World Health Organization (WHO) and the U.S. Centers for Disease Control and Prevention (CDC) continues to buttress the Global Tobacco Surveillance System through the use of a standard protocol that makes it possible to have information with a breakdown by sex in all components of the system. It has also provided technical assistance for implementation of the tobacco control measures with a human rights approach. This has been particularly important in its support to counteract the interference of the tobacco industry, which opposes measures to promote smoke-free environments.

Measures to Improve the Situation

39. The issue of tobacco control must remain a priority, since full implementation of the FCTC will save countless lives, not only in the long term, but in the short term as well, as demonstrated by studies that show a significant reduction in the incidence of acute myocardial infarction following implementation of policies on smoke-free environments.

40. Since 80% of the member States are legally bound by the Convention, it is essential to foster the inclusion of tobacco control in cooperation plans with the countries, along with use of the horizontal cooperation mechanism, through technical cooperation among countries.

41. It is necessary to play a more active role at the national level to facilitate the creation or strengthening of coordinating entities and technical units responsible for addressing the issue of tobacco control.

42. Action by the tobacco industry usually requires a rapid and coordinated response. The Organization should widely disseminate information on the different types of technical cooperation available in each case, in addition to promoting coordination with other government and civil society actors in order to optimize the interventions.

43. It is recommended that tobacco control be a component of broader projects, since many areas, such as chronic noncommunicable diseases and maternal and child health, could benefit and at the same time help to mobilize new sources of financing. Moreover,

it is important to continue and intensify inclusion of the gender and human right perspective in the tobacco control agenda.

Action by the Executive Committee

44. The Executive Committee is requested to take note of this progress report and establish that a progress report be submitted every two years to coincide with the end of the biennium.

References

1. Pan American Health Organization. WHO Framework Convention on Tobacco Control: Opportunities and Challenges for Its Implementation in the Region of the Americas [online]. 48th Directing Council of PAHO, 60th Session of the WHO Regional Committee for the Americas (Resolution CD48.R2) , 29 September-3 October 2008; Washington (DC), US. Washington (DC): PAHO; 2008 (Resolution CD48.R2) [accessed 22 March 2011]. Available at: <http://www.paho.org/english/gov/cd/cd48.r2-e.pdf>.
2. Pan American Health Organization. Strengthening the Capacity of Member States to Implement the Provisions and Guidelines of the WHO Framework Convention on Tobacco Control. [online]. 50th Directing Council of PAHO, 62nd Session of the WHO Regional Committee for the Americas; 27 September-1 October 2010; Washington (DC), US. Washington (DC): PAHO; 2010 (Resolution CD50.R6) [(accessed 22 March 2011). Available at: http://new.paho.org/hq/index.php?option=com_content&task=view&id=3149&Itemid=2401&lang=en.

D. IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

Introduction

45. The purpose of this report is to give an account of the progress made by Member States of the Region of the Americas and the Pan American Health Organization (PAHO) toward fulfilling their obligations and commitments in implementing the International Health Regulations (2005) since the last report to the 50th Directing Council, held in 2010 (Document CD50/INF/6).

Promote Regional and Global Partnerships

46. States Parties are gradually taking ownership and embracing the spirit of the Regulations in terms of transparency, shared responsibility, and mutual support, driven also by existing subregional integration mechanisms and initiatives. Recognizing the benefits of this approach, PAHO continues to promote and collaborate with such mechanisms and initiatives. It also continues to strengthen collaboration with other international organizations and technical institutions identified as key to supporting implementation of the Regulations.

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

47. The National IHR Action Plans (NAP) are the cornerstones of IHR (2005) implementation at the national level. Of the 28 States Parties that developed their NAP, at least 10 have conducted the costing exercise for such plans. Country-specific support provided by PAHO for the implementation of NAPs includes: (a) finalization and adjustment of the NAP; (b) strengthening of the National IHR Focal Point Office through the development of standard operating procedures, training in the use of Annex 2 of the Regulations, study visits to the WHO IHR Contact Point for the Region at PAHO Headquarters, and introduction of the IT platform for event management with support from the Ministries of Health of Brazil and Chile; (c) training of Rapid Response Teams; and (d) the establishment of competencies for field epidemiology.

48. PAHO supported country missions to facilitate the implementation of IHR (2005) provisions at points of entry, in particular those related to the port designation process, promoting intersectoral interactions between public health and point-of-entry authorities, and other ministries (e.g. ministries of transport, defense, among others), stressing the importance of integrating public health functions and a cost-effective approach to the designation of points of entry. With support from the Government of Spain, PAHO facilitated the translation of key documents on IHR implementation at points of entry.

49. The States Parties have committed to establishing core capacities for surveillance and response by June 2012, but it can be anticipated that not every country in the Region will meet the deadline. This deadline should be regarded as a target set to maintain the momentum and a step in the sustainable and ongoing preparedness process where countries adapt lessons learned and evidence-based best practices.

Strengthen PAHO/WHO Regional and Global Alert and Response Systems

50. PAHO continued fulfilling its obligations as the WHO IHR Contact Point for the Region of the Americas, facilitating the public health event management process: risk detection, risk assessment, response, and risk communication. From 1 January to 3 November 2010, a total of 110 public health events of potential international concern were detected and assessed. For 60 out of the 110 events considered, verification was requested and obtained from the national IHR Focal Points.

51. PAHO supported national authorities in their response efforts during a nosocomial outbreak of pulmonary plague in a known plague focus in Peru in August 2010. PAHO also supported Haiti and Dominican Republic following the reintroduction of cholera in Haiti in October 2010. Over 100 experts were deployed to support cholera response efforts, including those mobilized through the Global Outbreak Alert and Response Network (GOARN). Institutions and governments that contributed substantially to the response include the CDC, United States; the Public Health Agency of Canada; the European Centre for Disease Prevention and Control; the Institut de veille sanitaire, France; the Ministries of Health of Brazil, Peru, and Spain, and the Government of Cuba. Cuba deployed an additional 1,500 health workers to strengthen its already substantial, ongoing presence, as well as the Governments of Argentina, Brazil, Ecuador, and Perú also sent personnel.

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

52. The review and/or amendment of the national legal framework to ensure its compatibility and consistency with IHR (2005) provisions remains a challenge in Central America and the Caribbean.

53. In 2010, all but five States Parties in the Region submitted the annual confirmation or update of the NFP contact details. As of 31 January 2011, the IHR Roster of Experts includes 75 experts from the Region of the Americas.

54. As of 31 January 2011, 379 ports in 17 States Parties in the Region of the Americas were authorized to issue Ship Sanitation Certificates. The list of authorized ports is regularly updated and posted online¹.

55. In 2010, eight States Parties from the Region informed WHO about their vaccine requirements for travelers. The information will be included in the 2011 edition of WHO publication *International Travel and Health*.

56. In spite of the fact that the IHR (2005) signal the commitment of States Parties to strengthen *capacity* for surveillance and response while ensuring mutual accountability², to date, there are no legal obligations concerning the format of the annual report to be used by States Parties for reporting to the World Health Assembly. Between 2007 and 2009, several tools to evaluate and measure the progress made in implementing the IHR (2005) were developed worldwide and in the Region. Attempting to reach a Region-wide consensus on the IHR (2005) implementation monitoring approach, the States Parties agreed to continue using monitoring tools that have been developed and validated at the national or subregional level and have already been used at the national level. The low acceptance in the Region of the tool proposed by WHO to report to the Sixty-third WHA is signaled by the lowest regional submission rate recorded over the past three years (57%, 20/35 States Parties).

IHR (2005) Review Committee

57. The IHR (2005) Review Committee³ was convened pursuant to Resolution WHA61.2 (2008), following the Director-General's proposal to the 126th Executive Board to review the functioning of the IHR during the pandemic (H1N1) 2009. The main findings, recommendations, and conclusions of the Review Committee were presented in the "*Preview Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009*"⁴ (hereafter referred to as Preview Document) and presented at the last meeting of the Review Committee, open to Member States (Geneva, 28-30 March 2011), for comments and discussion.

58. The three overarching conclusions offered by the Review Committee in the Preview Document indicate that: (a) the IHR (2005) helped improving the world's preparedness to cope with public health emergencies, although core capacities called for in Annex 1 of the IHR are not yet fully operational throughout all levels of the public

¹ Available at http://www.who.int/ihr/ports_airports/portslanding/en/index.html.

² Global Health Security and the International Health Regulations. Andrus JK, Aguilera X, Oliva O, Aldighieri S. BMC Public Health. 2010 Dec 3;10 Suppl 1:S2.

³ Information about Review Committee is available at:
http://www.who.int/ihr/review_committee/en/index.html.

⁴ Available at http://www.who.int/ihr/preview_report_review_committee_mar2011_en.pdf.

health system and are not on a path to be timely implemented worldwide; (b) WHO performed well in many ways during the pandemic, confronted systemic difficulties and demonstrated some shortcomings; no evidence of malfeasance was found by the Review Committee; and, (c) the world is ill-prepared to respond to a severe influenza pandemic or to any similar global public health event; in addition to the establishment of core capacities, factors of different nature might help in advancing global preparedness.

59. Inputs and suggestions to the Preview Document will be compiled and consolidated in the final report of the Review Committee and the document will be submitted to the Sixty-fourth World Health Assembly. Should additional related issues emerge during the Sixty-fourth World Health Assembly, this report will be complemented orally during the 148th Session of the Executive Committee.

E: PROGRESS TOWARD ACHIEVEMENT OF THE HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS IN THE REGION OF THE AMERICAS

Introduction

60. The Millennium Development Goals (MDGs),¹ set in 2000 by the 189 member countries of the United Nations through the Millennium Declaration, were reaffirmed at the Summit of 2010. The Member States of the Pan American Health Organization (PAHO) have expressed a clear commitment to meeting the targets set to reach the [MDGs](#), in the conviction that health is an essential factor in social, economic, and political development. The Organization has deemed that the best way to make progress toward meeting these targets is to improve equity in health both among and within countries, giving priority to vulnerable areas and groups, as well as populations living in poverty. The MDGs and their associated targets are key dimensions of the [PAHO](#) commitment to health policies with quantifiable results.

61. This report is based on the commitments made during the 45th Directing Council of 2004, which adopted Resolution [CD45.R3](#) on the MDGs and health targets ([CD45/8](#)); the report of the World Health Assembly [A63/7](#) (2010) and Resolution [WHA63.15](#) (2010); and the resolution of the Millennium Summit adopted by the United Nations General Assembly ([A/RES/65/1](#)[2010]) as it pertains to the Region of the Americas. The report also proposes strategic action for the next four years.

Background

62. The year 2010 marked four-fifths of the way to the target date set for achieving the MDGs, a time frame that began in 1990 and will end in 2015. Although the Region of the Americas seems to be on the way to achieving of the health-related MDGs, it must be recognized that the regional averages tend to conceal major disparities among and within the countries. Moreover, the rate at which the targets are met differs from country to country, regardless of the level of development.

63. According to estimates by the Economic Commission for Latin America and the Caribbean ([ECLAC](#)), between 2003 and 2008 the proportion of people living in poverty in Latin America and the Caribbean fell by 11 percentage points, decreasing from 44% to 33%; similarly, the proportion of people living in extreme poverty fell from 19% to 13%. Even with this progress, it was calculated that in 2008, 180 million people

¹ There are eight Millennium Development Goals. They refer to the eradication of poverty, universal primary education, gender equality, the reduction of child mortality, the improvement of women's health, combating HIV/AIDS, malaria, and other diseases, environmental sustainability, and development of a global partnership for development.

were living in poverty and 71 million in extreme poverty. For this reason, in the [Inter Agency Report on MDGs](#) it was agreed that three aspects of equality would be emphasized: equal rights, the closing of gaps, and the welfare of future generations through sustainable development (I–2).

64. With the adoption of Resolution [CD45.R3](#) in 2004, the countries have implemented activities with support from the Organization's different technical areas, emphasizing measurement, quality, and monitoring of the progress made toward meeting the targets. Furthermore, through numerous documents, the countries have made a commitment to:

- reduce subnational inequalities (in 2006 [CD47/INF/2](#) , [CD47/inf/1](#) and in 2007 [CSP27/14](#));
- reduce poverty and hunger (RIMSA [CD46/14](#) [2005], [CD48/19. Rev. 1](#) [2008]);
- improve nutrition (in 2006 [CD47/18](#), [CD47.R8](#) and [CD49/23. Rev. 1](#) 2009);
- reduce gender inequity ([CD46/12](#) [2005]);
- reduce infant mortality (in 2006 [CD47/12](#), [CD47/11. Rev. 1](#), [CD47.R19](#), [CD47.R10](#), and in 2008 [CD48/7](#), [CD48.R4](#), [Rev. 1](#));
- improve maternal health ([WHA55.19](#)²[2002] and [A57.13](#) [2004]) ;
- combat HIV/AIDS (in 2005 [CD46/20](#) and [CD46.R15](#)), malaria ([CD46/17](#) [2005], and in 2007 [CSP27/9](#) and [CSP27.R11](#)); and tuberculosis (in 2005 [CD46/18. Rev.1](#) and [CD46.R12](#));
- promote sustainable development (in 2008 [CD48/16](#), [CD48/16, Add. II](#), and in 2010 [CD50/19](#), [CD50/19, Add. I](#) and [CD50/19, Add. II](#));
- strengthen health systems that are based on primary care and respond to the health determinants (in 2008 [CD48/14, Rev. 1](#), [CD48/14, Add II](#), and in 2009 [CD49.R22](#));
- strengthen vital and health statistics ([CD48/9](#) [2008], [CD49/16](#) [2009], in 2007 [CSP27/13](#), [CSP27/12](#) and [CD50/INF/6](#) [2010]).

65. This progress report is based on the data provided by the Member States and published annually by PAHO within the framework of the Regional Core Health Data and Country Profile Initiative ([CD/45/14](#) [2004] and [CD50/INF/6](#) [2010]), and on global data generated by the United Nations Inter-Agency and Expert Group on MDG Indicators, which provides standardized figures based on population projections or adjusted data (I–3).

² This document is currently available in English only.

Analysis of the current situation

66. The degree of progress toward achievement of the MDGs varies from country to country and target to target.

67. For the purposes of this report, both the information from the countries (referred to here as “PAHO”), routine records, and country calculations, and from the estimates of the Economic Commission for Latin America and the Caribbean (ECLAC/CELADE), which oversees the interagency group, were considered.^{3,4,5,6}

68. A study was conducted using information for the period 1990-2009, equivalent to 76% of the time allotted for achieving the MDGs. The problems that affect use of the information from routine systems are primarily lack of coverage of the numerator and/or denominator of the indicators. This makes it necessary to use calculations done by the countries and international organizations, which do not always coincide.⁷

69. MDG 4 is analyzed with the data from PAHO, using mortality in children under 1 year of age, since this age group accounts for 80% of the deaths in children under 5.

70. **Infant mortality** continues to move downward in the Region. In 1990, the infant mortality rate (IMR) was 42 per 1,000 l.b. (live births.) in Latin America and the Caribbean and in 2009, 19 per 1,000 l.b., for a 55% reduction and an annual average reduction of 2.9% (4). It is calculated that in 2009 there were 199,000 infant deaths in the Americas. The public health measures that have contributed to this decline are: progress in the implementation of the high-impact, low-cost primary health care strategy; free universal programs for routine vaccination; oral rehydration therapy; child growth and development monitoring; increased coverage of basic services, especially drinking water

³ Organización Panamericana de la Salud. Información y análisis de salud: situación de la salud en las Américas: indicadores básicos del 2004 al 2010. Washington (DC) US.

⁴ Comisión Económica para América Latina y el Caribe/Centro Latinoamericano y Caribeño de Demografía. Tasas de mortalidad infantil estimadas según quinquenios. Países de América Latina 1950-2050 [Internet]. CEPAL/CELADE. Santiago de Chile, Chile (accessed 1 November 2010). Available at: http://www.eclac.org/ceclade/proyecciones/basedatos_BD.htm.

⁵ Institute for Health Metrics and Evaluation. Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970-2010: a systematic analysis of progress towards millennium development goal 4 [Internet]. IHME; 2010 [accessed 1 November 2010]. Available at: <http://www.healthmetricsandevaluation.org/resources/datasets/2010/mortality/results/child/child.html>.

⁶ United Nations Children's Fund/World Health Organization/World Bank/United Nations Population Division. The Inter-agency Group for Child Mortality Estimation: Trends in infant mortality rates (1960-2009) [Internet]. IGME; 2010 [accessed 1 November 2010]. Available at: http://www.childinfo.org/mortality_imrcountrydata.php.

⁷ PAHO is executing a strategy for improving vital and health statistics (CD48/9 [2008]) that consists of two components: a) working with the countries to strengthen and improve statistics, and b) coordinating with international organizations to avoid duplication of efforts and the use of techniques or hypothesis that differ when calculating the indicators.

and sanitation; an increase in the educational level of the population, especially women; declining fertility; and poverty reduction.⁸ It should be noted that there is great heterogeneity among the countries of the Region and among population groups and territories within countries.

71. Based on the official figures that PAHO receives from its Member States, the lowest IMR are seen in Canada, Chile, Costa Rica, Cuba, the United States of America, and Uruguay, (from 6 to 10 per 1,000 l.b., depending on the series used); Bolivia and Haiti have the highest figures (from 50 to 80 per 1,000 l.b., depending on the series) —values eight times higher than in the countries with the lowest rates.

72. In the Caribbean countries (English- and French-speaking), the series are more unstable because small populations are involved and their situation is more homogeneous than in the Latin American countries. The French Departments of the Americas (Guadeloupe, French Guiana, and Martinique) and Anguilla have the lowest IMR (below 10 per 1,000 l.b.) while Guyana, Suriname, and Trinidad and Tobago have the highest in the subregion (20-40 per 1,000 l.b. according to different estimates).

73. **Maternal mortality** in the Region has declined, but with trends that differ from country to country. In 1990, the maternal mortality ratio (MMR) was 140 per 100,000 live births in Latin America and the Caribbean and 84 in 2008, a 40% reduction, with an average annual reduction of 3% since 1990. The number of maternal deaths in the Americas in 2008 is calculated at 10,242 (5).

74. Based on the official figures that PAHO receives from its Member States, the percentage change in the maternal mortality ratio (MMR) was analyzed, using the MMR figures available in 2000 as the baseline and comparing it with the most recent figures available between 2005 and 2009. If a country did not have the MMR for 2000, the figure for 1999 or 2001 was used.

75. This downward trend is observed in 15 countries of the Region, which show different degrees of progress ranging from -2.9% up to -44.3%. In addition, there are countries that reported increases until 2008, an increase largely attributable to improvements in the monitoring of maternal deaths – for example, greater capture of the indirect causes of death observed in Canada, the United States, and the Dominican Republic. It should be pointed out that for 2009, we expect an increase in maternal

⁸ This statement is also supported in paragraph 4 of this same document. In 1990 there were 200 million poor and 93 million people living in extreme poverty; in 2007 there were 184 million poor and 68 million living in extreme poverty. In 2008, notwithstanding the food crisis, the number of poor fell to 180 million; however, the number of people living in extreme poverty rose to a 71 million. Therefore, according to the 2008 data from ECLAC, the number of people living in extreme poverty increased, but at the same time it can be said that poverty in general has fallen since 1990 (by 11 percentage points and 20 million people).

mortality in the majority of the countries due to the 2009 influenza A (H1N1) epidemic. The report with this information will be published in the “Health Situation in the Americas: Basic indicators 2011” pamphlet.

76. It is important to note that in several countries, the expansion of coverage in prenatal care, delivery by skilled birth attendants, contraceptive access and use, and the intensification of maternal mortality surveillance are strategies that are contributing to lower maternal mortality. Nevertheless, although the maternal mortality indicator has improved, the analysis is hindered by a lack of information in the series, because of the size of populations and/or the scarcity of sources that cover all the years foreseen for the analysis of the MDGs. It should be pointed out that reducing maternal mortality remains a pending issue and that most of the countries in the Region will not succeed in meeting the target by the established date.

77. Concerning the calculation of the number of new **HIV** infections (UNAIDS, 2010. Global Report) for the countries of the Region, a reduction in morbidity has generally been observed, with differing trends in mortality. In 2009, around 7% of the total new HIV infections worldwide—that is, 179,000 cases—corresponded to the Region; of these, 92,000 occurred in Latin America, 70,000 in North America, and 17,000 in the Caribbean (3). UNAIDS is responsible for monitoring the achievement of Targets 6A and 6B.

78. The epidemic has not yet been halted or reversed. On the contrary, the risk of the further spread of the infection is still present, even among women, youth, and indigenous populations (3). For the period 2004-2008, with respect to the proportion of the HIV+ population in Latin America and the Caribbean with access to antiretroviral drugs, there has been an increase in the number of pregnant women (from 35% to 54%) and children under 15 (from 65% to 76%) who have access to treatment.

79. For the period 2000-2009, the Region reported a 56% drop in morbidity from **malaria**, along with a 60% drop in mortality from this cause; 18 of the 21 countries with endemic malaria managed to lower their numbers by 2009. Of these, eight have reported reductions of over 75%; while four of them have had reductions of over 50%. Since 2005, there has been a sustained reduction in transmission in the Americas (6).

80. With respect to **tuberculosis**, 21 countries in the Region have made progress. Nevertheless, multidrug resistance still poses a challenge. The 2010 WHO report on tuberculosis control, (which contains data reported by the countries of the Region) notes a 4% annual rate of reduction in TB incidence in the Americas, making it the Region of the world with the sharpest decline. At the same time, the Region of the Americas has already met the targets of a 50% reduction in the TB prevalence and mortality rates set for 2015 (7).

81. With respect to **sustainable access to safe water**, the responsibility in the interagency group rests with UNICEF and WHO, agencies that, through the Joint Monitoring Program (JMP) use information based on household surveys and censuses, with standardized definitions to ensure comparability in time and between countries. According to the available regional JMP data for 2008, access to improved water sources stands at 93% (97% in urban areas and 80% in rural areas). The challenge is greater among the population in the lowest income quintiles. The JMP will improve monitoring by providing a breakdown of the data, which will make it possible clarify the definition of the sources of access to improved water and pay closer attention to the measurement of water quality. Work is beginning on the preparation of post-2015 indicators on the right to clean water and sanitation, recently declared a human right by the United Nations General Assembly (8).

82. In regard to **basic sanitation**, according to the JMP data for 2008, there is 80% coverage with improved basic sanitation in the Region. In rural areas, this coverage is only 55%, making it necessary to continue promoting this service in rural and peri-urban areas. Furthermore, progress needs to be made in improving service quality, reducing unimproved sanitation services and defecation in the open, and improving wastewater treatment in urban areas (8). The challenge is greater among the population in the lowest income quintiles (2).

Proposal

83. In order to meet the targets it is necessary: a) to guarantee joint efforts among the countries of the Region, considering that some must speed up activities; b) to maintain PAHO's leadership in monitoring and technical cooperation to improve health system performance; and c) to improve national health information systems to ensure increasingly valid, reliable and timely data from the usual systems.

84. The countries will be requested to continue pursuing the following strategic lines for the achievement of MDGs: a) Review and consolidation of information systems; b) Strengthening of systems based on primary health care (PHC). It is proposed that the health systems of municipalities in more highly vulnerable situations be strengthened with the renewed PHC framework; c) Reduction of inequity within countries, giving priority to the most vulnerable municipalities and excluded population groups, as a response to the social determinants of health. It is proposed that initiatives targeting such municipalities and groups, such as Faces, Voices, and Places, healthy municipalities, the Alliance for Nutrition and Development, and Safe Motherhood, be strengthened; d) Public policy-making to ensure the sustainability of achievements and action on the social and environmental determinants of health by promoting "health in all policies." It is proposed that advantage be taken of all political and technical forums to bring the issue

of the challenges of equity in our Region to the forefront; and, e) Intensification of intersectoral and interagency work to pool and target efforts.

Action by the Executive Committee

85. The Executive Committee is requested to take note of this report and issue its comments and suggestions, so that the work of PAHO in this line of technical cooperation reinforces activities that further promote achievement of the health-related MDGs by 2015.

86. The Member States are requested to intensify their efforts to achieve the MDGs through targeted actions in the five proposed strategic lines

87. It is recommended that a progress report be submitted in 2013 in preparation for the consolidated report to the United Nations General Assembly in 2015.

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F. REVIEW OF THE PAN AMERICAN CENTERS

Introduction

88. This document was prepared in response to the mandate of the Governing Bodies to periodically examine and evaluate the Pan American Centers.

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

89. Given the convergence of human and animal health, there is a growing need for the Pan American Health Organization (PAHO) to exercise leadership in the areas of zoonoses, food safety, and food security (which includes animal diseases that have an impact on food security—foot-and-mouth disease, for example).

Recent Progress

90. An institutional development project for PANAFTOSA was implemented, in which basic administrative processes were reviewed and improved. Operating costs were broken down so that technical cooperation for the eradication of foot-and-mouth disease will be financed largely by voluntary contributions from Brazil's Ministry of Agriculture, Livestock, and Food Supply, and other public and private organizations in the agriculture sector through a trust fund that will pool the financial resources mobilized for regional coordination of the Hemispheric Program for the Eradication of Foot-and-mouth Disease (PHEFA). The PHEFA Action Plan 2011-2020 was approved at a special meeting of the Hemispheric Committee for the Eradication of Foot-and-mouth Disease (COHEFA) in December 2010.

91. In addition, the regional and global coordination mechanisms for early warning and rapid response to serious health risks associated with zoonoses, foodborne diseases, and animal diseases that have an impact on food security are being strengthened under the International Health Regulations (2005), in close collaboration with the World Animal Health Organization. Next September, the remodeling of the laboratory of Brazil's Ministry of Agriculture, Livestock, and Food Supply (biosafety level 4, in accordance with the standards of the World Animal Health Organization [OIE]) in Pedro Leopoldo (Minas Gerais) will be completed, permitting the transfer of the PANAFTOSA reference laboratory from the Center's headquarters in Duque de Caxias (Rio de Janeiro) to the new biosafety installations at the Pedro Leopoldo National Agricultural Laboratory.

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

92. BIREME is a specialized center founded in 1967 to channel the Organization's technical cooperation in health sciences information and technology to the Region. The Center operates in collaboration with the Government of Brazil, represented by the Ministry of Health, the Ministry of Education, the Ministry of Health of São Paulo State, and the Federal University of São Paulo (UNIFESP). This cooperation was formalized through the BIREME Maintenance Agreement, which has been renewed successively since its signing. The last renewal extended the Agreement through 31 December 2011.

93. The principal document establishing the Center's new governance structure and institutional framework is the Statute of BIREME, in effect since January 2010. This document was approved by the 49th Directing Council (2009), following an **extensive** consultative process in which the Government of Brazil, under the leadership of the Ministry of Health, actively participated.

94. The Statute of BIREME establishes an Advisory Committee, made up of five members appointed by the Directing Council of PAHO and two permanent members (PAHO and Brazil).

95. In 2009, the 49th Directing Council selected five Member States to serve on the BIREME Advisory Committee: Argentina, Chile, and the Dominican Republic (with a three-year term), and Mexico and Jamaica (with a two-year term). The difference in terms was designed to guarantee the rotation and continuity of members in the future.

96. The new Statute of BIREME applies jointly with the BIREME Maintenance Agreement, which will remain in force until end of this year. The financial resources that BIREME members contribute to the library's maintenance in 2011 will be transferred by means of a new Headquarters Agreement for BIREME, which is currently pending approval by the Government of Brazil. The 2011 contribution of the Ministry of Health of Brazil is estimated at around US\$ 2.2 million.

Recent Progress

97. The BIREME Advisory Committee took office on 31 August 2010, with the five nonpermanent members and two permanent members (Brazil and PAHO) participating. During this session, the Advisory Committee's rules of procedure and a series of measures and meetings related to the implementation of BIREME's new institutional framework were approved. These activities are expected to conclude in 2011.

98. In order to establish BIREME's new institutional framework, the following measures have been programmed:

- (a) Signing of a Headquarters Agreement for BIREME. PAHO/WHO and the Ministry of Health of Brazil have drawn up a Headquarters Agreement, which has been under review by the Ministry of Foreign Affairs since the second half of 2010.
- (b) Establishment and signing of an agreement on BIREME's facilities and operations on the UNIFESP campus. This process will begin once the new Headquarters Agreement is signed.
- (c) Definition of the BIREME financing regime for the coming years, based on the contributions of PAHO/WHO and the Government of Brazil.
- (d) Creation of the Scientific Committee in 2011, in coordination with the BIREME Advisory Committee.
- (e) Holding of the second regular meeting of the Advisory Committee at BIREME by the end of the first semester 2011.
- (f) Harmonization of all dimensions of institutional management processes, regularization of work and cooperation exchanges between PAHO institutions in the country.
- (g) Preparation of the new biennial plan, in coordination with PAHO'S Knowledge Management and Communication Area and based on the cooperation strategy in Brazil.

99. At the 51st Directing Council of PAHO in 2011, two new members should be elected to the BIREME Advisory Committee on expiration of the term of Jamaica and Mexico (Resolution CD49.R6 [2009]).

Pan American Center for Sanitary Engineering (CEPIS)

100. As noted in Resolution CD50.R14, on 30 September 2010 the agreement between the Government of Peru and PAHO/WHO to transform CEPIS into the Regional Technical Team on Water and Sanitation (ETRAS) was signed. ETRAS operates out of the facilities of the Representative Office in Peru as part of the Sustainable Health and Development Area (SDE) of PAHO. At the decision of the parties, the agreement establishing CEPIS, signed on 8 April 1971 by the Government of Peru and PAHO/WHO, was terminated on the date that the agreement establishing ETRAS was signed.

101. Consequently, information on CEPIS will no longer be included in the periodic review of the Pan American Centers. However, ETRAS' activities will be part of the periodic report on program performance under the respective strategic objectives.

Latin American Center for Perinatology and Human Development (CLAP)

Recent Progress

102. The Government of Uruguay, through the State Health Services Administration (ASSE), made a commitment to providing a physical space for the relocation of CLAP and the PAHO/WHO Representative Office, a matter that to date is still pending.

103. A study was conducted on merging the administrative services of CLAP and the PAHO/WHO Representative Office in Uruguay, and a proposal was submitted that contained the steps necessary to bring about the administrative merger and transfer to the new facilities.

104. Extension V of the Agreement between the Government of the Eastern Republic of Uruguay, the University of the Republic, and PAHO/WHO to continue the activities of CLAP was signed. The new agreement expires on 28 February 2016.

Regional Program on Bioethics

105. Pursuant to Resolution CD50.R14, the different modalities of collaboration with the Member States in bioethics were evaluated, and it was resolved that the regional program would be consolidated under the Office of Gender, Diversity, and Human Rights (DRG). Consequently, information about the Regional Program on Bioethics will no longer be included in the periodic evaluations of the Pan American Centers. Instead, the program's activities will be part of the periodic reports on program performance under the respective strategic objectives.

106. In addition, consultations way with the Government of Chile and the University of Chile are under way to identify joint activities in this important field. This could result in a new agreement to replace the agreement for the operation of the Regional Program on Bioethics, signed by the Government of Chile, the University of Chile, and PAHO/WHO on 13 January 1994.

Subregional Centers (CAREC and CFNI)

Caribbean Epidemiology Center (CAREC)

107. CAREC is currently devoted to maintaining its customary services, expanding them as necessary and appropriate during its transition to the Caribbean Public Health Agency (CARPHA) as noted in Resolution CD50.R14 (2010), study and support groups in the areas of human and financial resources and laboratory management have been created for the transition process. These groups are continuing their efforts to ensure an orderly and transparent transition to CARPHA. Some of the priority areas include a definition of the sphere of action, the functions and in increase in the capacity of the CAREC laboratory, and the laboratory network that will be established under the CARPHA structure.

108. CAREC has benefited from the support and guidance of the CAREC Council and has taken into consideration the decisions that the Council for Human and Social Development (COHSOD) and the Caucus of Caribbean Community (CARICOM) Ministers of Health have made concerning CARPHA.

Caribbean Food and Nutrition Institute (CFNI)

109. Pursuant to the request in Resolution CD50.R14 (2010), CFNI continues collaborating with the CARICOM teams in matters related to CARPHA to guarantee that the issues of food security and the components of nutrition are included in its execution plans. CFNI programs are under review to facilitate the definition of the functions that will be subsumed by CARPHA.

110. The possibility of entering into agreements with institutions in this subregion for the transfer of other functions, such as hospital food services and dietetics and human resources education, continues to be explored. This distribution of responsibilities within each priority area was endorsed by the CFNI Policy Advisory Committee in resolutions 2, 3, 4, and 7 of 19 July 2010.

111. In order to obtain greater technical and administrative efficiency, it was decided to relocate the PAHO/WHO Representative Office in Jamaica to the CFNI building. On 29 November 2010, a modification of the CFNI headquarters lease agreement was signed by the University of the West Indies and PAHO/WHO to enable the two offices to be consolidated. In addition, a cost estimate has been obtained for the renovations and improvements necessary to accommodate the staff from the Representative Office and CFNI in the same physical space. The renovations include improved security, reorganization of the offices; and a new telephone system, which has been sent from Washington. The precise date of the transfer has yet to be determined.