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## PROGRESS REPORTS ON TECHNICAL MATTERS

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**A. PLAN OF ACTION ON HEALTH IN ALL POLICIES:  
PROGRESS REPORT**

**Background**

1. Health in All Policies (HiAP) is both an enabler of health equity and a collaborative strategy to incorporate health considerations into decision making across sectors and policy areas in a more decisive and effective way. The regional plan of action is in line with the spirit of the 1978 Alma-Ata Declaration (1), the 1986 Ottawa Charter for Health Promotion (2), the 2011 Rio Political Declaration on Social Determinants of Health (3), and the interdependent and multisectoral framing of the 2030 Agenda for Sustainable Development. The HiAP approach promotes comprehensive, intersectoral action to address underlying social, economic, environmental, and political determinants of population health.

2. The Plan of Action on Health in All Policies, adopted in September 2014 by PAHO's 53rd Directing Council (Resolution CD53.R2 and Document CD53/10) (4, 5), sets specific goals and targets for a five-year period, 2014-2019, and corresponds to the World Health Organization's (WHO) Health in All Policies Framework for Country Action (6). This report summarizes progress in the implementation of the regional Plan of Action on HiAP. The report is based on regional evidence and best practices documented by Member States, and draws from training workshops and stakeholder consultations within and beyond the Region of the Americas.

**Update on Progress Achieved**

3. The Region of the Americas is the first WHO Region to adopt a regional Plan of Action on HiAP. Drafted by PAHO with significant input from Member States and from regional and global experts, the Plan of Action marks a significant milestone in the global acceptance of the HiAP approach as a means to encourage collective and coordinated action for health. The Plan of Action identifies six strategic lines of action: *a)* establish the need and priorities for HiAP; *b)* frame planned action; *c)* identify supportive structures and processes; *d)* facilitate assessment and engagement; *e)* ensure monitoring, evaluation, and reporting; and *f)* build capacity.

4. As requested by Member States, PAHO convened an Expert Consultation in Washington, D.C., in March 2015 to define concrete steps to operationalize HiAP in the Americas. The primary outputs of the consultation were a road map for HiAP implementation, in line with the regional Plan of Action on HiAP (7); the white paper "Health in All Policies: From the Local to the Global" (8), which provides evidence-based options and opportunities for local governments to develop and implement HiAP; and the document "Plan of Action on Health in All Policies: Validation of Implementation Indicators" (9), which presents an analysis of the 12 indicators of the regional Plan of Action with a view to facilitating their application.

5. The PAHO Task Force and Working Group on Health in All Policies and the Sustainable Development Goals was established in May 2015 to identify and optimize strategic priorities for engaging with other sectors in the context of the Sustainable Development Goals (SDGs). The group has produced a series of guiding documents on harmonizing the HiAP and SDGs agendas, including a Concept Note (10) and a Reference Note (11). Effective multisectoral practices have been documented in “Advancing the Health in All Policies Approach in the Americas: What Is the Health Sector’s Role?” (12) and “Health in All Policies: Case Studies from the Region of the Americas” (13), as well as an online platform (14), to which 16 countries have submitted experiences.

6. Using the WHO HiAP Training Manual as a guide, four HiAP training courses were offered in Brazil, Chile, Mexico, and Suriname to participants from the entire Region during 2015 and 2016. A total of 16 countries participated in these trainings. Having carried out the initial stage of capacity building at the regional level, the Strategic Evaluation of Capacity Building for HiAP in the Region of the Americas was held in February 2017, where a two-year work plan was developed (15).

7. The status of the progress made on indicators and targets are presented in the table below.

### Progress Toward the Objectives and Targets of the Plan of Action

Objective	Indicator and target	Progress
1.1 Assess the potential impacts of public policies on people’s health, health equity, and health systems, ensuring that those responsible for policy-making are aware of and understand these potential policy impacts on health.	1.1.1 Number of countries with established national/regional networks of multisectoral working groups and stakeholders to evaluate the impact of government policies on health and health equity.  Baseline (2014): 6 Target (2019): 18	PAHO’s Expert Consultation provided the foundation for the formation of national and regional networks to share experiences in HiAP implementation. Moreover, networks were formally established by 16 countries during the sub-regional HiAP training courses and these are now fully functional.
	1.1.2 Number of countries and territories implementing the Health in All Policies Framework for Country Action.  Baseline (2014): 6 Target (2019): 18	In 2015, 6 countries were implementing the HiAP Framework for Country Action. It is expected that an additional 16 countries will be implementing the Framework by the end of 2017.

<p><b>2.1</b> Promote policy dialogue and implement national policies based on data, analysis and evidence required to implement, monitor and evaluate HiAP.</p>	<p><b>2.1.1</b> Number of countries and territories that have implemented policies to address at least two priority determinants of health among target populations.</p> <p>Baseline (2014): 6 Target (2019): 27</p>	<p>In 2015, 9 countries had implemented policies to address at least two priority determinants of health among target populations. It is expected that an additional 18 countries will have implemented such policies by the end of 2017.</p>
	<p><b>2.1.2</b> Number of countries that formally exchange information and best practices at least once every two years on policies addressing health inequities and HiAP.</p> <p>Baseline (2014): 6 Target (2019): 27</p>	<p>30 experiences and <i>Good Practices</i> related to HiAP from 16 countries have been documented on PAHO's online HiAP platform (14), which aims to provide guidance and support by sharing experiences across the Region demonstrating that HiAP is very context-specific.</p>
<p><b>2.2</b> Produce a national health equity profile with an emphasis on the evaluation of the determinants of health.</p>	<p><b>2.2.1</b> Number of countries and territories producing equity profiles that address at least two priority determinants of health at the national or subnational level.</p> <p>Baseline (2014): 1 Target (2019): 18</p>	<p>In 2015, 9 countries had developed equity profiles. It is expected that an additional 18 countries will have equity profiles by the end of 2017. Those are being developed using a specific methodology based on WHO's guidelines on monitoring health inequalities as well as the third recommendation from the Commission on the Social Determinants of Health.</p>
<p><b>3.1</b> Identify a specific mechanism by which the health sector can engage within and beyond the public sector in policy dialogue and in the implementation of HiAP.</p>	<p><b>3.1.1</b> Number of countries and territories with a specific mechanism, such as intersectoral committees or HIA, by which the health sector can engage within and beyond the public sector.</p> <p>Baseline (2014): 6 Target (2019): 18</p>	<p>Five additional countries have reported that specific mechanisms were in place to engage with other sectors and as such it is expected that the target will be met by 2019. Moreover, the PAHO Task Force and Working Group on HiAP and the SDGs have produced several tools in order to be able to develop and monitor formal mechanisms and intersectoral committees at the national level. These tools are expected to obtain results for this objective during the remaining lifespan of the Plan of Action.</p>
<p><b>3.2</b> Identify supportive structures and processes in the implementation of HiAP, as appropriate, at the national and subnational</p>	<p><b>3.2.1</b> Number of countries that have identified supportive structures and processes in the implementation of HiAP, as appropriate, at the national and subnational governments through the</p>	<p>In 2014, 6 countries had identified supportive structures and processes in the implementation of HiAP at both the national and the local level. An additional 5 countries have since achieved the indicator.</p>

governments through the inclusion of HiAP in development plans.	inclusion of HiAP in development plans, as appropriate. Baseline (2014): 6 Target (2019): 18	
<b>3.3</b> Strengthen accountability mechanisms so that they can be applied to different sectors.	<b>3.3.1</b> Number of countries with accountability mechanisms, which support civil society engagement and open access to information. Baseline (2014): 4 Target (2019): 12	There is no information available on progress beyond the baseline countries (BOL, BRA, ELS, PRY), as there are no reports on accountability mechanisms at the country level at this time. This is an area that should be strengthened in coming years.
<b>4.1</b> Increase participation of civil society and communities in the policymaking and evaluation process involving HiAP to reduce health inequities.	<b>4.1.1</b> Number of countries and territories with mechanisms to engage communities and civil society in the policy development process across sectors. Baseline (2014): 9 Target (2019): 18	Using the Healthy Municipalities, Cities and Communities approach, 12 countries have committed and established mechanisms to engage communities and civil society in the policy development process across sectors, as evidenced by the signing of the Declaration of Santiago, Chile (16).
	<b>4.1.2</b> Number of countries and territories with specific strategies to engage those experiencing inequities in policy discussions at the local, subnational, and national levels. Baseline (2014): 10 Target (2019): 22	The development of equity profiles has provided 18 countries with the opportunity to address inequities in policy discussions and further draw upon the HiAP approach.
<b>5.1</b> Develop a system for measuring the impact and outcomes of HiAP with respect to health and health equity in order to assess policies and identify and share best practices.	<b>5.1.1</b> Number of countries and territories that monitor, evaluate, and report on progress towards introducing health and health equity in the development and implementation of government policies. Baseline (2014): 0 Target (2019): 12	Six countries have published case studies and country experiences highlighting progress toward introducing health and health equity in the development and implementation of government policies (13, 14).

<p><b>6.1</b> Build capacity in the workforce in the health sector and other sectors on the HiAP approach, and encourage the implementation of HiAP among these groups.</p>	<p><b>6.1.1</b> Number of countries and territories with recognized institutes such as national public health institutes, universities and collaborating centers offering training courses on the implementation and monitoring of HiAP and related concepts.</p> <p>Baseline (2014): 0 Target (2019): 8</p>	<p>Three countries have institutes that offer capacity training courses for HiAP, including the Oswaldo Cruz Foundation (FIOCRUZ, BRA), the Latin American School of Social Sciences (FLACSO, CHL), and the National Institute of Public Health (INSP, MEX). These institutional partners conducted four HiAP trainings throughout the Region during 2015 and 2016. A total of 180 participants from 16 countries participated.</p>
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### Action Needed to Improve the Situation

- a) Further strengthen monitoring systems in order to capture the impact of HiAP particularly with regard to distributional changes in the social determinants of health as well as health inequalities in line with the WHO recommendation.
- b) Member States to increase capacity for the integration of HiAP networks and institutions, as well as other preexisting regional networks, to expand the channels through which information on HiAP is disseminated and exchanged.
- c) Strengthen network coordination, particularly with regard to effective network management, virtual communication, and online education.
- d) Continue PAHO support for HiAP-focused practitioners and advocates, and scale up capacity building. In addition to creating opportunities to develop skills, share expertise, exchange ideas, and build networks to scale up systematic work across sectors, capacity building encourages regional ownership of the HiAP framework and advances health in the context of the 2030 Agenda for Sustainable Development.

### Action by the Executive Committee

8. The Executive Committee is invited to take note of this progress report and offer any recommendations it deems relevant.

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## **B. CHRONIC KIDNEY DISEASE IN AGRICULTURAL COMMUNITIES IN CENTRAL AMERICA: PROGRESS REPORT**

### **Background**

1. In the past two decades, Central America has witnessed a growing number of cases of people with chronic kidney disease (CKD) who die from it. A type of CKD has been observed among those cases whose etiology is unrelated to the most common causes of the disease, diabetes mellitus and hypertension. This type of nontraditional chronic kidney disease, or kidney disease of nontraditional or still unknown etiology (hereinafter CKDnT) is more common than in the Region of the Americas as a whole and is on the rise. El Salvador has disseminated the results of its 2015 National Survey of Chronic Noncommunicable Diseases in the Adult Population (ENECA, Spanish acronym), which revealed a CKD prevalence of 12.6 per 100,000 populations and a CKDnT prevalence of 3.8 per 100,000 population. In Guatemala, the CKD prevalence rates obtained from the database of the Health Management Information System (SIGSA, Spanish acronym) for the period 2008-2015 show a 75% increase, with a rate of 4 per 100,000 population in 2008 and 7 in 2015, together with an 18% increase in mortality. In 2013, during the 52nd Directing Council, the Member States of the Pan American Health Organization (PAHO) approved the concept paper *Chronic Kidney Disease in Agricultural Communities in Central America* through Resolution CD52.R10. In 2015, the Directing Council took note of report CD54/INF/5, and the Director of the Pan American Sanitary Bureau (PASB) pointed out that, despite the work that had been done, few concrete results had been obtained to address the problem of chronic kidney disease in young people of working age. This document describes the progress made since the last progress report (1-4).

### **Update on progress achieved**

2. During the period in question, the Central American countries (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama) made progress developing and implementing action plans aimed at strengthening local capacity to provide a comprehensive response to CKDnT in the most affected municipalities (whose combined population in El Salvador, Guatemala, Honduras, and Panama, is approximately 4,073,769). In El Salvador, the agricultural areas of San Miguel and Usulután are being addressed; in Guatemala, the departments of Escuintla, Quetzaltenango, Petén<sup>1</sup>, and Chimaltenango; in Nicaragua, the municipality of Chinandega<sup>2</sup>; and in Panama, the provinces of Coclé, Chiriquí, and Veraguas, where renal clinics have been set up. In addition, during that same period, the Director of PASB approved an interprogrammatic project with a total budget of US\$ 1 million<sup>3</sup>. Some 70% of those resources were allocated to provide direct support to countries, with a focus on the most affected communities.

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<sup>1</sup> This is the largest department in Guatemala and has the highest risk of CKDnT.

<sup>2</sup> This municipality had a population of 134,720 in 2015.

<sup>3</sup> Unless otherwise indicated, all monetary figures in this document are expressed in U.S. dollars.

3. The countries made progress in developing policy options and tools to improve interventions involving care for people living with CKD/CKDnT. El Salvador began drafting dialysis and kidney transplantation protocols. In 2016, the Panamanian Society of Nephrology prepared clinical practice guidelines for CKD prevention, diagnosis, and management. At the regional level, PAHO, in coordination with the Latin American Society of Nephrology and Hypertension (SLANH), launched the online course Prevention and Management of Chronic Kidney Disease<sup>4</sup> in 2016 through the Virtual Campus for Public Health (VPHC); as of March 2017, 5,000 physicians from Central America and Mexico had registered for the course. Furthermore, during the Subregional Meeting of the PAHO/WHO Strategic Fund for the Central American countries and the Dominican Republic<sup>5</sup>, a course on CKDnT prevention and management was held for teams at the first level of care to promote use of the Strategic Fund to improve access to medicines and supplies for noncommunicable diseases, including CKDnT (5, 6).

4. The countries made progress in strengthening epidemiological, occupational, and environmental surveillance and registry systems, with emphasis on CKDnT. El Salvador has identified 148 municipalities with high case numbers and will start keeping records on stage-5 patients receiving dialysis in the five Ministry of Health (MoH) hospitals that provide this service. It will also conduct a study to determine the demand for medicines and supplies. Guatemala has prepared protocols for sentinel surveillance and renal dialysis and transplantation registry—instruments that are useful for epidemiological surveillance. It has also developed a CKDnT registry system in Escuintla, Chimaltenango, Quetzaltenango, and Petén. Honduras, in turn, has a virtual platform for registering CKD patients undergoing renal replacement therapy. Panama is conducting a preventive health census with support from the Society of Nephrology, with the objective of training general practitioners in the detection of people with kidney disease. The Preventive Health Census was conducted in 10 provinces, two districts, 13 health regions, three government institutions, and four penitentiaries. Also, through coordination with the National Institute of Statistics and Census, detailed information is obtained on causes of deaths, permitting geospatial analysis of CKDnT mortality. During the period in question, PAHO concluded consultations with national authorities, academics, and WHO Collaborating Centers for the ICD-10 to reach agreement on the definitions of a clinical case of CKDnT, a suspected and probable case, and a selection algorithm for optimizing the registry of deaths from that cause (7).

5. The countries improved their mechanisms for advocacy and intersectoral action. El Salvador, through its Ministry of Health (MINSAL), formed a national CKD commission, chaired by the Vice Minister of Health, in coordination with the Ministry of Agriculture and Livestock (MAG) and the National Health Forum (FNS) in its capacity as social participation entity. Guatemala formed a National Technical Advisory Commission to monitor the plan's activities; its members included the Guatemalan Association of Nephrology (AGN), the Health, Work, and Environment Program (SOA-SALTRA-USAC), the Guatemalan Social Security Institute (IGSS), the CDC-Central

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<sup>4</sup> Course launched on 14 July 2016.

<sup>5</sup> This subregional meeting was held in Nicaragua from 26 to 28 April 2017.

America, and PAHO. Panama formed a multidisciplinary intersectoral team to study CKDnT and define prevention and control activities. It is also preparing informative instructional materials to educate family members and the general public about ways of preventing the disease.

6. At the regional level, the “Regional Research Agenda for Addressing Chronic Kidney Disease of Nontraditional Etiology in Central America”<sup>6</sup> was defined. Generic CKDnT research protocols are being developed to ensure the harmonization and quality of research in epidemiological studies in the Region. In addition, a systematic review of studies on the association between agricultural chemicals and CKDnT was conducted, identifying more than 20 studies of uneven (often poor) quality. El Salvador has disseminated the results of the 2015 National Survey on Chronic Noncommunicable Diseases in the Adult Population (ENECA) and is working on a secondary analysis of the CKD database (8).

### **Action Necessary to Improve the Situation**

7. Based on the progress and challenges faced by the countries with respect to CKDnT, the following is recommended:

- a) Strengthen local capacity for a comprehensive response to CKDnT in affected municipalities, implementing local plans for preventing and managing the disease and boosting response capacity at the first level of care for the identification and monitoring of people at risk, early detection, and integrated management of CKD, diabetes, and hypertension. Furthermore, provide training for personnel (health teams, employers, workers, etc.) and include relevant risk factors for CKD/CKDnT in municipal or local management.
- b) Develop policy options, tools, and technical support to improve interventions involving care for people living with CKD/CKDnT, including the standardization and implementation of guidelines for the care of patients with CKD/CKDnT, use of the Strategic Fund to cut costs and improve access to medicines, and implementation of supply management guidelines.
- c) Strengthen epidemiological, occupational, and environmental surveillance, along with registry systems, with emphasis on CKDnT, through the application of the case definition for epidemiological surveillance of CKD and capacity-building to improve dialysis and transplant registry systems and preventive occupational and environmental intervention registries.

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<sup>6</sup> Consultations on this instrument with the countries are currently under way. The document summarizes the work of an online survey to identify research priorities for addressing CKDnT. The purpose of the survey is to conduct a systematic evaluation of the literature in the databases of different international organizations, identifying the key actors in the research conducted in the Central American countries and publications of CKD research agendas over the past five years.

- d) Promote advocacy and intersectoral action for CKDnT prevention, including the mapping of actors and work with civil society, patient organizations, family members, trade associations, unions, and medical associations, as well as the review and development of legal frameworks to protect workers' health in relation to occupational diseases, especially CKDnT.
- e) Strengthen communication strategies for disseminating research findings and raising the alert about CKDnT as an occupational disease and implement the regional research agenda.

### **Action by the Executive Committee**

- 8. The Executive Committee is requested to take note of this report and formulate the recommendations it deems pertinent.

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## C. PLAN OF ACTION FOR UNIVERSAL ACCESS TO SAFE BLOOD: MIDTERM REVIEW

### Background

1. Universal access to safe blood for transfusion requires the strengthening of key strategies such as: self-sufficiency in blood and blood products through voluntary non-remunerated blood donation, improvements in the quality of donated blood (from the donor's arm to the recipient's arm), the maximization of appropriate blood use, the strengthening of human resources, the adoption of new advances, and the establishment of strategic partnerships with the different sectors involved in the area.
2. In 2014, the countries of the Region reaffirmed their commitment to universal health through the *Strategy for Universal Access to Health and Universal Health Coverage* (Document [CD53/5, Rev. 2](#)). This commitment is also evidenced in the goals of the Strategic Plan of the Pan American Health Organization 2014-2019. Universal access to safe blood transfusions and blood products is essential for universal health coverage, helping to save millions of lives and improve the health of the people who need it (1, 2).
3. Since 1975, the World Health Assembly and the Executive Board of the World Health Organization (WHO) have considered many documents and adopted numerous resolutions on blood safety ([WHA28.72](#) [1975], [EB79.R1](#) [1987], [WHA40.26](#) [1987], [WHA45.35](#) [1992], [WHA48.27](#) [1995], [WHA53.14](#) [2000], [WHA55.18](#) [2002], [WHA56.30](#) [2003], [WHA58.13](#) [2005], [WHA63.12](#) [2010], [WHA63.18](#) [2010], and [WHA63.20](#) [2010]) (3-14).
4. Several such resolutions have been adopted in the Region of the Americas: [CD41.R15](#) (1999), [CD46.R5](#) (2005), [CE142.R5](#) (2008), and [CD48.R7](#) (2008). In 2014, the countries of the Region approved the Plan of Action for Universal Access to Safe Blood 2014-2019 (Document [CD53/6](#)) and corresponding resolution ([CD53.R6](#)), in which the Member States are urged to implement the Plan of Action and the Director to monitor and evaluate implementation of the Plan of Action and report periodically to the Governing Bodies (15-22).
5. The goal of the Plan is to promote universal access to safe blood through voluntary altruistic non-remunerated blood donation, appropriate blood use, and greater leadership on the part of the health authorities, who are urged to implement quality management programs in the transfusion chain (from promoting voluntary donation to monitoring patients) and to integrate the blood system into the national health system. The Plan calls for the ultimate restructuring of blood services into efficient, sustainable models (22).
6. In addition, the Plan defines four strategic lines of action aimed at maintaining achievements and tackling new challenges: *a*) effective and sustainable integration of national programs and services into the national health system to achieve blood self-sufficiency, safety, efficiency, availability, and universal access to blood and blood

products; *b*) self-sufficiency in safe blood and blood products through 100% voluntary non-remunerated donations; *c*) quality management in the national blood system and screening for transfusion-transmitted infections; and *d*) health surveillance, hemovigilance, risk management, monitoring, and evaluation. Each strategic line has its respective objectives and progress indicators, which will be examined in this document (22).

### Progress toward meeting Plan of Action objectives<sup>1,2,3</sup>

Strategic line	Objective	Indicator and target	Progress
1. Effective and sustainable integration of national blood programs and services into the national health system to achieve blood self-sufficiency, safety, efficiency, availability, and universal access to blood and blood products.	1.1	1.1.1. By 2019, 36 countries will have a specific functioning entity in the ministry of health that is responsible for planning, monitoring, and evaluation of the national blood system. (Baseline 27/41)	27 countries have a specific entity, 17 in Latin America and 10 in the Caribbean.
		1.1.2. By 2019, 21 countries will have a functioning intersectoral national blood commission or advisory mechanism. (Baseline 14/41)	16 countries have a national commission, 8 in Latin America and 8 in the Caribbean.
		1.1.3. By 2019, 26 countries will have a blood policy that includes self-sufficiency, availability, and universal access to safe blood and blood products. (Baseline 18/41)	23 countries have a national blood policy, 14 in Latin America and 9 in the Caribbean.
	1.2	1.2.1. By 2019, 21 countries will have an integrated intersectoral national strategic blood plan that includes human resources training, monitoring and evaluation of the plan, and guaranteed resources for its implementation. (Baseline 13/41)	15 countries have a national strategic plan, 10 in Latin America and 5 in the Caribbean.

<sup>1</sup> It should be borne in mind that the number of countries and territories evaluated and monitored in this plan has increased, as some territories that formerly issued a joint report have now been disaggregated by French Department of the Americas (DFA: Martinique, Guadeloupe, and French Guiana), although this latter department was not included because blood is not processed there.

<sup>2</sup> The calculation tables for the verification of indicators are based on the PAHO/WHO 2017 publication Supply of Blood for Transfusion in Latin American and Caribbean Countries 2014 and 2015, currently in production, with data sources from the national blood programs and ministries of health of Latin America and the Caribbean (23). Available from:

[http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=38018&Itemid=270](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=38018&Itemid=270) (24). (Spanish only)

<sup>3</sup> The baseline year is 2012.

Strategic line	Objective	Indicator and target	Progress
	<b>1.3</b>	<b>1.3.1.</b> By 2019, 17 countries with more than one processing center will have increased the average number of units processed (including screening) per blood bank/year to over 5,000 units as a result of the restructuring of the blood services network. (Baseline 12/25)	18 countries process more than 5,000 units of blood per blood bank/year, 9 in Latin America and 9 in the Caribbean.
2. Self-sufficiency in safe blood and blood products through 100% voluntary non-remunerated donations.	<b>2.1</b>	<b>2.1.1.</b> By 2019, 12 countries will have calculated their blood needs at the national and subnational level. (Baseline 6/41)	14 countries have calculated their blood needs, 6 in Latin America and 8 in the Caribbean.
	<b>2.2</b>	<b>2.2.1.</b> By 2019, 16 countries will have reached 100% voluntary non-remunerated blood donations. (Baseline 8/41)	10 countries have 100% voluntary blood donations, 2 in Latin America and 8 in the Caribbean.
3. Quality management in the national blood system and screening for transfusion-transmitted infections.	<b>3.1</b>	<b>3.1.1.</b> By 2019, 41 countries will screen 100% of blood units for transfusion for HIV, HBV, HCV, syphilis, and <i>T. cruzi</i> . (Baseline 39/41)	39 countries screen 100% of blood units, 18 in Latin America and 21 in the Caribbean.
		<b>3.1.2.</b> By 2019, 27 countries will have a national program for external serology performance evaluations. (Baseline 22/41)	30 countries have a national program for external serology performance evaluations, 13 in Latin America and 17 in the Caribbean.
		<b>3.1.3.</b> By 2019, 18 countries will have a national program for external immunohematology performance evaluations. (Baseline 12/41)	17 countries have a national program for external immunohematology performance evaluations, 7 in Latin America and 10 in the Caribbean.
	<b>3.2</b>	<b>3.2.1.</b> By 2019, 12 countries will have functioning transfusion committees in at least 75% of hospitals that perform daily transfusions. (Baseline 7/41)	19 countries have transfusion committees, 10 in Latin America and 9 in the Caribbean.
		<b>3.2.2.</b> By 2019, 30 countries will have national guidelines in place	23 countries have guidelines in place for

Strategic line	Objective	Indicator and target	Progress
		for the appropriate use of blood and blood products. (Baseline 20/41)	the appropriate use of blood and blood products, 14 in Latin America and 9 in the Caribbean.
		<b>3.2.3.</b> By 2019, there will be a 5% reduction in the Region in the number of red blood cell units discarded due to expiration. (Baseline 10.3%)	The percentage of discards due to expiration for Latin America and the Caribbean is 2.99%. <i>(* See explanation for the reporting of this indicator in paragraph 9 of this report)</i>
<b>4.</b> Health surveillance, hemovigilance, risk management, monitoring, and evaluation.	<b>4.1</b>	<b>4.1.1.</b> By 2019, 30 countries will have a national model for inspection, surveillance, and oversight in blood services. (Baseline 20/41)	25 countries conduct inspections of blood services, 15 in Latin America and 10 in the Caribbean.
	<b>4.2</b>	<b>4.2.1.</b> By 2019, 7 countries will have a national hemovigilance system. (Baseline 2/41)	9 countries have a national hemovigilance system, 5 in Latin America and 4 in the Caribbean.
	<b>4.3</b>	<b>4.3.1.</b> By 2019, 41 countries will annually report the indicators of the national plan in response to the implementation of the regional Plan 2014-2019. (Baseline 0/41)	36 countries have reported data for monitoring the indicators of the Plan, 18 in Latin America and 18 in the Caribbean.
	<b>4.4</b>	<b>4.4.1.</b> By 2019, 7 countries will have drafted risk management plans based on hemovigilance information. (Baseline 0/41)	5 countries have reported having risk management plans based on the hemovigilance information, 1 in Latin America and 4 in the Caribbean.

### Progress and challenges

7. Latin American and Caribbean countries have made real efforts to achieve self-sufficiency, safety, and efficiency. Considering the established objectives (with targets and baselines for each indicator), progress has been made in all indicators except 1.1.1 and 3.1.1. The majority of the countries have specific national entities that coordinate the response to safe blood and blood product needs; however, updated national blood plans and policies with an integrated, intersectoral approach are still needed, as are functioning

national intersectoral commissions that facilitate implementation. Progress is slowly being made in the restructuring of blood services networks, which is essential for ensuring the availability of blood and access to it anywhere it is needed. Given the geodemographic characteristics of some Caribbean countries, this restructuring of blood services networks may not be applicable. (See Reference 24, Tables 1-5).

8. More countries know their national blood needs, which facilitates greater availability and access to blood and blood products. However, the challenge persists of achieving regular voluntary altruistic non-remunerated donation as the first pillar of blood safety. In this regard, the countries are making very slow progress toward reaching the target of 100% for this kind of donation. However, while some countries have not yet reached that target, they have at least substantially increased the number of voluntary non-remunerated donors—an effort that should be recognized. (See Reference 24, Tables 6 and 7).

9. With respect to quality management in Latin America, 100% screening was achieved for HIV, hepatitis B and C, and syphilis markers, but not for *T. cruzi*. The average screening achieved in 21 Caribbean countries is 99.99%. Progress has been made in the implementation of national programs for external serology performance evaluation; nevertheless, the challenge of establishing the same program for immunohematology remains. With respect to the rational use of blood and blood products, some progress has been made in establishing national guidelines for clinical use and hospital transfusion committees. With respect to the discarding of red blood cells due to expiration, at the time the plan was prepared, this data had not been disaggregated by expiration and other causes; as a result, the indicator reported was based on red blood cells discarded for both causes. The majority of countries in the Region are currently in a position to report exclusively about expiration; thus, the percentage of discards has fallen, due, on the one hand, to this factor and, on the other, to the progress made in restructuring the services and knowledge of blood needs, as explained in paragraphs 7 and 8, respectively. (See Reference 24, Tables 8-12).

10. Inspection and oversight of blood services, hemovigilance, and risk management still pose a real challenge. The weakness of information management systems and mechanisms hinders the knowledge, research, and data analysis needed to evaluate self-sufficiency, availability, access, and the risks associated with the transfusion chain. (See Reference 24, Tables 13-16).

#### **Action necessary to improve the situation**

- a) Ensure resource allocation based on national blood safety targets and plans.
- b) Restructure integrated blood services networks in the national health system, promote regular voluntary altruistic non-remunerated donation, and strengthen human resources, quality management, appropriate use of blood and blood products, health surveillance, hemovigilance, and risk management, including all

- processes that involve both donors and patients (throughout the transfusion chain).
- c) Strengthen information management systems that will make it possible to visualize and determine whether there is a sufficient, timely, accessible, and safe blood supply and how it is linked with national morbidity and mortality.
  - d) Continue Pan American Sanitary Bureau support to the Member States for increasing blood safety through self-sufficiency, availability, timeliness, and access based on regular voluntary altruistic non-remunerated donations.

### **Action by the Executive Committee**

11. The Committee is requested to take note of this report and formulate the recommendations it deems pertinent.

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## **D. ADDRESSING THE CAUSES OF DISPARITIES IN HEALTH SERVICE ACCESS AND UTILIZATION FOR LESBIAN, GAY, BISEXUAL, AND TRANS (LGBT) PERSONS: PROGRESS REPORT**

### **Background**

1. The approval of the concept paper on *Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual and Trans (LGBT) Persons* Resolution CD52.R6, by the PAHO Member States during the 52nd Directing Council in 2013 (1) marked an important milestone in working towards universal health by recognizing that marginalized populations, including LGBT persons, historically face stigma and discrimination as well as other conditions that constitute critical barriers to health. Under Resolution CD52.R6, the Member States are urged to *a*) promote health services that respect human dignity and health rights taking into account sexual and gender diversity; *b*) enact policies, plans, and legislation that are sensitive to the stigma and discrimination experienced by LGBT persons and that allow for increased availability and access to health services for these populations; and *c*) collect data on LGBT persons' health and access to health services.

2. This report summarizes progress in the implementation of Resolution CD52.R6, describes the existing gaps, and offers recommendations for strengthening its implementation. It is based on the findings from a regional assessment commissioned by the Director of the Pan American Sanitary Bureau (PASB) and carried out in 2016-2017 (the assessment). The information for the assessment was drawn from the responses to two online questionnaires, one addressed to Ministry of Health (MOH) personnel in the Member States and the other to nongovernmental organizations (NGOs), supplemented with an extensive review of the literature on the subject.<sup>1</sup> The final report on the assessment will be published soon.<sup>2</sup> It was prepared in consultation with Member States and relevant stakeholders and utilizes a conceptual framework using the Strategy for Universal Access to Health and Universal Health Coverage (2) as the guide for strengthening the health system's response to the health needs of LGBT populations.

### **Update on Progress Achieved**

3. Member States are making progress in providing health services to meet the health needs of LGBT persons. Two-thirds of the countries responding to the survey reported that they offer LGBT-sensitive services through the public health system. In addition, LGBT nongovernmental organizations provide a wide array of services. The

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<sup>1</sup> A total of 33 countries and territories responded to the MOH questionnaire (Argentina, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos, United States of America, Uruguay, Venezuela, British Virgin Islands), while 28 NGOs from 18 countries responded to the other questionnaire.

<sup>2</sup> To appear under the title: *Addressing the Causes of Disparities in Health Service Access and Utilization: Assessing the Health Situation and Access to Care for LGBT People in the Americas*.

health inequities and concerns reported in the literature can be extrapolated to LGBT populations in the Americas.<sup>3</sup> Even though Member States recognize a range of health problems affecting the LGBT populations, LGBT health needs and health inequities are largely considered from an HIV/STI bias. As a result, the needs of trans persons and lesbian and bisexual women are rendered invisible. This perspective is reflected in the provision, structure, and funding of health services and ultimately impacts the overall health of LGBT persons.

4. The assessment shows that, despite efforts by Member States, the provision of health services tailored to the needs of LGBT persons is heterogeneous in the Region. Most often, the services are offered through the public health system on an undifferentiated basis and are centralized in large urban settings. In the case of HIV, for example, even though services are prevalent and are claimed to be LGBT-sensitive, they may: *a*) fail to provide adequate preventive measures; *b*) lack resources to meet the health needs of LGBT persons; *c*) be offered in settings where LGBT individuals are still stigmatized and discriminated against; and *d*) entail direct payment at the point of service. It is clear that improving HIV services for LGBT persons continues to be crucial.

5. With regard to policies and legislation, half the Ministries of Health of PAHO Member States reported having antidiscrimination policies in place and laws tailored to meet the specific needs of LGBT persons. Furthermore, 48.5% of the MOH respondents confirmed that their country or territory had a national legal framework and/or a set of laws that promote the rights of LGBT persons, “including from the perspective of the right to health where nationally recognized and promoting the right to the enjoyment of the highest attainable standard of health” (2). Almost half of all the responding countries and territories have enacted legislation aimed at eradicating violence and discrimination against LGBT persons, while 33.3% have existing laws (or laws in preparation) calling for the creation of LGBT-sensitive health services. Examples of laws promoting LGBT rights cited by the MOH respondents included such subjects as antidiscrimination, LGBT-inclusive adoption, marriage/civil unions, gender identity, universal health, and gender violence. In addition, more than half the respondents reported that they have developed policies and laws that address LGBT health.

6. Health-related legislation cited by the MOH respondents includes laws that recognize LGBT groups as a population in conditions of vulnerability with unique health needs. However, some countries and territories still have laws that criminalize LGBT persons. This situation is critical because, according to the literature reviewed, laws of this kind can create an environment in which violence against LGBT individuals is permitted or tolerated, further promoting abuse towards these populations. Even though

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<sup>3</sup> The health issues mentioned most often in terms of health service inequities and gaps included: limited availability of hormone therapy; transition-related surgical procedures; health complications related to unsupervised use of hormones and bodily modification (e.g., use of industrial oil or liquid silicone) for transgender populations; access to services to address anal health, mental health, and certain types of cancer in gay men; access to pre- and postexposure prophylaxis and human papillomavirus (HPV) vaccination for gay and bisexual men; and access to gynecological services, reproductive health services, and certain types of cancer and sexual violence for lesbian women.

policies and laws exist, their application and enforcement varies widely within and between countries and territories.

7. The participating countries and territories have a wide array of mechanisms for accountability that articulate different government structures, including the Ministry of Health and Office of the Ombudsman, as well as LGBT Nongovernmental organizations (NGOs) and civil society organizations (CSOs). Fewer than 20% of the MOH respondents cited the creation of specific entities or councils that focus exclusively on issues related to sexual and gender diversity. Initiatives of this kind are more likely to be found in countries and territories where LGBT-affirmative legislative actions and policies are more robust (3).

8. More than 50% of the countries reported having policies, norms, or guidelines for delivering health services to LGBT persons. Most of the existing health policies and standards focus on HIV prevention and treatment and do not address additional health needs. Nevertheless, a number of the MOH respondents (24.2%) reported that they have policies and guidelines on sexual and gender diversity or standards of care for LGBT populations. Examples of these norms include the promotion of specific health services (particularly for transgender individuals, such as the provision of hormone therapy) and LGBT-friendly clinics, nondiscrimination on the basis of sexual orientation and gender identity in the health care context, and best practices for LGBT health care. In addition, about 70% of the MOH respondents reported the existence of LGBT-focused training activities related to HIV/STI, human rights, health needs, or stigma and discrimination.

9. The assessment indicates that stigma and discrimination continue to be major obstacles to access health services for LGBT persons. The majority of MOH and NGO respondents (75% and 96.4%, respectively) referred explicitly to stigma and discrimination as a barrier to health for LGBT persons. They note that these individuals may avoid or delay care or hide their sexual orientation and/or gender identity from their health care providers in an effort to protect themselves against stigmatization. In fact, lack of competence in dealing with LGBT health issues on the part of health care providers was identified as a main barrier by 92.9% of the NGO respondents. LGBT individuals often end up relying on NGOs, CSOs, or other networks to obtain information, improve their health literacy, and find health services that are tailored to their needs without any support from health authorities in the dissemination of this information. The pathologization of LGBT identities, particularly transgender identities, continues to disempower LGBT individuals and may become the foundation for stigma in health care settings. It is also at the cornerstone of the prevalence of conversion therapy.

10. In addition, the fact that LGBT individuals are not well represented in positions of authority or in the health care context further ostracizes them from the health system by making them invisible and preventing them from making decisions that would benefit their health and their community. Some studies in the Region have shown that LGBT persons report experiencing violence and discrimination on the part of health care providers. To address stigma and discrimination, 78.8% of the respondents stated that a number of LGBT-inclusive strategies are applied in their health care settings. The most

widely used inclusion strategies are the creation of accessible processes for filing complaints and the posting of visible nondiscrimination statements. In addition, most LGBT NGOs/CSOs/networks provide legal counseling to the LGBT community in cases of discrimination. Legal services might take the form of peer support, guidance from volunteer attorneys, association with human rights protection organizations, and links to an ombudsman office.

11. Other barriers identified are limitations on health insurance coverage, discrimination in the labor market or educational settings, and scarcity of resources for the provision of appropriate health services. Reduced health insurance coverage was also noted in the literature reviewed. In fact, because of difficulties in the labor market, one estimate indicates that approximately 90% of trans women living in the Americas engage in sex work, and estimates for individual countries may be even higher. Also, studies have reported that LGBT persons are more likely to delay or not receive care because of its restrictive cost (4-7).

12. More than half the MOH respondents reported that their countries gather disaggregated LGBT health data. Even though LGBT health data can be gathered by including questions about sexual orientation and gender identity (SOGI) in health data collection tools, health information systems, hospital records, and national censuses, this is far from a typical situation in the Americas. Even when such questions are asked, they might not be included in all tools, or they may be drafted in a way that limits the inclusion of all L-G-B-T identities (i.e., using "sex" instead of gender, and following a binary male/female model), further complicating the collection of data on LGBT health. The importance of gathering health and demographic data in the Region has been emphasized in previously published literature and extensive research is being done by NGOs, CSOs, universities, and government institutions to fill this information gap.

13. In addition to the preparation of the regional assessment commissioned by the Director of the PASB, the Bureau's work continues on advocating for increased access to quality and comprehensive health services for LGBT populations. This effort includes training in human rights and LGBT rights, regional meetings on gender diversity and universal health, advocacy for LGBT inclusion in documents and policies, and the implementation of other related resolutions (Resolution CD50.R8, Health and Human Rights, approved in 2010 (8), Resolution CD54.R9, Strategy on Health-related Law, approved in 2015 (9), and Resolution CD53.R14, Strategy for Universal Access to Health and Universal Health Coverage, approved in 2014, to mention a few).

### **Action Necessary to Improve the Situation**

14. In light of the analysis of progress made so far and the challenges that remain, the following actions are needed:

- a) Strengthen and/or establish LGBT-sensitive and comprehensive health services grounded in evidence that addresses the specific health needs of LGBT persons taking into account gender identity and diversity of expression. Each L-G-B-T

- population requires particular health services in order to meet its unique health needs, and therefore specific care standards or guidelines for each L-G-B-T identity are necessary. In order to improve access, it is important to avoid the centralization of LGBT-sensitive services, develop capacity in the first level of care, and promote LGBT-sensitive services in both the public and private sectors. It is also essential to ensure that information regarding LGBT health resources is available at the community and health service level and to develop strategies that allow health providers to refer LGBT persons to other services that are LGBT-sensitive.
- b) Improve the training of health care providers so that they are able to address LGBT health needs with gender-, diversity-, and rights-based approaches that will help to end any form of discrimination. Collaborate with educational authorities to modify the curricula of health-related academic programs to include LGBT content, either as modules within existing courses or as specific independent courses.
  - c) Consider the specific health needs of LGBT persons in the development and/or implementation of health policies and health system strengthening initiatives as part of the effort to advance toward universal health. Share information on all LGBT health policies and standards of care with a view to fostering their adoption. Reinforce mechanisms of accountability with the active participation of government agencies or other bodies in monitoring effective compliance.
  - d) Improve efforts to ensure that LGBT persons can enjoy access to and the use of health services without discrimination by including provisions in their antidiscrimination laws that explicitly forbid discrimination on the basis of sexual orientation and gender identity. Train and sensitize legislators and policy-makers on issues related to sexual and gender diversity, with emphasis on the impact of stigma and discrimination on LGBT health.
  - e) Strengthen health information systems and surveillance mechanisms so that they can generate periodic reports that include LGBT health conditions and barriers to access. Include sexual orientation and gender identity items in existing nationally representative health surveys in order to gather data that can be disaggregated by sexual orientation and gender identity. This information is crucial to tailoring health services, policies, and legislation to meet the needs of LGBT populations. It is also necessary in order to monitor barriers and assess health needs.
  - f) Strengthen intersectoral mechanisms and links to the community in order to improve the health and well-being of LGBT persons. This includes cooperation and coordination between the MOH and the education, labor, justice, social welfare, and housing ministries, law enforcement agencies, legislatures, and LGBT NGOs/CSOs/networks.
  - g) Use Resolution CD54.R9, Strategy on Health-related Law, together with Resolution CD53.R14 Strategy for Universal Access to Health and Universal Health Coverage and other PAHO resolutions, to foster the establishment of legal, policy, and regulatory frameworks that promote enjoyment of the highest

attainable standard of health as a fundamental right of every human being without distinction of sex, gender, gender identity, or gender expression.

### **Action by the Executive Committee**

15. The Executive Committee is invited to take note of this progress report and to formulate the recommendations it deems relevant.

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## **E. HEALTH AND HUMAN RIGHTS: PROGRESS REPORT**

### **Background**

1. This report summarizes progress made under the *Health and Human Rights* concept framework adopted by the PAHO Member States at the 50th Directing Council (document CD50/12 and Resolution CD50.R8 [2010]) (1, 2).

2. The report is based on an analysis of technical cooperation provided in different areas in accordance with the commitments undertaken in Resolution CD50.R8. Various sources have been used for the analysis, including PAHO resolutions and strategies, instruments of international law, and progress made with several projects that take a human rights approach.

### **Update on progress achieved**

3. The *Health and Human Rights* conceptual framework establishes six specific areas of technical collaboration in which the Member States undertake to use, within their respective national frameworks, human rights instruments applicable to health. Resolution CD50.R8 has facilitated the following progress:

- a) The mainstreaming of human rights in PAHO Governing Bodies documents through collaboration with the technical units in subjects related to access to universal health, healthy life course, maternal mortality, social determinants, noncommunicable diseases and related risk factors, and the health of groups in situations of vulnerability;
- b) The Directing Council's adoption, in 2013, of the concept paper (3, 4) on *Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual, and Trans (LGBT) Persons*, which was an important milestone in the work done with human rights instruments, complementing Resolution CD50.R8.
- c) The use of human rights instruments has helped enact laws that incorporate international human rights standards that have implications for the right to health and other related human rights in areas such as patients' rights (Chile), prevention of violence against women (Nicaragua), and prevention of all forms of discrimination based on gender or sexual orientation (El Salvador).
- d) Human right training has been complemented by national and subregional workshops to encourage Member States to implement Resolution CD54.R9 (2015), *Strategy on Health-related Law* (5). This strategy establishes four fundamental lines of action to facilitate and promote the formulation, implementation, or revision of legal and regulatory frameworks based on promoting, respecting, and protecting human rights.

- e) PAHO, together with the Institute of Equity in Health (IHE) and with the support of 15 Member States, established the *Commission on Equity and Health Inequalities in the Region of the Americas* (6, 7). The purpose of the Commission is to further understanding of the main factors contributing to health inequalities through a multidisciplinary approach, including human rights. To this end, the Commission will analyze variables related to gender identity, sexual orientation, ethnicity, and race, among others.
- f) PAHO has engaged in technical collaboration with the Member States of the Organization of American States (OAS). Between 2011 and 2015 PAHO has provided technical assistance to the OAS in formulating legal provisions related to the health and development of older persons. This effort concluded with the adoption by the OAS of the *Inter-American Convention on Protecting the Human Rights of Older Persons* (8), which entered into force on 11 January 2017. This Convention is the first international treaty on the subject.
- g) According to data compiled by the Special Olympics organization<sup>1</sup> between 2014 and 2015 (9), 48.2% of persons with intellectual disabilities suffered a disorder related to the skin or nails, 69% of adults suffered from overweight or obesity, 51% had signs of gingivitis, and 27% did not pass hearing tests. In order to address this situation, PAHO has strengthened the technical capacities of the health authorities in support of the review or formulation of policies, plans, and laws concerning persons with disabilities, in accordance with the *Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities* (10).

#### **Action needed to improve the situation**

- 4. In light of the progress made in the Region of the Americas in the incorporation of human rights instruments into its health policies, with the support of PAHO, the Member States are urged to continue this work and step up efforts with a view to:
  - a) Strengthening collaboration with human rights ombudsmen and the legislative and judicial branches of the PAHO Member States in order to coordinate their actions through a human rights approach, which includes the right to enjoy the highest attainable standard of health. This can be done by developing regulatory frameworks to protect human rights and by removing legislative barriers that penalize certain behaviors.
  - b) Intensifying efforts so that issues involving human rights, gender, ethnicity, and the social, economic, environmental, political, and cultural determinants that

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<sup>1</sup> Special Olympics is the largest sports organization in the world devoted to children and adults with intellectual disabilities. Its *Unified Sports*® program offers training and competition to more than 5.3 million athletes and partners in almost 170 countries. The *Special Olympics Healthy Athletes*® program offers health services and information to more than 1.7 million extremely needy athletes in more than 130 countries.

- contribute to the enjoyment of the highest attainable standard of health are aligned with regional priorities and the global commitment to achieve the Sustainable Development Goals (SDGs).
- c) Strengthening the role played by PAHO in the commissions and bodies created by human rights treaties, such as the Inter-American Commission on Human Rights (IACHR), United Nations agencies, and the Special Procedures.
  - d) Promoting the use of human rights instruments as a conceptual and legal framework for all health-related issues.
  - e) Strengthening the technical capacity of the health authorities to promote programs to train health workers about international human rights instruments applicable to persons with intellectual disabilities.

#### **Action by the Executive Committee**

- 5. The Executive Committee is asked to take note of this progress report and make any recommendations it deems pertinent.

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## F. PLAN OF ACTION ON IMMUNIZATION: MIDTERM REVIEW

### Introduction

1. During the 54th Directing Council of the Pan American Health Organization (PAHO) in September 2015, Member States approved a resolution to adopt the Plan of Action on Immunization (Document CD54/7, Rev. 2) as the guiding framework for immunization in the Americas (1). The Plan aims to continue progress, as well as identify and overcome immunization challenges currently faced by countries in the Americas, and is aligned with the WHO's Global Vaccine Action Plan (2). This report summarizes the Region's mid-term progress towards achievement of the objectives of the Plan in 2015 and 2016. It also highlights the challenges that will need to be overcome in the next two years in order to meet the goals set forth by the Plan. The sources consulted to compile this report include: *a*) reports by the countries' ministries of health; *b*) PAHO-WHO/UNICEF's Joint Reporting Form on immunization (JRF); and *c*) the compilation of research and other available resources. The report will be reviewed by the PAHO Technical Advisory Group on Vaccine-preventable Diseases (TAG) and shared with Member States for their knowledge and action.

### Update on the Progress Achieved

2. The Plan established the road map to achieving equitable access to immunization for all populations in the Americas. Countries are working to leverage the commitment towards achieving universal health coverage in order to obtain better immunization coverage and strengthen health systems as a vehicle to increase immunization coverage.

3. The Plan established 13 objectives (7 general and 6 specific) and 29 indicators. At the time of the preparation of this mid-term review, as shown in the table below, the situation in the Region is as follows: 16 indicators are on track; 3 are in progress; and 10 of the indicators are off track and will require a concerted effort and urgent action to achieve the stated targets.

General (GO) and Strategic Objectives (SO)	Indicator	Status
<b>GO 1.1</b> Maintain the Region's status as polio-free	<b>GO 1.1.1</b> Number of countries and territories reporting cases of paralysis due to wild poliovirus or the circulation of vaccine-derived poliovirus (cVDPV) in the last year  Baseline: 0 in 2013 Goal: 0 in 2020	As of 2016, 0/51 countries or territories in the Region reported cases of paralysis due to wild poliovirus or cVDPV.
<b>GO 1.2</b> Maintain elimination of measles, rubella, and CRS	<b>GO 1.2.1</b> Number of countries and territories in which endemic transmission of	As of 2016, 0/51 countries or territories in the Region reported endemic cases of the measles or

General (GO) and Strategic Objectives (SO)	Indicator	Status
	measles or rubella virus has been reestablished  Baseline: 0 in 2013; 1 in 2015 Goal: 0 in 2020	rubella virus.
<b>GO 1.3</b> Maintain achievements reached in vaccine-preventable disease control	<b>GO 1.3.1</b> Number of countries and territories that meet the indicators for monitoring the quality of epidemiological surveillance of acute flaccid paralysis (AFP) cases  Baseline: 2 in 2013 Goal: 13 in 2020	As of 2016, two countries in the Region have improved the epidemiological surveillance of polio. This indicator is off track. Countries should focus efforts on strengthening the capacity to detect suspected cases (i.e., suspected case rates).
	<b>GO 1.3.2</b> Number of countries and territories that meet the indicators for monitoring the quality of epidemiological surveillance of suspect measles, rubella and congenital rubella syndrome cases  Baseline: 9 in 2013 Goal: 18 in 2020	As of 2016, there are 17 countries that have met the epidemiological surveillance indicators.
	<b>GO 1.3.3</b> Number of countries and territories that administer hepatitis B vaccine to newborns during the first 24 hours  Baseline: 18 in 2013 Goal: 25 in 2020	As of 2016, 22 countries and territories have adopted the universal birth dose vaccination policy and 14 countries and territories only vaccinate newborns born to hepatitis B-positive mothers as part of their efforts to control hepatitis B virus perinatal transmission.
<b>SO 1.1</b> All countries make a commitment to vaccination as a priority for health and development	<b>SO 1.1.1</b> Number of countries and territories that have a legislative or regulatory basis for their immunization program  Baseline: 28 in 2013, 26 approved legislation and 2 pending approval Goal: 32 in 2020	As of 2016, no additional countries have approved legislations for their immunization programs. This indicator is off track.
	<b>SO 1.1.2</b> Number of countries and territories having an immunization technical	As of 2016, there is no additional country in the Region that reports having the support of a well-

General (GO) and Strategic Objectives (SO)	Indicator	Status
	advisory committee that meets WHO's criteria for good operation Baseline: 15 in 2013 Goal: 18 in 2020	functioning National Immunization Technical Advisory Group (NITAG). Of importance, Haiti was the most recent country to establish a NITAG in March 2017. This indicator is off track.
	<b>SO 1.1.3</b> Number of countries and territories that have a current annual immunization plan of action that includes operational and financial plans Baseline: 25 in 2013 Goal: 35 in 2020	As of 2016, 41 countries have an up-to-date annual immunization plan.
<b>SO 1.2</b> Individuals and communities understand the value of the vaccines	<b>SO 1.2.1</b> Number of countries and territories that report having monitored public satisfaction with vaccination during Vaccination Week in the Americas or other activities Baseline: 0 in 2013 Goal: 15 in 2020	As of 2016, six countries and territories have reported using Vaccination Week as a platform to monitor public awareness, acceptance, and satisfaction with vaccination during Vaccination Week in the Americas in 2016.

General (GO) and Strategic Objectives (SO)	Indicator	Status
<b>GO 2.1</b> Eliminate neonatal tetanus as a public health problem in all countries	<b>GO 2.1.1</b> Number of countries and territories with municipalities reporting rates of neonatal tetanus (NTT) above 1/1,000 live births Baseline: 1 in 2013 Goal: 0 in 2020	In 2017, Haiti will evaluate the plan of action implemented in 2015 for NTT elimination.
<b>GO 2.2</b> Meet DPT vaccination coverage targets at all levels	<b>GO 2.2.1</b> Number of countries and territories reporting national average coverage of at least 95% with three doses of DPT vaccine in children under 1 year Baseline: 19 in 2013 Goal: 35 in 2020	As of 2015, 20 countries have reached 95% coverage with DPT3. This indicator is off track in the Region.
	<b>GO 2.2.2</b> Number of countries and territories reporting coverage of at least	As of 2015, 13 countries report DPT3 coverage of at least 80% in each district. This indicator is off

General (GO) and Strategic Objectives (SO)	Indicator	Status
	80% in each district or equivalent with three doses of DPT vaccine in children under 1 year  Baseline: 12 in 2013 Goal: 35 in 2020	track. Countries and the Pan American Sanitary Bureau have been working on focusing efforts in those geographic areas with low immunization rates.
<b>SO 2.1</b> Immunization benefits extend equitably to all people and social groups	<b>SO 2.1.1</b> Number of countries and territories reporting coverage by income quintile or other subgroups that make it possible to monitor vaccination equity  Baseline: 0 in 2013 Goal: 15 in 2020	As of 2016, there is no country in the Region reporting coverage by income. Although this indicator is off track, there have been two workshops to train 21 countries in the methodology to measure inequities.

General (GO) and Strategic Objectives (SO)	Indicator	Status
<b>GO 3.1</b> Introduce vaccines in accordance with technical and programmatic criteria	<b>GO 3.1.1</b> Number of countries and territories that have introduced one or more new vaccines into their national vaccination schedules  Baseline: 32 in 2013 Goal: 40 in 2020	As of 2016, 33 countries and territories have introduced new vaccines in their national schedules.
<b>SO 3.1</b> Decision-making is evidence-based and impact assessments ensure that policies are adopted to maximize the benefits of vaccination	<b>SO 3.1.1</b> Number of countries and territories that have conducted studies prior to the introduction of a vaccine (e.g., cost-effectiveness analysis)  Baseline: 14 in 2013 Goal: 20 in 2020	As of 2016, 16 countries have conducted studies prior to the introduction of new vaccines.
	<b>SO 3.1.2</b> Number of countries and territories that have conducted studies after the introduction of a vaccine (e.g., impact assessments, operational review, etc.)  Baseline: 9 in 2013 Goal: 15 in 2020	As of 2016, 12 countries have conducted studies after the introduction of new vaccines.

General (GO) and Strategic Objectives (SO)	Indicator	Status
<p><b>GO 4.1</b> Achieve the expected results proposed by the Post-2015 Development Agenda for reductions in infant mortality and maternal mortality</p>	<p><b>GO 4.1.1</b> Number of countries and territories whose immunization schedules include vaccination of pregnant women against influenza and/or with tetanus-diphtheria vaccine, as tracers of maternal vaccination</p> <p>Baseline: 27 in 2013 Goal: 35 in 2020</p>	<p>As of 2016, influenza vaccination is indicated for pregnant women in 31 countries in Latin America and the Caribbean (LAC). The pertussis-containing vaccine is indicated for pregnant women in 18 countries (all of them included in the 31 countries that have influenza vaccination).</p>
	<p><b>GO 4.1.2</b> Number of countries and territories that offer other preventive interventions integrated with vaccination</p> <p>Baseline: 4 in 2013 Goal: 20 in 2020</p>	<p>As of 2016, six countries offer preventive interventions integrated with vaccination (i.e., deworming).</p>
<p><b>SO 4.1</b> Supplies are available for the immunization program on a sustainable basis with national resources</p>	<p><b>SO 4.1.1</b> Number of countries and territories that finance more than 90% of their immunization programs with national resources</p> <p>Baseline: 27 in 2013 Goal: 35 in 2020</p>	<p>As of 2015, 34 countries in the Americas are able to fund their own programs with domestic resources.</p>
	<p><b>SO 4.1.2</b> Percentage of birth cohort in Latin America and the Caribbean that has access to an adequate vaccine supply of quality vaccines</p> <p>Baseline: 100 in 2013 Goal: 100 in 2020</p>	<p>As of 2016, 100% of the cohort has access to an adequate vaccine supply of quality vaccines.</p>
	<p><b>SO 4.1.3</b> Number of countries and territories that procure vaccines through the Revolving Fund that meet the criteria for accuracy of demand for vaccines and supply</p> <p>Baseline: 10 in 2013 Goal: 30 in 2020</p>	<p>As of 2016, only four countries and territories procured vaccines through the RF and met the criteria for accuracy of demand for vaccines and supply. This indicator is off track. Increased national financial burden, the introduction of IPV and switch of polio trivalent to bivalent are some of the reasons why countries had to update planned quantities.</p>

General (GO) and Strategic Objectives (SO)	Indicator	Status
		PAHO's technical assistance included updating authorities on vaccine markets, resolving supply issues and facilitating actions to improve demand planning and financial performance.
SO 4.2 Strengthened immunization services are part of comprehensive, well-run health services	SO 4.2.1 Number of countries and territories that have dropout rates below 5% between the first and the third dose of DPT vaccine  Baseline: 11 in 2013 Goal: 35 in 2020	As of 2015, 26 countries have the DPT1-3 dropout rate under 5%. The performance of this indicator shows that countries should work harder to improve the quality of immunization services being provided and can spark measures to correct the problems and improve DPT3 coverage within the current infrastructure.
	SO 4.2.2 Number of countries and territories with coverage above 95% for third dose of DPT vaccine sustained for three or more consecutive years  Baseline: 13 in 2013 Goal: 35 in 2020	As of 2015, ten countries and territories have maintained DPT3 coverage above 95% for three or more consecutive years. This indicator is off track. There is a need to continue strengthening national health systems as countries add vaccines to their national programs, so that coverage with all vaccines reaches and is sustained at the target of 95% or more.
	SO 4.2.3 Number of countries and territories that have conducted exercises to identify and correct barriers to reaching the unvaccinated or under-vaccinated populations  Baseline: 22 in 2013 Goal: 35 in 2020	As of 2016, 23 countries and territories have implemented vaccination activities targeting distant populations in an effort to reduce the number of susceptibles. This indicator is off track. The Region continues to prioritize the implementation of strategies to reach under/unvaccinated populations, including close collaboration with countries to define needs and follow-up actions.
	SO 4.2.4 Number of countries and territories that have held activities to improve the	As of 2016, 14 countries and territories have held activities to improve the quality of their

General (GO) and Strategic Objectives (SO)	Indicator	Status
	<p>quality of their coverage data and that include these activities in their annual action plans</p> <p>Baseline: 12 in 2013 Goal: 25 in 2020</p>	<p>immunization data.</p>
	<p><b>SO 4.2.5</b> Number of countries and territories that have a national system for computerized nominal immunization registry</p> <p>Baseline: 3 in 2013 Goal: 10 in 2020</p>	<p>As of 2016, five countries currently use EIR systems at the national level</p>
	<p><b>SO 4.2.6</b> Number of countries and territories that report having had a stock-out of a vaccine or related supplies for one full month or more at any level (local, subnational, or national)</p> <p>Baseline: 11 in 2013 Goal: 0 in 2020</p>	<p>As of 2015, 21 countries have reported stock-out, mainly for shortage of vaccine at global level. This indicator is off track. Countries should review the vaccine supply chain system to optimize the steps in the process and accommodate the strategies to maximize effectiveness and efficiency.</p>
	<p><b>SO 4.2.7</b> Number of countries and territories that have strengthened post-marketing surveillance of vaccines in the Expanded Program on Immunization (EPI)</p> <p>Baseline: 4 in 2013 Goal: 10 in 2020</p>	<p>As of 2016, 28 countries and territories have strengthened post-marketing surveillance of vaccines in the Expanded Program on Immunization.</p>
	<p><b>SO 4.2.8</b> Number of countries and territories that hold vaccination activities geared to health workers</p> <p>Baseline: 19 in 2013 Goal: 25 in 2020</p>	<p>As of 2016, 25 countries in the Region have been working to improve the knowledge and skill of their health workers.</p>

**Challenges and actions needed to improve immunization in the Region**

4. Immunization is among the most cost-effective health interventions implemented historically. In order to reach its full potential, as well as make greater progress with the objectives of the Plan, countries should reinforce the following areas of work taking their own reality into consideration:

- a) *Enhance legal frameworks.* Countries should establish or reinforce vaccine legislation in order to protect the financial sustainability of the program
- b) *Ensure that the benefits of immunization are equally shared by all.* With the objective of increased coverage at all levels, immunization programs should work with health systems in order to extend the services to people currently not covered and take advantage of the integrated approaches with other interventions at the primary care level.
- c) *Maintain and strengthen national commitment to immunization programs.* Although countries have invested in purchasing new and more expensive vaccines, financial resources are needed to support and improve programmatic activities such as supervision, training, and technical assistance. One challenge is the economic situation faced by many middle income countries in the Region with competing health priorities. The investment should be linked to a measurable evaluation framework.
- d) *Increase disease surveillance.* Suspected case-based surveillance of polio, measles and rubella is the most powerful tool to maintain gains and avoid re-establishment of the circulation of these viruses in the Region. Countries should enhance the performance of integrated epidemiological and laboratory surveillance of vaccine-preventable diseases (VPDs), take advantage of this network, and include other VPDs, as well as boost sentinel surveillance.
- e) *Invigorate information system.* Countries should work to ensure high quality collection, management, analysis and use of data at all levels to make the most informed decisions. These activities should focus on training, assessing the data quality of their systems, and exploring the use of new technologies, among others.
- f) *Enhance communication and social mobilization.* Efforts to increase confidence in and uptake of vaccines based on evidence should be made by countries through engaging communities and utilizing new mobile and internet-based technologies.

**Action by the Executive Committee**

5. The Executive Committee is invited to take note of this report and formulate the recommendations it deems pertinent.

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## **G. STRATEGY AND PLAN OF ACTION ON EPILEPSY: MIDTERM REVIEW**

### **Background**

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on the progress achieved in the implementation of the Strategy and Plan of Action on Epilepsy, adopted in September 2011 (document CD51/10, Rev. 1 (1) and Resolution CD51.R8) (2). This strategy and plan of action lays the foundation of technical cooperation to tackle epilepsy in the Region, complementing the Strategy and Plan of Action on Mental Health approved by the Directing Council of PAHO in 2009 (3), the PAHO Strategic Plan 2014-2019 (4), and the Plan of Action on Mental Health 2015-2020 (5). Other related documents include several resolutions and regional technical documents on epilepsy adopted by PAHO and the Member States, as well as the Mental Health Gap Action Programme (mhGAP), initiated by WHO in 2008, and its corresponding intervention guide (2010), which includes a module on the treatment of epilepsy in primary health care settings (6-12). In 2015, the World Health Assembly adopted a resolution concerning the need for coordinated action at the country level to address the social and health implications of the burden associated with epilepsy (Resolution WHA 68.20) (13). It should be noted that the action plan does not present a precise logical framework and not all strategic areas have targets and corresponding indicators.

### **Progress update**

2. The countries of the Region have made progress toward many objectives with important advances in the implementation of strategic areas 2 and 4. Despite evident and significant progress, barriers persist. In particular, at the country level, the discussion of strategies and service models for epilepsy is often under the responsibility of professional associations. Ministries of health have difficulties managing the issue directly with their own resources. PAHO focuses its efforts in this direction, promoting and facilitating the involvement of authorities, and working in regular contact with the ministries and medical associations of Latin America and the Caribbean.

3. Data on the Member States (see table below) were obtained through the report on Epilepsy in Latin America and the WHO Project Atlas for Neurological Disorders (14, 15). These instruments, together with the information available in Mortality Data for Health in the Americas 2012, constitute the main references in the preparation of this report (16).

<b>Strategic area 1: Programs and legislation for the care of people with epilepsy and protection of their human rights.</b>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Situation</b>
<b>1.1</b>	<b>1.1.1</b> Number of countries with a national epilepsy plan in place. Baseline: 10 countries in 2010 Target: 20 by 2015; 30 by 2020	18 countries in 2016 (14, 15). The targets were too ambitious. Proposal: adjust target to 25 countries by 2020.
<b>1.2</b>	<b>1.2.1</b> Number of countries that have modified/amended and updated the legislative framework for epilepsy to bring it into line with international human rights standards. Baseline: not defined in 2012 Target: 10 countries by 2015; 25 by 2020	10 countries in 2016 (14, 15). Agreement among countries on the need for specific legislation on epilepsy is not unanimous. Proposal: reduce target to 15 countries by 2020.
	<b>1.2.2</b> Instrument and methodology for comprehensive evaluation of national epilepsy programs and services developed and published. Baseline: no instrument published in 2010 Target: 1 instrument published by 2012; 1 revised by 2020	Questionnaire on basic information about programs, services, and resources, prepared in 2013 (14).  Questionnaire now under revision in light of the WHO Neurology Atlas.
	<b>1.2.3</b> Number of countries that have evaluated their national epilepsy program and/or services. Baseline: 0 countries in 2010 Target: 25 countries by 2014; 30 by 2020	Specific information is not available. It is proposed to align this indicator with 1.1, and to reformulate the target to 20 countries by 2020
	<b>1.2.4</b> Regional epilepsy mortality rate (per 100,000 population). Baseline: 0.8 in 2010 Target: < 0.8 (plan does not specify year).	Rate per 100,000 population in 2012 (most recent information available): 0.50 in North America; 1.04 in Latin America and the Caribbean; 0.84 in the Americas (16).

<i>Strategic area 2: Health services network for the treatment of people with epilepsy, with emphasis on primary health care and the provision of drugs.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Situation</b>
<b>2.1</b>	<p><b>2.1.1</b> Preparation and publication of a regional epilepsy training module (guides), based on the competencies required to meet the needs, targeting primary care workers.</p> <p>Baseline: 1 guide in 2010 (mhGAP-IG)</p> <p>Target: 1 guide adapted to the regional level by 2013; 1 guide reviewed by 2020</p>	<p>The mhGAP Intervention Guide/ Epilepsy Module prepared by WHO in 2010 meets the requirements of the regional training module proposed in this indicator. This guide, including the epilepsy module, has been published and made available to the countries of the Region in English (2010), French (2011), Spanish (2012), and Portuguese (2015). In addition, this module has been adapted at the country level and is being used in around 30 countries and territories, according to the WHO methodology (12).</p>
<b>2.2</b>	<p><b>2.2.1</b> Percentage of people with epilepsy who are not treated.</p> <p>Baseline: 60% in 2009</p> <p>Target: 30% by 2020</p>	<p>Pilot study in Honduras with a program for community-based intervention. Treatment gap reduced from 53% in 1997 to 13% in 2014 (14).</p> <p>A new regional study of the treatment gap is planned for 2017, similar to the one carried out in 2013 on the mental health treatment gap. All countries in the Region that have available data will be included.</p>

<b>Strategic area 3: Education and sensitization of the population, including people with epilepsy and their families.</b>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Situation</b>
<b>3.2</b>	<p><b>3.2.1</b> Preparation and publication of regional guides for the design and implementation of epilepsy prevention activities in the countries.</p> <p>Baseline: no guide in 2010 Target: 1 guide by 2013; revised by 2020</p>	The document on regional guides for the design and implementation of epilepsy prevention activities was prepared in 2016. It is expected to be completed by the first semester of 2017.

<b>Strategic area 4: Strengthening of the ability to produce, assess, and use information on epilepsy.</b>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Situation</b>
<b>4.1</b>	<p><b>4.1.1</b> Publication of a regional methodological document for the development of epilepsy indicators, prepared through a consultative process with the participation of a group of experts.</p> <p>Baseline: no document in 2010 Target: 1 document by 2014</p>	<p>Partially achieved through the use of data/indicators from the PAHO Regional Report and the WHO Atlas for Neurological Disorders (14, 15).</p> <p>It should be completed in the 2017-2020 period.</p>
	<p><b>4.1.2</b> Regional report on epilepsy, concluded and published.</p> <p>Baseline: 1 report in 2008 Target: 1 by 2015; 1 by 2020</p>	Report on Epilepsy in Latin America and the Caribbean, 2013 (14).
<b>4.2</b>	<p><b>4.2.1</b> Publication of a collection of epidemiological research on epilepsy in Latin America and the Caribbean.</p> <p>Baseline: no publication in 2010 Target: 1 by 2015; 1 by 2020</p>	A technical document was published on the most important Latin American experiences in the field of epilepsy (programs, services, and epidemiological research), based on two regional workshops held in Chile (2013) and Honduras (2015) (14).

### **Actions needed to improve the current situation**

- a) Adjust the targets of the Strategy and Plan of Action on Epilepsy to reflect more realistic goals.
- b) Consolidate and implement instruments and studies to evaluate the contents and standards included in the Strategy and Plan of Action on Epilepsy.
- c) Support joint efforts by the Pan American Sanitary Bureau (PASB) and the Member States in the development of health systems, human resources, and services in order to improve the quality of care, and bridge the gap of treatment.
- d) Promote resource allocation consistent with the identified needs and established goals.
- e) Strengthen information and surveillance systems, improve epidemiological information, and increase survey coverage of marginalized populations and other vulnerable groups.

### **Action by the Executive Committee**

4. The Committee is requested to take note of this report, approve the adjustments of the targets for indicators 1.1.1 and 1.2.1, and formulate the recommendations it considers relevant.

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## **H. PLAN OF ACTION ON MENTAL HEALTH: MIDTERM REVIEW**

### **Background**

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress in the implementation of the Plan of Action on Mental Health, approved in October 2014 (Document CD53/8 and Resolution CD53.R7) (1). The basis for the preparation of this plan and, in general, for current technical cooperation on mental health in the Region, is the Strategy and Plan of Action on Mental Health, approved by the Directing Council of the Pan American Health Organization (PAHO) in 2009, revised and aligned with the Comprehensive Mental Health Action Plan implemented by the World Health Organization (WHO) in 2013 (2, 3). This is complemented by the PAHO Strategic Plan 2014-2019 (4). Other precedents include regional resolutions, declarations, and technical documents on mental health approved by PAHO and the Member States, as well as the Mental Health Gap Action Program (mhGAP), launched by WHO in 2008, and its corresponding Intervention Guide of 2010 (5-12).

### **Progress update**

2. Progress has been made in most of the objectives, as described in the table below. The countries of the Region are making serious efforts to shift the focus of care from services provided in traditional psychiatric hospitals to a community-based model that offers continuous comprehensive care for people with mental illness and their families. Numerous events have been held throughout the Region, and practical technical tools have been shared. The integration of mental health in primary care has been strengthened in recent years by training primary care personnel in the use of the WHO mhGAP instrument, which consists of interventions for the prevention and management of mental, neurological, and substance use disorders in nonspecialized health care settings. However, the process must be reinforced with monitoring and evaluation tools that will make it possible to understand the impact of the efforts underway.

3. The Member States periodically submit their data through survey reports, epidemiological yearbooks, the Regional Mental Health Atlas for the Americas (PAHO), and the WHO-AIMS tool on mental health systems. These instruments, together with the reports issued by PAHO, such as *Suicide Mortality in the Americas* (2014), *Core Indicators – Health Situation in the Americas* (2016), and those from the technical missions of the Pan American Sanitary Bureau (PASB) staff in charge are the main sources used in the preparation of this report.

<i>Strategic Line of Action 1: Develop and implement policies, plans, and laws in the field of mental health and mental health promotion, to achieve appropriate and effective governance.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>1.1</b>	<p><b>1.1.1</b> Number of countries that have a national mental health plan or policy in line with regional and global mental health plans.</p> <p>Baseline: 22 in 2013 Target: 30 in 2020</p>	In 2015, 27 countries had an independent mental health policy or plan (13, 14).
<b>1.2</b>	<p><b>1.2.1</b> Number of countries that have national laws on mental health consistent with international human rights instruments.</p> <p>Baseline: 8 in 2013 Target: 18 in 2020</p>	<p>In 2015, 22 countries had an independent mental health law (13, 14).</p> <p>Furthermore, in seven countries, mental health legislation was part of the general health or disability laws (13).</p>

<i>Strategic Line of Action 2: Improve the response capacity of systems and services for mental health and the care of psychoactive substance-related disorders to provide comprehensive, quality care in community-based settings.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>2.1</b>	<p><b>2.1.1</b> Number of countries that have increased the rate of persons seen in outpatient mental health facilities above the regional average (975/100,000 population).</p> <p>Baseline: 19 in 2013 Target: 30 in 2020</p>	In 2015, 21 countries reported a number of annual consultations in outpatient mental health facilities above the regional average (13, 14).
<b>2.2</b>	<p><b>2.2.1</b> Number of countries where psychiatric hospitals have reduced the number of beds by at least 15%.</p> <p>Baseline: 0 Target: 10 in 2020</p>	Using the information submitted by 31 countries in 2013, a baseline regional average of 39.43 beds per 100,000 population was established; furthermore, four countries reported having no beds in their psychiatric hospitals (14). As of 2015, 16 of the 31 countries included in the baseline had reduced the number of beds in psychiatric hospitals by at least 15% (13). The baseline will be expanded as we obtain relevant information.

<b>2.3</b>	<p><b>2.3.1</b> Number of countries that have integrated a mental health component into primary care.</p> <p>Baseline: 15 in 2013 Target: 25 in 2020</p>	<p>In 2015, 23 countries submitted information on primary care workers who had received at least two days of mental health training in the past two years (13, 14).</p>
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*Strategic Line of Action 3: Prepare and implement promotion and prevention programs in the area of systems and services for mental health and for the care of alcohol- and substance-related disorders, with particular attention to the life course.*

<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>3.1</b>	<p><b>3.1.1</b> Number of countries with operational multisectoral mental health promotion and prevention programs.</p> <p>Baseline: 20 in 2013 Target: 25 in 2020</p>	<p>Although 14 countries reported having formal programs for mental health promotion and the prevention of mental illness in 2015, all the countries have activities with similar goals in different sectors, and these efforts have been growing (13).</p>
<b>3.2</b>	<p><b>3.2.1</b> Annual number of suicide deaths per 100,000 population. No increase in the regional suicide rate by 2020 compared to 2013.</p> <p>Baseline: 7.3 x 100,000 population in 2013 Target: &lt; 7.3 x 100,000 population</p>	<p>The baseline established for the indicator corresponds to data from the period 2005-2009, published in 2014 (15).</p> <p>The average regional suicide rate was 7.96 per 100,000 population, according to the available data for 2012. Of the 34 countries with available information, 19 reported an annual suicide rate below the baseline (16).</p> <p>The apparent increase in the suicide rate in the short term may be related to the effort to collect better, more complete data in the Region.</p>
	<p><b>3.2.2</b> Number of countries that develop and implement national suicide prevention programs.</p> <p>Baseline: 6 in 2013 Target: 20 in 2020</p>	<p>In 2015, 11 countries reported having formulated a national suicide prevention strategy (13).</p> <p>However, the prevention component is present in the plans and strategies of 27 countries, and the difference lies in the scope of these strategies and their degree of implementation.</p>

<i>Strategic Line of Action 4: Strengthen information systems, scientific evidence, and research.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>4.1</b>	<p><b>4.1.1</b> Number of countries with a basic set of agreed upon mental health indicators, systematically compiled and reported annually.</p> <p>Baseline: 21 in 2013 Target: 30 in 2020</p>	<p>In 2015, 25 countries reported having a basic set of mental health indicators (13).</p> <p>In Central America in particular, PAHO, in collaboration with the Council of Ministers of Health of Central America (COMISCA), recently streamlined and standardized these indicators, providing assistance to the countries to implement the compendium of indicators obtained. Work is also underway to incorporate these indicators into the Subregional Suicide Observatory for Central America and the Dominican Republic so as to make it a mental health observatory.</p>

#### **Action necessary to improve the situation**

- a) Encourage efforts between the PASB and the Member States to develop the mental health systems, human resources, and treatment services necessary for bridging the gap and improving the quality of care.
- b) Strengthen information and surveillance systems, improve epidemiological information, and increase survey coverage of marginalized populations and other vulnerable groups.
- c) Promote resource allocation consistent with the needs identified and the targets set.
- d) Providing a more accurate figure for the regional suicide rate will require a complete analysis of the period 2010-2015. This report is scheduled to be published in 2018, and its results will be included in the final report on this plan of action.

#### **Action by the Executive Committee**

4. The Executive Committee is invited to take note of this report and formulate the recommendations it deems pertinent.

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## **I. PLAN OF ACTION ON DISABILITIES AND REHABILITATION: MIDTERM REVIEW**

### **Background**

1. The purpose of this document is to inform the Governing Bodies of the Pan American Health Organization (PAHO) about progress in the implementation of the *Plan of Action on Disabilities and Rehabilitation*, approved in October 2014 (Document CD53/7, Rev. 1 and Resolution CD53.R12) (1). This Plan lays the foundation for technical cooperation in the Region to address the issue of disabilities and rehabilitation, in line with the *WHO Global Disability Action Plan 2014-2021: Better health for all people with disabilities* and the United Nations Convention on the Rights of Persons with Disabilities (2, 3). Other supporting instruments include the resolutions and technical reports of PAHO/WHO, as well as the Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (4, 5).

### **Progress update**

2. The countries of the Region have made great progress toward meeting the objectives of Strategic Lines of Action 1 and 2, strengthening the rehabilitation component of the health care model and its linkage with primary care. Moreover, they have promoted the development of inclusive health programs to facilitate the access of persons with disabilities to all health services and improve their quality of life. In Strategic Line 3, great strides have been made in including disability data in health information systems, especially through the use of the International Classification of Functioning, Disability, and Health, which facilitates decision-making to address the real life conditions and health needs of persons with disabilities.

3. The data on the Member States (see Table below) were obtained from survey reports, epidemiological yearbooks, and ministry of health websites. These instruments, together with reports from the technical missions of the Pan American Sanitary Bureau (PASB) staff in charge are the main references used in the preparation of this report.

<i>Strategic Line of Action 1: Promote equity within the framework of the health policies, plans, and legislation on disability to improve governance.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>1.1</b>	<p><b>1.1.1</b> Number of countries that have implemented national disability and rehabilitation plans consistent with regional and global plans and the Convention on the Rights of Persons with Disabilities (CRPD) and other related international standards.</p> <p>Baseline 2013: 6 Target 2019: 14</p>	<p>As of 2016, 13 countries in the Region had specific national plans on disability and rehabilitation in the health sector that were consistent with the PAHO and WHO plans of action and other international standards such as the CRPD (6, 7).</p>
<b>1.2</b>	<p><b>1.2.1</b> Number of countries with specific legislation on disability consistent with international human rights instruments and the technical guidelines of PAHO/WHO.</p> <p>Baseline 2013: 6 Target 2019: 16</p>	<p>As of 2016, 22 countries in the Region had specific legislation on disability consistent with international human rights instruments (6, 7).</p>
<b>1.3</b>	<p><b>1.3.1</b> Number of countries with the disability component in their disaster and emergency risk management plans.</p> <p>Baseline 2013: 1 Target 2019: 9</p>	<p>As of 2016, eight countries in the Region had specific disaster and emergency risk management plans that address the needs of persons with disabilities.</p> <p>Furthermore, six countries mention care for persons with disabilities in the activities of their disaster and emergency risk management programs (8).</p>

<b>Strategic Line of Action 2: Strengthen the health sector's habilitation and rehabilitation services network, which includes the provision of assistive technology and community-based rehabilitation.</b>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>2.1</b>	<b>2.1.1</b> Number of countries that have attained at least 12% access to habilitation and rehabilitation services and social services for persons with disabilities.  Baseline 2013: 0 Target 2019: 16	As of 2016, only one country had reported attaining this indicator. Work is currently under way with five more countries to evaluate access to habilitation and rehabilitation services (9, 10).
	<b>2.1.2</b> Percentage of countries that include the Community-based Rehabilitation Strategy (CBR) in national rehabilitation programs in accordance with the PAHO/WHO matrix.  Baseline 2013: 3 Target 2019: 19	As of 2016, CBR had been included in the national rehabilitation plans of 12 countries in the Region (23% of the total 52 countries and territories). Three more countries had begun planning to include this strategy in their national rehabilitation programs (10-14).
	<b>2.1.3</b> Percentage of countries that include assistive technology devices for persons with disabilities as part of their service delivery systems.  Baseline 2013: 6 Target 2019: 20	As of 2016, 14 countries in the Region (26% of the total 52 countries and territories) had explicitly included assistive technology devices for persons with disabilities who need them under their national programs for care to persons with disabilities (10-14).
<b>2.2</b>	<b>2.2.1</b> Number of countries that have formulated or updated habilitation and rehabilitation regulations.  Baseline 2013: 3 Target 2019: 16	As of 2016, 14 countries in the Region had formulated or updated their regulations and habilitation/rehabilitation service networks in the health sector. Three more countries are in the process of planning their rehabilitation service network (10-14).

<b>Strategic Line of Action 3: Promote the production and analysis of data on disabilities and support research.</b>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>3.1</b>	<b>3.1.1</b> Percentage of countries that have included the International Classification of Functioning, Disability, and Health (ICF) in their disability certification systems.  Baseline 2013: 6 Target 2019: 19	As of 2016, 11 countries (21% of the total 52 countries and territories) had included use of the ICF in disability certification (10, 15, 16).
	<b>3.1.2</b> Number of countries whose national surveillance systems incorporate the set of indicators used by the International Classification of Functioning, Disability, and Health (ICF).  Baseline 2013: 6 Target 2019: 18	As of 2016, 11 countries had incorporated use of indicators used by the ICF in their national surveillance systems (10, 15, 16).
<b>3.2</b>	<b>3.2.1</b> Number of countries that systematically include disability data in the health information system, disaggregated by age, sex, and ethnic origin (type of disability, degree of severity, origin, or cause).  Baseline 2013: 2 Target 2019: 16	As of 2016, 10 countries in the Region had included disability data in their health information systems. (10, 15, 16).
<b>3.3</b>	<b>3.3.1</b> Number of countries that subsidize, at least two research projects per year on disability, habilitation, and rehabilitation.  Baseline 2013: 0 Target 2019: 14	As of 2016, 6 countries in the Region had financing programs that prioritized the issue of disability and rehabilitation (10.)

### **Action necessary to improve the situation**

- a) Encourage joint efforts between the PASB and the Member States to develop and strengthen habilitation and rehabilitation services, human resources, and the services necessary for bridging access gaps and improving the quality of care.
- b) Expand decentralized habilitation and rehabilitation services to ensure geographic coverage linked to the health services network, especially their coordination with primary health care.
- c) Support the adoption and use of the International Classification of Functioning, Disability, and Health (ICF) as a tool for strengthening information and surveillance systems, including functioning and disability data in health information systems, improving epidemiological information, and promoting research.
- d) Promote resource allocation consistent with needs identified and the targets set.

### **Action by the Executive Committee**

4. The Executive Committee is requested to take note of this report and formulate the recommendations it deems pertinent.

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## J. PLAN OF ACTION FOR THE COORDINATION OF HUMANITARIAN ASSISTANCE: MIDTERM REVIEW

### Background

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on the achievements made with implementation of the *Plan of Action for the Coordination of Humanitarian Assistance* (Document CD53/12) (1), adopted in October 2014 by means of Resolution CD53.R9 (2014).

2. The goal of the Plan is to facilitate strengthening of the health sector in the Member States, in addition to improving coordination for receiving and providing humanitarian health assistance in emergencies and disasters.

### Progress update

3. This report is based on updates received from Member States through their participation in regional meetings of ministry of health disaster coordinators, from PAHO/WHO country offices, from direct coordination with subregional entities and agencies, as well as from the databases of the PAHO Health Emergencies Department (2-4).

4. The Plan of Action is comprised of three strategic lines: *a*) strategic alliances, cooperation among countries, and international agreements; *b*) foreign medical teams; and *c*) leadership, coordination, and accountability.

5. The report indicates that all midterm targets have been met. Agreements establishing the health logistics network are in process of confirmation for signature with countries or entities. Implementation of the UNASUR resolution and of new strategic alliances will require a longer time. Countries are implementing strategies and working groups to update their mechanisms and procedures to facilitate the request, provision, and registry of emergency medical teams (EMTs). It should be noted that the Americas is the most advanced Region in implementation of the global EMT initiative.

<i>Strategic line of action 1: Strategic alliances, cooperation among countries, and international agreements.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>1.1.</b> Increase partnerships and cooperation for rapid and effective international health	<b>1.1.1</b> Number of multilateral agreements that facilitate humanitarian health assistance. Baseline: 3	A multilateral agreement, the Union of South American Nations (UNASUR), through a Declaration from its 10th Summit of Ministers of Health, <sup>1</sup> recognized the initiative for standardization of both national and foreign

<sup>1</sup> *Declaración sobre estándares mínimos de equipos médicos de emergencia (EMT)*

<i>Strategic line of action 1: Strategic alliances, cooperation among countries, and international agreements.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
assistance.	Target 2017: 4	emergency medical teams.
	<b>1.1.2</b> Number of countries that participate in the inter-American health sector network for emergencies. Baseline: 0 Target 2017: 10	Twelve UNASUR countries, signatories of the Declaration, form part of the inter-American health sector network for emergencies.
	<b>1.1.3</b> Number of countries that participate in the inter-American health logistics network. Baseline: 0 Target 2017: 10	Five countries—Argentina, Dominican Republic, Colombia, Ecuador, and Peru—are reviewing the agreements to form the logistics network and have demonstrated their interest in establishing bilateral agreements with PAHO.

<i>Strategic line of action 2: Foreign Medical Teams.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>2.1.</b> Establish a regional mechanism for registry of foreign medical teams.	<b>2.1.1</b> Number of countries that implement the system for registry of foreign medical teams. Baseline: 0 Target 2017: 15	Four countries have implemented CICOM — Medical Information and Coordination Cell for national and foreign medical teams — for the request, registry, and coordination of emergency medical teams during emergencies occurring to date in Colombia, Costa Rica, Ecuador, and Haiti.
	<b>2.1.2</b> Number of countries that have up-to-date procedures for receipt and provision of international health assistance. Baseline: 5 Target 2017: 15	Twelve countries in South America have implemented training workshops on coordination procedures for the receipt and provision of medical emergency teams. Five countries in the Region are integrating the procedures into their national mechanisms (Chile, Colombia, Costa Rica, Ecuador, and Peru).

<i>Strategic line of action 3: Leadership, coordination, and accountability.</i>		
<b>Objective</b>	<b>Indicator, baseline, and target</b>	<b>Status</b>
<b>3.1.</b> Strengthen the capacity of the ministries of health to lead and coordinate international humanitarian assistance.	<b>3.1.1</b> Number of ministries of health that have mechanisms for coordination of humanitarian health assistance. Baseline: 3 Target 2017: 10	Twenty countries have an Emergency Operations Center in the ministry of health to coordinate the health sector response to emergencies and disasters at the national level. <sup>2</sup>
	<b>3.1.2</b> Number of countries with personnel trained to coordinate humanitarian health assistance. Baseline: 3 Target 2017: 10	Ten countries in the Region have personnel trained in humanitarian health assistance coordination. In 2016, 42 experts received training to strengthen ministry of health capacity for leadership and coordination of international humanitarian assistance. <sup>3</sup>  Twenty-one countries in the Region have trained 64 national experts as emergency medical team coordinators, to be deployed to support national authorities in information management and coordination of emergency medical teams.  In Colombia, the Health Cluster was activated, headed by the Ministry of Health with PAHO support.

### **Necessary actions to improve the situation**

- a) Endorse and disseminate guidelines on coordination of humanitarian health assistance; continue implementation of the Plan of Action and the road map established by the advisory committee.
- b) Promote strengthening of the emergency medical team initiative in countries, by providing training of national medical teams, preparation of national mechanisms to request and register these teams, as well as the establishment of the Medical Information and Coordination Cell (CICOM) for national and foreign medical teams.

<sup>2</sup> Report of the Regional Meeting of Health Disaster Coordinators, October 2015.

<sup>3</sup> *Informe sobre la reunión del grupo de consulta para el liderazgo y la coordinación de la asistencia humanitaria en salud de las Américas*, 15 June 2016.

- c) Continue incorporation of countries into the inter-American health logistics network and support definition of minimum contents, the establishment and updating of procedures for the loan, shipment, donation, and replenishment of medical supplies and provisions, in addition to the harmonization and dissemination of procedures.

### **Action by the Executive Committee**

6. The Executive Committee is invited to take note of this midterm report and formulate the recommendations it deems relevant.

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## **K. COOPERATION FOR HEALTH DEVELOPMENT IN THE AMERICAS: PROGRESS REPORT**

### **Background**

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress in the implementation of Resolution CD52.R15 (2013) (1), *Cooperation for health development in the Americas*, linked to policy document CD52/11 (2013) (2), which states: “The goal of the policy is to strengthen cooperation among countries and horizontal partnerships within and across regions in order to proactively share health solutions that effectively and sustainably address common health problems, particularly in priority areas such as facilitating universal access to health care and addressing the social determinants of health. Cooperation among countries and horizontal partnerships can also be used to tackle equity issues and asymmetries within and among countries. Shared solutions and exchanges should be increasingly evidence-based in order to strengthen the scientific approach to these types of cooperation.”

2. Resolution CD52.R15 requests the Director of the Pan American Sanitary Bureau (PASB) to “present the Directing Council or the Pan American Sanitary Conference with periodic evaluations of the implementation and impact of the policy on cooperation for health development in the Americas, especially cooperation which, for the Organization, involves resource mobilization in order to highlight the possible challenges and success factors that could help to further improve the policy, beginning with the 29th Pan American Sanitary Conference;”.

### **Update on Progress achieved**

3. In fulfillment of the mandate of the resolution and policy document on cooperation for health development in the Americas, a qualitative evaluation of the program for technical cooperation among countries (TCC) has been conducted that details the opportunities and challenges facing the Region, as well as the steps that the Organization is taking to support cooperation among countries for health development.

4. Consultations on South-South and triangular cooperation were held with the Member States (in Panama in 2015 and the Dominican Republic in 2016) to promote cooperation among countries and capitalize on existing good practices.

5. With regard to the promotion of South-South and triangular cooperation, reports of the UN Secretary-General submitted to the General Assembly in 2015 and 2016 recognized PAHO as an important partner for the development of policy and dialogue in this field (3, 4).

6. With a view to incorporating the guidelines of the policy document into the daily work of the Organization, the practice of cooperation among countries has been institutionalized through planning and the identification of opportunities for cooperation

in the biennial work plan for 2016-2017. Cooperation among countries for health development has also been included in the biennial work plan for 2018-2019.

7. PAHO has also enlisted the support of many regional stakeholders, including United Nations agencies, international cooperation agencies, and regional integration mechanisms, to encourage dialogue and involve all stakeholders in initiatives to promote cooperation among countries. It is likewise negotiating formal cooperation agreements with entities such as MERCOSUR, UNASUR, and the Ibero-American General Secretariat (SEGIB).

8. In response to requests from the Member States, PAHO created the Program for Strengthening Cooperation for Health Development in the Americas, in partnership with the FIOCRUZ Center for International Relations in Health (CRS/FIOCRUZ), a PAHO/WHO Collaborating Center for global health and South-South cooperation, to strengthen the capacities of international relations offices. Representatives of 33 Member States participated in this training program, which included two in-person meetings, virtual sessions, and work with mentors in areas connected with diplomacy and health cooperation, current global health challenges, global health governance, health in regional and subregional integration process, and health in foreign policy in the Region.

9. PAHO has worked in the production of information and documentation on South-South and triangular cooperation, especially through the report *La Cooperación Sur-Sur y triangular en el sector de la salud en Iberoamérica* [South-South and triangular cooperation in the health sector in Ibero-America] (5), a joint publication with the Ibero-American General Secretariat. In addition, it has also compiled information through PASB and the PAHO/WHO representative offices on initiatives in which the Organization has been involved. Thus, between 2014 and 2016, 51 initiatives classified as “completed” and “under implementation” were identified, in addition to 34 in the “development” phase. Concerning the initiatives that are “completed” and “under implementation,” the following should be noted:

- a) The South American subregion accounts for 39% of the initiatives, while Central America and the Caribbean account for 29% and 25%, respectively. The remaining 7% corresponds to the North American subregion and to initiatives with other regions of the World Health Organization (WHO).
- b) All PAHO Member States have participated in these initiatives, either through direct involvement or regional integration mechanisms, particularly in the Caribbean through the Caribbean Community (CARICOM) and the Caribbean Public Health Agency (CARPHA).
- c) A significant portion of the initiatives (46%) have a component related to Category 4 (Health Systems) of the PAHO Strategic Plan. These are followed by those linked to Category 1 (Communicable Diseases, 21%) and Category 2 (Noncommunicable Diseases and Risk Factors, 14%).
- d) Concerning the 2030 Agenda for Sustainable Development, the vast majority of

the initiatives are related to Goal 3 (“Ensure healthy lives and promote well-being for all at all ages”), especially target 3.8 (“Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”) (6).

**Action necessary to improve the situation**

10. With the purpose of continuing to fulfil the mandate of the Governing Bodies and Member States, PASB must continue to implement capacity-strengthening programs with both Member States and strategic partners, as well as within the Organization, in order to institutionalize this approach and better respond to the different challenges for cooperation among countries.

11. The Organization will carry on working closely with international cooperation agencies, regional integration mechanisms, and the other partners to promote cooperation among countries for health development.

12. PASB will continue its efforts to disseminate good practices and lessons learned with regard to cooperation among countries, and will provide continuity for activities related to the registry, documentation, and analysis of cooperation among countries and its impact on health development.

13. In order to continue supporting cooperation among countries for health development, and considering the opportunities and challenges involved in this kind of cooperation, PASB has implemented a mechanism to finance projects for cooperation among countries, along with procedural guidelines, project templates, and evaluation methodologies, which are being disseminated among the Member States and strategic partners.

14. In order to keep the Governing Bodies of PAHO informed about compliance with the mandates of Resolution CD52.R15, progress reports will be submitted every two years.

**Action by the Executive Committee**

15. The Executive Committee is invited to take note of this report and offer its comments and recommendations to further the promotion of cooperation among countries for health development in the Americas.

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## **L. REVIEW OF THE CHARGE ASSESSED ON THE PROCUREMENT OF PUBLIC HEALTH SUPPLIES FOR MEMBER STATES: PROGRESS REPORT**

### **Background**

1. The Pan American Health Organization (PAHO) procurement activities have been supported over the years by three procurement mechanisms: the Revolving Fund for Vaccine Procurement (Revolving Fund), the Regional Revolving Fund for Strategic Public Health Supplies (Strategic Fund), and the reimbursable procurement on behalf of Member States. The Revolving Fund was established in 1977 pursuant to Directing Council Resolution CD25.R27 in order to facilitate the timely availability of quality vaccines at the lowest prices. The Strategic Fund was established in 1999 following requests from Member States for assistance in the procurement of strategic supplies focused on combating HIV/AIDs, tuberculosis, malaria, and neglected diseases. Since 2013, the Strategic Fund incorporates medicines to prevent and treat noncommunicable diseases. The total value of goods procured on behalf of Member States continues to rise significantly every year. In 2016, it was approximately 15% higher than in the previous period (Revolving Fund, US\$ 628 million;<sup>1</sup> Strategic Fund, \$82 million).

2. In 2013, the 52nd Directing Council adopted Resolution CD52.R12, *Review of the Charge Assessed on the Procurement of Public Health Supplies for Member States (1)*. This resolution called for an increase in the charge assessed on the procurement of all public health supplies to 4.25% effective 1 January 2014. It also requested the Director to review the charge assessed and to present a report on the revenue and expenses tied to the use of the 1.25% of the total fee to cover administrative, operating, and staffing costs at the end of each biennium. Revenue generated from the remaining 3% of the fee is applied to the capitalization of procurement mechanisms on behalf of Member States.

### **Update on Progress Achieved**

3. The accrued revenue generated from the 1.25% fee during the 2014-2015 biennium totaled \$14,725,000. In keeping with current practice for the allocation of support costs, the revenue was made available for the following biennium, 2016-2017. Bearing this practice in mind, as well as the amount generated, a work plan and budget for 2016-2017 biennium was prepared and approved by the Director of the Pan American Sanitary Bureau (PASB) (Table 1). The budget for the plan, amounting to \$12.1 million, supports all the costs of key personnel assigned to the procurement mechanisms, as well as activities in support of the approved operational framework and its four key enabling functions.

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<sup>1</sup> Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

**Table 1. Approved Budget, 2016-2017**

<b>Staffing</b>		<b>\$10,362,700</b>
	Revolving Fund for Vaccines	1,513,000
	Health Systems Strengthening	893,100
	Procurement	4,694,900
	Legal	180,390
	Finance	1,022,000
	Sub-regional (CPC, ELS, PER)	2,059,310
<b>Supporting Activities</b>		<b>\$1,735,000</b>
<b>Totals</b>		<b>\$12,097,700</b>

4. Details on the operational framework, its four enabling functions, and the supporting activities to be implemented by the staff are described below. Since the biennium ends in December 2017, actual expenditures will be reported to the PAHO Directing Council in 2018.

#### *Strengthening of Knowledge and Awareness*

5. Technical cooperation missions were carried out on behalf of both Funds to increase awareness as well as understanding of supply chain management and demand forecasting, and to assist in trouble-shooting issues related to quality, supply, and financing.

6. With support from the national country offices, working missions provided training and other institutional strengthening activities in areas related to supply chain management and improved utilization of the Funds. As a result, countries are now able to reduce risky stock situations (excesses or shortages) and improve the forecasting of needs for essential medicines and vaccines. In addition, using an interprogrammatic approach, technical cooperation included support on the improvement of treatment guidelines and the rational use of medicines. Also, plans were made to develop a forecasting tool and design an appropriate demand forecasting platform to support countries in preparing plans to meet their demands for vaccines and syringes.

7. In addition, country missions provided advice and assistance in analyzing the potential savings from using the Funds. For example, to ensure the availability of hard-to-procure medicines, vaccines, and other emergency and strategic health supplies for neglected tropical diseases, malaria, and other diseases, the Strategic Fund conducted consolidation-of-demand exercises and found ways to incentivize the timely supply of products.

8. With support from the Centers for Disease Control and Prevention (CDC), staff from both Funds worked together to develop a communications framework. The framework distinguishes between common areas of collaboration across both Funds and specific areas of work integral to the continued development of each Fund, as well as their communication with Member States.

***Increasing the Efficiency of Operations***

9. During the period of this report, staff supported by this charge developed a series of specific strategies geared towards improving supplier engagement and performance. Eligibility and technical criteria were reviewed for products procured through these mechanisms and the findings were presented at a suppliers' forum organized by PASB. These criteria were included in all new calls for bids. This initiative streamlined the bid solicitation process, by eliminating ad hoc changes and reducing the time required to review documents from competing suppliers, which improved the efficiencies of both Funds.

10. Vaccine supply challenges for inactivated polio vaccine (IPV), yellow fever (YF), and seasonal influenza were monitored closely by the Revolving Fund in coordination with PAHO Country Offices and the Regional Immunization Program. A review and analysis of credit lines linked to national immunization plans and national budgets was also initiated.

11. Personnel covered by this charge worked intensively on increasing Strategic Fund membership, which now stands at 30 Member States. The expanded membership resulted in larger procurement volume, which allowed to negotiate better terms and conditions, including prices, for the Member States.

12. In January 2016, PAHO deployed a new enterprise resource planning system to manage all operational, financial, and procurement transactions across the Organization, including those related to both Funds. With the goal to provide countries with timely updates on the status of their orders and financial obligations, staff assigned full time to these Funds are developing a set of reports and dashboards that will be integrated into this new system, thus leveraging its functionalities. These tools will provide a better picture of the performance of both Funds and ensure greater efficiency.

***Developing Market Intelligence***

13. PASB staff from across the Organization who are funded by this charge participated in the Annual Developing Country Vaccine Manufacturers Network (DCVMN) meeting, held in Buenos Aires in October 2016. This event provided an opportunity to gather market intelligence and promote awareness of the Revolving Fund's success over the past four decades with this key group of suppliers. Staff gave talks as part of the agenda and met separately with suppliers. The PAHO vaccine market outlook was published along with the results of the meeting (2). In this same vein, ongoing quarterly meetings are held with all vaccine suppliers under long-term agreements with the Revolving Fund. These meetings provide an opportunity to review supply/demand performance, identify challenges, and gather market intelligence.

14. Member States are kept up to date on changes in the vaccine market through regional forums and country visits. Ongoing monitoring of the vaccine market continued despite the challenges associated with aligning the regional demand with the supply.

15. Using funds provided from this charge, the Strategic Fund conducted a series of strategic meetings with Member States in order to better understand their needs, identify opportunities for collaboration, and explore ways to improve support in the exchange of information on pricing and market trends. Staff have participated actively in fora and international meetings with other United Nations agencies and international organizations, sharing information on market trends, practices, potential new suppliers, and challenges and opportunities.

16. In addition, meetings have been held with vendors on a regular basis to discuss current business, new products, changes in the market, and potential new strategies and areas of collaboration.

### ***Leveraging Strategic Alliances and Partnerships***

17. During the period, existing partnerships were strengthened and new ones were forged. The Revolving Fund staff supported by this charge networked with the Global Alliance for Vaccines and Immunization (GAVI) during negotiations with suppliers of pneumococcal vaccine in 2016 and again in 2017. In addition the Revolving Fund in collaboration with the Gates Foundation successfully implemented a supply agreement on bivalent human papilloma virus (HPV) vaccine for Member States.

18. The Strategic Fund developed and strengthened partnerships with key international organizations such as the United States Agency for International Development (USAID), UNICEF, and the Global Fund to Fight Tuberculosis, AIDS, and Malaria (GFTAM). The Strategic Fund now has access to long-term agreements and beneficial price arrangements as part of its collaboration with GFTAM and UNICEF. To strengthen the capacity of Member States in supply chain management and demand forecasting, PAHO signed a collaborative agreement with the GFTAM in this area. A joint bid has been issued together with UNICEF for responding to requests for antimalarials.

19. A meeting was held with representatives from GFTAM to review vendor performance and discuss prices, which resulted in long-term agreements with significant savings on behalf of the Member States.

### **Actions Necessary to Improve the Situation**

20. PASB will continue to monitor the situation to ensure that the procurement activities and staff needed to manage these two Funds are covered by revenue generated by the charge assessed on the procurement of public health supplies on behalf of Member States.

### **Action by the Executive Committee**

21. The Executive Committee is invited to take note of this progress report and offer any recommendations it deems relevant.

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## **M. STATUS OF THE PAN AMERICAN CENTERS**

### **Introduction**

1. This document was prepared in response to the mandate from the Governing Bodies of the Pan American Health Organization (PAHO) to conduct periodic evaluations and reviews of the Pan American Centers, and report on institutional matters or technical progress of strategic importance to the Organization.

### **Background**

2. The Pan American Centers have been an important modality of PAHO technical cooperation for almost 60 years. During this period, PAHO has created or administered 13 centers,<sup>1</sup> eliminated nine, and transferred the administration of one of them to its own Governing Bodies. This document presents up-to-date strategic information on the Latin American and Caribbean Center on Health Sciences Information (BIREME); the Latin American Center for Perinatology/Women's and Reproductive Health (CLAP/WR); and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA).

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

3. BIREME is a specialized center of PAHO founded in 1967 to channel the cooperation that the Organization provides to Member States in relation to scientific and technical information, and the sharing of knowledge and evidence that contribute to the ongoing improvement of health systems, education, and research.

4. Within the Pan American Sanitary Bureau (PASB)'s organizational structure, BIREME is situated in the Office of Knowledge Management, Bioethics, and Research, and has a specific Biennial Work Plan (BWP) 2016-2017 approved by the Director of PASB.

### ***Institutional Structure of BIREME***

5. BIREME's institutional framework was established by the Agreement on Maintenance and Development of the Center ("Maintenance Agreement"), signed by PAHO and the Ministries of Health and Education of Brazil, the Ministry of Health of the State of São Paulo, and the Federal University of São Paulo (UNIFESP) in 2004.<sup>2</sup>

6. In 2009, recognizing that the institutional framework of BIREME did not adequately meet BIREME's current and future governance, management, and financing needs, the 49th Directing Council of PAHO adopted Resolution CD49.R5 approving a new Statute for BIREME and requesting the Director of PASB to undertake negotiations

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<sup>1</sup> BIREME, CAREC, CEPANZO, CEPIS, CFNI, CLAP, CLATES, ECO, INCAP, INPPAZ, PANAFTOSA, PASCAP, and Regional Program on Bioethics in Chile.

<sup>2</sup> The first agreement was signed on 3 March 1967 and the last one on 2 December 2004.

with the Government of Brazil to conclude a new Headquarters Agreement regarding the maintenance of BIREME as well as its privileges and immunities in that country.

7. The 2004 Maintenance Agreement expired on 1 March 2015.

### ***Current Status of the Institutional Frameworks***

#### ***Facilities and operations agreement***

8. Efforts are in progress for the full implementation of the new institutional framework of BIREME, as the PAHO/WHO Representative in Brazil and the BIREME Director are in the process of continuing the negotiations initiated with the Government of Brazil regarding the Headquarters Agreement. Meanwhile, a specific cooperation agreement (*Termo de Cooperação para o desenvolvimento e aprimoramento de BIREME*) was signed on 2 February 2017 with the Ministry of Health of Brazil. This new agreement recognizes BIREME's legal status as a Pan American Center that is an integral part of PAHO, in accordance with the basic agreements signed between the Organization and the Government of Brazil. It also stipulates the financial contributions that the Government of Brazil should make for the maintenance of BIREME in 2017 and 2018.

### ***Recent Progress at BIREME***

9. The sixth session of the BIREME Advisory Committee was held on 2 February 2017 with the participation of representatives from Argentina, Jamaica, Panama, Peru, and Trinidad and Tobago to make recommendations to support financial sustainability and technical cooperation of the Center. A session was also held to select and appoint representatives to the BIREME Scientific Committee.

10. The third session of the Scientific Committee will be held in the second semester of 2017. The selected members are recognized specialists in the areas of information and knowledge management and related areas from Brazil, Colombia, Costa Rica, Cuba, Jamaica, and Mexico.

### ***Short-term Objectives for BIREME***

11. The- objectives include:
  - a) continuing negotiations with the Government of Brazil to finalize a Headquarters Agreement, which will contribute to the effectiveness of BIREME as an institution and strengthen the Center operationally and financially;
  - b) implementing the recommendations of the BIREME Advisory Committee, as agreed upon in the sixth session of the Committee on 2 February 2017;
  - c) holding the third session of the BIREME Scientific Committee in the second semester of 2017;

- d) holding the 10th edition of the Regional Congress on Information in Health Sciences (CRICS) in coordination with the host country;
- e) developing and implementing BIREME's Financial Resources Mobilization Plan, in accordance with PASB' internal policy for the Center's financial sustainability.

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

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. In a process of decentralization, the Center merged with the Women's Health unit in 2005, when it became the Latin American Center for Perinatology/Women's and Reproductive Health (CLAP/WR), and also began operating as a decentralized unit linked to the Department of Family, Gender and Life Course (FGL). The general objective of CLAP/WR is to promote, strengthen, and improve the capacities of the countries of the Region of the Americas with regard to health care for women, mothers, and newborns.

#### ***Recent Progress at CLAP/WR***

13. A comprehensive external evaluation of CLAP/WR was performed at the end of 2016. The final results of the evaluation confirm that, within the framework of national efforts made by the countries of Latin America and the Caribbean to improve access to and quality of care in the areas of maternal and neonatal health and sexual and reproductive health (SRH), CLAP/WR adds value and is widely recognized by the ministries of health of the Region as a valuable PAHO asset that boosts national response capacities. The technical cooperation provided through CLAP/WR is recognized as excellent and well adapted to the specific needs of the countries. CLAP/WR promotes working partnerships with regional actors (professional associations, nongovernmental organizations, United Nations agencies, donor agencies, organized groups, and others) and with PAHO units and departments. A positive aspect highlighted by the evaluation was the expansion of technical coordination to the countries of the English-speaking Caribbean, increasing from two countries served in the 2014-2015 biennium to 10 in the current biennium (2016-2017).

14. The evaluation concluded that there is a need to progressively strengthen CLAP/WR while seeking to optimize technical cooperation. As part of the recommendations, four scenarios were presented to strengthen the Center in a strategic and structured manner to ensure its sustainability. A 30-month time frame was established for FGL to establish specific short- and medium-term lines of work aimed at maximizing the technical cooperation provided by CLAP/WR. The evaluation emphasized that the international and regional commitments made in light of the 2030 Agenda for Sustainable Development provide an opportunity to progressively improve the effectiveness of technical cooperation. It is suggested that efforts should focus on countries' key priorities, while also strengthening advocacy in order to

contribute to the sustainability of national efforts in maternal and neonatal health and SRH.

15. CLAP's Basic Agreement signed between The Government of the Eastern Republic of Uruguay, the University of the Republic of Uruguay and PAHO expired on 28 February 2016. A new Basic Agreement for CLAP/WR's current institutional and strategic structure is being negotiated with the Government of the Eastern Republic of Uruguay.

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

16. PANAFTOSA is a PAHO center located in the Brazilian state of Rio de Janeiro. It was created in 1951 pursuant to an agreement subscribed between the Government of Brazil and PAHO. Its initial purpose was to execute the Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA Spanish acronym). In 2005, the zoonotic reference, research, and technical cooperation activities on food safety were transferred from the Pan American Institute for Food Protection and Zoonoses (INPPAZ) to PANAFTOSA.

#### ***Recent Progress at PANAFTOSA***

17. The Center had an administrative review in September 2016 and an external technical evaluation of PANAFTOSA is ongoing. The evaluation is expected to be completed in June 2017, and the evaluation report will be presented to the Director shortly.

18. With the support of PANAFTOSA, the surveillance, prevention, and control of rabies cases, both in humans and animals, have been strengthened in 18 countries (Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela).

19. In Haiti, the availability of human pre-exposure prophylaxis was increased within the country, following the donation of human rabies vaccines from Brazil and Paraguay. In addition, over 160 health professionals from 84 medical health centers in 63 municipalities were trained on the clinical case management of people attacked by dogs, in accordance with the protocols and guidelines recommended by PAHO/WHO, adapted to the country situation. Specific support was also provided for the development of a project proposal to eliminate dog-mediated rabies on the Island of Hispaniola (Dominican Republic and Haiti). Canine rabies surveillance has been strengthened in coordination with the United States Centers for Disease Control and Prevention.

20. With regard to Foot-and-mouth Disease (FMD), PANAFTOSA continues to coordinate PHEFA for eradication efforts. Currently, there is no evidence of FMD transmission among animals in South American countries, and no new outbreaks have been reported since April 2013.

***Cooperation Agreements and Resource Mobilization***

21. The annual contribution of the Ministry of Agriculture, Livestock, and Supply of Brazil (MAPA Portuguese acronym) fully covers the maintenance costs of the Center. In addition, PANAFTOSA has been able to mobilize voluntary contributions for FMD eradication in South America, and these contributions support the Center's technical cooperation for regional coordination of PHEFA. This has permitted PANAFTOSA to use regular financial resources for technical cooperation in zoonoses and food safety. The Center has also been able to mobilize voluntary contributions for food safety and zoonosis from government agencies in the animal health sector, including from Ecuador's Agricultural Quality Assurance Agency (Agrocalidad) and Paraguay's National Service for Animal Health and Quality (SENACSA Spanish acronym). Finally, PAHO, through PANAFTOSA, renewed the technical cooperation agreement signed with the Health Surveillance Secretariat (SVS)/Ministry of Health Brazil as well as one signed with the National Health Surveillance Agency (ANVISA Portuguese acronym) Brazil, both of which support foodborne and zoonotic diseases and food safety.

**Action by the Executive Committee**

22. The Executive Committee is invited to take note of this report and to formulate any recommendations it deems necessary.

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