Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

154th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 16-20 June 2014

Provisional Agenda Item 7.6

CE154/INF/6
7 May 2014
Original: English/Spanish*

PROGRESS REPORTS ON TECHNICAL MATTERS

CONTENTS

* Original in English: sections A, D, E, and F. Original in Spanish: sections B, C, and G.

A. STRATEGY AND PLAN OF ACTION ON CLIMATE CHANGE

Background

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

Update on Progress Achieved

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

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

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

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

6. ***Adaptation*** *(Support the evaluation of the population's vulnerability to climate change and identify adaptation interventions)*: PAHO supported countries in their vulnerability assessments under different projects and with several partners. Several countries include health in their national adaptation plans, and some have completed or started health sector-specific adaptation plans.

Action Necessary to Improve the Situation

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

Action by the Executive Committee

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

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

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

References

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

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

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

Introduction

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

Background

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

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

Situation Analysis

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

5. The national commissions prepared reports on elimination, endorsed by each country, and submitted them to the IEC through PAHO/WHO. These reports were carefully reviewed by the IEC, whose comments were channeled through PAHO/WHO for improvement and subsequent submission of a final version.

6. IEC members visited eight countries to study the progress made and to identify the challenges faced in maintaining elimination. Special monitoring required more than one visit and online sessions with national authorities in the countries that presented

sustained outbreaks of measles in the period 2011-2013, or that identified sporadic cases of rubella during retrospective searches.

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

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

a) Member States have documented the last case of endemic transmission of measles and rubella in their countries and territories. Subsequently reported cases were import-associated, according to epidemiological and molecular epidemiology data. The last endemic cases of measles and rubella in the Region occurred on 16 November 2002 and on 3 February 2009, respectively. The last endemic case of CRS was in a child born on 26 August 2009.

b) From 2003 to 2010, historically low numbers of (import-associated) measles cases were reported in the Americas, with an annual average of 156 cases and a total of 1,249 cases for this period. In 2011, 1,369 measles cases were reported—a figure almost nine times higher than the annual average reported from 2003 to 2010. In 2012, the number of cases decreased to 143, and in 2013, 473 cases were reported.[1] These peaks in measles case reporting coincide with widespread measles outbreaks in Europe and Africa.

c) There have been few import-associated rubella cases, with a total of 68 cases reported in seven countries for the period 2009–2013 (an average of 13 cases per year). In 2012, three import-associated cases of CRS were reported in the United States.

d) In the period 2009-2013, the Region, on average, met the targets for four of the five epidemiological surveillance indicators[2] (>80%) on a continuous basis (83-91%). The adequate investigation indicator was achieved only in 2011, since in several countries there were difficulties in visiting homes in the 48 hours following reports of suspected cases.

[1] Data for 2013 (as of 5 May 2014).

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

e) Given the differences among and within countries in terms of sustained achievement of surveillance indicators, 16 of 23 countries with national commissions carried out active institutional and community case-finding in the period 2010-2013, to document the absence of measles and rubella cases in their territories. These countries established criteria for identifying areas for active case-finding, such as municipalities not reporting suspected cases, areas with a heavy flow of tourists or migrants, areas experiencing population shifts, border regions, areas with low vaccination coverage, and the presence of at-risk ethnic groups.

f) For the same period and with the purpose of documenting the absence of CRS cases, 16 of 23 countries with national commissions carried out retrospective searches for suspected cases, using several sources of information. Criteria for selecting the institutions where the searches would be made included level of care and services provided, as well as being located in areas with unreliable notification of suspected CRS cases. In collaboration with national health authorities, scientific associations, and experts from international organizations such as PAHO, each country created an analysis unit for the review and final classification of the compatible cases found. No case of CRS was confirmed.

g) Since the presence of dengue cases in several countries could have masked measles and rubella cases, 15 of 23 countries with national commissions and the Caribbean subregional commission tested a percentage of samples from patients with exanthema for measles and rubella in areas where the dengue virus was circulating. The same was done with dengue-negative samples in areas where suspected cases of measles had been reported. None of the processed samples tested positive for measles or rubella.

h) Genotype D9 was isolated in the last endemic outbreak of measles reported in Colombia and Venezuela in 2002. Since 2003, countries have documented importation of measles cases by identifying viral genotypes. For the period 2009-2013, viruses of genotypes B3, D4, D5, D6, D7, D8, D9, G3, H1, and H2 were identified in 90% of cases. Genotypes D4 and D8, which mainly circulate in Europe, have been found in 88% of outbreaks; while genotype B3, which circulates mainly in Africa, was identified in the longest outbreak (Ecuador 2011-2012).

i) Rubella virus genotype 1C has been identified as endemic in the Americas, because it has not been found in other regions of the world. The last case of 1C transmission occurred in 2005. From 2006 to 2009, genotype 2B was isolated in outbreaks reported in three countries and is also considered endemic in the Region. For the period 2009-2013, reported genotypes 1E, 1G, 1J, and 2B have been linked to imported cases.

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

people aged 20–39). To complement the cohort analysis, 18 of 23 countries with commissions estimated the accumulation of susceptible individuals, prior to defining the target population for follow-up and speed-up campaigns. Latin American countries have carried out at least one follow-up campaign in the last five years.

9. At the fifth meeting of the IEC, Brazil presented the current epidemiological situation of the sustained measles outbreak affecting the states of Ceará and Pernambuco, where 379 cases have been confirmed for the period 2013-2014[3]. The date of rash onset was 19 March 2013 for the first case and 22 April 2014 for the latest case. The cases are distributed in 24 of 185 municipalities in Pernambuco and 12 of 184 municipalities in Ceará. Children under 1 year are the age group most affected by this outbreak (42%), in which genotype D8 has been identified. The country has conducted a vaccination campaign aimed at children under 5 in the affected states and has stepped up epidemiological surveillance as part of the attempt to interrupt this outbreak.

10. After reviewing the data presented in the elimination reports, including the data from the outbreak in Brazil, the IEC concluded at its fifth meeting that it will wait for solid evidence of interruption of the measles virus in Brazil, in order to declare the elimination of measles, rubella, and CRS in the Americas.

Sustainability of Measles, Rubella, and CRS Elimination

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

12. Maintaining elimination requires ≥95% coverage with two doses of MMR or MR[4] at the municipal level. The second dose of MR or MMR prevents the accumulation of susceptible children from reaching dangerous levels. In 2012, average coverage in the Region for the first dose (MMR1) was 94%, but only 77% for the second dose (MMR2). Bolivia, the Dominican Republic, Guatemala, Haiti, and Honduras have not introduced MMR2 into their routine immunization schedules, but do give a second dose in periodic follow-up campaigns (every 4–5 years). In order to achieve the highest possible coverage with MMR2, in 2013, the PAHO/WHO Technical Advisory Group (TAG) on Vaccine-preventable Diseases recommended administering MMR2 at 15–18 months, simultaneously with other vaccines in the regular program, such as the first booster of the diphtheria, tetanus, and whooping cough (DPT) vaccine.

13. Five countries implemented follow-up campaigns in 2012 and 2013, while eight countries will do so in 2014 and 2015. To ensure uniform coverage ≥95% in all

[3] Data to epidemiological week 18 (2014).

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

municipalities, all countries that have carried out campaigns have implemented rapid monitoring of vaccination. Countries that will be stepping up vaccination in high-risk areas will continue to use this methodology, making it possible to identify pockets of unvaccinated people that could otherwise be masked by average coverage figures reported by municipalities.

14. PAHO/WHO Member States have strengthened their surveillance systems to detect every case of measles or rubella that occurs. Epidemiological alerts have been issued for major international events such as the Soccer World Cup 2014 in Brazil and the U-20 World Cup in Colombia. Coordination has been strengthened with the private sector, including laboratories, because many import-associated measles and rubella cases have been detected in the private sector. Intersectoral work with institutions involved in tourism has also been strengthened, so that their workers are properly vaccinated. On the recommendation of their national commissions, at least four countries have evaluated their epidemiological surveillance systems, using PAHO/WHO guidelines, with special emphasis on "silent areas."

15. In order to strengthen national research capabilities and the timely control of outbreaks, PAHO/WHO developed and validated guidelines that collect lessons learned in the control of outbreaks in the post-elimination phase. The Organization also continues to provide technical assistance for follow-up training at subnational levels and for the formation and institutionalization of rapid response teams to deal with outbreaks.

Call to Action (Next Steps)

16. The president of the IEC will present the evidence indicating that measles, rubella, and CRS elimination has been achieved in the Americas, provided the data from Brazil is available. In addition, Member States and strategic partners will be called upon to continue their sustained commitment to maintaining elimination. To this end, the countries should:

a) Implement actions aimed at maintaining elimination and progressively integrate them into their annual immunization plans, in order to maintain continued political support and allocation of financial resources.

b) Continue implementing vaccination strategies (routine program, follow-up campaigns), to ensure high and uniform population immunity levels.

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

d) Disseminate the lessons learned from the process of documenting and verifying elimination, including actions to support elimination.

Action by the Executive Committee

17. The Executive Committee is invited to take note of this IEC report and to make any recommendations it deems appropriate in order to maintain measles and rubella elimination in the Region of the Americas.

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

Background

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

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

Progress Report

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

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

5. Information was obtained from 26 of the 27 countries; however, to measure the trend of the maternal mortality ratio (MMR), information was available from only 22 countries (Annex A).

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

a) The regional MMR (data from 22 countries) has fallen from 69.1 per 100,000 live births to 54.3, a reduction of 21.4%. One country presented data from sentinel institutions instead of national data.

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

c) The other impact indicator is for severe maternal morbidity (SMM). On the baseline, 10 countries reported monitoring SMM; today, 14 countries have national data. However, for nine of these countries the data does not appear to be coherent, based on the expected frequency of this event in relation to maternal mortality *(5)* (Annex B).

7. None of the countries is in a position to give a full report on all 19 process and outcome indicators. Since the beginning of the plan, only four of 24 countries gave responses concerning 80% or more of the requested indicators (Annex C). The indicators for which the least data are available are: *i)* use of magnesium sulfate in cases of severe preeclampsia (12%); *ii)* screening for family violence in institutional childbirth (23%); *iii)* proportion of use of oxytocics during the third stage of labor (35%); and *iv)* postpartum care (44%). Of these indicators, *i* and *iii* are highly important, since they are related to the two leading causes of maternal mortality (hypertensive disorders in pregnancy and hemorrhages). The rate of use of modern contraceptive methods was monitored in only 52% of the countries; many countries take this information from demographic and health surveys which, due to their frequency, have not been updated since the Plan began. These indicators are based solely on national information, in some cases broken down by age groups and in others by ethnic factors or by area of residence *(3, 4)*.

Recommended Measures to Improve the Situation

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

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

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

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

Action by the Executive Committee

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

Annexes

References

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

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

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

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

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

Annex A

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

COUNTRY	Maternal mortality ratio (100,000)	Year	Maternal mortality ratio (100,000)	Year
Argentina	39,8	2011	34,9	2012
Belize	41,8	2012	0,0	2013
Bolivia	229,0	2003		
Brazil	64,7	2011		
Canada	7,6	2009		
Chile	17,9	2012	22,6	2013
Colombia	71,6	2010	53,6	2013
Costa Rica	30,0	2012	15,6	2013
Cuba	33,4	2012	38,9	2013
Dominican Republic	106,3	2011	113,0	2012
Ecuador	58,5	2012	40,0	2013
El Salvador	50,8	2011	38,0	2013
Guatemala	123,5	2012	118,5	2013
Guyana	143,9	2012	111,1	2013
Haiti §	1084,4	2012	211,8	2013
Honduras	82,3	2011	66,1	2013
Jamaica	95,7	2011	91,1	2013
Mexico	43,0	2011	39,9	2013
Nicaragua	61,9	2011	51,0	2013
Panama	80,5	2011	64,9	2012
Paraguay	88,7	2011	95,3	2013
Peru	93,4	2011	63,4	2013
Suriname	82,4	2011	39,2	2013
United States of America	16,9	2010		
Uruguay	6,4	2011	16,4	2013
Venezuela	65,9	2011	66,1	2013

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

Countries whose MMR has increased

Countries whose MMR has decreased

No data

Annex B

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

Country	MMR	MM by cause	MM by age	Severe Maternal Morbidity (SMM)	SMM by cause	SMM by age	MMR by subnational level	MMR by urban/ rural area	MMR by ethnic group	Reporting rate (%)
Argentina	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Belize	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Bolivia	NO	YES †	YES ‡	YES *	YES **	NO	NO	NO	NO	44%
Brazil	YES	YES	YES	NO	NO	NO	YES	NO	YES	56%
Canada	YES	YES	YES	YES *	YES	YES	YES	YES	NO	89%
Chile	YES	YES	YES	YES *	YES **	YES	YES	YES	YES	100%
Colombia	YES	YES	YES	YES	YES	YES	YES	YES	YES	100%
Costa Rica	YES	YES	YES	YES	YES	YES	YES	YES	YES	100%
Cuba	YES	YES	YES	YES	NO	NO	YES	YES	YES	78%
Dominican Republic	YES	YES	YES	NO	NO	NO	YES	NO	NO	44%
Ecuador	YES	YES	YES	NO	NO	NO	YES	NO	NO	44%
El Salvador	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Guatemala	YES	YES	YES	YES *	YES	YES	YES	NO	YES	89%
Guyana	NO	YES	YES	YES *	NO	NO	YES	YES	YES	67%
Haiti	YES §	NO	NO	YES	YES **	NO	YES	YES	YES	67%
Honduras	YES	YES	YES	YES *	YES **	YES	YES	NO	NO	78%
Jamaica	YES	YES †	YES	YES	YES **	NO	YES	YES	YES	89%
Mexico	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Nicaragua	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Panama	YES	YES	YES	NO	NO	NO	YES	NO	YES	56%
Paraguay	YES	YES	YES	NO	NO	NO	YES	YES	YES	67%
Peru	YES	YES †	YES ‡	NO	YES **	NO	NO	NO	NO	44%
Suriname	YES	YES	YES	YES	YES	YES	NO	NO	NO	67%
United States of America	NO	NO	NO	NO	NO	NO	YES	YES	YES	33%
Uruguay	YES	YES	YES	YES	YES **	YES	YES	YES	YES	100%
Venezuela	YES	YES	YES	YES *	YES **	NO	YES	NO	YES	78%
Reporting rate (%)	88%	92%	92%	54%	50%	31%	88%	62%	73%	
Number of countries	23	24	24	14	13	8	23	16	19	

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

§ reports only selected institutions; does not correspond to population data

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

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

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

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

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

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

Country	Rate of use of contraceptive methods	Postpartum and/or post-abortion contraceptive counseling and provision of contraceptives by health services	Percentage of maternal deaths due to abortion	Prenatal coverage with 4 or more check-ups	Institutional coverage of deliveries	Post-partum check-up 7 days after delivery	Use of oxytocics during the third stage of labor in institutional births	Use of magnesium sulfate in cases of severe preeclampsia/ eclampsia in health facilities	Safe blood in facilities that provide emergency obstetric care	Screening for family violence during pregnancy (in institutional childbirth)
Argentina	X	X	X	X	X	-	X	X	X	X
Bolivia	-	X	X	X	X	X	-	-	-	-
Brasil	X	-	-	X	-	X	X	-	X	X
Chile	X	X	X	-	X	X	-	-	-	-
Colombia	-	-	X	X	X	-	-	-	-	-
Costa Rica	X	-	X	X	X	X	X	-	X	-
United States of America	-	-	-	X	-	-	-	-	X	-
Suriname	-	X	X	X	X	-	-	-	X	-
Cuba	-	X	X	X	X	X	-	-	X	-
Guatemala	X	-	X	X	X	-	-	-	-	-
Dominican Republic	-	X	X	-	X	X	-	-	-	-
Ecuador	-	-	X	-	X	-	-	-	-	-
El Salvador	-	X	X	-	X	X	X	-	X	-
Guyana	X	-	-	X	-	-	-	-	X	-
Haiti	X	-	-	X	X	X	-	-	X	-
Jamaica	X	X	X	X	X	-	X	-	X	-
Honduras	X	X	X	X	X	X	-	-	X	-
Mexico	-	-	X	X	X	-	-	-	X	-
Paraguay	-	X	X	-	X	-	-	-	-	X
Canada	-	-	X	-	X	-	X	X	-	X
Nicaragua	X	X	X	X	X	X	X	X	X	-
Belize	X	X	X	-	X	-	X	-	X	-
Uruguay	-	X	X	X	X	-	X	-	X	X
Venezuela	X	-	X	-	X	X	-	-	X	-
Peru	X	-	X	X	X	X	-	-	X	X
Number of countries that submit reports	**13**	**13**	**21**	**17**	**22**	**12**	**9**	**3**	**17**	**6**
%	**52%**	**52%**	**84%**	**68%**	**88%**	**48%**	**36%**	**12%**	**68%**	**24%**

Annex C *(cont.)*

Country	Caesarean section rate	Maternal deaths due to obstructed labor	Coverage of childbirth care provided by skilled personnel, as defined by WHO	Coverage of postpartum care provided by skilled personnel, as defined by WHO	Emergency obstetric care facilities that perform an audit of all maternal deaths	Public reports on maternal health that include national statistics on maternal mortality and the MMR	Health system has a functioning perinatal information system	Health system keeps records of severe maternal morbidity	Coverage of maternal deaths in vital record systems is 90% or more	Number of indicators per country	Total % per country
Argentina	X	X	X	X	X	X	X	X	X	**18**	95%
Bolivia	X	X	X	-	-	X	X	X	-	**11**	58%
Brasil	X	X	X	-	X	X	X	X	X	**14**	74%
Chile	X	X	-	-	-	X	X	X	X	**11**	58%
Colombia	X	X	X	-	-	X	X	X	X	**10**	53%
Costa Rica	X	X	X	X	X	X	X	X	X	**16**	84%
United States of America	X	-	X	-	-	X	X	X	X	**8**	42%
Suriname	X	X	X	-	X	X	X	X	X	**13**	68%
Cuba	X	X	X	X	X	X	X	X	X	**15**	79%
Guatemala	X	X	X	-	-	-	-	X	-	**8**	42%
Dominican Republic	X	X	X	-	X	X	X	X	X	**12**	63%
Ecuador	X	X	X	-	-	X	X	X	X	**9**	47%
El Salvador	X	X	X	X	X	X	X	X	X	**15**	79%
Guyana	X	X	X	X	X	X	X	X	X	**12**	63%
Haiti	X	-	-	-	-	X	X	X	-	**9**	47%
Jamaica	X	X	-	-	X	X	X	X	X	**14**	74%
Honduras	X	-	X	X	X	X	X	X	X	**15**	79%
Mexico	X	X	-	-	X	X	X	X	X	**11**	58%
Paraguay	X	X	X	-	-	X	X	X	X	**11**	58%
Canada	X	X	X	-	-	X	X	X	X	**12**	63%
Nicaragua	X	X	X	X	X	X	X	X	X	**18**	95%
Belize	X	X	X	X	X	X	X	X	X	**15**	79%
Uruguay	X	X	X	X	X	X	X	X	X	**16**	84%
Venezuela	-	X	X	X	X	X	X	X	X	**13**	68%
Peru	X	-	X	-	-	X	X	X	-	**12**	63%
Number of countries that submit reports	**24**	**21**	**21**	**10**	**15**	**24**	**24**	**25**	**21**		
%	**96%**	**84%**	**84%**	**40%**	**60%**	**96%**	**96%**	**100%**	**84%**		

D. IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS

1. The purpose of this report is to provide an update on the status of the implementation of the International Health Regulations (IHR; hereafter also referred to as the "Regulations"). It updates the last report presented in 2013 to the 152nd Session of the Executive Committee *(1)* and highlights issues requiring concerted action by States Parties in the Region of the Americas for the future implementation of the Regulations.

2. The Pan American Health Organization (PAHO) serves as the World Health Organization (WHO) IHR Contact Point for the Region of the Americas and facilitates the management of public health events though the established communication channels with the National IHR Focal Points (NFP). In 2013, all 35 States Parties in the Region submitted an annual confirmation or update of the contact details for their NFP. Routine connectivity tests, performed in 2013, between the WHO IHR Contact Point and the NFP in the Region were successful for 33 of the 35 States Parties (94%) by e-mail, and for 32 of the 35 States Parties (91%) by telephone.

3. In the period from 1 January to 31 December 2013, a total of 82 public health events of potential international concern were identified and assessed in the Region. For 54 of the 82 events (66%), national health authorities, including through the NFP on 40 occasions, were the initial source of information. Verification was requested and obtained for 13 events identified through informal or unofficial sources. Of the 82 events considered, 40 (49%), affecting 20 States Parties in the Region, were of substantiated international public health concern. The largest proportion of these 40 events was attributed to infectious hazards (20 events, 50%), and the etiologies most frequently recorded were dengue viruses (3 events) and chikungunya virus (3 events). The remaining 20 events of substantiated international public health concern were attributed to the following hazards: food safety (7), product-related (5), undetermined origin (4), zoonosis-related (2), chemical (1), and radiation-related (1).

4. Significant public health events that affected, or had public health implications for, States Parties in the Americas in 2014 (1 January-6 May 2014) are highlighted below:

a) Chikungunya virus was detected in December 2013 in the Caribbean subregion. As of 6 May 2014 this virus has spread to seven States Parties and nine territories in the Caribbean subregion, with autochthonous transmission documented in 14 of these 16 States Parties and territories.

b) The first imported case of Middle East respiratory syndrome coronavirus (MERS-CoV) infection in the Region was detected in the United States in May 2014. In response to the spread of MERS-CoV, which started in 2012 and is still occurring mainly in the Eastern Mediterranean Region, the Director-General of

WHO (DG) convened the "IHR Emergency Committee concerning Middle East respiratory syndrome coronavirus" (MERS-CoV IHR EC). Between July and December 2013, the MERS-CoV IHR EC met four times, and the advice provided did not determine the declaration of a Public Health Emergency of International Concern (PHEIC) by the DG.

c) Three States Parties (Cameroon, Pakistan, and Syria) are exporting wild poliovirus. In addition, seven States Parties (Afghanistan, Equatorial Guinea, Ethiopia, Iraq, Israel, Nigeria, and Somalia) are currently infected with wild poliovirus but not currently exporting. Given the seriousness of the situation, the DG convened the "IHR Emergency Committee concerning the international spread of wild poliovirus" (Polio IHR EC). Following the first meeting of the Polio IHR EC on 28-29 April 2014, the DG determined the international spread of wild poliovirus a PHEIC, and temporary recommendations were formulated accordingly. PAHO advised States Parties in the Americas to continue applying the recommendations by the Technical Advisory Group on Vaccine-preventable Diseases to maintain the Americas free of wild poliovirus.

5. Pursuant to Articles 5 and 13 of the IHR, and subsequent to the request for extension and the submission of National IHR Extension Action Plans 2012-2014 in June 2012, 29 of the 35 States Parties of the Americas (83%) were granted an extension, until 15 June 2014. This was intended to give countries more time to establish core capacities detailed in Annex 1 of the Regulations. The deadlines related to core capacities stipulated in the IHR should be regarded more as milestones in an ongoing public health preparedness process and as an incentive for national authorities to secure resources to maintain core capacities. These target dates are, nevertheless, challenging to meet.

6. Therefore, in compliance with the above-mentioned IHR provisions that allow the target date to be further extended to 15 June 2016, and following approval by the WHO Executive Board in its 134th session of the criteria related to the potential request for an additional extension, all 35 States Parties in the Region were invited to formally communicate their position vis-à-vis the potential additional extension no later than 15 April 2014. Through virtual and face-to-face meetings, PAHO accompanied States Parties in their decision-making process related to the potential additional 2014-2016 extension.

7. As of 6 May 2014, 29 of the 35 States Parties in the Region (83%) formally communicated to PAHO and WHO their position vis-à-vis the potential additional 2014-2016 extension. Of these, 21 States Parties requested the extension, and all but two of the 21 submitted National IHR Extension Action Plans 2014-2016; six States Parties that were granted the 2012-2014 extension have determined that the core capacities were present and could be maintained. Two States Parties, which in 2012 had determined that the core capacities were present, have reiterated their ability to maintain them. PAHO and WHO are conducting an ongoing technical review of the National IHR Extension Action Plans 2014-2016 that have been submitted.

8. The requests for extension and the National IHR Extension Action Plans 2014-2016 submitted will be considered by an IHR Review Committee that will be convened to advise the Director-General of WHO on the extension-granting process, expected to be concluded by 15 June 2014. A summary of the requests submitted by States Parties for the additional 2014-2016 extension is presented in the table attached as an annex.

9. States Parties Annual Reports submitted to the World Health Assemblies between 2011 and 2014 showed steady improvements at the regional level for most of the core capacities. However, the status of the core capacities across the subregions continues to be heterogeneous, as highlighted in the States Parties Annual Reports submitted. As of 6 May 2014, 33 of 35 States Parties in the Americas (94%) have reported to the Sixty-seventh World Health Assembly.

10. When these recent reports are compared to the States Parties Annual Reports submitted to the Sixty-sixth World Health Assembly, the data show States Parties making progress in a number of core capacities. The most significant areas of progress are, in descending order, legislation, policy, financing (+14%); preparedness (+13%); radiation-related events (+12%); risk communication (+12%); human resources (+11%); coordination and communication with the NFP (+9%); zoonotic events (+8%); and chemicals-related events (+7%). No substantial changes are observed for the remaining five capacities. A summary of the Annual Reports submitted by States Parties in the Americas to the 67th World Health Assembly is provided in the Annex.

11. Despite progress made, the most critical weaknesses observed in the Region—with scores below 60%—are still related to the capacities to prepare for and respond to chemicals-related (55%) and radiation-related events (53%). PAHO continues to intensify joint efforts with other international specialized agencies (e.g., the International Atomic Energy Agency) and partners with relevant expertise in the Region (e.g., the WHO Collaborating Centre for Prevention, Preparedness and Response to Chemical Emergencies at the Companhia Ambiental do Estado de São Paulo, Brazil, and the Public Health Agency of Canada) to support the efforts of States Parties in the Region to attain these capacities.

12. Core capacities at designated points of entry and compliance with other relevant IHR provisions have been strengthened through the partnership with the International Civil Aviation Organization. This has also been supported under the umbrella of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA). The Fifth CAPSCA Americas Meeting was held in Barbados on 2-6 September 2013. The initial interactions with the Inter-American Committee on Ports of the Organization of American States are also promising in terms of efforts to support national authorities in their efforts to establish an effective intersectoral approach to public health at ports.

13. As of 6 May 2014, 484 authorized ports in 27 States Parties in the Region of the Americas were authorized to issue Ship Sanitation Certificates *(2)*. Through the NFP, States Parties were invited to provide their comments to the procedures proposed by WHO headquarters for the voluntary certification of designated airports and ports.

14. Twenty-nine of the 35 States Parties in the Region provided contributions to the 2014 update of the WHO publication "International Travel and Health" *(3)* in a broadly participatory process. Several virtual meetings between PAHO and national authorities of selected countries were held in order to discuss the mapping of the risk for yellow fever transmission as well as yellow fever vaccination requirements and recommendations for travelers.

15. The WHO Strategic Advisory Group of Experts on Immunization recommended in 2013 that a single dose of yellow fever vaccine is sufficient to confer sustained immunity and lifelong protection against yellow fever disease and that a booster dose of the vaccine is not needed. This recommendation led to Resolution EB134.R10, "Implementation of the International Health Regulations (2005)," by the 134th WHO Executive Board session, on the amendment of Annex 7 of the IHR, recommending its adoption by the 67th World Health Assembly *(4)*.

16. As of 6 May 2014, the IHR Roster of Experts included 407 experts, 111 of whom are from the Region of the Americas, including eight designated by the respective State Party.

17. An important IHR-related recent achievement in the Region was the unanimous approval of Decision CD52(D5), "Implementation of the International Health Regulations," by the 52nd Directing Council of PAHO, 65th Session of the WHO Regional Committee for the Americas *(5)*. This signaled substantially increased ownership, commitment, and leadership by States Parties in the Region, which should be nurtured to maintain the IHR as a relevant framework for global health security beyond 2016.

18. In compliance with the request by States Parties through Decision CD52(D5), PAHO organized the "Regional Meeting in the Americas on the Implementation of the International Health Regulations (IHR)," in Buenos Aires, Argentina, on 29-30 April 2014. The meeting focused on the monitoring and reporting of IHR implementation status after 2016. The meeting led to the agreement, in principle, on a road map for the Americas for reviewing the IHR implementation monitoring mechanisms at global level through the PAHO and WHO Governing Bodies.

19. A significant challenge for the implementation of the IHR in the foreseeable future is related to the lack of satisfactory metrics to demonstrate the actual benefits from their implementation as well as progress made toward their sustainable implementation.

Action by the Executive Committee

20. The Executive Committee is invited to take note of this report and provide any recommendations it may have.

Annex

References

1. Pan American Health Organization. Implementation of the International Health Regulations [Internet]. 152nd Session of the Executive Committee; 2013 Jun 17-21, Washington (DC), US. Washington (DC): PAHO; 2013 (Document CE152/INF/7-H, Rev.1) [cited 2014 May 6]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=21610&Itemid=270&lang=en

2. World Health Organization IHR list of authorized ports [to issue Ship Sanitation Certificates] [Internet]. Geneva: WHO; 2014 [cited 2014 May 6]. Available from: http://who.int/ihr/ports_airports/ihr_authorized_ports_list.pdf?ua=

3. World Health Organization. International travel and health [Internet]. Geneva: WHO; c2014 [cited 2014 May 6]. Available from: http://www.who.int/ith/en/

4. World Health Organization. Implementation of the international health regulations (2005) [Internet]. 134th Session of the Executive Board; 2014 Jan 20-25, Geneva (Switzerland). Geneva: WHO; 2014 (Resolution EB134.R10) [cited 2014 May 6]. Available from: http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_R10-en.pdf

5. Pan American Health Organization. Implementation of the international health regulations [Internet]. In: Final Report, 52nd Directing Council of PAHO, 65th Session of the Regional Committee of WHO for the Americas; 2013 Sep 30-Oct 4, Washington (DC), US. Washington (DC): PAHO; 2013. p. 92-93 (Decision CD52[D5]) [cited 2014 May 6]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=24484&Itemid=270&lang=en

Annex

Summary Table: States Parties Annual Reports to the 67th World Health Assembly and Status of Requests for an Additional Extension (2014-2016) for Establishing IHR Core Capacities

State Party	Requested and obtained 2012-2014 extension	Formally communicated position vis-à-vis 2014-2016 extension	Requested 2014-2016 extension	Submitted the State Party Annual Report to 67th WHA	Legislation, policy, financing	Coordination and communication NFP	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Antigua and Barbuda	Yes	Yes	Yes	Yes	100	66	95	65	50	57	100	45	86	100	80	85	23
Argentina	Yes	Yes	No	Yes	50	73	80	83	100	86	100	90	27	100	60	69	62
Bahamas		Yes	Yes	No	-	-	-	-	-	-	-	-	-	-	-	-	-
Barbados	Yes	Yes	Yes	Yes	100	53	100	89	90	86	60	96	100	100	73	54	15
Belize	Yes	Yes	Yes	Yes	25	56	85	82	26	57	40	73	12	67	27	15	0
Bolivia (Plurinational State of)	Yes	Yes	Yes	Yes	100	87	85	65	41	71	40	96	21	89	53	15	69
Brazil	No	No	-	Yes	100	90	90	100	90	100	80	96	80	89	93	62	92
Canada	No	No	-	Yes	100	83	100	100	100	100	100	100	100	100	100	100	100
Chile	No	No	-	Yes	75	100	90	89	100	43	20	86	46	89	93	31	92
Colombia	No	Yes	No	Yes	100	63	50	76	33	100	80	76	83	89	67	77	69
Costa Rica	No	Yes	No	Yes	100	100	95	100	71	100	80	76	97	100	100	77	62
Cuba	Yes	No	-	Yes	100	100	95	100	100	100	100	100	100	100	100	92	100
Dominica	Yes	Yes	Yes	Yes	75	100	72	83	62	100	25	37	75	100	86	46	31
Dominican Republic	Yes	Yes	Yes	Yes	75	90	75	76	81	100	100	90	64	56	27	31	69
Ecuador	Yes	Yes	Yes	Yes	25	56	60	23	18	14	40	41	59	78	53	15	92
El Salvador	Yes	Yes	No	Yes	100	100	100	100	90	100	100	100	90	100	67	54	69
Grenada	Yes	Yes	Yes	Yes	75	83	85	64	16	57	60	45	50	100	67	46	0
Guatemala	Yes	Yes	No	Yes	50	100	100	94	100	100	100	75	54	100	100	100	67
Guyana	Yes	Yes	Yes	Yes	100	83	80	100	90	86	100	100	38	100	67	62	0
Haiti	Yes	Yes	Yes	Yes	25	46	95	76	20	100	60	60	21	67	20	0	0
Honduras	Yes	Yes	Yes	Yes	75	56	90	64	43	0	75	66	9	100	40	31	23
Jamaica	Yes	Yes	Yes	Yes	100	66	70	87	71	57	20	47	62	67	67	62	23
Mexico	Yes	Yes	No	Yes	100	70	95	89	90	71	100	100	89	100	93	69	92
Nicaragua	Yes	Yes	No	Yes	100	83	100	82	90	100	60	86	68	100	80	92	100
Panama	Yes	Yes	Yes	Yes	75	83	95	83	70	71	40	96	71	89	87	23	38
Paraguay	Yes	Yes	Yes	Yes	100	90	70	83	53	100	60	100	34	67	73	69	77
Peru	Yes	Yes	Yes	Yes*	-	-	-	-	-	-	-	-	-	-	-	-	-
Saint Kitts and Nevis	Yes	Yes	Yes	Yes	50	83	80	89	36	57	60	81	45	100	67	8	0
Saint Lucia	Yes	No	-	No	-	-	-	-	-	-	-	-	-	-	-	-	-
Saint Vincent and the Grenadines	Yes	Yes	Yes	Yes	50	83	80	89	36	57	60	81	45	100	67	8	0
Suriname	Yes	Yes	Yes	Yes	50	83	85	89	48	43	0	100	84	67	87	62	0
Trinidad and Tobago	Yes	Yes	Yes	Yes	50	40	95	76	71	71	20	81	77	89	87	54	77
United States of America	No	No	-	Yes	100	100	100	94	100	100	100	50	100	100	100	100	100
Uruguay	Yes	Yes	No	Yes	100	83	100	94	81	100	100	71	91	100	100	69	62
Venezuela (Bolivarian Republic of)	Yes	Yes	Yes	Yes	50	90	90	94	80	71	100	86	59	100	87	92	92
Caribbean (n=13)**					69	72	86	84	55	71	54	73	61	89	69	46	21
Central America (n=7)***					82	87	94	86	78	82	79	84	65	92	72	58	61
South America (n=9)****					78	81	79	79	66	76	69	82	56	89	75	55	79
North America (n=3)*****					100	84	98	94	97	90	100	83	96	100	98	90	97
Region of the Americas (n=32)					77	79	87	84	67	77	68	79	64	91	74	55	53

* Due to late submission, data from Peru not included in the analaysis performed on 6 May 2014

**Caribbean: Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago

***Central America: Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama

****South America: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela

*****North America: Canada, Mexico, United States

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

Background

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

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

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

Update on Progress Achieved

Progress

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

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

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

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

8. Cases of dog-transmitted rabies are delimited to a small number of well-defined geographic areas in a few countries. Since 1982, when the Regional Program for the Elimination of Human Rabies began, reported cases of rabies transmitted by dogs have decreased by ~95% (from 355 in 1982 to 10 in 2012) *(1).* Though only six countries

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

reported cases between 2009 and 2012, and although the number of annual human fatalities remains low *(1)*, persistent pockets of transmission remain, leading to a sustained risk of infection for people in the Region. In Latin America, prevention of house-to-house transmission and prevention of human deaths from plague have been strengthened in the four countries with human cases and natural foci. Between 2010 and 2012, in Latin America only Peru reported confirmed cases of human plague (24 cases with some fatalities). A few suspect cases were reported in Bolivia *(4)*; and sporadic cases were reported in the USA through 2013.

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

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

Lessons Learned:

11. Among the principal lessons learned, we note:

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

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

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

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

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

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

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

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

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

Action Necessary to Improve the Situation

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

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

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

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

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

Action by the Executive Committee

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

References

1. Clavijo A, Del Rio Vilas VJ, Mayen FL, Yadon ZE, Beloto AJ, Natal Vigilato MA, et al. Gains and future road map for the elimination of dog-transmitted rabies in the Americas (Perspective Piece) [Internet]. *Am J Trop Med Hyg* 2013;89(6):1040-1042 [cited 2014 Apr 23]. Extract available from: http://www.ajtmh.org/content/89/6/1040.extract

2. World Health Organization. World malaria report: 2012 [Internet]. Geneva: WHO; 2012 [cited 2014 Apr 23]. Available from: http://www.who.int/malaria/publications/world_malaria_report_2012/en/

3. World Health Organization. Soil-transmitted helminthiases: number of children treated in 2012 [Internet]. *WHO Weekly Epidemiological Record No. 13* 2014; 89:133-140 [cited 2014 Apr 23]. Available from: http://www.who.int/wer/2014/wer8913.pdf?ua=1

4. Schneider MC, Najera P, Aldighieri S, Galan DI, Bertherat E, Ruiz A, et al. Where does human plague still persist in Latin America? [Internet]. *PLoS Negl Trop Dis* 2014;8(2):1-14. [cited 2014 Apr 23]. Available from: http://www.plosntds.org/article/info%3Adoi%2F10.1371%2Fjournal.pntd.0002680

5. Pan American Health Organization. Strategy and plan of action for the elimination of mother-to-child transmission of HIV and congenital syphilis: mid-term evaluation [Internet]. 52nd Directing Council of PAHO, 65th Session of the WHO Regional Committee for the Americas; 2013 Sep 30-Oct 4; Washington (DC), US. Washington (DC): PAHO; 2013 (Document CD52/INF/4-B) [cited 2014 Apr 28]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=22576&Itemid=270&lang=en

6. Pan American Health Organization. Pertusis/diphtheria/tetanus/mumps data final classificartion, 2011-2012 [Internet]. In: Immunization Newsletter 2013 Apr vol. 35, no. 2, p.7. Washington (DC): PAHO; 2013. [cited 2014 Apr 23]. Available from: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&cad=rja&uact=8&ved=0CCkQFjAB&url=http%3A%2F%2Fwww.paho.org%2Fhq%2Findex.php%3Foption%3Dcom_docman%26task%3Ddoc_download%26gid%3D23412%26Itemid%3D&ei=pSlYU5nrHq7hsAS_n4CoBA&usg=AFQjCNFEAZuhbig9X7ltAI3oTPVvcdikMg

F. PLAN OF ACTION ON SAFE HOSPITALS

Background

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

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

Update on Progress Achieved

Progress toward the goals

Objective	*Goals*	*Status*
1	By 2011, 80% of the countries will have established a national safe hospitals program.	26 countries (74%) include disaster risk reduction in the health sector; 20 countries (51%) have a national safe hospitals policy; and 17 countries (49%) have a formal safe hospitals program.
2	By 2013, 90% of the countries will have an information system on the construction of new hospitals or the improvement of existing hospitals.	31 countries (89%) apply the Hospital Safety Index to assess hospital safety from disasters. At least 10 countries (29%) have an online system for integrated management of health facilities' information.
3	By 2013, at least 80% of the countries in the Region will have established mechanisms for the supervision of hospital construction work and other investments in health facilities.	12 countries (34%) have formally established independent supervision mechanisms for hospital construction.
4	By 2015, all countries will have included	9 countries with new health

Objective	*Goals*	*Status*
	measures that guarantee the operation of health facilities in the event of a disaster in all new health investment projects.	investment projects have included safe hospital concepts in them.
5	By 2015, 90% of the countries will have up-to-date standards for the design, construction, and operation of new, safe health facilities.	17 countries (49%) have up-to-date standards for the design of safe health facilities.
6	By 2015, at least 90% of the countries will have improved the safety of the existing health facilities in disasters.	34 countries (97%) are improving the safety of their health facilities by implementing disaster reduction interventions.

Challenges and Lessons Learned

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

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

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

d) Strengthening multisectoral participation of stakeholders both within and outside the health sector is critical for achieving success. For example, the countries with greater success in implementing the Safe Hospitals Initiative[6] are those where the national disaster management organization assumed an active role along with the health sector.

Action Necessary to Improve the Situation

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

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

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

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

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

Action by the Executive Committee

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

G. STATUS OF THE PAN AMERICAN CENTERS

Introduction

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

Background

2. The Pan American Centers have been an important modality of PAHO technical cooperation for almost 60 years. In that period, PAHO has created or administered 13 centers,[7] eliminated nine, and transferred the administration of one to its own governing bodies. This document presents up-to-date information on the Pan American Foot-and-Mouth Disease Center (PANAFTOSA); the Latin American and Caribbean Center on Health Sciences Information (BIREME); and the Latin American Center for Perinatology/Women's and Reproductive Health (CLAP/WR).

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

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

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

initiatives be implemented with improved interagency cooperation and with the coverage and continuity required to achieve their objectives, targets, and results.[8]

Recent Progress

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

5. With regard to food safety, a growing number of institutions in the Region are now contributing to regional intersectoral food safety networks for the prevention of foodborne diseases (e.g. the Inter-American Network of Food Analysis Laboratories (INFAL), the Global Foodborne Infections Network (GFN) and the PulseNet Latin America and Caribbean network); in particular, they are addressing the impact of antimicrobial resistance and promoting an integrated approach involving different actors and sectors (e.g. human and veterinary medicine, agriculture, and environmental and consumer sectors). The PulseNet Latin America and Caribbean network received the IHRC[9] PulseNet Innovations Award in 2013 "in recognition of [the] innovative use of instructional technology with the potential to significantly enhance the functionality of PulseNet in outbreak investigations". The challenge is now to maintain PAHO's excellence and relevance within the context of budgetary reductions in this area, while continuing to innovate and mobilize new resources. In addition, PANAFTOSA has been leveraging its unique technical capacity within PAHO to strengthen the collaboration between the World Health Organization (WHO), the Food and Agriculture Organization of the United Nations (FAO), and OIE for combatting antimicrobial resistance, in the spirit of the "One Health" approach.

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

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

[9] International Health Resources Consulting, Inc.

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

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

Cooperation Agreements and Resource Mobilization

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

9. PAHO, through PANAFTOSA and the Secretariat for Health Surveillance of the Ministry of Health of Brazil, signed an annex to the technical cooperation agreement in 2012, contributing US$ 1,618,914[10] to strengthen the National Health Surveillance System and the management capacity of Brazil's Unified Health System in order to reduce the burden of zoonosis and of vector-borne, waterborne, and foodborne diseases on the human population. The technical cooperation agreement was renewed in 2013 and the amount of US$ 4,918,409 was added—a threefold increase since 2012. Other technical cooperation and financial agreements have been established with the Wellcome Trust (Sanger Institute) to build the professional capacity of health workers, and faculty and students of health-related professions such as medicine, microbiology, veterinary medicine, and nursing; with the Joint Institute for Food Safety and Applied Nutrition (JIFSAN) for cooperation on food safety; and with the Association of American

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

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

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

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

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

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

13. BIREME's governance structures currently include the Advisory Committee and the Scientific Committee (new framework), in addition to the National Advisory Committee (CAN) (previous framework).

14. PAHO and Brazil are permanent members of the BIREME Advisory Committee, which also comprises five nonpermanent members. The 28th Pan American Sanitary Conference selected Cuba, Ecuador, and Puerto Rico for the BIREME Advisory Committee, with a three-year mandate (2013-2015), replacing Argentina, Chile, and the Dominican Republic, whose mandates ended in 2012. The 51st Directing Council selected Bolivia and Suriname (2012-2014), replacing Jamaica and Mexico, whose mandates ended in 2011. The members of the Advisory Committee have held four working sessions since it was established.

15. The Scientific Committee was established in July 2013 and is made up of five health information experts from five countries: Brazil, Canada, Honduras, Trinidad and Tobago, and the United States. The members of the Scientific Committee have held one working session since it was established. In the context of the objectives and expected results of the Committee, a virtual meeting was also held to strengthen communication among the members.

Recent Progress

16. The session to establish the BIREME Scientific Committee was held on 25 July 2013 in the city of São Paulo, Brazil, and attended by representatives of Brazil, Honduras and Trinidad and Tobago; Canada and the United States of America participated by remote link.

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

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

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

b) Agreement on BIREME's facilities and operations on the UNIFESP campus: Several meetings were held with the president of the university and with designated authorities on the subject of the institutional relationship between BIREME and UNIFESP, as well as the terms of the agreement. It is expected that meetings will be held in 2014 to monitor this process, including those requested by the president, focusing on a detailed review of the mutual responsibilities of BIREME and UNIFESP. However, signing of the agreement remains subject to the signing of the Headquarters Agreement with the Government of Brazil, cited in the previous paragraph.

c) Definition of the financing mechanism for BIREME based on the contributions from PAHO and the Government of Brazil, stipulated in article 6 of the Statute: Regular contributions will be defined by mutual consent to support the approved biennial work plans, in accordance with the provisions of the Statute. The results obtained by the Center in the last 18 months were presented at the second meeting of the National Advisory Committee (CAN) on the BIREME Maintenance and Development Agreement, held on 23 January 2014 at PAHO/WHO Brazil. The corresponding report was approved by representatives of the Ministry of Health of Brazil, the Secretariat of Health of the State of São Paulo (SES-SP), and

UNIFESP. It is estimated that the Ministry's contribution to the maintenance and financing of the BIREME work plan for 2015 will be the same amount as in 2014: $3.8 million reais (approximately $1.5 million). This sum will be transferred to PAHO through a supplementary agreement to the BIREME Maintenance and Development Agreement, which is in the authorization process.

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

Challenges

19. The upcoming challenges in this period include:

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

b) expanding the BIREME Maintenance and Development Agreement if the new institutional framework is not completely established in 2014; and

c) holding negotiations for the prompt signing of the agreements to transfer the corresponding contributions for the maintenance of BIREME in 2014—in particular, the contribution from the Ministry of Health of Brazil.

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

20. The Latin American Center for Perinatology (CLAP) was created in 1970 through an agreement between the Government of the Eastern Republic of Uruguay, the University of the Republic of Uruguay, and PAHO. This agreement is renewed periodically and its latest extension is in effect until 28 February 2016. In a process of decentralization, the Center merged with the Women's Health unit in 2005, when it became the Latin American Center for Perinatology/Women's and Reproductive Health (CLAP/WR), and also began operating as a decentralized unit linked to the Family, Gender and Life Course (FGL) unit. The general objective of CLAP/WR is to promote, strengthen, and improve the capacities of the countries of the Region of the Americas with regard to health care for woman, mothers, and newborns.

Recent Progress

21. On 10 January 2014 the new Director/Unit Chief of CLAP/WR assumed her functions. The new management analyzed the available resources and implemented

changes to reduce costs and favor a more efficient use of resources. Arrangements were also made to generate additional resources with extrabudgetary funds.

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

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

24. The WHO publication "Safe abortion: technical and policy guidance for health systems" was translated into Spanish[11] and Portuguese[12] and disseminated in the countries of the Region (20,000 copies).

25. Within the framework of the strategy for the Elimination of Mother-to-child Transmission of HIV and Congenital Syphilis, a project is being developed for technical cooperation among countries in Central America (El Salvador, Honduras, Nicaragua, and Panama), with the inclusion of Belize, Costa Rica, and the Dominican Republic in the monitoring of the global indicators of congenital syphilis, using IAPA databases.

26. Based on the input from the mid-term evaluation of the Regional Plan for Newborn Health, progress was made in the preparation of instruments and technical guidelines to improve the quality of neonatal care associated with the main causes of mortality. A process was also initiated to generate information that will make the burden of prematurity more visible on the political agenda, and to prepare a regional map of the

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

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

status of legislation and programs for neonatal screening. Finally, an instrument was developed to evaluate the implementation of evidence-based interventions to enable countries to assess improvements in practices associated with neonatal care.

27. With regard to the initiative to merge the Center's facilities with the Representative Office in Uruguay, consideration is being given to renting a floor in the United Nations building, where both units would operate. There are agreements on the administrative merger that is underway, and studies of its financial costs are being carried out.

Action by the Executive Committee

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

- - -