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PROGRESS REPORTS ON TECHNICAL MATTERS

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A. SOCIAL DETERMINANTS OF HEALTH

Introduction

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

Background

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

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

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

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

Update on the Current Situation

8. The SDH approach was included in the noncommunicable diseases outcome document (UN Resolution A/RES/66/2 [2012]) (4) as a result of efforts to advocate for this approach. Similarly, WHO, PAHO, and Ministries of Health in the Region actively promoted and advocated for health inequity and the social determinants of health to be addressed in the Rio+20 agenda, which were reflected successfully in the final outcome document

(<http://www.uncsd2012.org/rio20/thefuturewewant.html>) of the United Nations Conference on Sustainable Development (hereafter referred to as the “Rio+20 Conference”).

9. Also concerning the Rio+20 Conference, countries in the Region participated in a Regional Consultation on Sustainable Development, after which recommendations were published in a report that was widely disseminated. Countries of the Region also: participated and contributed to PAHO’s Rio+20 Seminar Series, where the focus was equity; contributed to the contents of the Rio+20 Tool Box (<http://new.paho.org/tierra/>); and participated in a meeting with 54 PAHO/WHO Collaborating Centers to discuss how best to use the recommendations from the World Conference on Social Determinants of Health in preparing for the Rio+20 Conference (5).

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

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

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

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

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

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

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

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

15. A five-year WHO Strategy and Global Plan of Action (2012–2017) to implement the Rio Declaration is currently being drafted and will be reviewed in a number of consultations.
16. PAHO has been supporting the preparation of the Strategy and Global Plan of Action, convening meetings and discussions.
17. The SDH approach is being addressed and promoted in preparation for the 8th Global Conference on Health Promotion, to be held in Helsinki in 2013. Its central theme will be “Health in All Policies.”

Action to Improve the Situation

18. In line with the recommendations that emerged during the Regional Consultation on the Social Determinants of Health, PAHO will do the following:
 - (a) enhance and strengthen intersectoral action through the *Faces, Voices and Places* initiative;
 - (b) collect disaggregated data improving both the analysis and understanding of inequities and social gradients in health within the Region, as well as within countries;
 - (c) actively promote and advocate for the inclusion of the approach of the social determinants of health when formulating the post-2015 Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs);
 - (d) work with and extend PAHO’s networks, with the goal of strengthening technical cooperation on the social determinants of health;
 - (e) ensure that the SDH approach is mainstreamed in PAHO’s policies, programs and projects within the planning cycle for PAHO’s Strategic Plan 2014–2019 and the Biennial Work Plan 2014–2015 as well as in the methodology applying the cross cutting priorities within technical cooperation at the country and sub-regional level; and
 - (f) promote the SDH approach in addressing health inequalities in the Region by strengthening the competencies of policymakers, opinion shapers and health leaders in the application of this approach in the development of sound public health policies, strategies, and plans at the national, subregional, and regional level.

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B. PLAN OF ACTION FOR IMPLEMENTING THE GENDER EQUALITY POLICY

Background

1. Member States approved the Pan American Health Organization's (PAHO) Gender Equality Policy during the 46th Directing Council (Resolution CD46.R16, [2005]). The resolution requested of the Director "...within the available financial means, as mandated within the various processes of institutional strengthening, to develop an action plan for the implementation of the Gender Equality Policy, including a performance monitoring and accountability system" (1).
2. The requested Plan of Action was approved by Member States in 2009 (Resolution CD49.R12) (2). It provides a roadmap with monitoring indicators for the Pan American Sanitary Bureau (PASB) and the Member States to implement the Gender Equality Policy. The plan requires the Director to report on progress of its implementation. This is the first such report presented to the Governing Bodies.

Methodology

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

Update

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

Results in Disaggregating Health Information

PASB Gender, Diversity and Human Rights Office

5. GDR has developed a number of tools for training producers and users of health information on how to integrate a gender and intercultural perspective in the use of health information and in health information systems. To strengthen the capacity of countries to produce, analyze, and use health information that includes gender indicators, GDR has developed (with UN partners) the third biennial statistical brochure “Gender, Health and Development in the Americas: Basic Indicators 2009;” “Health of Women and Men in the Americas: Profile 2009;” and other documents.¹

Table 1. Technical Areas: Number and Percentage of Guidelines with Disaggregated Data by Sex, Age, and Ethnicity, 2005–2010

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

Source: Table compiled by GDR based on technical units’ self-administered questionnaire results

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

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

7. Countries reported having between 1 and 19 guidelines for integrating gender in health information, policies, and programming (with Bolivia reporting the highest

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

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

number), and between 1 and 20 publications (with both Peru and Uruguay reporting the highest number). The themes most addressed were violence against women, HIV, sexual and reproductive health, mental health, and noncommunicable diseases. Countries that disaggregated information by sex predominantly reported that they had included a gender analysis and used information for decision making, advocacy, monitoring, and training. The countries that published gender and health profiles were Bolivia, Costa Rica, Honduras, Mexico, Panama, Peru, and Uruguay. Colombia, Nicaragua, and Trinidad and Tobago reported that gender analysis was included in their country's health situation reports.

8. The PAHO Gender Equality Policy calls for recognizing the importance of home-based health care that is predominantly provided by women and is unpaid. With PASB support, Colombia, Costa Rica, Ecuador, Peru, and Uruguay have included this care in time use surveys. Costa Rica is publishing the analysis of unpaid care. Colombia, Ecuador, and Mexico are developing satellite health accounts that quantify this contribution within the framework of national accounts. Additionally, Chile, Costa Rica, Mexico, and Peru reported having policies and/or publications on unpaid health care and gender.

Results in Capacity-Building on Gender and Health

PASB Staff Training on Gender and Health

9. The GDR Senior Advisor is part of the PASB management team that determines staff training opportunities. In 2008 and 2009, GDR trained the PWR Gender Focal Points, the ministries of health, and partners from national women's agencies and civil society organizations during four-day subregional workshops. As a result, more than 100 people at the country level and 30 PASB headquarters staff were trained. Since then, GDR has developed a virtual course on "Gender and Health with a Human Rights and Cultural Diversity Perspective" to train intersectoral country teams. In 2011, 42 persons from five priority countries, and 16 from PASB, were trained.

Gender and Health Training in Member States

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

Results of Gender and Health Plans and Participation of Civil Society

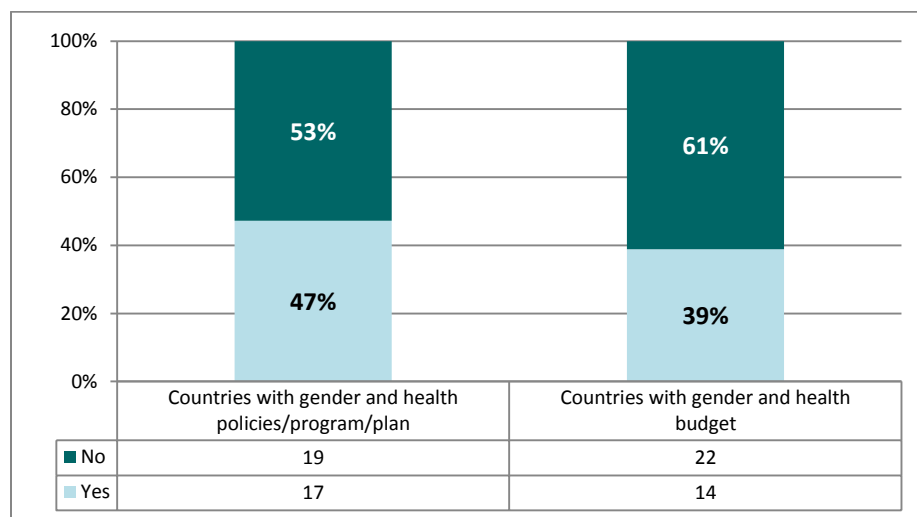
Technical Advisory Group on Gender and Health (TAG/GEH)

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

Gender Equality Policies and Budgets

12. Numerous Member States have passed national gender equality or equal opportunity laws that also apply to the health sector. Seventeen countries reported having specific health and gender policies, as indicated in Table 2 below. Fourteen countries reported budgets assigned by law. Many countries noted that by practice, their gender activities were mostly donor-funded.

Table 2. Percentage of Countries with Gender and Health Policies/Programs/Plans and Budgets (2011)



Source: Table compiled by GDR based on countries' self-administered questionnaire results.

Results in Gender Equality in Health Monitoring Mechanisms

13. PASB has developed and implemented gender tools and checklists for reviewing Biennial Work Plans, Country Cooperation Strategies, and Governing Body documents and resolutions. These tools, which also measure the integration of human rights and

cultural diversity, have been included in the PASB's operation, planning, and training manuals.

Intersectoral Participation in Ministry of Health Advisory Groups

14. The participation of many different stakeholders in integrating gender in health is vital because trained partners can support ministry of health efforts with respect to gender.

Actions to Improve the Situation

Conclusion

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

Recommendations

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

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

18. During PAHO's 150th Session of the Executive Committee, Member States validated the need for gender equality in health efforts to be integrated and intersectoral, reflecting synergies with the Health Agenda for the Americas 2008-2017, a social determinants of health approach, and continued attention to best practices. The Executive Committee recommended that presentations be made on the full version of PAHO's gender equality monitoring report in all countries.

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

Introduction

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

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

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

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

Background

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

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

Progress and Early Results

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

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

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

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

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

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

12. With respect to the subline of action on “Suboptimal Nutrition and Nutritional Deficiencies,” data show that among children in the Region, chronic malnutrition is the most prevalent form of growth failure. However, overweight and obesity is also a

growing problem: 7% to 12% of children under 5 years of age are obese, six times the percentage of children who are currently underweight (3). Although the prevalence of chronic malnutrition is declining, about one-third of children are stunted in Bolivia and Ecuador, and about half in Guatemala. National data mask increasingly wide disparities within countries based on income, rural or urban residence, and ethnicity. Because stunting starts during the prenatal period and is transmitted intergenerationally, its eradication requires health-service and intersectoral approaches, using a life-course framework. In the health sector, PAHO promotes policies and programs to support optimal breastfeeding and complementary feeding, growth assessment, treatment of severe acute malnutrition, micronutrient supplementation, and food fortification, as well as measures to increase access to health services. PAHO also advocates approaches across a range of other sectors, including housing and environment, water and sanitation, education, food security, employment and family income, and social protection, targeted to areas where nutritional deficiencies are most prevalent. Moreover, PAHO has learned from successful experiences in reducing chronic malnutrition in Brazil, Mexico, and Peru and has shared these with other countries. Other examples include Chile's *Crece Contigo* program and conditional cash transfers in several countries.

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

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

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

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

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

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

Agriculture Organization convened a regional meeting in 2011, which involved teams from 17 countries.

Conclusion

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

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

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

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

Background

1. The Regional Strategic Plan for HIV/AIDS/STI, 2006–2015 was approved by PAHO Member States in September 2005 (Resolution CD46.R15).¹ It provides guidance to the countries of the Americas to respond effectively to the HIV epidemic and to prevent and control sexually transmitted infections (STI). The overall objective of the Plan is “by 2015, to halt and begin to reverse the spread of HIV/AIDS as well as STI in the Region by providing universal access to prevention, care, and treatment.” Toward this end, the Plan aims to strengthen national plans in all countries of the Region. It encourages international and national planners to consider the long-term impact and sustainability of programs and to view the trends of the diseases in relation to other long-term economic and human development goals.
2. The Plan includes five critical lines of action:
 - (a) strengthening health sector leadership and stewardship and fostering the engagement of civil society;
 - (b) designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity;
 - (c) strengthening, expanding, and reorienting health services;
 - (d) improving access to medicines, diagnostics, and other commodities; and
 - (e) improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination.
3. For each line of action, specific strategies, targets, milestones, and indicators are defined in the Plan, which also establishes the role of the Pan American Sanitary Bureau in support of the Plan, including its oversight and management.
4. The Plan calls for a mid-term evaluation, which was conducted during March–July 2012, to inform, reorient, and update the targets, priorities, and strategies for the remaining years of the Plan.

¹ The Regional HIV/STI Plan for the Health Sector, 2006-2015 was published in November 2005 and can be accessed from http://www.paho.org/english/ad/fch/ai/HIV_Regional_Plan_2006-2015_ENGLISH.pdf

Purpose of the Mid-term Evaluation

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

Scope of the Evaluation

6. The mid-term evaluation covered the first implementation period (2006–2011) and had a regional scope, with specific attention to subregional processes, issues, and outcomes. There was a strong focus on the updating of health sector strategies based on new technical guidance and initiatives and the scientific evidence behind them, including:
 - (a) The WHO Global Health Sector Strategy on HIV/AIDS 2011–2015 and its Operational Plan for 2012–2013, endorsed by the World Health Assembly in 2011 and 2012, respectively;
 - (b) the UNAIDS Strategy 2011–2015: Getting to Zero, which aims to revolutionize HIV prevention; catalyze the next phase of treatment, care, and support; and advance human rights and gender equality for the HIV response;
 - (c) the global call and Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in Latin America and the Caribbean;
 - (d) new evidence regarding HIV treatment as prevention; and
 - (e) the WHO/UNAIDS Treatment 2.0 platform for optimization of HIV treatment.

Methodology

7. The mid-term evaluation applied a mix of regional and subregional approaches to allow for the highest possible level of stakeholder consultation and participation.

8. The methodology had four main components:
 - (a) desk review of regional and subregional plans and reports and recent global and regional technical documents;
 - (b) face-to-face consultations with stakeholders during regional and subregional events, including two subregional consultations on HIV testing (Colombia and Panama, April 2012) and a meeting of chief medical officers from the Caribbean (St. Lucia, May 2012);
 - (c) stakeholder surveys by e-mail and in-depth telephone interviews with selected stakeholders, including national program managers, laboratory directors, people living with HIV, civil society organizations, advocates, UN partners, representatives from subregional entities—such as the Pan Caribbean Partnership against HIV and AIDS (PANCAP) and the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA)—and PAHO regional, subregional, and country staff; and
 - (d) consultation with the PAHO Technical Advisory Committee (TAC) on HIV/STI. The preliminary findings of the mid-term evaluation were presented at a TAC meeting in June 2012 for review, discussion, and validation.

Implementation Process

9. Two consultants were contracted to support the mid-term evaluation, one for the Caribbean process and the other for Latin America. The consultants worked closely with the PAHO team to identify and gather suitable and appropriate documents, develop data collection tools, and identify stakeholders to be interviewed.

10. In the Caribbean, a Steering Committee chaired by the Minister of Health from Grenada was established. The Steering Committee provided input into the development of the methodology and implementation process via virtual meetings and held a face-to-face meeting in June 2012 for review and discussion of the findings. In addition, the University of the West Indies provided support for data collection and analysis.

11. In total, more than 40 individual stakeholders and 12 partner organizations participated in the surveys and interviews. The overall response rate was close to 80%. The findings of the two processes were presented to the TAC in June 2012, during the sixth TAC meeting in Washington, D.C. Comments and recommendations of the TAC have been incorporated in the final mid-term evaluation report.

Key Findings Related to the Overall Objective, Targets, and Milestones

12. The Region has made progress toward the Plan's overall objective to "halt and begin to reverse the spread of HIV/AIDS as well as STI in the Region by providing

universal access to prevention, care, and treatment.” The estimated incidence rate of HIV infections in Latin America and the Caribbean fell from 21.1 per 100,000 population in 2005 to 19.1 cases per 100,000 in 2010, a 9.4 percent decrease.² New HIV infections in Latin America stabilized, and new infections in the Caribbean were reduced by a third from 2005 levels. The Region also noted a significant reduction in the number of pediatric HIV cases, with a 60% decline in the Caribbean and 38% decline in Latin America from 2001 levels. Increased access to antiretroviral therapy contributed to a 36% reduction in HIV-related deaths in Latin America and a 50% reduction in the Caribbean during the period 2001–2010.

13. Specific findings related to the three overall targets of the Plan are as follows:

- (a) reduction in estimated number of new HIV infections: the estimated number of new infections declined by 30% in the Caribbean and by 4% in the entire Latin American and Caribbean Region during the first implementation period;
- (b) improved access to antiretroviral treatment: the coverage of antiretroviral treatment has improved significantly in the Region, with an estimated coverage of 70% at the end of 2011, the highest of any developing region in the world. Nine countries had achieved the global universal access target of 80% by the end of 2011. An additional five were on track to achieve it, with estimated coverage of 70%–79%; and
- (c) with the adoption of the Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis, the third target was updated from less than 5% to less than 2% mother-to-child transmission of HIV by the year 2015. As shown in the Situation Analysis Report,³ five countries (Anguilla, Antigua and Barbuda, Canada, Cuba, and the United States) might have achieved the elimination targets by the end of 2011. An additional seven countries (Argentina, Bahamas, Brazil, Chile, Guyana, Suriname, and Uruguay) were on track, with mother-to-child transmission rates between 2% and 7%.

14. Although the mid-term evaluation did not include an in-depth, country-by-country review of the 20 targets and 55 milestones under the five critical lines of action, in general it concluded that all these targets and milestones have been addressed during the first implementation period and have been incorporated into current programmatic priorities and subregional plans for continued action.

² Sources: Numerator: WHO/UNAIDS/UNICEF, *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress towards Universal Access* (2011). Denominator: United Nations, Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2010 Revision* (2011).

³ Pan American Health Organization, *2010 Situation Analysis: Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in the Americas*.

Key Findings Related to Processes and Developments in the Subregions

15. The mid-term evaluation confirmed that the Regional Plan has served as the basis for development of subregional plans for the Caribbean, Central American, and Andean subregions, and for national plans. All countries in the Region have national strategic plans for HIV, with defined health sector interventions. The Southern Cone did not develop a subregional plan, but the Regional Plan also guided collective and country-level action in this subregion.

16. Stakeholders confirmed that the Plan informed the regional plans of other development partners and subregional and country proposals submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other donors.

17. The Plan contributed to inclusion of HIV as a topic in regional, subregional, and national dialogues. It helped bring about greater investment in the health sector response to HIV, including programs and services of prevention and comprehensive care for key populations such as men who have sex with men (MSM), female and male sex workers, persons deprived of liberty, drug users, and transgender persons.

18. Consistent participation of civil society groups and people living with HIV was also noted.

19. The Caribbean assessment noted various changes under way, including the establishment of the Caribbean Public Health Agency (CARPHA) and the evolving roles of the PANCAP Secretariat and some development partners, and emphasized the importance of a stable and continuing role for PAHO in this changing environment.

Key Findings Related to PAHO's Contribution to the Regional Response and Perceptions of Stakeholders and Partners

20. Partners and stakeholders appreciated PAHO's leadership in the regional HIV health sector response and the high quality of technical documents, such as the various operational guidelines and blueprints developed by PAHO.

21. PAHO was recognized for addressing sensitive and potentially controversial issues such as MSM and transgender health, as well as issues regarding human rights, stigma, and discrimination.

22. PAHO was recognized for the support provided to other programs and partners, such as the GFATM and U.S. government-funded programs.

23. The stakeholders endorsed the natural transition from the critical lines of action to the current four programmatic priorities or “flagships”:

- (a) elimination of mother-to-child transmission of HIV and congenital syphilis;
- (b) prevention and care for key populations;
- (c) treatment optimization (Treatment 2.0); and
- (d) strategic information.

This process adds specificity and allows programming to catch up with new global strategies and guidance, in particular the WHO Global Health Sector Strategy.

24. In addition, respondents emphasized the critical importance of a health systems approach that centers on strengthening of health systems and on integration and decentralization of HIV in the health systems. This was especially important for the Caribbean respondents and was endorsed as a priority by the Caribbean ministers at the 16th special meeting of the Council for Human and Social Development on health, held in April 2012.

25. Stakeholders in the Caribbean also recommended that PAHO maintain a robust subregional and country presence and develop a clear framework for HIV/STI-related technical cooperation for the period 2013–2015. This is expected to be a time of transition, with evolving roles for CARPHA and PANCAP. Alignment of this strategy with the Caribbean Cooperation in Health 2010–2015 (CCH-III) and with the Caribbean Regional Strategic Framework on HIV and AIDS 2012–2015 was noted as critical.

Key Issues and Challenges

26. PAHO has reduced its presence at the country level and has limited country-level follow-up to regional initiatives and capacity-building events.

27. Civil society respondents indicated a need for stronger partnership with civil society organizations and networks, especially in relation to ongoing advocacy for strengthening treatment and care programs and safeguarding human rights.

28. Stakeholders asked for strengthening of PAHO’s Regional Revolving Fund for Strategic Public Health Supplies and for continued support for regional price negotiations for medicines and commodities, strengthening of national procurement and supply management systems, and prevention of stock-outs.

29. Persistent verticality of HIV programs and services must be addressed, and continued advocacy is needed for an approach focused on comprehensive health systems, primary health care, and integration of HIV.

30. Information systems remain weak, in spite of significant PAHO support in this area, and the availability and use of strategic information remains a challenge.

Conclusions

31. The Regional HIV/STI Plan for the Health Sector 2006–2015 remains relevant as the overall guiding framework for the regional response to HIV.

32. Within the context of the Plan, a natural refocusing of programmatic priorities from the critical lines of action to the four flagships was endorsed. These four flagships are in line with regional priorities and with the most current global strategies and guidance.

33. Partners and stakeholders as well as members of the TAC called for PAHO to continue its leading and facilitating role in the health sector response at the regional and national levels, focusing on fewer interventions, upstream technical cooperation, and deeper engagement in policy making.

34. Stakeholders urged PAHO to support countries in the efficient use and mobilization of resources to guarantee essential services, protect the gains and address the unfinished agenda.

35. Health systems strengthening, integration, and decentralization must remain cross-cutting priorities, while strengthening of human resources continues to be a funding priority.

E. CURRENT DENGUE SITUATION

Introduction

1. Dengue, an endemic disease in the Region of the Americas with epidemic cycles, continues to be a significant public health problem. Its persistence is associated with the presence of social and environmental determinants, such as population growth, migration, uncontrolled or unplanned urbanization, and large poverty belts in cities, including many of our capitals.
2. Environmental determinants are the ones most directly related to the persistence of dengue. The lack of basic services is one of the primary problems, especially the chronic deficit in the continuous provision of water service, serious problems with the environmental management of wastewater and appropriate waste collection, as well as inadequate behavior regarding the use and disposal of non-biodegradable materials. In addition to harming the environment, these problems produce conditions that are highly conducive to the proliferation of the dengue vector and other vectors.
3. This report presents an update on the situation of this disease and progress in the activities promoted by the Member States for its prevention and control.

Background

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

Situation Analysis

5. The dengue epidemiological situation in the Americas continues to be highly complex, with all four serotypes of the disease in circulation and conditions that are very propitious for their transmission. The number of reported cases peaked in 2010 at 1.6 million, 50,235 of them severe, and 1,185 deaths. In 2011, morbidity declined by 39% and the number of deaths by 40%, with 1,044,279 cases and 719 deaths. It appears that this trend will continue in 2012. There was also a 39.1% reduction in the percentage of severe cases in 2011 with respect to the preceding four years, which may be related to the application of the new case management guidelines that recommend timely care of warning signs indicating severity at the primary care level.

6. Currently, 23 countries and territories of the Americas have prepared a national IMS-dengue. In addition, four subregional IMS-dengue have been prepared (Andean subregion, Southern Cone, Central America, and the English-speaking Caribbean).

7. The IMS-dengue evaluation process began in Mexico in 2008. Since then, 18 countries and territories have been evaluated. The Dengue International Task Force (GTI-dengue for its Spanish acronym) and the national technical groups carried out all of the evaluations jointly. Since 2003, GTI-dengue has provided technical support during outbreaks and epidemics and has strengthened the capacity of technical personnel in the countries. Today, the Group promotes the use of new tools such as the Larval Index Rapid Assay of *Aedes aegypti*, (known as LIRAA, by its Portuguese acronym), Geographic Information Systems (GIS), new diagnostic tests, and the new dengue classification.

8. During the 2009-2010 biennium, important outbreaks were reported in Argentina, Brazil, Bolivia, Colombia, Dominican Republic, Guadeloupe, Honduras, Martinique, Paraguay, Puerto Rico, and Venezuela. The response to the problem has been tangibly more comprehensive with the participation of municipalities, the private sector, the community, and the media, in addition to the health sector. The outbreaks in Santa Cruz de la Sierra (Bolivia), the Chaco (Argentina), and Honduras are examples of this. It is important to highlight the mutually supportive work among the countries of the region and the role of PAHO/WHO in the coordination of the increasingly greater collaboration among the countries, which includes the wide-ranging and constant exchange of resources, personnel, and equipment.

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

10. Training continues to be provided to the countries on methodology for risk communication and health promotion, in order to progress in changing human behavior as part of the community approach to the social and environmental determinants of dengue. In 2011, a publication that systematized the lessons learned in this extremely complex area was prepared and distributed to all the countries.

11. IMS-dengue is influencing the development of public policy, laws, and ordinances to improve the environment and tackle the social and environmental determinants that cause dengue. Greater extrasectoral impetus is needed, however, in addressing these determinants in order to ensure the sustainability of current efforts. In this context, community participation plays a decisive role, about which we must be aware.

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

13. The introduction of the new guidelines aims at paying particular attention to case monitoring in primary care, especially with regard to the detection of warning signs that indicate the severity of the case. This enables timely intervention for the hydration of patients and reducing the risk that these cases progress to more-serious forms or to death.

14. Entomological surveillance is one of the components where the greatest difficulties have been found, in particular with regard to infrastructure, material and human resources, and the great loss in logistics and quality of work that are needed. At present, the countries are strengthening surveillance and technical vector control in different ways, and PAHO/WHO together with other partners (such as the Centers for Disease Control and Prevention of the United States, different scientific and academic institutions, industry representatives, and experts from the countries) are working to identify lessons learned and to seek new tools, technologies, and methodologies that enable increasing national capabilities for entomological surveillance and integrated vector control.

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

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

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

17. Cooperation from the Spanish and Canadian governments played a critical role in the progress made in the last two bienniums. The Mesoamerica Project for dengue will be a source of support for the countries of that subregion in the coming years.

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

19. The Organization is working to identify and preserve all the innovations and initiatives that have had good outcomes with regard to prevention and control, especially in relation to social communication, community participation, and behavior change. A recent noteworthy example is that of Panama, where the increase in the vector is the result of major investments in public works. In response, an agreement was reached with the industry and the construction companies that established new regulatory standards for the responsibility of these companies, to ensure that the works do not produce locations conducive to the appearance of mosquito breeding sites.

20. It is important to look beyond the health sector and citizen responsibility, in order to identify all the opportunities that we have to combat this vector, which is becoming increasingly adapted to domestic life.

Proposal

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

F. IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS

Introduction

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

Promote Regional and Global Partnerships

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

¹ Document *La Salud Pública en las Américas – Instrumento para la Medición del Desempeño de las Funciones Esenciales de Salud Pública* (PAHO 2001) is available from:

http://new.paho.org/hq/dmdocuments/2010/FESP_Instrumento_Medicion_Desempeno.pdf.

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

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

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

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

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

⁴ Information available from the following sources:

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

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

8. PAHO partnered with the International Atomic Energy Agency (IAEA) to conduct a workshop to strengthen national infrastructure for radiation safety and the security of radioactive sources in Member Countries of the Caribbean Community (CARICOM). The workshop was held in Jamaica on 11-15 June 2012.

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

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

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

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

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

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

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

14. In the Regulations, according to the provisions of Articles 5 and 13 as well as Annex 1, States Parties should have assessed their core capacities for surveillance and response, including at designated points of entry, by 15 June 2009. In addition, they should have developed a National IHR Action Plan for attaining core capacities by 15 June 2012 and have institutionalized the mechanisms to maintain them after that date.

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

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

17. As anticipated in the Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, which was submitted to the 64th WHA, “many States Parties lack core capacities to detect, assess, and report potential health threats and are not on a path to complete their obligations for plans and infrastructure by the 2012 deadline specified in the IHR” (3). The deadline for States Parties to submit their request for extension of 2012 was 15 June 2012. As of 11 July 2012⁷, globally, 90 (46%) of the 194 States Parties requested and obtained an extension of the 2012 deadline. In the Region of the Americas, as of 11 July 2012, 28 of the 35 States Parties had requested and obtained the extension, five had determined that the core capacities were present, and two had not officially communicated their decision.

18. The status of core capacities in the Region is rather heterogeneous across the subregions, as can be seen from the picture emerging from direct interactions with national authorities as well as from the State Party Annual Report submitted to the 65th

⁷ Of States Parties from the Americas Region, the United States of America has a current target date of 18 July 2012 because the Regulations entered into force on 18 July 2007.

WHA by 31 of the 35 States Parties (89%) as of 18 May 2012.⁸ The table in the annex to this document shows the average core capacities score by subregion (in percent)—as defined in the WHO document IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties (4), which constitutes the basis of the format proposed by WHO for reporting to the WHA. The current situation at the global level and in other Regions was presented at the 65th WHA (2012) in Implementation of the International Health Regulations (2005): Report by the Director-General (5).

19. The most critical weaknesses identified included the following areas: radiation emergencies, chemical events, points of entry, human resources, and preparedness. With some variability, these areas were captured and addressed in the National IHR Action Plans submitted by States Parties, together with their requests to extend the 2012 deadline. While PAHO completes the exercise to analyze the submitted plans, substantial resource mobilization efforts at the international level should be initiated to support States Parties in addressing identified gaps.

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

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

⁸ Submission status by country of the State Party Annual Report (hereafter referred to as “the Report”) to the 65th World Health Assembly as of 15 April 2012 is as follows:

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

establish and maintain competencies in field epidemiology according to models that best fit each national context.

22. In compliance with the recommendations formulated by the Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, and following the request made by various WHO Member States during the 130th Session of the Executive Board, WHO headquarters and its Regional Offices carried out an analysis of factors that limit country progress towards achieving national core capacities, as well as any possible actions that PAHO/WHO should take to overcome these obstacles. The full analysis was presented to the 65th WHA (2012) in the report entitled Implementation of the International Health Regulations (2005) - Report on development of national core capacities required under the Regulations (6). This report led to the elaboration and approval of Resolution WHA65.23 on the Implementation of the International Health Regulations (2005) (7). Resolution WHA65.23 details actions to be taken by States Parties and by the WHO Secretariat to ensure the implementation of National IHR Action Plans and to define related monitoring procedures. In anticipation of additional requests for extension of the deadline for establishing core capacities to 2016, an IHR Review Committee will be convened as per Article 50 of the Regulations.

Strengthen PAHO/WHO Regional and Global Alert and Response Systems

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

24. PAHO continues to support the authorities in Haiti and the Dominican Republic in their efforts to control the cholera outbreak. On 11 January 2012, the Presidents of Haiti and the Dominican Republic—together with PAHO/WHO, UNICEF, and CDC—called for major international investments in water and sanitation infrastructure to

eliminate cholera from the island of Hispaniola.⁹ This was followed by a binational meeting, attended by PAHO Assistant Director and held in Haiti in March 2012, aiming at harmonizing the cholera national action plans of Haiti and the Dominican Republic.

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

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

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

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

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

29. As of 31 March 2012, 412 ports in 19 States Parties of the Region of the Americas were authorized to issue Ship Sanitation Certificates. The list of authorized ports is being regularly updated and posted online.¹⁰

30. In 2011, 15 States Parties from the Region informed WHO of their vaccine requirements for travelers. This information has been included in the 2012 edition of the WHO publication International Travel and Health (ITH) (8). PAHO has taken action to increase the transparency of procedures and participation related to the definition of areas at risk for yellow fever transmission. A two-step approach for updating yellow fever vaccination requirements for travelers should be introduced at global level and should be reflected in the 2013 edition of the ITH.

⁹ *Call to Action: A Cholera-Free Hispaniola*; see <http://new.paho.org/colera/>.

¹⁰ The list of authorized ports is available at http://www.who.int/ihr/training/ihr_authorized_ports_list.pdf.

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Annex

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

Capacity	Subregion				Americas ⁵
	<i>North America¹</i>	<i>Caribbean²</i>	<i>Central America³</i>	<i>South America⁴</i>	
National legislation, policy, and financing	92%	42%	71%	81%	64%
Coordination and communication with national focal points	82%	68%	87%	70%	74%
Surveillance	90%	79%	78%	71%	78%
Response	88%	79%	75%	75%	78%
Preparedness	68%	51%	57%	62%	57%
Risk communication	76%	76%	69%	67%	72%
Human resources	100%	47%	42%	58%	55%
Laboratory	80%	66%	78%	78%	73%

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

² The Caribbean subregion includes Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Haiti, Jamaica, Saint Lucia, Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago; the response rate was 13 out of 13 States Parties (100%). The table reflects information provided by 12 States Parties.

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

⁴ The South American subregion includes Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay, and Venezuela; the response rate was 9 out of 12 States Parties (75%). The table reflects information provided by 9 States Parties. Information related to the surveillance and response capacities from Argentina, Bolivia, Brazil, Chile, Colombia and Paraguay was submitted using the format developed by MERCOSUR and was converted into the WHO format. Information related to points of entry from Argentina, Bolivia, Brazil, Colombia, and Paraguay was submitted in a format not allowing its conversion into the WHO format.

⁵ For the Region of the Americas, the response rate was 32 out of 35 States Parties (91%). The table reflects information provided by 30 States Parties.

Capacity	Subregion				Americas ⁵
	<i>North America¹</i>	<i>Caribbean²</i>	<i>Central America³</i>	<i>South America⁴</i>	
Points of entry	71%	56%	56%	41%	46%
Zoonotic events	82%	77%	78%	78%	78%
Food safety	92%	71%	59%	68%	70%
Chemical events	75%	32%	35%	54%	43%
Radiation emergencies	86%	19%	50%	43%	39%

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

Introduction

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

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

Update on the Current Situation

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

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

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

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

¹ Detailed information on the baseline for measuring the 20 Regional Goals for Human Resources 2007–2015 can be found at the following website: <http://www.paho.org/baseline20goalsshr>

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

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

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

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

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

Challenge 2: Put the right people in the right places

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

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

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

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

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

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

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

10. *Goal 10:* Regarding the international recruitment of health care workers, only 2 out of the 23 countries (less than 10%) reported having adopted an international code of practice or having developed ethical norms related to such recruitment. Those countries are Barbados and Jamaica.

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

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

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

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

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

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

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

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

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

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

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

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

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

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H. STATUS OF THE PAN AMERICAN CENTERS

Introduction

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

Background

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

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

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

Recent Progress

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

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

6. In December 2011, PAHO, through PANAFTOSA, and the Secretariat of Health Surveillance of the Ministry of Health of Brazil signed a technical cooperation agreement to contribute to strengthening the National Health Surveillance System and the management capacity of the Unified Health System of Brazil to reduce the burden of zoonoses, vector-borne diseases, and water- and food-borne diseases on the human population. The agreement also includes actions regarding knowledge management and South-South cooperation, and builds on the 60 years of prolonged and valuable collaboration with the Ministry of Agriculture, Livestock, and Supply of Brazil, highlighting the important role of PANAFTOSA as a center for intersectoral technical cooperation between animal health and public health.

7. It is worth underscoring that the linkage among health, agriculture, and the environment was the main theme of the 16th Inter-American Meeting at Ministerial Level on Health and Agriculture (RIMSA 16): *Agriculture, Health, and Environment: joining efforts for the well-being of the Americas*, which was held in Santiago (Chile), 26-27 July 2012, coordinated by PANAFTOSA. Preceding RIMSA 16, there also took place three technical events: the 12th Meeting of the Hemispheric Committee for the Eradication of Foot-and-Mouth Disease (COHEFA 12), the Sixth Meeting of the Pan-American Commission on Food Safety (COPAIA 6), and the Inter-Agency Forum: “Toward integrated epidemiologic surveillance.” RIMSA 16 and these three technical events benefitted from the technical and financial contribution of the Government of Chile, through the Ministries of Health and Agriculture. The final report of RIMSA 16, which produced the Consensus of Santiago, will be presented to the Governing Bodies in 2013. The final reports of the technical events preceding RIMSA 16, as well as the Santiago Consensus, are available on the web pages of PANAFTOSA.¹

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

8. BIREME is a PAHO specialized center that was established in 1967 to channel the technical cooperation provided by the Organization to the Region with regard to scientific and technical information on health. On 1 January 2010, the new Statute of BIREME became effective and, on 31 August of the same year, the BIREME Advisory Committee was formed.

¹ <http://ww2.panaftosa.org.br/rimsa16/>

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

Recent Progress

10. The second meeting of the BIREME Advisory Committee took place on 25 October 2011, at the offices of BIREME in São Paulo (Brazil). The committee members reaffirmed their support for the institutional development of the Center, which includes the implementation of a new institutional framework, preparation and signing of a new Headquarters Agreement, and financing for its work plans, in addition to setting up the Scientific Committee in 2012 and organization of the IX Regional Congress on Health Sciences Information, to be held in Washington, D.C. on 22-24 October 2012.

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

- (a) BIREME Headquarters Agreement: PAHO/WHO and the Ministry of Health of Brazil prepared a headquarters agreement, which has been in the pipeline for approval since 6 August 2010. Following the change in government in Brazil, contacts with the Executive Secretariat of the Ministry of Health have been maintained. The Executive Secretariat of the Ministry of Health of Brazil invited the Director of BIREME to a meeting in late February 2012 to consider the status of the adoption of BIREME's new institutional framework. The discussion was broadened at a meeting on 21 March 2012 with the participation of: the Executive Secretariat; two other Ministry of Health Secretaries; representatives from FIOCRUZ (Oswaldo Cruz Foundation), UNIFESP (Federal University of São Paulo), ABRASCO (Brazilian Association of Collective Health), the Health Secretariat of São Paulo State (SES SP), the PAHO/WHO Representative Office in Brazil; the Manager of the Area of Knowledge Management and Communication of PAHO, and the Director of BIREME.
- (b) Agreement for BIREME facilities and operation on the São Paulo campus of the UNIFESP: the terms of this agreement are being negotiated with UNIFESP, and it will be signed once the Headquarters Agreement with the Government of Brazil, cited in the previous paragraph, has been signed.
- (c) Determination of the financing mechanism for BIREME based on the PAHO and Government of Brazil contributions stipulated in Article 6 of the Statute: Regular

- contributions will be determined by mutual consent to support the biennial work plans approved in accordance with the Statute's provisions. In the first meeting of the BIREME Advisory Committee in 2012, held on 1 June, the Ministry of Health of Brazil approved a contribution of 3.8 million Reales (approximately 1.8 million U.S. dollars) to finance the BIREME work plan for the year 2012. This amount will be transferred to PAHO through Additional Term No. 20 of the BIREME Maintenance and Development Agreement, which is in the process of being signed as of the publication date of this document.
- (d) Establishment of the Scientific Committee in coordination with the BIREME Advisory Committee. The process for submission of nominations to elect members of the Scientific Committee took place in the first half of 2012. Proposals were received from thirteen Member States, which will be presented to the BIREME Advisory Committee in the second half of year for nomination, in accordance with the approved Terms of Reference for the Committee.

12. The BIREME biennial work plan (2012-2013) in the form of a sub-entity of the Area of Knowledge Management and Communication (KMC) of PAHO was prepared in an integrated manner with KMC, with which coordination continues for its enhancement and consolidation.

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

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

Recent Progress

14. The search continues to find a site for the offices of CLAP and of the PAHO/WHO Representative Office in Uruguay. In late 2011, five sites were visited that did not meet the necessary requirements. In the first half of 2012, the search has been resumed with visits to five private properties and to a governmental property belonging to the School of Veterinary Medicine. The latter was set aside because it will not be available within two years and the other properties did not meet the necessary physical and economic requirements.

Subregional Centers (CAREC and CFNI)

Caribbean Epidemiology Center (CAREC)

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

16. CAREC has received considerable support from Headquarters for all activities related to the transition. In preparation for this process, a working group was formed that is in charge of implementing a plan with respect to the products and the technical, administrative, and laboratory services that will be transferred to CARPHA. Subcommittees have been set up to support the transition in the areas of information, finances, and human resources.

17. CAREC has collaborated actively with the Executive Committee of CARPHA in approving its organizational structure, policies, procedures, and processes, including Personnel Regulations. It has also approved contracting officials for key posts such as the first CARPHA Director, the Director for Institutional Services, and the Director for Surveillance and Research.

18. The 37th Council of CAREC met on 23-24 July 2012. It took note of progress in the establishment of CARPHA, including the creation of a Working Capital Fund, negotiations with the Ministry of Health of Trinidad and Tobago for the provision of buildings and a laboratory for CARPHA, and updating of the list of countries which have signed the CARPHA Agreement. In addition, the Council stressed the need to standardize and integrate compiled national-level information and for legislation to be issued to support public health surveillance.

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

Caribbean Food and Nutrition Institute (CFNI)

20. The CFNI continues to maintain technical support to the member countries while, at the same time, it works with CARICOM on the various issues and processes necessary for an efficient and orderly transition to CARPHA.

21. The transition from CFNI to CARPHA has been programmed for the end of 2012. In preparation for the transition, the personnel from the CFNI subsidiary office in Trinidad and Tobago were relocated to CAREC headquarters, and agreements reached on retirement of some personnel.

22. Furthermore, the surveillance functions of CFNI and CAREC are being evaluated to merge them, when possible, to achieve greater effectiveness. Along these lines, the regional, subregional, and CFNI mandates and commitments have been reviewed, and those cooperation functions have been identified that could be transferred to other actors in the region recognized for technical excellence as well as those that will continue to be handled by the country offices, collaborating centers, and the Regional Office.

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

References

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