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PROGRESS REPORTS ON TECHNICAL MATTERS

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A. REGIONAL STRATEGY AND PLAN OF ACTION FOR NEONATAL HEALTH WITHIN THE CONTINUUM OF MATERNAL, NEWBORN, AND CHILD CARE (2008-2015): MIDTERM EVALUATION

Background

1. In October 2008, the 48th Directing Council of the Pan American Health Organization (PAHO) adopted, through Resolution CD48.R4, Rev. 1, the *Regional strategy and plan of action for neonatal health within the continuum of maternal, newborn, and child care (1)*. This resolution urges Member States to take into account this strategy and plan of action when formulating national plans aimed at reducing neonatal mortality in the context of the continuum of maternal, newborn, and child care. Monitoring of the strategy and plan of action, which is also included in the resolution, is an essential component for assessing the status of implementation and results, which will make it possible in turn to determine if it is necessary to adopt corrective measures to achieve the expected results.

Evaluation Scope and Methodology

2. This document provides a consolidation of the results of the midterm evaluation of the strategy and plan of action for the purpose of determining progress and achievements in the first phase of implementation (2008-2012), and of setting priorities and making recommendations for the 2013-2015 period. It analyzes processes and results at both the regional and country level.

3. The evaluation was based on the guidelines in the plan of action. Qualitative and quantitative methods were used to evaluate processes carried out at regional, subregional, and national levels, as well as their achievements and results. A participatory approach was used, with contributions from those responsible for the development and implementation of plans and measures in the ministries of health, scientific and academic associations, experts, cooperation agencies, collaborating centers, and relevant stakeholders.

4. The evaluation included four main components:

- (a) Review of plans and technical documents with relevant information related to strategies, goals, or expected results.
- (b) Data analysis from primary and secondary sources to respond to the indicators.
- (c) Promotion of a process in the countries of the Region to review implementation of the plan and its adaptation to national situations, as well as its results and lessons

- learned. Conclusions from this process were consolidated and analyzed at two subregional meetings.
- (d) Consultations with technical groups and groups of experts, such as the Regional Partnership for Neonatal Health and Technical Advisory Group on IMCI (IMCI-TAG)-Comprehensive Child Health, as well as with PAHO/WHO collaborating centers. A similar participatory consultation mechanism was encouraged with partners and other relevant organizations in the analysis and discussion process in the countries.

Situation Update

5. The following are among the most important achievements, in line with the plan's Strategic Areas:
- (a) The creation of an enabling environment for the promotion of neonatal health, development of national plans, and promotion of alliances in countries are essential strategies that have been implemented in the Region. Of the 29 countries that have reported results¹ (83% of the Region's countries), 72% has a national plan that includes maternal and neonatal health within the framework of the continuum of care, and three countries of the Region are in the process of developing a national plan. For the most part, the approved national plans that are underway include a monitoring system; approximately half of them have allocated a specific budget, and a large proportion of countries have neonatal health alliances or technical groups.
- (b) In general, a high proportion of births in the Region are attended by skilled personnel. However, in 20% of countries, the proportion of deliveries attended by skilled personnel is lower than 90%. It is primarily within countries where the most significant differences are found, both in terms of the proportion of births attended by skilled personnel and with regard to the proportion of institutional deliveries. In some geographical areas, fewer than 50% of births are institutional births; in many cases these are areas with a high indigenous population. Practically all countries (96%) report that they have guidelines, standards, or protocols for newborn care in health services, approved by national authorities. Home visits or other community interventions tied to newborn health are highly constrained in the countries of the Region.
- (c) The countries of the Region have functioning information systems, although with considerable variability in coverage and type of information. They also have systems aimed at assessing vital events (88.5%) as well as information systems in

¹ Information from an online survey developed for this purpose.

- health services (77%). Countries have made progress with formation of committees to analyze the cause of neonatal deaths (70% indicated that they have a committee of this type). Less frequent are community-based information systems (50%).
6. The Region of the Americas experienced a 55.6% reduction in the estimated neonatal mortality rate from 1990 to 2010 (from 18 to 8 per 1000 live births).² However, there is wide intercountry variability, with rates ranging from 2.8 to 27.3 per 1000 live births.
7. In the same period, a 50% reduction in the estimated neonatal mortality rate was seen in Latin America and the Caribbean. In this case, neonatal mortality for the years 1990 and 2010 showed a reduction from 22 to 11 per 1000 life births.² It is calculated that neonatal mortality declined 4% from 2008 to 2010.³
8. Neonatal mortality (<28 days of age) is the principal component of under-1 and under-5 mortality, and has increased in the Region since 1990. Neonatal mortality accounts for 57.1% of under-1 mortality and 44.4% of under-5 mortality in the Region of the Americas. In the case of Latin America and the Caribbean, these proportions are 61.1% and 47.8%, respectively. Neonatal mortality tends to be slightly higher for males, with an estimated median of 54.6%, although rates range from 45.2% to 61.1%.
9. There have been no major changes in neonatal mortality disaggregated by cause: prematurity (35.2%), birth defects (20%), asphyxia (15.2%), and infectious processes such as sepsis, meningitis, and tetanus (12.2%) account for over 85% of neonatal deaths, all of which are problems that can be prevented to a great extent with specific control measures and timely and quality treatment.
10. Other disorders that affect newborn health and that have an impact throughout life are considered equally high priorities and need to be addressed. Among them, prematurity (2) and low birth weight (3, 4, and 5), retinopathy of prematurity (6), congenital malformations, and specific metabolic or sensory problems contribute to varying degrees to the development of different disabilities and chronic diseases that considerably affect quality of life and social capital in the countries of the Region (7).

² The data are estimates by the United Nations Inter-agency Group for Child Mortality Estimation (IGME). Levels and Trends in Child Mortality. Report 2012 (August 2012 update available from: <http://www.childmortality.org>).

³ The data are the most recent estimates by the Institute for Health Metrics and Evaluation. Infant and Child Mortality Estimates by Country 1970-2010 (July 2012 update available from: <http://www.healthmetricsandevaluation.org>).

Measures to Improve the Situation

11. In view of the analysis regarding implementation at both the Region and country levels, the following are some measures to improve the situation in the 2013-2015 period:

- (a) Continue with implementation of the plan in the Region and promote development of national plans and strategic partnerships where they still do not exist.
- (b) Boost reduction of neonatal mortality, aiming measures specifically at the principal causes detected. Furthermore, countries should outline strategies that make it possible to intervene more intensively in geographical areas where access is more critical, as well as in areas with conditions causing greater vulnerability and exclusion (socioeconomic, ethnic, or other types of factors that are considered relevant).
- (c) Strengthen work in health services and at the community level. It is indispensable for Member States to strengthen these services, promoting universal access to good quality care and implementation of effective interventions, in the framework of inclusive, equitable, and high-quality health systems.
- (d) Boost newborn care within the framework of the continuum of care, involving stakeholders and linking measures to those proposed in the *Plan of action to accelerate the reduction of maternal mortality and severe maternal morbidity (8)* and the *Strategy and plan of action for integrated child health (9)*.
- (e) Further strengthen information systems for the purpose of making timely information available, both aggregated at the national level and disaggregated by geographical area and by the problems that make it possible to identify inequity, to contribute to the creation of surveillance and monitoring systems that provide the basis for measures that should be taken and that evaluate results.

Conclusions

12. Progress has been seen in implementation of the regional plan as well as in the achievement of results. However, it is indispensable to strengthen measures aimed at addressing those determinants that have an influence on both neonatal mortality and the development of diseases that will affect the quality of life of children and, consequently, that of their families and the community.

13. In this regard, it is necessary to strengthen healthcare networks to advance toward inclusive, equitable, and good-quality health systems within the framework of the

continuum of care, prioritizing, especially, work in the most vulnerable geographical areas and population groups.

14. Training of health professionals and improving quality of care are priority issues. The use of modern communication and training strategies that help to facilitate access to new knowledge that is transferred to practices and skills should be especially promoted.

15. It is indispensable to strengthen community-based work, furthering access to health care and the identification of risk factors, and promoting healthy habits and practices, particularly breastfeeding and growth and development monitoring.

16. Inequity is a persistent issue in the Region and requires a specific approach. To this end, it is indispensable to focus work within countries, particularly in those areas where the population is the most vulnerable.

17. It is indispensable to continue to strengthen information systems to make good quality information available, in a timely fashion and with the greatest possible degree of disaggregation, which will make it possible to detect inequity.

18. Strengthening alliances at both the regional level and in countries has proven to be a fundamental means for implementation of the plan, because it encourages visibility of the problem and advocacy for addressing it, an aspect that should also be strengthened in the countries of the Region.

19. PAHO should continue to promote and implement measures for technical cooperation among countries, to strengthen achievements made thus far.

Action by the Directing Council

20. The Directing Council is invited to take note of this report and offer any recommendations it may have.

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B. STRATEGY AND PLAN OF ACTION FOR THE ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND CONGENITAL SYPHILIS: MID-TERM EVALUATION

Background

1. In 2010, the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis was approved by Pan American Health Organization (PAHO) Member States (Resolution CD50.R12) (1). The objective of the strategy is to eliminate congenital syphilis and mother-to-child transmission of HIV in the Americas by the year 2015 through: (a) reduction of mother-to-child HIV transmission to 2% or less; (b) reduction of the incidence of mother-to-child transmission of HIV to 0.3 cases or fewer per 1,000 live births; and (c) reduction of the incidence of congenital syphilis to 0.5 cases or fewer (including stillborn infants) per 1,000 live births. The resolution requests the PAHO Director to promote coordination and implementation of the Strategy and Plan of Action, promote partnerships and technical cooperation among countries, and report periodically to the Governing Bodies on the progress and obstacles identified during execution of the Strategy and Plan of Action.

PAHO Support for Implementation of the Strategy and Plan of Action

2. The PAHO HIV/STI Project, the Latin American Center for Perinatology and Women and Reproductive Health (CLAP/WR), and the United Nations Children's Fund (UNICEF) are leading the support for implementation of the Strategy and Plan of Action. Other supporting partners include: the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), and the Centers for Disease Control and Prevention (CDC). Tools developed include a concept document (2), integrated clinical guidelines (3), a costing tool (4), a monitoring strategy (5), a field guide (6), and a validation methodology (7). Various capacity-building activities were also conducted in collaboration with the partners, and direct support was provided to priority countries. The HIV project is implementing an innovative strategy for more sustainable treatment programs in line with the UNAIDS/WHO Treatment 2.0 Initiative, which supports elimination efforts in the countries. In response to the resolution, PAHO also initiated reporting on the elimination targets in 2010, aligned with Universal Access reporting, based upon which two regional progress reports were prepared (8, 9). A mid-term evaluation of the implementation of the Strategy and Plan of Action was conducted in 2013.

Purpose of the Mid-term Evaluation

3. The mid-term evaluation aimed to: (a) assess progress and identify challenges related to implementation of the Strategy and Plan of Action, and (b) identify priority

countries and actions to accelerate progress towards achievement of the elimination targets by the year 2015.

Scope and Methodology

4. The mid-term evaluation covered the first three implementation years of the resolution (2010-2012). The evaluation accounted for a regional perspective with country-level outcomes and issues being the top priority. The following sources of information were consulted: (a) the global UNAIDS report (10); (b) regional reports (8, 9); (c) reports of three sub-regional stakeholder meetings held in 2012; and (d) a mid-term evaluation questionnaire sent to all countries and completed by 32.

Key Findings

Progress

- (a) Most of the countries (33 of them) have developed strategic and/or operational plans, and 30 countries have developed or updated their national guidelines.
- (b) Regional coverage of HIV testing among pregnant women increased from 29% in 2008 to approximately 66% in 2011. The estimated coverage of antiretroviral treatment for pregnant women living with HIV increased from 55% in 2008 to 70% in 2011 (67% in Latin America and 79% in the Caribbean). Consequently, new cases of HIV infection among children dropped by 24% in Latin America and by 32% in the Caribbean between 2009 and 2011.
- (c) The HIV mother-to-child transmission rate in Latin America and the Caribbean for 2011 is estimated to be 14.2% (5.8%–18.5%), a decline from 18.6% (10.5%-22.9%) in 2010.
- (d) Data reported by the countries in 2011 and 2012 indicate the following:
 - i. Eight countries achieved coverage of 90% or greater for HIV testing of pregnant women, and 10 countries reported antenatal syphilis screening at close to 90% or greater.
 - ii. Among the 15 countries reporting on syphilis treatment of pregnant women in 2011, the coverage ranged from 23% to over 95%, with nine countries reporting coverage of 90% or greater.
 - iii. Virological testing of HIV-exposed infants within two months of birth was low in the Region, with only three countries reporting levels close to 90% or greater. Country capacity to report and monitor these data needs to be strengthened. Significant loss to follow-up of infants prior to definitive diagnosis was noted by some of the countries.

- iv. Fourteen countries with antenatal care (ANC) coverage and syphilis testing greater than 80% reported congenital syphilis rates of less than 0.5 per 1,000 live births.
- v. Five countries with ANC coverage and HIV testing greater than 80% reported HIV vertical transmission rates of 2% or less, and an additional 10 countries had rates close to 2%.

Challenges

- (a) The available data indicate significant variances in progress. Some countries are still showing very low coverage of essential services.
- (b) Key challenges include:
 - i. need to strengthen health systems, health information and data collection systems and service delivery models that integrate ANC, HIV, and sexual and reproductive health (SRH);
 - ii. need for the promotion of early initiation of antenatal care and improvement of the quality of ANC;
 - iii. need for the strengthening of strategies to reach young women and other vulnerable groups with SRH and primary prevention interventions.

Conclusions

- (a) The mid-term evaluation indicates significant progress in implementation of the Strategy and Plan of Action for the elimination of mother-to-child transmission of HIV and congenital syphilis. However, intensified action is needed in order to address the low coverage of services in some countries.
- (b) The countries for which PAHO recommends intensified action are:
 - i. Those with HIV or syphilis testing of pregnant women under 50% in 2011: Dominican Republic, Guatemala, Haiti, Mexico, Nicaragua, Panama, and Paraguay.
 - ii. Those with HIV or syphilis testing of pregnant women between 50% and 70% in 2011: Antigua and Barbuda, Barbados, Bolivia, Colombia, Dominica, Honduras, Jamaica, Montserrat, Saint Lucia, and Turks and Caicos Islands.
- (c) The programmatic priorities for the second phase of the implementation period are: strengthening of the health information systems, development and sharing of models and best practices for HIV/SRH/MCH integration, and laboratory strengthening.
- (d) Continued emphasis on a health systems approach is essential in order to address the health systems barriers.

Action by the Directing Council

5. The Directing Council is requested to take note of this mid-term evaluation and offer any recommendations it may have.

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C. MILLENNIUM DEVELOPMENT GOALS AND HEALTH TARGETS IN THE REGION OF THE AMERICAS

Introduction

1. The Member States of the Pan American Health Organization (PAHO) have expressed a clear commitment to achieving the Millennium Development Goals ([MDGs](#)), in the conviction that health plays a crucial role in social, economic, and political development. The MDGs and their related targets are key to PAHO's commitment to health policies with quantifiable results. The Organization believes that the best way to address the MDGs is by strengthening equity in health through technical cooperation in priority countries and in the interior of middle-income countries, based on comprehensive, integrated interventions that prioritize vulnerable areas and groups and populations living in poverty.

2. This report responds to the commitment made in 2011 to report on the Region's progress and challenges in achieving MDGs directly related to health.

3. The report also includes some lines of discussion on health-related areas of the post-2015 Development Agenda stemming from the international meeting organized by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) that took place in Botswana in early March and from the regional consultations to address the commitments included on the United Nations Agenda.

Background

4. 2013 offers a two-year margin to support the countries through intersectoral and interinstitutional strategies aimed at stepping up the pace of progress towards the MDGs for 2015. The Region of the Americas is on the path to achieving MDGs related to health, which includes progress in water and sanitation services and in health determinants. These advances, however, occur at the national level and are not comparable to advances at the subnational level.

5. According to data from the Economic Commission for Latin America and the Caribbean (ECLAC), while poverty and extreme poverty levels are lower than ever in the Region, they are still a problem that must be tackled as a critical health determinant at the regional and national levels. ECLAC estimates that 167 million Latin Americans were living in poverty in 2012. Of these, 66 million were living in extreme poverty, with

incomes insufficient to ensure an adequate diet. Reducing chronic malnutrition therefore continues to be a priority.¹

Current Situation Analysis

6. Progress towards the MDGs varies from country to country in relation to every goal. In its analysis of the period from 1990 to 2011, this report uses information provided by the countries (referred to as PAHO), including routine registries and estimates generated by each country, and also draws on estimates provided by the Economic Commission for Latin America and the Caribbean (ECLAC/CELADE), which heads the Inter-agency Group (1, 2).

7. MDG 4 is evaluated based on mortality in children under one year of age, since this group accounts for over 60% of deaths in children under five in the Region of the Americas. This analysis draws on estimates generated by the Inter-agency Group. UNICEF is responsible for monitoring and evaluation of this indicator.

8. **Infant mortality** continues to decline in the Region. In Latin America and the Caribbean, the infant mortality rate (IMR) was 42 per 1,000 live births in 1990 compared to 16 per 1,000 live births in 2011, representing a 62.0% reduction (3).

9. An estimated 170,000 childhood deaths occurred in the Americas in 2011. Barbados, Canada, Chile, Costa Rica, Cuba, the United States of America, and Uruguay registered the lowest IMR (5 to 12 per 1,000 live births), while Bolivia and Haiti presented the highest levels (40 to 45 per 1,000 live births).

10. The series are more unstable in Caribbean countries (English and French-speaking) due to their small populations; the situation in these countries is more homogeneous compared to Latin American countries. The French Departments of the Americas (French Guiana, Guadeloupe, and Martinique) and Anguilla present the lowest IMR (under 12 per 1,000 live births), while Guyana and Suriname have the highest rates in the subregion, with 39 and 26 per 1,000 live births, respectively.

11. Public health interventions that have contributed to reductions in infant mortality include: (a) advances in high-impact, low-cost primary care; (b) mass immunization programs; (c) oral rehydration therapy; (d) well-child check-ups; (e) expanded coverage of basic services, especially drinking water and sanitation; (f) higher levels of schooling among the population, declines in fertility, and poverty reduction.

12. **Maternal mortality** has declined in the Region, although the trends vary among countries. The maternal mortality ratio (MMR) in Latin America and the Caribbean was

¹ Hacia el desarrollo Sostenible: América Latina y el Caribe en la Agenda post-2015. Draft for discussion. Feb 2013. Inter-agency Report coordinated by ECLAC.

140 per 100,000 live births in 1990, and 80 in 2010 (9,726 deaths in the Americas), a 41% reduction, with an annual average decline of 2.6% (4). Based on data from 33 countries and territories in the Region, the MMR declined in 25 countries. The Central American Isthmus showed reductions in the MMR ranging from 8.0% and 54.5%. In the Spanish-speaking Caribbean (Dominican Republic and Cuba) reductions in the maternal mortality ratios ranged from 9.6% to 57.5% in some countries, while increases of between 15.9% and 86.4% were observed in others. Nearly all the countries in the Andean Area and Southern Cone show reductions in the MMR ranging from 2.1% to 66.5%. Significantly, in several countries strategies such as expanded prenatal care coverage, deliveries attended by trained staff, and access to and use of contraceptives are helping to reduce maternal mortality. Currently, reported increases in the MMR may be due to improved monitoring and reporting of events, rather than an actual increase in mortality.

13. Estimates of new **HIV** infections in the countries of the Region (5) reflect a reduction in morbidity and mortality. In 2011, the Region accounted for nearly 6% of all new HIV infections worldwide (147,000 cases): 83,000 in Latin America, 51,000 in North America, and 13,000 in the Caribbean (5). The Caribbean is among the subregions that present the greatest decline in new infections relative to 2001 figures (42% fewer new infections). Moreover, the number of children who contracted HIV dropped by 24% in Latin America and 32% in the Caribbean in a two years period (2009-2011). The Joint United Nations Program on HIV/AIDS (UNAIDS) is responsible for monitoring goals 6A and 6B. While still not halted, the epidemic is starting to be reversed (5). As of the end of 2011, 68% of HIV-positive people in Latin America and the Caribbean had received treatment. This percentage surpassed the world average of 54%. Moreover, the percentage of HIV-positive pregnant women that had received antiretroviral medications in Latin America and the Caribbean rose from 36% to 70%.

14. For the 2000-2011 period, the Region reported a 58% reduction in morbidity, and a 70% reduction in mortality from **malaria**. Seventeen of the 21 malaria endemic countries had successfully reduced this disease in 2011, with 12 of those countries registering reductions of over 75% and the other five, over 50%. Of the four countries that presented increases, only one has shown a downward trend (with reductions beginning in 2005) and is on track to achieving the goal (6).

15. All 35 Member States have made progress in **tuberculosis** control, with a detection rate of 84% of the cases that WHO estimated for the Region of the Americas in 2011. Despite progress in control of this disease, however, multidrug resistance and coinfection with HIV (TB/HIV) still pose a significant challenge that must be addressed. According to the WHO Global Tuberculosis Report 2012 (which compiles data reported by the countries of the Region), the incidence of tuberculosis in the Americas is declining at a rate of 4% annually, making it the region with the fastest rate of decline in the world.

Moreover, the Region of the Americas has already reached and surpassed the goals proposed for 2015 of reducing tuberculosis prevalence and mortality by 50%.²

16. According to the data reported on **sustainable access to safe water**, access to improved water sources was 96% (99% in urban areas and 86% in rural areas) in the Region of the Americas (2010). The same figure for Latin America and the Caribbean was 94% (98% in urban areas and 81% in rural areas) (7, 8). It should be noted that no systematized information is available on water quality for the 86% of homes with access to piped water (1, 2), despite the known presence of contaminants that pose a health risk. In addition, increased use of bottled water has been observed (4), which threatens the human right to access to water (6) and poses an environmental challenge that requires further study.

17. Coverage levels of improved **basic sanitation** are at 88% in the Region of the Americas (91% in urban areas and 74% in rural areas). The same figure for Latin America and the Caribbean is 80% (84% in urban areas and 60% in rural areas). In addition to continuing to promote this service in rural and peri-urban areas, it is also necessary to make progress in the quality of this service, in reducing unimproved sanitation services and defecation in the open, and in urban wastewater treatment. The lower income quintiles pose the greatest challenge in this regard (8). It is important to point out that 25 million people in Latin America and the Caribbean still defecate in the open.

Progress in the Commitments Made in 2011

18. Work will continue along the strategic lines proposed in 2011 for achieving the MDGs: (a) Review and consolidation of information systems; (b) Strengthening of systems based on Primary Health Care (PHC); it is proposed that the health systems of municipalities in more highly vulnerable situations be strengthened with the renewed PHC framework; (c) Reduction of inequity within countries, giving priority to the most vulnerable municipalities and excluded population groups, as a response to the Social Determinants of Health (DSS). It is proposed that initiatives targeting such municipalities and groups, such as “Faces, Voices and Places,” Healthy Municipalities, the Alliance on Nutrition and Development, and Safe Motherhood be strengthened; (d) Public policy-making to ensure the sustainability of achievements and reaffirm “health in all policies.”

19. As for the post-2015 Development Agenda **on the health issue**, following WHO indications, PAHO has carried out regional consultations with the heads of health systems and services and with key stakeholders who are not always included in decision-making, such as mayors, indigenous and Afro-descendant leaders, and civil society organizations. There is consensus on the need to prioritize universal access to

² World Health Organization. Global tuberculosis control 2010. Geneva (Switzerland): WHO; 2010.

health care, understood as guaranteeing enjoyment of the right to health, by supporting health services coverage as well as interventions that act on social determinants of health as the priority objective to be presented on the post-2015 Development Agenda. It also proposes to examine the conclusions and outcomes of the meeting held in Botswana; continue to make progress in the MDGs directly related to health; optimize a healthy life throughout the life cycle as an overarching objective; take into account the rise in noncommunicable diseases (NCD); and promote universal coverage that should include, the goals of access to all key interventions and strengthening health systems. It will be necessary to ensure that all the countries study these results and to obtain a commitment to advance in access to health for all the inhabitants of the Americas.

Action by the Directing Council

20. The Directing Council is requested to take note of this report and make any observations and recommendations it deems pertinent.

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D. IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Background

1. This is a progress report on tobacco control in the Region of the Americas, as of 30 June 2013, in the framework of two resolutions, CD48.R2 (2008) adopted by the 48th Directing Council (1) and CD50.R6 (2010) adopted by the 50th Directing Council of the Pan American Health Organization (PAHO) (2).

Progress Report

2. The number of States Parties to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) that have ratified the Convention is 29 and remains unchanged since the last report was submitted (document CD51/INF/5). Although there have been certain advances in implementation of the “best buys” (3) (smoke-free places; health warnings; bans on tobacco advertising, promotion, and sponsorship; and tax increases), these have been slow and uneven both among the different measures and among countries.

3. The countries that have moved forward with the most comprehensive implementation of the Convention have begun to see results. Brazil and Uruguay show a substantial reduction in tobacco consumption in adults (4, 5) and other studies have found reductions in hospital admissions for myocardial infarction (6, 7).

4. In general, there is a trend toward the feminization of tobacco use in the Region, with a reduction in the consumption gap between adult women and men (8), which is even more pronounced in adolescents (prevalence in male adolescents 12.3%, in female adolescents 11.3%) (9).

5. The Global Tobacco Surveillance System furnishes information disaggregated by sex for both adults and adolescents. However, many countries in the Region still have not set up a national tobacco surveillance system. In this period, there has been a noteworthy increase in the number of countries that have comparable and nationally representative adolescent surveys; also noteworthy is the case of Panama, which will obtain representative data for its indigenous population in the Global Adult Tobacco Survey.

6. Brazil, Costa Rica, and Ecuador have adopted measures intended to increase tobacco taxes. Furthermore, for the first time, governmental delegates of tax-related administrations and ministries of health in the Region met to discuss effective tobacco tax and contraband control policies.

7. In 17 countries, all indoor public places and workplaces and public transportation are 100% smoke-free. Brazil,¹ Chile, Costa Rica, Ecuador, Jamaica, and Suriname are recent additions.

8. Twenty countries have legislation on tobacco packaging and labeling that is consistent with the minimum requirements of the FCTC. However, it should be noted that: (a) in one of these countries, the law does not require health warnings to include images: although it is true that this requirement is not mandatory in the FCTC, it is recommended in the guidelines on the issue approved by the States Parties; and (b) four of these countries still have not implemented the law. At the end of this biennium, 11 countries will have missed the deadline for implementation of this article.

9. Brazil,² Chile, and Suriname have joined Colombia and Panama in a total ban on tobacco advertising, promotion, and sponsorship, while five other countries have broad but not total restrictions. At the conclusion of this biennium, 22 countries that have still not complied with this article will have missed the FCTC deadline for its implementation.

10. Intense interference by the tobacco industry against tobacco control policies persists, including national and international lobbying and lawsuits. World Trade Organization (WTO) consultations have now been added.

11. The Pan American Sanitary Bureau has kept in continuous contact with the countries to provide technical support for both the drafting and the approval and implementation process for tobacco control legislation, and to defend it against industry attacks. The Manual for Developing Tobacco Control Legislation in the Region of the Americas³ was prepared, including the fundamental human rights that underlie tobacco control, as well as lessons learned at the country level in the implementation of the FCTC. The manual was presented at the 152nd session of the Executive Committee in June 2013. Furthermore, regional forums are being encouraged for discussion of supranational issues (such as the control of illicit trade and the interactions between trade agreements and the FCTC) and to facilitate exchange of information and experiences, not only among countries, but within them among sectors other than the health sector.

Recommended Measures to Improve the Situation

12. It is recommended that States Parties consider signing and subsequent ratification of the new Protocol to Eliminate Illicit Trade in Tobacco Products, adopted by the Fifth Session of the Conference of the Parties to the WHO FCTC.

¹ Regulation and implementation of the law are pending.

² Idem.

³ Available from:

http://www.paho.org/hq/index.php?option=com_content&view=article&id=1371%3Apublications-and-resources&catid=1279%3Ade-publications-and-resources&lang=en

13. It would be important for Member States to consider ratification of the WHO FCTC if they have still not done so, as well as the possibility of implementing the four tobacco control “best buys.”

14. Establishing, strengthening, and allocating resources for coordinating units and technical units responsible for tobacco control continues to be a challenge. The specific allocation of funds from tobacco taxes is one possible source of financing for this purpose.

15. Member States should consider the possibility of establishing national surveillance systems with data that is disaggregated by sex and, if possible, by socioeconomic status, and that is representative of minority populations, including indigenous populations. A standardized module of questions on tobacco is currently available. This module can be included in national surveys on broader topics, as a way to ensure international comparability of data with data from tobacco surveys in other countries, without creating an additional burden on national surveillance systems (10).

16. It is recommended that Member States consider including tobacco use detection and brief advice on smoking cessation in their primary health care systems, as well as more complex services at other levels, for people with serious addiction.

17. Regarding the existence of dissimilar positions in different international forums, for example, in WTO and WHO, Member States are reminded that there is no incompatibility between implementation of the FCTC and trade agreements (11). Furthermore, it is recommended that they consider the possibility of not including tobacco in future trade agreements.

18. Taking into account the impact that tobacco control will have on chronic noncommunicable diseases,⁴ it is recommended that Member States consider inclusion of the issue of tobacco control in the agenda of all United Nations agencies at the country level, as well as in all United Nations Development Assistance Framework (UNDAF) projects (12, 13).

Action by the Directing Council

19. The Directing Council is requested to take note of this progress report.

⁴ In accordance with the Political Declaration of the High Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, and pursuant to the Economic and Social Council (ECOSOC) resolution of July 2012.

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E. PLAN OF ACTION ON PSYCHOACTIVE SUBSTANCE USE AND PUBLIC HEALTH

Background

1. Technical cooperation to address this public health problem in the Region is based on the Strategy on Substance Use and Public Health (Document CD50/18, Rev. 1 and Resolution CD50.R2 [2010]) (1, 2), and on the Plan of Action on Psychoactive Substance Use and Public Health (Document CD51/9 and Resolution CD51.R7 [2011]) (3, 4), adopted by the PAHO Directing Council as a complement to the Strategy and Plan of Action on Mental Health (2009) (5, 6) and to the Hemispheric Drug Strategy (OAS/CICAD, 2010)¹ (7).

2. At the Forty-third General Assembly of the Organization of American States (OAS), held in Guatemala in June 2013, the Member States approved the “Declaration of Antigua Guatemala” (8), which emphasizes the role of public health in a comprehensive approach to addressing the world drug problem.

Progress Report

3. The Member States have made progress in recognizing the impact of psychoactive substance use on population health (7-10). However, in many countries, this recognition has not led to an increase or improvement in services, and a wide treatment gap persists. Primary health care still plays a very limited role in early identification, treatment, and counseling for people with substance abuse problems. Specialized services are limited and in many cases are based on inappropriate therapy models or internment in asylums.

4. PAHO has provided technical cooperation to the countries, both directly and within the framework of regional and subregional initiatives of the OAS, the Central American Integration System (SICA), and the Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD)² (10, 11).

¹ Approved in May 2010 by the Inter-American Drug Abuse Control Commission of the Organization of American States (OAS/CICAD).

² SICA Summit of Presidents of Central America: “New paths against drug trafficking” (Guatemala, 2012); Summit of Presidents and Heads of State (Cartagena, 2012); Agreement on “Advances in Comprehensive Addiction Care in PHC,” adopted at the XXVIII RESSCAD (Dominican Republic 2012); *The Drug Problem in the Americas* (OAS, 2013); Tenth Hemispheric Forum with Civil Society and Social Actors (OAS, 2013); 43rd OAS General Assembly (Guatemala, 2013); “Declaration of Antigua Guatemala” (Guatemala, 2013).

5. One example of country cooperation is the national workshops held in Costa Rica, Guatemala, and Panama with PAHO support, in which ministries of health and national drug enforcement agencies, as well as representatives of other sectors and civil society participated in order to further the public health approach in national plans and, especially, strengthen the role of the ministries of health.

6. PAHO is conducting a systematic review of the effectiveness of public health interventions that address the problem of substance use,³ to be published and presented before the end of this year.

7. PAHO has participated in expert groups with the United Nations Office on Drugs and Crime (UNODC), (12) the World Health Organization (WHO),⁴ and the Cooperation Programme between Latin America and the European Union on Drugs Policies (COPOLAD) (13).

8. The PAHO courses on brief interventions (14) and drug policy (15) are available to the Member States through the Virtual Campus for Public Health. A course on integrated primary health care services has also been offered in collaboration with COPOLAD.⁵

9. PAHO has signed a memorandum of understanding with the Inter-American Drug Abuse Control Commission (OAS/CICAD).⁶ This is an important strategic partnership that will support actions agreed upon at the country level between national drug enforcement commissions and the health sector. PAHO is also advancing in the implementation of the Regional Strategy and Plan of Action with COPOLAD⁷ and civil society organizations working on the issue at the national and regional levels.⁸

³ Report in preparation.

⁴ Guidelines for managing the use of psychoactive substances and associated disorders during pregnancy (WHO) (In development.)

⁵ Online course on comprehensive integrated social assistance and health care for drug dependency, with a primary care approach, offered by PAHO in collaboration with COPOLAD. The first cycle (2012) was attended by 59 students from 14 countries (Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, and Uruguay). The second cycle is in development.

⁶ In addition to the memorandum, PAHO helped prepare the report “The Drug Problem in the Americas;” organized the International Day against Drug Abuse and Illicit Trafficking with CICAD; and participated in expert groups on information systems, social integration, and court-supervised treatment options.

⁷ PAHO participates in the COPOLAD components related to human resource training, research, and the improvement of information systems.

⁸ Youth integration centers (ICJs) in Mexico, the Ibero-American network of NGOs working on drug dependency issues (RIOD), and Intercambios (civil society organization) in Argentina, among others.

Recommended Measures to Improve the Situation

10. PAHO should intensify its efforts to assist the Member States in the approval or review of drug policies, plans, and laws to ensure that they incorporate the public health approach and promote respect for human rights.

11. PAHO and its Member States should engage in a concerted capacity-building initiative to intensify an integrated response targeting users of psychoactive substances in the health care and social protection systems. PAHO should facilitate mechanisms that enable the Member States to share experiences.

12. The Member States should allocate resources on the basis of identified needs, with special attention to high-risk groups such as the indigent population, prisoners, sex workers, injecting drug users, children, and adolescents.

13. PAHO and its Member States should continue efforts to strengthen information and surveillance systems, improve epidemiological information, increase survey coverage of marginalized populations and other vulnerable groups, and use the social determinants approach for data analysis and programs.

14. PAHO, with the participation of its Member States, should update the information on programs, services, and resources in the Region focused on the prevention and treatment of substance-related disorders (16).

Action by the Directing Council

15. The Directing Council is requested to take note of this progress report and offer any recommendations it may have.

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F. REGIONAL PLAN ON WORKERS' HEALTH

Introduction

1. The Regional Plan on Workers' Health ([Resolution CD41.R13, 1999](#)) was designed to respond to the challenges that political, social, economic, and labor development imposed on the workforce in the 1990s. Its implementation at the national level has produced multiple outcomes with many ups and downs due to the lack of recognition of the important role that the workforce plays as a key driver of sustainable human development. Today, the challenge is to prioritize the protection of workers' health in recognition of the fact that when working people are in good health and enjoy good employment and job conditions they tend to be highly productive at the social, economic, and individual level (1). Although the Plan has been reviewed and adjusted by the Pan American Sanitary Bureau (the Bureau) during its 13 years of existence, it is now imperative to explore and devise new ways to address the complex problems that the Region's workforce confronts today. Accordingly, this report presents the background, summarizes the results obtained to date, explains the realities and the gaps facing workers' health today, and requests the Executive Committee's support in reconsidering the issue.

Background

2. The Plan came into being after the launch of the concept of "sustainable development" at the 1992 Earth Summit, which included the need to protect workers' health and safety ([UNCED, 1992](#)), and the Pan American Conference on Health and Environment in Sustainable Human Development ([PAHO, 1995](#)). The Plan was based on the mandates of the Governing Bodies of the Pan American Health Organization (PAHO) regarding workers' health ([Resolution CSP23.R14, 1990](#)) the Declaration on Occupational Health for All ([WHO, 1994](#)), and the Global Strategy on Occupational Health for All ([WHO, 1995](#); Resolution [WHA49.12](#)).

3. With the formulation of "Workers' Health: Global Plan of Action" ([Resolution WHA60.26, 2007](#)) and the determinations of the WHO Secretariat and the World Network of Collaborating Centers ([WHO/CC](#)), agreements were reached in 2012 to focus work on seven global priorities (2, 3) to which PAHO contributes in accordance with the Region's needs. Appendix 1 presents the milestones marking the Plan's origin and development.

4. The Plan's objectives were achieved by implementing actions in four programmatic areas: (a) quality of work environments, (b) policies and legislation, (c) promotion of workers' health, and (d) comprehensive health services for workers (4).

Focusing on these four areas, the Bureau provided technical cooperation to the countries, with the support of the Network of Collaborating Centers in Occupational Health, and established strategic alliances with the Inter-American Conference of Ministers of Labor of the Organization of American States ([ICML/OAS](#)), the International Labor Organization (ILO), the International Commission on Occupational Health ([ICOH](#)), and the United States National Alliance for Hispanic Workers, among others.

5. The Plan's results were evaluated in 2006 by means of a survey designed for this purpose and other sources of information available in the countries (5) and partially published in the report Health in the Americas 2007 ([PAHO, 2007](#)).

Update on the Situation

6. The Region's population and the economically active population (i.e., people between 15 and 65 years old) rose from 781 million to 954 million and from 351 million to 468 million, respectively, between 1996 and 2011 (6, 7). Around 60.2% (283 million) of the active population is in Latin America and the Caribbean, and 39.5% (185 million) is in North America. The employment conditions (salary, unemployment, and social protection among others) and working conditions (workplace hazards and risks) considered to be social determinants of health (8) have been transformed in the last 15 years because of the processes of change occurring in the working world (9) creating many inequities with regard to workers' health.

7. According to the ILO (10), for 2011 the highest rates of informal employment and people working in the informal sector were present in Bolivia, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, and Peru. Precarious work expanded in the Region, making employment relationships more fragile, affecting daily work life (11), and potentially affecting workers' health (12).

8. Other serious problems are: (a) child labor (13), which is mainly present in its most dangerous forms in informal employment (agriculture 60%, services 26%, and industry 7%, as well as in mining, fishing, and street work (14); (b) forced labor, perceived as abusive practices of semi-slavery, servitude, or work exploitation, and which increased from 1.3 to 1.8 million people for 2012 in Latin America and the Caribbean (15, 16); (c) inequities for working women (17); and (d) excluded population groups such as indigenous people, the elderly, and rural populations that in general have not been covered by social security (18).

9. Inadequate working conditions were detected through an analysis done by PAHO, based on a series of surveys carried out in Argentina, Chile, Colombia, Guatemala, and Nicaragua, indicating that uncontrolled exposure to work hazards persisted, with different levels of frequency and intensity (19), causing avoidable harm to workers' health. Estimates made on the basis of figures from 16 countries in the Region, based on working

populations covered by workers' compensation systems, indicated that in 2007 there were at least 7.6 million occupational accidents, with an approximate frequency of about 20,825 occupational injuries per day (19). For 2009, it is estimated that around 11,343 fatal occupational accidents occurred, among them 5,232 in Latin America and the Caribbean and 6,107 in the United States and Canada. Nevertheless, these figures do not reflect the complete regional picture, for two reasons: both exclude people who are not affiliated with social security systems, and there is significant under-recording of cases.

10. The ILO estimates that 2.34 million work-related deaths occur (20), but among them only 321,000 are caused by occupational injuries. The rest (86%) are attributable to occupational diseases. WHO estimates that the annual toll of nonfatal occupational diseases is around 160 million cases (21). PAHO estimates, based on information on insured populations in nine countries in the Region (19), indicate that in 2009 there was an estimated average of 281,389 cases. In the Region, only 1% to 5% of occupational diseases are effectively reported (19). This underreporting is due to the limited coverage (< 30%) of the health systems and services, and occupational risk management systems; the growth of the informal sector and the invisibility of rural workers; and the countries' deficiencies with regard to monitoring, detecting, and registering occupational diseases, among others.

11. The Global Burden of Disease Study 2010 (22) shows that the greatest risk for occupational mortality in age groups from 15 to more than 80 years old continues to be occupational injuries (higher in young men, although still noteworthy in people over age 65) and exposure to asthmogenic agents in men and women from 15 to 35 years old. Deaths from exposure to occupational carcinogens and particulates occur in both sexes and at both ends of the age spectrum, while deaths from exposure to particulates occur mainly in men and women over age 40: figures that show the long latency period of chronic illnesses caused by prolonged occupational exposures to hazards present in the workplace. The Global Estimates of Occupational Burden of Disease compiled by WHO's Global Health Observatory (23) considered the most frequent risk factors for occupational diseases to be airborne particulates, carcinogens, ergonomic stressors, noise, and risk factors for injuries.

12. The current situation indicates that despite the successes that the Plan has achieved during its years of existence, gaps persist that impose large and worrisome challenges if the countries are to overcome inequities in workers' health. Health systems are assuming the burden and the costs of providing health services to workers in the formal and informal sectors, as a result of treating occupational diseases that remain invisible due to the lack of proper diagnosis and record keeping.

13. In light of the situation described above, a call is needed to position and prioritize the subject of workers' health on the governmental agenda of the Member States and, in particular, of the health ministries. It is necessary to strengthen their leadership to

generate policies and programs aimed at prevention and at protecting workers' health, increasing the provision of health services, and providing universal coverage to workers through the primary health care services. Capacity-building will lead the Ministries to better meet people's needs and close the gaps in workers' health to achieve healthy, safe, dignified, and productive work.

Measures to Improve the Situation

14. Given that the Plan's is not uniform in scope and has not reached all of the countries in the Region, it is necessary to create and develop new initiatives to work with the Member States and redefine priorities for action, so that the health sector assumes leadership in providing preventive and treatment services, and can be strengthened and equipped with state-of-the-art tools, methods, and knowledge to meet the objective of protecting workers' lives and health.

15. All of this points to the need to reconsider the Plan so that the Pan American Sanitary Bureau can respond effectively to help Member States find solutions to occupational health inequities and meet the countries' needs for technical assistance.

Action by the Directing Council

16. The Directing Council is requested to take note of this report and consider the option to present a new Plan on workers' health for the consideration of the Governing Bodies for the period 2014–2019, so as to respond to the new global, regional, and national challenges, in accordance with the PAHO Strategic Plan 2014–2019.

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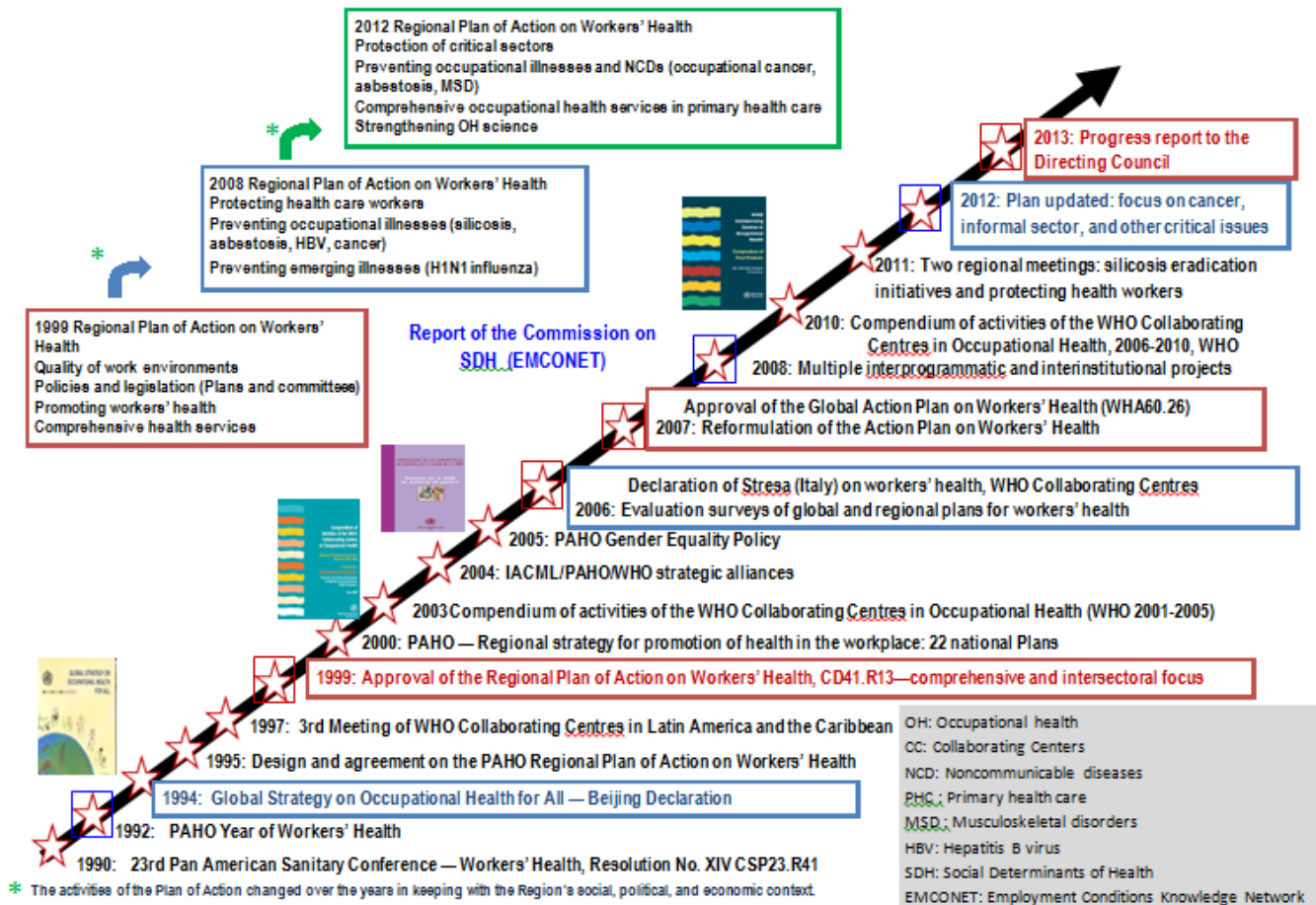
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Annex: Milestones in the evolution of the PAHO Regional Plan of Action on Workers' Health



G. TOWARDS THE ELIMINATION OF ONCHOCERCIASIS (RIVER BLINDNESS) IN THE AMERICAS

Background

1. Onchocerciasis is an infection produced by the parasite *Onchocerca volvulus* that is transmitted to humans by bites from flies of the genus *Simulium*. The disease causes itching, dermatological deformations, loss of vision, and blindness. The prevalence and the intensity of microfilaraemia significantly increase with age, but no association has been found with the gender of those affected (1, 2).
2. Onchocerciasis is endemic in 13 foci located in six countries of the Americas (Brazil, Colombia, Ecuador, Guatemala, Mexico, and Venezuela). The number of people exposed to the risk of infection and blindness has decreased from approximately 1.6 million in 1996 (3) to 379,234 in 2013 (see Annex A).
3. In 1991, the Directing Council of the Pan American Health Organization (PAHO) adopted Resolution [CD35.R14](#) related to the elimination of onchocerciasis in the Americas. The donation of medicines in the required amount and for the necessary time—announced in the [Ivermectin Donation Program](#) in 1987—was designed to contribute to the elimination of the disease. In 1993, with the support of PAHO, the [Onchocerciasis Elimination Program for the Americas](#) (OEPA) was created to pool the efforts of partner agencies with a view to achieving the elimination of the disease and providing technical and financial assistance to national programs. The goal was reaffirmed in Resolutions [CD48.R12 \(2008\)](#) and [CD49.R19 \(2009\)](#), which set 2012 as the year to achieve the goal of eliminating ocular morbidity and interrupting transmission of the disease in the Region.
4. This Progress Report submitted to the Governing Bodies of PAHO in 2013 sets forth the challenges that must be overcome to attain the goal set for the Region and to sustain the accomplishments achieved to date.

Achievements

5. Blindness caused by onchocerciasis has been considered to be eliminated in the Region of the Americas since 1995, as no new cases have been reported since that year. As a result of the regional initiative, as of 2013, 184,310 persons are considered as being no longer at risk, since the disease has been eliminated in the seven foci listed in Annex B. In the Yanomami region of Brazil and Venezuela, 20,495 persons are eligible to receive treatment, while 354,207 are living in post-treatment epidemiological surveillance zones (Annex B). The transmission of onchocerciasis has been eliminated in

seven foci and interrupted in four, which means that in these 11 foci, mass drug administration has been suspended (Annexes A, B, and C), and the goal established in Resolution CD48.R12 has been reached.

6. Colombia is the first country in the Americas and in the world to have eliminated the transmission of onchocerciasis, and in July 2013 received official verification from PAHO/WHO to that effect. Ecuador confirmed that transmission was eliminated, and in July 2013 formally requested verification from PAHO/WHO.

7. Guatemala and Mexico will complete their three years of post-treatment epidemiological surveillance in all of their foci in 2014 and, depending on the results of epidemiological assessments, could then request verification from PAHO/WHO.

8. In its focus in the Amazon, Brazil has been implementing a quarterly treatment regimen (4x/year) (4), in highly-endemic and meso-endemic communities since 2010 in order to accelerate the elimination process, while continuing the traditional regimen (2x/year) in the rest of the communities, bringing the country close to the goal of elimination.

9. Venezuela has interrupted transmission in two of its three foci. It will complete three years of post-treatment epidemiological surveillance in its North-Central focus in 2013 and could achieve elimination. Venezuela has also initiated post-treatment epidemiological surveillance in the Northeastern focus in 2013. In the Southern focus, where transmission continues, 9,615 people in 205 communities in Yanomami endemic areas are eligible for treatment. In highly-endemic and meso-endemic communities, Venezuela is implementing the quarterly treatment regimen (4x/year) (4), while continuing the two-round regimen in the rest of the communities.

10. Through scientific articles published in indexed journals (4-13), the countries have moved forward with the dissemination of scientific evidence that supports the achievements attained. In addition, since 1996, corresponding data are published annually in WHO's [*Weekly Epidemiological Record*](#).

11. The guidelines and procedures developed by OEPA with the participation of PAHO have been adopted by WHO and used in the countries where onchocerciasis is endemic.

Challenges

12. The Yanomami focus, shared by Brazil (Amazon focus) and Venezuela (Southern focus), is the final major challenge to eliminating onchocerciasis from the entire Region. This focus presents particular difficulties: (a) a population and geographical area split by

a political border; (b) a difficult physical access in both countries (jungle area); and (c) the affected communities are nomadic. Accordingly, the logistics required to reach this endemic area involves high logistic and operational costs, which currently makes it difficult to provide comprehensive care to the communities and achieve the required treatment coverage.

13. Another challenge is to ensure that once transmission of the disease has been interrupted, the countries: (a) continue surveillance activities to detect potential recrudescence (14); (b) document the process and request verification from PAHO/WHO once elimination is achieved, as was done by Colombia; and (c) address the challenges of the post-elimination period.

Next Steps

14. In view of the current situation analyzed in this report, the following steps are recommended going forward:

- (a) Issue a strong call for coordinated binational action in the Yanomami area (Southern focus in Venezuela and the Amazon focus in Brazil) for political decision-making that supports the implementation of the actions necessary for elimination of the disease. Furthermore, a plan of operation should be defined for the next five years, and treatment and comprehensive care should be provided in order to meet the goal to interrupt transmission in 2015 and eliminate onchocerciasis in 2019 (Annex C). This should be carried out within the framework of protecting Yanomami territories and employing an intercultural approach (15, 16).
- (b) During the three years of post-treatment epidemiological surveillance, promote the adoption of education and community participation methodologies through the integration of other public health programs and the maintenance of monitoring and evaluation in order to document and sustain the goal of elimination.
- (c) During the post-elimination phase, maintain an ecosystems approach that considers the determinants of health and includes epidemiological surveillance activities. This should be accomplished by integrating interventions to address neglected infectious diseases other than onchocerciasis and continuing to strengthen self-sustainability, primary care services, and the integrated sectoral and intersectoral approach (access to health services, education, housing, safe water, and basic sanitation).
- (d) Recommend that OEPA, with support from PAHO/WHO and in coordination with the six endemic countries and partner agencies, lead the impact assessment of elimination of onchocerciasis from the Region of the Americas and promote

the publication of lessons learned so that they can support the elimination of other diseases.

Action by the Directing Council

15. It is requested that the Directing Council take note of this Progress Report and formulate additional recommendations that it considers pertinent.

Annexes

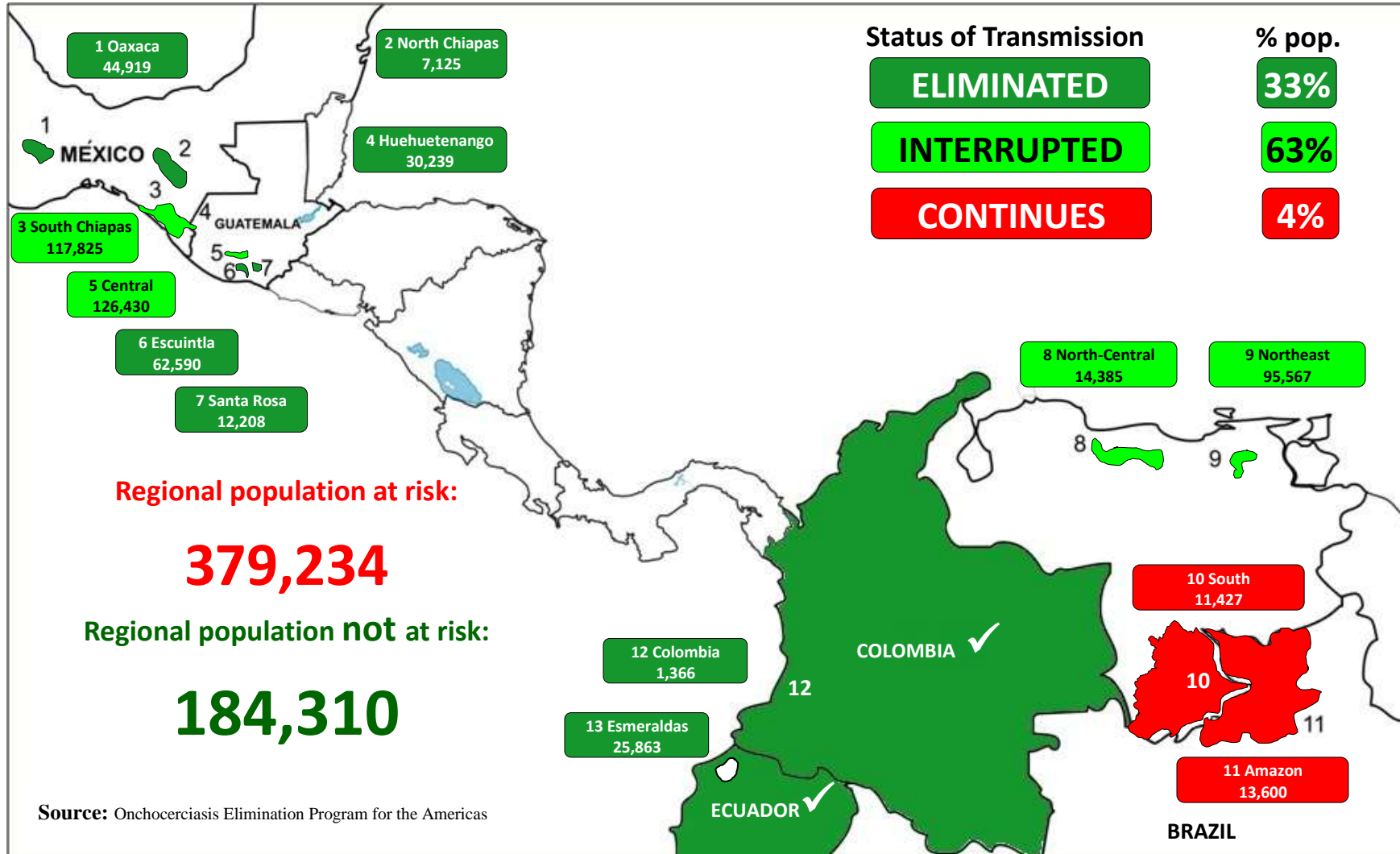
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Geographical Distribution of Onchocerciasis and the Status of its Transmission in the Americas, April 2013



**Current Status of Ocular Morbidity and Its Transmission in the
Region of the Americas, 2013**

Focus	Endemic communities	Population at risk	Population not at risk	Population under post-treatment epidemiological surveillance	Population eligible for treatment	Status of transmission
Escuintla—GUA	117		62,590			Eliminated
Santa Rosa—GUA	37		12,208			Eliminated
Northern Chiapas—MEX	13		7,125			Eliminated
López de Micay—COL	1		1,366			Eliminated
Huehuetenango—GUA	43		30,239			Eliminated
Oaxaca—MEX	98		44,919			Eliminated
Esmeraldas—ECU	119		25,863			Eliminated
Central—GUA	321	126,430		126,430		Interrupted
Southern Chiapas—MEX	559	117,825		117,825		Interrupted
North-Central—VEN	45	14,385		14,385		Interrupted
Northeastern—VEN	465	95,567		95,567		Interrupted
South—VEN	10	11,427			9,615	Continues
Amazon—BRA	22	13,600			10,880	Continues
Total	1,850	379,234	184,310	354,207	20,495	

Source: Onchocerciasis Elimination Program for the Americas

Expected Timetable to Achieve the Elimination of Onchocerciasis Transmission in the Endemic Countries in the Americas

Country	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Colombia		PTS			2011	PAHO/WHO has verified onchocerciasis elimination in Colombia in 2013.							
Ecuador				PTS			2013	Ecuador formally requested verification of elimination from PAHO/WHO.					
Guatemala						PTS			2015				
Mexico						PTS			2015				
Brazil										PTS			2019
Venezuela	Yanomami Area									PTS			2019
	Last year of mass drug administration.												
	Post-treatment epidemiological surveillance phase (PTS).												
	Year in which the country could request verification of onchocerciasis elimination from PAHO/WHO.												

Source: Onchocerciasis Elimination Program for the Americas (OEPA).

H. REGIONAL PLAN OF ACTION FOR STRENGTHENING VITAL AND HEALTH STATISTICS

Background

1. This is a progress report to the Directing Council of the Pan American Health Organization (PAHO) on the status of the achievement of the targets in the Regional Plan of Action for Strengthening Vital and Health Statistics (PEVS), (Resolution CD48.R6 [2008])¹ (I).

Progress Report

2. With regard to birth coverage (Table 1), by the middle of the last quinquennium (2005-2010),² it is estimated that 17 of 25 countries reached the coverage target: Argentina, Bahamas, Barbados, Belize, Brazil, Chile, Costa Rica, Cuba, Honduras, Mexico, Nicaragua, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, United States of America, Uruguay, and Venezuela (it is estimated that 12 surpassed the target). Three countries (Ecuador, Panama, and Paraguay) are believed to have increased coverage levels during that quinquennium and could reach the projected target if they maintain existing strengthening plans. Bolivia, Colombia, El Salvador, Guatemala, and the Dominican Republic are believed to have decreased their level compared to the previous period and these countries should make a special effort to reach the target.

3. With regard to death coverage (Table 2), by the middle of the last quinquennium (2005-2010), it is estimated that 11 of 25 countries reached the target: Argentina, Barbados, Belize, Chile, Cuba, Ecuador, United States of America, Mexico, Saint Vincent and the Grenadines, Trinidad and Tobago, and Uruguay (the last four are believed to have surpassed it). Bahamas, Brazil, El Salvador, Nicaragua, Panama, Paraguay, and Peru are believed to have increased their coverage during that

¹ This document only reports on birth and death coverage, since efforts to strengthen the health information systems (HIS) in quinquennium 2008-2013 were focused on these events, which are the principal source of data for the preparation of most of the Millennium Development Goal indicators. For both events, the PEVS contains the following targets for 2005 to 2013: countries with >90% coverage should at least maintain it; countries with 80-90% should reach at least 90%; countries with 61-79% should improve coverage by at least 10%; and countries with ≤60% should improve coverage by at least 20%. The other indicators mentioned in the annex to Resolution CD48.R6 (2008) are currently being evaluated and will be available in late 2013.

² Since uniform information is only available from routine birth and death records through 2011 and from current estimates for quinquennia (2000-2005 and 2005-2010) from ECLAC/CELADE, this report analyzes changes in coverage between averages for those quinquennia. In the next two years (2014/2015) it is expected that routine data up to 2013 will become available for numerators of the rates and up-to-date country projections based on the last censuses in the 2010 round for denominators of those rates. Thus, more realistic values will be available to evaluate changes in coverage rates.

quinquennium and could reach the target if they maintain processes for strengthening health information systems. The slight decline in Costa Rica, a country with almost complete coverage, and the declines in Colombia, Guatemala, the Dominican Republic, and Venezuela may be associated (particularly in Costa Rica and Venezuela) with the use of estimates that have not yet been adjusted in light of their new census. Finally, no data are available for Bolivia and Honduras for the last period.

4. In addition to actions taken to improve this statistical coverage, the PEVS strategy for quinquennium 2008-2013 included measures to lay the groundwork for improving the quality of mortality data and other health statistics. In 2010, the Latin American and Caribbean Network for Strengthening Health Information Systems (RELAC SIS) was established in Lima. This network has already implemented two work plans (2010-2011 and 2012-2013) have been implemented, based on the dissemination of good practices suggested by countries in the Region in the context of horizontal cooperation between countries.³

5. The disseminated practices include courses given on WHO family of international classifications, in particular the International Classification of Diseases (ICD-10), and the guidelines provided for the establishment of national reference centers for mortality and morbidity, serving Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru; guidelines drafted for systematic searches for maternal deaths; transfer of technology for assisted coding using the ICD-10 and epidemiological surveillance; the development of online courses to learn coding using the ICD-10; and activities to raise awareness among medical professionals with regard to the coding of causes of death.

6. Given the importance of using routine data and up-to-date estimates to monitor the PEVS objectives, a progress report should be prepared by 2015 in order to ensure the plan's sustainability and any necessary adjustments for the period 2013-2017, so that without neglecting the achievements of many of the countries, efforts are focused on technical cooperation so that countries where the situation is more critical can move forward in improving the coverage and quality of vital statistics and health statistics.

7. It is also necessary to strengthen horizontal cooperation; exchange good practices through RELAC SIS; include the countries of the English-speaking Caribbean in the network; and maintain partnerships with international technical and financing agencies.

³ Promoted and financed by cooperation and development agencies (USAID, CIDA); international organizations (Economic Commission for Latin America and the Caribbean [ECLAC]—in particular its statistics and population divisions, such as the Latin American and Caribbean Demographic Center [CELADE]); WHO collaborating centers (Mexican Center for the Classification of Diseases [CEMECE]); national disease classification centers (Argentina); and academic units (such as MEASURE Evaluation) whose results are available at: www.relacsis.org.

Action by the Directing Council

8. The Directing Council is invited to take note of this progress report and offer any recommendations it deems necessary for ensuring attainment of the Plan of Action.

Annex

References

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Birth and Death Coverage. 2000-2005 and 2005-2010. PEVS 2013 Targets.

Table 1. BIRTHS. Progress in coverage between quinquennia 2000-2005 and 2005-2010

Selected countries of the Americas							
Group by coverage at baseline	Country	2000-2005	CD48.R6 Target	2013 Target (%Coverag	2005-2010	Progrebs by 2010	Effort to make by 2013
1 ≥91%	USA	100,0	Maintain level	100,0	100,0	Reached	
	Mexico*	100,0	Maintain level	100,0	100,0	Reached	
	Argentina**	100,0	Maintain level	100,0	100,0	Reached	
	Bahamas	100,0	Maintain level	100,0	100,0	Reached	
	Barbados#	97,0	Maintain level	97,0	100,0	Reached and Improved	
	Cuba**	96,8	Maintain level	96,8	96,8	Reached	
	Uruguay**	96,2	Maintain level	96,2	100,0	Reached and Improved	
	Venezuela**	96,5	Maintain level	96,5	100,0	Reached and Improved	
	Chile**	95,1	Maintain level	95,1	98,3	Reached and Improved	
	St Vicent	94,8	Maintain level	94,8	95,4	Reached and Improved	
	Costa Rica**	94,6	Maintain level	94,6	99,8	Reached and Improved	
	Trinidad and Tobago	92,9	Maintain level	92,9	93,6	Reached and Improved	
	Guatemala	91,8	Maintain level	91,8	81,6	Declined (10.2 points)	10,2
	El Salvador	91,2	Maintain level	91,2	82,8	Declined (8.4 points)	8,4
2 80-90%	Panama*	84,6	Reach 90%	90,0	88,4	Improved w/o reaching	1,6
	Ecuador*	83,0	Reach 90%	90,0	84,6	Improved w/o reaching	5,4
3 61-79,9%	Nicaragua	79,6	Improve 10%	87,6	89,3	Reached and Improved	
	Bolivia**	79,2	Improve 10%	87,1	52,9	Declined (26.3 points)	34,2
	Colombia	78,7	Improve 10%	86,6	76,4	Declined (2.3 points)	10,2
	Brazil**	74,1	Improve 10%	81,5	90,8	Reached and Improved	
	Dom. Rep.**	69,3	Improve 10%	76,2	62,9	Declined (6.4 points)	13,3
	Honduras#	68,0	Improve 10%	74,8	100,0	Reached and Improved	
	Peru	62,3	Improve 10%	68,5	100,0	Reached and Improved	
4 ≤60%	Paraguay***	60,1	Improve 20%	72,1	65,0	Improved w/o reaching	7,1
	Belize#	50,00	Improve 20%	60,00	96,4	Reached and Improved	

* Countries with adjusted estimates based on circa-2010 censuses.

** Countries with circa-2010 censuses that have not yet released adjusted estimates. Current United Nations estimates are used.

Countries with registry data in PAHO.

Table 2. DEATHS. Progress in coverage between quinquennia 2000-2005 and 2005-2010

Selected countries of the Americas								
Group by coverage at baseline	Country	2000-2005	CD48.R6 Target	2013 Target (%Coverag	2005-2010	Progress by 2010	Effort to make by 2013	
1 ≥91%	USA	100,0	Maintain level	100,0	100,0	Reached		
	Cuba**	100,0	Maintain level	100,0	100,0	Reached		
	Uruguay**	100,0	Maintain level	100,0	100,0	Reached		
	Chile**	100,0	Maintain level	100,0	100,0	Reached		
	Argentina**	99,0	Maintain level	99,0	99,0	Reached		
	St Vicent	100,0	Maintain level	100,0	100,0	Reached		
	Barbados	100,0	Maintain level	100,0	100,0	Reached		
	Costa Rica**	97,3	Maintain level	97,3	93,5	Declined (3.8 points)		
	Trinidad and	99,4	Maintain level	99,4	100	Reached and Improved		
	Mexico*	94,9	Maintain level	94,9	100,0	Reached and Improved		
	Ecuador*	93,5	Maintain level	93,5	94,6	Reached and Improved		
	Guatemala	93,2	Maintain level	93,2	89,5	Declined (3.7 points)	3,7	
	2 80-90%	Venezuela**	89,1	Reach 90%	90,0	71,1	Declined (18.0 points)	18,9
		Brazil**	86,4	Reach 90%	90,0	87,0	Improved w/o reaching	3,0
Panama*		84,4	Reach 90%	90,0	85,8	Improved w/o reaching	4,2	
3 61-79,9%	Colombia	81,6	Reach 90%	90,0	78,0	Declined (3.6 points)	12,0	
	Bahamas	75,6	Improve 10%	83,2	76,9	Improved w/o reaching	6,3	
	El Salvador	75,6	Improve 10%	83,2	79,0	Improved w/o reaching	4,2	
	Honduras	68,0	Improve 10%	74,8	nd			
	Paraguay**	62,4	Improve 10%	68,6	67,9	Improved w/o reaching	0,7	
4 ≤60%	Nicaragua	57,4	Improve 20%	68,9	62,0	Improved w/o reaching	6,9	
	Dom. Rep.**	50,4	Improve 20%	60,5	49,9	Declined (0.5 points)	10,6	
	Peru	57,1	Improve 20%	68,5	58,8	Improved w/o reaching	9,7	
	Belize	50,0	Improve 20%	60,0	80,5	Reached and Improved		
	Bolivia**	31,1	Improve 20%	37,3	nd			

* Countries with adjusted estimates based on circa-2010 censuses.

** Countries with circa-2010 censuses that have not yet released adjusted estimates. Current United Nations estimates are used.

nd: No data.

I. STATUS OF THE PAN AMERICAN CENTERS

Introduction

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

Background

2. The Pan American Centers have been an important modality of PAHO technical cooperation for almost 60 years. In that period, PAHO has created or administered 13 centers,¹ eliminated nine, 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 two Subregional Centers, the Caribbean Epidemiology Center (CAREC) and the Caribbean Food and Nutrition Institute (CFNI), which were transferred at the end of 2012 to the Caribbean Public Health Agency (CARPHA).

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. The articulation between health, agriculture, and the environment constituted the main theme of the 16th Inter-American meeting, at the Ministerial Level, in Health and Agriculture (RIMSA 16): *Agriculture, Health, and Environment: joining efforts for the well-being of the Americas*, which was held in Santiago, Chile, on 26-27 July 2012, under the coordination of PANAFTOSA. There were three technical events held preceding RIMSA 16: the 12th Meeting of the Hemispheric Committee for the Eradication of Foot-and-mouth Disease in the Americas (COHEFA 12); the 6th Meeting of the Pan American Commission for Food Safety (COPAIA 6); and the Interagency Forum "Toward integrated epidemiological surveillance." RIMSA 16 and these three technical events had technical and financial support from the Government of Chile, through the ministries of health and agriculture. The final report of RIMSA 16, which culminated in the Consensus of Santiago (Chile), will be submitted separately to

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

the Directing Council. The final reports on the technical events preceding RIMSA 16 and on the Consensus of Santiago are available on the PANAFTOSA website.²

Recent Progress

4. Within the framework of the institutional development project for PANAFTOSA which began in 2010, the financial contributions from sources specifically interested in foot-and-mouth disease eradication in South America are supporting technical cooperation of the Center in relation to regional coordination of the 2011-2020 Action Plan of the Hemispheric Program for Eradication of Foot-and-mouth Disease (PHEFA). Accordingly, it has been possible to channel a significant proportion of the regular financial resources of the Center toward technical cooperation in the areas of zoonosis and food safety. The generous contribution from the Ministry of Agriculture, Livestock, and Food Supply of Brazil continues to provide full support for the maintenance costs of the Center.

5. At the end of 2012, PAHO, through PANAFTOSA, and the Secretariat for Health Surveillance of the Ministry of Health of Brazil signed an Annex to the Technical Cooperation Agreement for contributing to the strengthening of the National Health Surveillance System and the management capacity of the Unified Health System of Brazil, to reduce the burden on the human population of zoonoses, vector-borne, waterborne, and foodborne diseases. This Agreement and its Annex also include activities for knowledge management and South-South cooperation, in addition to the valuable sustained collaboration for more than 62 years with the Ministry of Agriculture, Livestock, and Food Supply of Brazil. These collaborative activities reinforce the important function of PANAFTOSA as a center of intersectoral technical cooperation on animal health and public health.

6. At the beginning of this year a new Technical Cooperation Agreement was signed with the Latin American Development Bank (CAF) for foot-and-mouth disease control in the border areas of the Andean countries. In addition, technical cooperation agreements are being negotiated with public organizations of other Member States, on activities in all the spheres of activity of PANAFTOSA: zoonosis, food safety, and foot-and-mouth disease.

7. Within the framework of the action plan for elimination of human rabies transmitted by dogs, which lays out the actions for the last stage of elimination to be reached in 2015, diagnostic laboratories are being strengthened through training of professionals and review of the national plans for elimination in priority countries through evaluation missions. Technical cooperation has been provided for a wildlife rabies outbreak in Ecuador, through training of field and laboratory professionals. Among

² <http://ww2.panaftosa.org.br/rimsa16/>

other assistance, support is being provided to laboratories in Central America and Colombia for the diagnosis of equine encephalitis; in Panama, training has been given to animal health and public health professionals for integrated surveillance of yellow fever in primates and vectors; and in Peru, collaboration has been provided in the preparation of the intersectoral national plan for surveillance, prevention, and control of echinococcosis/hydatidosis.

8. Country programs for food safety have been strengthened through direct technical cooperation and organization of in-person intersectoral workshops in collaboration with other international and regional organizations. These included workshops on the following subjects: food safety in emergencies and response to outbreaks; integrated surveillance of foodborne diseases; integrated monitoring of antimicrobial agents in the primary animal chain of production, and risk analysis and modernization of food protection services. A workshop on risk management was organized during the regional meeting of Codex Alimentarius, with participants of all the countries of the Region. Six interactive virtual seminars were organized with more than 1,500 participants on quality management from the laboratories of the Inter-American Network of Food Analysis (INFAL).

9. Since January 2012 there have been no cases of foot-and-mouth disease recorded in the countries of South America. The subregions of North America, Central America, and the Caribbean are free of this disease. Within the framework of the 2011-2020 Action Plan of PHEFA, technical cooperation and training were provided in the area of surveillance, laboratory work, and program management to Bolivia, Brazil, Colombia, Ecuador, Guyana, Panama, Paraguay, Peru, Uruguay, and Venezuela. Technical cooperation was provided to Paraguay in response to foci in 2011 and 2012, for the preparation and coordination of a national study of circulation of the foot-and-mouth disease virus. Bolivia also received technical cooperation for the preparation and coordination of a national study of circulation of the virus, based on the experience in Paraguay.

10. In 2012, Panama was accepted as a full member of the South American Commission for the Control of Foot-and-Mouth Disease (COSALFA), which held its 40th regular meeting in that country in April 2013.

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

11. BIREME is a specialized center of PAHO founded in 1967 to administer the supply of technical cooperation that the Organization provides to the countries of the Region in scientific and technical information on health. On 1 January 2010 the new BIREME Statute went into effect, and on 31 August of the same year the Advisory

Committee of BIREME was established. Since then, the members of the Advisory Committee have held three working sessions.

12. The 28th Pan American Sanitary Conference selected Cuba, Ecuador, and Puerto Rico for the Advisory Committee of BIREME, with a mandate of three years, replacing Argentina, Chile, and Dominican Republic, the mandates of which expired in 2012.

13. BIREME is currently characterized by the coexistence of its previous institutional framework and its new one: the Center's statute took effect on 1 January 2010 and the agreement governing its maintenance and development will remain in effect until 31 December 2013. BIREME governance structures currently include the Advisory Committee and the Scientific Committee (new framework), as well as the National Advisory Committee (previous framework).

Recent Progress

14. The fourth meeting of the BIREME Advisory Committee will be held in late 2013, on BIREME premises. The third meeting was held on 5 December 2012. The members of the Advisory Committee reaffirmed their continued support for the institutional development of the Center, including the implementation of the new institutional framework, the drafting and signing of the Headquarters Agreement, and the financing of its work plans, in addition to the setup of the Scientific Committee, the organization of the IX Regional Congress on Information in Health Sciences (CRICS9), and the holding of the the VI Meeting of Regional Coordination of the Virtual Health Library (BVS6) in Washington, D.C., from 20 to 24 October 2012. At its third meeting, the Advisory Committee of BIREME approved the appointment of the members of the Scientific Committee, according to the criteria defined by PAHO. The specialists in this committee come from five countries: Brazil, Canada, United States, Honduras, and Trinidad and Tobago.

15. In the context of the lines of action for implementing the new institutional framework of BIREME, the following points should be noted:

- (a) Headquarters Agreement for BIREME. PAHO and the Ministry of Health of Brazil prepared a headquarters agreement, which was submitted for approval on 6 August 2010. After a series of negotiations that took place during the year 2012, on 4 October of the same year the Executive Secretariat of the Ministry of Health of Brazil, through the PAHO/WHO Representative Office in Brazil, presented a new version of the *Agreement between the Federative Republic of Brazil and the Pan American Health Organization on the installation of the Latin American and Caribbean Health Sciences Information Center*, as proposed by the Government of Brazil. This new version was reviewed in PAHO Headquarters and referred to the Ministry of Health of Brazil with observations, since it involved substantive

- changes from the previous proposal, particularly regarding the privileges and immunities to be accorded to PAHO. The document continues to be studied by the Brazilian Ministry of Health's legal advisory service (CONJUR).
- (b) Agreement on BIREME's installations and operations on the Federal University of São Paulo (UNIFESP) campus: several meetings have been held with university authorities on the subject of the institutional relationship between BIREME and UNIFESP, as well as the terms of the agreement. Signing of the agreement remains subject to the signing of the Headquarters Agreement with the Government of Brazil, cited in the previous paragraph.
 - (c) Definition of the financing mechanism for BIREME based on contributions from PAHO and the Government of Brazil, stipulated in article 6 of the Statute. Regular contributions will be defined by mutual consent to support the approved biennial work plans, in accordance with the provisions of the Statute. At the first meeting of the National Advisory Committee (CAN) on the BIREME Maintenance and Development Agreement in 2013, held on 2 July, the results achieved by the Center in the past 18 months were presented. The corresponding report was approved by representatives of the Ministry of Health of Brazil, the Secretariat of Health of the State of São Paulo (SES-SP), and the Federal University of São Paulo (UNIFESP). It is estimated that the Ministry's contribution to the maintenance and financing of the BIREME work plan for 2013 will be 3.8 million reais (approximately US\$1.7 million)— the same amount as in 2012. This sum will be transferred to PAHO through Additional Term No. 24 of the BIREME Maintenance and Development Agreement, which is under negotiation at the date of publication of this document.
 - (d) Establishment of the Scientific Committee in coordination with the BIREME Advisory Committee. The session for establishment of BIREME's Scientific Committee was held on 25 July 2013 in the city of São Paulo (Brazil), with the members from Brazil, Honduras, and Trinidad and Tobago in attendance; the members from Canada and the United States participated remotely. The report on the meeting is being prepared and will soon be submitted for the consideration and approval of all Advisory Committee members. The presentation of candidacies to elect members to the Scientific Committee took place in the first half of 2012. Proposals were received from thirteen PAHO Member States and the candidacies were presented to the Advisory Committee during its third session, where the members of the Scientific Committee were appointed in accordance with the Committee's terms of reference.
16. The BIREME biennial work plan for 2012-2013 as an entity under the PAHO Knowledge Management and Communication Department was prepared together with the Department, with which it coordinates its ongoing development and implementation.

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

17. The Latin American Center for Perinatology (CLAP) was created in 1970, through an agreement between the Government of the Eastern Republic of Uruguay, the University of the Republic of Uruguay, and PAHO. This agreement is renewed periodically and its latest extension is in effect until 28 February 2016. The general objective of CLAP is to promote, strengthen, and raise the capacities of the countries of the Region of the Americas with regard to health care for women, mothers, and newborns.

Recent Progress

18. At the request of the Director of the Pan American Sanitary Bureau, a mission to CLAP/SMR was carried out in March/April 2013 to study the center's programmatic approaches, regional work program, capacity to respond to requests by the countries, management and coordination issues, and available human and financial resources. After analyzing the mission's results and recommendations, it was decided that CLAP/SMR will continue to operate as a "decentralized center/unit." Within the framework of the new PAHO Strategic Plan 2014-2019, CLAP/SMR will prioritize interventions related to maternal, neonatal, and reproductive health, according to the different epidemiological and operational realities in the Region. In this programmatic context, CLAP/SMR will focus its actions on human resources training, quality of care, information systems, policy-making, and legislation related to the following plans approved by the Governing Bodies: *i*) Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care; *ii*) Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity; and *iii*) Strategy and Plan of Action for the Elimination of Mother-to-child Transmission of HIV and Congenital Syphilis. Efforts will also continue for CLAP/SMR and the PAHO/WHO Representative Office in Uruguay to progressively share human resources for administrative management and in shared physical spaces.

19. The Baseline Plan was prepared for stepping up reduction in maternal mortality and severe maternal morbidity. A complementary form on Perinatal Clinical History was developed, jointly with WHO and experts of the Region, for registering cases of extremely serious maternal morbidity in the Perinatal Information System (SIP). Implementation of the project for technical cooperation among countries in Central America (El Salvador, Honduras, Nicaragua, Panama) was finalized, and a new proposal was prepared with the same purposes incorporating Belize, Costa Rica, and the Dominican Republic. Within the framework of the strategy for Elimination of Vertical Transmission of the Maternal Syphilis and HIV, the tool for certification and its field testing was implemented for the certification of Chile as a country that has achieved the

goal of elimination of congenital syphilis. CLAP/SMR assumed responsibility for implementation of the neonatal component of health and proceeded to a mid-term evaluation of the Regional Plan for Newborn Health. CLAP/SMR was accepted as a member of the executive committee of the LAC Forum on family planning. Education for midwifery educators was promoted through the Caribbean Regional Midwives Association, given the need for strengthening midwifery in the Region.

20. The search continues for a site for the CLAP offices and the PAHO/WHO Representative Office in Uruguay. During 2011 and 2012, visits were made to several private properties and to a government site belonging to the School of Veterinary Medicine, but these did not meet the necessary requirements. The latter was ruled out since it will not be available for two years, and the other properties did not meet the physical and financial requirements. New negotiations have recently been held with Universidad de la República regarding the possible provision of an exclusive area at the Institute of Hygiene, Faculty of Medicine. This option will be reconsidered in the first half of 2014, when the corresponding facilities are no longer occupied.

Subregional centers (CAREC and CFNI)

21. On 31 December 2012 the transition from CAREC and CFNI to the Caribbean Public Health Agency (CARPHA) became effective, in accordance with the provisions in the Agreement between PAHO and CARPHA for the transfer of CAREC and CFNI to CARPHA. Previously, on 13 December, a special ceremony of closure for CAREC and CFNI was held with the participation of staff members of the Ministry of Health of Trinidad and Tobago, CARICOM, the Interim Director of the CARPHA, and PAHO staff members. The Transfer Document was signed by the Interim Director of CARPHA and the Chief of Administration of the Pan American Sanitary Bureau on the same date. As a consequence of these steps, information on CAREC and CFNI will no longer be included in the context of evaluations of the Pan American centers.

Caribbean Epidemiology Center (CAREC)

22. In 2012, CAREC concentrated in maintaining its normal services, while preparing for the transition. To this end, PAHO constituted a working group for implementing a plan on the technical, administrative, and laboratory products and services to be transferred to CARPHA. Furthermore, several subcommittees were formed to support the transition in the areas of information, finances, and human resources.

23. At the same time, CAREC collaborated actively with the Executive Committee of CARPHA in the approval of its organization chart, policies, procedures, and processes, including the Staff Regulations. In addition, it supported contracting staff members for

key posts, including the first Director of CARPHA, the Director of Institutional Services, and the Director of Surveillance and Research.

24. The other missions CAREC programmed for the fourth quarter of 2012 were carried out in accordance with the transition plan. This made it possible for the transition to take place efficiently and in an orderly manner without interruptions to the services CAREC has provided to its Member States.

Caribbean Food and Nutrition Institute (CFNI)

25. CFNI maintained its technical support for the member countries in 2012, while at the same time it worked with CARICOM on the various subjects and processes necessary for an efficient and orderly transition to CARPHA. As noted in previous paragraphs, the transition from CFNI to CARPHA took place on 31 December 2012.

26. PAHO will continue to offer technical cooperation to the Member States in accordance with its mandates and regional and subregional commitments, but some cooperation functions will be transferred to other entities of the Region, for example, universities, United Nations agencies, nongovernmental organizations, and collaborating centers. In this regard, PAHO will promote partnership and network consolidation.

27. The technical documents of CFNI were transferred to the library of the University of the West Indies (UWI) and digitized in order to make them available to the countries.

28. The office of the PAHO/WHO Representative Office in Jamaica was transferred to the CFNI building on the UWI campus.

Action by the Directing Council

29. The Directing Council is asked to take note of this progress report and to make the additional recommendations that it considers pertinent.

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