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ANNUAL REPORT OF THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU

Building on the Past and Moving into the Future with Confidence

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To the Member States:

In accordance with the Constitution of the Pan American Health Organization, I have the honor to present the 2012–2013 annual report on the work of the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization. The report highlights the Bureau's major achievements in providing technical cooperation during this period within the framework of the 2008–2013 Strategic Plan of the Pan American Health Organization, defined by its Governing Bodies.

The report is complemented by the Financial Report of the Director and the Report of the External Auditor for 2012.

Dr. Carissa F. Etienne
Director

Building on the Past and Moving into the Future with Confidence

"Conditions have converged to create a unique moment for health in the Americas. I believe that we have the power to effect change: in maternal and child health, in noncommunicable diseases, in infectious diseases, in strengthening health systems, and achieving universal access to care. We have a powerful potential for health to be a driving force for change."

Dr. Carissa F. Etienne
Director, Pan American Sanitary Bureau
Pan American Health Organization

Foreword

1. In September 2012, when I was elected Director of the Pan American Sanitary Bureau (PASB) by the 28th Pan American Sanitary Conference, I pledged to lead a process of renewal that would uphold the core values and principles of this more-than-a-century-old institution and also encourage innovation to make it a more effective agent for change. Since I assumed the post of Director in February 2013, I have been pleased to find that the core values of universality, equity, and Pan American solidarity remain robust within the Organization, while a collective confidence and optimism have combined to create heightened expectations about PAHO's future. It is a source of great satisfaction to find myself at the helm of an organization with strong traditions of excellence and pride in its achievements but also with a palpable openness to change and improvement.

2. One of my first tasks as Director was to begin a process of consultations with staff and Member States on how to restructure PASB, PAHO's secretariat, to enhance synergy and complementarity in our technical cooperation programs. Two months later, I announced a new organizational structure, with a first round of changes that took effect on 1 July 2013. My goal in this undertaking was to position PAHO as a flexible, transparent, and responsive organization that brings expertise and innovation to its collaboration with Member States.

3. I have continued to consult with staff, our Member States, and other partners and stakeholders to share ideas, assess needs, and identify opportunities in which PAHO's work can make a real difference in improving health conditions in the Americas. In all these consultations I have advocated for four priorities: reducing inequities in health, strengthening health systems, addressing the social and environmental determinants of health, and achieving universal health coverage, by which I mean access to quality health

care for everyone without fear of impoverishment. I believe that advancing these priorities is critical to realizing the vision for the Region of the Americas: societies that are free of inequity, where people have the social conditions and the healthy environments they need to live long, dignified, healthy, and productive lives.

4. In my consultations, I have been heartened, though not surprised, to find that PAHO's staff and stakeholders share this vision, welcome these priorities, and are equally eager to find new opportunities to work together to advance them more effectively and sustainably.

5. I have also been heartened to confirm, during my first months as PASB's Director, that PAHO is beginning its new journey from a position of strength. I have been impressed by the wealth of expertise, the energy and the enterprise, the passion and the dedication that PAHO's staff and partners bring to their work.

6. These first months have also reconfirmed my view that our countries, our Region, and our Organization are facing new times and new conditions that call for new ways of working to advance public health. We know that our Member States are the repositories of much of the knowledge, expertise, and wisdom that we need to improve health throughout the Region. This means that one of PAHO's most important roles—if not its most important role—is as a strategic partner that supports efforts to build political will, share knowledge, and mobilize collaborative, multisectoral action both within and among our member countries.

7. Reviewing this report, it is clear that PAHO's technical cooperation has contributed to important progress in a wide range of areas, from the elimination and control of infectious diseases to the strengthening of health systems, tackling the social determinants of health, and ensuring that those who are affected by diseases have access to prevention, care, and rehabilitation services.

8. This report presents highlights of this progress and specific achievements over the past year, from mid-2012 to mid-2013. This period includes the final seven months of PAHO's former administration and the first five months under my leadership. The Organization's work during this period was guided by the 2008–2013 PAHO Strategic Plan but also included the development of a new Strategic Plan for 2014–2019.

9. As required by PAHO's Governing Bodies, the report provides an accounting of the activities of the PASB, and every achievement described herein was supported with technical cooperation from PASB programs at the regional or country level. However, the great majority of these achievements were the result of joint efforts between PASB staff, their counterparts in the ministries of health, and partners within Member States and in the international community. For this reason, the report refers not just to activities

of the PASB but to the achievements of PAHO, that is, the secretariat and the Member States together.

10. This report presents strong evidence of this Organization's continuing strength and the value of its work. In this regard, I wish to acknowledge and thank my predecessor, former PASB Director Mirta Roses Periago, for her stewardship of this Organization. I believe that PAHO has a bright future, with great potential to play an even larger role in improving health conditions and strengthening health on the international and national development agendas. I look forward to leading this Organization into that future, with strong support from our Member States, so that we can together complete our unfinished business, take on new challenges, and ultimately realize the dream of health for every woman, man, and child in the Americas.

Dr. Carissa F. Etienne
Director

Chapter I. Continuity and Change

11. The last six months of 2012 and the first half of 2013—the general period covered by this report—were a time of both continuity and change at the Pan American Health Organization (PAHO), Regional Office for the Americas of the World Health Organization (WHO). During 2012, PAHO celebrated its 110th year, an achievement in itself that was made more noteworthy by the impressive health gains recorded in the Americas over the previous century. These include a gain of 45 years in average life expectancy and an 11-fold drop in infant mortality since 1902, the eradication of smallpox and polio and the elimination of measles, rubella, and congenital rubella syndrome, expanded access to drinking water and sanitation, and significant expansion of health coverage. Today, the Region of the Americas has the highest rates of antiretroviral treatment for HIV/AIDS of any WHO region along with levels of vaccination coverage that are among the highest in the world.

12. Through several organizational iterations, what is PAHO today—the world's oldest international health agency—played a crucial leadership role in many of these achievements, and the tradition of Pan Americanism it pioneered continues to contribute to health progress throughout the hemisphere and beyond.

13. The Pan American Sanitary Bureau (PASB), PAHO's secretariat, worked closely with PAHO Member States throughout 2012–2013, providing technical cooperation to advance health, protect achievements, and address both persisting and new challenges. This work was guided by the PAHO Strategic Plan 2008–2013, the Health Agenda for the Americas 2008–2017, and other regional mandates established by PAHO Member States as well as national priorities identified through PAHO's country cooperation strategies (CCSs).

14. In January 2013, PAHO swore in its 10th Director, Dr. Carissa F. Etienne, formerly PAHO Assistant Director and WHO Assistant Director-General for Health Systems and Services. Over the subsequent three months, the Director conducted a comprehensive and inclusive process of consultation with stakeholders and staff members to identify ways to position PAHO as a flexible, transparent, and responsive organization that brings both expertise and innovation to its collaboration with Member States. This consultative process included two town-hall style meetings with staff at PAHO headquarters and several visits to Member States.

15. In April 2013, the Director announced a new organizational structure intended to strengthen PAHO's role as the Americas' premier public health agency in a dynamic and complex environment. The changes, effective 1 July 2013, were aimed at maximizing synergy and complementarity in the Organization's core technical programs. As a consequence, a special task force led by the Director of Administration oversaw adjustments in programming, personnel, and administrative processes.

16. The new structure has five core technical cooperation departments—Family, Gender, and Life Course (FGL); Communicable Diseases and Health Analysis (CHA); Noncommunicable Diseases and Mental Health (NMH); Health Systems and Services (HSS); and Emergency Preparedness and Disaster Relief (PED)—as well as a special program on Sustainable Development and Health Equity (SDE).

17. In addition, five administrative departments report to the Director of Administration: Human Resources Management (HRM), Financial Resources Management (FRM), Information Technology Services (ITS), General Services Operations (GSO), and Procurement and Supply Management (PRO). Together with PED, three additional departments report to the Deputy Director: Planning and Budget (PBU); External Relations, Partnerships, and Governing Bodies (EPG); and Knowledge Management and Communications (KMC), which provides services to other departments as well as technical cooperation to Member States.

18. Four special offices report to the Director: Country Focus Support (CFS), Legal Counsel (LEG), the Chief of Staff (COS), and Internal Oversight and Evaluation Services (IES). Two others—the Ethics Office and the Ombudsperson (OMB)— are independent and, together with IES, are part of PAHO's Integrity and Conflict Management System.

19. PAHO continues its strong presence in the Region, with 28 country offices in Member States. In addition, the Organization retains management of three Pan American technical centers: the Latin American Center for Perinatology – Women's Reproductive Health (CLAP) in Montevideo, Uruguay; the Latin American and Caribbean Center on Health Sciences Information (BIREME) in São Paulo, Brazil; and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) in Rio de Janeiro, Brazil. During the reporting period, the former Caribbean Epidemiology Center (CAREC) and Caribbean Food and Nutrition Institute (CFNI) completed the process of transitioning to the Caribbean Public Health Agency (CARPHA) in Trinidad and Tobago, which became operational in January 2013.

20. PASB played an active role, in consultation with the Member States' Countries Consultative Group (CCG), in finalizing the proposed 2014–2019 PAHO Strategic Plan, which is being submitted to the 52nd PAHO Directing Council in September 2013 for approval. Reflecting the priorities of PAHO's new leadership as well as Member States' collective priorities, the new plan seeks to improve population health through action that advances sustainable development and health equity. This includes action to address social determinants, advance universal health coverage, and incorporate health into all policies, programs, initiatives, and interventions.

21. The new Strategic Plan differs from the previous strategic plan in that its strategic objectives—redefined as "categories"—are fewer (6 versus 16 in the previous plan) and are designed to better reflect interprogrammatic work. The number of indicators was

reduced (from 256 to 106), and they were redefined to measure progress in advancing health status rather than to assess processes. An important feature of the new plan is its inclusion of goals, indicators, and targets on health equity. It also reflects closer alignment with WHO, being the first PAHO strategic plan to follow the finalization of WHO's General Programme of Work, in this case for 2014–2019.

22. Both the new organizational structure and the PAHO Strategic Plan 2014–2019 seek to enhance the ability of the PASB to work alongside Member States to promote health and well-being, reduce the burden of communicable and noncommunicable diseases, advance a multisectoral approach to address the social determinants of health, and foster collaboration toward the achievement of universal health coverage. The Organization's work toward these goals over the next six years will build on a rich body of experience, expertise, and collaboration and on many achievements from existing programs and projects implemented by PAHO or with its support.

Chapter II. Technical Cooperation and Achievements

23. The following sections of this report highlight achievements in Member States and at the regional level during mid-2012 to mid-2013 that were led or supported by PAHO's technical cooperation programs. Following these highlights are developments in the Organization's management and governance during the reporting period. Finally, the report discusses lessons that have been learned from the achievements and challenges during this period, which can be applied to improve the effectiveness and lasting impact of Organization's technical cooperation going forward.

Health Systems and Services

24. Health systems and services that are equitable, efficient, and well organized and that promote universal access are an essential foundation for improving the health of the population. Throughout 2012–2013, the Organization worked with Member States to strengthen health systems based on a renewed primary health care strategy and with a view to advancing universal health coverage.

25. Bolivia, Costa Rica, the Dominican Republic, El Salvador, Guyana, Mexico, Uruguay, and the countries of the Caribbean all worked to advance toward universal health coverage with support from PAHO as well as the United Kingdom's Department for International Development (DFID), the Australian Agency for International Development (AusAID), and the Spanish Agency for International Development Cooperation (AECID). PAHO's work included support for the development of a roadmap outlining the path toward universal health coverage for Caribbean countries.

26. Information on out-of-pocket spending on health care was collected for Canada and the MERCOSUR countries to facilitate analysis of the determinants of such spending and the redistributive effects of public health expenditures. A number of health economics units from the Region's ministries of health carried out discussions with partners including the UN Economic Commission for Latin America and the Caribbean (ECLAC), the World Bank, and the International Monetary Fund (IMF) on such issues as non-remunerated health care, "fiscal space," and the prospects for expanding public health spending.

27. During 2012–2013, PAHO conducted or supported a number of studies on expanding health coverage. An analysis conducted in Brazil, Chile, Colombia, Jamaica, Mexico, and Peru examined which public policies were most likely to be effective in improving coverage and equity. A study in the Dominican Republic evaluated the financial impact of the health component in the country's subsidized insurance scheme, while studies in El Salvador evaluated health reform gains and the challenges in consolidating them.

28. Eighty technicians from 18 countries took a virtual course on designing and managing health-care benefit packages. As follow-up, PAHO organized a community of practice for sharing information and experiences among personnel working on this issue. El Salvador, Mexico, Peru, and Uruguay have all developed or updated their guaranteed health-care benefit packages.

29. The Organization supported member countries in strengthening their legal frameworks to promote the right to health and access to care through a number of legislative and regulatory initiatives. As of 2013, 18 of the Region's countries include the right to health in their constitutions, and in Chile, Colombia, Guyana, Haiti, and Peru the concept of social protection in health is a basic tenet in their health systems. The Organization helped Panama draft a new Health Code and supported El Salvador's Ministry of Health in formulating legislation on vaccines that went into effect in January 2013.

30. The Organization provided support for strategic planning and restructuring of health systems in Aruba, the Bahamas, and Curaçao as well as in the former Netherlands Antilles islands of Bonaire, Saba, and Sint Eustatius, which restructured their health sectors following changes in their constitutional status in 2010. To promote the primary health care approach to organizing health systems and services, PAHO created the Primary Health Care Collaborative Network, which allows experts from different countries to exchange information and identify and disseminate best practices. It has grown to some 450 members and 14 regional communities of practice and inspired the creation of similar communities of practice at the national level in Brazil and Chile. With PAHO support, Brazil implemented a program to improve access to and quality of primary care and completed evaluations for about half the country's 40,000 primary care teams.

31. PAHO partnered with the Andalusian School of Public Health to validate a situation analysis for hospitals in 10 Latin American and Caribbean countries and territories—the Dominican Republic, El Salvador, Jamaica, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Trinidad and Tobago, and Uruguay—and worked with Colombia's Antioquia National Faculty of Public Health to authenticate an analysis of emergency services in 14 countries. Health service managers in a number of countries used PAHO's Productive Management Methodology for Health Services (PMMHS) to analyze the efficiency and quality of health care and the costing and financing of health-care services.

Chronic kidney disease from nontraditional causes in Central America

A disconcerting increase in chronic kidney disease from non-traditional causes (CKDnT) with high mortality has been observed in agricultural communities of Central America, mainly in El Salvador and Nicaragua. In response, the Member States of the Central American Integration System (SICA) and the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA) issued the Declaration of San Salvador on CKDnT in April 2013. CKDnT was deemed a serious public health problem; urgent multisectorial, multidisciplinary, and participatory action was called to address it. As part of its technical cooperation, PAHO is supporting the strengthening of health surveillance systems and research capacity to better understand the causes and consequences of CKDnT, as well as providing support in the organization of health services.

32. PAHO supported countries' efforts to align their research policies with the regional Policy on Research for Health (CD49/10), approved by PAHO Member States in 2009, and with WHO's 2010 Strategy on Research for Health (WHA63.21). During 2012–2013, the Council of Central American Ministers of Health (COMISCA) used the regional policy as a framework for establishing the Commission on Research for Health for Central America and the Dominican Republic. WHO's Advisory Committee on Health Research worked with PAHO to develop a scorecard for monitoring the regional policy's implementation.

33. Also during the reporting period, 19 Latin American and Caribbean countries increased their share of clinical trials included in WHO's International Clinical Trials Registry Platform, and Peru fulfilled the technical requirements for being included as a data provider in the platform. With support from a network of regional and international experts, 12 countries adopted standards and used platforms to translate knowledge into practice. Chile launched a platform for the review of research by ethics committees.

34. PAHO supported country efforts in the area of patient safety and infection control. Brazil launched a new National Patient Safety Program and developed legislation for implementing the program in its Unified Health System. The Bahamas developed a national action plan to improve prevention and control of healthcare-associated infections.

Human resources for health

35. PAHO worked with countries to improve planning and management of the health workforce, both in ministries of health and at the local level. This included support for several subregional efforts to improve policymaking and planning on human resources. PAHO's Office of Caribbean Program Coordination coordinated with CARICOM ministries of health and other actors to develop a subregional human resources roadmap

with specific milestones for improving the governance and skills of human resources in health in the Caribbean in 2012–2017. In the Andean region, the Organization helped develop a policy on human resources in health within the framework of the Andean Health Agency/Hipólito Unanue Agreement, approved by Andean health ministers in 2012. In its role as advisory body for COMISCA, PAHO worked with teams from Belize, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, to implement the Development Plan for Human Resources in Health for Central America.

36. In collaboration with the health ministries of Jamaica, Peru, and Uruguay and the PAHO/WHO Collaborating Center on Health Workforce Planning and Research at Dalhousie University, Canada, and the Collaborating Center for Health Workforce Planning and Information at the University of the State of Rio de Janeiro, Brazil, PAHO helped design a regional initiative on human resource goals. It includes a second round of measurements of 20 regional goals for human resources in health for 2007–2015 and an analysis of human resource programs linked to priority goals at the national level.

37. As part of the integrated strengthening of human resources, a proposal on competencies for pharmaceutical services was approved by representatives of pharmacy schools from 23 countries.

38. Between mid-2012 and mid-2013, more than 2,800 individuals participated in 67 courses offered by the Virtual Campus for Public Health on topics including aging and health, the right to health, essential public health functions, the renewal of primary health care, and gender. PAHO's Edmundo Granda Ugalde program for leadership in international health provided education and training for 39 health professionals from 19 countries during 2012. In addition, PAHO supported efforts by 30 schools of medicine in eight countries—Argentina, Brazil, Chile, Canada, Colombia, Guatemala, Nicaragua, and the United States—to align their curricula with primary health care. PAHO's Expanded Textbook and Instructional Materials Program (PALTEX) included 54 new books and issued 26 new editions during 2012–2013.

39. PAHO also played a key supporting role in facilitating South-South cooperation on human resources development involving Cuba and other countries in the Americas. During 2012–2013, more than 300 Cuban health workers conducted training activities outside Cuba, and nearly 800 health workers travelled to Cuba to attend events or participate in training.

40. The Regional Observatory of Human Resources in Health was consolidated as a platform for the exchange of experiences, information, and knowledge on human resources policies oriented toward universal health coverage and the development of health systems based on primary health care. By mid-2013, 12 countries had joined the

observatory, facilitating online dialogue and sharing of experiences between countries and other stakeholders.

Medicines and health technologies

41. To strengthen national pharmaceutical policies, PAHO gathered information on 24 countries and made the results available to the respective Member States at a regional meeting in Quito, Ecuador, in 2013. The Organization prepared guidelines for developing pharmaceutical policies that encompass the right to health, universal health coverage, and social determinants involved in ensuring access to safe and effective medicines.

42. With PAHO's support, the Council for Human and Social Development (COHSOD) approved the Caribbean pharmaceutical policy in 2012 and in the same year Barbados approved its National Pharmaceutical Policy. PAHO also supported El Salvador in the development and approval of the National Medicines Policy in 2012 and the creation of the National Regulatory Authority. Through regulatory measures, El Salvador achieved a 35% reduction in medicines prices.

43. PAHO helped strengthen the capacity of Mexico's Federal Commission for Protection against Health Risks (COFEPRIS), which achieved recognition by PAHO as a Regulatory Authority of Reference in November 2012.

44. PAHO helped strengthen quality control of tuberculosis medicines in CARICOM's drug control laboratories in Guyana, Jamaica, Suriname, and Trinidad and Tobago with funds from Argentina's Ministry of Foreign Relations through the Argentine Fund for South-South and Triangular Cooperation (FO.AR). The 10th phase of the external quality control program for laboratories from 23 countries began in late 2012 with the support of the US Pharmacopeial Convention (USP). PAHO also supported a South-South cooperation initiative in which Cuba worked with member countries of the Bolivarian Alliance for the Peoples of Our Americas (ALBA) in the area of pharmaceutical regulation.

45. With support from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, PAHO assisted the Dominican Republic, Guatemala, and Honduras in preventing stock-outs of antiretroviral drugs by improving demand forecasting and other aspects of supply chain management. This work included the incorporation of a special drug monitoring tool into the Regional Platform on Access and Innovation for Health Technologies (PRAIS).

PAHO Strategic Fund

The Regional Revolving Fund for Strategic Public Health Supplies, known as the PAHO Strategic Fund, continued to play an important role in promoting access to high-quality, essential public health supplies for Member States. From June 2012 through June 2013, 18 of the Region's countries used the fund to purchase some $34 million in medicines and other essential public health supplies; seven used the fund's capital account to avoid the risk of drug shortages. During the reporting period, PAHO updated the fund's list of medicines to include 16 additional drugs for treating noncommunicable diseases (NCDs).

46. As part of PRAIS, a new observatory on health technology, access, and innovation concluded its first year of operations in May 2013. In addition, indicators for the health technology sector were validated in 19 countries. By mid-2013, PRAIS had some 1,000 users and more than 20 active communities of practice sharing information to improve governance and the regulation of health technologies.

47. PAHO also supported initiatives to ensure the availability of safe blood and blood products in the Region. Technical and legal analyses and subregional plans for blood safety and HIV for 2013–2017 were prepared for the Andean region and for Central America and the Dominican Republic. A technical cooperation project involving PAHO and the blood products laboratory at the National University of Córdoba (Argentina) made it possible for Brazil to make significant advances in the safety of blood products and to strengthen production of blood products.

48. In partnership with the International Atomic Energy Agency (IAEA), PAHO collaborated in the development of the agency's new (2016–2021) strategic plan and has played an important role in ensuring the safety and good working order of radiation therapy equipment in the Region. During 2012–2013, more than 150 pieces of radiation therapy equipment were inspected, and the IAEA's thermoluminescent dosimetry (TLD) postal dose audit service was used to certify equipment calibration. A joint project with Rotary International installed and calibrated 30 pieces of basic digital radiography equipment in first-level care institutions in Guatemala. PAHO also worked with RAD-AID—a nonprofit organization dedicated to increasing radiology services in the developing world—to provide education and training, assessments, and equipment planning in Haiti. Trinidad and Tobago received support in managing radiation overexposure.

49. At the regional level, the 28th Pan American Sanitary Conference in September 2012 officially endorsed the new IAEA Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards, which detail requirements for protecting people and the environment from harmful effects of ionizing radiation and ensuring the safety of radiation sources.

50. PAHO Member States in 2012 approved a resolution on Health Technology Assessment and Incorporation into Health Systems (CSP28.R9), which calls for strengthening and expanded use of evaluation processes to inform decision-making. The Health Technology Assessment Network of the Americas (REDETSA), which is coordinated by PAHO, increased participation to 25 members.

51. PAHO also worked in 2012–2013 to strengthen medicine-selection processes through both the Virtual Campus of Public Health and direct support for the development or updating of essential medicines lists in Barbados, Chile, Guatemala, Guyana, and Paraguay. This collaboration contributed to collective country savings of some $15 million in 2012.

52. The new Pharmacovigilance Group of the Pan American Network for Drug Harmonization (PANDRH) commenced activities in December 2012, in close connection with the Latin American and Caribbean Network of Drug Information Centers (RED CIM LAC). Regulatory authorities have been collaborating in pharmacovigilance through this mechanism.

Communicable Diseases

53. PAHO's technical cooperation supported Member States' efforts to reduce the burden of communicable diseases and to progress toward the elimination of those diseases considered eliminable. This work focused on strengthening capacity in disease prevention and control, preparedness, surveillance, detection, risk reduction, and response to hazards to human health, including events of potential international concern as defined in the International Health Regulations (IHR).

HIV, tuberculosis, hepatitis, and sexually transmitted infections

54. In 2012, PAHO's program on HIV and sexually transmitted infections (STIs) conducted a mid-term evaluation of the regional HIV/STI Plan for the Health Sector 2006–2015. The estimated incidence of HIV infection in Latin America and the Caribbean had declined from 21.1 per 100,000 population in 2005 to 19.1 per 100,000 in 2011. Pediatric cases declined significantly during the period 2001-2011 by 60% in the Caribbean and 38% in Latin America. Increased access to antiretroviral therapy had contributed to a 36% reduction in HIV-related deaths in Latin America and a 50% reduction in the Caribbean during the period 2001–2010. As a result of the mid-term evaluation, PAHO refocused its HIV/STI technical cooperation on four priorities: treatment optimization, elimination of mother-to-child transmission of HIV and congenital syphilis, prevention and care for key populations, and strategic information.

55. To that end, PAHO organized subregional briefings for Latin American and Caribbean countries on the implementation of the Treatment 2.0 platform, which seeks to

maximize the efficacy and effectiveness of HIV treatment. The Organization held two subregional meetings on the Treatment 2.0 framework. PAHO sent optimization missions to six countries—Bolivia, the Dominican Republic, Ecuador, El Salvador, Honduras, and Venezuela. These countries began implementing priority actions including voluntary migration of patients to preferred regimens, improvements in forecasting and supply chain management (supported by the PAHO Strategic Fund), strengthened community participation, decentralized services, and expanded access to HIV testing and counseling.

56. Together with the Global Fund to Fight AIDS, Tuberculosis, and Malaria, PAHO helped countries strengthen capacity for procurement and supply chain management to reduce stock-outs of antiretroviral drugs and related health products. A new regional platform to monitor antiretrovirals was created with support from the Global Fund and is being managed by the PAHO Strategic Fund.

57. The Organization developed a methodology for validating the achievement of targets for eliminating mother-to-child transmission of HIV and congenital syphilis, which was implemented in pilot projects in Chile and Saint Lucia. A 2012 progress report based on the methodology showed that regional coverage of HIV testing among pregnant women had increased from 29% in 2008 to approximately 66% in 2011, estimated antiretroviral coverage for pregnant women with HIV had increased from 55% in 2008 to 70% in 2011, and new cases of HIV infection among children had dropped by 24% in Latin America and 32% in the Caribbean between 2009 and 2011. Six countries—the Dominican Republic, Guatemala, Mexico, Nicaragua, Panama, and Paraguay—had less than 50% coverage of HIV or syphilis testing for pregnant women in 2011. PAHO partnered with the U.S. Centers for Disease Control and Prevention (CDC) to help countries including Bolivia and Trinidad and Tobago review and revise syphilis-testing algorithms and introduce point-of-care testing.

58. PAHO spearheaded the development of tools for providing comprehensive care for transgender persons and their communities. Based on expertise generated in this area, the Organization contributed to a technical dialogue for reframing transgenderism in the new International Classification of Diseases (ICD). It also facilitated training in Brazil and the Southern Cone countries on care for members of key populations and, in a collaborative effort with UN Women, developed a training package for health-care providers on integration of gender and human rights in HIV and sexual and reproductive health services. Also during the reporting period, Nicaragua's National Assembly approved a new law that guarantees the rights of people with HIV, which PAHO supported by working with the assembly's Health Commission and providing expertise for the national consultation.

59. By 2012–2013, the Region of the Americas had already achieved and surpassed the global Stop TB Partnership targets of reducing tuberculosis cases and deaths by 50% by 2015. According to WHO's 2012 global TB report, the Americas had the highest

annual rate of decline in TB incidence of any WHO region, at 4%. Nevertheless, multidrug-resistant tuberculosis (MDR-TB) and TB/HIV co-infection remain significant challenges for the Region.

60. During 2012–2013, 21 countries were implementing nationwide programs for PAHO-recommended case management of MDR-TB, 20 countries had introduced new technologies for TB diagnosis (GenXpert and line probe assays, LPAs), and 13 countries had adopted special approaches to TB control in indigenous populations.

61. In partnership with USAID, PAHO supported the implementation of a special framework for TB control in large cities in three pilot cities: Bogotá, Colombia; Guarulhos, Brazil; and Lima, Peru. Suriname adopted a new National Strategic Plan for Tuberculosis Control, and a new regional Center of Excellence for Tuberculosis was established in El Salvador to train new staff members of TB programs on implementing the "Stop TB" strategy.

62. PAHO developed a comprehensive regional strategy on viral hepatitis infection for the Americas. Seventeen countries expressed support for the strategy, and Argentina, Brazil, Colombia, Jamaica, and Peru have begun implementing specific activities aligned with it.

Neglected, tropical, and vector-borne diseases

63. During the reporting period, malaria remained endemic in 21 PAHO member countries, but 12 countries had already attained the MDG target for malaria, with cases reduced more than 75% since 2000. Several countries were moving beyond control toward elimination. In 2012–2013, Costa Rica and Ecuador joined Argentina, El Salvador, Mexico and Paraguay in the pre-elimination phase, by reducing cases to under 5 per 1,000 population and rolling out national elimination plans. Guatemala and Nicaragua remained in control phase but reoriented their national malaria programs toward action for pre-elimination. Guyana and Haiti both updated their malaria strategic plans, and Guyana also took steps to strengthen its malaria surveillance system and improve its rapid-response capacity. The countries of the Guyana Shield—Brazil, French Guiana, Guyana, and Suriname—strengthened cross-border coordination of their malaria control efforts.

64. Continuing improvements in malaria pharmacovigilance helped the countries better monitor the development of anti-malarial drug resistance. Routine antimalarial surveillance by Suriname detected a potential loss of sensitivity of first-line malaria drugs. Other achievements in 2012–2013 included the launch of a new regional Malaria Research Agenda and procurement of malaria medicines and supplies through the PAHO Strategic Fund by 12 countries. In addition, PAHO recognized and promoted malaria

"best practices" from Brazil, Ecuador, and Paraguay through its Malaria Champions contest, honoring the winners on Malaria Day in the Americas 2012.

65. During 2012–2013, Aruba, Bonaire, Curaçao, Jamaica, Sint Eustatius and Sint Maarten developed new strategies for integrated management of dengue prevention and control, El Salvador increased funding for the implementation of its existing strategy, which emphasizes broad intersectoral action. Bolivia and Chile achieved improvements in their dengue programs' performance. The progressive introduction of WHO's new classification of dengue in seven countries—Bolivia, the Dominican Republic, Guatemala, Honduras, Mexico, Panama, and Paraguay—improved patient care by increased detection of potentially severe cases.

66. Countries continued their efforts to fight neglected infectious diseases, achieving several important milestones during the reporting period. Belize was certified in November 2012 as having interrupted transmission of Chagas disease by its principal vector, *Triatoma dimidiata*. Bolivia was certified for interrupting *Triatoma infestans*, its principal Chagas vector, in all 21 municipalities of the department of La Paz. Argentina eliminated its principal vector in several endemic areas, and Paraguay did so in the department of Alto Paraguay.

Colombia becomes the first country to eliminate onchocerciasis

In 2013, WHO officially certified Colombia as free of transmission of onchocerciasis, or river blindness, making it the first country in the world to eliminate the disease. The achievement followed the country's 16-year effort to control onchocerciasis in a remote Pacific southwest community through the use of the antiparasitic drug ivermectin, epidemiological surveillance, and community education. The effort was led by Colombia's National Institute of Health with support from the Ministry of Health and Social Protection, PAHO, the Carter Center's Onchocerciasis Elimination Program of the Americas (OEPA), and Merck laboratories' Mectizan Donation Program.

67. In addition to Colombia's achievement, work toward the elimination of onchocerciasis has progressed in 13 areas in five other countries—Brazil, Ecuador, Guatemala, Mexico, and Venezuela. Ecuador is in the process of verification; Guatemala and Mexico may be similarly verified in 2015. Venezuela has interrupted transmission in two of its focal areas, although two remaining areas in the Yanomami region (which stretches into Brazil) have proven more difficult because of their remoteness and the high mobility of their mostly nomadic residents.

68. Seven countries launched new national plans of action for control and elimination of neglected infectious diseases: Brazil, Colombia, El Salvador, Guatemala, Guyana, Honduras, and Suriname. Eighteen countries developed action plans for control of

geohelminths, while *Honduras* and Paraguay launched mass deworming campaigns. Brazil implemented a campaign to treat geohelminths and for the early detection and treatment of leprosy targeting 7 million school-age children, with a special effort focused on detecting trachoma in high-risk groups of children. Haiti treated nearly 8 million people during 2012 for lymphatic filariasis, which represented about 60% of the total population at risk for this disease in the Americas.

International Health Regulations, epidemic alert and response, and water-borne diseases

69. As WHO's Contact Point for the International Health Regulations (IHR) in the Americas, PAHO contributed to the detection and management of over 100 events of potential international public health concern during mid-2012 to mid-2013. As part of the risk management process, event verification (when applicable) was obtained within the 48-hour window stipulated by IHR, and all events were jointly assessed with States Parties. Information and guidance related to these public health events was disseminated through 22 epidemiological alerts and 67 reports. In addition, PAHO provided support for outbreak response, including the deployment of international experts to the Bahamas, Barbados, Belize, and Peru for outbreaks of dengue, carbapenemase-producing *Klebsiella pneumoniae, Acinetobacter baumanii* and *Enterobacter cloacae*. PAHO also supported Chile in responding to an unusual increase in cases of meningococcal disease caused by *N. meningitidis* W 135.

70. Six of the 35 IHR States Parties in the Americas—Brazil, Canada, Chile, Colombia, Costa Rica, and the United States—determined that their core capacities for surveillance and response, including at designated points of entry, were in place by the established IHR deadline of June 2012. The remaining 29 States Parties obtained a two-year extension, until June 2014. PAHO provided support for these countries' efforts to improve their core capacities through the implementation of National IHR Extension Action Plans 2012–2014.

71. IHR States Parties Annual Reports submitted to the 66th World Health Assembly showed considerable heterogeneity in the status of core capacities in countries of the Americas. Compared with the previous year, progress was noted in capacities related to designated points of entry, laboratories, management of events related to zoonotic and food safety hazards, and surveillance. The most critical weaknesses were related to capacities for managing events associated with chemical and radiation hazards. To accelerate capacity building, PAHO partnered with the IAEA to organize two workshops for Caribbean Community (CARICOM) countries in 2012 and a workshop for the countries of the Central American Integration System (SICA) in 2013.

72. Although the spread of cholera in Hispaniola has slowed compared with the epidemic's early stages, Haiti and the Dominican Republic continued to battle the disease

in 2012–2013. Between mid-2012 and mid-2013[1], Haiti reported 103,046 new cholera cases and 850 deaths, while the Dominican *Republic* reported 5,220 new cases and 52 deaths.

Regional Coalition to Eliminate Cholera in Hispaniola

An important development was the creation in June 2012 of the Regional Coalition for Water and Sanitation to Eliminate Cholera in Hispaniola by PAHO in partnership with UNICEF, the U.S. Centers for Disease Control and Prevention (CDC), the Spanish Agency for International Development Cooperation (AECID), and the Inter-American Association of Sanitary Engineering (AIDIS). Launched at AIDIS's 33rd congress in Salvador, Bahia, Brazil, the coalition was a response to a January 2012 "call to action" by the governments of Haiti and the Dominican Republic for the international community to mobilize resources to support major new investments in water and sanitation to make it possible to eliminate cholera.

With technical support from the Regional Coalition, both Haiti and the Dominican Republic during late 2012 developed detailed national plans of action for eliminating cholera by 2022. Haiti's plan calls for $2.2 billion in investments over 10 years, including $443.7 million for the first two years. The Dominican Republic's plan calls for $77 million in investments over 10 years, including $33 million for the first two years.

By mid-2013, the Regional Coalition had grown to 20 members, had tallied pledges of more than $200 million (including $29.1 million in new funds), and was working to help mobilize the additional resources needed to fully fund the cholera elimination plans.

73. Influenza surveillance continued to improve in the countries of the Americas during 2012–2013. With the implementation of the Severe Acute Respiratory Illness (SARI) Surveillance System, 62 hospitals in 13 countries were reporting weekly data by June 2013 using internationally accepted indicators.

74. In addition, 27 national influenza centers throughout the Region were compiling, analyzing, and disseminating weekly virologic data to monitor seasonal influenza viruses and viruses with pandemic potential and to contribute to the selection of global vaccine strains. To integrate laboratory and epidemiologic data in the countries, PAHO developed an information system, PAHOFlu, which was installed in 14 hospitals and nine laboratories in Bolivia and Chile, with plans to expand the system to other countries of the region.

75. Twenty of the Region's countries were by mid-2013 participating in a surveillance system for anti-microbial resistance based on routine data from

[1] Epidemiological week 23 in 2012 to week 23 in 2013.

microbiological laboratories. Five countries—Barbados, Ecuador, Guatemala, Panama, and Paraguay—strengthened their capacity to identify, investigate, and respond to outbreaks linked to health care.

76. The dissemination of microbiology standards contributed to standardization and agreement on procedures for the regional Surveillance Network on Antimicrobial Resistance. Among new pathogens being monitored by national public health laboratories was *Neisseria gonorrhoeae,* which has developed resistance to third-generation cephalosporin antibiotics.

77. As part of its work to strengthen laboratory capacity, PAHO assisted 18 national information centers and laboratories in improving their ability to perform real-time PCR and immunofluorescence for influenza and other respiratory viruses and provided essential supplies for laboratory diagnosis of bacterial meningitis and pneumonia in 14 countries and at CAREC.

78. The Organization facilitated the inspection of laboratories in Brazil (National Institute of Quality Control in Health), Colombia (National Institute for Food and Drug Surveillance), and Mexico (Commission for Analytical Control and Expansion of Coverage). In September 2012, the 10th phase of PAHO's External Quality Control Program for official laboratories responsible for the quality control of drugs was carried out in 23 countries, with a focus on pyrazinamide tablets for treatment of tuberculosis.

79. PAHO developed a guide based on the Stepwise Improvement Process for strengthening laboratory quality management systems for the Caribbean, in consultation with health experts from 22 countries and territories. Professionals from 31 countries were trained in bio-risk management and were certified in the safe transport of infectious samples.

Veterinary public health and food safety

80. Through its Pan American Center on Foot-and-Mouth Disease (PANAFTOSA), PAHO provided technical cooperation on veterinary public health and food safety, focusing on the elimination of foot-and-mouth disease and human rabies while also working to strengthen national capacities to reduce the risks of zoonoses and food-borne illness.

81. During the reporting period, the Region of the Americas experienced no outbreaks of foot-and-mouth disease, complying with the commitments of the Hemispheric Program for the Eradication of Foot and Mouth Disease. At the country level, Peru was declared free of foot-and-mouth disease in May 2012, Ecuador remained free of outbreaks for its second consecutive year, and Bolivia expanded the area free of disease

to 40% of its territory. Meanwhile, Paraguay was in the process of being certified as free of foot-and-mouth disease with vaccination.

82. Seven countries—Brazil, Chile, Colombia, the Dominican Republic, Ecuador, Haiti, and Peru—strengthened laboratories for diagnosing rabies through training and the establishment of a new Latin American and Caribbean Network of Rabies Diagnosis Laboratories. Haiti and the Dominican Republic updated their programs to control rabies transmitted by dogs.

83. A new regional Food Safety Strategy for 2013–2017 was endorsed by the Pan American Commission for Food Safety (COPAIA 6) and by 15 countries during the 2012 Inter-American Meeting at the Ministerial Level on Health and Agriculture (RIMSA 16). Five countries—Bolivia, Panama, Peru, Uruguay, and Venezuela—strengthened their laboratory capacity for analysis of food-borne pathogens. In addition, a South-South cooperation project between Brazil, Colombia, and Cape Verde and a North-South effort between Canada and Caribbean countries were expanded to include strengthening of food safety along with capacity building for evaluating microbiological and chemical risks.

Health information and analysis

84. PAHO published the latest edition of its flagship publication, *Health in the Americas*, *2012 edition*, during the reporting period. This comprehensive quinquennial report provides essential, accessible regional and country health data and analysis for health authorities, policymakers, academicians, students, other analysts, and the general public.

85. At the country level during 2012–2013, Antigua and Barbuda, the Bahamas, Haiti, and Jamaica developed new policies and action plans for their health information systems to improve the quality of their surveillance data. The Dominican Republic, Ecuador, and El Salvador began using the web-based ViEpi epidemiological surveillance system, and Jamaica installed an integrated surveillance system for vaccine-preventable diseases. In addition, 13 countries strengthened their capacity to guide health sector priority setting and decision-making by developing national "Basic Indicators" brochures.

86. In 2012, 17 of 25 countries reached the agreed target on reporting national statistics on births. Additionally, 11 of 25 countries reached the target on reporting national statistics on deaths.[2]

[2] 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%. (Regional Plan of Action for Strengthening Vital and Health Statistics, Document CD48/9 [2008])

87. Twenty-five facilitators from Bolivia, Ecuador, Paraguay, and Peru and 100 coders from El Salvador, Guatemala, Honduras, and Nicaragua received training in the International Classification of Diseases, 10th Edition (ICD-10). Bolivia and Ecuador provided training on ICD-10 to some 200 health technicians through subnational courses. Eight countries—Argentina, Chile, Costa Rica, Ecuador, Guatemala, Paraguay, Uruguay, and Venezuela—began using an electronic system for coding mortality according to ICD-10, provided by Mexico.

Family, Gender, and Life Course

88. PAHO recognizes the central role of the family and community in promoting and protecting health as a social value and a human right and uses a life-course approach, addressing the specific needs of each population group. Technical cooperation in this area seeks to promote the health, nutrition, and comprehensive development of children from infancy through adolescence and protect achievements in immunization while expanding access to its benefits. A central priority of this work during the reporting period was to accelerate reductions in maternal and neonatal mortality.

Immunization

89. The countries of the Americas continued to lead the way in the introduction of new vaccines where supported by the appropriate evidence. As of June 2013, 17 countries and territories had introduced rotavirus vaccine into their national immunization programs, protecting 86% of all children under age 1 in the Region. Twenty-one countries and five territories included pneumococcal vaccine in their routine schedules, covering 81% of children under 1. In addition, seven countries had introduced the human papillomavirus (HPV) vaccine, covering 51% of all girls aged 10-14 years in the Americas.

90. Other new vaccine introductions during 2012–2013 included pentavalent vaccine in Haiti; pneumococcal conjugate vaccine in Argentina, Bahamas, Guatemala, Paraguay, and Trinidad and Tobago; inactive polio vaccine in Brazil, seasonal influenza vaccine in Dominica, and varicela and hepatitis A in Paraguay. A number of countries also made progress in expanding immunization coverage during 2012–2013.

91. PAHO's technical cooperation in support of these achievements focused on capacity building for rapid monitoring of vaccine coverage and surveillance and analysis of data on vaccine-preventable diseases. In addition, PAHO's ProVac initiative helped countries develop capacity for making evidence-based decisions on the introduction of new vaccines.

PAHO Revolving Fund

The PAHO Revolving Fund for Vaccine Procurement supported immunization achievements during the reporting period by providing credit lines and making bulk purchases on member countries' behalf to ensure a continuous supply of high-quality vaccines and syringes for national immunization programs. By mid-2013, 39 countries and territories were participating in the Revolving Fund, which translates into more than $518 million dollars in vaccines acquired for the Region during 2012, 6.5 times the amount purchased in 2000.

92. PAHO provided important support to help maintain the elimination of polio, measles, rubella and congenital rubella syndrome, including the development of a regional plan of action to strengthen rapid-response capacity in the countries. As part of these efforts, five countries—Argentina, Bolivia, Colombia, Ecuador and Haiti—received PAHO support for strengthening surveillance and outbreak response.

93. In April 2013, PAHO celebrated the 11th annual Vaccination Week in the Americas, the Americas' largest regional health initiative. Forty-four countries and territories participated, reaching out to over 44 million people. All WHO regions also participated in the second World Immunization Week.

Maternal, child, and adolescent health

94. PAHO supported countries' efforts throughout 2012–2013 to reduce maternal and child mortality through expanded coverage of antenatal care and childbirth with trained assistance, access to and use of contraceptives, and guidelines and training for improved obstetric and pediatric care. These and other interventions were in line with the 2011 regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity (CD51/12 [2011]) and the 2008 Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care (CD48/7 [2008]), for which a mid-term evaluation was completed.

95. Countries including Argentina, Colombia, Dominica, the Dominican Republic, Haiti, and Paraguay developed or advanced the implementation of national programs to reduce neonatal mortality and improve maternal health, with PAHO support. Guyana implemented a neonatal care program at its main hospital that significantly lowered neonatal mortality in the facility. Guatemala adapted and implemented the Code Red strategy for managing obstetric hemorrhage, while Brazil launched the new Stork Network (Rede Cigonha), which makes use of expert committees and social mobilization to reduce maternal and neonatal mortality.

96. In a collaborative effort with Texas Children's Hospital, a PAHO/WHO Collaborating Center, El Salvador's San Juan de Dios Hospital in the department of

San Miguel and Panama's Children's Hospital became centers of excellence for training in classification, evaluation, and treatment of pediatric emergencies.

97. During 2012–2013, CLAP's Perinatal Information System (SIP) was being used as the national standard in nine countries and was being implemented as the national standard in six others: Bahamas, Belize, Colombia, Costa Rica, Guyana, and Mexico. In a technical cooperation between countries (TCC) project, El Salvador, Honduras, Nicaragua, and Panama strengthened their use of SIP to produce better and more complete information, particularly in the area of mother-to-child transmission of HIV and syphilis. Also, a methodology for validating the achievement of targets for eliminating mother-to-child transmission of HIV and congenital syphilis was developed and pilot-tested in Chile and Saint Lucia.

98. With support from PAHO and the UN Development Group for Latin America and the Caribbean (UNDG-LAC), six countries—Bolivia, Brazil, Guatemala, Honduras, Mexico, and Peru—elaborated a roadmap for implementing the Information and Accountability on Women's and Children's Health framework for reporting, oversight, and accountability on women's and children's health. These roadmaps will be submitted to WHO for financing of priority implementation activities and are expected to help guide the allocation of future resources from other sources.

99. PAHO supported member countries' efforts to address multiple health challenges facing adolescents and youths in the Americas. These include high fertility rates, substance abuse, violence, and the rising trend in physical inactivity and overweight/obesity. Low-income, cross-border, and ethnic minority youths are disproportionately affected by many of these problems, and PAHO focused both research and intervention on these groups. The Organization also supported member countries in the areas of risk prevention and promotion of healthy behaviors at the individual, family, and community levels.

100. By 2013, 28 countries had established national adolescent health programs and were moving forward with their implementation in regions and departments. PAHO's support for these efforts emphasized a life course, gender, and human rights framework and a focus on vulnerable and at-risk populations. Key areas of work included prevention of gender-based violence, comprehensive sexual and reproductive health services, and prevention of adolescent pregnancy and HIV/AIDS.

101. PAHO collaborated in an initiative supported by the Government of Norway to improve adolescent health in countries including the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, and Panama. Six of these developed strategies during 2012–2013 to adapt health policies to the health and development needs of adolescents, based on interventions and services recommended by the Integrated Management of Adolescent Needs (IMAN) Strategy. Bolivia, Colombia, Ecuador, and

Peru implemented the Strengthening Families Program—supported by PAHO, the European Union, and PRADICAN (Program against Illicit Drugs in the Andean Community)—to reduce risky behaviors among adolescents and strengthen communication between parents and teens.

102. With technical and financial support from PAHO and the U.S. CDC, the Eastern Caribbean countries carried out the Caribbean Health Survey, the results of which showed illicit drug use, violence, teen pregnancy, and obesity/lack of physical activity as major health issues facing the subregion's adolescents. Based on the survey's findings, Barbados, St. Kitts and Nevis, and St. Vincent and the Grenadines developed adolescent health policies in line with the PAHO Regional Strategy for Improving Adolescent and Youth Health (CD48/8 [2008]).

Nutrition

103. PAHO supported the development and implementation of national strategic nutrition plans in a number of the Region's countries. In infant and young child nutrition, the Organization supported countries in implementing, regulating, and monitoring the Code of Marketing of Breast-milk Substitutes. This work contributed to legislation passed by El Salvador's congress, a breastfeeding policy decreed by Mexico's secretary of health, and a regulation to implement legislation on the breast-milk code signed by Panama's president. PAHO supported sending teams from Chile and Mexico to Brazil to observe their successful breastfeeding program and human milk banking. A tool to promote programming in breastfeeding and complementary feeding, ProPAN (Process for the Promotion of Child Feeding), was finalized and widely distributed through face-to-face meetings and webinars.

104. In Central America, the Dominican Republic, and Paraguay, PAHO supported efforts to prevent chronic malnutrition and to develop norms and regulations for micronutrient supplementation and food fortification. The Organization also worked with countries to develop guidelines on the marketing of foods to children.

Oral health

105. PAHO's technical cooperation in oral health during the period included support for a study on the oral health status of school-age children in Barbados, using WHO's 1987 protocol and the oral health component of Health Canada's 2010 Canadian Health Measures Survey. The study found dental caries in 55% of Barbadian 6-year-olds, 43% of 12-year-olds, and 58% of 15-year-olds. The results compared unfavorably with figures from 2001, at 37%, 37%, and 45%, respectively.

106. PAHO also supported Haiti's launch of a 2013–2022 strategic oral health plan, Paraguay's systematic implementation of a national oral health policy, and Panama's

expansion of coverage with fluoridated water and implementation of the Caries-Free Communities strategy.

107. In 2013, PAHO and Colgate-Palmolive renewed a cooperation agreement that seeks to improve the oral health of children and adolescents living in remote communities in Colombia, Guatemala, Honduras, Mexico, and Peru. The collaboration will focus on training and raising awareness of the risk factors associated with oral diseases.

Aging

108. PAHO continued supporting member countries' efforts to adapt their health policies and systems to address the changing needs of a rapidly aging population and to promote prevention to keep seniors healthy and active. As of 2013, 18 countries had developed policies, legal frameworks, and/or national plans on aging and health, and at least five others were in the process of developing them.

109. More than 200 health managers from 18 Latin American and 11 Caribbean countries and territories were trained as part of a 10-month specialization program on public health and aging created by PAHO and partners to improve primary health care for older adults. In addition, PAHO brokered an agreement with the Inter-American Center for Social Security Studies and more than 15 Latin American and Caribbean universities to develop a Public Health and Aging Consortium that will advocate for healthy aging as a main public health priority. Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Mexico, and the United States are currently represented in the consortium.

Noncommunicable Diseases and Mental Health

110. In September 2012, the 28th Pan American Sanitary Conference approved the Regional Strategy for Noncommunicable Diseases 2012–2025 (CSP28/9, Rev. 1). The strategy is consistent with WHO's global strategy and plan of action on NCDs and includes four main lines of action: policies and partnerships, risk and protective factors, a health system response, and surveillance and research. It emphasizes the four highest-burden NCDs in the Americas—cardiovascular disease, cancer, diabetes, and chronic respiratory diseases—and their four main risk factors—tobacco, unhealthy diet, physical inactivity, and harmful use of alcohol. The strategy seeks to raise the profile of NCDs on countries' development and economic agendas and promotes an "all-of-society" approach involving governments, the private sector, academia, and civil society. In line with the new regional strategy, 10 countries—Antigua and Barbuda, Belize, Costa Rica, Dominica, Guyana, Nicaragua, Panama, Paraguay, Saint Kitts and Nevis, and Suriname—established or revised national multisectoral NCD policies, strategies, or plans during 2012–2013.

111. At the regional level, PAHO convened the new SaltSmart consortium, which brought together health and nutrition experts from governments, civil society, and universities with representatives of industry. In 2013, the consortium endorsed a multi-year plan to cut dietary salt consumption in the Americas in half by the year 2020. The plan proposes a series of commitments and actions, including campaigns to raise public awareness about the importance of salt reduction and steps to reduce salt in industrially processed foods.

Women's Cancer Initiative

In February 2013, PAHO launched the new Women's Cancer Initiative, an alliance of public and private organizations committed to reducing breast and cervical cancer, the leading cancers among Latin American and Caribbean women. The initiative will undertake joint efforts in areas including advocacy and communication; capacity building for detection, diagnosis, treatment and care; improved access to services and treatment; wider vaccination against human papillomavirus (HPV); and expanded research. Along with the SaltSmart consortium, the Women's Cancer Initiative was launched within the framework of the Pan American Forum for Action on NCDs (PAFNCD).

112. Several countries implemented new or enhanced programs for NCD care into their health services. Dominica, Saint Lucia, Saint Vincent and the Grenadines, and Suriname launched programs for integrated management of chronic diseases focused on primary care, while Colombia, Ecuador, Jamaica, Mexico, and Peru developed new programs specifically for prevention and control of cancer. To support these and similar programs, PAHO defined a set of essential and affordable medicines for treatment of NCDs that member countries could purchase through the PAHO Strategic Fund.

113. Argentina, Bolivia, El Salvador, Guatemala, Honduras, and Jamaica strengthened their national cervical cancer screening programs through training for health-care providers, improved quality of testing, increased screening coverage, and assured diagnosis and treatment for women with abnormal test results. At least a dozen other countries improved their cancer registration systems and procedures.

114. Sixteen countries implemented the Chronic Care Passport, a patient-held card developed through PAHO technical cooperation that fosters adherence to medication, encourages self-care and prevention, and facilitates NCD data collection. More than 1,500 health professionals and 500 patients from throughout the Region registered to take an online course on diabetes self-management offered through the Public Health Virtual Campus.

Legislation and regulation to address NCD risk factors

PAHO supported efforts in a number of countries to address NCDs and their risk factors through legislative and regulatory initiatives. Chile and Bolivia were among countries that enacted new laws complying with the Framework Convention on Tobacco Control (FCTC), while Bolivia set up an intersectoral commission for implementation of the FCTC. Antigua and Barbuda, Bolivia, Dominica, Grenada, Guyana, Peru, Saint Lucia, Saint Kitts and Nevis, and Saint Vincent and the Grenadines were by mid-2013 developing legislative proposals for FCTC implementation.

To confront the growing problem of overweight and obesity in both children and adults, countries including Brazil, Chile, Ecuador, and Peru passed laws to regulate advertising, promotion, and labeling of industrially processed foods, including restrictions on marketing to children. Chile, Costa Rica, Ecuador, Mexico, Peru, and Uruguay adopted or implemented new norms or guidelines promoting healthy school meals, and Brazil entered into an agreement with its national federation of private schools for this purpose. In Mexico, PAHO helped advocate for new taxes on sugar-sweetened beverages.

Also during the period, Paraguay approved new regulations to reduce the salt content of industrially produced bread.

115. In the area of disabilities and rehabilitation, the Organization assisted Andean countries in developing a common policy on care for people with disabilities. Implementation began in Bolivia, Chile, Colombia, Ecuador, Peru, and Venezuela in the areas of development and strengthening of networks for comprehensive rehabilitation services; use of WHO's International Classification of Functioning, Disability and Health (ICF); and interventions for social protection of people with disabilities.

116. Seven countries—Argentina, Bolivia, Chile, Colombia, Costa Rica, Paraguay, and Venezuela—began implementing the PAHO Community-based Rehabilitation strategy, and baseline information was updated on the situation of people with disabilities in nine countries: Argentina, Brazil, Chile, Ecuador, Mexico, Paraguay, Peru, Uruguay, and Venezuela.

Mental health

117. Countries throughout the Region advanced in the implementation of WHO's Mental Health Gap Action Program (mhGAP). This Program promotes scaling up of services for mental, neurological, and substance use disorders. During the reporting period, 18 countries and territories in the Region were using mhGAP to integrate mental health into primary health services or to develop plans for this purpose.

118. During 2012–2013, a number of countries and territories completed or advanced in developing mental health policies and legislation. Anguilla, Antigua and Barbuda, Barbados, the British Virgin Islands, Costa Rica, Panama, Suriname, and Venezuela developed new or updated existing national mental health policies and plans. Argentina promulgated regulations related to its Mental Health Law, which protects the rights of people suffering from mental disorders, while Jamaica and the British Virgin Islands carried out reviews of mental health legislation.

119. Professionals from Anguilla, Antigua and Barbuda, and Jamaica received training on psychological first aid (PFA) in disasters and emergencies, and drafted mental health and psychosocial components for their national health disaster plans. The Bahamas, Suriname, and Trinidad and Tobago also provided training on mental health in disasters and PFA.

120. PAHO published the Regional Report on the Assessment of Mental Health Systems in Latin America and the Caribbean, which evaluates 34 countries and territories. The report provides a baseline for future evaluation of progress in mental health reform.

121. Harmful use of alcohol is a critical risk factor for mental health and other NCDs as well as for injuries and reproductive problems. To that end, PAHO supported a meeting of the Pan American Network on Alcohol and Public Health in 2012, in which representatives of 30 countries generated recommendations for implementing the 2011 Plan of Action to Reduce the Harmful Use of Alcohol. In 2013, PAHO launched several virtual courses in this area, including a course on alcohol screening and brief interventions for health workers and courses on public health and alcohol and drug policies for health policymakers. The Organization also worked throughout 2012–2013 to strengthen countries' implementation of the 2011 Plan of Action on Psychoactive Substance Use and Public Health, providing technical cooperation to ministries of health in coordination with other sectors.

Sustainable Development and Environmental Health

122. PAHO worked to strengthen member countries' capacities to address environmental health issues and social determinants of health through intersectoral work and promotion of "health in all policies". PAHO participated in the global and regional processes such as the UN Conference on Sustainable Development (Rio+20), the Congress of the Inter-American Association of Sanitary Engineering (AIDIS), and other consultations to address these issues.

123. With PAHO support, Latin American and Caribbean countries advocated successfully on health issues at the June 2012 Rio+20 Conference. PAHO's "Rio+20" toolkit and an ongoing seminar series provided information and space for debate on these

issues for stakeholders in the health sector. In February 2013, PAHO and AECID organized a consultation on health in the post-2015 development agenda in Antigua, Guatemala, with civil society representatives and mayors of vulnerable municipalities from 15 countries. In addition, PAHO supported Saint Lucia in preparing for a UNDP-sponsored national consultation on the post-2015 agenda, one of 50 such consultations held around the world. PAHO also facilitated preparations for the 8th Global Conference on Health Promotion in Helsinki in June 2013 through the development and dissemination of a toolkit on "Health in All Policies."

124. To follow up on the recommendations from the Rio Declaration on Social Determinants of Health, Belize, the Dominican Republic, and Trinidad and Tobago established intersectoral committees during the reporting period. Argentina, Brazil, Canada, Chile, Costa Rica, Cuba, El Salvador, Mexico, and Peru strengthened their existing committees. With support from Canada and WHO, an analysis summarizing economic rationales for other sectors to address social determinants of health was conducted in Mexico, documented, and finalized. PAHO assisted Honduras and Peru in strengthening capacity to measure and monitor health disparities within the framework of social determinants of health.

125. PAHO worked with countries to build capacity to carry out intersectoral work and advocacy for "health in all policies" and to advance health equity. The Organization developed a tool to help countries document and systematize examples of intersectoral work at the national, subnational, and local levels that exemplifies the "health in all policies" approach. Sixteen countries used the tool to develop their own case studies. In addition, Brazil, Chile, El Salvador, and Mexico gathered evidence that a health-in-all-policies approach has important effects on health equity.

126. The Organization facilitated the presentation of several regional case studies at the 8th Global Conference on Health Promotion in Helsinki in June 2013. These included Brazil's Bolsa Familia ("Family Allowance") and Brazil sin Miseria ("Brazil without Poverty") initiatives, Canada's experience with "health equity in all policies," Chile's Choose Healthy Living initiative, Ecuador's National "Good Living" Plan, El Salvador's Intersectoral Health Commission (CISALUD), and Mexico's National Accord for Nutritional Health - Strategy against Obesity.

127. As part of its work promoting healthy settings, PAHO helped develop new digital platforms that integrate the websites and social media channels of the Healthy Schools Network, the International Ecoclubs Network, and the Ibero-American Network of Healthy Universities, with plans to develop similar platforms for the Healthy Municipalities and Communities Network. Ecuador became the first country to establish national norms for the accreditation of healthy markets, using concepts proposed by PAHO.

128. Also during the period, the Ciclovías (Open Streets) movement grew to include 354 participating towns, cities, and neighborhoods in the Americas. Some 240 of the newest programs are in Peru and are the result of new incentives for municipalities provided by the Ministry of Economy and Finance.

Violence and human security

129. In collaboration with the U.S. CDC, PAHO in 2012 published *Violence against Women in Latin America and the Caribbean: A Comparative Analysis of Population-based Data from 12 Countries.* This is the first comparative report with nationally representative data on violence against women in Latin America and the Caribbean. To facilitate future comparative analyses, PAHO supported an effort by the Andean Community of Nations to standardize indicators for gender-based violence.

130. In conjunction with PAHO/WHO Collaborating Centers, PAHO supported efforts to develop national plans for prevention of violence and injuries in Trinidad and Tobago and gender-based violence in Guyana, while helping to strengthen capacity for primary prevention of violence against women in Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Paraguay, and Peru. In Guatemala, this work included the development of local plans for prevention of violence and crime, including gender-based violence, as part of the UN Joint Program on Conflict Prevention and Peacebuilding, sponsored by the MDG Achievement Fund.

131. PAHO's U.S.–Mexico border office helped implement a USAID-funded program in Ciudad Juárez, the Violence and Injury Prevention (VIP) Project, which has become a model for other cities and municipalities in Mexico. As part of this program, the Organization helped strengthen the Observatory for Safety and Peaceful Coexistence at the Autonomous University of Ciudad Juarez; build capacity among primary care and social service providers, first responders, and community organizations; and improve the knowledge management and communication skills of the media and the community.

132. PAHO provided training in information gathering and analysis on violence prevention, and by mid-2013 24 countries had appointed a focal point to provide data to WHO's Global Status Report on Violence Prevention. With support from the U.S. CDC's National Center for Injury Prevention and Control (NCIPC), a PAHO/WHO Collaborating Center, PAHO contributed to assessing and strengthening surveillance systems on violence and injuries in countries including Belize, Haiti, and Trinidad and Tobago.

133. PAHO supported the development and implementation of health components in projects to improve human security in Brazil, Colombia, and Guatemala, funded by the UN Trust Fund for Human Security. In 2012, the Organization launched a Technical Reference Document on Human Security Implications for Public Health, outlining a

collaborative human security approach that brings together diverse organizations and policies to address the root causes of people's vulnerabilities. During the reporting period, case studies of projects using such an approach were finalized in Brazil, Colombia, the Dominican Republic, Guatemala, Mexico, and Peru.

Chemical safety

134. Fourteen countries of the Americas participated in the third session of the International Conference on Chemicals Management, held in Nairobi, Kenya, in September 2012. As a result of this participation, several countries submitted applications for resources from the Strategic Approach for International Chemical Management (SAICM), a policy framework for promoting chemical safety around the world.

135. Member States also took an active role in the intergovernmental negotiating committee drafting the Minamata Convention on Mercury, a legally binding global treaty to prevent chemical emissions and releases. As a result of the negotiations, an article on health was included in the final text of the treaty, which will be open for signature at a special meeting in Japan in October 2013. In related work, PAHO translated the WHO technical guidance document *Replacement of mercury thermometers and sphygmomanometers in health care* into Spanish and disseminated it in the Region of the Americas.

Workers' and consumers' health

136. In December 2012, a "Call for Action on Workers' Health and Safety in the Caribbean" was approved and endorsed by representatives of eight Caribbean countries and territories: Bahamas, Barbados, Belize, Grenada, Jamaica, Saint Kitts and Nevis, Saint Lucia, and Turks and Caicos. The document calls for the creation of a Caribbean Plan of Action on Workers' Health and Safety and urges an intersectoral approach. The effort was led by PAHO in collaboration with national labor and health authorities and St. George's University in Grenada (a PAHO/WHO Collaborating Center), with support from Canada's Department of Foreign Affairs, Trade, and Development (DFAIT), and the National Insurance Board (NIB) of the Bahamas, among others.

137. In conjunction with CAREX Canada and PAHO/WHO Collaborating Centers, PAHO supported training on occupational cancer and estimating occupational exposure to carcinogens as part of efforts to build the regional CAREX, an information system with data on workers' exposure to carcinogens. Five countries—Canada, Colombia, Costa Rica, Nicaragua, and Panama—participated in the construction of occupational exposure matrices that were used to raise awareness and empower 28 industrial hygienists in Latin America to use the methodology.

138. Experts on public health surveillance from 15 countries were mobilized during the reporting period to participate in the Consumer Safety and Health Network (RCSS), coordinated by PAHO and the Organization of American States (OAS). They received training in management of consumer product safety surveillance systems offered in conjunction with the Pompeu Fabra University of Barcelona.

Road safety

139. In the context of the UN Decade of Action for Road Safety (2011–2020), a number of countries in the Americas developed, approved, or implemented new plans and laws aimed at reducing traffic fatalities. These included Ecuador, which improved its legislation on traffic injury risk and protective factors (PAHO helped develop technical norms on the use of protective helmets by motorcyclists), as well as Dominica, Guyana, and Uruguay. El Salvador ratified a new Law for the National Fund for Victims of Traffic Accidents (FONAT), which prioritizes the problem of traffic accidents and deaths on the public agenda. In addition, Mexico progressed in its implementation of the Mexican Road Safety Initiative (IMESEVI) in all 31 states. In late 2012, Brazil incorporated all state capitals and the Federal District into its Vida no Trânsito ("Life in Traffic") project, which focuses on speed management and reducing drunk driving.

140. The Mesoamerica Road Safety Plan, developed with assistance from PAHO and WHO, was unanimously approved by ministers of health, infrastructure, and transportation from 10 countries: Belize, Colombia, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, and Panama. Based on a global model developed by the UN Road Safety Group, the plan provides a basis for action that can be contextualized in different cultures, and by different governments, businesses, and institutions.

Water and sanitation

141. PAHO worked with countries to develop and implement water and sanitation (WATSAN) strategies and plans. These included Ecuador, El Salvador, and Honduras as well as Nicaragua, which implemented a program focused on removing arsenic from water supplies in rural communities. Grenada developed a Water Safety Plan based on the methodology developed by WHO and the International Water Association, while Colombia, Costa Rica, and Paraguay implemented the methodology at the ministerial level and locally with local partners.

142. In addition, PAHO supported an assessment of water, sanitation, and hygiene in the Bahamas and supported the implementation of water quality monitoring parameters in Antigua and Barbuda. In collaboration with UNICEF, PAHO facilitated technology transfer from Haiti to the Dominican Republic and Colombia for surveillance and

monitoring of water quality using short message service (SMS), or text messaging. The initiative will provide the basis for development of a regional guide on this subject.

143. In collaboration with the International Water Management Institute (IWMI) and the Swiss Tropical and Public Health Institute (TPH), PAHO assisted with the identification of five Resource Recovery and Reuse sites in Lima, Peru, for two pilot projects that will generate evidence on the application of Sanitation Safety Plans (SSPs) for WHO's upcoming SSP manual.

144. PAHO developed new regional coordination tools for risk management in water, sanitation, and hygiene during emergencies. These include a "coordination checklist" and a "rapid guide" for establishing different responsibilities between the UN Cluster and a new Virtual Coordination Platform. Nine countries—Belize, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay—incorporated these tools into their water and sanitation coordination mechanisms with PAHO support. A new PALTEX textbook, Water and Sanitation: New Paradigms, was launched in Belo Horizonte during the AIDIS meeting.

145. PAHO also promoted country involvement in and follow-up of the 2012 Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS 2012), and Member States provided contributions and feedback on proposed goals for water and sanitation in the post-2015 development agenda.

Disaster Preparedness and Response

146. Following extensive consultations with countries and other stakeholders, PAHO's Emergency Preparedness and Disaster Relief program in 2012–2013 revised its strategic approach to comprise three main lines of work: improving capacity of Member States to provide a timely and appropriate response to disasters, complex emergencies, and other crises; enhancing capacity of national health systems for emergency preparedness and disaster risk reduction; and increasing the effectiveness of PAHO and the UN Health Cluster in responding to disasters. Technical cooperation ranged from leadership and advocacy to training, technical guidance, and provision of software, manuals, tools, and equipment. In addition, PAHO coordinated the deployment of experts to assist countries' health sector response during emergencies.

147. During the reporting period, 21 new disaster risk reduction and response grants were mobilized, totaling some $10 million. The funds supported disaster response in nine countries: Colombia (internally displaced persons), Cuba and the Dominican Republic (for Hurricane Sandy), El Salvador (tropical depression 12), Guatemala (San Marcos earthquake), Haiti (for Hurricane Sandy and cholera), Panama (internally displaced persons) Paraguay (flooding), and Peru (dengue and flooding). The funds also supported disaster risk reduction and preparedness in the Dominican Republic, Grenada, Guyana,

Haiti, Jamaica, Saint Lucia, Suriname, and Trinidad and Tobago and for the Region as a whole.

148. In June 2012, PAHO inaugurated its new Emergency Operations Center (EOC) in Washington, D.C., and adopted a new policy and procedures to improve its delivery of cooperation during emergency response operations. The EOC follows an Incident Management System model with three levels of activation: level 1, during events of lesser impact for which PAHO's country office can provide the necessary support, and level 2 or 3 during higher-impact disasters that require mobilization of varying levels of international support.

149. PAHO also increased its surge capacity to respond to emergencies through training of existing as well as new members of the Regional Health Response Team. The team includes experts in epidemiological surveillance, alert and response, emergency logistics, water and sanitation, mental health, and risk communication, among other fields. Members are mobilized from among PAHO's own staff and from partner organizations such as ministries of health and universities.

150. During the reporting period, members of the Regional Health Response Team were mobilized to support seven PAHO Member States during disasters: Haiti (Hurricane Isaac), Jamaica (Hurricane Sandy), Ecuador (floods in Costa and Sierra), Costa Rica (earthquake in Nicoya), Guatemala (San Marcos earthquake), Peru (dengue outbreak), and the Dominican Republic (cholera outbreak in Higuey Prison).

151. At the country level, Argentina, Bolivia, Colombia, Chile, Ecuador, Paraguay, and Peru established national disaster response teams to coordinate disaster surge support in the health sector, with PAHO support. The teams may also be deployed to neighboring countries during emergencies, either as South-South cooperation or as part of the PAHO Regional Health Response Team.

152. A number of countries strengthened their health response capacity in emergencies. Seven countries— Anguilla, Chile, Dominica, Jamaica, Peru, Saint Vincent and the Grenadines, and Trinidad and Tobago—developed or updated their health disaster plans during the period. Dominica and Jamaica trained first responders in emergency care and treatment, while Anguilla, Antigua, the Bahamas, and Jamaica trained responders in mental health and psychosocial support. Haiti and the Dominican Republic expanded their early warning and rapid response systems for epidemics to encompass all hazards, including environmental risks for health. Grenada developed standard operating procedures for a new health Emergency Operations Center, identified a suitable location, and prepared a list of basic equipment needed for the EOC.

153. The Logistics Support/Supply Management System (LSS/SUMA), developed by PAHO to manage humanitarian health supplies during emergencies, was formally

adopted by Ecuador and Peru, while the Dominican Republic adopted the system in one national and eight regional supply warehouses.

Safe hospitals

PAHO continued to promote risk reduction in the health sector through the Safe Hospitals Initiative and its Hospital Safety Index (HSI), a tool for assessing the probability that a health facility will remain functioning in emergency situations. By mid-2013, the HSI had been applied in more than 2,900 hospitals and other health facilities in 32 countries and territories of the Americas. During the reporting period, 20 countries used the HSI and implemented policies and strategies to improve the safety of existing hospitals. PAHO also updated the Hospital Safety Index for Small and Medium Hospitals and launched a new self-instruction course on how to use the HSI. At least 10 countries installed and used the online Safe Hospitals Database, developed by PAHO to monitor progress on the safe hospitals initiative and identify measures needed to protect the continued operation of health facilities during disasters.

The Safe Hospitals Initiative was included in the strategic plans of the Meeting of Ministers of Health of the Andean Region (REMSAA), the Andean Health Organization - Hipolito Unanue Agreement (ORAS/CONHU), and the Andean Committee for Disaster Prevention and Response (CAPRADE). During 2012–2013, Colombia, the Dominican Republic, Guatemala, Mexico, and Peru made significant progress updating their respective building codes to ensure that all newly built hospitals can continue operating in disasters.

154. In partnership with the U.K. Department for International Development (UKAid), PAHO initiated the implementation of the Smart Hospitals initiative in the Caribbean, to reduce the carbon footprint of health facilities and improve disaster resiliency.

155. PAHO supported subregional efforts to improve disaster preparedness and response, including the new Andean Strategic Plan for Disaster Risk Management 2013–2017, approved by the ministers of health of the Andean region. The Ministers also named a Technical Commission for Emergencies and Disasters and appointed the directors of disasters offices in the ministries of health to implement the strategic plan. PAHO also helped update a guide for cooperation between Andean countries, which was approved by CAPRADE and served as a technical reference for the preparation of a similar guide for the MERCOSUR countries.

156. In partnership with the U.S. CDC, PAHO supported the creation of the Technical Commission for Risk Management in Central America and the Dominican Republic (CTGERS), an advisory body to COMISCA that will monitor disaster preparedness, response, and cooperation. A Central American Plan for Comprehensive Risk Management of Public Health Disasters and Emergencies 2013–2018 was developed with

PAHO support and approved by COMISCA. It will guide work in the area of disasters and health and allow Member States of the Central American Integration System (SICA) to integrate cooperation mechanisms and strengthen health disaster units.

Knowledge Management and Communications

157. In 2012, the 28th Pan American Sanitary Conference approved the first regional strategy and plan of action on knowledge management and communications. It seeks to promote the development and dissemination of health information and knowledge based on scientific data; facilitate horizontal collaboration through partnerships and networks; and promote strategies for using knowledge to advance individual, social, and policy changes to improve and protect health.

158. During 2012–2013, Bolivia, the Dominican Republic, El Salvador, Honduras, Panama, and Venezuela were among countries that established or expanded virtual health libraries (VHLs) with support from PAHO's Latin American and Caribbean Center on Health Information Sciences (BIREME), in São Paulo, Brazil. Nine new institutions in Mexico's Sonora state, along with Arizona State University, were incorporated into the Border Virtual Health Library (BVHL), for which PAHO's U.S.-Mexico Border Office serves as secretariat. Mexico implemented a new Network of PAHO/WHO Collaborating Centers to facilitate the exchange of knowledge, experiences, and best practices among different centers.

PAHO/WHO Collaborating Centers

Nine new PAHO/WHO Collaborating Centers were designated in the Americas between mid-2012 and mid-2013, bringing the total number of active Collaborating Centers in the Region to 185—out of more than 800 centers globally. Collaborating Centers include research institutes, university departments and research centers, and other organizations that carry out activities in support of PAHO/WHO's programs in a broad range of areas, from human resources for health to communicable and noncommunicable diseases, nutrition, mental health, health technologies, and many others.

159. Six countries—Aruba, Brazil, Chile, Costa Rica, Guatemala, and Peru—received PAHO support to develop or implement new plans and strategies for promoting *eHealth*, which uses new information and communication technologies to improve health care. The future of *eHealth* initiatives was also a major focus of the 9th Regional Congress on Health Sciences Information (CRICS9), held at PAHO headquarters in October 2012, which drew more than 400 participants from 30 countries.

160. Between June 2012 and June 2013, PAHO published more than 250 scientific and technical publications. The Pan American Journal of Public Health, PAHO's peer-reviewed scientific journal, published 13 issues during the period, including special issues on cardiovascular disease prevention and dietary salt reduction (October 2012) and equity in health systems (February 2013).

161. Argentina, Cuba, Honduras, and Mexico participated in the PAHO Blue Trunk Library initiative, an effort to democratize access to health information by sending collections of up-to-date medical publications to remote communities using blue metal trunks. Brazil also participated through a South-South cooperation effort that provided publications to Portuguese-speaking countries.

162. During the reporting period, 20 countries gained access to the WHO HINARI platform, which provides free or very low cost online access to the major journals in biomedical and related social sciences to health institutions in more than 100 countries. Virtual learning platforms helped the Organization deliver new tools, concepts, and knowledge to more than 3,000 professionals in the Region.

Management and Governance

163. PAHO continued to pursue policies and practices aimed at enhancing management and efficiency, transparency, accountability, and ethics and fair treatment in the workplace. These efforts were initiated by the outgoing administration and received added impetus with the election of PASB's new Director.

164. The Organization continued to implement a results-based management (RBM) framework during the reporting period, with important advancements made in conjunction with the development of the 2014–2019 Strategic Plan. These included a refined results chain to better reflect achievements and joint accountability of the PASB and ministries of health, and improved results statements and indicators for outputs, outcomes, and impact. The new indicators will be incorporated into the Performance Monitoring and Assessment (PMA) process during the implementation of the new Strategic Plan. In addition, the PMA exercise—a key component of a results-based approach—enhances the management function in monitoring the progress of reporting departments and country offices, with a view to improving managerial accountability.

165. In 2012, the 28th Pan American Sanitary Conference approved a new PAHO Budget Policy to guide resource allocation for operations at the regional, subregional, and country levels. It incorporates recommendations made by the office of Internal Oversight and Evaluation Services (IES) based on its evaluation of the previous budget policy, as well as adjustments in response to the Organization's own lessons learned. Changes include new standards for country presence to ensure the availability of sufficient funds

to maintain robust engagement with Member States, the incorporation of income inequality (the Gini coefficient) into an expanded needs-based assessment of countries, a results-based component designed to accelerate the achievement of programmatic targets in countries, and improved modeling and statistical techniques to provide more realistic and workable resource distribution results.

166. As part of the mid-term evaluation of the Health Agenda for the Americas 2008–2017 (SPBA7/4 [2013]), IES examined PASB's implementation of the agenda. The evaluation confirmed that PAHO's Strategic Plan 2008–2013 had been closely aligned with the Health Agenda for the Americas and that its strategic objectives had served to harmonize the agenda with WHO's strategic objectives and with the work of other international organizations in the Region.

167. During 2012–2013, IES conducted audits in several country offices, assessing their adherence to results-based management, among other issues. However, IES also began an effort to collect and organize the vast amount of information available from previous evaluations. This process produced the Organization's first list of all evaluations performed both internally and by external stakeholders, a critical first step in determining and understanding the lessons learned from these activities.

168. Several new initiatives, tools, and policies designed to streamline and enhance the Organization's technical cooperation operations were rolled out during the reporting period. In August 2012, PASB approved a new information technology (IT) strategy and introduced a new IT governance process to coordinate the development of all expenditures on technology projects at PAHO headquarters, in country offices, and in collaborating centers. In addition, the internet domains of PAHO country offices and centers were merged into a single PAHO domain and computer software was standardized, to reduce complexity, increase security, simplify support, and facilitate the implementation of future information technology and knowledge management initiatives. The initial phases of a new "PAHO in the Cloud" initiative also were implemented, allowing Headquarters staff to access their desktop environments from anywhere and on any device and to remotely access PAHO tools, services, and shared repositories.

169. PAHO continued to implement its enterprise risk management (ERM) program for identifying, monitoring, evaluating, and managing ongoing risks inherent in PAHO's business operations and technical cooperation activities. During 2012–2013, a new PAHO Enterprise Risk Management Policy was approved and published in the PAHO/WHO E-Manual, and a new Enterprise Risk Management Handbook was published (linked to the country office Operations Manual). Risk assessments were performed for the PAHO Revolving Fund; for all the Organization's administrative offices; for BIREME and the country offices in Chile and Mexico; and for nine country offices participating in a CIDA-funded project on women, children and excluded

populations. In addition, 49 risk management focal points were trained in risk assessment at PAHO Headquarters and in Barbados, Brazil, and Panama.

170. In late 2012, the Organization developed a "business case" for using an enterprise planning system for the PASB's Management Information System (PMIS). Finalized in January 2013, the business case included a cost-benefit analysis of the project and recommendations on the selection of the appropriate software. Following a formal request-for-proposals process that concluded in mid-2013, the Organization identified the specific software to be used and the system-integrator company that will implement it.

171. Improvements to the Organization's purchase of goods and services included staff training conducted at headquarters and in the country offices, the launch of a pilot project to implement an electronic tendering system in the Guatemala country office, and electronic tools that allow technical programs to track, monitor, and review their purchases of goods and services and track their delegation of authority in procurement matters. Procurement efforts on behalf of Member States included long-term agreements for the purchase of vaccines and syringes for countries' national routine vaccination programs as well as antiretrovirals. PAHO also negotiated the procurement of new and strategic vaccines including yellow fever and HPV, while 16 new items were included in the Strategic Fund's list of commodities.

Caribbean Public Health Agency, CARPHA

After more than 30 years of being administered by PAHO, the Caribbean Epidemiology Center (CAREC) and the Caribbean Food and Nutrition Institute (CFNI) were transferred during 2012-2013 to the Caribbean Public Health Agency (CARPHA), which became fully operational in January 2013. In addition to supporting the new agency's development, PAHO provided extensive human resources support for the incorporation of CAREC and CFNI. Based in Trinidad and Tobago, CARPHA will provide a collective response to public health challenges for residents and visitors in the Caribbean.

172. PAHO continued to offer extensive opportunities for its staff to develop new skills and knowledge during the reporting period. Initiatives included a new Learning Portal and individual learning plans for different units and departments. A new online Career Development Portal, launched in late 2012, provides tools for staff to enhance their professional growth, including a roadmap for career development, tools for career assessments and self-discovery, eLearning courses, and other information about career options, opportunities, and resources.

173. In addition to IES, several special offices and entities led the Organization's efforts to promote transparency, ethics, and workplace fairness. They include the Ethics Office and the Ombudsperson, which together with IES, LEG, HRM, the Board of Appeal, and the Information Security Office (ISO), are part of PAHO's Integrity and Conflict Management System. In addition, the PAHO Staff Association continued its active engagement with staff and the new administration to ensure fairness and equity.

174. During 2012, the PAHO Ethics Office addressed 84 consultations from staff and reviewed 43 reports of possible ethical breach, 32 of which came via the toll-free, confidential Ethics Help Line and 29 of which were submitted anonymously. The Ethics Office also provided training on PAHO's Code of Ethical Principles and Conduct, published a brochure on "Zero Tolerance for Fraud and Corruption," and issued specific guidelines for staff on how to remain neutral and objective during the process to elect PASB's new Director.

175. As coordinator of PAHO's Integrity and Conflict Management System, the Ethics Office spearheaded a revision of the Organization's policy on preventing and resolving workplace harassment. The new policy, issued in September 2012, broadened the scope of behaviors that constitute harassment and developed a special new form to facilitate reporting of formal allegations.

176. The office of the PAHO Ombudsperson received 104 visitors from the Organization's headquarters, country offices, and centers in 2012, expressing workplace concerns, frustrations, or problems. Top issues included supervisory effectiveness, department climate, respect and treatment, career progression and development, work-related stress and work-life balance, and administrative decisions and application of rules. The Office of the Ombudsman made a number of recommendations in its 2012 annual report, including the re-establishment of an "in-person" new employee orientation program, review of contract provisions regarding national and international PAHO consultants with a view to strengthening compliance with both their letter and spirit, and greater fairness and equity for PAHO workers contracted through employment agencies.

Chapter III. Lessons Learned and Moving Forward

177. PAHO's technical cooperation contributed to many successes in countries and at the regional and subregional levels during the period of this report. Yet many challenges remain. Going forward with new leadership, a new structure, and renewed commitment, the Organization must address those challenges by building on its achievements and learning from experience. Some of the notable lessons learned from PAHO's technical cooperation programs during 2012–2013 are highlighted with a view to improving the Organization's effectiveness in the coming years.

178. Inequity in health remains one of the most important public health challenges in the Americas, a region that in economic terms is one of the most inequitable in the world. PAHO's technical cooperation seeks to reduce health inequities through efforts to expand access to health services, advance toward universal health coverage, and address the social determinants of health. A number of lessons have been learned from this work over the past year.

179. Most countries of the Region recognize health as a basic right, and those that have not incorporated this right into their constitutions act in accordance with international treaties or agreements that include the concept of health care as a right. Nevertheless, guaranteeing health care as a right also requires the creation of legal and regulatory frameworks that enable the development of social-protection-oriented health policies and the achievement of universal health coverage. PAHO has a fundamental role in the search for and the promotion of consensus on these important issues and in providing support for addressing the more technical challenges.

180. It is important to recognize that there is no one-size-fits-all pathway to advancing universal coverage; countries must approach this goal at their own pace and according to their individual needs. In nearly every case, however, efforts to advance universal health coverage have greater impact and sustainability with the inclusion of civil society and the private sector throughout the process.

181. Social security institutions are important potential partners in the pursuit of universal health coverage. As major health-care providers in many countries, they have valuable insights regarding the development of services and models of care. PAHO can promote effective coordination and productive dialogue between these and other potential partners under the leadership of each country's health authority.

182. It is also essential to include communities and municipal authorities in underserved or at-risk areas in efforts to advance universal health coverage as well as other health efforts. Collaboration between health authorities and local actors often brings to light challenges and costs of health inequity that would otherwise remain hidden.

183. Efforts to increase intersectoral action are fundamental to addressing the social determinants of health and reducing health inequities. This requires engagement and coordination with sectors beyond health and strong advocacy for "health in all policies." Equally important is strong institutional capacity to marshal evidence on health inequalities as well as on the impact of policies and programs on health equity and the progressive attainment of universal health coverage. Invariably, it will be essential for data—especially those related to social determinants of health—to be disaggregated at the local level to better identify health gaps in vulnerable populations and to develop appropriate interventions.

184. Strategic partnerships with other actors are increasingly important for PAHO's work and for advancing health in the Region. The Organization has a long record of partnering successfully with other government sectors—including agriculture and education—as well as with nongovernmental and faith-based organizations, universities, foundations, other development agencies, and communities. PAHO has also been a key facilitator of horizontal cooperation, especially South-South and triangular cooperation to exchange expertise and technologies and to promote, document, and share best practices and lessons learned. Going forward, this work should be strengthened and expanded as a top priority of PAHO's technical cooperation work.

185. PAHO's strategy of country-focused cooperation emphasizes the need to identify and address specific country needs and priorities, to coordinate with other in-country cooperation actors, and to promote sustainability through capacity building and country leadership. Country "ownership" is vital not only to the success of technical cooperation but also to the sustainability of achievements. It requires alignment of technical cooperation programs with established national policies and priorities. Key stakeholders must be involved in the consultation process and implementation as well as in monitoring and data collection. This not only ensures greater "buy-in," it builds capacity for country leadership.

Lessons from the Health Agenda for the Americas

A mid-term evaluation of the Health Agenda for the Americas 2008–2017 was conducted during 2012 and, after being presented in draft form to the 28th Pan American Sanitary Conference (CSP28/6), was finalized in early 2013 (SPBA7/4). The evaluation was a country-led process involving all 35 PAHO Member States, five subregional integration bodies, and 19 UN and other cooperation agencies.

The final report concluded that, in its first five years, the Health Agenda for the Americas had been used in the preparation of numerous health plans, policies, and strategies at the national level, to a "fair degree" at the subregional level, but only to a limited degree by other international organizations. The report found significant progress in all eight action areas,* but expressed concern regarding trends in indicators for maternal mortality, dengue, tuberculosis, HIV/AIDS, obesity, and public versus out-of-pocket spending on health.

The report made a series of recommendations for the agenda's implementation over the next five years, including:

- Stronger dissemination of the agenda and advocacy for its use at the subnational, national, and regional levels and in other sectors and international organizations.
- Stepped-up efforts by countries in areas that have seen the least progress, such as maternal mortality, dengue, TB, obesity, chronic diseases and their risk factors, social protection systems, and boosting national public spending on health.
- Improved data collection to facilitate monitoring of progress on the agenda's implementation.
- More research on issues including social determinants of health, NCDs and their risk factors, the impact of skilled attendance at birth on maternal and child mortality, and health inequities.
- Stronger promotion of the agenda within PAHO's secretariat (PASB) as well as externally with PAHO funding partners and in collaborative agreements.

*Strengthening the national health authority; tackling health determinants; increasing social protection and access to quality health services; diminishing health inequalities among countries and inequities within them; reducing the risk and burden of disease; strengthening the management and development of health workers; harnessing knowledge, science and technology; strengthening health security.

186. Human resources capacity must be an overarching consideration for all technical cooperation, as it can facilitate or hinder its success. In the area of NCDs, for example, increased political commitment has not automatically translated into adequate human resources for managing national NCD programs, implementing strategies, or improving quality at the level of patient care. Technical cooperation programming must ensure that countries have strategic human resources plans that are well aligned with projects and programs.

187. Partnerships with relevant international organizations and professional associations can help leverage technical assistance and maximize the use of resources—"doing more with less"—which is especially important in light of continuing global economic difficulties. Enhancing coordination between partners can also lead to better results; in many instances, however, the role and responsibilities of PAHO and other partners need to be redefined or adjusted to better address project needs. Joint communication efforts and coordination on priority health issues have led to greater engagement with and participation of various stakeholders and communities.

188. The need for more effective coordination is particularly urgent in the case of emergencies and disasters. Although most countries in the Region now have the capacity to respond to minor or moderate emergencies without international support, responding to major disasters and coordinating massive international assistance remains a significant challenge. Ministries of health should take the lead in establishing coordinating mechanisms in the health sector for receiving and sending international humanitarian assistance. There is also a need for better mechanisms to coordinate the participation of actors in the Health Cluster and ensure adaptability according to national context, ideally through the involvement of fewer and more specialized actors. This would help create synergies among agencies.

189. Another important lesson is the critical need to strengthen interprogrammatic work. Regional programs for integrated control of neglected infectious diseases are an example. These have been implemented jointly by programs for immunization, nutrition, childhood diseases (IMCI), tuberculosis, and malaria. Greater interprogrammatic coordination in occupational and environmental health could help to reduce a significant burden of both communicable and noncommunicable diseases.

190. A continued focus on integrated networks of health services based on primary health care strategies is essential to overcome the continuing segmentation and fragmentation of many countries' health systems. Together with health systems strengthening and decentralization, integration must remain a cross-cutting priority for the achievement and sustainability of universal health coverage.

191. An essential part of these efforts is the integration of mental health care into primary care services. This is critical to reducing the large treatment gap for people with mental disorders; more than two-thirds do not receive any care for their condition. At the same time, much work remains to be done to reform psychiatric services and to radically transform the old "asylum" model of hospital-based psychiatric care into a community-based model of care.

192. Access to evidence-based information to support decision-making continues to be a challenge in many areas of technical cooperation. For example, in the field of disaster

risk reduction, evidence on the costs of investment in hospital safety versus the costs of damaged facilities and lost health services is critical for influencing governments, public opinion, and donors. Promoting research for health in other areas remains essential as well, to build the evidence base for policymaking, resource allocation, and the selection of interventions.

193. Equally important is the development of tools and processes for evaluation and the systematization of technical cooperation experiences to inform programming and policymaking. This is especially true in emerging areas of action that may require new forms of cooperation, often across different disciplines and sectors. For example, a number of initiatives are now under way in the Region that address health inequities through action on the social determinants of health, but these have not been adequately documented or systematized. PAHO can advance this work by helping to measure the impact of health policies, programs, and interventions on the equitable distribution of health gains across different population groups. The resulting evidence can be used to identify new or to adapt existing strategies, policies and programs to more effectively address these issues.

194. New communication technologies are already changing the way PAHO provides technical cooperation and have significant potential for creating cost savings and expanding collaboration and reach. Three key PAHO portals—the Regional Platform on Access and Innovation for Health Technology, the Regional Observatory on Human Resources for Health, and the Collaborative Network on Primary Health Care—provide channels for communication and serve as repositories of structured and contextualized information. Virtual meetings can, at lower cost, effectively complement or substitute face-to-face meetings with greater efficiency. However, this change can require a significant cultural shift.

195. Increased Internet access and the growing prevalence of mobile devices are expanding audiences for *eHealth* initiatives and call for continuing innovation in this area. Fully exploiting the potential of new communication technologies for health will also require capacity building—at both the regional and country levels—in the management of new communication tools, new sources of information, and new ways to both collect and share data.

196. Financial constraints continue to present challenges for both the PASB and Member States. This is nowhere clearer than in the pursuit of universal health coverage. Most of the Region’s countries recognize access to health care as a fundamental right, but all struggle to assemble the necessary resources to guarantee this right. Technical cooperation aimed at increasing efficiency in health systems and building capacity in the financing of health systems is as important as efforts to make quality health care more accessible.

197. Mobilizing financial resources is also critical for preparedness and prevention. Many countries have included disaster risk reduction among their health sector priorities, but they lack resources to make the necessary investments in health infrastructure, essential services, equipment, and training. Engaging the financial sector to strengthen preparedness and prevention, for both disasters and public health more generally, is critical. It is also important to include preparedness and prevention into countries' development agendas.

198. In a context of limited resources, advocacy, communication, and intersectoral collaboration are especially important to help shape opinion and mobilize political support for health. For example, PAHO's advocacy on neglected infectious diseases led a number of countries to include them in their national health agendas, and a number of donors have shown growing interest in supporting work toward elimination of these diseases. The 2011 UN High-Level Meeting on NCDs, along with global and regional resolutions, has helped mobilize interest and technical changes to improve the quality and effectiveness of NCD programs. Similarly, support from PASB's new Director has been critical for the all-of-society approach to the elimination of cholera transmission on Hispaniola.

199. Forging strategic alliances with other agencies is essential in this resource constrained environment—Organization of American States, World Bank, Inter-American Development Bank. A strategic alliance with the OAS's Inter-American Conference of Ministers of Labor has helped raise the profile of workers' health on the regional political agenda. Furthermore, the April 2013 San Salvador Declaration on chronic kidney disease from untraditional causes drew attention to this disease that is devastating agricultural communities on Central America's Pacific Coast. Forging a solution to the problem will require scientists, agricultural communities, and environmental, labor, and agricultural authorities to work together.

200. Multisectoral action will remain particularly important for technical cooperation and advocacy around NCDs. Involving other sectors, including civil society organizations, is critical to reducing risk factors for NCDs. However, while there are sound examples of collaboration with other sectors, not all have proven sustainable. Efforts to mobilize health partnerships with other sectors could be strengthened by identifying mutual interests that can serve not only health but also other public policy goals.

201. In the area of veterinary health, food safety efforts have involved strong collaboration between industry; academia; and the health, agriculture, environment, and consumer sectors. Private-sector support for the Hemispheric Program for the Eradication of Foot-and-Mouth Disease has included essential financing as well as participation in political-strategic decisions that have been key for the sustainability of national programs.

202. Working with the private sector, while both desirable and essential, requires clear and effective rules of engagement to preempt potential conflicts of interest, both real and perceived. Interdisciplinary consultation and input—from technical cooperation areas as well as legal experts—are an essential part of developing rules of engagement and identifying potential difficulties.

203. Full implementation of health strategies and policies can be difficult to achieve when these impact the private sector. Industrial interests have mounted strong opposition to regulatory efforts aimed at supporting breastfeeding, regulating marketing and advertising of processed foods, and implementing the provisions of the Framework Convention on Tobacco Control (FCTC). To counteract such opposition, PAHO's support must include advocacy as well as technical support for legislation.

204. North-South and South-South collaboration remain valuable ways of promoting and adapting successful public health experience in different countries of the Americas and beyond. Good examples include: agreements between Brazil and Health Canada to strengthen food safety systems and among MERCOSUR countries to address HIV in shared border areas; collaboration among Argentina, the Caribbean Public Health Agency (CARPHA), and PAHO to exchange experiences and strengthen cooperation in areas including noncommunicable diseases, HIV, medicines, transplants, and social determinants of health; and the creation of PAHO Centers of Excellence in countries to promote evidence-based policy-making on the introduction of new vaccines.

205. An important value-added of PAHO's work is the impact that many of its strategies and initiatives have beyond the Region of the Americas. World Immunization Week, held for the second time in 2013, was a global effort inspired by the regional Vaccination Week in the Americas, which celebrated its 11th anniversary in 2013. Other examples include PAHO's promotion of access to quality medicines and health technologies and the adoption of PAHO technical materials on critical disaster topics in both Member States and in other regions of the world. The wide adoption of the Hospital Safety Index, for example, demonstrates that simple, low-cost tools, if practical and applicable in a range of settings, can enhance participation and stimulate action and investments to save lives around the world.

206. Going forward, PAHO has a central role to play in ensuring that health authorities and other public health advocates from the Americas contribute effectively to the post-2015 international development agenda. Spaces for dialogue and toolkits such as PAHO's "Rio+20," "Health in All Policies," and "Development Agenda 2015" can be useful for encouraging and guiding countries' participation in these processes.

207. The results of regional and global consultations on health in the post-2015 development agenda are also key for PAHO's own progress going forward. These consultations have produced general agreement on the following points:

(a) Health must be at the center of sustainable development; it not only contributes to development but is a key outcome and indicator of inclusive, equitable, people-centered, and human-rights–based development. The post-2015 development agenda will require a rigorous framework—different from existing development models—that clearly defines the role of health as well as intersectoral action that supports "health in all policies."

(b) Countries must redouble efforts to ensure that the Millennium Development Goals are met. Going forward, however, goals must be redrawn and analyzed to reflect sub-national achievements and shortcomings and to stimulate more synergistic approaches to improving conditions for the most vulnerable groups.

(c) New health priorities must be added to the MDGs that address major contributors to the global and regional burden of disease, particularly noncommunicable diseases and their risk factors, and mental health.

(d) A core goal that must be included in the new agenda is universal health coverage, understood as access to health for all with quality that addresses social determinants as well as people's health needs in a human rights framework. Universal coverage must include access to all key interventions, including promotion, prevention, treatment, rehabilitation, and social protection for all. Achieving this people-centered goal requires strong and equitable national health systems that can deliver quality services.

(e) The overall vision of the post-2015 sustainable development agenda must be centered on human well-being and "living well" and include as a goal maximizing health at all stages of life for every man, woman, and child.

(f) All this must happen recognizing the need to sustain efforts to prevent and control infectious diseases such as HIV, TB, malaria, and vaccine-preventable diseases.

208. The challenge will be to keep these concepts and issues—especially universal health coverage and the reduction of health inequities—at the top of the development agenda. This will require active and sustained engagement in future international fora by the countries of the Americas, with PAHO's full support.

Acronyms and Abbreviations

AECID	Spanish Agency for International Development Cooperation
AIDIS	Inter–American Association of Sanitary Engineering
ALBA	Bolivarian Alliance for the Peoples of Our Americas
AusAID	Australian Agency for International Development BIREME
BIREME	Latin American and Caribbean Center on Health Information Sciences
BVHL	Border Virtual Health Library
CAPRADE	Andean Committee for Disaster Prevention and Assistance
CAREC	Caribbean Epidemiology Center
CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CCG	Countries Consultative Group
CCS	Country Cooperation Strategy
CD	Directing Council
CDC	Centers for Disease Control and Prevention (United States)
CFNI	Caribbean Food and Nutrition Institute
CHA	Communicable Diseases and Health Analysis
CISALUD	Intersectoral Health Commission (El Salvador)
CLAP	Latin American Center for Perinatology – Women's Reproductive Health
COFEPRIS	Federal Commission for Protection against Health Risks (Mexico)
COHSOD	Council for Human and Social Development
COMISCA	Council of Central American Ministers of Health
COPAIA	Pan American Commission for Food Safety
COS	Chief of Staff
CRICS	Regional Congress on Health Sciences Information
CSP	Pan American Sanitary Conference
CTGERS	Technical Commission for Risk Management in Central America and the Dominican Republic
DFAIT	Department of Foreign Affairs, Trade, and Development (Canada)
DFID	Department for International Development (United Kingdom)
ECLAC	Economic Commission for Latin America and the Caribbean
EPG	External Relations, Partnerships and Governing Bodies
FCTC	Framework Convention on Tobacco Control
FGL	Family, Gender and Life Course
FO.AR	Argentine Fund for South–South and Triangular Cooperation
FONAT	National Fund for Victims of Traffic Accidents
FRM	Financial Resources Management
GLAAS	Global Analysis and Assessment of Sanitation and Drinking Water
GSO	General Services Operations

Acronyms and Abbreviations *(cont.)*

HPV	Human papillomavirus
HRM	Human Resources Management
HIS	Hospital Safety Index
HSS	Health Systems and Services
IAEA	International Atomic Energy Agency
ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability and Health
IES	Internal Oversight and Evaluation Services
IHR	International Health Regulations
IMAN	Integrated Management of Adolescent Needs
IMCI	Integrated Management of Childhood Illness
IMESEVI	Mexican Road Safety Initiative
IMF	International Monetary Fund
ISO	Information Security Office
ITS	Information Technology Services
IWMI	International Water Management Institute
KMC	Knowledge Management and Communications
LEG	Legal Counsel
LPA	Line probe assay
LSS/SUMA	Logistics Support/Supply Management System
MDR–TB	Multidrug–resistant tuberculosis
MERCOSUR	Southern Common Market
MhGAP	Mental Health Gap Action Program
NCDs	Noncommunicable diseases
NCIPC	National Center for Injury Prevention and Control
NIB	National Insurance Board (Bahamas)
NMH	Noncommunicable Diseases and Mental Health
OAS	Organization of American States
OEPA	Onchocerciasis Elimination Program of the Americas
OMB	Ombudsperson
ORAS/CONHU	Andean Health Organization/Hipolito Unanue Agreement
PAHO	Pan American Health Organization
PALTEX	Expanded Textbook and Instructional Materials Program
PANAFTOSA	Pan American Center on Foot–and–Mouth Disease
PANDRH	Pan American Network for Drug Harmonization
PASB	Pan American Sanitary Bureau
PBU	Planning and Budget
PED	Emergency Preparedness and Disaster Relief
PFA	psychological first aid
PMA	Performance Monitoring and Assessment

Acronyms and Abbreviations *(cont.)*

PMMHS	Productive Management Methodology for Health Services
PRADICAN	Program against Illicit Drugs in the Andean Community
PRAIS	Regional Platform on Access and Innovation for Health Technologies
PRO	Procurement and Supply Management
ProPAN	Process for the Promotion of Child Feeding
RBM	Results–based management
RCSS	Consumer Safety and Health Network
RED CIM LAC	Latin American and Caribbean Network of Drug Information Centers
REDETSA	Health Technology Assessment Network of the Americas
REMSAA	Meeting of Ministers of Health of the Andean Region
RIMSA	Inter–American Meeting at the Ministerial Level on Health and Agriculture
Rio+20	UN Conference on Sustainable Development
SAICM	Strategic Approach for International Chemical Management
SARI	Severe acute respiratory illness
SPBA	Subcomittee on Program, Budget and Administration
SDE	Sustainable Development and Health Equity
SICA	Central American Integration System
SIP	Perinatal Information System
SMS	Short message service
SSP	Sanitation Safety Plan
STI	Sexually transmitted infection
TB	Tuberculosis
TCC	Technical cooperation between countries
TLD	Thermoluminescent dosimetry
TPH	Tropical and Public Health Institute (Switzerland)
UKAid	U.K. Department for International Development
UNDG–LAC	UN Development Group for Latin America and the Caribbean
USP	United States Pharmacopeial Convention
VHL	Virtual health library
WATSAN	Water and sanitation
WHA	World Health Assembly
WHO	World Health Organization
WSP	Water Safety Plan

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