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#### PROGRESS REPORTS ON TECHNICAL MATTERS

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\*Original in English: sections A, C, D, E, F, G, H, J, and K. Original in Spanish: sections B and I.

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**A. STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN: PROGRESS REPORT**

**Background**

1. Recognizing the importance of the health system's role in addressing violence against women, in October 2015, the Member States of the Pan American Health Organization (PAHO) approved the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women 2015-2025 (Document CD54/9 Rev. 2) (1). The purpose of this document is to report to the Governing Bodies of PAHO on the progress made toward implementation of the Strategy and Plan of Action, which provide a roadmap for health systems to join a multisectoral effort to prevent and respond to violence against women in the Region of the Americas. This report is informed by a review of published and gray literature, together with consultations with Member States. It also draws on information gathered through the technical cooperation efforts undertaken since the approval of the Strategy and Plan of Action.

2. The Region of the Americas was the first WHO region to have its highest authorities approve a framework for action on violence against women. Subsequently, the World Health Assembly approved in May 2016 the Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in particular against Women and Girls, and against Children (2), which is firmly aligned with PAHO's regional Strategy and Plan of Action. The action proposed in the two documents are aimed at supporting country efforts to meet SDG target 5.2, which calls for the elimination of all forms of violence against all women and girls. In fact, the approval of mandates at both the regional and global levels has contributed to increased requests by Member States for support in addressing violence, especially violence against women and violence against children.

3. Violence against women affects one in three women in the Americas and can lead to profound and long-lasting health consequences for survivors, including physical injury, unwanted pregnancy, sexually transmitted infections (including HIV/AIDS) and a range of negative mental health outcomes, such as anxiety, depression, and increased risk of suicide (3, 4). Violence during pregnancy has been associated with a higher risk of pregnancy complications, including miscarriage, preterm delivery, and low birth weight (3, 5). Also, violence against women has important negative consequences for children. Evidence suggests that long-term health and social consequences of children's exposure to intimate partner violence against their mothers are similar to those of physical and emotional child abuse and neglect (5-8). Childhood exposure to intimate partner violence, for instance, has been linked to higher rates of under-five child mortality, as well as to an increased risk of perpetrating or experiencing violence against women later in life (4).

## Analysis of Progress Achieved

4. The strategic lines of the PAHO Strategy and Plan of Action are to strengthen: *a)* the availability and use of evidence; *b)* the political and financial commitment to addressing violence against women within health systems; *c)* the capacity of health systems to respond to violence against women, and *d)* the role of health systems in preventing violence against women. As the table below illustrates, progress has been made in most objectives, although some areas have seen more gains than others. Countries have made significant progress in their efforts to strengthen national standard operating procedures and prepare their health workforce to address violence against women (Objectives 3.1 and 3.2 of the Strategy and Plan of Action), areas in which PAHO has provided substantial technical cooperation. Significant progress has also been made in making emergency health services available to rape survivors. Some progress has been observed in the number of countries that have produced nationally representative estimates of the prevalence of intimate partner and sexual violence against women, though only eight countries have conducted repeated surveys that allow for trend analyses. However, major challenges remain in terms of data quality and comparability. Finally, little progress has been made in ensuring that health budgets include funding to support health system efforts to address violence against women. In fact, considering the magnitude of violence against women in the Americas and the far-reaching adverse effects of such violence on the health of women and their children, funding for this area of work remains woefully inadequate.

5. As requested by the Member States, PAHO has provided substantial support for efforts to strengthen health system capacity to respond to violence against women. The Bureau has produced evidence-based normative guidance to support the development of national policies and protocols and has held regional, subregional, and national capacity building workshops to train health care providers. Moreover, PAHO is supporting the development of two training curricula for health care providers. Finally, PAHO has completed a comparative analysis of violence against women prevalence estimates for the Region.

| <i>Strategic Line of Action 1: Strengthen the availability and use of evidence about violence against women</i>           |   |  |
|---|---|--|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>  | <b>Status</b>  |
| <b>1.1</b> Increase the collection and availability of epidemiological and service-related data on violence against women | <b>1.1.1</b> Number of Member States (MS) that have carried out population-based, nationally representative studies on violence against women (or that have included a module on violence against women in other population-based demographic or health surveys) within the past five years<br><br>Baseline (2015): 14<br>Target (2025): 22 | A total of 18 countries in the Region have conducted violence against women surveys in the past five years. A number of additional surveys are ongoing, with a particular concentration in the Caribbean, which, to date, has faced a dearth of prevalence data on violence against women. |

| Objective | Indicator, baseline, and target   | Status   |
|-----------|---|--|
|           | <p><b>1.1.2</b> Number of MS that have carried out population-based, nationally representative studies on violence against women within the past five years (or that have included a module on violence against women in other population-based demographic or health surveys) that include an analysis of prevalence of violence against women across different ethnic/racial groups</p> <p>Baseline: 2<br/>Target: 10</p> | <p>Currently, 9 countries have included an analysis of violence against women across different ethnic/racial groups in their last population-based, nationally representative studies conducted in the past 5 years. In some cases, countries collect data that would allow for an analysis of prevalence estimates by ethnicity and race but do not conduct such analyses. An additional 5 countries have violence against women prevalence estimates disaggregated by ethnicity/race, but these were produced more than 5 years ago. Methodological challenges in the measurement of the variables of ethnicity and race remain, however, and the resulting data are often not comparable across settings.</p> |
|           | <p><b>1.1.3</b> Number of Member States that are able to provide data on homicide, disaggregated by age, sex, and relationship of the victim to the perpetrator</p> <p>Baseline (2015): 9<br/>Target (2025): 15</p>   | <p>No progress has been made in this indicator, as 9 countries can currently provide homicide data disaggregated by age, sex, and relationship of the victim to the perpetrator. A few countries can provide these estimates on request but do not analyze homicide data this way on a regular basis. Additional countries can provide the number of homicides disaggregated by sex but do not regularly collect information on the relationship between victim and perpetrator, which is needed to determine the magnitude of intimate femicide/feminicide, a form of violence against women thought to be highly prevalent in the Region of the Americas.</p>  |

| <b><i>Strategic Line of Action 2: Strengthen political and financial commitment to addressing violence against women within health systems.</i></b> |  |   |
|---|--|---|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>   | <b>Status</b>   |
| <b>2.1</b> Strengthen national and subnational policies and plans to address violence against women within the health system                        | <b>2.1.1</b> Number of Member States that have included violence against women in their national health plans and/or policies<br><br>Baseline (2015): 18<br>Target (2025): 35                                    | In 2017, 20 countries included violence against women within their national health plans/policies. In most of these plans, violence against women is recognized as a determinant of poor health outcomes and is addressed in strategic objectives and actions for health.   |
|   | <b>2.1.2</b> Number of Member States whose national health budget has one or more dedicated lines to support prevention and/or response to violence against women<br><br>Baseline (2015): 4<br>Target (2025): 10 | There has been minimal progress in this indicator, and 5 countries currently have lines in their national health budget to address violence against women. However, in other countries, national mechanisms for the advancement of women (such as women's ministries) have allocated funding in their budgets for improving the health response to violence against women survivors.  |
|   | <b>2.1.3</b> Number of Member States that have established a unit (or units) or focal point(s) in the Ministry of Health responsible for violence against women<br><br>Baseline (2015): 4<br>Target (2025): 10   | Considerable progress has been made in this indicator, and 10 countries in the Region currently have a violence against women unit or focal point in the Ministry of Health. Although the following is not an indicator in this Strategy and Plan of Action, some countries have a focal point in a different ministry or as an independent entity. Some of these entities include the participation of the Ministry of Health. |

| Objective  | Indicator, baseline, and target  | Status  |
|--|--|---|
| <b>2.2</b> Increase the health system's participation in multisectoral plans, policies, and coalitions to address violence against women | <p><b>2.2.1</b> Number of Member States that have a national or multisectoral plan addressing violence against women that includes the health system, according to the status of the plan:</p> <ul style="list-style-type: none"> <li>▪ in development;</li> <li>▪ currently being implemented</li> </ul> <p>Baseline (2015): 13<br/>Target (2025): 20</p> | Significant progress has been made in this indicator, and the target has been exceeded. Currently, 21 countries have a national or multisectoral plan addressing violence against women that includes the health system. However, in several cases, these plans do not specify the role of health systems, and significant challenges remain in terms of the actual implementation of existing plans. |

*Strategic Line of Action 3: Strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner and/or sexual violence*

| Objective  | Indicator, baseline, and target   | Status  |
|--|---|---|
| <b>3.1</b> Strengthen national standard operating procedures (protocols, guidelines) for providing safe and effective care and support for women experiencing intimate partner violence and/or sexual violence | <p><b>3.1.1</b> Number of Member States that have national standard operating procedures/protocols/ guidelines for the health systems response to intimate partner violence (IPV) consistent with the WHO guidelines (10, 11)</p> <p>Baseline (2015): 6<br/>Target (2025): 15</p> | In 2017, 14 countries met this indicator.   |
|  | <p><b>3.1.2</b> Number of Member States that provide comprehensive post-rape care services in emergency health services, consistent with WHO guidelines (10, 11)</p> <p>Baseline (2015): 2<br/>Target (2025): 15</p>  | In 2017, 13 countries provided emergency post-rape care services consistent with WHO guidelines.  |
| <b>3.2</b> Increase the capacity of health professionals to respond to violence against women  | <p><b>3.2.1</b> Number of Member States that have included the issue of violence against women in their continuing education processes for health professionals</p> <p>Baseline (2015): 2<br/>Target (2025): 10</p>   | <p>In 2017, 5 countries met this indicator.</p> <p>There is greater recognition of the need to prepare health care providers to identify and provide appropriate care to survivors; however, regional capacity to conduct trainings on violence against women remains limited. PAHO is helping to address this gap.</p> |

| <i>Strategic Line of Action 4: Strengthen the role of the health system in preventing violence against women</i>            |   |   |
|---|---|---|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>  | <b>Status</b>   |
| <b>4.1</b><br>Strengthen the participation and commitment of the health system in efforts to prevent violence against women | <b>4.1.1</b> Number of Member States that have a multisectoral coalition/task force in place for coordinating efforts to prevent violence against women that includes the participation of Ministries of Health<br><br>Baseline (2015): 3<br>Target (2025): 10                                | Significant progress has been made in this indicator, and the target has been exceeded. Currently, 21 countries have put in place a multisectoral mechanism to coordinate action on violence against women that includes the Ministry of Health.  |
|   | <b>4.1.2</b> Number of Member States that have a national or multisectoral plan addressing violence against women (that includes the health system) that proposes at least one strategy to prevent violence against women, by type of strategy<br><br>Baseline (2015): 0<br>Target (2025): 10 | In 2017, 17 countries had strategies in place to prevent violence against women. It is worth noting, however, that such strategies do not always address the intersections between different forms of violence (for instance, the intersections between violence against women and violence against children), which may lead to fragmentation and, potentially, reduced effectiveness. |

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

6. In light of the progress described above, the actions needed to improve the situation include:
- a) Continue to increase the availability, quality, comparability, and use of epidemiological data on violence against women, in particular the availability of trend data and prevalence estimates for groups in situations of vulnerability due to their ethnicity/race, disability status, or other condition.
  - b) Strengthen the capacity of researchers and national statistics institutes to conduct research on violence against women that follows international ethical and methodological recommendations.
  - c) Continue to build the capacity of health care providers to compassionately and effectively respond to survivors of violence against women, including by seeking opportunities to integrate the topic of violence against women in university-level education in the health care professions.
  - d) Ensure that emergency contraception is part of a comprehensive health response for rape survivors.

- e) Promote resource allocation, particularly within health budgets, consistent with the magnitude of violence against women and the far-reaching nature of its consequences to public health and beyond.
- f) Continue to bolster the evidence about the multiple ways in which violence against women intersects with other forms of violence, in particular violence against children, and develop strategies to address these forms of violence in an integrated manner, when applicable.

### **Action by the Directing Council**

- 7. The Directing Council is invited to take note of this progress report and provide any comments it deems pertinent.

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## **B. PLAN OF ACTION FOR THE PREVENTION OF OBESITY IN CHILDREN AND ADOLESCENTS: MIDTERM REVIEW**

### **Background**

1. The purpose of the present document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress with execution of the Plan of Action for the Prevention of Obesity in Children and Adolescents 2014-2019, approved at the Organization's 53rd Directing Council in October 2014 (Document CD53/9, Rev. 2 and Resolution CD53.R13) (1, 2). The overall goal of the Plan is to halt the growing epidemic of obesity in children and adolescents. Achieving this goal requires a multisectoral, life-course approach that is based on the social-ecological model and focuses on transforming the current obesogenic environment into opportunities for increased intake of nutritious foods and physical activity (1).

### **Analysis of Progress Achieved**

2. At the end of the third year of execution there is progress toward meeting the indicators in the Plan, as summarized below. To evaluate this progress, information relating to the indicators as of 31 December 2017 was compiled from the following sources: the Global Database on the Implementation of Nutrition Action (GINA) of the World Health Organization (WHO), reports from the World Breastfeeding Trends Initiative (WBTi), the WHO Global Nutrition Policy Review (GNPR), the Global School-based Student Health Survey (GSHS), the WHO Country Survey of Capacity and Response to Noncommunicable Diseases (NCD CCS), and the database of the Open Streets Network of the Americas (CRA, for its abbreviation in Spanish). In addition, documentation was compiled from the United Nations Food and Agriculture Organization (FAO), the Pan American Health Organization, the World Health Organization, the United Nations Children's Fund (UNICEF), and PAHO focal points. Finally, government documents related to the objectives of the Plan were consulted on the Internet.<sup>1</sup>

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<sup>1</sup> Complete information about the evaluation process is available at the website for the Plan of Action: [https://www.paho.org/hq/index.php?option=com\\_content&view=article&id=11373%3Aplan-of-action-prevention-obesity-children-adolescents&catid=8358%3Aobesity&Itemid=4256&lang=en](https://www.paho.org/hq/index.php?option=com_content&view=article&id=11373%3Aplan-of-action-prevention-obesity-children-adolescents&catid=8358%3Aobesity&Itemid=4256&lang=en).

| <i>Strategic Line of Action 1: Primary health care and promotion of breastfeeding and healthy eating</i>  |   |  |
|---|---|--|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>  | <b>Status</b>  |
| <b>1.1</b> Include in health care services the promotion of healthy eating based on national food-based dietary guidelines as well as other activities related to the prevention of obesity | <b>1.1.1</b> Number of countries with primary health care services that have incorporated family-oriented obesity prevention activities, including promotion of healthy eating and physical activity<br><br>Baseline: 1 in 2014<br>Target: 10 in 2019 | 9 countries have clinical tools that incorporate family-oriented obesity prevention activities such as the promotion of healthy eating and physical activity as part of their primary health care services.  |
| <b>1.2</b> Reinforce efforts to implement the Global Strategy for Infant and Young Child Feeding  | <b>1.2.1</b> Number of countries that regularly (at least every three years) publish their results of monitoring implementation of the International Code of Marketing of Breastmilk Substitutes<br><br>Baseline: 5 in 2014<br>Target: 15 in 2019     | 1 country regularly publishes reports on monitoring of implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent resolutions.<br><br>4 of the baseline countries failed to monitor implementation of the Code in accordance with the established timeframe. |
|   | <b>1.2.2</b> Number of countries that have at least 50% of maternity health services BFHI-certified <sup>2</sup><br><br>Baseline: 0 in 2014<br>Target: 5 in 2019  | 4 countries reported that at least 50% of their maternal health services have been BFHI certified or recertified in the last five years.   |

| <i>Strategic Line of Action 2: Improvement of school nutrition and physical activity environments</i>  |  |  |
|--|--|--|
| <b>Objective</b>   | <b>Indicator, baseline, and target</b>   | <b>Status</b>  |
| <b>2.1</b> Ensure that national school feeding programs as well as the sale of foods and beverages in schools (“competitive foods”) comply with norms and/or regulations that promote the consumption of healthy foods and water and prevent the availability of | <b>2.1.1</b> Number of countries that have national or subnational school feeding programs that comply with the nutritional needs of children and adolescents and are in line with the national food-based dietary guidelines<br><br>Baseline: 3 in 2014<br>Target: 12 in 2019 | 18 countries have school feeding programs that comply with their national nutritional guidelines, meet nutritional macronutrient requirements, or provide lists of healthy foods to use in preparing school menus. |

<sup>2</sup> Baby-Friendly Hospital Initiative.

| Objective  | Indicator, baseline, and target   | Status   |
|--|---|--|
| energy-dense nutrient-poor products and sugar-sweetened beverages  | <p><b>2.1.2</b> Number of countries in which at least 70% of the schools have norms and/or regulations for the sale of foods and beverages in schools (“competitive foods”) that promote the consumption of healthy foods and water and prevent the availability and consumption of energy-dense nutrient-poor products and sugar-sweetened beverages</p> <p>Baseline: 8 in 2014<br/>Target: 16 in 2019</p> | <p>15 countries have norms or regulations for the sale of foods and beverages (“competitive foods”) that promote the consumption of healthy foods and water or that restrict the availability of sugar-sweetened beverages and energy-dense nutrient-poor products.</p>  |
|  | <p><b>2.1.3</b> Number of countries where at least 70% of the schools have a source of clean drinking water</p> <p>Baseline: 3 in 2014<br/>Target: 12 in 2019</p>   | <p>25 countries reported that at least 70% of their schools have a source of potable water.</p>  |
| <p><b>2.2</b> Promote and strengthen school and early learning policies and programs that increase physical activity</p> | <p><b>2.2.1</b> Number of countries where at least 70% of schools have launched a program that includes at least 30 minutes a day of moderate to intense (aerobic) physical activity</p> <p>Baseline: 0 in 2014<br/>Target: 10 in 2019</p>  | <p>No information is available for this indicator.</p> <p>However, among the countries that have data from the Global School-based Student Health Survey (13-15-year-olds), none reported that at least 70% of the students in their secondary school were physically active at least 60 minutes a day for five or more days during the past week.</p> <p>The average estimated physical activity (60 minutes a day, five times or more per week) is 25.84%.</p> |

| <i>Strategic Line of Action 3: Fiscal policies and regulation of food marketing and food labeling</i>   |  |  |
|---|--|--|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>   | <b>Status</b>  |
| <b>3.1</b> Implement policies to reduce children and adolescents' consumption of sugar-sweetened beverages and energy-dense nutrient-poor products                                      | <b>3.1.1</b> Number of countries that have passed legislation to tax sugar-sweetened beverages and energy-dense nutrient-poor products<br><br>Baseline: 1 in 2014<br>Target: 10 in 2019  | 5 countries have approved legislation that imposes taxes on sugar-sweetened beverages.   |
| <b>3.2</b> Enact regulations to protect children and adolescents from the impact of marketing of sugar-sweetened beverages, energy-dense nutrient-poor products, and fast foods         | <b>3.2.1</b> Number of countries that have implemented regulations to protect children and adolescents from the impact of marketing of sugar-sweetened beverages, energy-dense nutrient-poor products, and fast foods in line with the Recommendations from a Pan American Health Organization Expert Consultation on the Marketing of Food and Non-alcoholic Beverages to Children in the Americas<br><br>Baseline: 1 in 2014<br>Target: 15 in 2019 | 3 countries have implemented regulations to protect the child and adolescent population from the impact of promotion and marketing of sugar-sweetened beverages, fast food, and energy-dense nutrient-poor products. |
| <b>3.3</b> Develop and implement norms for front-of-package labeling that promotes healthy choices by allowing for quick and easy identification of energy-dense nutrient-poor products | <b>3.3.1</b> Number of countries that have norms in place for front-of-package labeling that allow for quick and easy identification of energy-dense nutrient-poor products and sugar-sweetened beverages that take into consideration Codex norms<br><br>Baseline: 1 in 2014<br>Target: 15 in 2019  | 2 countries have implemented labeling systems to discourage the consumption of processed or ultra-processed products that are high in sugar, fat, and salt.  |

| <i>Strategic Line of Action 4: Other multisectoral actions</i>   |  |  |
|--|--|--|
| <b>Objective</b>   | <b>Indicator, baseline, and target</b>   | <b>Status</b>  |
| <b>4.1</b> Engage other government institutions and, as appropriate, other sectors   | <b>4.1.1</b> Number of countries in which implementation of this Plan of Action is supported by a multisectoral approach<br><br>Baseline: 0 in 2014<br>Target: 10 in 2019                        | 8 countries have a multisectoral strategy or plan of action for the prevention of overweight or obesity. |
| <b>4.2</b> Improve access to urban recreational spaces such as the “open streets” programs                                       | <b>4.2.1</b> Number of countries in which the population in at least five cities has access to “open streets” programs<br><br>Baseline: 6 in 2014<br>Target: 15 in 2019                          | 9 countries have at least five cities with “open streets” programs.                                      |
| <b>4.3</b> Take measures at the national or subnational level to increase the availability and affordability of nutritious foods | <b>4.3.1</b> Number of countries that have created incentives at national level to support family farming programs<br><br>Baseline: 5 in 2014<br>Target: 21 in 2019                              | 19 countries have created incentives at the national level to support family farming programs.           |
|  | <b>4.3.2</b> Number of countries that have introduced measures to improve relative prices and/or the affordability of healthy [healthful] foods<br><br>Baseline: 3 in 2014<br>Target: 10 in 2019 | 18 countries have fairs or farmers markets that promote access to healthy foods.                         |

| <i>Strategic Line of Action 5: Surveillance, research, and evaluation</i>  |   |  |
|--|---|--|
| <b>Objective</b>   | <b>Indicator, baseline, and target</b>  | <b>Status</b>  |
| <b>5.1</b> Strengthen country information systems so that trends and determinants of obesity, disaggregated by at least two equity stratifiers, are routinely available for policy decision-making | <b>5.1.1</b> Number of countries that have an information system to report on dietary patterns and overweight and obesity in a nationally representative sample of pregnant women and school-aged children and adolescents, every two years<br><br>Baseline: 3 in 2014<br>Target: 8 in 2019 | 4 countries have systems for reporting on dietary patterns and overweight and obesity in women of childbearing age, children, and adolescents. |

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

3. In light of the progress described above, the actions needed to improve the situation include:
- a) Adopt clinical guidelines for the prevention, early detection, and control of overweight and obesity, to be applied at the first level of care.
  - b) Adopt legislation that covers all the provisions of the International Code of Marketing of Breastmilk Substitutes and subsequent resolutions and monitor compliance on a regular basis. Continue to encourage the protection of maternal health and increase the number of centers that provide maternal health services through the Baby-Friendly Hospital Initiative (BFHI).
  - c) Establish standards for school feeding programs and the sale of foods and beverages in schools to ensure the intake of fruits, vegetables (including legumes, tubers, and whole grain cereals), and water, to reduce the consumption of processed or ultra-processed products that are high in sugar, fat, and salt. In addition, promote physical activity in schools.
  - d) Ensure that sugar-sweetened beverages and products with high caloric content and low nutritional value are taxed, are not promoted to children or adolescents under 16 years old, and have front-of-package labels that can be correctly, quickly, and easily identified.
  - e) Increase the number of cities with access to recreational bike paths and parks.
  - f) Promote policies for improving the availability and access to healthy food.
  - g) Establish or update surveillance systems for regular monitoring of eating patterns, overweight, and obesity in children and adolescents and also, most importantly, pregnant women.

### **Action by the Directing Council**

4. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

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## **C. STRATEGY AND PLAN OF ACTION ON URBAN HEALTH: MIDTERM REVIEW**

### **Background**

1. The Region of the Americas is the most urbanized region in the world. Nearly 80% of its population is currently living in urban centers, and by 2030 this proportion is expected to reach 85% (1). The purpose of this report is to summarize progress made in the Region in terms of implementing the regional Strategy and Plan of Action on Urban Health, adopted in September 2011 by the 51st Directing Council of the Pan American Health Organization (PAHO) (Document CD51/5) (2). The Strategy and Plan set objectives over a 10-year period (2012-2021) to strengthen the organizational capacity and stewardship role of the ministries of health and municipal governments in advocating for sustainable urban growth that puts human beings and communities at the center of planning. It also aimed to tackle health inequities and to address the needs and capitalize on the assets of the spectrum of urban populations through policies, programs, and services for people and communities living and working in urban settings (2).

### **Analysis of Progress Achieved**

2. Since the adoption of the Plan, health and development have become increasingly recognized as linked global priorities, noted at such events as the Seventh Session of the World Urban Forum (2014) and Habitat III, the third United Nations Conference on Housing and Sustainable Urban Development (2016). At the Regional level, this movement was catalyzed by the 3rd Regional Forum on Urban Health (2015). The participants, representing cities and nations, shared key knowledge and identified Health in All Policies (HiAP) and health promotion within the framework of Healthy Cities, Municipalities, and Communities as areas for action.

3. The Region of the Americas has been a driving force for global revitalization of the Healthy Cities movement. In collaboration with the Latin American and Caribbean Network of Health Promotion Managers (Redlac Promsa) and Chile's Ministry of Health, PAHO organized a Mayors' Pre-Forum in Santiago, Chile, in July 2016, during which mayors and health promotion personnel from 12 countries of the Region exchanged experiences and adopted the Declaration of Santiago (3) to guide development of a Healthy Cities, Municipalities, and Communities Strategy. This initiative was led by a committee of members from the World Health Organization (WHO) Collaborating Centre on Healthy Cities and Municipalities (CEPEDOC); Ministries of Health staff from Argentina, Chile, Cuba and Mexico; and development staff from Chile and Peru.

4. Multisectoral approaches are a core component of sustainable urban development and a highly active area for PAHO, carried out institutionally under Health in All Policies. The Region of the Americas was the first to establish a Plan of Action to define clear steps for implementation of the HiAP approach (4). As of 2016, 180 participants from 16 countries of the Region had received training in Health in All Policies (4).

5. “Making cities and human settlements inclusive, safe, resilient, and sustainable” is enshrined as a global priority in the 2030 Agenda as Sustainable Development Goal 11 (5). In April 2018, following the regional meeting at the Economic Commission for Latin America and the Caribbean (ECLAC) to review progress toward fulfillment of the Sustainable Development Goals (SDGs), the United Nations High-level Political Forum on Sustainable Development in July 2018 will review SDG 11 in depth. Attention to these issues presents exceptional opportunities to advance the urban health agenda.

6. The Strategy and Plan of Action on Urban Health aimed to initiate a series of activities that would establish urban health priorities as key considerations for national, subnational, and municipal policymaking and planning. PAHO has consistently worked to provide appropriate resources, in particular technical expertise and coordinating power, to support national and regional capacity-building. Specific information on progress toward fulfilling the objectives so far is presented below.

| Specific objective               | Indicator, baseline, and target  | Status  |
|----------------------------------|--|---|
| 1. Develop urban health policies | Number of countries with national development plans and policies at the national and subnational levels, as appropriate, that introduce health and health equity into urban development<br><br>Baseline (2011): 6<br>Target (2021): 18 | As of 2017, 21 countries had introduced health and/or health equity as an aspect of urban development in their national (or subnational) development plans and policies (6).<br><br>As of 2017, 12 cities in 5 countries had reported policies to reduce excessive demand for transport services and infrastructure, such as vehicle and parking restrictions, carpools, and congestion pricing (7). <sup>1</sup> |

<sup>1</sup> The Region of the Americas has taken a leading role in implementing innovative urban transportation policies and interventions that favor urban health and equity. Sustainable transport increases equitable access to services and opportunities in a way that minimizes negative environmental consequences as well as safety and affordability. As of 2017, Latin American cities reported having 1,912 km of bus and rapid transport routes in 67 cities and 13 countries; 3,486 km of bicycle routes in 51 cities in 10 countries; 1,041 km of metro/subway/light rail track in 19 cities in 7 countries, and 47 km of aerial tram routes in 7 cities in 4 countries. Interest is increasing in *ciclovías recreativas*—in other words, multisectoral programs that temporarily or permanently designate streets for nonmotorized leisure uses, with 457 cities in 16 countries of Latin America reporting action in this area (7).

| Specific objective   | Indicator, baseline, and target   | Status  |
|--|---|---|
| <p><b>2.</b> Adjust urban health services to promote health and improve coverage</p>                     | <p>Number of countries with a National Health Plan, and subnational health plan as appropriate, integrating an urban health equity framework, with consideration of vulnerable groups</p> <p>Baseline (2011): 6<br/>Target (2021): 25</p> | <p>Data indicate increasing interest in integrated urban health approaches in the Region. Fourteen countries are using their national health plans to address issues related to urban health equity, enhance intersectoral collaboration and community participation, and utilize evidence-based interventions. For example, some countries have focused on modifying conditions in urban environments to better support population health (8).</p> <p>Additionally, in 2 countries, the WHO Age-friendly Cities and Communities initiative is being implemented in over 50 cities, with 6 countries in LAC having at least one city or community engaged in this initiative (9).</p>   |
| <p><b>3.</b> Construct health-promoting normative frameworks and participatory governance strategies</p> | <p>Number of countries that apply PAHO's public health guidelines for urban health planning</p> <p>Baseline (2011): 3<br/>Target (2021): 18</p>   | <p>As of 2017, 10 cities in the Region had joined the BreatheLife campaign, which mobilizes cities and people to bring air pollution to safe levels by 2030 (10).</p> <p>PAHO has worked to facilitate technical and strategic connections that support the tremendous energy in the Region for urban health, maintaining a country focus by prioritizing capacity building and network forming in key technical areas.</p> <p>Member States have established national processes to promote and disseminate public health guidelines and criteria for urban housing and planning.</p> <p>In compliance with WHO indoor air quality guidelines, countries are working to replace traditional cookstoves and heaters with cleaner technologies to reduce household emissions from solid fuels (11).</p> <p>PAHO is also disseminating WHO guidance on household battery disposal and lead exposure reduction.</p> <p>The United Nations estimates that clearly defined procedures in law or policy for participation by urban service users and communities in program planning are</p> |

| Specific objective  | Indicator, baseline, and target  | Status   |
|---|--|--|
|   |  | present in 29 of the Region's countries for drinking water management, and 25 countries for sanitation management (12).  |
| <p><b>4.</b> Expand national and regional networks for healthy urban development</p>                          | <p>Number of countries with a national healthy municipalities network applying PAHO's Healthy Municipalities Toolkit in communities with more than 100,000 inhabitants</p> <p>Baseline (2011): 5<br/>Target (2021): 24</p> | <p>In response to accelerating interest in the Region, in 2018 a new Healthy Municipalities and Communities Toolkit was developed in partnership with Kansas University. Eight countries are expected to pilot or implement the toolkit by the end of 2018.</p> <p>Substantial work has been done towards Activity 4.1 of the Strategy and Plan of Action on Urban Health.<sup>2</sup> Using the Healthy Municipalities, Cities, and Communities approach, 12 countries have committed to and established mechanisms to engage communities and civil society in the policy development process across sectors, as evidenced by signature of the 2016 Declaration of Santiago (3). Additionally, as of 2018, 4 countries/territories have joined the International Health Promoting Universities and Colleges Working Group, with 8 countries reporting national university health promoting networks.</p> <p>Finally, as of 2017, 14 cities in 8 countries of the Region had committed to the UN-Women's Global Flagship Program Initiative "Safe Cities and Safe Public Spaces" (13).</p> |
| <p><b>5.</b> Strengthen knowledge, capacity, and awareness to respond to emerging urban health challenges</p> | <p>Number of countries with surveillance systems that include indicators for urban health</p> <p>Baseline (2011): 4<br/>Target (2021): 15</p>  | <p>As of 2016, 15 countries had surveillance systems in place capable of reporting on key urban health information according to indicators of health outcomes, health system outputs, risk factors, and health determinants (14).</p> <p>As of 2017, 27 countries had completed their Health Vulnerability and Adaptation Assessments for Climate Change. Through</p>  |

<sup>2</sup> Activity 4.1: Buttress and stress the urban health component in national and regional networks and build upon and through existing regional networks such as the Network of the Americas for Healthy Municipalities, Cities and Communities; Health Promoting Schools; Healthy Housing; Faces, Voices, and Places; and global networks such as Safe Communities.

| Specific objective | Indicator, baseline, and target   | Status   |
|--------------------|---|--|
|                    | <p data-bbox="483 1472 855 1675">Number of countries that apply guidelines on assessment and action tools for health impact and/or health equity impact assessments in national or city policies, programs, or projects</p> <p data-bbox="483 1709 699 1776">Baseline (2011): 3<br/>Target (2021): 15</p> | <p data-bbox="868 327 1373 527">this process, ministries of health can assess current health system vulnerabilities to climate change, estimate future disease burden and risks, and identify adaptation policies and projects to address the vulnerabilities.</p> <p data-bbox="868 560 1390 760">In preparation for Habitat III, held in Quito, Ecuador, in September 2016, 19 countries of the Region submitted national reports that articulated experiences in managing urban issues, which helped inform the New Urban Agenda (15).</p> <p data-bbox="868 770 1382 1100">In line with Activity 5.4 of the Strategy and Plan of Action on Urban Health,<sup>3</sup> in September 2015, the United Nations University International Institute for Global Health (UNU-IIGH), Drexel Dornsife School of Public Health, and ECLAC formed a partnership for urban health research in the LAC region: the Urban Health Network for Latin America and the Caribbean (SALURBAL).</p> <p data-bbox="868 1131 1390 1461">The network brings together regional experts in urban health, supports intraregional research and training linkages, and seeks to identify and disseminate important lessons both within and beyond the LAC region (16). Thanks to a major research grant recently awarded to network members, PAHO and Drexel University are actively discussing collaboration opportunities on a large regional urban health study.</p> <p data-bbox="868 1472 1382 1709">As of 2017, 2 countries developed capacity to use Innov8, an online action planning organizer and collaboration tool, to evaluate and provide recommendations for the integration of gender, equity, and human rights into their programs. The tool was adapted for use in the Region with Spanish</p> |

<sup>3</sup> Activity 5.4: Build closer ties with academicians and universities, fostering action by collaborating centers, promoting the funding of pertinent research, as identified from observatories and practice related to the impact of urbanization on health and the social gradient.

| Specific objective | Indicator, baseline, and target | Status  |
|--------------------|---------------------------------|---|
|                    |                                 | <p>translation and a component on ethnicity for future use (17).</p> <p>Fifteen countries are partnering with the Commission on Equity and Health Inequalities in the Americas, aiming to understand the factors leading to health inequities in the Region, including both the positive and negative effects of urbanization (18), and ways to address them.</p> |

### Action Necessary to Improve the Situation

7. As an agent of mobilization at the national, regional, and global level, PAHO is responsible for supporting Member States in developing appropriate strategies and policies for urban health planning, identifying mechanisms for achieving multisectoral action, and collecting and sharing national urban health experiences, lessons learned, and best practices. Strategic action is recommended in the following areas:

- a) Strengthen regional capacity in urban design, its implementation, and monitoring.
- b) Continue PAHO support for engagement on the part of ministries of health, city leadership, other sectors of government, the private sector, and civil society. Partnerships can be enhanced through participatory decision-making; public-private collaboration, particularly for urban planning; and Health in All Policies.
- c) Ensure equal access to opportunities for all people by calling upon city authorities to systematically consider the needs of women, children and youth, people with disabilities, older persons, indigenous people, and other marginalized groups.
- d) Member States are encouraged to enhance their systems for collecting data and reporting on urban health indicators, investing in capacity-building where required. Relationships among urban health and determinants of health personnel in Member States, PAHO Country Offices and Headquarters, should be strengthened and efforts should be made to harmonize programming with the 2030 Agenda for Sustainable Development.

### Action by the Directing Council

8. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

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## **D. PLAN OF ACTION ON ANTIMICROBIAL RESISTANCE: MIDTERM REVIEW**

### **Background**

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress in implementation of the Plan of Action on Antimicrobial Resistance (AMR), approved in October 2015 (Document CD54/12, Rev. 1 and Resolution CD54.R15) (1). The goal of the Plan of Action is for Member States to take all necessary action possible, in accordance with their context, needs, and priorities, to ensure their capacity to treat and prevent infectious diseases through the responsible and rational use of safe, effective, accessible, and affordable quality-assured medicines and other health technologies. The Plan fits within the framework of universal health coverage, specifically with regard to timely access to quality medicines, and is in line with the Global Action Plan on Antimicrobial Resistance adopted by the 68th World Health Assembly in May 2015 (2).

2. Recognizing the solid evidence on the estimated burden of disease and economic impact of AMR (3, 4) and understanding that the situation is a global crisis that endangers sustainable development, the United Nations General Assembly (UNGA) adopted a political declaration on antimicrobial resistance in 2016 (5).

### **Analysis of Progress Achieved**

3. An increasing number of countries recognize AMR as a priority intersectoral area of action in the health, agriculture, and livestock sectors. The Pan American Sanitary Bureau (PASB) is supporting countries to develop multisectoral approaches by providing multicountry workshops, tools, and consultations. In total, 30 countries have completed or are in the process of developing national action plans. Continued support will be needed to finalize these national action plans and ensure human and financial resources for their implementation and monitoring. Successful and sustainable implementation of the national action plans will go hand in hand with reaching the targets of this Plan of Action.

4. Progress has been made in all five of the strategic lines of action described in the Plan of Action. The specific steps taken toward each of the objectives and indicators are summarized in the tables below.

| <i>Strategic Line of Action 1: Improve awareness and understanding of antimicrobial resistance through effective communication, education, and training</i> |   |  |
|---|---|--|
| <b>Objective</b>  | <b>Indicator, baseline and target</b>   | <b>Status</b>  |
| <b>1.1</b> Promote the need for recognition of antimicrobial resistance as a priority intersectoral action  | <b>1.1.1</b> Number of countries that have campaigns on antimicrobial resistance and rational use aimed at the general public and professional sectors<br><br>Baseline: 9 in 2015<br>Target: 20 in 2020   | In 2017, 31 countries worked to raise awareness and understanding of AMR risks for human health through participation in World Antibiotic Awareness Week, training activities, or national campaigns (6, 7). It is important for countries to continue and expand nationwide awareness-raising activities and measure the impact of their efforts. |
|   | <b>1.1.2</b> Number of countries that carry out intersectoral activities to contain antimicrobial resistance, including professional training activities<br><br>Baseline: 5 in 2015<br>Target: 10 in 2020 | By 2017, 11 countries were carrying out training and educational activities from a One Health perspective as part of integrated surveillance activities.   |

| <i>Strategic Line of Action 2: Strengthen knowledge and scientific grounding through surveillance and research</i>            |  |  |
|---|--|--|
| <b>Objectives</b>   | <b>Indicator, baseline and target</b>  | <b>Status</b>  |
| <b>2.1</b> Maintain and improve national resistance surveillance systems to monitor the impact of resistance on public health | <b>2.1.1</b> Number of countries that annually provide laboratory-based data on antimicrobial resistance<br><br>Baseline: 20 in 2015<br>Target: 35 in 2020 | As of 2017, 19 Latin-American countries were participating in the ReLAVRA <sup>1</sup> network (8, 9) and providing AMR data to PAHO on an annual basis. In addition, data from Canada and United States of America are publicly available. Additional technical collaboration is urgently needed to support the Caribbean countries and territories, 10 of which are already in the process of strengthening their laboratory capacity toward developing national AMR surveillance systems. |

<sup>1</sup> Latin American Surveillance Network of Antimicrobial Resistance (ReLAVRA).

| Objectives   | Indicator, baseline and target   | Status   |
|--|--|--|
|  | <p><b>2.1.2</b> Number of countries in patient-centered antimicrobial drug resistance surveillance networks</p> <p>Baseline: 0 in 2015<br/>Target: 10 in 2020</p>  | <p>Four countries have joined the Global AMR Surveillance System (GLASS) (10), which collects patient-centered AMR data. The ReLAVRA network is aligning to the GLASS methodology to support countries that have made the national decision to adopt it.</p>   |
|  | <p><b>2.1.3</b> Number of countries that report and analyze the use of antimicrobial drugs in humans and animal</p> <p>Baseline: 2 in 2015<br/>Target: 5 in 2020</p>   | <p>As of 2017, 4 countries were reporting and analyzing the use of antimicrobial drugs in both humans and animals (6, 7). In all, 11 countries had a system in place for monitoring antimicrobial use in human health (6, 7) and 19 countries reported data on antimicrobial use in animals to the World Organisation for Animal Health (OIE) (11).</p>                        |
| <p><b>2.2</b> Develop a national resistance surveillance system that includes data on zoonotic pathogens transmitted through food and through direct contact</p> | <p><b>2.2.1</b> Number of countries and territories with multisectoral collaboration mechanisms to implement integrated antimicrobial resistance surveillance programs</p> <p>Baseline: 3 in 2015<br/>Target: 11 in 2020</p> | <p>In 2017, 10 countries had implemented an integrated AMR surveillance program or had started to develop one with multisectoral collaboration.</p>  |
| <p><b>2.3</b> Promote the monitoring of HIV resistance to antiretrovirals in the countries of the Region</p>   | <p><b>2.3.1</b> Number of countries that monitor HIV antiretroviral resistance in accordance with PAHO/WHO recommendations</p> <p>Baseline: 3 in 2015<br/>Target: 15 in 2020</p>   | <p>In 2017, 6 countries were monitoring HIV antiretroviral resistance in line with WHO-recommended HIV drug resistance surveillance guidelines (12, 13). In addition, implementation was ongoing in 11 countries and in different stages of planning in 9 countries.</p>   |
| <p><b>2.4</b> Have up-to-date information on the magnitude and trend of multidrug-resistant TB, to help strengthen the prevention of resistance</p>              | <p><b>2.4.1</b> Number of countries that perform susceptibility testing on 100% of previously treated TB cases</p> <p>Baseline: 3 in 2015<br/>Target: 12 in 2020</p>   | <p>As of 2016, 3 countries were performing drug susceptibility testing (DST) on 100% of previously treated TB cases (14). With the progressive implementation of molecular diagnostic methods in a number of countries, the percentage of previously treated patients with drug susceptibility testing (DST) is increasing but has not yet reached 100% in most countries.</p> |

| Objectives   | Indicator, baseline and target   | Status   |
|--|--|--|
|  | <p><b>2.4.2</b> Number of countries that diagnose more than 85% of estimated cases of multidrug-resistant TB among reported tuberculosis cases</p> <p>Baseline: 6 in 2015<br/>Target: 16 in 2020</p> | <p>As of 2017, only 1 country was diagnosing more than 85% of estimated cases of MDR-TB, including rifampicin-resistant TB (RR-TB), among reported TB cases, in accordance with the current WHO classification of drug-resistant TB (14).</p> <p>There have been changes to the WHO definition of MDR-TB, which currently includes RR-TB, thereby superseding the criteria used to establish the 2013 baseline and target values. This indicator should be updated to reflect the current classification by WHO of drug-resistant TB and rephrased as “Number of countries that diagnose over 85% of estimated cases of MDR/RR-TB among reported tuberculosis cases.” Accordingly, the baseline and target could be modified more realistically to 1 and 10 countries, respectively.</p> |
| <p><b>2.5</b> Have evidence obtained through studies that monitor antimalarial drug efficacy and resistance, to help improve treatment quality</p>                       | <p><b>2.5.1</b> Number of countries that conduct periodic studies that monitor antimalarial drug efficacy and drug resistance</p> <p>Baseline: 6 in 2015<br/>Target: 11 in 2020</p>                  | <p>Therapeutic efficacy studies and/or surveillance with molecular markers have been implemented in 8 countries to monitor drug efficacy and resistance, pursuant to PAHO/WHO guidelines (15).</p>   |
| <p><b>2.6</b> Have a regional research agenda that can generate evidence applicable to public health on effective mechanisms for containing antimicrobial resistance</p> | <p><b>2.6.1</b> Preparation of a regional research agenda on public health actions to contain antimicrobial resistance</p> <p>Baseline: 0 in 2015<br/>Target: 1 in 2020</p>                          | <p>By the first semester of 2019, a consultation of Member States and other relevant stakeholders will be held to formulate the research agenda on public health actions for containing antimicrobial resistance.</p>  |

| <b>Strategic Line of Action 3: Reduce the incidence of infections through effective sanitation, hygiene, and preventive measures</b>   |   |   |
|--|---|---|
| <b>Objective</b>   | <b>Indicator, baseline and target</b>   | <b>Status</b>   |
| <b>3.1</b> Establish strategies to boost national capacities to contain, treat, prevent, monitor, and communicate the risk of diseases caused by multidrug-resistant organisms | <b>3.1.1</b> Number of countries with infection prevention and control programs that include national data on health care-associated infections<br><br>Baseline: 9 in 2015<br>Target: 18 in 2020      | As of 2017, 10 countries had an infection prevention and control (IPC) program in place that included mandatory surveillance for health care-associated infections (HAIs).                  |
|  | <b>3.1.2</b> Number of countries in which infection prevention and control capacities are evaluated<br><br>Baseline: 13 in 2015<br>Target: 18 in 2020   | As of 2017, 18 countries had been evaluated for infection prevention and control capacities using a standardized guide (17). Of these 18 countries, 13 had a national IPC program in place. |
|  | <b>3.1.3</b> Number of countries that have an evaluation of their health infrastructure with regard to the control of aerosol-transmitted infections<br><br>Baseline: 0 in 2015<br>Target: 10 in 2020 | By 2017, 18 countries had made an evaluation of their health infrastructure with regard to the control of aerosol-transmitted infections (17).  |

| <b>Strategic Line of Action 4: Optimize the use of antimicrobial drugs in human and animal health</b>   |  |   |
|---|--|---|
| <b>Objective</b>  | <b>Indicator, baseline and target</b>  | <b>Status</b>   |
| <b>4.1</b> Establish national strategies to mitigate antimicrobial resistance and monitor the rational use of antibiotics, including strengthening the role of antibiotics committees | <b>4.1.1</b> Number of countries that have a written strategy for containing antimicrobial resistance (year of latest update), with a plan to measure results<br><br>Baseline: 3 in 2015<br>Target: 14 in 2020 | In 2017, according to the Global Monitoring of Country Progress on AMR self-assessment (6-7), 14 countries had a national action plan in place and an additional 16 countries were developing such plans. |

| Objective | Indicator, baseline and target  | Status  |
|-----------|---|---|
|           | <p><b>4.1.2</b> Number of countries that have created and funded a special national, intersectoral group to promote the appropriate use of antimicrobial drugs and prevent the spread of infections</p> <p>Baseline: 5 in 2015<br/>Target: 15 in 2020</p>                           | <p>By 2017, 8 countries had created a national intersectoral group to promote the appropriate use of antimicrobial drugs and prevent the spread of infections.</p>  |
|           | <p><b>4.1.3</b> Number of countries that have produced, through a funded national intersectoral group, reports and recommendations to promote the appropriate use of antimicrobial drugs and prevent the spread of infections</p> <p>Baseline: 5 in 2015<br/>Target: 15 in 2020</p> | <p>The same 8 countries from the previous indicator (4.1.2) have produced reports and recommendations to promote the rational use of antimicrobials and prevent the spread of infection.</p>  |
|           | <p><b>4.1.4</b> Number of countries where nonprescription antibiotics are sold, despite regulations to the contrary</p> <p>Baseline: 15 in 2015<br/>Target: 11 in 2020</p>  | <p>As of 2017, 5 countries had regulations to ensure that antibiotics are sold and acquired only by prescription.</p> <p>To complement this indicator the Bureau is also collecting the information on the number of countries with regulations in place to ensure that antibiotics are sold and acquired only by prescription. As of 2017, 5 countries had regulations to ensure that antibiotics are sold and acquired only by prescription, while in 2015, 3 had such regulations and at the end of the implementation of this plan 10 countries should have them.</p> |

| <i>Strategic Line of Action 5: Prepare economic arguments for sustainable investment that takes into account the needs of all countries, and increase investment in new drugs, diagnostic tools, vaccines, and other actions.</i> |  |  |
|---|--|--|
| <b>Objective</b>  | <b>Indicator, baseline and target</b>  | <b>Status</b>  |
| <b>5.1</b> Generate and systematize evidence to document the economic impact of antimicrobial resistance  | <b>5.1.1</b> Number of countries that produce studies that quantify the economic impact of antimicrobial resistance<br><br>Baseline: 11 in 2015<br>Target: 20 in 2020  | A literature search showed that 13 countries produce studies that quantify the economic impact of antimicrobial resistance.  |
| <b>5.2</b> Promote intersectoral cooperation for greater efficiency in the development, introduction, regulation, and use of new antimicrobial drugs, diagnoses, and vaccines   | <b>5.2.1</b> Number of countries that are advancing in the development of agreements or new regulatory measures to evaluate new vaccines, diagnostic methods, and antimicrobial drugs, and that have included these in their health agendas<br><br>Baseline: 6 in 2015<br>Target: 11 in 2020 | In 2017, 8 countries were working on agreements or new regulatory measures to evaluate new vaccines, diagnostic methods, and antimicrobial drugs and had included these measures on their health agendas.                            |
| <b>5.3</b> Develop a mechanism for exchanging information and experts among government, private sector, academia, and industry  | <b>5.3.1</b> Available mechanism for the exchange of information and experiences between different sectors<br><br>Baseline: 0 in 2015<br>Target: 1 in 2020   | By the first semester of 2019, an expert consultation on AMR will be organized to get expert advice on the best mechanism for exchanging information and experts between the government, the private sector, academia, and industry. |

### **Action Needed to Improve the Situation**

5. In order to reach the targets for 2020, it will be important for PAHO to convene multicountry workshops on AMR topics, with emphasis on a multisectoral One Health approach, while also providing countries with tailor-made consultations in order to ensure the completion and sustainable implementation of national action plans. Detailed implementation, budget plans, and specific working groups are needed at the country level to ensure implementation of the strategic objectives for surveillance, infection prevention and control, and appropriate use of antibiotics in all sectors. The availability of financial and human resources at the country level is crucial and therefore Ministries of Finance should be actively involved.

6. AMR surveillance has been conducted in many countries for decades, but there is now a need to expand this surveillance to include antimicrobial use and to integrate the agricultural sector (18, 19). At the same time, it is important to work on further improvement of existing surveillance systems in line with GLASS, with special emphasis on those areas in which surveillance is still in its early development.

7. Member States have regulations in place and are urged to enforce them, in particular with regard to the dispensing of antibiotics only by prescription. They are also urged to implement antimicrobial stewardship programs in hospitals and at the first level of care, as well as to monitor and evaluate national sales and the rational use of antimicrobials in humans and animals as part of their national plans.

8. Member States should pay urgent attention to the implementation of intervention strategies to improve the prevention and control of health care-associated infections, which is also essential to limiting the development and spread of multidrug-resistant bacteria.

9. With support from PAHO, Member States should make investments to ensure universal access to new diagnostic methods for testing drug susceptibility, including molecular techniques. Regarding tuberculosis, Member States should work on testing and improving routine surveillance for drug-resistant cases. In the area of HIV/AIDS, Member States should urgently address the emergence of resistance to antiretroviral medicines and align the HIV component of national AMR action plans with the new WHO Global Action Plan on HIV Drug Resistance (21). In malaria, the decline in cases has made it more difficult to carry out therapeutic efficacy studies (TESs), the gold standard methodology for evaluating the efficacy of antimalarial drugs. In light of this situation, Member States are urged to continue monitoring the efficacy and resistance of antimalarials using molecular markers and TESs where possible (15).

### **Action by the Directing Council**

10. The Directing Council is invited to take note of this report and formulate the recommendations it deems pertinent.

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## **E. PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF VIRAL HEPATITIS: MIDTERM REVIEW**

### **Background**

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress in implementation of the Plan of Action for the Prevention and Control of Viral Hepatitis (Document CD54/13, Rev. 1 [2015]), which covers the period from 2016-2019 (1).
2. The Plan is aligned with the vision, goals, and strategic directions of the WHO Global Health Sector Strategy for Viral Hepatitis 2016-2021 (2), endorsed by the World Health Assembly (WHA) in May 2016, which calls for the elimination of viral hepatitis as a public health threat by 2030 as indicated by a 90% reduction in incidence and a 65% reduction in prevalence. In addition, the Plan reflects inclusion of the global objective to combat viral hepatitis under Goal 3 of the Sustainable Development Goals (SDGs).
3. The regional response should take into account several key features of viral hepatitis. In 2016, PAHO estimated that 2.8 million people in the Region were living with hepatitis B (HBV) and another 7.2 million with hepatitis C (HCV), while approximately 125,000 died from viral hepatitis in 2013 (3). Around 96% of the mortality from viral hepatitis is a result of chronic hepatitis B and C infection leading to cirrhosis and primary liver cancer, or hepatocellular carcinoma (HCC). In fact, approximately 78% of HCC worldwide is a result of chronic hepatitis B or C infection (2). Therefore, efforts to control hepatitis incidence and mortality should be focused on hepatitis B and C. New treatments are very effective: hepatitis B and C antivirals can reduce the risk of developing liver cancer by around 75%, giving the added public health benefit that action to eliminate hepatitis will reduce HCC incidence in the Region. New direct-acting antivirals (DAAs) for HCV can cure this infection in 95% of cases with these first-line drugs alone and in 99.9% of cases when second-line drugs are accessible.
4. Globally and in the Region of the Americas, the hepatitis response has been hampered by a lack of international funding globally. Thus, the hepatitis response depends almost entirely on the availability of domestic resources.

### **Analysis of Progress Achieved**

5. The following tables summarize the Region's midterm progress toward achievement of the objectives of the Plan in 2016-2017. It also highlights the challenges that will need to be overcome over the next year in order to meet the goals set forth in the Plan.
6. It should be noted that the indicators in the Plan of Action are policy indicators and therefore do not quantify the strength or breadth of any individual country's response.

| <i>Strategic Line of Action 1: Promoting an integrated comprehensive response</i>  |   |   |
|--|---|---|
| <b>Objective</b>   | <b>Indicator, baseline, and target</b>  | <b>Status</b>   |
| <b>1.1</b> Promote integration of viral hepatitis prevention, surveillance, diagnosis, care, and control interventions and services within the health sector and implement them in a concerted and effective manner with relevant partners and stakeholders.                       | <b>1.1.1</b> Number of countries that have a structured and budgeted national strategy or plan related to prevention, treatment, and control of viral hepatitis<br><br>Baseline: 10 in 2015 (8)<br>Target: 20 | 15 countries and territories (7)<br><br>This indicator is critical to supporting national action. By the end of 2017, 5 additional countries had developed national hepatitis strategies or plans that go beyond immunization.            |
| <b>1.2</b> Promote the development and implementation of coordinated public health policies and interventions with the aim of eliminating hepatitis B and hepatitis C in PAHO Member States by 2030.   | <b>1.2.1</b> Number of countries with goals of elimination of hepatitis B and hepatitis C as public health problems<br><br>Baseline: 0 in 2015 (8)<br>Target: 6   | 0 countries (7)<br><br>While all countries and territories are committed to the Global Health Sector Strategy to eliminate viral hepatitis as a public health threat by 2030, so far no countries have implemented it as national policy. |
|  | <b>1.2.2</b> Number of countries with goals of elimination of mother-to-child transmission of hepatitis B<br><br>Baseline: 1 in 2012 (9)<br>Target: 5   | 12 countries and territories (7)<br><br>Going forward, these countries and territories will be working within the terms of the EMTCT-Plus initiative.   |
| <b>1.3</b> Implement information and communication activities and campaigns at the regional, subregional, national, and local levels to raise awareness of the existence, severity, and routes of transmission of viral hepatitis and measures to prevent and control the disease. | <b>1.3.1</b> Number of countries that commemorate World Hepatitis Day through awareness campaigns or major thematic events<br><br>Baseline: 10 in 2015 (8)<br>Target: 20                                      | 12 countries and territories (7)<br><br>World Hepatitis Day is well established on the calendar of major public health celebrations in the Region.  |

| <b>Strategic Line of Action 2: Fostering equitable access to preventive care</b>  |   |   |
|---|---|---|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>  | <b>Status</b>   |
| <p><b>2.1</b> Maintain and expand HBV immunization programs in order to increase coverage for all children and for members of key populations and vulnerable groups.</p>  | <p><b>2.1.1</b> Number of countries that maintain high HBV coverage (95% or above) as part of the routine childhood vaccination schedule (below 1 year of age)</p> <p>Baseline: 15 in 2013 (10)<br/>Target: 25</p>  | <p>17 countries and territories (10)</p> <p>In 2017 Region-wide, hepatitis B vaccination coverage increased from 90% to 91% and 2 additional countries reached 95% or above.</p>  |
|   | <p><b>2.1.2</b> Number of countries that have included immunization of newborns against HBV within the first 24 hours in their vaccination programs</p> <p>Baseline: 18 in 2013 (10)<br/>Target: 25</p>   | <p>21 countries and territories (7)</p> <p>In addition to 21 countries and territories providing universal birth dose (BD), an additional 13 countries provide BD vaccine only to neonates of HBsAg-positive mothers.</p> |
| <p><b>2.2</b> Encourage countries to conduct epidemiological, burden of disease, and health technology assessment, such as cost-effectiveness analyses to support evidence-based decisions regarding the introduction of hepatitis A vaccine (HAV).</p> | <p><b>2.2.1</b> Number of countries that have conducted HAV epidemiological, burden of disease, and health technology assessments, such as cost-effectiveness analyses, to inform vaccine introduction</p> <p>Baseline: 5 in 2013 (11 -15)<br/>Target: 10</p> | <p>9 countries (16)</p> <p>Sporadic outbreaks of HAV transmission among men who have sex with men have been described in several countries across the Region.</p>   |
| <p><b>2.3</b> Strengthen the capacity of the health sector to conduct the necessary actions to promote the strictest application of norms, protocols, and recommendations to prevent viral hepatitis infections in health care settings.</p>            | <p><b>2.3.1</b> Number of countries with measures for the prevention of hepatitis B among health workers</p> <p>Baseline: 13 in 2015 (8)<br/>Target: 26</p>   | <p>32 countries and territories (7)</p> <p>These 32 countries and territories have specific strategies in place to prevent HBV transmission among health workers.</p>   |

| Objective  | Indicator, baseline, and target  | Status   |
|--|--|--|
| <b>2.4</b> Strengthen the capacity of the health sector to develop and implement policies and strategies to prevent viral hepatitis infections among people who use drugs and other key populations. | <b>2.4.1</b> Number of countries with viral hepatitis prevention and control strategies, such as HBV vaccine, targeting key populations<br><br>Baseline: 8 in 2015 (8)<br>Target: 20 | 14 countries and territories (7)<br><br>The increase to 14 countries and territories is attributed to the expansion of HBV catch-up vaccine programs in key populations. |

*Strategic Line of Action 3: Fostering equitable access to clinical care*

| Objective  | Indicator, baseline, and target   | Status   |
|--|---|--|
| <b>3.1</b> Adapt and implement norms and standards for screening, diagnosis, care, and treatment of viral hepatitis. | <b>3.1.1</b> Number of countries that have developed guidelines for prevention, care, and treatment of hepatitis B in line with the latest WHO recommendations<br><br>Baseline: 16 in 2012 (9)<br>Target: 25          | 18 countries and territories (7)<br><br>The major shift in recommended treatment occurred in 2015, with therapy limited to oral antivirals with a high barrier to resistance. There are 18 countries and territories that have national guidelines consistent with these new regimens. |
|  | <b>3.1.2</b> Number of countries that have developed guidelines for screening, diagnosis, care, and treatment of hepatitis C in line with the latest WHO recommendations<br><br>Baseline: 6 in 2015 (8)<br>Target: 15 | 12 countries and territories (7)<br><br>New recommendations were published in April 2018. There are 12 countries and territories that have guidelines consistent with previous WHO guidance.   |
|  | <b>3.1.3</b> Number of countries that have started offering publicly funded HBV diagnosis and treatment<br>Baseline: 11 in 2015 (8)<br>Target: 20   | 22 countries and territories (7)<br><br>These 22 countries and territories offer treatment (although in many countries access is limited).   |

| Objective   | Indicator, baseline, and target  | Status  |
|---|--|---|
|   | <p><b>3.1.4</b> Number of countries that have started offering publicly funded HCV diagnosis and treatment</p> <p>Baseline: 6 in 2015 (8)<br/>Target: 10</p>   | <p>15 countries and territories (7)</p> <p>These 15 countries and territories offer some form of publicly funded hepatitis treatment. Numbers of patients remain limited in most countries, where access to treatment has often been decided on the basis of judiciary rulings.</p> |
|   | <p><b>3.1.5</b> Number of countries that include in their national essential medicine lists and/or formularies one or more drugs recommended in WHO 2015 guidelines for HBV treatment</p> <p>Baseline: 10 in 2015 (8)<br/>Target: 20</p>   | <p>22 countries and territories (7)</p> <p>The most recent edition of WHO guidelines for HBV treatment was published in 2015.</p>   |
|   | <p><b>3.1.6</b> Number of countries that include in their national essential medicine lists and/or formularies one or more drugs recommended in WHO 2014 guidelines for HCV treatment</p> <p>Baseline: 8 in 2015 (8)<br/>Target: 15</p>  | <p>10 countries (7)</p> <p>These 10 countries are using one of the direct-acting antivirals (DAAs) referenced in the HCV treatment guidelines<sup>1</sup></p>   |
| <p><b>3.2</b> Adapt and implement norms and standards for treatment of viral hepatitis (B and C) in HIV coinfecting patients.</p> | <p><b>3.2.1</b> Number of countries that have updated their antiretroviral treatment criteria, including the recommendation of initiating antiretroviral therapy (ART) regardless of CD4 count in HIV patients with severe HBV-related chronic liver disease</p> <p>Baseline: 24 in 2014 (17)<br/>Target: 30</p> | <p>30 countries and territories (18)</p> <p>This number includes 22 countries and territories that recommend HIV treatment for all infected individuals and 8 in which HIV treatment is indicated for patients with HIV and severe HBV-related liver disease.</p>                   |

<sup>1</sup> Recommended direct-action antiviral therapy has shifted greatly over the past three years. WHO now recommends pangenotypic regimens, three forms of which are currently offered. Both the dynamic nature of therapy and high prices have impaired access and uptake of treatment.



| <i>Strategic Line of Action 4: Strengthening strategic information</i>   |   |  |
|--|---|--|
| <b>Objective</b>   | <b>Indicator, baseline, and target</b>  | <b>Status</b>  |
| 4.1 Increase and strengthen countries' capacity to develop and implement strategies for the surveillance, prevention, control, and/or elimination of viral hepatitis.                | 4.1.1 Number of countries that report cases of acute and chronic hepatitis B<br>Baseline: 8 in 2015 (8)<br>Target: 16   | 22 countries (7)<br>Subregional meetings to support hepatitis strategic information and surveillance were held in South and Central America during 2016.         |
|  | 4.1.2 Number of countries that report cases of hepatitis C infection.<br>Baseline: 13 in 2015 (8)<br>Target: 26   | 18 countries (7)<br>See comment for 4.1.1 above.<br>These 18 countries report at least some cases of acute or chronic hepatitis C.                               |
|  | 4.1.3 Number of countries conducting surveys on prevalence of viral hepatitis B or C in the general population and/or key populations<br>Baseline: 11 in 2015 (8)<br>Target: 18 | 14 countries<br>These 14 countries report conducting at least one prevalence survey on HBV or HCV.   |
| 4.2 Increase countries' capacity to analyze, publish, and disseminate national data on viral hepatitis and impact of responses disaggregated by age, gender, and cultural diversity. | 4.2.1 Number of countries that have published a national report on viral hepatitis<br>Baseline: 8 in 2015 (8)<br>Target: 15   | 13 countries (7)<br>These 13 countries have published national viral hepatitis baseline reports through the PAHO country-level hepatitis data mining initiative. |

| <i>Strategic Line of Action 5: Strengthening laboratory capacity to support diagnosis, surveillance and safe blood supply</i> |   |   |
|---|---|---|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>  | <b>Status</b>   |
| 5.1 Implement innovative technologies for laboratory diagnosis and monitoring of treatment responses.                         | 5.1.1 Number of countries that implement standardized and effective technologies for HBV patient monitoring<br>Baseline: 10 in 2015 (8)<br>Target: 20 | 19 countries and territories (7)<br>These 19 countries conduct HBV monitoring in line with WHO- recommended laboratory tests. |

| Objective   | Indicator, baseline, and target   | Status   |
|---|---|--|
|   | <p><b>5.1.2</b> Number of countries that implement standardized and effective technologies for HCV confirmation, including serology, genotyping, and patient monitoring</p> <p>Baseline: 8 in 2015 (8)<br/>Target: 15</p> | <p>19 countries and territories (7)</p> <p>These 19 countries and territories conduct HCV monitoring in line with WHO recommended laboratory tests.</p>  |
| <p><b>5.2</b> Implement norms to improve the safety of blood supplies and blood components.</p> | <p><b>5.2.1</b> Number of countries that screen 100% of blood transfusion units for HBV and HCV</p> <p>Baseline: 39 in 2014 (19)<br/>Target: 41</p>   | <p>41 countries and territories</p> <p>Coverage of blood donation screening continues to be very high at the regional level. Differences in reporting processes in some countries and territories explains the lack of increase since 2015 in the number of countries that screen 100% of transfusion units.</p> |

7. In addition to progress toward implementation of the Plan of Action, PAHO has embarked on an initiative that emphasizes the integrated prevention of mother-to-child transmission of HIV, hepatitis B, syphilis, and Chagas disease within the common platform of mother and child health. This integrated framework, Elimination of Mother-to-Child Transmission of HIV, Syphilis, Hepatitis B, and Chagas Disease (EMTCT-Plus) (4), is planned to be implemented in at least two Member States during 2018. The goals of the EMTCT-Plus initiative are aligned with, and therefore complement, those of the regional Plan of Action for the Prevention and Control of Viral Hepatitis and the Global Health Sector Strategy on Viral Hepatitis 2016-2021.

### Action Necessary to Improve the Situation

8. In light of the progress described above, the actions needed to improve the situation include:

- a) An absolute increase in domestic funding allocation to hepatitis B and C is required in most countries and territories, given the current lack of international funds to support national hepatitis' responses.
- b) In order to strengthen countries' capacities to develop and utilize strategic information and cost-effectiveness analyses in decision-making, provide Member States with support in national planning and in studying hepatitis B and C "investment cases"—i.e., modeling the burden of disease based on empiric

- epidemiological data and projecting the potential impact and costs associated with population-level interventions aimed at meeting agreed global elimination targets.
- c) Work with Member States to ensure that the provision of hepatitis services is free from stigma and discrimination and delivered using an approach that respects human rights, equity, ethnicity, and gender.
  - d) Strengthen the capacity of Member States to generate and report strategic information on viral hepatitis disaggregated by gender, age, key population status, and ethnicity, to assist in the continued development of an evidence-base for strategic planning in viral hepatitis prevention, care, and control.
  - e) Continue expanding programs for the prevention of mother-to-child transmission (PMTCT) of HBV while also adopting the new EMTCT-Plus platform that includes HIV, syphilis, and Chagas disease alongside these existing efforts.
  - f) Promote the urgent expansion of access to hepatitis B and C diagnosis, care, and treatment consistent with WHO recommended practice within national health systems and health insurance systems, including for key populations and indigenous peoples.
  - g) Engage further with affected communities and groups representing affected communities to accelerate uptake of testing and treatment and demand for other hepatitis-related services.
  - h) Continue to support Member States in accessing affordable and quality hepatitis diagnostics and medicines for HBV and HCV and in incorporating recommended HBV and HCV antiviral therapies into national hepatitis treatment guidelines.
  - i) PAHO has recognized the dynamic nature of direct-acting antiviral therapy for HCV since the Directing Council approved the 2016 Plan of Action, and accordingly the Bureau will support Member States in including affordable new pangenotypic DAAs in national lists of essential medicines and health insurance programs, as well as in procuring these agents through the Strategic Fund.

### **Action by the Directing Council**

9. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

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## **F. PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF TUBERCULOSIS: MIDTERM REVIEW**

### **Background**

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress in the implementation of the Plan of Action for the Prevention and Control of Tuberculosis, approved in October 2015 (Document CD54/11 and Resolution CD54.R10) (1, 2). The goal of the Plan of Action is to accelerate the reduction in tuberculosis incidence and mortality, leading to the end of the epidemic in the Region of the Americas. Implementation of the Plan of Action will make it possible, by 2019, to meet the goals stipulated in the PAHO Strategic Plan 2014-2019. The Plan of Action is within the framework of the World Health Organization's (WHO) Global Strategy and Targets for Tuberculosis Prevention, Care and Control after 2015, subsequently known as the End TB Strategy, which was adopted by the Sixty-seventh World Health Assembly in May 2014 (3).

2. In November 2017, the First WHO Global Ministerial Conference on Ending TB in the Sustainable Development Era: A Multisectoral Response was organized by WHO and the Russian Federation. The conference issued the Moscow Declaration to End TB (4), in which countries affirmed their commitment to end the TB epidemic by 2030. The Declaration calls on WHO to support accelerating the response to meet the targets agreed under the End TB Strategy and the Sustainable Development Goals, through increased national and global commitments. The Region of the Americas is the WHO region closest to achieving the elimination target first, and PAHO has committed to provide all necessary support to its Member States toward this end. The Moscow conference will be followed in 2018 by the first United Nations General Assembly (UNGA) high level meeting on ending tuberculosis, which will further engage the highest political level in the commitment to achieve TB elimination.

### **Analysis of Progress Achieved**

3. Since 2015, countries in the Region have developed and/or updated their National TB Strategic Plans based on the Global Strategy and the Regional Plan of Action. Progress has been made on the three outcome indicators and on the indicators for the three strategic lines of action outlined in the Plan of Action. The main sources of information for this midterm review are the WHO Global Tuberculosis Report 2017 (5), reports of monitoring and evaluation visits to national TB programs, and reports of regional and subregional consultations and workshops (6).

| <i>Outcome Indicators</i>   |  |   |
|---|--|---|
| <b>Indicator</b>  | <b>Baseline and target</b>   | <b>Status</b>   |
| <b>1.</b> Cumulative number of patients with bacteriologically confirmed TB treated successfully in programs that have adopted the WHO-recommended strategy since 1995  | Baseline:<br>1.45 million patients in 2013<br><br>Target:<br>2.50 million patients in 2019 | As of 2015 (most recent available cohort), 2.05 million TB patients had been successfully treated in countries.     |
| <b>2.</b> Annual number of patients with presumed or confirmed multidrug-resistant TB (MDR-TB), based on WHO definitions (2013), including rifampicin-resistant (RR-TB) cases, receiving MDR-TB treatment in the Region | Baseline:<br>2,960 patients in 2013<br><br>Target:<br>5,490 patients in 2019               | As of 2016 (most recent available data), 3,509 presumptive or confirmed MDR/RR-TB patients have received treatment. |
| <b>3.</b> Percentage of new patients with diagnosed TB, compared to the total number of incident TB cases   | Baseline:<br>79% in 2013<br><br>Target:<br>90% in 2019                                     | As of 2016 (most recent available data), 81% of estimated TB incident cases were diagnosed.                         |

4. For the first strategic line, technical cooperation has been provided to National TB Programs (NTP) through country missions and capacity-building events. Capacity for early diagnosis and case detection has been stepped up through a regional grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria to strengthen TB laboratories of 20 countries (7). Treatment of TB and drug-resistant TB has been strengthened through technical support provided by the regional Green Light Committee (rGLC), and TB drug management is improving through joint work with the PAHO Strategic Fund. Likewise, TB/HIV collaboration has been strengthened, including updating of regional clinical guidelines. Other TB co-morbidities (TB/diabetes and TB/tobacco) have been further addressed.



| <i>Strategic Line of Action 1: Integrated tuberculosis prevention and care, focused on those persons affected by the disease</i>  |   |  |
|---|---|--|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>  | <b>Status</b>  |
| <b>1.</b> Strengthen integrated prevention and care of tuberculosis, focused on those persons affected by the disease, in accordance with international standards for tuberculosis care | <b>1.1</b> Number of countries that diagnose and treat tuberculosis in accordance with international standards for tuberculosis care<br><br>Baseline: 20 in 2013<br>Target: 35 in 2019      | As of 2017, 25 countries have updated their national tuberculosis guidelines to include WHO recommendations on TB diagnosis and treatment.<br><br>Progress on this indicator is constrained by the frequent updates of TB recommendations, especially on new diagnostics and drugs. Likewise, review and approval processes at country level may delay updating of national guidelines.<br><br>PAHO is supporting NTPs in these processes. |
|   | <b>1.2</b> Number of countries that carry out systematic preventive therapy for contacts (under age 5) of active tuberculosis cases<br><br>Baseline: 5 in 2013<br>Target: 20 in 2019        | As of 2017, 15 countries are providing preventive therapy with isoniazid to children under 5 years of age who are contacts of active TB cases, as recommended by PAHO/WHO.<br><br>The activity reflected in this indicator is key to preventing TB disease in a highly vulnerable group, and critical along with TB case findings to achieve TB elimination. Efforts are being made to increase notification and follow-up.                |
|   | <b>1.3</b> Number of countries that carry out systematic preventive therapy of TB/HIV co-infection, in accordance with national guidelines<br><br>Baseline: 5 in 2013<br>Target: 10 in 2019 | As of 2017, seven countries notify initiation of isoniazid preventive therapy (IPT) in people with HIV. There is anecdotal evidence that this activity is being widely conducted in HIV services, but available data are scarce.<br><br>Some countries have developed innovative ways to ensure recording and reporting of this information.   |
|   | <b>1.4</b> Number of countries that diagnose over 85% of estimated cases of MDR-TB among reported tuberculosis cases<br><br>Baseline: 6 in 2013<br>Target: 16 in 2019                       | As of 2017, only one country is diagnosing more than 85% of estimated cases of MDR-TB, including rifampicin-resistant TB, among reported TB cases, following the current classification by WHO of  |

| Objective | Indicator, baseline, and target   | Status  |
|-----------|---|---|
|           |   | <p>drug-resistant TB (8) and the introduction in countries of the rapid molecular diagnostic test, Xpert® MTB/RIF.</p> <p>There have been changes to the WHO definition of MDR-TB, which currently includes RR-TB, thereby superseding the criteria used to establish the 2013 baseline and target values. This indicator needs to be adjusted accordingly.</p> <p>PAHO is facilitating the implementation of the Xpert® MTB/RIF assay. It is also providing support for the improvement of routine surveillance of drug-resistant TB that will improve the available data and thus make possible more realistic estimates.</p> <p>Note: This indicator should be updated to reflect the current classification by WHO of drug-resistant TB and rephrased as “Number of countries that diagnose over 85% of estimated cases of MDR/RR-TB among reported tuberculosis cases.” Accordingly, the baseline and target could be modified more realistically to 1 and 10 countries, respectively.</p> |
|           | <p><b>1.5</b> Number of countries that initiate treatment of 100% of reported cases of MDR-TB</p> <p>Baseline: 6 in 2013<br/>Target: 12 in 2019</p>               | <p>As of 2017, 14 countries initiate treatment for all of their reported MDR-TB cases. This already exceeds the 2019 target. Intense technical support was provided by MDR-TB experts through the regional Green Light Committee mechanism.</p>   |
|           | <p><b>1.6</b> Number of countries where 100% of cases of TB/HIV co-infection receive antiretroviral therapy</p> <p>Baseline: 6 in 2013<br/>Target: 15 in 2019</p> | <p>As of 2017, nine countries provide antiretroviral therapy to all TB/HIV co-infected patients. PAHO is providing support to countries to fulfill this important indicator, and HIV programs are increasing access to antiretrovirals, thus benefiting co-infected patients.</p>   |

5. Political commitment has been enhanced through coordination with the TB Regional Parliamentary Caucus (9), including representatives from 20 countries of the Americas. Support was provided to the annual commemoration of World TB Day. Intensified work on vulnerable populations (children and indigenous groups) and involvement of civil society organizations have been promoted; support for strengthening TB information analysis has been given; and steps have been taken to promote inclusion of TB patients in social protection programs.

| <i>Strategic Line of Action 2: Political commitment, social protection, and universal coverage of tuberculosis diagnosis and treatment</i>  |   |   |
|---|---|---|
| <b>Objectives</b>   | <b>Indicator, baseline, and target</b>  | <b>Status</b>   |
| 2. Formulate and implement, in accordance with the Global Strategy, national tuberculosis control plans that strengthen political commitment and an integrated approach to tuberculosis control, within the framework of the Strategy for Universal Access to Health and Universal Health Coverage, and social protection | <b>2.1</b> Number of countries that have implemented updated plans in accordance with the Global Strategy<br><br>Baseline: 0 in 2013<br>Target: 30 in 2019                      | As of 2017, 21 countries are implementing national strategic plans for TB based on the End TB Strategy.   |
|   | <b>2.2</b> Number of countries that have financed their updated strategic plans in accordance with the Global Strategy<br><br>Baseline: 0 in 2013<br>Target: 30 in 2019         | As of 2016, 15 countries reported that their updated national strategic plans for TB were funded. Funding for TB activities was 67% domestic, 15% international, and 18% unfunded; the preceding year the unfunded proportion was 21%.  |
|   | <b>2.3</b> Number of countries that have community networks working in tuberculosis control<br><br>Baseline: 3 in 2013<br>Target: 10 in 2019                                    | As of 2017, 13 countries have established community networks supporting TB prevention and control activities in coordination with health officials and facilities. Based on experiences in these countries, PAHO is promoting the creation of a regional community network that will facilitate the establishment and expansion of national networks. |
|   | <b>2.4</b> Number of countries with established regulations on the registry, importation, and manufacture of medical products<br><br>Baseline: 28 in 2013<br>Target: 30 in 2019 | As of 2017, 31 countries have established regulations on aspects related to registry, importation, and manufacture of medical products, including those for TB (drugs, diagnostics, and supplies), exceeding the target (10, 11).   |

| Objective | Indicator, baseline, and target  | Status  |
|-----------|--|---|
|           | <p><b>2.5</b> Number of countries that include people affected by tuberculosis in social protection programs</p> <p>Baseline: 5 in 2013<br/>Target: 15 in 2019</p> | <p>As of 2017, 10 countries have social protection programs in which TB patients are included. In some instances their families also benefit. A lesson learned with the implementation of these social protection programs concerns their sustainability. When such programs are in place for only a short period of time, there can be negative effects, such as loss of adherence to treatment.</p> |

6. For the third strategic line, introduction of new diagnostic technology (GeneXpert® and Line Probe Assay) and new drugs (bedaquiline and delamanid) has been fostered. National capacity was developed through training (SORT-IT) for implementing operational research. The initiative for TB control in large cities has been expanded to 13 urban centers. Development of active DR-TB pharmacovigilance has taken place in five pilot sites, and follow-up of seven low-burden countries in the TB elimination initiative has been done.

| <i>Strategic Line of Action 3: Operational research and implementation of innovative initiatives and tools for tuberculosis prevention and control</i>  |   |   |
|---|---|---|
| Objective   | Indicator, baseline, and target   | Status  |
| <p><b>3.</b> Implement innovative initiatives and tools for tuberculosis control, using operational research in each Member State to measure and evaluate their contribution in terms of diagnosis and treatment outcomes</p> | <p><b>3.1</b> Number of countries with established and functional national tuberculosis research networks that include national TB control programs</p> <p>Baseline: 1 in 2013<br/>Target: 10 in 2019</p> | <p>As of 2017, three countries have established national TB research networks that are functional and that coordinate with the NTP, and other countries are in the process of developing them.</p>  |
|   | <p><b>3.2</b> Number of countries that have operational research plans for tuberculosis</p> <p>Baseline: 1 in 2013<br/>Target: 10 in 2019</p>   | <p>As of 2017, six countries have developed TB operational research plans on specific topics. Other countries are setting their research priorities as a first step toward developing a plan.</p>   |
|   | <p><b>3.3</b> Number of countries that use the new tools for tuberculosis control</p> <p>Baseline: 11 in 2013<br/>Target: 20 in 2019</p>  | <p>As of 2017, 16 countries are using new tools for TB prevention and control, including new diagnostics (GeneXpert® and Line Probe Assay). Innovative initiatives for TB control are being implemented in large cities and have contributed to an increase in TB case detection.</p> |

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

7. Consider reaffirming the commitments and calls to action of the Moscow Declaration to end TB, including strengthening of interprogrammatic and intersectoral interventions; civil society participation in TB prevention and control; coordinated action with the regional TB parliamentary caucus to increase political commitment and domestic funding by governments; and operational research to inform policy; and, also, following up on the decisions issued by the UNGA high level meeting on ending tuberculosis in September 2018.
8. Strengthen TB case detection in countries in order to address the existing gap of 50,000 undiagnosed cases in the Region which maintains the transmission of TB, by developing strategies such as information and communication campaigns on the symptoms of the disease targeted at vulnerable populations, better promotion of TB services, and reinforcement of health sector staff training on TB, among others.
9. Develop and/or strengthen services suitable for populations vulnerable to TB, such as children, prisoners, indigenous peoples, afro descendants, drug addicts, street dwellers, and the poor in urban settings , taking into consideration social and cultural aspects.
10. Promote early diagnosis for both sensitive and drug resistant TB using molecular tests for rapid diagnostics such as GeneXpert®— at the first level of care for initial diagnosis as it may also serve as a multi-disease diagnostic platform—and Line Probe Assay.
11. Pursue the strengthening of the TB laboratory networks through effective transportation of samples, quality control, and interconnectivity for realtime transmission of results.
12. Promote the shift towards a TB patient-centered approach to improve treatment of affected populations in an integrated manner. Actions aimed at facilitating adherence to treatment, like introducing and expanding shorter MDR-TB regimens, the use of fixed-dose combinations, of the latest pediatric dispersible presentations, and innovative ways to supervise treatment, as well as addressing stigma that still surrounds TB, are urgently needed.
13. Study the increasing presence of TB co-morbidities, especially those linked to diabetes and mental health (addictions) and develop innovative interprogrammatic approaches to address them.
14. Promote the inclusion of TB patients and their families in existing social protection schemes in countries to alleviate their needs and facilitate treatment adherence and outcome as evidence has shown.
15. Improve dissemination of TB information within the health information system in countries, and the data analysis directed toward decision making.

**Action by the Directing Council**

16. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

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**G. PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF HIV AND SEXUALLY TRANSMITTED INFECTIONS 2016-2021: MIDTERM REVIEW**

**Background**

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress in implementation of the Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021 (1). The Plan is aligned with the vision, goals, and strategic lines of the WHO global health sector strategies for HIV and sexually transmitted infections (STIs) for the 2016-2021 period (2, 3), as well as the Global Strategy for Women's, Children's, and Adolescents' Health 2016-2030 (4). It also adheres to the framework of the Sustainable Development Goals (SDGs). Its implementation will contribute to the goal of ending AIDS as a public health problem under SDG 3 (5). The goal of this Plan of Action is to accelerate progress toward ending the AIDS and STI epidemics as public health problems in the Region of the Americas by 2030 through reduction in the incidence of new HIV infections, AIDS-related mortality, and STI-related complications. The Plan also integrates the goals of the previous Regional Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (6).

**Analysis of Progress Achieved**

2. This report summarizes the Region's midterm progress toward achievement of the objectives of the Plan as of 2016-2017. It also highlights the challenges that will need to be overcome in the next three years in order to meet the goals set forth in the Plan. The tables below include baselines, targets, and progress in the overall impact indicators, as well as in the indicators related to the objectives of the Plan under each strategic line.

3. Unless otherwise specified, the main sources consulted to compile this report were the UNAIDS/WHO/UNICEF Global AIDS Monitoring data collection system (GAM) (7, 8) and the 2017 PAHO/UNAIDS HIV Prevention in the Spotlight report (9), complemented by desk reviews of national plans, strategies, and policies.



| Goal   | Impact indicator  | Status   |
|--|---|--|
| To accelerate the progress towards the end of AIDS and STI epidemics as public health problems by 2030 in the Region of the Americas | <b>1.</b> Estimated number of new HIV infections <sup>a, b</sup><br>Baseline: 120,000 (2014) <sup>c</sup><br>Target: 40,000 (2020)                          | 120,000 (2016) (7). No change in estimated new infections has been observed. Expanding and innovating HIV combination prevention strategies is a regional priority.  |
|  | <b>2.</b> Estimated number of AIDS-related deaths <sup>a, b</sup><br>Baseline: 50,000 (2014) <sup>c</sup><br>Target: 19,000 (2020)                          | 49,000 (2016) (7). Estimated AIDS-related deaths are down by 2%. Late diagnosis continues to limit the impact of treatment on HIV-related mortality.   |
|  | <b>3.</b> Rate (%) of mother-to-child transmission (MTCT) of HIV <sup>b, d</sup><br>Baseline: 12% (2014) <sup>c</sup><br>Target: 2% or less (2020)          | 9% (2016). The MTCT rate in Latin America is estimated to have fallen by 32%, but it is stagnant in the Caribbean. To lower it, greater effort is needed to reach adolescent and adult women from key populations and those under conditions of vulnerability.   |
|  | <b>4.</b> Incidence of congenital syphilis (cases/1,000 live births) <sup>d, e, f</sup><br>Baseline: 1.4% (2014) <sup>g</sup><br>Target: 0.5 or less (2020) | 1.6 (2016). The main factors affecting progress are insufficient use of point-of-care diagnostics, shortages of benzathine penicillin G, late access to antenatal care, and low coverage of adequate treatment for pregnant women and their partners.  |
|  | <b>5.</b> Estimated number of new cases of cervical cancer <sup>e, h</sup><br>Baseline: 83,200 (2012)<br>Target: 79,000 (2020)                              | No updated estimates were available from WHO/International Agency for Research on Cancer Globocan. Implementation of the new PAHO Plan of Action for Cervical Cancer Prevention and Control 2018-2030 will help to monitor this indicator through improvements in data collection, analysis, and modeling. |

| <i>Strategic Line of Action 1: Strengthened stewardship, governance, strategic planning, and information</i>   |   |   |
|--|---|---|
| Objective  | Indicator, baseline and target  | Status  |
| <b>1.1</b> Develop and update national HIV and STI plans and/or strategies aiming at ending AIDS and STI epidemics as a public health problem and in | <b>1.1.1</b> Number of countries with a national HIV/AIDS strategy that incorporates the regional prevention and 90-90-90 targets <sup>e, i</sup><br>Baseline: 20 (2015)<br>Target: 30 (2020) | 33 (2016). Regional prevention and 90-90-90 targets have been incorporated in national HIV plans or strategies in 33 countries. |

| Objective                          | Indicator, baseline and target   | Status   |
|------------------------------------|--|--|
| line with global and regional ones | <p><b>1.1.2</b> Number of countries and territories validated for having achieved the elimination of mother-to-child transmission of HIV and syphilis<sup>e, i</sup></p> <p>Baseline: 1 (2015)<br/>Target: 20 (2020)</p> | 7 (2017). One country was validated in 2015 and 6 in 2017 (all Caribbean); 6 additional countries applied in 2016 but were not validated: 3 failed to meet the targets and 3 will be reassessed in 2018. |
|                                    | <p><b>1.1.3</b> Number of countries that have developed national STI strategies in line with the Global Health Sector Strategy for STIs<sup>e, i</sup></p> <p>Baseline: 9 (2015)<br/>Target: 20 (2020)</p>               | 11 (2016). There were 11 countries that had developed national STI plans or strategies in line with the WHO Global Health Sector Strategy on STIs.   |

*Strategic Line of Action 2: Strengthened normative framework for health promotion, HIV/STI prevention, diagnosis, care, and treatment*

| Objective   | Indicator, baseline and target   | Status   |
|---|--|--|
| 2.1 Review and update guidelines and norms for health promotion, prevention, diagnosis, comprehensive care and treatment of STIs, HIV and co-infections | <p><b>2.1.1</b> Number of countries and territories that have updated their national HIV care and treatment guidelines in line with latest WHO ones<sup>d, e</sup></p> <p>Baseline: 5 (2015)<br/>Target: 25 (2020)</p> | 22 (2017). So far, 22 countries have updated their national guidelines, including the WHO “treat all” recommendation, and 6 more are currently in the process of revising their policies.    |
|   | <p><b>2.1.2</b> Number of countries and territories that have updated their national STI management guidelines in line with latest WHO ones<sup>e, i</sup></p> <p>Baseline: 0 (2015)<br/>Target: 17 (2020)</p>         | 16 (2016). Following publication of the new WHO STI management guidelines in 2015, 16 countries reported that their national guidelines are now in alignment with these latest global norms. |

| Objective   | Indicator, baseline and target   | Status   |
|---|--|--|
| 2.2 Implement and increase coverage of key interventions for health promotion, HIV prevention, diagnosis, care, and treatment     | 2.2.1 Number of countries with at least 90% of estimated people with HIV who have been diagnosed <sup>b, d</sup><br>Baseline: 0 (2014)<br>Target: 10 (2020)                                    | 0 (2016) (8). No country has yet reached the target, although 3 countries report having diagnosed greater than 85% of their estimated population with HIV (81% for Latin America as a whole; 64% for the Caribbean).                           |
|   | 2.2.2 Number of countries with at least 80% coverage of antiretroviral therapy (ART) among estimated people living with HIV <sup>b, d</sup><br>Baseline: 0 (2014)<br>Target: 10 (2020)         | 0 (2016) (8). No country has yet reached the 80% target, although 3 countries reached coverage between 60% and 70% (58% for Latin America; 52% for the Caribbean). LAC as a whole saw a significant increase, from 48% in 2015 to 56% in 2016. |
| 2.3 Implement and increase coverage of key interventions for STI prevention, diagnosis and treatment, including EMTCT of syphilis | 2.3.1 Number of countries and territories with at least 95% coverage of syphilis treatment among pregnant women <sup>e, i</sup><br>Baseline: 14 (2014)<br>Target: 30 (2020)                    | 19 (2016). The main challenges are insufficient use of point-of care diagnostics and failure to adopt immediate treatment, shortage of benzathine penicillin G, and late access to antenatal care.   |
| 2.4 Implement strategies for the prevention and control of HIV/STI antimicrobial resistance                                       | 2.4.1 Number of countries that monitor gonococcal antimicrobial resistance in accordance with PAHO/WHO recommendations <sup>e, i</sup><br>Baseline: 8 (2015) <sup>j</sup><br>Target: 23 (2020) | 12 (2016). The number of countries reporting data on gonococcal antimicrobial resistance through the ReLAVRA network increased, but surveillance based on a standardized methodology still needs to be expanded.                               |

**Strategic Line of Action 3: Expanded and equitable access to comprehensive and quality HIV/STI services**

| Objective  | Indicator, baseline and target  | Status   |
|--|---|--|
| 3.1 Increase equitable access to and coverage of interventions for HIV/STI combination prevention in key populations | 3.1.1 Regional median of the proportion (%) of gay men and other MSM that have been tested for HIV in last 12 months and know the result <sup>b, d, k</sup><br>Baseline: 47% (2014)<br>Target: 90% (2020) | 48% (2016) (9). Countries adopted more focused approaches, including community-based outreach activities, to increase MSM access to HIV testing. Most of these programs are still highly dependent on donor funding. |

| Objective                                      | Indicator, baseline and target   | Status  |
|--|--|---|
|  | <p><b>3.1.2</b> Regional median of the proportion (%) of female sex workers that have been tested for HIV in last 12 months and know the result<sup>b, d, k</sup></p> <p>Baseline: 65% (2014)<br/>Target: 90% (2020)</p>   | 65% (2016) (9). Same as above.  |
|  | <p><b>3.1.3</b> Regional median of the proportion (%) of gay men and other MSM that used a condom in last episode of anal sex with a male partner<sup>b, d, k</sup></p> <p>Baseline: 64% (2014)<br/>Target: 90% (2020)</p> | 63% (2016) (9). No improvement was observed for this indicator. WHO recommends not only improving traditional prevention approaches but also adopting new biomedical interventions (e.g., PrEP and non-occupational PEP). |
|  | <p><b>3.1.4</b> Number of countries that report data on access to HIV testing or prevention services in transgender women<sup>b, d</sup></p> <p>Baseline: 1 (2015)<br/>Target: 10 (2020)</p>                               | 15 (2016) (8). The number of countries collecting information on transgender women has significantly increased, already exceeding the target for 2020.  |
| 3.2 Increase quality of HIV care and treatment | <p><b>3.2.1</b> Number of countries that achieve 90% of retention on ART at 12 months<sup>b, d</sup></p> <p>Baseline: 5 (2014)<br/>Target: 18 (2020)</p>   | 5 (2016) (8). Although only 5 countries have reached the 90% target, 7 more countries have a 12-month retention rate of greater than 80%.   |
|  | <p><b>3.2.2</b> Number of countries that achieve 90% of viral suppression (viral load &lt;1000 copies/ml) in persons on ART<sup>b, d</sup></p> <p>Baseline: 1 (2015)<br/>Target: 10 (2020)</p>                             | 2 (2016) (7). Although only 2 countries have reached the 90% target (Brazil and Chile), 5 more countries have viral suppression rates of greater than 80%.  |

| Objective  | Indicator, baseline and target  | Status  |
|--|---|---|
| <b>3.3</b> Promote and strengthen effective participation of civil society in the provision of health promotion, HIV/STI prevention, diagnosis, care and treatment | <b>3.3.1</b> Number of countries with peer support offered to persons with HIV in care and treatment <sup>b, d, 1</sup><br>Baseline: 21 (2015)<br>Target: 33 (2020) | 28 (2016). More countries are offering peer support for persons with HIV on treatment, but this activity is still highly dependent on external funding or volunteer service. No information is available on coverage. |

*Strategic Line of Action 4: Increased and improved financing of HIV/STI response with equity and efficient use of resources for sustainability*

| Objective  | Indicator, baseline and target   | Status   |
|--|--|--|
| <b>4.1</b> Ensure universal access to nationally funded HIV/STI prevention, diagnosis, care and treatment services | <b>4.1.1</b> Number of countries with no or low dependency on external funding for the HIV response (0-5% of total funding) <sup>e, m</sup><br>Baseline: 11 (2014)<br>Target: 17 (2020)                                | Data on overall dependency of HIV response on external funding not yet available. In 2017, only 6 countries reported no dependency on external funding for HIV prevention (9). |
| <b>4.2</b> Promote efficiency in the procurement of HIV/STI medicines and other strategic commodities              | <b>4.2.1</b> Number of countries utilizing the PAHO Strategic Fund or other regional mechanisms to improve access to ARVs and other HIV/STIs/OIs commodities <sup>e, i</sup><br>Baseline: 15 (2015); Target: 20 (2020) | 19 (2016). In 2016, 13 countries procured antiretroviral medicines through the PAHO Strategic Fund. OECS procures ARVs through a pooled procurement mechanism.                 |

<sup>a</sup> Source: UNAIDS, Spectrum estimates (data validated and approved by the countries).

<sup>b</sup> Baseline and target refer to Latin America and the Caribbean.

<sup>c</sup> Baseline and target updated in 2017 to reflect new UNAIDS estimates for 2014.

<sup>d</sup> Source: UNAIDS/WHO/UNICEF, Global AIDS Monitoring (GAM).

<sup>e</sup> Baseline and target refer to the Region of the Americas.

<sup>f</sup> Source: EMTCT reports from countries applying for validation (another source in addition to GAM).

<sup>g</sup> Baseline was updated in 2017 to reflect updated information on the number of cases of congenital syphilis published or shared with PAHO by the countries. The delays were due to late notification of cases and work on improving the information systems.

<sup>h</sup> Source: WHO/IARC Globocan estimates or country estimates.

<sup>i</sup> Source: PAHO desk review.

<sup>j</sup> Baseline updated to reflect desk review of available results from ReLAVRA.

<sup>k</sup> These baseline proportions represent the median value of a series of results gathered from behavioral surveys.

<sup>l</sup> The original indicator (*Number of countries with community workers engaged in ART patient support*) has been dropped from the GAM. The current indicator, baseline, and target have been updated to reflect the current data collection system.

<sup>m</sup> Source: UNAIDS, Aidsinfo. Available from: <http://aidsinfo.unaids.org>

**Action Necessary to Improve the Situation**

4. Countries should accelerate their national responses directed toward ending the AIDS and STI epidemics as public health problems by 2030 and expanding equitable access and coverage of HIV and STI services within the broader framework of universal health and current ongoing processes of health system reform (10).

5. Strengthening HIV and STI prevention programs with a person- and community-centered combination approach is critical to increasing the impact on HIV incidence. The full range of high-impact interventions recommended by WHO, including PrEP and non-occupational PEP for sexual exposure, should be fully offered with a special focus on key populations and others in situation of vulnerability (11-13). In addition, new communication technologies should be adopted to promote access to information and prevention services among adolescents and youth. The contribution of civil society should be acknowledged and funding should be increased to ensure the sustainability of civil society-led services.

6. Evidence-based, innovative, and effective approaches to improving HIV testing services need to be incorporated and expanded, including key population-focused community-based testing, “testing for triage” by trained lay providers, HIV self-testing, and voluntary assisted partner notification (14, 15). Barriers to HIV testing need to be urgently addressed, including complex and inefficient diagnostic algorithms, national norms and regulations that limit task shifting to perform rapid tests, requirements for signed informed consent, mandatory pre-test counseling (in favor of shorter pre-test information), and parental consent for adolescents.

7. Countries should fully adopt EMTCT Plus, the new platform for eliminating mother-to-child transmission that integrates interventions for the elimination of perinatal HIV, perinatal HBV, congenital syphilis, and congenital Chagas into enhanced maternal and child health and sexual and reproductive health programs at the primary health care level. Continued efforts are needed to encourage pregnant women and their partners to seek early antenatal care, including early screening and immediate interventions and follow-up. Point-of-care services and community-based interventions are essential strategies for increasing the rate of screening, particularly among adolescent and women in conditions of vulnerability (16).

8. Countries should accelerate adoption and full implementation of the WHO “treat all” recommendation and proceed with rapid initiation of antiretroviral therapy (17, 18), prompt revision of current policies, rational use of antiretroviral medicines and introduction of new more potent agents (e.g. dolutegravir), assurance of quality care, and measures to maximize adherence, retention, prevention, and control of HIV drug resistance (19). In keeping with the integrated health service delivery network model, HIV care and treatment services should be decentralized and integrated into all levels of the health system with efficient resolution capacity at the first level (20).

9. In addition, it is urgent to improve the efficiency of supply chain management and ensure the availability of essential drugs, including antiretroviral medicines, penicillin and

other antibiotics, as well as laboratory commodities. The PAHO Strategic Fund will seek to fast-track the inclusion of new WHO-recommended antiretroviral medicines and fixed-dose combinations in its list and expand its role in supporting more efficient procurement of strategic lab commodities (21).

10. Furthermore, it is critical to enhance strategic information aimed at ensuring that the response is sustainable. Priority areas include maintaining and expanding surveillance of HIV drug resistance and gonococcal antimicrobial susceptibility promoting a standardized methodology for data reporting (22); improving congenital syphilis surveillance and aligning case definitions with international standards; strengthening the capacity of Member States to generate strategic information disaggregated by gender, age, key populations, and ethnicity; and enhancing their capacity to analyze current investments and outcomes in the HIV and STI response.

11. It also remains imperative to address structural barriers, particularly stigma and discrimination in health care settings towards people living with HIV and key populations. Greater effort should be made to ensure that people-centered services are offered by sensitized health care providers, including the adoption of supportive policies and norms, the creation of transparent mechanisms for the monitoring of discrimination in health care settings with meaningful civil society engagement, and the availability of mechanisms for redress (23).

12. In the context of reductions in external funding and transition to domestic resources, it is critical to improve the sustainability of the response to HIV. Member States should consider adhering to the recommendations endorsed at the Third Latin American and Caribbean Forum on HIV, held in November 2017 in Port-au-Prince, Haiti, which set forth specific actions aimed at sustaining the response to HIV with a view to eliminating AIDS by 2030, based on the principles of human rights and universal health (24).

### **Action by the Directing Council**

13. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

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## H. PLAN OF ACTION FOR MALARIA ELIMINATION 2016-2020: MIDTERM REVIEW

### Background

1. The Plan of Action for Malaria Elimination (Document CD55/13) and the corresponding Resolution CD55.R7 approved by the 55th Directing Council of the Pan American Health Organization (PAHO) in September 2016 provide the framework for technical cooperation with countries and other stakeholders toward achieving the Region's malaria targets for the year 2020 (1, 2). The Plan is strongly aligned with the World Health Organization's Global Technical Strategy for Malaria 2016-2030 (3), the Action and Investment to Defeat Malaria 2016-2030 (AIM) (4), and the United Nations Sustainable Development Goals (SDGs) (5).

2. Apart from malaria, the Plan also contributes to the fulfillment of other important mandates from the PAHO Directing Council, including the Strategy for Universal Access to Health and Universal Health Coverage (2014) (6); the Elimination of Neglected Diseases and Other Poverty-related Infections (2009) (7); the Policy on Research for Health (2009) (8); and Integrated Vector Management: A Comprehensive Response to Vector-borne Diseases (2008) (9).

### Analysis of Progress Achieved

3. The principal reference for preparation of the main updates is the list of targets that the Region has committed to for the period 2016-2020, which are as follows:

- a) further reduction of malaria morbidity by 40% or more (based on 2015 official figures);
- b) further reduction of malaria-related deaths by 40% or more (based on 2015 official figures);
- c) implementation of efforts to eliminate malaria in 18 of the 21 endemic countries and attainment of malaria-free status in at least four countries;
- d) implementation of innovative approaches to address challenges in countries where progress has been limited;
- e) prevention of the reestablishment of malaria in countries that have been declared malaria-free.

4. In 2016, four countries and territories in the Region (Belize, Bolivia, Guatemala, and French Guiana) reported a reduction of over 10% in the number of *Plasmodium falciparum* (Pf) and *P. vivax* (Pv) cases relative to 2015. However, the Region showed an overall increase of 26%, influenced primarily by the continuing epidemic in Venezuela, which has recorded in recent years the highest number of malaria cases in its history. Peru experienced a 12% increase in Pf infections, while overall case increases of approximately 50% were also

reported in Colombia, Ecuador, and Nicaragua. Case increases of less than 50% were noted in the Dominican Republic, Guyana, Haiti, Honduras, Mexico and Panama, reaffirming the fragileness of the Region's achievements between the years 2000 and 2015. Malaria deaths in the Region have likewise increased by 43%, from 159 in 2015 to 228 in 2016 (10).

5. Seven countries of the Region (Belize, Costa Rica, Ecuador, El Salvador, Mexico, Paraguay, and Suriname) were included by WHO in the group of 21 countries worldwide with the potential to eliminate local transmission of malaria by 2020 (11). Considerable progress has been made in Mesoamerican countries and Suriname in terms of reorienting their respective programs from control to elimination. Paraguay received official certification of malaria elimination from WHO in June 2018 while the process for Argentina is also progressing, with the goal of obtaining certification by the end of 2018.

6. With guidance from the Malaria Technical Advisory Group (Malaria TAG) and in coordination with partners, PAHO promoted operational innovation and strategies to accelerate progress in areas with greater challenges. These efforts include the Diagnosis-Treatment-Investigation and Response (DTI-R) initiative (12) and targeted approaches for hard-to-reach populations. A total of 27 countries and territories continue to be malaria-free in the Region. Fifteen of them are considered to still be receptive and vulnerable to malaria, of which 10 have recently ramped up efforts to prevent reestablishment.

***Strategic Line of Action 1: Universal access to good-quality malaria prevention interventions, integrated vector management, and malaria diagnosis and treatment***

| <b>Objective</b>  | <b>Indicator, baseline, and targets</b>  | <b>Status</b>   |
|---|--|---|
| <b>1.1</b> Reinforce country capacity in terms of access to and compliance with malaria prevention and case management interventions through effective supply chain management, information, education, and communication efforts, among others | <b>1.1.1</b> Number of Member States and territories implementing malaria prevention and case management efforts<br><br>Baseline: 33<br>Target: 51 | Twenty of the 21 malaria-endemic countries in the Region have now made an official commitment to malaria elimination and are implementing corresponding efforts, although operational and technical challenges remain. Of the 15 nonendemic countries which remain receptive and vulnerable to the disease, 10 have been updated regarding their risk and are in the process of reinforcing their capacities. |

| Objective  | Indicator, baseline, and targets   | Status   |
|--|--|--|
| <p><b>1.2</b> Reinforce country capacity to address specific vector management problems, including monitoring of insecticide resistance</p>  | <p><b>1.2.1</b> Number of countries (both malaria endemic and nonendemic) that are implementing integrated vector management based on PAHO/WHO guidelines (including insecticide resistance surveillance and vector behavior studies)</p> <p>Baseline: 15<br/>Target: 18</p> | <p>Sixteen countries reported distribution of long-lasting insecticide-treated bednets free of charge; 15 countries reported use of indoor residual spraying as a malaria intervention. However, challenges regarding quality and coverage of interventions need to be further addressed.</p>  |
| <p><b>1.3</b> Enhance institutional, network, and country readiness to perform and manage appropriate and adequate malaria diagnosis and treatment in various program contexts</p> | <p><b>1.3.1</b> Number of malaria-endemic countries reporting malaria drug efficacy and drug resistance surveillance data to PAHO, per PAHO/WHO guidelines</p> <p>Baseline: 14<br/>Target: 17</p>  | <p>Fifteen malaria-endemic countries are reporting surveillance data to PAHO on malaria drug efficacy and/or drug resistance, per PAHO/WHO guidelines.</p>   |
|  | <p><b>1.3.2</b> Number of countries implementing PAHO/WHO guidelines for quality malaria diagnosis and treatment</p> <p>Baseline: 23<br/>Target: 51</p>  | <p>Twenty-five countries are currently following PAHO/WHO guidelines for quality malaria diagnosis and treatment; 21 reference laboratories in 20 countries are participating in the external quality assurance program (EQAP) for malaria diagnosis; and 2 additional nonendemic Caribbean countries (JAM, MTQ) indicated interest in participating in EQAP starting in 2018.</p> |

| <b><i>Strategic Line of Action 2: Reinforced malaria surveillance toward evidence-based decision-making and response</i></b>  |  |   |
|---|--|---|
| <b>Objective</b>  | <b>Indicator, baseline, and targets</b>  | <b>Status</b>   |
| <b>2.1</b> Further improve surveillance systems with early detection of cases and outbreaks and advocate collection of malaria data (by case, including information on age, sex, ethnicity, and other variables that facilitate appropriate analysis of disparities and inequalities between populations) | <b>2.1.1</b> Number of countries reporting malaria surveillance data annually to PAHO/WHO, by subnational level, sex, age, and other, by subnational level, sex, age, and other equity-related variables <sup>1</sup><br><br>Baseline: 27<br>Target: 51  | Thirty-five countries and territories are reporting malaria surveillance data annually to PAHO/WHO, by subnational level, sex, age, and other equity-related variables.     |
| <b>2.2</b> Strengthen and improve data-informed decision-making through epidemiological information exchange at all levels: regional, between countries with common borders, and within the countries themselves  | <b>2.2.1</b> Number of malaria-endemic countries <sup>2</sup> that are exhibiting strengthened data-informed decision-making (based on the PAHO malaria data verification tool) and sharing epidemiological information<br><br>Baseline: 0<br>Target: 21 | Twelve countries in the Region have used the PAHO malaria data verification tool, shared epidemiological information, and strengthened their data-informed decision-making. |

| <b><i>Strategic Line of Action 3: Strengthened health systems, strategic planning, monitoring and evaluation, operational research, and country-level capacity building</i></b>  |  |   |
|--|--|---|
| <b>Objective</b>   | <b>Indicator, baseline, and targets</b>  | <b>Status</b>   |
| <b>3.1</b> Improve recruitment, training, and retention of health personnel trained in malaria in country health systems and within PAHO/WHO to facilitate relevant technical cooperation at various levels of work (regional, inter-country, and intra-country) and program (particularly malaria elimination) contexts | <b>3.1.1</b> Number of countries implementing plans for training health personnel on malaria<br><br>Baseline: 21<br>Target: 33 | Twenty-one malaria-endemic and 10 nonendemic countries have recently participated in various malaria elimination field missions, capacity-building activities, and workshops. |

<sup>1</sup> Place of residence, race/ethnicity/culture/language, occupation, religion, education, socioeconomic status, social capital, and other possible factors such as disease status or disability.

<sup>2</sup> Given the ongoing malaria elimination efforts, the number of malaria-endemic countries in the Region is likely to be less than 21 by 2020.

| Objective  | Indicator, baseline, and targets  | Status   |
|--|---|--|
| <p><b>3.2</b> Reinforce malaria policy development and strategic planning in collaboration with countries and stakeholders</p>   | <p><b>3.2.1</b> Number of countries with national strategic plans (focusing on/including malaria) that align with WHO-recommended strategies and components of the PAHO Plan of Action for Malaria</p> <p>Baseline: 31<br/>Target: 51</p> | <p>Seventeen of the 21 malaria-endemic countries have updated their respective national malaria plans toward elimination, while 10 nonendemic countries have indicated interest and some have requested PAHO support in developing a malaria outbreak response plan/guideline.<sup>3</sup></p> |
| <p><b>3.3</b> Strengthen the capacity of national programs in the areas of management and logistics in collaboration with partners and stakeholders</p>                              | <p><b>3.3.1</b> Number of malaria-endemic countries with no stock outs of key malaria supplies (including antimalarials) at the national level in a given year</p> <p>Baseline: 19<br/>Target: 21</p>                                     | <p>Nineteen of the 21 malaria-endemic countries had no stock outs of key malaria supplies in 2017.</p>   |
| <p><b>3.4</b> Develop financial strategies to sustain malaria prevention and elimination efforts at different levels in collaboration and synergy with partners and stakeholders</p> | <p><b>3.4.1</b> Number of countries with sustained domestic funding for malaria efforts</p> <p>Baseline: 20<br/>Target: 51</p>  | <p>Twenty of the 21 malaria-endemic countries have maintained domestic funding for malaria efforts, although financial gaps persist.</p>   |
| <p><b>3.5</b> Reinforce operations research in program development and management</p>  | <p><b>3.5.1</b> Number of countries conducting malaria operational research, including IVM topics</p> <p>Baseline: 13<br/>Target: 21</p>  | <p>Thirteen malaria-endemic countries continue to engage in malaria operational research, including integrated vector management (IVM) topics.</p>   |

<sup>3</sup> The list of 26 countries which have achieved the indicator as of 2018 is not necessarily the same as the 31 baseline countries noted in 2015. Reporting of status/progress for this indicator is now also guided by the Framework for Malaria Elimination published by WHO in 2017.

| <b><i>Strategic Line of Action 4: Strategic advocacy, communications, and partnerships and collaborations</i></b>   |  |   |
|---|--|---|
| <b>Objective</b>  | <b>Indicator, baseline, and targets</b>  | <b>Status</b>   |
| <b>4.1</b> Support the development and strengthening of capacities through existing malaria networks, partnerships, and collaborations in the Region  | <b>4.1.1</b> Number of countries participating in regional-level networks and collaborations<br><br>Baseline: 19<br>Target: 42   | Twenty of the 21 malaria-endemic countries are participating in various networks and collaboration initiatives, while 10 nonendemic countries have recently affirmed the importance of maintaining a network among those that remain receptive and vulnerable to malaria, particularly in terms of preventing and managing outbreaks. |
| <b>4.2</b> Optimize opportunities for coordination, synergy, and information sharing with other existing PAHO/WHO initiatives (e.g., integration of malaria efforts with maternal and child health in community and local health care programs, communications and social mobilization, health promotion and education interventions, programs on neglected diseases, and occupational health) and policies | <b>4.2.1</b> Number of countries engaged in interprogrammatic and/or synergistic actions advocated under PAHO/WHO initiatives and policies<br><br>Baseline: 18<br>Target: 26 | Nineteen of the 21 malaria-endemic countries are currently engaged in interprogrammatic and/or synergistic actions advocated under PAHO/WHO initiatives and policies.   |
| <b>4.3</b> Strengthen and support efforts to identify, document, and replicate best practices, including models of disease elimination and successful integration of cross-cutting issues   | <b>4.3.1</b> Number of countries with identified best practices in their malaria activities<br><br>Baseline: 13<br>Target: 15  | To date, 27 malaria best practices have been identified, documented, and shared by 14 countries in the Region.  |



| <b>Strategic Line of Action 5: Focused efforts and tailored approaches to facilitate malaria elimination and prevent reestablishment in malaria-free areas</b> |  |  |
|--|--|--|
| <b>Objective</b>   | <b>Indicator, baseline, and targets</b>  | <b>Status</b>  |
| <b>5.1</b> Resolve critical gaps in key target populations <sup>4</sup> in relation to the achievement of malaria elimination goals                            | <b>5.1.1</b> Number of countries implementing strategies to address malaria among populations in situations of vulnerability<br><br>Baseline: 10<br>Target: 18 | Seventeen of the 21 malaria-endemic countries have updated their national malaria plans toward elimination and integrated specific strategies for populations in situations of vulnerability.          |
| <b>5.2</b> Address critical knowledge and technical gaps, including those pertaining to <i>P. vivax</i> and the preparation for end-game scenarios             | <b>5.2.1</b> Number of countries implementing the 2015 WHO <i>P. vivax</i> recommendations (13)<br><br>Baseline: 0<br>Target: 16                               | All 19 endemic countries with <i>P. vivax</i> transmission are currently implementing key <i>P. vivax</i> elimination recommendations, although operational and technical challenges remain.           |
| <b>5.3</b> Implement the process of malaria program reorientation toward malaria elimination and certification (as may be requested by Member States)          | <b>5.3.1</b> Number of countries supported in terms of malaria program reorientation toward malaria elimination<br><br>Baseline: 10<br>Target: 18              | Twenty-one malaria-endemic countries have received direct technical support for malaria program reorientation.   |
| <b>5.4</b> Sustain key capacities in countries that have eliminated local malaria transmission   | <b>5.4.1</b> Number of nonendemic countries supported in terms of maintaining key malaria capacities<br><br>Baseline: 9<br>Target: 17                          | Ten of the 15 nonendemic countries <sup>5</sup> in the Caribbean that continue to be receptive and vulnerable to potential malaria reintroduction participated in a malaria workshop in November 2017. |

### Challenges and Lessons Learned

7. While the Region has been strongly sensitized regarding the concept, prospects for, and importance of malaria elimination, operational and technical challenges continuously surface as a reflection of underlying political and administrative problems evolving in endemic countries. While countries of the Region have officially expressed their

<sup>4</sup> For example, pregnant women, children, persons living with HIV/AIDS, travelers, mobile populations, miners, loggers, banana and sugarcane plantation workers, indigenous groups, populations in areas of armed and/or social conflict, and people living in border areas or areas of common epidemiological interest.

<sup>5</sup> The WHO Framework for Malaria Elimination published in 2017 clarified that the assessment of the risk for malaria re-establishment should take into account factors pertaining to receptivity or the ability of the ecosystem to allow malaria transmission; and vulnerability or the probability that malaria parasites will be imported into a country or areas. Based on this, it was determined that while most countries can have imported cases, only 15 non-endemic countries in the Region are at actual risk of malaria re-establishment.

commitment to malaria elimination, local support and resources are still inadequate in many areas where malaria transmission remains pervasive.

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

8. To mitigate the current situation, countries are encouraged not only to sustain, but to increase their domestic resource commitments for the elimination of malaria, raise their commitment to the highest political level and implement their respective national plans for malaria elimination, incorporating strategies that operationalize the WHO Framework for Malaria Elimination (14) and the concept of surveillance as an intervention. Early access to diagnosis, treatment, and investigation of cases must be central to a malaria elimination agenda that involves other actors and the community. Partners and stakeholders are likewise called to engage with PAHO in boosting advocacy efforts, including high-level advocacy calls and missions, to ensure that malaria remains high on the political and development agenda of affected countries so that malaria programs receive appropriate support in their work toward elimination. These and other key provisions outlined in Resolution CD55.R7 (2) are reiterated in this appeal for corresponding action by Member States, partners, and relevant stakeholders.

### **Action by the Directing Council**

9. The Directing Council is invited to take note of this report and make any comments it deems pertinent.

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## I. PLAN OF ACTION FOR DISASTER RISK REDUCTION 2016-2021: PROGRESS REPORT

### Background

1. This document reports to the Governing Bodies of the Pan American Health Organization (PAHO) on the progress made in the implementation of the Plan of Action for Disaster Risk Reduction 2016-2021 (Document CD55/17, Rev. 1 and Resolution CD55.R10 [2016]) (1, 2).

### Analysis of Progress Achieved

2. This report is based on information obtained at the regional and subregional meetings of health disaster coordinators of the ministries of health in 2016 and 2017, and on the results of a questionnaire developed for monitoring of the plan, to which 32 countries and territories<sup>1</sup> responded.

| <i>Strategic Line of Action 1: Recognizing disaster risk in the health sector</i> |  |   |
|---|--|---|
| <b>Objective</b>  | <b>Indicator, baseline, and target</b>   | <b>Status</b>   |
| <b>1.1</b> To evaluate disaster risk in the health sector                         | <b>1.1.1</b> Number of countries that have evaluated disaster risk in the health sector<br><br>Baseline: 0<br>Target: 35 | Seven countries have evaluated disaster risk in the health sector (Bolivia, Brazil, Canada, Colombia, Cuba, Peru and United States of America).<br><br>In 16 countries and territories, risk assessment is currently in progress (Argentina, Bermuda, Cayman Islands, Chile, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Saint Vincent and the Grenadines, and Venezuela). |

<sup>1</sup> As of 6 July 2018, the following countries and territories had responded to the questionnaire on implementation of the Plan of Action for Disaster Risk Reduction 2016-2021: Argentina, Bahamas, Barbados, Belize, Bermuda, Bolivia, Brazil, British Virgin Islands, Canada, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, Turks and Caicos Islands, United States of America and Venezuela.

| <i>Strategic Line of Action 2: Governance of disaster risk management in the health sector</i>                             |  |  |
|--|--|--|
| <b>Objective</b>   | <b>Indicator, baseline, and target</b>   | <b>Status</b>  |
| <b>2.1</b> To strengthen the organizational structure of disaster risk management offices in the ministries of health      | <b>2.1.1</b> Number of countries with full-time staff assigned to disaster risk reduction<br><br>Baseline: 15<br>Target: 30  | Antigua and Barbuda and Haiti joined the 15 countries that have full-time staff and an allocated budget for health disaster risk reduction.  |
| <b>2.2</b> To promote country leadership in disaster risk management for health, fostering sectoral and intersectoral work | <b>2.2.1</b> Number of countries that have a sectoral mechanism for coordination, implementation, and monitoring of disaster risk management for health<br><br>Baseline: 9<br>Target: 15 | Thirty-one countries have a disaster program: in 19 countries, emergency and disaster risk management is officially established within the structure of the ministry of health; six countries have an established office or unit, although they do not have the necessary resources to operate; another six countries have an office or unit responsible for other matters that has also been tasked with this responsibility. |

| <i>Strategic Line of Action 3: Safe, smart hospitals</i>   |  |   |
|--|--|---|
| <b>Objective</b>   | <b>Indicator, baseline, and target</b>   | <b>Status</b>   |
| <b>3.1</b> To improve the safety of integrated health services networks through the application of safe hospital criteria in planning, design, construction, and operation of these services | <b>3.1.1</b> Number of countries that include safe hospital criteria in the planning, design, construction, and operation of health services<br><br>Baseline: 28<br>Target: 35 | Nineteen countries have a national policy on safe hospitals.<br><br>In 29 countries, the hospital safety index (HSI) is being applied to evaluate the safety of the structural, nonstructural, and functional components of hospitals.<br><br>The vast majority of the hospitals in the countries affected in 2017 by hurricanes (Harvey, Irma, and Maria) and by earthquakes (including Dominica, British Virgin Islands, and Mexico) continued operating. In Peru, the coastal El Niño of 2017 affected less than 1% of health facilities, causing damage and interruptions of service. |

| Objective   | Indicator, baseline, and target  | Status   |
|---|--|--|
| <b>3.2</b> To improve the security of integrated health services networks through the development and application of criteria to address climate change through both adaptation and mitigation in the planning, design, construction, and operation of these services | <b>3.2.1</b> Number of countries that include criteria for disaster mitigation and for adaptation to climate change in the planning, design, construction, and operation of health services<br><br>Baseline: 2<br>Target: 15 | Seven Caribbean countries are implementing, in health facilities, activities to mitigate disaster risk and measures to adapt to climate change.<br><br>Thirteen countries and two territories have established national teams to evaluate the hospital safety index and the “green” checklist. |

*Strategic Line of Action 4: Health sector capacity for emergency and disaster preparedness, response, and recovery*

| Objective  | Indicator, baseline, and target  | Status   |
|--|--|--|
| <b>4.1</b> To strengthen health sector capacity for emergency and disaster response and early recovery | <b>4.1.1</b> Number of countries that have tested plans and procedures for emergency and disaster response and early recovery<br><br>Baseline: 6<br>Target: 35 | Twenty-eight countries have a national plan for response to health emergencies. 17 of these plans have been updated in the last two years.<br><br>Twenty-one countries have an emergency operations center (EOC) under the ministry of health for coordination of emergency and disaster response in the health sector.<br><br>Eight countries have a multisectoral plan for recovery after emergencies and disasters. |

### Action Necessary to Improve the Situation

3. It is necessary to develop and disseminate tools that the health sector may use for assessing disaster risks, preparing plans for a multi-hazard response, evaluating the state of preparedness for emergencies and disasters, and developing plans for recovery after disasters. Furthermore, it is necessary to validate and implement disaster risk management initiatives that address indigenous populations and people with disabilities. Finally, ministries of health should continue to strengthen their health emergency programs through staffing and financing.

### **Action by the Directing Council**

4. The Directing Council is invited to take note of this progress report and provide any comments it deems pertinent.

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

### **Background**

1. The Pan American Health Organization (PAHO) procurement activities have been supported over the years by three procurement mechanisms: the Revolving Fund for Vaccine Procurement (Revolving Fund - RF), the Regional Revolving Fund for Strategic Public Health Supplies (Strategic Fund - SF), and the reimbursable procurement mechanism on behalf of Member States. The Revolving Fund was established in 1977 pursuant to Directing Council Resolution CD25.R27 to facilitate the timely availability of quality vaccines at the lowest prices. The Strategic Fund was established in 1999 following requests from Member States for assistance in the procurement of strategic public health supplies focused on combating HIV/AIDs, tuberculosis, malaria, and neglected diseases. Since 2013, the Strategic Fund incorporates medicines to prevent and treat noncommunicable diseases. The mechanism for Reimbursable Procurement on behalf of Member States was established by the Directing Council of PAHO in 1951 to support procurement of health program items that are unobtainable or difficult to procure in Member States.<sup>1</sup> For the 2016-2017 biennium, the total cost of goods procured through the three procurement mechanisms was approximately US\$ 1.363 billion.<sup>2</sup>

2. In 2013, the 52nd Directing Council adopted Resolution CD52.R12, Review of the Charge Assessed on the Procurement of Public Health Supplies for Member States (*I*). This resolution called for an increase in the charge assessed on the procurement of all public health supplies to 4.25% effective 1 January 2014. It also requested the Director to review the charge assessed and to present a report on the revenue and expenses tied to the use of the 1.25% of the total fee to cover administrative, operating, and staffing costs at the end of each biennium. Revenue generated from the remaining 3.0% of the fee is applied to the capitalization of the respective fund used on behalf of Member States.

3. An initial report was presented at the 29th Pan American Sanitary Conference (Document CSP29/INF/7) in September 2017.

### **Update on Progress Achieved**

4. The biennium 2016-2017 was the first biennium under Resolution CD52.R12 for which a systematic process of defraying the costs of activities associated with the three procurement mechanisms was initiated and sustained. Accumulated revenues from the 2014-2015 biennium revenue from these three mechanisms totaled approximately \$14.7 million.

5. An initial work plan and budget for 2016-2017 was prepared and approved by the Director of the Pan American Sanitary Bureau (PASB). The work plan supported staff

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<sup>1</sup> Resolution CD5.R29.

<sup>2</sup> Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

dedicated to the management of the three procurement mechanisms and a corresponding Operational Framework. Approximately, \$8.3 million was disbursed during the biennium 2016-2017 as shown below. Most of these resources (approximately \$7.3 million or 88%) met staffing expenses in procurement, finance, quality control and management, legal and for the office of the Revolving Fund for Vaccines. A balance of approximately \$6.4 million remained.

|                          |             |              |
|--------------------------|-------------|--------------|
| Revenue Earned 2014-2015 |             | \$14,725,216 |
| Expenditure 2016-2017    |             | \$8,346,264  |
| Staff <sup>3</sup>       | \$7,322,340 |              |
| Operations               | \$1,023,924 |              |
| Balance                  |             | \$6,378,952  |

6. In collaboration with PAHO country offices and Member States, staff supported by this revenue processed more than 3,900 purchase orders representing more than \$1.363 billion for the costs of goods, freight and insurance sold in support of vaccines, syringes and cold chain equipment for national immunization programs and essential medicines for HIV/AIDs, tuberculosis, malaria, and the prevention and treatment of noncommunicable diseases.

7. To further strengthen the value of these three procurement mechanisms for Member States, PASB staff collaborated to address three areas of work, namely *a)* increasing the efficiency of operations, *b)* developing market intelligence, and *c)* strengthening knowledge and awareness.

8. In the biennium 2018-2019 the assessed charge will fully fund staff and operations and enable a scaling up of operations considering recommendations forthcoming from the Revolving Fund Assessment, the Strategic Fund Business Plan and other initiatives to ensure the continued improvement of services to Member States.

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

9. PASB will continue to monitor the situation to ensure that the procurement activities and staff needed to manage both the Revolving Fund and the Strategic Fund, as well as the reimbursable procurement mechanism on behalf of Member States are covered by revenue generated by the charge assessed on the procurement of public health supplies on behalf of Member States.

### **Action by the Directing Council**

10. The Directing Council is invited to take note of this progress report and provide any comments it deems relevant.

<sup>3</sup> For positions filled during the biennium actual expenses are reflected.

## References

1. Pan American Health Organization. Review of the charge assessed on the procurement of public health supplies for Member States [Internet]. 52nd Directing Council of PAHO, 65th Session of the WHO Regional Committee for the Americas; 2013 Sep 30-Oct 4; Washington, DC. Washington, DC: PAHO; 2013 (Document CD52/15) [cited 2017 May 15]. Available from:  
[http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=2574&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=2574&Itemid=270&lang=en)

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

### **Introduction**

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

### **Background**

2. The Pan American Centers have been an important PAHO technical cooperation modality for almost 60 years. During this period, PAHO has created or administered 13 centers,<sup>1</sup> closed nine,<sup>2</sup> and transferred the administration of one of them to its own Governing Bodies.<sup>3</sup> This document presents up-to-date strategic information on the Latin American and Caribbean Center on Health Sciences Information (BIREME), the Latin American Center for Perinatology, Women and Reproductive Health (CLAP/WR), and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA).

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

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

4. Under the organizational structure of the Pan American Sanitary Bureau (PASB), BIREME is situated in the Department of Evidence and Intelligence for Action in Health and has a specific Biennial Work Plan 2018-2019 approved by the Director of PASB.

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

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

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

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

<sup>2</sup> CAREC, CEPANZO, CEPIS, CFNI, CLATES, ECO, INPPAZ, PASCAP, and the Regional Program on Bioethics in Chile.

<sup>3</sup> INCAP.

BIREME and requesting the Director of PASB to undertake negotiations with the Government of Brazil to draw up a new Headquarters Agreement for BIREME that defines the responsibilities of the Government with regard to the maintenance of BIREME, as well as its privileges and immunities in that country.

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

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

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

8. Efforts are under way to fully implement BIREME's new institutional framework, with the PAHO/WHO Representative in Brazil and the BIREME Director continuing the negotiations on the Headquarters Agreement with the Government of Brazil. Meanwhile, a specific five-year cooperation agreement (*Termo de Cooperação para o desenvolvimento e aprimoramento da BIREME*) was signed with the Ministry of Health of Brazil on 2 February 2017. This new agreement recognizes BIREME's legal status as a Pan American Center that is an integral part of PAHO, pursuant to the basic agreements signed between the Organization and the Government of Brazil. It also stipulates the financial contributions to be made by the Government of Brazil for BIREME's maintenance.

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

9. The third session of the BIREME Scientific Committee was held from 6 to 7 December 2017, attended by recognized experts in information and knowledge management and related fields from Brazil, Colombia, Costa Rica, Cuba, Jamaica, and Mexico. The main recommendations were to: *a)* support and promote open science policies and practices (open access, open data, metrics, and alternative metrics); *b)* evaluate public policies for the implementation of Sustainable Development Goals 6 and 7 of the 2030 Agenda for Sustainable Development; and *c)* promote information exchange among countries on successful projects and experiences.

10. Within the context of the 50th Anniversary of BIREME, lines of action were developed to strengthen its technical cooperation at the local, national, and regional levels.

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

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

- institutional consolidation of BIREME as a reference center on scientific evidence and information for the Latin American and Caribbean countries;
- c) implementing the recommendations of the BIREME Scientific Committee, as agreed upon in the third session of the Committee, to strengthen the Center's technical cooperation program, considering its products and services in the area of scientific communication and networks;
  - d) holding the 10th Regional Congress on Health Sciences Information (CRICS10) in Brazil from 23 to 25 October 2018, in coordination with the host country;
  - e) developing and implementing BIREME's Financial Resources Mobilization Plan, pursuant to PASB's internal policy for the Center's financial sustainability.

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

12. The Latin American Center for Perinatology, Women and Reproductive Health (CLAP/WR) was created in 1970 through an agreement between the Government of Uruguay, the University of the Republic of Uruguay, and PAHO. The Center merged with PAHO's Women's Health unit in 2005, and at the same time began operating as a decentralized unit linked with the Department of Family, Health Promotion and Life Course. The general objective of CLAP/WR is to promote, strengthen, and improve country capacities in the Region of the Americas in terms of health care for women, mothers, and newborns.

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

13. The strategic approach taken by CLAP/WR has focused on South-South cooperation, the sharing of good practices, and a community-based approach to reduce maternal and neonatal mortality. The Center has *a*) participated in priority interdepartmental projects in areas such as Argentina's Chaco region; *b*) increased access and improved the quality of health care in maternal-neonatal services in post-conflict areas in Colombia; and *c*) promoted healthy birthing homes (*Casas Maternas Saludables*) in Nicaragua to reduce inequities in the accessibility and quality of services—especially for rural women and children, indigenous and Afro-descendent populations, and other groups.

14. The CLAP/WR Network's capacities in terms of the monitoring and care of women have been strengthened in 60 sentinel centers in 16 countries, with emphasis on maternal near-miss and post-obstetric contraception and the project for women who have had an abortion/miscarriage (the project *Mujeres en situación de aborto-MUSA*), including post-obstetrical event contraception (post-partum and post-abortion), in accordance with applicable national laws and regulations. Nearly 4,000 professionals have been trained to serve as trainers and build capacity in obstetric emergencies, maternal death surveillance and response, midwifery, auditing of neonatal deaths, contraception, and use of the Perinatal Information System (SIP) through in-person and virtual workshops

15. As a result of the inter-programmatic project on zero maternal deaths from hemorrhage supported by the Director, twelve countries are building technical capacities to manage obstetric emergencies: Bolivia, Brazil, Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru and Suriname. Six countries have trained personnel in obstetric care (Brazil, Colombia, Dominican Republic, Mexico, Trinidad and Tobago, and Uruguay) and five countries have developed national plans to promote maternal health and reduce maternal mortality (Belize, Dominican Republic, Grenada, Jamaica, and Trinidad and Tobago).

16. The new Perinatal Information System (SIP PLUS) will enable countries to improve and simplify implementation of the different types of electronic clinical registry and reporting systems. The Perinatal Information System is currently being implemented at different levels in 22 countries, eight of them in the English-speaking Caribbean.

17. A new Basic Agreement on CLAP/WR's current institutional and strategic structure was signed by the Organization with the Government of Uruguay in October 2017.

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

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

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

19. The Center underwent an administrative review in September 2016 and an external technical evaluation in September 2017. The technical evaluation recommendations were submitted to PASB Executive Management and approved by the Director in December 2017. The evaluation concluded that although areas for strengthening had been identified, PANAFTOSA should capitalize on its intersectoral and interdisciplinary "One Health" collaboration strategies to optimize technical cooperation and provide the Americas with a powerful champion in veterinary public health. The recommendations, presented to the Director, will be implemented during the current biennium (2018-2019) through a road map that has been developed.

20. Regarding the elimination of human rabies transmitted by dogs, PANAFTOSA has worked with the PAHO/WHO Representative Office in Haiti to provide training to over 250 health professionals from the 10 departments in the country on the clinical case management of people exposed to dog bites. Some 15,000 doses of human rabies vaccine donated by Brazil and Paraguay are available in more than 140 medical health centers. Mass national canine rabies vaccination campaigns were jointly planned in Guatemala and Haiti.

21. The 16th Meeting of Rabies Program Directors of the Americas (REDIPRA 16) was held from 29 to 30 November 2017 in Guatemala to discuss the challenges of eliminating human rabies transmitted by dogs in the Americas. The main recommendations were to: *a*) strengthen PANAFTOSA's technical cooperation in priority countries (Bolivia, the Dominican Republic, Guatemala, and Haiti); *b*) promote strategies for rabies surveillance and control in border areas; and *c*) ensure that all REDIPRA's participating countries have the basic laboratory capabilities for rabies diagnosis by the end of 2018.

22. During 2017, PANAFTOSA continued to coordinate the South American Initiative for the Control and Surveillance of Cystic Echinococcosis/Hydatidosis, including the publication of a protocol for local hydatidosis prevention and control.

23. Regarding venomous snake and arthropod poisoning, the Center has increased its collaboration with the Butantan Institute in Brazil and the Clodomiro Picado Institute in Costa Rica to measure the impact on health and determine technical cooperation needs, such as epidemiological information and the availability of antivenins.

24. In response to the foot-and-mouth disease outbreak in Colombia (June 2017), PANAFTOSA provided technical cooperation to the country to strengthen its response capacity. It also held the Sixth Extraordinary Meeting of the South American Commission for the Fight against Foot-and-Mouth Disease (COSALFA) in July 2017, attended by representatives from 13 countries, to discuss and recommend measures to address the risks to the Region. The agreement on a regional foot-and-mouth disease antigen and vaccine bank was completed and submitted to the countries for consideration.

25. PANAFTOSA has strengthened its technical cooperation in food safety risk analysis and antimicrobial resistance (AMR). The Food Safety Risk Analysis Consortium was established with support from various institutions and experts to prepare the countries to improve food safety risk analysis. The Center has been heading an interagency group that coordinates action on AMR in animals. In 2017, technical cooperation activities in food safety were conducted in Argentina, Chile, Colombia, Costa Rica, the Dominican Republic, Guyana, Paraguay, and Suriname.

### ***Cooperation Agreements and Resource Mobilization***

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



control and food safety. PANAFTOSA also collaborates with the World Organization for Animal Health (OIE), the Food and Agriculture Organization of the United Nations (FAO), and the Inter-American Institute for Cooperation on Agriculture (IICA) to support Member States.

**Action by the Directing Council**

27. The Directing Council is invited to take note of this report and provide any comments it deems pertinent.

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