

**FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE PAN AMERICAN HEALTH ORGANIZATION
WASHINGTON, DC
APRIL 7, 1995**

[Acknowledgements: Dr. George Alleyne [al-lean], director of PAHO; Dr. Ciro de Quadros [kwah-drose], director of PAHO's Special program on Vaccines and Immunization; Dr. Peter Bourne, chair of the American Association for World Health]

I am pleased to be here on World Health Day, which marks an historic opportunity for all nations to come together to improve the health of our global family. I also want to thank all of you at PAHO who are on the front lines every day promoting better health throughout our hemisphere. You are the real champions of children, and for all of your work, I thank you.

Nothing is more important to our shared future than the well-being of children, and for that reason I am especially pleased that children are the focus of this year's World Health Day.

As you may know, I just returned yesterday from a 10-day trip to South Asia, where I saw firsthand some of the world's greatest health challenges, and also some of the most innovative, thoughtful methods of bringing better health care to children and women in poor and remote areas. For me, the trip was an inspiring reminder of how much progress can be made when the will and commitment are there to help those in need.

Today's world is one of great promise for the 130 million children of our own hemisphere. Great promise because our children are our lifeline to prosperity and progress in the exciting and unpredictable century that lies ahead. Great promise because there are millions of healthy children across the Americas whose futures are filled with hope.

And great promise because of historic commitments born at the Summit of the Americas last December that will translate into greater opportunity and justice for young people from the Queen Elizabeth Islands to Tierra del Fuego. Among other initiatives, government leaders endorsed the goal of making basic health services available to all citizens, which will be extremely beneficial to children, who are most vulnerable to illnesses and unhealthy living conditions.

I also want to commend the First Ladies who participated in the symposium on children in Miami and worked with Dr. Alleyne to clarify our common vision and goals. Today, First Ladies across the Americas are turning rhetoric into reality by helping launch PAHO's historic campaign to eliminate measles from the hemisphere by the year 2000. Later this year, many of the wives of heads of states and governments will convene in Paraguay to review our efforts and share our experiences in working to meet this goal.

The campaign to eliminate measles is vital to all of our futures. It will save the lives of countless children in every country and will bring primary health care to every "barrio" and "aldea" [pronounced all-day-uh -- which means village] in our hemisphere.

I say this with confidence because we know, from past experience, that it can be done. The Pan American Health Organization already has led the world in getting rid of the polio virus. Since the World Health Organization resolved to fight polio in 1988, the number of polio cases around the world has declined by 82 percent. Today, 145 countries are polio-free. Last September, the Americas became the first region in the world to be declared formally free of polio -- and not a single case has been detected in the region since August of 1991 [in Peru].

All of you should take great pride in that achievement. You succeeded in getting many nations and public and private institutions involved, and that is no small feat.

Now the work must continue in other parts of the world. And in our region, we must turn our attention to another major health threat to children: measles.

My husband often talks about children as the greatest resource of every nation. And one of the best ways to build on that resource is to invest in children, especially their health.

This is an urgent mission because, just as we live in a time of great promise for children, we also live in a time of great peril. More than half of the population in this hemisphere is under age 23. And too many of our young people suffer from poverty, hunger, illiteracy and inadequate health care.

But the statistics need not be so grim. While ushering children into the world is the province of families, protecting them from avoidable diseases must be viewed as the shared responsibility of our larger human family.

lm draft 4/6/95

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My husband often talks about the importance of investing in our greatest resource: our children. And one of the best ways to invest in children is to invest in their health.

This is an urgent mission because, just as we live in a time of great promise for children, we also live in a time of great peril. More than half of the population in this hemisphere is under age 23. And too many of our young people suffer from poverty, hunger, illiteracy and inadequate health care.

While ushering children into the world is the province of families, protecting them from avoidable diseases must be viewed as the shared responsibility of our larger human family.

We all know that a sick child has much less chance of learning, growing, and fulfilling his or her potential than a child who is healthy. A sick child has much less reason to be hopeful and optimistic about the future. A sick child is much less likely to develop into a healthy, productive adult. That is why it is our responsibility as a community of nations to insist that all children receive the health care they need.

We have the - vaccinations.
Technology ~~is not a problem~~. The vaccinations exist and they are far cheaper than long-term treatments for major diseases or the disabilities that accompany them. All we need now is the commitment to make these immunization campaigns succeed.

The United States has been a proud partner of past efforts to eliminate major childhood disease in this hemisphere. Nearly half of all external donor funding for the polio campaign came from the United States Agency for International Development. The United States currently is providing nearly \$7 million a year as part of our child survival programs in the countries of the Americas.

Today I am pleased to announce that the United States will join in partnership with PAHO in the campaign to eliminate measles across the hemisphere. PAHO has estimated that an additional \$46 million is needed for immunization programs between now and the end of the century.

Through USAID, the United States plans to extend a five-year, \$20 million grant to PAHO to advance hemispheric health care priorities. Although the United States, like many other nations, is operating under severe budget constraints, our government hopes to allocate \$8 million directly to the Regional Expanded Program on Immunization which includes support to the measles campaign.

At the same time, we have every expectation that, just as with the polio effort, our country programs and our worldwide technical support will help boost the campaign to eliminate measles. During the polio campaign, those country programs more than doubled our regional commitment.

One of the most important aspects of your campaign to eliminate measles is that it will advance all of our immunization efforts. Perhaps equally important, it reflects a larger vision of health reform that extends a basic package of integrated health services throughout the region. And in that way it carries forward the Summit of the Americas's Plan of Action.

Although our specific health challenges may differ from country to country and our recipes for progress may require different ingredients, we share a common future and a common cause. We must not work in isolation to solve our problems. Whether we are health organizations, NGOs, governments, or First Ladies, we must join together as partners who appreciate the value of sharing our knowledge and experience.

And we must remember that, when it comes to helping our children, words alone are not enough. Policy papers are not enough. Documents and studies are not enough.

Ultimately we must be guided by a desire in our hearts to see that all children have the gift of hope in their lives.

As the wonderful Chilean poet Gabriela Mistral once wrote: "Many things we need can wait; the child cannot."

Thank you very much.

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Thank you very much for helping us turn words into deeds.

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Washington International School Choir

Performing:

"We Are the Children of Tomorrow"
(words and music by Terre McPheeters)

"We Are the World"
(words and music by Michael Jackson and Lionel Richie)

Director: Joicey White Granados

Sebastian Eikhof-Moncayo	Chile/Argentina
John Hardy	United States
Camilla Harrigan	Virgin Islands/Chile
Sonja Johanssen	Japan/Sweden
Eva Keatlev	United States
Seun Ladega	Nigeria
Nathaniel Lee	Malaysia/El Salvador
Stephanie Ly	Vietnam
Emilia Mahaffey	United States/Scotland
Tara Nicolas	Haiti
Beatrice Traa	Holland/Equador
Amandine Weinrob	France
Turan Tuluy	Turkey/United States
Samantha Samuel	India



AAWH

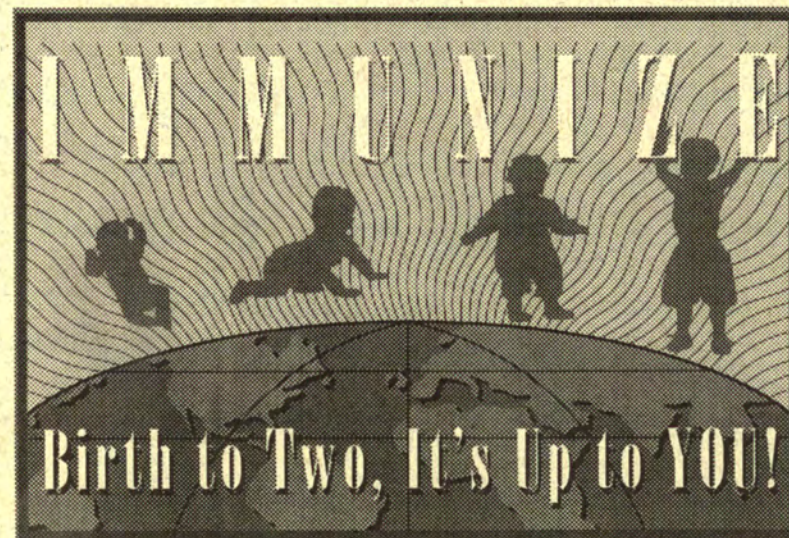
The American Association for World Health

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Paper

World Health Day April 7, 1995



Cosponsored by:



American Association for World Health
Pan American Health Organization
U.S. Department of Health and Human Services

“The designation of World Health Day was one of the first official acts of the World Health Organization (WHO). First observed on July 22, 1948, World Health Day was later changed to April 7, the day the official constitution of WHO was formally adopted. Since 1950 World Health Day has focused on a specific global issue each year.

“As we observe World Health Day 1995 in the U.S., we do so with pride in the successes that we in the Americas have already achieved. In a dramatic and unprecedented breakthrough in the fight against poliomyelitis, the Pan American Health Organization (PAHO) announced that wild poliovirus transmission has been interrupted in the Americas. In just six years PAHO was able to marshal the efforts of several international agencies and thousands of volunteers to conquer this crippling disease. Indeed, it has been more than three years since a case of polio was reported in the Americas. This success is a testament to the benefits of community cooperation in pursuing a single, achievable goal.

“Building on this, we in the United States are able to extend our focus this World Health Day beyond WHO’s international theme, ‘Target 2000: A World Without Polio.’ We have embraced a broader national goal — ‘Immunize: Birth to Two, It’s Up to You!’”

Richard L. Wittenberg
American Association for World Health

AAWH — The American Association for World Health — was founded in 1953 as an educational and charitable, non-governmental membership organization. It serves as the U.S. committee for the World Health Organization and the Pan American Health Organization, WHO’s Regional Office for the Americas. AAWH also serves as a voice of public opinion to sustain U.S. participation in solving international health challenges through governmental and voluntary channels. Its purposes are to inform the American public about major health challenges that affect people both here and abroad, and to promote cooperative solutions that emphasize grassroots involvement.

AAWH annually promotes international health issues through activities such as World Health Day (April 7), World No-Tobacco Day (May 31) and World AIDS Day (December 1).

Think Globally, Act Locally

Thanks to the following organizations for their support of World Health Day 1995:

Centers for Disease Control and Prevention
Pan American Health Organization
Office of International Health, Department of Health & Human Services
Lederle-Praxis Biologicals

AGENDA – World Health Day April 7, 1995 – 9:30 a.m.-12:45p.m.

Welcome and Introductions	Richard L. Wittenberg <i>President and CEO</i> <i>American Association for World Health (AAWH)</i>
World Health Day Proclamation	Marlene Kelley, M.D. <i>Acting Commissioner</i> <i>D.C. Commission of Public Health</i>
Welcome and Statement	George Alleyne, M.D. <i>Director</i> <i>Pan American Health Organization (PAHO)</i>
Remarks	Jo Ivey Boufford, M.D. <i>Principal Deputy Assistant Secretary for Health</i> <i>U.S. Department of Health and Human Services</i>
World Health Day Awards	Peter G. Bourne, M.D. <i>Chairman of the Board, AAWH</i>
Panel Discussion: "Using Past Successes"	Peter G. Bourne, M.D., Moderator

Panelists

Betty Bumpers
Cofounder
Every Child By Two

Karen Ignagni
President and CEO
Group Health Association of America

Geraldine Marullo
Executive Director
American Nurses Association

Walter A. Orenstein, M.D.
Director, National Immunization Program
Centers for Disease Control & Prevention

Karen L. Ray
Project Director, National Health Program
Congress of National Black Churches

Jim Weill
General Counsel
Children's Defense Fund

Introduction of Keynote Speaker	George Alleyne, M.D.
Keynote Speech	Hillary Rodham Clinton <i>First Lady</i>
Special Presentation	Richard L. Wittenberg Peter G. Bourne, M.D.
Songs of Inspiration	Washington International School Choir <i>Joice White Granados, Director</i>
Closing	Richard L. Wittenberg

**FIRST LADY HILLARY RODHAM CLINTON
REMARKS FOR THE FIRST LADIES' SYMPOSIUM ON
CHILDREN OF THE AMERICAS
MIAMI, FLORIDA
DECEMBER 10, 1994**

Welcome to all of my colleagues and friends from across the Americas, and to all of our distinguished guests.

It is an honor and privilege for me to host this wonderful symposium here in Miami. Let me begin by expressing my gratitude to the First Ladies of Latin America, the Caribbean, and Canada for your help and guidance in preparing for this session. Your extraordinary efforts in previous First Ladies' meetings in Colombia, Costa Rica, and most recently in St. Lucia, have provided a foundation for all of our work -- today and into the future.

I hope that in the course of our gathering here, and in the weeks and months ahead, we will learn much from each other and find new inspiration to address the needs of children, families, and women across our hemisphere.

Today, we live in an age of great promise -- and great peril -- for the 130 million children of the Americas. Great promise because our children are our lifeline to prosperity and democracy in the decades ahead. And we all take pleasure in knowing that there are millions of happy, healthy children across the Americas whose futures are filled with hope.

But there are perils too, because from the Queen Elizabeth Islands to Tierra del Fuego, our children are shouldering burdens rarely encountered by older generations.

Children suffering from hunger, poverty, homelessness, inadequate health care, disease, illiteracy, violence, and abuse are not confined to a single nation or a single continent. The cries of desperate children are sadly heard in every nation represented here. And it is the plight of those children that brings us together today, not just as the spouses of heads of state or as representatives of our governments, but as mothers, sisters, daughters, grandmothers, aunts, neighbors and friends who believe that every child in every country deserves a fair chance in life.

The political leaders convening at this historic summit have set forth an agenda to promote prosperity and democracy throughout the hemisphere through trade initiatives, sustainable development, and more effective government.

Today, summit leaders are outlining goals to ensure the economic, social and physical well-being of children, which Dr. Alleyne will outline later in greater detail:

The proposed Summit Plan of Action calls for universal access to education so that all children, regardless of economic or social status, racial or ethnic origin, or gender, will receive the basic tools necessary to become full members of society. The goal of requiring children to attend and complete primary school is also under discussion. If this goal is achieved, it will help eradicate child labor and give children a greater hope of acquiring the skills and knowledge needed in a modern global economy.

Beyond the important issue of school attendance, the Summit initiative on education also addresses the nutritional needs of children so they can learn more effectively.

The proposed Summit Plan of Action calls for equitable access to basic health services, which will be particularly beneficial to children, who are most vulnerable to illnesses and unhealthy living conditions.

Specific programs being recommended will address child, infant, and maternal mortality rates, as well as increasing immunization efforts to eradicate childhood diseases, such as measles, that still afflict too many children. We need only look to the disappearance of new polio cases in the Western hemisphere to know the success of these immunization programs.

We all know that the role of caregiver is crucial to the development of healthy and secure children. And we all know that the primary caregivers in society most often are women. The Summit proposal to strengthen the role of women will increase opportunities for women to participate in all spheres of life -- political, social, and economic.

Empowering women with economic self-reliance, access to quality health care and education is not only a valuable step forward in itself. It's an important step forward for children.

While we recognize that our political leaders are responsible for devising policies and programs to meet these important goals, we also know that, as First Ladies, we have a significant role to play.

Just as advocacy organizations, social institutions, and dedicated individuals are critical to progress, we, too, can help push the agenda forward in our respective countries.

When it comes to children's issues, women have a special calling. And that's why we have a duty to raise our voices for

the voiceless -- our children, the youngest and most vulnerable among us.

This week I've had particular reason to think about the difference one woman alone can make on behalf of children, even against extraordinary odds. My friend, Elizabeth Glaeser, died last weekend after losing a long battle with AIDS.

Elizabeth contracted HIV through a blood transfusion while hemorrhaging during the delivery of her first child, Ariel. Unbeknownst to her, her daughter, and then a son born later, also contracted the virus.

When Elizabeth learned that she and her children had been infected with HIV, she dedicated herself to raising awareness about AIDS. From a small office in Los Angeles, she created the Pediatric AIDS Foundation, which has raised over \$30 million since its founding in 1988.

Elizabeth often said she was motivated and strengthened by the memory of her daughter, who died four years ago at the age of seven. Her son, now 10, lives with HIV every day.

If Elizabeth could continue to contribute so much on behalf of children throughout her own illness, I know we can make our own contributions too. Of course, we will not all be involved in the same ways, or even on precisely the same issues. I know, for example, that AIDS is not as prevalent in many of your countries as it is in mine. That's why each of us must find a venue appropriate to our own situation as First Lady or government representative. But whatever role we choose represents a rare opportunity to make a difference in the lives of tens of millions of children -- and in the future of all of the Americas.

There is an urgency to our mission. More than half of our population in this hemisphere is under age 23. Ushering children into the world is, of course, the province of families. But building safe and nurturing communities for them to grow up in . . . making sure they have access to schools that teach them to read and write . . . protecting them from avoidable diseases . . . training them for productive adulthoods. . . and honoring their rights in the face of violence and abuse -- these are our collective responsibilities.

This concept was eloquently expressed in a pastoral letter issued in the United States several years ago by the National Conference of Catholic Bishops. In that letter, entitled *Putting Children and Families First*, the bishops said:

"No government can love a child, and no policy can substitute for a family's care. But, government can either support or undermine families. There has been an unfortunate,

unnecessary and unreal polarization in [the] discussion [of] how best to help families. The undeniable fact is that our children's future is shaped both by the values of their parents and the policies of our nation."

As adults, we must take responsibility for our children so that they can learn to take responsibility for themselves. And we must insist that society's most vital institutions -- family, school, and church -- create the conditions necessary for our children to fulfill all their God-given potential.

To be sure, our challenges differ from country to country, and our recipes for progress may require different ingredients. The purpose of this gathering is not to prescribe one solution, but to share ideas and opinions and learn from each other's experiences.

Here in the United States, for example, we are not doing enough to ensure that women receive adequate pre- and post-natal health care, particularly poor women and teenagers. In 1992, 22 percent of pregnant women in this country received no pre-natal care.

As the rest of the world knows all too well, my nation faces significant challenges in stopping an epidemic of gun violence that daily claims the lives of children in our cities and towns. Today, homicide is the leading cause of death for African American youth in the United States and violence is the second leading cause of death for youngsters between the ages of 10 and 14.

Combined with violence is an equally disturbing scourge of narcotics use among our young people. Illegal drugs are readily available in too many communities in the United States, and even in some of our schools. Studies show that as many as seven million children abuse alcohol and drugs to some extent.

At the same time, we are making progress on behalf of some of our children -- progress that is visible right here in Miami. Just yesterday I had the opportunity to visit Jackson Memorial Hospital and Drew Elementary School -- two institutions that have achieved remarkable successes in disadvantaged communities.

Jackson Memorial Medical Center, which is affiliated with the University of Miami, has the difficult task of caring for some of the poorest and neediest residents of this city. The newborn intensive care unit that I visited yesterday serves the highest risk population in Dade County -- but the hospital has achieved the lowest infant mortality rates in the state.

The hospital also has devised innovative ways of serving its community. A mobile van brings doctors and nurses to those who

might otherwise go without necessary treatment and care.

Drew Elementary School is located in a predominantly African-American neighborhood. Community leaders devised a cultural exchange program in which students from Drew and a predominantly Hispanic school called Seminole Elementary come together for a variety of activities that promote tolerance and understanding. To enhance communication across cultures, students at Drew take Spanish from the second grade on.

The positive educational climate at Drew is reflected in the student attendance rate: 95 percent of the school's students come to class every day.

Drew has succeeded because parents, teachers, the school principal and community leaders have worked hard to create an environment where children feel safe, secure, and confident that they will thrive. The adults have taken responsibility; and the children are learning to take responsibility as well.

In every one of our nations, dedicated, energetic, and caring people are battling on the front lines to solve some of society's most vexing problems. The purpose of this gathering is to educate each other about our challenges and our successes -- and to make our efforts more cooperative by sharing the knowledge and experience each of us holds within us.

When we return to our capitals, I hope we will not be guided solely by documents, policy papers, and official pronouncements, but also by the desire in our hearts to see that all children have the gift of hope in their lives.

In the words of Gabriela Mistral [Mee-strall], the visionary Chilean educator, poet, and Nobel prize winner for literature: "Let me be more maternal than a mother; able to love and defend with all of a mother's fervor the child that is not flesh of my flesh."

Her message echoes a feeling we all share: That no child can wait for tomorrow.

Thank you for coming to Miami, and for joining together in this important cause.

And now, let us go from words to deeds.

[Introduce UNICEF video]

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SUGGESTED REMARKS FOR FIRST LADY HILLARY RODHAM CLINTON
WORLD HEALTH DAY
Friday, April 7, 1995, PAHO Headquarters

The countries of the Americas have made a formal, historic and life-affirming commitment to equitable access to basic health services. I am proud that the US government was able to be the host to the Summit of the Americas and I am convinced that the commitments made there will mean greater justice for all the peoples of the hemisphere.

I also am pleased that the first ladies of the countries of the hemisphere participated in the Symposium on Children of the Americas on December 9, 1995 and made their own determination to be advocates for quality health care and for educational opportunity.

The participation of Sir George Alleyne at the Symposium on Children and his compelling presentation helped to direct our discussions and advance a common vision of the pursuit of human development in the Americas.

Today, on this World Health Day, I am particularly proud to join with you in a concrete step to advance the goal of human development through better health. Eliminating measles from the Western Hemisphere will save the lives of children and advance in assuring access to primary health care into every "barrio" [neighborhood] and "aldea" [village] in the hemisphere.

And we know that it can be done. Because you at the Pan American Health Organization already have led the way for the entire world in ending the scourge of poliomyelitis. The region of the Americas was declared formally free of polio in September 1994. Not a single case of polio has been detected in the Americas since August 1991 in Peru, an achievement that should give all of you great pride. You led a multilateral and multinational campaign of public and private institutions to achieve that goal.

The US Government was a partner with you then, in providing nearly half of all external donor funding, through U.S. Agency for International Development (U.S.A.I.D.). Even today, we are providing nearly \$7 million a year as part of our child survival programs in the countries of the Americas.

I am pleased to be able to announce that we will be a partner with you again in your campaign to eliminate measles. PAHO has estimated that in addition to what is currently being committed by the countries, an additional \$46 million in donor resources are need for immunization programs between now and the end of the century.

The US Government, through USAID, plans to extend a five-year, \$20 million grant to PAHO to advance hemispheric health care priorities. As part of this grant and in the context of severe budget constraints, the US Government hopes to allocate some \$8 million directly to the Regional Expanded Program on Immunization which includes support to the measles elimination campaign. At the same time, we have every expectation that, just as during the polio effort, our country programs and our worldwide technical support, will provide significant additional support for the measles elimination goal every year. Let me add that during the polio campaign, those country programs more than doubled our regional commitment.

I think that it is crucial that your program to eliminate measles will advance all of our immunization efforts. Perhaps equally important, that program is part of a health reform concept aimed at extending a basic package of integrated health services throughout the region. You are leading the way toward health reform as called for in the Plan of Action of the Summit of the Americas. We are pleased to be a member country of the Pan American Health Organization and we are proud to be a partner in the efforts to achieve health reform.

**WORKPLAN
FOR THE FOLLOWUP OF THE
SYMPOSIUM ON CHILDREN OF THE AMERICAS
(DRAFT 3/2/95)**

I. Equitable Access to Basic Health Services

Summit Goal: To reduce child mortality by one-third and maternal mortality by one-half by the year 2000. (Based on 1990 levels)

Objective: **ELIMINATE MEASLES IN THE AMERICAS**

Activity: Launch Measles Elimination campaign

Date/Place: Pan American Health Organization Headquarters
Washington, DC
April 7, 1995 9:00 am (tentative)

Purpose: To launch the "Measles Elimination Campaign" in the Americas which is expected to eliminate the indigenous transmission of measles by the year 2000.

Discussion:

Mrs. Clinton has been invited to launch this six year (1995 - 2000) project in the region of the Americas. Similar efforts are being organized in the other countries of the region where the respective First Ladies will also participate simultaneously in the launching of this initiative.

Outputs:

- Elimination of the indigenous transmission of measles by the year 2000.
- Increased vaccination coverage (DPT/Measles/OPV/BCG) to 95% in children under one year of age.
- 80% of women in childbearing age living in high risk areas will have been vaccinated with 2 doses of the Tetanus Toxoid (T.T.) vaccine.
- Weekly routine surveillance of fever and rash illnesses from at least 50% of all health establishments into their disease surveillance system in all countries.

■ Computerized Rash and Fever Illness surveillance software installed in all countries for collecting and analyzing suspected measles cases.

■ Annual country work plans showing the cost of different immunization activities by type of cost and source of funding in all countries.

■ Updated norms and manuals which reflect the development of new vaccine technologies and improved methods of disease control.

■ Regional laboratory network for supporting the processing of samples for measles diagnosis.

■ Information exchange meetings of immunization managers (a minimum of 24 subregional meetings and 6 regional meetings during the life of project).

■ InterAgency coordination through the InterAgency Coordination Committees (ICCs) consolidated in every country.

Specific Tasks:

■ PAHO will instruct their field offices to organize an event involving the First Ladies in the respective countries to launch the Measles Campaign on April 7.

■ Mrs. Clinton will send a letter, attaching the Rapporteur's Report of the Miami Symposium, to the First Ladies in the Americas with a cover letter announcing her plans to launch the campaign on April 7 and encouraging them to promote similar events in their respective countries.

■ Review the action plans that each country will prepare for the elimination of measles at the planned meeting of the Association of First Ladies to be held in Paraguay in October 1995.

■ PAHO will seek funding for the support of the estimated \$46 million Measles Elimination Project in the Americas through international and national sources.

Funding for the Activity:

2
VISIBILITY
al or fin.
Suggested in
para 9 Govt
support of NGO
local women's
support
help encourage
financial
support
women
achieve
goal

1st Ladies
encouraging
partnership

*

*

(Pending input from PAHO)

Objective: REDUCE MATERNAL MORTALITY RATES IN THE AMERICAS

Activity: Maternal Mortality Conference

Date\Place:

Purpose:

Discussion:

Outputs:

Specific Tasks:

Funding for the Activity:

before the Summit

II. Universal Access to Education

Summit Goal: To achieve a primary completion rate of 100 percent and a secondary enrollment rate of at least 75 percent by the year 2010.

Objective: To achieve a significant increase in the number of girls who complete primary school.

Activity: International Conference on Girls' and Women's Education

Date/Place: Guatemala
July or August (proposed)

Purpose: To issue a declaration on girls' education and its role in the sustainable development of the Americas.

Discussion:

Research has demonstrated that investments in the education of girls yield a higher return than any other investment in a country's development. When countries focus resources on the education of girls, they achieve a wide range of benefits, including significant improvements in infant, child and maternal mortality; individual and family nutrition and health; domestic, agricultural and industrial productivity; democratic participation and individual and family well being.

Guatemala has promoted an innovative Girls' Education Initiative that counts on the support of public and private sector leaders and is receiving financial support from the Japanese, IDB and World Bank as well as the Guatemalan private and public sectors. Guatemala also has one of the lowest levels for girls education in the region and thus would serve as an interesting site to discuss the issues confronting the achievement of girls completing primary school.

Outputs:

- Provide an impetus for girls education as an important component of sustainable development in all countries of the region.

- Build consensus among key actors so that girls' education is seen as a social and economic development issue, not a gender issue.

- Establish country and hemispheric targets for addressing specific country and hemispheric barriers to girls' education and for achieving increased enrollment and completion rates for girls in primary and secondary school.

✓

- Issue a Declaration on girls education and its role in the sustainable development of the Americas.

Specific Tasks:

- Mrs. De Leon could host the international conference in Guatemala and invite Mrs. Clinton to launch the event.
- Mrs. Clinton could address the participants by highlighting the importance of investing in education of girls as a sound development investment for countries with limited resources.
- The conference could provide an opportunity for the participants of the region to examine international research on girls' education, to share lessons learned from each country in the Americas on effective policies, programs and practices for increasing educational opportunities for girls, to present reports from each country on specific barriers to girls' education and strategies for addressing barriers, and to discuss strategies for promoting public and private-sector collaboration.
- Participants at the conference could visit schools and communities where girls' education projects are currently being implemented. They will be able to observe first-hand the effects of the public and private sector collaboration that is now benefitting girls, boys, families, and communities in Guatemala.
- A planning team representing the international and national community could be established to provide logistical and technical support to those hosting the conference.
- USAID could send its coordinator on girl's and women's education to Guatemala to manage the planning process with the planning team.

Funding for this Activity:

Allocation of resources to girls' education.

(Pending input from IDB???)

Objective: To galvanize the educational reform movement in the Americas.

Activity:

FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE PAN AMERICAN HEALTH ORGANIZATION
WASHINGTON, DC
APRIL 7, 1995

[Acknowledgements: Dr. George Alleyne [al-lean], director of PAHO; Dr. Ciro de Quadros [kwah-drose], director of PAHO's Special program on Vaccines and Immunization; Dr. Peter Bourne, chair of the American Association for World Health]

trip
I am pleased to be here on a ^{WHS} day that marks an historic opportunity for all nations to come together to improve the health of our global family. I also want to thank PAHO for honoring me with this award. But I must say that the real honorees are the people in this room who work on the front lines every day on behalf of children throughout the western Hemisphere. You are the real champions of children, and for all of your work, I thank you.

Nothing is more important to our shared future than the well-being of children, and for that reason I am especially pleased that children are the focus of this year's World Health Day.

Today's world is one of great promise -- and great peril -- for the 130 million children of this hemisphere. Great promise because our children are our lifeline to prosperity and progress in the new century that awaits us. Great promise because of the work you and others do to promote better health among children and families.

And great promise because of historic commitments born at the Summit of the Americas last December that will translate into greater opportunity and justice for young people from the Queen Elizabeth Islands to Tierra del Fuego.

I especially want to commend the First Ladies who participated in the symposium on children in Miami and worked with Dr. Alleyne to clarify our common vision and goals. Today, First Ladies across the Americas are turning rhetoric into reality by helping launch an historic campaign to eliminate measles from the hemisphere by the year 2000.

This campaign will save the lives of countless children in every country and will bring primary health care to every "barrio" and "aldea" [all-day-uh -- village] in our hemisphere.

We know it can be done. The Pan American Health Organization already has led the world in getting rid of the polio virus. Last September, the Americas were declared formally free of polio and

not a single case has been detected in the region since August of 1991 [in Peru]. All of you should take great pride in that achievement. You succeeded in getting many nations and public and private institutions involved, and that is no small feat.

Now the work must continue in every nation, and among nations who join together as partners in a common cause.

For the past two years, President Clinton has talked about the importance of investing in our greatest global resource: our children. And one of the best ways to invest in children is to invest in their health.

More than half of the population in this hemisphere is under age 23. While ushering children into the world is the province of families, protecting them from avoidable diseases must be viewed as our collective responsibility.

We all know that a sick child has much less chance of learning, growing, and fulfilling his or her potential than a child who is healthy. A sick child has much less reason to be hopeful and optimistic about the future. A sick child is much less likely to develop into a healthy, productive adult. That is why it is our responsibility as a larger community of nations to see to it that all children receive the health care they need.

The technology is not a problem. The vaccinations exist and they are far cheaper than long-term treatments for major diseases or the disabilities that accompany them. All we need now is the will and the commitment to make these immunization campaigns succeed.

Today I am pleased to announce that the United States will join in partnership with PAHO to help eliminate measles across the hemisphere. Through USAID, the United States plans to extend a five-year grant to PAHO to advance hemispheric health care priorities. Although our nation, like many others, is operating under severe budget constraints, we hope to allocate funds directly to the Regional Expanded Program on Immunization which includes support to the measles campaign. Already today the United States is providing substantial funding that includes about \$7 million a year as part of our child survival programs in countries of the Americas.

At the same time, we have every expectation that, just as with the polio effort, our country programs and our worldwide technical support will help boost the campaign to eliminate measles. During the polio campaign, those country programs more than doubled our regional commitment.

Your program to eliminate measles will advance all of our immunization efforts. Perhaps equally important, that program

reflects a larger notion of health reform aimed at extending a basic package of integrated health services throughout the region. Thank you for leading the way toward health reform as called for in the plan of Action of the Summit of the Americas.

Although our specific health challenges may differ from country to country and our recipes for progress may require different ingredients, our

In partnership with AID, UNICEF, the Inter-American Development Bank, the Canadian Public Health Association, Rotary International, and NGOs in every country of the Western Hemisphere, PAHO conducted comprehensive educational efforts and mass immunizations throughout the Americas. By 1990, 80% of all children in the Americas were immunized every year. There has not been a case of polio in the Americas for more than three years, and 145 countries reported no polio in 1994. (The last U.S. case of polio was 1979.)

When the disease is completely eradicated from the world, PAHO estimates that the US could save approximately \$200 million every year by discontinuing the vaccination.

Background on WHO Immunization Efforts

As you know, there has been tremendous progress in immunization programs throughout the world during the past decade. In 1984, the world's immunization coverage rate was 20%; by 1994, the rate had grown to 75%.

In the rest of the world, immunization coverage rose from 15 percent in 1980 to 75 percent in 1990. Polio is now under control in over 140 countries and major efforts will be needed in the Asian subcontinent, Africa and Eastern Europe. Support from the US (CDC, NGOs, AID) will be needed to achieve global polio eradication. The measles elimination in the Americas will provide the template for the eventual global eradication of measles.

World Health Day Event

The purpose of this event is to make the elimination of measles a more visible goal in the Americas, by highlighting the Measles Elimination Program and encouraging NGOs and IFIs and others to support the initiative; and to promote the establishment of country-level immunization partnerships. The First Ladies of other countries in the Americas will be hosting events similar to this one to promote the Measles Elimination Program.

The audience of approximately 350 will be comprised of members of the WHO, PAHO, and the American Association for World Health, representatives from NGOs and IFIs and donors to the measles initiative.

(Need more background on the event)

Acknowledge: Dr. George Alleyne, Dr. Ciro de Quadros, Director of PAHO's Special Program on Vaccines and Immunization, Dr. Peter Bourne, Chair of the American Association for World Health

(tba: Carol Lancaster -- USAID deputy director)

19580

**EMBARGOED UNTIL 00.01 H GMT
FRIDAY, 7 APRIL 1995**

**Press Release WHO/25
6 April 1995**

GLOBAL POLIO INCIDENCE DECLINES BY 82 PER CENT

Poliomyelitis cases have declined by 82% since 1988 when the World Health Organization (WHO) resolved to eradicate the disease from the world. Dr Ralph Henderson, WHO's Assistant Director-General, announced that only 6,241 cases of polio were reported worldwide during 1994 compared to 35,255 in 1988.

Vast areas of the world are becoming polio-free. According to WHO, there are now 145 polio-free countries in the world. "We are on line to eradicate the disease by the year 2000 provided we keep the momentum and concentrate resources on those areas of the world which still suffer from polio", comments Dr Henderson.

There are still two geographical areas where polio eradication efforts need to be intensified and extended, namely, parts of the Indian sub-continent and Central and Western Africa. The former accounts for 75% of the global polio incidence. It should be noted though, that global polio reporting is incomplete. Some countries, for instance, do not record polio cases at all. WHO estimates that on average less than one case out of 10 is being reported.

The occasion of this year's World Health Day is being used by 18 countries of the Middle East, the Caucasus, and Central Asia Republics (MECACAR) to carry out two-round National Immunization Days. In the course of this largest ever multi-country immunization effort over 60 million children will be immunized.

In spite of adverse conditions - many of the participating countries are going through a painful phase of economic and social restructuring while others are in the midst of military conflict and social strife - the first round of immunization went remarkably well. Despite the loss of its vaccine stocks and vaccine refrigeration facilities in a recent artillery attack on Kabul, the National Immunization Programme in Afghanistan is firmly on course to reach two million children with its immunization

Press Release WHO/25

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Page 2

campaign scheduled for 29 April through to 4 May 1995. During last year's immunization campaign the fighting was stopped across Afghanistan to allow all children to be immunized. Truces for immunization have also been previously declared in El Salvador, Lebanon, Sudan, and the Philippines.

Apart from the MECACAR countries, an additional 14 countries around the world will be conducting National Immunization Days reaching a further 45 million children.

China holds the world record in mass immunization - in 1993 and 1994, it twice managed to immunize 83 million children in the course of two days. China's success in reducing dramatically polio incidence in the country is the key element for the whole of the Western Pacific Region to become the second polio-free area in the world. The first region was the Western hemisphere where the last polio case was recorded in Peru in August 1991.

"Polio eradication is too big a job for any organization to be able to do it single-handedly", explains Dr Henderson. "From the very beginning of the global polio eradication campaign WHO has been privileged to work very closely with a coalition of partners ranging from UNICEF to Rotary International and the US Centres for Disease Control and Prevention".

"UNICEF has participated fully in this endeavour and has worked very closely with WHO, Rotary International and other partners and is very pleased with the progress in the Americas, East Asia, and the Middle East and North Africa", comments Dr Terrel Hill, Principal Advisor, UNICEF. "However, much more needs to be done and we welcome the World Health Day theme "A World Without Polio". The multi-country activities being implemented on World Health Day will provide an impetus for maintaining political will and the global partnership, reaching the previously unreached children, improving disease surveillance, and assuring the achievement of other goals as well. UNICEF procured and shipped more than 180 million doses of polio vaccine during the last five months in readiness for the National Immunization Days coinciding with World Health Day".

The global effort to eradicate polio is an historic collaboration between the public and private sectors. Rotary International is the first private sector organization to provide internationally coordinated support for a public health campaign. "Through the US\$ 246 million PolioPlus Programme, Rotary International provides both funds for vaccine and the organizational and promotional skills of tens of thousands of Rotarians", says Dr John Sever, General Coordinator of Rotary's PolioPlus Task Force.

Immunization programmes are very costly. Since the last polio outbreak in 1978, the United States of America has been spending over US\$ 250 million annually on polio immunization. Once eradication is achieved and polio immunization can be stopped, this money will be saved. Additional savings will come from a reduced need to provide medical care and rehabilitation services to polio victims.

Smallpox eradication - one of the most significant achievements in the history of public health - demonstrated the enormous cost effectiveness of disease control programmes. Since the last case of smallpox was detected in Somalia in 1977, the world has saved over US\$ 20 billion. The potential worldwide savings from polio eradication have been calculated to be as much as US\$ 3 billion each year.

Press Release WHO/25

Page 3

"But before we can sit back and enjoy the financial and public health benefits of polio eradication, the job has to be finished", says Dr Jong-Wook Lee, Director of the Global Programme for Vaccines and Immunization. "The polio-endemic countries meet 80% of the costs of polio eradication. But they do need help. The remaining 20% needed from external assistance amounts to US\$ 100 million a year right up to the year 2000". Although a single dose of the oral polio vaccine is inexpensive - UNICEF price per dose is only US\$ 9 - the required volume of the vaccine makes it the most expensive component of the eradication campaign, the other four elements being logistics, personnel, laboratory services and research.

"Polio, universally feared just some 40 years ago, was successfully controlled in industrialized countries thanks to the development of effective vaccines and large-scale immunization programmes", explains Dr Hiroshi Nakajima, WHO's Director-General, "Polio has now been forgotten by the citizens of these nations, but because polio is highly infectious every country without exception will have to continue its polio immunization programmes until all countries of the world are polio-free".

For further information please contact Mr Valery Abramov, Health Communications and Public Relations, WHO, Geneva. Tel. No. (41 22) 791 2543. Fax No. (41 22) 791 4858.

AGENCY FOR INTERNATIONAL DEVELOPMENT
OFFICE OF CENTRAL AMERICAN AFFAIRS
WASHINGTON, D.C. 20523



DATE:

4/5/95

FACSIMILE COVER SHEET

TO: NICOLE RABNER

FAX NO: 456-6244
FROM: LILIANA AYALDE
FAX NO. (202) 647-0102
SUBJECT: SPEECH

NO. OF PAGES (INCLUDING THIS COVER SHEET):

COMMENTS:

HOPE these remarks help. They include
our (USAID's) suggested comments + PATOS.
Let me know how it goes.

*The Pan American Health Organization,
American Association for World Health and
U.S. Department of Health and Human Services*

*Cordially invite you to join our national and international celebration
to promote childhood immunization at the*

1995 World Health Day Program

Friday, April 7, 1995 - 9:30 a.m.

with keynote speaker

Hillary Rodham Clinton

First Lady

*Pan American Health Organization
525 23rd Street, NW • Washington, D.C.*

Please R.S.V.P. by Monday, April 3, 1995 to: 202-466-5883



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037-2895, USA

CABLE ADDRESS: OFSANPAN
FAX (202) 223 5971
TELEPHONE (202) 861 3200

IN REPLY REFER TO:

DEC/49/1 (0439)

24 March 1995

Ms. Melanne Verveer
Office of the First Lady
The White House

Dear Melanne:

I am attaching for your information the following documents related to the celebration of World Health Day on April 7, 1995:

1. A so-called press kit with information on the Celebration of World Health Day
2. The summary document of the Measles Elimination Program
3. Possible talking points for Ms. Clinton's speech
4. The invitation
5. The final draft of the Program

Please do not hesitate to get in touch with me if you need any additional information.

I will be in my office until Tuesday evening, 28 March, when I will be departing for Europe.

If you need to contact anybody after that time, please call our Deputy Director, Dr. David Brandling-Bennett, at (202) 861-3178. He will be delighted to help you.

I am sorry I will miss this wonderful event. I am sure it will be a tremendous success!

Sincerely,

Irene Klinger, Chief
Office of External Relations

**Suggested Talking Points
for
First Lady Hillary Rodham Clinton during WORLD HEALTH DAY
7 April 1995, PAHO Headquarters, 12:00 am**

1. Immunizations are recognized as a very cost-effective health intervention in our health armamentarium. Tragically, every year more than 3 million children are still killed by measles or disabled by polio, two diseases that can be eradicated as was the case with smallpox.
2. In the last decade we observed tremendous progress in immunization programs throughout the world, with coverage increasing from a 20% in 1984 to 75% in 1994. In the Western Hemisphere we have witnessed the victory against polio with the eradication of this disease from our region. The last case in the Americas was detected in Peru, in August 1991. This was accomplished with strong PAHO leadership and coordination of the international support from the U.S. Agency for International Development, UNICEF, Rotary International, the Inter-American Development Bank and the Canadian International Development Agency that helped make the national efforts a resounding success.
3. The strategies developed by the Pan American Health Organization are now being applied in the rest of the world and it is expected that the world will be free of polio by the year 2000. The US, through the U.S. Agency for International Development and the Centers for Disease Prevention and Control, has been a strong supporter of immunization programs throughout the world and gave strong support to PAHO for the achievement of the victory against polio in the Western Hemisphere - 37% of all donor funds during the first full year.
4. It is now time to support the worldwide eradication of polio so that the gains in the Americas are sustained and the rest of the world's children are also free of this disease. When this happens, the US alone will save around \$200 million yearly because vaccination could then, and only then, be discontinued.
5. Here in the Americas, the challenge is to maintain the gains that were made with increasing immunization coverage and polio eradication and initiate, as approved by the Pan American Sanitary Conference, a major battle against measles and eliminate this disease from our Hemisphere by the year 2000.
6. Every country of this Hemisphere is committed to face this challenge. If the needed resources are made available the Americas once again, as it was the case with smallpox and polio, can provide the world with the template for the global eradication of measles.

FINAL DRAFT AGENDA
World Health Day 1995 (WHD95)
April 7, 1995

9:30 - 12:30	WORLD HEALTH DAY 1995 NATIONAL PROGRAM (All speakers listed are confirmed)	
9:30 - 9:45	Welcome and Introductions	Richard L. Wittenberg President & CEO, AAWH
9:45 - 9:50	WHD95 Proclamation	Marlen Kelley, M.D. Acting D.C. Commissioner of Public Health
9:50 - 10:00	Welcome and Statement	Sir George Alleyne Director, PAHO
10:00 - 10:20	Remarks (HHS Official)	Phil Lee Assistant Secretary for Health or Jo Ivey Boufford, M.D. Deputy Asst. Secretary for Health
10:20 - 10:50	International & National WHD Awards	Peter G. Bourne, M.D. Chairman of the Board AAWH
10:50 - 11:50	Panel Discussion	
	moderator:	Peter G. Bourne, M.D. AAWH
	panelists:	Betty Bumpers Cofounder Every Child By Two Jim Weill General Counsel Children's Defense Fund Karen L. Ray Project Director, National Health Program Congress of National Black Churches

Geraldine Marullo
Executive Director
American Nurses Association

Karen Ignagni
President & CEO
Group Health Association of
America

11:50 - 12:00 Introduction of Keynote
Speaker

Sir George Alleyne
Director, PAHO

12:00 - 12:20 Keynote Speaker

Hillary Rodham Clinton
First Lady

12:20 - 12:30 Closing

Dr. Donna Shalala
Secretary for Health and Human
Services

12:30 Songs of Inspiration

Washington D.C. International
School Choir

ADDRESS BY FIRST LADY OF THE USA DURING WORLD HEALTH DAY
7 April 1995, PAHO Headquarters, 12 am

TALKING POINTS

1. Immunizations are recognized as the most cost-effective health intervention in our health armamentarium. It is therefore tragic that still every year, more than 3 million children are killed by measles or disabled by poliomyelitis, two diseases that can be eradicated as was the case with smallpox.
2. In the last decade we observed tremendous progress in immunization programs throughout the world, with coverage increasing from a 20% in 1984 to 75% in 1994. In the Western Hemisphere we have witnessed the victory against poliomyelitis, with the eradication of this disease from our region. The last case in the Americas was detected in Peru, in August 1991. This was accomplished under strong PAHO leadership and coordination of the international support lent by the Agency for International Development, UNICEF, Rotary International, the Inter-American Development Bank and the Canadian International Development Agency that helped make the national efforts a resounding success.
3. The strategies developed by the Pan American Health Organization are now being applied in the rest of the world and it is expected that the world will be free of poliomyelitis by the year 2000. The USA, through its Agency for International Development and the Center for Disease Prevention and Control, has been a strong supporter of immunization programs throughout the world and gave strong support to PAHO for the achievement of the victory against polio in the Western Hemisphere.
4. It is now necessary to provide support to the worldwide eradication of polio to ensure that the gains in the Americas are sustained and the rest of the world's children are also free of this disease. When this happens, the USA alone will save around US\$200 million yearly because vaccination could then be discontinued.
5. For us, here in the Americas, the challenge is now to maintain the gains that were made with increasing immunization coverage and polio eradication and initiate, as decided by the Pan American Sanitary Conference a major battle against measles and eliminate this disease from our Hemisphere by the year 2000.
6. Every country of this Hemisphere is committed to face this challenge. If the needed resources are made available the Americas, once again, as it was the case with smallpox and polio, can provide the world with the template for the global eradication of measles.
7. The USA pledges its strong support to this initiative in the amount of US\$15 million as a grant to PAHO to coordinate the fight against this killer disease. We shall wipe out measles from the Western Hemisphere by the year 2000 as a fitting gift of the XXth to the XXIst century. That is our challenge.



Each year millions of the world's children are not immunized against life-threatening diseases.
Your child deserves protection when needed the most!

RESOURCE BOOKLET

American Association for World Health
1129 20th Street, NW, Suite 400 • Washington, DC 20036-3403
Telephone 202-466-5883



THE WHITE HOUSE

WASHINGTON

January 12, 1995

I am pleased to join communities throughout the United States in celebrating World Health Day, 1995, "Immunize: Birth to Two, It's Up to You!"

We have long understood the importance of childhood immunizations in preventing the spread of dangerous diseases. Unfortunately, in 1993, our nation's immunization rate was only about 67 percent, leaving hundreds of thousands of children vulnerable to many life-threatening, preventable illnesses.

Last April, in an effort to address this urgent problem, I launched the Childhood Immunization Initiative, which was designed to boost immunization levels for children age two or younger. If we are to protect our children and provide them with an environment in which they can thrive and succeed, families, communities, and government all must work together to take responsibility for the generations to come.

World Health Day 1995 is an important part of that effort, teaching people the invaluable benefits of preschool immunization. I encourage all of you to take an active role in this vital task of making our world safer for children everywhere.

Bill Clinton

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WORLD HEALTH DAY OVERVIEW

What is World Health Day?

World Health Day provides a forum for information and discussion about health conditions worldwide. Its objective, as established by the World Health Organization (WHO), is "Health for All by the Year 2000." It is observed annually on April 7 in the 189 member countries of WHO.

History of World Health Day

The designation of World Health Day was one of the first official acts of WHO. First observed on July 22, 1948, World Health Day was later changed to April 7, the day the official constitution of WHO was formally adopted. Since 1950, World Health Day has focused on a specific global issue each year.

As one of its world objectives, WHO strives to attain the highest possible level of health for all people it serves. The Pan American Health Organization (PAHO), based in Washington, DC, is the regional office of WHO for the Americas. The American Association for World Health (AAWH), also located in Washington, DC, serves as the U.S. Committee for WHO.

Previous Themes

The Director-General of WHO chooses the World Health Day theme based on recommendations submitted by member countries. The selected themes reflect conditions that threaten the health of individuals worldwide. Past themes include the following:

- Our Planet, Our Health: Think Globally, Act Locally
- Health for All, All for Health
- Healthy Youth - Our Best Resource
- Should Disaster Strike - Be Prepared
- Heartbeat - The Rhythm of Health
- Injuries Hurt Us All - We Can Prevent Them!
- Oral Health for a Healthy Life

Global Theme for 1995 - "Target 2000: A World Without Polio"

The World Health Organization has designated World Health Day 1995 as "Target 2000

- A World Without Polio." Many countries and regions have already made dramatic progress towards global eradication of poliomyelitis. The necessary means to eradicate this disease already exist: effective vaccines, proven strategies and well-coordinated laboratory services. Indeed, the target of eradicating polio by the year 2000 can be achieved.

In conjunction with the efforts of PAHO and WHO throughout the world, the United States will be expanding upon WHO's World Health Day theme in an effort to focus on all childhood vaccine-preventable diseases. AAWH has designated the World Health Day 1995 theme as "Immunize: Birth to Two, It's Up to You!"

World Health Day 1995 in the United States - "Immunize: Birth to Two, It's Up to You!"

Few means to protect our children from illnesses are as certain as immunization. Over the past 40 years, WHO has promoted the worldwide immunization of children with great success. Their global programs have reached more than 100 million infants each year. In addition,

World Health Day 1995 Goals

- Enhance community participation on World Health Day by supporting the goals of Healthy People 2000
- Educate the public in an effort to improve childhood immunization rates in the Americas
- Raise awareness about the benefits of immunizing children by two years of age
- Disseminate information about age-appropriate immunization
- Inform the public that vaccines really do protect and save lives
- Alert the public of the risks involved when children are not immunized
- Provide easy access to immunization information through toll-free numbers
- Support all efforts to increase childhood immunization rates
- Strengthen cooperation by expanding partnerships among public and private organizations to support efforts to immunize by two years of age

they have rid many parts of the world of polio and have successfully eradicated smallpox.

Through vaccination, a child can be protected from polio, rubella, pertussis, diphtheria, measles, mumps, tetanus, Haemophilus influenza type b (Hib), and hepatitis B. Immunization has become the basic tool of the public health practitioner, a means to save and improve countless lives, and the source of significant savings in health care costs. Yet despite the wide availability of vaccines, many preventable illnesses and deaths are still caused by infectious diseases in the United States and abroad.

Activities

The goals of World Health Day 1995 are to highlight and discuss childhood immunization issues on April 7 and throughout the following year. The World Health Day resource kit will

encourage and suggest ways to continue year-long participation but the success of World Health Day depends on the commitment of those who will organize and participate in World Health Day events!

World Health Day activities should be designed to increase awareness and stimulate community participation. Everyone, from preschoolers to senior citizens, can participate in World Health Day. Possible activities include classroom lectures, television programs, magazine articles, and governmental resolutions and proclamations. This planning kit will provide many more suggestions.

Health promotion is best achieved through activities linking individual, professional and community efforts. Governmental health agencies, voluntary health associations, schools, universities, the private sector and the media all play important roles in drawing public attention to World Health Day.

PLANNING YOUR WORLD HEALTH DAY EVENT

1. Getting started by forming an organizing committee

- Identify individuals and organizations in your area who may be interested in planning a World Health Day event. The state coordinators and national, state and local organizations listed in this booklet can help you do this; although you may already be aware of local health, educational or other professional societies and organizations that may wish to join in a concerted, area-wide effort. Check into church groups, philanthropic organizations, service organizations and clubs for additional support.
- Identify organizations and order materials as soon as possible.

2. Choose the activity

- Is there a specific childhood immunization challenge that you are aware of in your community? If not, it is always appropriate to raise the awareness of the importance of immunization.
- Use suggestions for activities that follow to help you decide how best to celebrate World Health Day in your community.

- Decide whether to have one centralized event or several small ones.
- Reach a consensus on the type of program that will be organized and how to sustain commitment throughout the year.
- Set goals to be evaluated at the end of the event(s).

3. Create a planning schedule

- Form World Health Day planning committees and subcommittees and assign various duties to these groups.
- Schedule dates and deadlines for planning your activities.

4. Identify community resources and sources of talent

- Identify and use sources of talent and expertise in your community.
- Contact people early to give them plenty of preparation time.
- Decide on your financial needs and establish partnerships in the community for support. Often local businesses will provide prizes for a raffle or give-away.

5. Set the date and implement the plan

- April 7 is World Health Day. However, we encourage you to plan observances throughout the year.
- Keep on schedule by periodically ensuring that planners are continuing communication.
- **Remember to promote "Immunize: Birth to Two, It's Up to You!" everyday with events throughout the year.**

6. Decide who will participate

- Determine the number of people you would like to attend your event. Encourage a wide variety of groups to attend.

7. Publicize your event

- Submit news releases to newspapers, TV and radio stations; produce and distribute posters and flyers; and announce your World Health Day event at other meetings. Refer to the sample news release on page 14 and to the Media Relations Guide for World Health Day on page 11 of this booklet.

8. Choose the location

- You may need to reserve space in advance. Make sure the location is suited for the activity you are planning. Some things you may wish to check for include the follow-

ing: adequate space, facilities, lighting, acoustics, accessibility, parking and availability of audio-visual equipment.

9. Make hospitality arrangements

- Good hospitality will ensure a successful event. Prepare invitations, programs with acknowledgments, welcoming committees, name tags, giveaways from local businesses, and post event appreciation notices for those who assisted. Also, if possible provide refreshments/food services during your activities.

Remember, it's better to begin modestly and succeed than to attempt too big a project and fail!

10. Evaluation

- Evaluate the day's activities: Did they accomplish what they intended to do? Was there successful coordination of events? What was the approximate number of people served by the program? How many volunteers helped and were they well organized? List ways to improve future programs.

11. Send back follow-up report

- Your feedback is important and will assist us in evaluating the effectiveness of the resource booklet and the success of your program (see page 34).

THINGS YOU CAN DO ON WORLD HEALTH DAY AND BEYOND

World Health Day is a community effort but the first step begins with the individual. There are various activities that each person can initiate and continue throughout the year.

What can I do?

- Talk to your friends and family members about childhood immunization
- Write to your elected officials (mayor, governor, congresspersons, senators) and encourage an active response to the immunization needs in your community
- Mobilize groups in which you are a member to participate in World Health Day 1995
- Promote and encourage on-going immunization programs
- Order materials from the CDC/National Immunization Program and share information with others (see p. 32)

- Write a letter or Op-Ed article to your local newspaper demonstrating support for World Health Day 1995

More things you can do

At Work...

- Ask your employer to help establish April 7, 1995 as a day to address the issues of childhood immunization
- Distribute information on childhood immunization and World Health Day 1995
- Submit a proclamation to your employer stating that your organization recognizes

World Health Day and the importance of immunizing children by age two

- Initiate a program to have immunization messages inserted in paycheck envelopes and printed on bags and cartons
- Encourage neighborhood businesses to distribute immunization information to their customers
- Develop cards with the World Health Day logo, your business logo, and the national and local immunization information hotlines
- Encourage your office to display posters or flyers about immunization
- Make a long-term commitment for immunization promotion in the workplace by continuing programs throughout the year

At School...

- Hand out and discuss the "Ten Things You Need to Know about Childhood Immunization" on page 23 of this booklet
- Set aside class time for a special lesson on childhood immunization
- Develop and distribute tray covers for the cafeterias reminding people about the importance of immunizations
- Sponsor a poster, t-shirt, or bumper sticker design contest
- Air public service announcements about World Health Day and the importance of childhood immunization over the school public address system
- Distribute information on the immunization schedule to students to bring home to their families; encourage students to ask parents about the immunization status of their younger siblings
- Arrange special service projects by university, civic, religious and social clubs
- Write an article or letter to the editor of the school paper; include statistics about the rates of childhood immunization by two years of age in your community and/or state

At Worship...

- Create World Health Day displays at your place of worship
- Encourage your religious leader to speak about childhood immunization

- Conduct a Children's Sabbath focusing on childhood immunization
- Start a service program: Members of your congregation can work to educate community members about childhood immunization and immunization schedule for new-borns
- Actively assist members of the congregation in getting their children immunized fully: assign a committee to remind parents when children are due for shots, provide transportation to a free express clinic, provide baby-sitting services while parents are at the clinic
- Spread the word in the community about the importance of well-child care, putting special emphasis on full immunizations for infants and toddlers
- Conduct health fairs and workshops on well-child care, immunizations and Medicaid eligibility for members of your congregation and community
- Encourage long-term commitment of your religious community to increasing the rates of childhood immunization by age two

At Medical Associations and Health Maintenance Organizations...

- Distribute immunization information
- Hold a public information session about the importance of immunizing our children by age two
- Initiate a program to have immunization messages inserted in paycheck envelopes, and printed on bags and other materials
- Urge individual practitioners to get involved in the campaign to reach infants and toddlers by educating parents, monitoring patient compliance and forwarding immunization data to the central tracking system if one exists
- Stress the importance of keeping immunization appointments to your patients
- Join forces with other professional medical associations, coordinating and pooling efforts where appropriate
- Ask all providers to serve Medicaid families and provide immunizations to all children in their care

- Emphasize to health care providers the importance of the CDC Standards for Pediatric Immunization Practices (see page 32)

At Hospitals...

- Encourage doctors and nurses to educate mothers-to-be throughout pregnancy on the importance of immunizations for their babies
- Give mothers of newborns information on getting their children immunized before they leave the hospital using videos and published materials
- Register newborns, infants and toddlers with the city's central immunization tracking system, obtaining parent's permission while they are on the premises
- Offer to link parents of newborns, infants and toddlers with volunteers from your hospital who can help ensure that children get all their shots on time
- Check the immunization status of all children in out-patient clinics and emergency rooms and develop follow-up procedures for those who need shots
- Develop and distribute tray covers for the cafeterias reminding people about the importance of immunizations

PARTICIPATE IN NATIONAL INFANT IMMUNIZATION WEEK (Apr. 22-28, 1995)

Although 96 percent of children are adequately vaccinated by kindergarten, approximately one-third of American children under age two are inadequately protected against childhood diseases — in certain parts of the U.S., more than half the children are not immunized by age two. National Infant Immunization Week (NIIW), April 22-28, is commemorated annually to offer one opportunity to focus the nation's attention on these facts and to expand efforts to address the underimmunization problem.

NIIW activities will be occurring throughout the country and are designed to increase awareness of age-appropriate immunization and to involve new partners in long-term efforts focused on increasing and sustaining higher immunization rates. Some community activities during National Infant Immunization Week will include extended evening and weekend hours at immunization clinics, awareness-raising events designed to capture community and media attention, and high-profile national and state leaders drawing further attention to the importance of childhood immunization.

You are encouraged to participate in NIIW activities. For more information, contact your state or local public health department or the U.S. Centers for Disease Control and Prevention at 404-639-8226.

MEDIA RELATIONS GUIDE FOR WORLD HEALTH DAY

The media offers us the means to communicate quickly and persuasively with large numbers of people. Media coverage of World Health Day will help spread the message of the importance of childhood immunization by age two and increase participation in various health promotion activities.

Following are some tips to help you deal with the media — reporters and editors — to maxi-

mize the effectiveness of telling your story and communicating your messages.

Important things to remember about news and reporters:

- News is what is different today than it was yesterday

- Editors look for conflict, criticism and controversy — be prepared to respond to it
- Emphasize the positive side of the issue — whenever possible, turn negatives to positives

How to prepare yourself for all media interviews:

- Don't even think about answering questions unless you feel you are fully prepared - you can always offer to call a reporter back
- Decide what you can say and how you can say it
- Think about what questions your responses are likely to trigger and prepare answers
- Think about how you can get your own message in
- Instead of answering the reporter's questions, ask questions - interview the interviewer
- Have your own agenda and make opportunities to talk about it — a point you want to make about some of the positive issues (things you/your community have/has done to promote childhood immunization)

Your message should be simple and succinct.

A possible message for World Health Day 1995 may be:

Childhood vaccines can prevent nine infectious diseases and are among the most vital and cost-effective medical interventions. Remember our slogan, "Immunize: Birth to Two, It's Up to YOU!"

Remember to restate your objective message in every answer.

Some DOs for media interviews:

- Take the initiative and make your points in every answer
- Keep answers short and simple
- Use colorful words, analogies, absolutes and clichés

- Stop talking when you've answered a question
- Say "I don't know" when you don't
- Be positive in making your points

Important DONTs:

- Don't use jargon, acronyms or technical terms
- Don't speak off the record
- Don't become angry or provoked
- Don't speculate, guess or conjecture
- Don't ever lie to a reporter

Key Points for Newspaper Interviews

- Know before the interview begins what it is about and be well prepared
- Be prepared to offer greater detail and substantiating documents to print reporters
- Be aware that print reporters for larger newspapers are more likely to be specialists in their area

Key Points for Radio Interviews

- Remember that radio news reporters want very short and simple answers
- Commit to appear on talk shows or listener call-in shows only after you know the host's agenda

Key Points for TV Interviews

Studies indicate that how we look in a television or personal appearance is far more important than what we say.

- Maintain steady eye contact with the reporter during a television news interview
- Exaggerate your smile — when you smile your body language says, "I'm confident and comfortable in what I'm saying"
- When sitting, lean slightly forward in the chair, with feet flat on the floor
- The more conservative your dress, the better — blues, beiges and grays are best
- Avoid wearing glasses because they tend to reflect studio and outdoor lights

Proclamation for World Health Day 1995

WHEREAS the health of all people is one true measure of a nation [state/county/city];
and

WHEREAS the health of Americans is inseparably linked with the health of peoples
throughout the world; and

WHEREAS all the nations of the world, acting through the World Health Organization,
of which the United States is an active member, are pledged to the goal of Health
for All by the Year 2000; and

WHEREAS April 7 of each year has been established by the World Health Organization
as World Health Day - an occasion to educate and to inform, to encourage increased
community involvement, to focus on the unity of our health concerns; and

WHEREAS the World Health Organization, recognizing that many countries and
regions have already made dramatic progress towards the global eradication of
polio, designated World Health Day 1995 as "Target 2000 - A World Without Polio"
emphasizing that eradicating polio can be achieved in the next six years and will end
much human suffering; and

WHEREAS there have been no cases of polio identified in the Western Hemisphere for
the last three years, the American Association for World Health is promoting the
1995 World Health Day theme in the United States as "Immunize: Birth to Two, It's
Up to You!" as it is estimated that only about two-thirds of American children under
age two receive all the immunizations they need; and

WHEREAS the American Association for World Health recognizes that immunizations
are among the most vital and cost-effective medical interventions available and
protect young children from nine infectious diseases;

NOW THEREFORE, I, _____, Governor/Executive/Mayor of
_____, do hereby declare April 7, 1995, as World Health Day and urge
all of our citizens to take part in observances and activities on this day and
throughout the year which are designed to advance the cause of childhood
immunization by promoting awareness and by encouraging participation in the
worldwide efforts of attaining "Health for All by the Year 2000."



SAMPLE NEWS RELEASE

World Health Day is an event that is open to all segments of the community. In your news release, it is important to emphasize and encourage community participation and to stress the direct links between individual, community and global health. The following sample of a news release can be quoted from liberally and sent to local newspapers and radio and TV stations. In addition, it can be used to announce World Health Day in community flyers, school newsletters, office memos, computer bulletins or any other media that will get the message out to the people you would like to reach.

The name and telephone number of a local contact person should appear at the top of your news release. Your release should also contain information about your local observance and how people can get involved.

(YOUR COMMUNITY) TO COMMEMORATE WORLD HEALTH DAY 1995

On April 7, 1995, World Health Day will kick off "Immunize: Birth to Two, It's Up to You!" Locally, *(name of your organization)* will be coordinating World Health Day events such as *(insert description of your organization's event, including time and location)*. This day is intended to mobilize governments, communities, and individuals to immunize children against all vaccine-preventable diseases.

World Health Day in the United States emphasizes community involvement in promoting childhood immunization. On the national level, the American Association for World Health, in cooperation with the World Health Organization, its western affiliate the Pan American Health Organization, and the U.S. Department of Health and Human Services, is coordinating activities around the country for World Health Day.

Here in *(name of community)*, *(name of community leader)* will be officially endorsing World Health Day 1995 when he/she reads the World Health Day Proclamation at *(location)* in commemoration of this year's theme for World Health Day 1995, "Immunize: Birth to Two, It's Up to You!"

Childhood vaccines prevent nine infectious diseases, including polio, measles, diphtheria, mumps, pertussis, rubella, tetanus, hepatitis B and Hib. However, the national immunization level among young children is about 67%, leaving hundreds of thousands of children not vaccinated. Here, in *(name of community)*, according to *(source of statistics)*, as of *(date)*, *(percentage)* of children are immunized before the age of two.

(Insert descriptions of specific World Health Day activities that are planned for your area, as well as the organizing groups). For additional information on these World Health Day activities contact *(name of contact)* at *(phone number)*.

The ultimate goal is to have as many people as possible within U.S. communities and around the world communicating about the importance of childhood immunizations to improve childhood immunization rates.

For more information on the World Health Day activities that are planned for *(name of community)* call *(name of contact person)* at *(phone number)*.

Other Targeted News Releases

You can write news releases that target specific groups. For example, you can write ones that are aimed at people of different age brackets, ethnicities or genders. Remember to follow the same guidelines for writing a news release that are outlined above.

TARGET 2000 - A WORLD WITHOUT POLIO

What is Polio?

Poliomyelitis is caused by infection with one of the three types of poliovirus. Most infections with poliovirus are asymptomatic, and less than 1% result in paralysis. Approximately 1 in every 200 persons infected with poliovirus will become paralyzed. Paralysis rates are highest with poliovirus type 1, the most frequent cause of epidemics. Polio is predominantly a disease of the very young, with 70%-90% of cases occurring in those less than 3 years of age. The disease is seasonal with peaks in the hot and humid summer months. The virus is spread primarily through the fecal-oral route, particularly in areas where sanitation is poor, and by the respiratory route in countries with a high level of sanitation.

Polio vaccines

In the 1950s, Jonas Salk and Albert Sabin developed effective polio vaccines which not only protect the individual child from paralysis, but can also eradicate the virus completely. Over the past 20 years, the effective use of these vaccines eliminated polio from most of the developed world. However, the virus persists in less developed countries.

Polio Eradication Initiative

In 1988, the World Health Assembly launched an initiative to eradicate poliomyelitis by the year 2000. "Eradication" means that there will be no wild poliovirus, not just elimination of the clinical disease. Since that time, experience has clearly demonstrated that eradication of poliomyelitis is practical and that the World Health Organization target of eradicating the disease by the year 2000 can be achieved.

What progress has been made thus far?

The number of countries reporting zero incidence of poliomyelitis rose to 141 in 1993, the highest ever recorded. A total of 7,898 cases was registered in 46 countries during the year, or less than half of the 15,911 cases which occurred in 58 countries in 1992 (see figure 1, p. 16): Global Incidence of Poliomyelitis, 1988 and Global Incidence of Poliomyelitis, 1993.

Since September 1991, the Western Hemisphere as a whole has reported zero cases of paralytic poliomyelitis. At the present time, apart from the Western hemisphere, there are five zones where polio is either absent or occurs at very low levels. These emerging polio-free zones are: Western and Central Europe, North Africa, Southern and Eastern Africa, the Arabian Peninsula and the Western Pacific.

The WHO Western Pacific Region recorded a 60% decline in the number of reported cases of poliomyelitis and is well on target of becoming the second polio-free area in the world in 1995.

The South-East Asia Region recorded a 54% decline in the number of polio cases in 1993.

Against the backdrop of almost universal decline in the number of reported polio cases there is one Region - the Eastern Mediterranean - which reported a 24% increase in polio incidence last year. For the most part, the increase is due to large outbreaks of the disease in Pakistan and The Sudan.

Why must polio be eradicated, not just controlled?

Until all countries are free of polio, no country can be free of it! Even in nations with zero reported cases and high immunization levels, the virus can be "imported" and may spread. Until polio is wiped out, aggressive immunization and monitoring programs must continue so that polio is not imported back for example, into the Americas from other regions.

Polio Eradication Network (PEN)

Although 80% of the world's children have been vaccinated against polio, 20% have not been reached. To ensure a polio-free world, six global health agencies and Nongovernmental Organizations (NGOs) joined together to form the Polio Eradication Network (PEN). PEN is composed of WHO, UNICEF, the Pan American Health Organization (PAHO), Rotary International, the U.S. Centers for Disease Control and Prevention (CDC) and the Task Force for Child Survival and Development. PEN is

working to publicize the global polio eradication effort and communicate its progress, needs and goals.

The PolioPlus program of Rotary International

As part of the Expanded Program on Immunization (EPI) against vaccine-preventable childhood diseases conducted by WHO, Rotary International began "PolioPlus" in 1985 to control polio worldwide and pledged to provide all the polio vaccine necessary for up to five consecutive years to any developing nation's immunization program. By 1989, Rotary International was purchasing more than 80 percent of all the polio vaccine sent to developing countries by UNICEF and PAHO. As of 1994, Rotary has allocated more than US \$200 million for PolioPlus projects in 100 countries.

For more information on Rotary International's PolioPlus program, please contact: Public Relations, Rotary International, 1560 Sherman

Avenue, Evanston, IL 60201-3698, (708) 866-3000.

The Benefits of a Polio-Free World

The global eradication of poliomyelitis is highly cost beneficial. Polio eradication will cost an estimated \$100 million a year for ten years. But the benefits of eradicating polio will exceed the costs by approximately US \$125 million by the year 2005. The short-term cost of achieving the goal is outweighed by the long-term financial and humanitarian benefits. Children will no longer be disabled by polio. Costly rehabilitation of children with polio as well as the purchase and delivery of vaccines will no longer be necessary.

In the U.S., the cost savings in 1993 from not having to vaccinate against polio would have totaled \$230 million. The total annual cost of polio vaccine was \$111 million and the total annual cost of administering the vaccine was \$119 million.

In the 1950s, Jonas Salk and Albert Sabin developed effective polio vaccines which not only protect the individual child from paralysis, but can also eradicate the virus completely



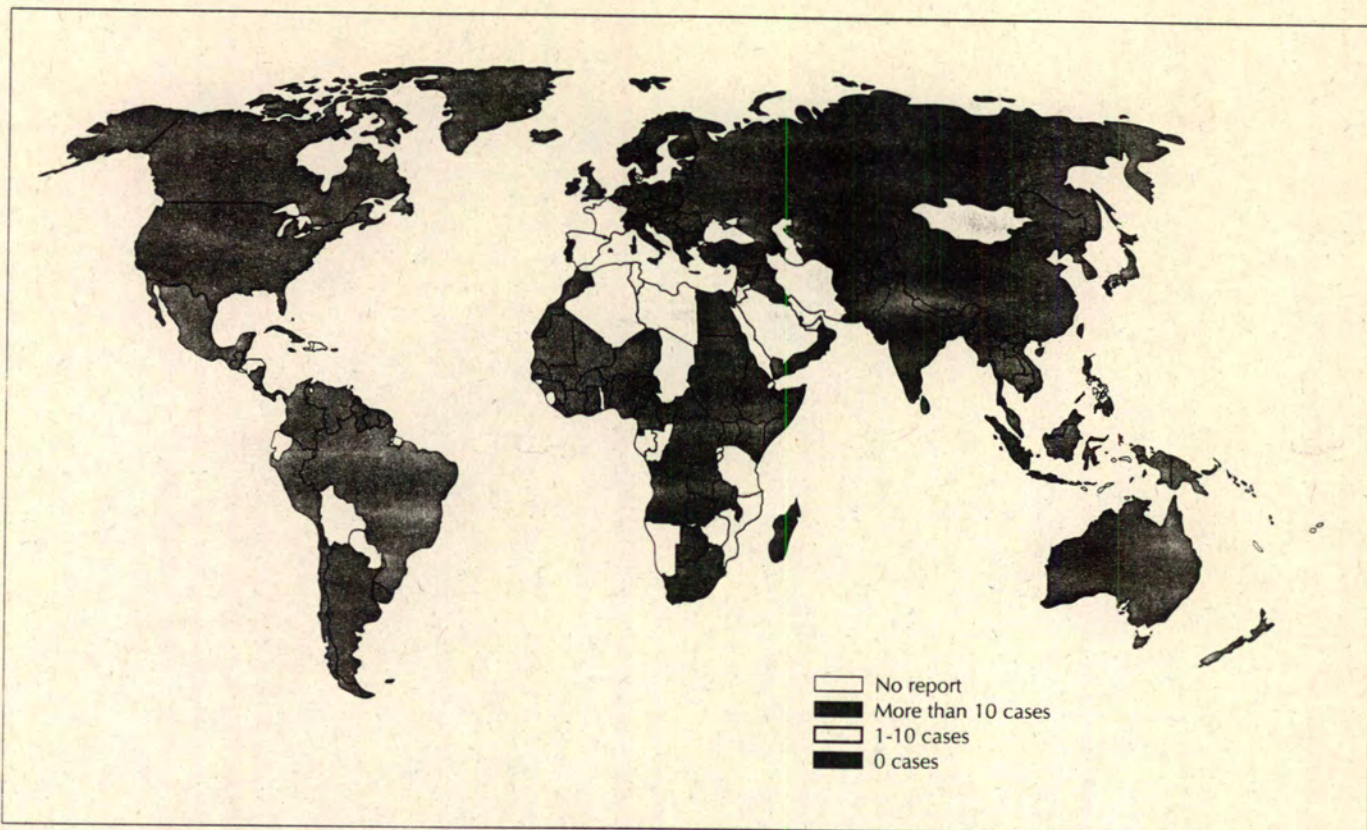


Figure 1a. Global Incidence of Poliomyelitis, 1988. (Data available as of August 1994.)

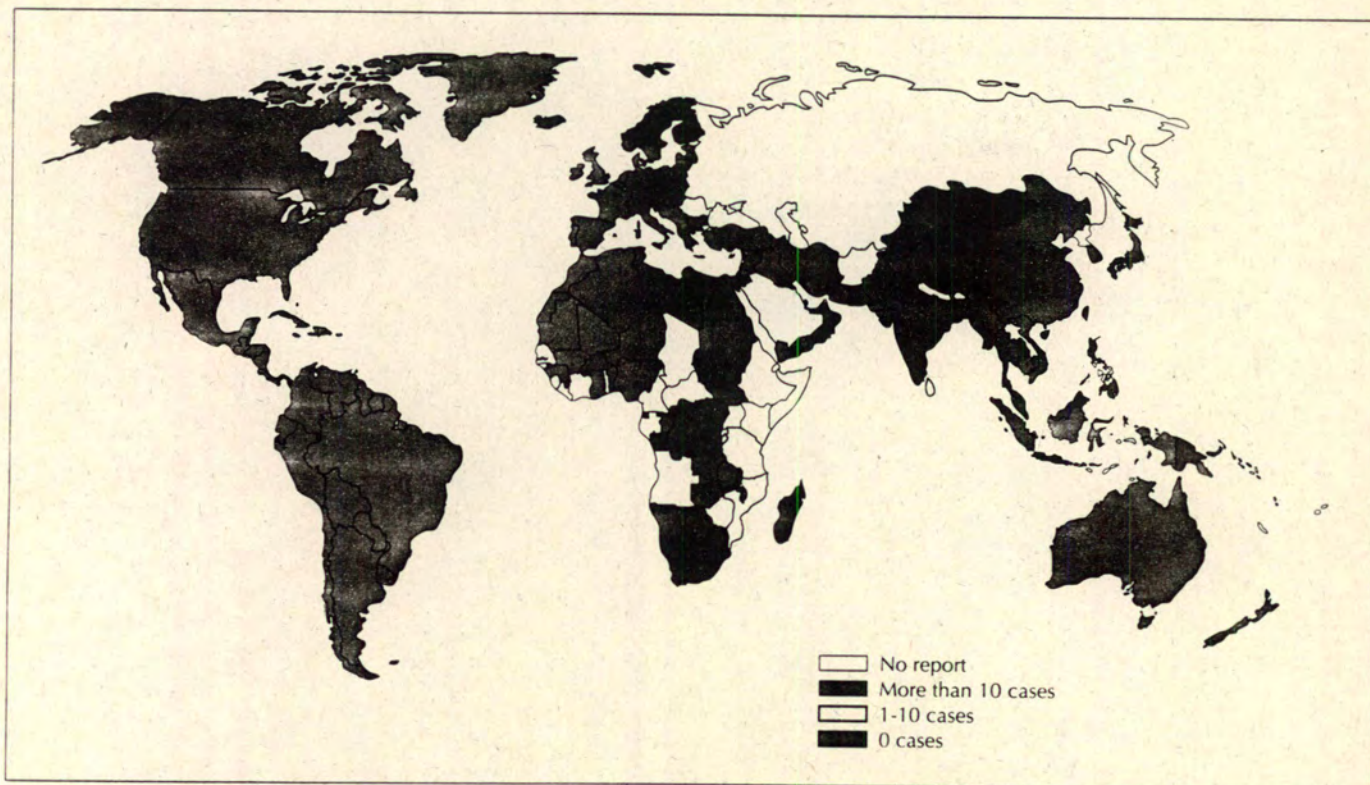


Figure 1b. Global Incidence of Poliomyelitis, 1993. (Data available as of August 1994.)
Does not reflect recent political boundary changes.

ERADICATION OF POLIO: A SUCCESS STORY IN THE AMERICAS

On September 29, 1994, Dr. Frederick C. Robbins, Chairman of the International Commission for the Certification of Poliomyelitis Eradication (ICCPE), announced, "Based on the impressive evidence presented, the ICCPE concludes that the wild poliovirus transmission has been interrupted in the Americas."

In 1978, fewer than one in four children was immunized in the first year of life in the Americas. At that time, polio was endemic in most countries of Central and South America. In response, the Pan American Health Organization (PAHO) stepped up anti-polio efforts and in 1985, declared the eradication of polio, one of its principal goals. By 1991, polio caused by the wild virus was limited to two countries, Colombia and Peru, and only within restricted areas of each country. Extensive and comprehensive mass immunizations were conducted in these high risk areas with apparent interruption of transmission and eradication of the virus. The last detected case occurred in Peru, with a date of paralysis of August 23, 1991.

In the United States, the first great epidemic occurred in Vermont in 1894. Other outbreaks followed: In 1918-1919 and again in 1931, an outbreak occurred in New York, in 1932 in New Jersey and Pennsylvania, and in 1935 in Boston. Thousands of children were left paralyzed or confined to iron lungs from the explosion of cases throughout the United States in the 1950s. The last U.S. case was in 1979.

With the development of vaccines in 1954 by Jonas Salk and in 1957 by Albert Sabin, and the commitment of PAHO and other national organizations, there have been no cases of polio in the Americas since 1991.

The interruption of the wild poliovirus in the Western Hemisphere demonstrates that the elimination of all vaccine-preventable childhood diseases is achievable. In addition, this success shows the effectiveness of unifying our national efforts to immunize children by age two, and the value of launching a national campaign for World Health Day 1995, "Immunize: Birth to Two, It's Up to You!"

Childhood Immunization in the United States

In the era before vaccines, hundreds of thousands of American children died from infectious childhood diseases. Today, children who are not immunized, particularly infants, are still at risk of serious illness and death.

Consider these facts:

- Childhood vaccines can prevent nine infectious diseases: polio, measles, diphtheria, mumps, pertussis (whooping cough), rubella (German measles), tetanus, hepatitis B and Hib (the most common cause of spinal meningitis).
- Immunizations are among the most vital and cost-effective medical interventions available. More than \$30 are saved for every \$1 spent on DTP (diphtheria/tetanus/pertussis) vaccine; more than \$21 are saved for every \$1 spent on MMR (measles/mumps/rubella) vaccine; and more than \$6 are saved for every \$1 spent on polio vaccine.
- The immunization level among young children for 1993 in the U.S. was about 67%, leaving hundreds of thousands of children not vaccinated. In some inner cities and rural areas, the rate was as low as 36%.
- 44% of the individuals who contracted measles in the 1990 epidemic were preschoolers who were old enough for immunization but were not immunized.
- All 50 states and the District of Columbia already have immunization laws or requirements for school children and for children attending licensed family day care centers. Although immunizations are recommended for preschoolers, often children are not immunized until entering school, and thus are at risk of infection, and increase the risk of infection for others, between birth and the time entering school. "Immunize: From Birth to Two, It's Up to You" stresses the importance of early immunization.

What are some barriers to immunization?

The number of clinics and the time available for providing immunizations — Having sufficient number of clinics open at times when parents can bring their children for immunization is an important way to make vaccines more available and easy to access.

The cost of immunizations — The cost of fully immunizing a child has increased over the past decade in part because a number of life-saving vaccines have been added to the schedule, for example *Hemophilus Influenza* Type B and Hepatitis B vaccines. Other reasons for the increasing cost of immunization are the excise tax, adding more doses of the traditional vaccines — like a second dose of MMR — and the added cost of administration of vaccines. Some studies have suggested that the cost of immunization may play a role in missed opportunities when providers refer some patients to local health clinics for immunizations.

Missed Opportunities — Every visit of a child to a health care provider should be an opportunity to determine his or her immunization status. If a vaccine is due, it should be given if no contraindications exist. Missed opportunities may increase immunization coverage by about 30%.

Parents lacking knowledge of recommended age for immunizations — Although most parents know that children must have their vaccines to enter school, many do not know that most vaccines are scheduled by age two. Efforts are needed to educate parents about getting their children immunized on time.

Lack of a health care information system — A computer-based system that can register children, remind parents when immunizations are due, and give providers reliable access to the immunization records of the children they serve can help address several immunization barriers. Moreover, it could assess progress toward the national goal of immunizing 90% of children with the basic immunization series by the second birthday.

Overcoming barriers: The Childhood Immunization Initiative (CII)

President Clinton launched the Childhood Immunization Initiative (CII) — a national comprehensive approach to increase vaccination levels for children under the age of 2 years by marshaling the efforts of the public and private sectors, health care professionals, and volunteer organizations.

Goals by 1996

- Reduce most diseases preventable by childhood vaccination to zero
- Increase vaccination levels for 2-year-old children to at least 90% for the initial and most critical doses in the vaccine series, and 70% for more recently introduced vaccines
- Begin building a vaccine delivery system to maintain these achievements in the United States within a reformed health care system

Goals by 2000

- Maintain zero levels of diseases preventable by childhood vaccination
- Further increase immunity by increasing vaccination levels for 2-year-olds to 90 percent for the complete series of recommended vaccine doses against all nine vaccine-preventable diseases
- Finish building a comprehensive vaccine delivery system that reliably guarantees protection to all children

Actions

The CII enhances the following five broad areas designed to attain the goals for 1996 and beyond:

1. Improve the quality and quantity of vaccination delivery services.

Federal funding to the states and some cities tripled in 1994 to \$128 million to build up the public health infrastructure. These funds will be used to provide more clinics in underserved areas, to extend clinic hours, and hire needed staff. Additional funding is being provided to establish computer immunization in-



Thousands of children were left paralyzed or confined to iron lungs from the explosion of cases throughout the United States in the 1950s. The last U.S. case was in 1979.

formation systems to help remind parents when immunizations are due.

II. Reduce immunization costs for parents.

The Vaccines for Children Program will provide free vaccines to needy children. About 60 percent of children are eligible, including those without health insurance coverage, all those who are enrolled in Medicaid, and Native Americans/Alaskan Natives. The program became operational October 1, 1994.

III. Increase community participation, education, and partnerships.

The national outreach program is designed to increase awareness of age-appropriate immunization and expand community participation in the effort to promote proper immunization. Outreach consultants are working with state and local organizations and health officials to enhance and expand partnerships among public and private organizations. In addition, partnerships are being formed with national organizations to involve them with local immunization efforts and help disseminate the message about age-appropriate immunization.

IV. Improve surveillance of vaccination coverage and disease.

Funding has been provided to states to help detect disease so it can be controlled before it leads to epidemics. Immunization coverage will be measured at the national, state, and local levels to monitor progress and detect under-immunized populations. Assessments assist public and private providers to measure immunization levels in populations they serve.

V. Improve vaccines and vaccine use.

A single childhood immunization schedule has been developed. The Initiative will also support research into new vaccines or vaccine combinations. Although available vaccines are very safe and effective, CDC has worked to develop better information to provide parents on the risks and benefits of vaccination.

For more information on the Childhood Immunization Initiative (CII) please contact the CDC toll-free National Immunization Information Hotline, 1-800-232-2522 (English); 1-800-232-0233 (Spanish).

RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE

United States – January 1995

Vaccines are listed under the routinely recommended ages. Shaded bars indicate range of acceptable ages for vaccination.

Age ► Vaccine ▼	Birth	2 mos	4 mos	6 mos	12 ⁵ mos	15 mos	18 mos	4-6 years	11-12 years	14-16 years
Hepatitis B ¹	HB-1	HB-2		HB-3						
Diphtheria, Tetanus, Pertussis ²		DTP	DTP	DTP	DTP or DTaP at 15+ m			DTP or DtaP	Td	
H. influenzae type b ³		Hib	Hib	Hib	Hib					
Polio		OPV	OPV	OPV				OPV		
Measles, Mumps, Rubella ⁴					MMR			MMR or	MMR	

1 Infants born to HBsAg-negative mothers should receive the second dose of hepatitis B vaccine between 1 and 4 months of age, provided at least 1 month has elapsed since receipt of the first dose. The third dose is recommended between 6 and 18 months of age.

Infants born to HBsAg-positive mothers should receive immunoprophylaxis for hepatitis B with 0.5 ml Hepatitis B Immune Globulin (HBIG) within 12 hours of birth and 0.5 ml of either Merck Sharp & Dohme vaccine (Recombivax HB) or of SmithKline Beecham (Engerix-B) at a separate site. In these infants, the second dose of vaccine is recommended at 1 month of age and the third dose at 6 months of age. All pregnant women should be screened for HBsAg in an early prenatal visit.

2 The fourth dose of DTP may be administered as early as 12 months of age, provided at least 6 months have elapsed since DTP3. Combined DTP-Hib products may be used when these two vaccines are to be administered simultaneously. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is licensed for use for the 4th and/or 5th dose of DTP vaccine in children 15 months of age or older and may be preferred for these doses in children in this age group.

3 Three *H. influenzae* type b conjugate vaccines are available for use in infants: HbOC [HibTITER] (Lederle Praxis); PRP-T [ActHIB; OmniHIB] (Pasteur Mérieux, distributed by SmithKline Beecham; Connaught); and PRP-OMP [PedvaxHIB] (Merck Sharp & Dohme). Children who have received PRP-OMP at 2 and 4 months of age do not require a dose at 6 months of age. After the primary infant Hib conjugate vaccine series is completed, any licensed Hib conjugate vaccine may be used as a booster dose at 12-15 months.

4 The second dose of MMR vaccine should be administered EITHER at 4-6 years of age OR at 11-12 years of age.

5 Vaccines recommended in the second year of life (12-15 months of age) may be given at either one or two visits.

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and the American Academy of Family Physicians (AAFP)

VACCINE-PREVENTABLE CHILDHOOD DISEASES

Polio

- Serious cases cause paralysis and death
- Mild cases cause fever, sore throat, nausea, headaches, and stomach aches; may also cause neck and back pain or stiffness
- Polio vaccine prevents this disease

Diphtheria

- Respiratory disease spread by coughing and sneezing
- Gradual onset of sore throat, and low-grade fever
- Membrane in throat can interfere with swallowing and cause suffocation
- Heart failure or paralysis can result if disease is not treated
- Diphtheria toxoid (contained in DTP, DT and Td vaccines) prevents this disease

Tetanus

- Neurologic disease also known as lockjaw
- Bacteria enters the body through a break in the skin
- Produces a poison (toxin) that attacks the nervous system
- Early symptoms are headache, irritability and stiffness in the jaw and neck
- Later, causes severe muscle spasms in the jaw, neck, arms, legs, back and abdomen
- May require intensive care in hospital
- In the U.S., most cases are in adults; 4 out of every 10 tetanus cases aged 20 or older will die from the disease
- In developing countries, tetanus frequently affects newborn babies; more than 500,000 babies died from neonatal tetanus in 1993
- Tetanus toxoid (contained in DTP, DT and Td vaccines) prevents this disease

Pertussis

- Highly contagious respiratory disease also known as whooping cough
- Causes severe spasms of coughing that can interfere with eating, drinking and breathing
- Complications include pneumonia, convulsions and encephalitis
- One out of every 3 cases of pertussis encephalitis will die, another 1 of 3 will have permanent brain damage
- In the U.S., about 65% of reported cases are in children under age 5, and half of those are in infants under 1 year of age
- About 3,500 cases are reported in the U.S. each year
- Pertussis vaccine (contained in DTP vaccine) prevents this disease

Measles

- Highly contagious respiratory disease
- Causes rash, high fever, cough, runny nose and red, watery eyes, lasting about a week

- Causes ear infections and pneumonia in 1 out of every 12 to 15 children who get it
- Causes encephalitis that can lead to convulsions, deafness or mental retardation in 1 to 2 of every 2,000 people who get it
- Of every 1,000 people who get measles, 1 to 2 will die
- Measles vaccine (contained in MMR, MR and measles vaccines) prevents this disease

Mumps

- Causes fever, headache and swelling of one or both cheeks or sides of the jaw
- One out of every 10 who get mumps may get meningitis or encephalitis
- Inflammation of the testicles occurs in about 4 of every 10 adult males who get mumps
- May result in hearing loss, which is usually permanent
- Mumps vaccine (contained in MMR vaccine) prevents this disease

Rubella

- Also known as German measles
- Mild disease in children and young adults, causing rash and fever for 2 to 3 days
- Causes devastating birth defects if acquired by a pregnant woman; there is at least a 20% chance of damage to the unborn baby if a woman is infected early in pregnancy
- Rubella vaccine (contained in MMR vaccine) prevents this disease

Haemophilus influenzae type b (Hib)

- Before the introduction of infant vaccination, 1 child in 200 was affected before age 5
- Causes meningitis, pneumonia, sepsis, arthritis, and skin and throat infections
- More serious in children under age 1; after age 5, there is little risk of getting the disease
- Before 1992, Hib was the most common cause of bacterial meningitis in the U.S.
- One out of 20 children who get Hib meningitis will die and 15 - 30% of survivors will have permanent brain damage
- Hib vaccine prevents this disease

Hepatitis B Virus (HBV)

- Infants born to HBV-infected mothers have up to an 85% chance of getting HBV infection
- HBV infection is spread within families and communities
- Infection at birth or during early childhood can result in long-term chronic illness
- People with chronic infection can develop chronic liver disease and liver cancer
- HBV vaccine prevents this disease

10 THINGS YOU NEED TO KNOW ABOUT IMMUNIZATION

1. "Why should my child be immunized?"

Children need immunizations (shots) to protect them from several dangerous childhood diseases. These diseases have serious complications and can even kill children.

2. "What diseases do vaccines prevent?"

- Measles
- Mumps
- Polio
- Rubella (German measles)
- Pertussis (Whooping cough)
- Diphtheria
- Tetanus (Lockjaw)
- Haemophilus influenzae type b (Hib disease)
- Hepatitis B

3. "How many shots does my child need?"

The following vaccinations are recommended by age two and can be given in five visits to a doctor or clinic:

- 1 vaccination against measles/mumps/rubella (MMR)
- 3-4 vaccinations against Hib (a major cause of spinal meningitis)
- 3 vaccinations against polio (OPV)
- 4 vaccinations against diphtheria, tetanus, and pertussis (DTP)
- 3 vaccinations against Hepatitis B

4. "Are the vaccines safe?"

Serious reactions to vaccines are extremely rare, but do occur. However, the risks of serious disease from not vaccinating are far greater than the risks of serious reaction to the vaccination.

5. "Do the vaccines have any side effects?"

Yes, possible side effects can occur with vaccination: slight fever, rash or soreness at the sight of injection. Slight discomfort is normal and should not be a cause for alarm. Your health care provider can assist you with additional information.

6. "What do I do if my child has a serious reaction?"

If you think your child is experiencing a persistent or severe reaction, call your doctor or get the child to a doctor right away. Write down what happened and the date and time it happened. Ask your doctor, nurse or health department to file a Vaccine Adverse Event Report form or call 1-800-338-2382.

7. "Why can't I wait until school to have my child immunized?"

Immunization must begin at birth and most vaccinations completed by two. By immunizing on time (by age two), you can protect your child from being infected and prevent the infection of others at school or at daycare centers. The young are especially susceptible to disease because their bodies have not built up the necessary defenses to fight infection.

8. "Why is a vaccination health record important?"

A vaccination health record helps you and your health care provider keep your child on schedule. A record should be started at birth when your child should receive his/her first vaccination and updated each time your child receives the next scheduled vaccination. This information will help you should you move to a new area, change health care providers, or when your child is enrolled in daycare or starts school. Remember to bring this record with you every time your child has a health care visit.

9. "Where can I get free vaccines?"

The Vaccines for Children Program will provide free vaccine to needy children. About 60 percent of children are eligible, including those without health insurance coverage, all those who are eligible for Medicaid, and Native Americans/Alaskan natives.

10. "Where can I get more information?"

You can call the National Immunization Hotline for further immunization information at 1-800-CDC-2522 (English) or at 1-800-CDC-0233 (Spanish).

GLOSSARY

Antibody — A specific protein in the blood that is produced in response to stimulation by a specific antigen.

Antigen — A substance "recognized" by the body as being foreign; it results in the production of specific antibodies directed against it.

Encephalitis — Inflammation of the brain substance; usually of viral origin.

Epidemic — Occurrence in the community or region of a group of illnesses (or an outbreak) of similar nature, clearly in excess of normal expectancy and derived from a common or a propagated source.

Fecal-Oral Route — A mode of disease transmission where the infectious agent is excreted in fecal matter and ingested orally. Most commonly the infectious agent is ingested in food prepared by a person who has used the toilet but not washed their hands.

Immune — Having antibodies, therefore being protected from a specific antigen.

Immunization — The act of inducing antibody formation, thus leading to immunity.

Incidence — Number of new events occurring in a defined time.

Meningitis — An inflammation of the lining of the brain.

Prevalence — Number of events present at a single point in time.

Vaccination — Administration of any antigen in order to induce immunity; it is not synonymous with immunization since vaccination does not imply success.

Vaccine — A specifically prepared antigen which upon administration to a person will result in immunity.

Virus — An infectious agent.



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First Draft
For Discussion Purposes Only - 3/3/95

PLAN OF ACTION TO REDUCE MATERNAL MORTALITY IN THE AMERICAS

The social conditions of the majority of women in Latin America have changed only slightly in recent years. Women continue to be affected by preventable problems. Even though public policy addresses women's issues, women still receive little education, information, and health care.

Maternal mortality and morbidity is a serious problem. Every year, 20,000 women die in the hemisphere and at least 3 million are hospitalized from maternal complication--complications that are preventable. Failure to provide women with general as well as reproductive health care affects the health of families and communities, and the well being of the countries themselves. Eleven countries in the Region still have maternal mortality rates over 100 per 100,000 live births compared to less than 4 per 100,000 in USA, Canada. Abortion is estimated at 65 per 1,000 women of childbearing age. Some service infrastructure has been developed, but the quality of health care services shows little improvement.

To cope with these problems and needs, the Ministries of Health of the countries of the Region, during the XXIII Pan American Sanitary Conference in 1990, approved the Regional Plan for the Reduction of Maternal Mortality in the Americas. The accompanying resolution urges the member governments to:

Develop a comprehensive health care policy addressing women and the prevention of maternal morbidity and mortality. This policy must be implemented through the design and execution of national plans that build public awareness, the participation of other sectors, and with proper finances.

Most countries of the Region have National Plans of Action--comprehensive health care policies addressing women and the prevention of maternal mortality and morbidity. Although international institutions and the countries have endorsed the Plans, their endorsement has not brought about the increased allocation of resources needed. Technical cooperation, and to a lesser extent, financial assistance has been modest until now. A mobilization of national and international resources is needed if the Plans are to produce change.

Today, these National Plans need political and financial support. The special attention given to Maternal Mortality and Morbidity during the Symposium of the Children at the Summit of the Americas last December, provides a renewed opportunity to address this very important problem. The involvement of the First Ladies of priority countries of the

Region in this effort, could make these Plans viable by increasing national and international awareness and commitment to this urgent problem that every year results in 20,000 maternal deaths and millions of episodes of illness.

In this context the celebration of an hemispheric or regional conference to reduce maternal mortality and morbidity could be an extremely important step in the fight to conquer this preventable problem.

We recommend sponsoring the Conference in Honduras or Guatemala for at least eleven countries of the Region which have the highest maternal mortality. The objective of this conference is to convince the first ladies to champion at the international and national levels the financial commitment, the cooperation, interdependence, and resource sharing among countries as they work together with international institutions, governments, and nongovernment institutions to improve maternal health. The conference would focus on improving women's health and alleviating one of their most pressing needs: maternal death.

Much accumulated knowledge exists today about ways to reduce maternal mortality and morbidity. Several successful interventions have been developed as solutions to problems related to maternal mortality. The Conference will help spread the knowledge of these interventions:

Strengthen family planning activities to prevent abortion and unwanted pregnancies. Most countries have formulated family planning policies that include this activity in maternal and child health care, but the majority of the countries are not carrying them out.

Improve delivery care in all health centers. Improving maternal health services depends on substantial investment of new resources, or in its absence, finding ways to reassign governmental resources more efficiently.

Improve the coverage and quality of prenatal care. Countries indicate interest in increasing the coverage and quality of care. However, they must go beyond putting women in touch with the health services. They must follow through with good care that diminishes risks.

Implement alternative health care models. Countries of the Region have had success with maternity waiting homes, birthing centers, and clean delivery at home. These low cost alternatives should be promoted using community participation and management.

Develop human resources. Health care providers at all levels must be trained not only for basic but for intermediate and advanced care. Moreover, local health systems must be restructured so that providers, after they are trained, are permitted to apply their new skills and improve the quality of service offered.

Improve the epidemiological surveillance of maternal deaths and basic reproductive health statistics. Adequate information systems are need to improve maternal care. Countries must commit to them.

Mobilize financial resources for identifying. Strategies for finding internal and external funding must be developed. Countries must also be more creative in finding ways to use their funds more effectively.

The conference will provide a forum for discussing these issues. Country representatives will bring to the participants updates on the progress of their country's National Plan: what is being done at present, what is planned for the future, which problems remain difficult to solve, what help needs to be provided.

The year 1995 marks the tenth anniversary of the Safe Motherhood Initiative, an outgrowth of the 1985 Nairobi Conference. It is also the fifth anniversary of the approval of the original Regional Plan for the Reduction of Maternal Mortality in the Americas, approved by the Ministers of Health at the 23rd Panamerican Sanitary Conference. The Conference for Reduction of the Maternal Mortality will be an important milestone on the efforts to bolster commitment to maternal health. Our desire is that the First Ladies would lead their countries in this campaign to achieve health for mothers, the cornerstone of our societies, the keys to stability and well being in our culture.

Time Table: March - October 1995 (see attached table)

Preparatory activities for the period March-October 1995 have already begun and by July 1995 the evaluation report on how the Plan of Action has performed in the last five years will be ready for publication and distribution. In the interim, several publications developed by PAHO/AID will be distributed among the priority countries.

By April 1995, the Scientific Technical Advisory Committee for the Reduction of Maternal Mortality will meet in Atlanta, Georgia (CDC) and will make recommendations based in the regional evaluation for the development of an updated Plan of Action for the year 2000. Countries will develop their national reports and these will be published by July 1995 with PAHO and AID support.

Concerning the participation of The First Ladies in these efforts, it is expected that The White House, (Mrs. Clinton's Office), will send letters in early April to her counterparts, encouraging their involvement and cooperation to create national partnerships to reduce maternal morbidity and mortality, initiate actions and prepare for the Conference. The Conference to be held late August-early September will last three working days and after it, PAHO/AID will be supporting the development of revised National Plans of Action for the period 1995-2000. The preliminary calculation of costs for a 5-year period will be developed, and costs will be born jointly by the countries, bilateral and multilateral agencies.

take goal
9/5/95
what's
been
done
jump to
2nd
half?
Campaign

consider
launch in
Oct at
summit

In April
agree on
revised plan

Finally, progress on the implementation of the reduction plans will be reported by The First Ladies at the First Ladies' Summit in Paraguay, in October 1995.

The estimated cost for the initial process is \$325,000 US. PAHO will request its administration for a grant of \$60,000. The U.S. government/AID is expected to contribute approximately \$265,000. Invitations will be made to other international agencies. If they respond positively, PAHO and USAID funding would then be less.

(first draft - for discussion only)

PLAN FOR THE REDUCTION OF MATERNAL MORTALITY IN THE AMERICAS

TIMETABLE AND ESTIMATED BUDGET (Period March-October 1995)

Acti- vity	Description	Date	Funded by	Estimated need for new funds
A	Letter from the USA First Lady Mrs. Clinton to her counterparts	April	PAHO/CDC	**
B	Support to promotional activities by First Ladies at national level (27 countries)	May-June	PAHO/AID	US\$ 95,000
C	Data collection for evaluation of the Regional Plan of Action	April	PAHO	**
D	Data Analysis and report published	July	PAHO/AID	30,000
E	Technical and financial support for national evaluation and publications	July	PAHO	30,000
F	Scientific Technical Advisory Committee	April	PAHO/CDC	**
G	Development of 4 supporting documents	June	PAHO/AID	30,000
H	Drafting and updating Plan of Action	July	PAHO	**
I	FIRST LADIES' REGIONAL CONFERENCE (48 PAID PARTICIPANTS)	August/September (1st. Week)	AID/PAHO	90,000
J	Completion of revised National Plans for Action at country level	July	PAHO/AID	25,000
K	Report to the Paraguay First Ladies' Meeting	November	PAHO	**
K	Immediate follow-up actions	1995-1996	PAHO/AID	25,000
	TOTAL			US\$325,000

** Already funded



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

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IN REPLY REFER TO:

DRAFT

ELIMINATION OF INDIGENOUS TRANSMISSION
OF MEASLES OF THE AMERICAS
1996-2000

PLAN OF ACTION

FEBRUARY 1995

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PREFACE

Resolution XVI, approved by the Ministers of Health of the Region of the Americas, during their meeting of the XXIV Pan American Sanitary Conference, that met in Washington, D.C. in September 1994, set the target of measles elimination from the Western Hemisphere by the year 2000.

This decision builds on the remarkable completion of the initiative to eradicate poliomyelitis from the Americas and several successful national or multi-country initiatives to eliminate measles.

In 1987 Cuba launched the first measles elimination initiative in the Hemisphere. This was followed in 1989 by the countries of the English Speaking Caribbean and subsequently by several other Latin American countries. United States and Canada also have national targets for measles elimination. By November 1994, all Latin American countries had implemented strategies to eliminate measles, either individually or in multi-country cooperation and more than 80% of the children (9 months to 15 years of age) in the Region had received a dose of measles vaccine regardless of their previous vaccination status. Measles incidence, therefore, reached an all time low in the Region.

In 1985, the Director of the Pan American Health Organization appointed a Technical Advisory Group (See Appendix V) to advise the Organization on the acceleration of the Expanded Program on Immunization and the eradication of the indigenous transmission of wild poliovirus in the Americas in 1985. This group is presently composed of the following seven members:

-Dr. José Manuel Borgono
Chief, Office of International Affairs
Ministry of Health
Santiago, Chile

-Dr. Donald A. Henderson
Science Advisor
Department of Health and Human Services
Washington, D.C., USA

-Dr. Alan Hinman
Director, Center for Prevention Services
Centers for Disease Control
Atlanta, Georgia

-Dr. Joao Baptista Risi, Jr.
Advisor on Science and Technology
Ministry of Health
Brasilia, Brazil

-Dr. Hilda Alcala
Department of Neurology
Children's Hospital
Mexico City, Mexico

-Dr. Peter Figueroa
Principal Medical Officer
Epidemiology
Ministry of Health
Kingston, Jamaica

In August, 1994, at its XIth meeting held in Washington, D.C., the PAHO/EPI Technical Advisory Group (TAG), recommended that "these national measles elimination initiatives would be greatly enhanced if a regional measles elimination initiative was launched in a coordinated effort".

This recommendation was then endorsed by the XXIV Pan American Sanitary Conference in September, 1994.

The proposed Plan of Action for the coordinated Regional initiative to eliminate indigenous transmission of measles from the Western Hemisphere is contained in the following pages.

1. INTRODUCTION

The Expanded Program on Immunization (EPI) has its basis in resolution WHA 27.57, adopted by the World Health Assembly in May 1974. General program policies, including the EPI goal of providing immunization services for all children of the world by 1990 (resolution WHA 30.53, 1977) were endorsed by resolution CD 25.27 of the Pan American Health Organization (PAHO) Directing Council in September 1977.

The long-term objectives of the EPI are to:

- reduce morbidity and mortality from diphtheria, whooping cough, tetanus, measles, tuberculosis and maintain the eradication of poliomyelitis by providing immunization services against these diseases for every child in the world by 1990 (other selected diseases may be included when and where applicable);
- promote countries' self-reliance in the delivery of immunization services within the context of comprehensive health services; and
- promote regional self-reliance in matters of vaccine production and quality control.

Supporting EPI long term objectives are goals set for in the Plan of Action for implementing the World Declaration on the Survival, Projection, and Development of Children on the 1990s. The EPI in the Americas has met the goals set forth in the World Summit for Children in relation to the goals of the elimination of Neo-natal Tetanus and morbidity/mortality due to measles.

2. EXECUTIVE SUMMARY

On September 29th, 1994 the International Commission for the Certification of Poliomyelitis Eradication declared that the Region of the Americas was certified as being polio-free. The last case of poliomyelitis caused by the indigenous wild poliovirus was detected in Junin, Peru in August of 1991. The Region now has entered a new era: The maintenance phase, which requires the continuation of surveillance of all cases of Acute Flaccid Paralysis in children under 15 years of age and that vaccine coverage level with OPV(3) be kept at 80% or better.

The Region has already met the goal of the elimination of Neo- Natal Tetanus established by WHO of less than 1 case per 1000 live births.

Because of the measles initiatives undertaken by the different countries in the Region and the dramatic success that the strategy has had on the incidence of measles, the Ministers of Health of the Region voted to eliminate the transmission of measles by the year 2000.

The purpose of the project is to support elimination of the transmission of measles in the Western Hemisphere by the year 2000.

The strategy calls for: the expansion of the current surveillance system, used so successfully for the eradication of polio to include rash and fever surveillance for the detection of possible measles cases; aggressive outbreak response; the achievement and maintenance of 90% measles vaccine coverage; and

intensive social mobilization of NGOs and community groups for supporting the effort and for enhancing the community's responsibility for the prevention of disease in their communities.

Previous research has shown that the polio eradication effort had many positive outcomes, one of them being the increased awareness of the benefits of immunization and the importance of preventive health care. Therefore, it is expected that the measles elimination effort will build on this by internalizing the value of preventing diseases through immunization.

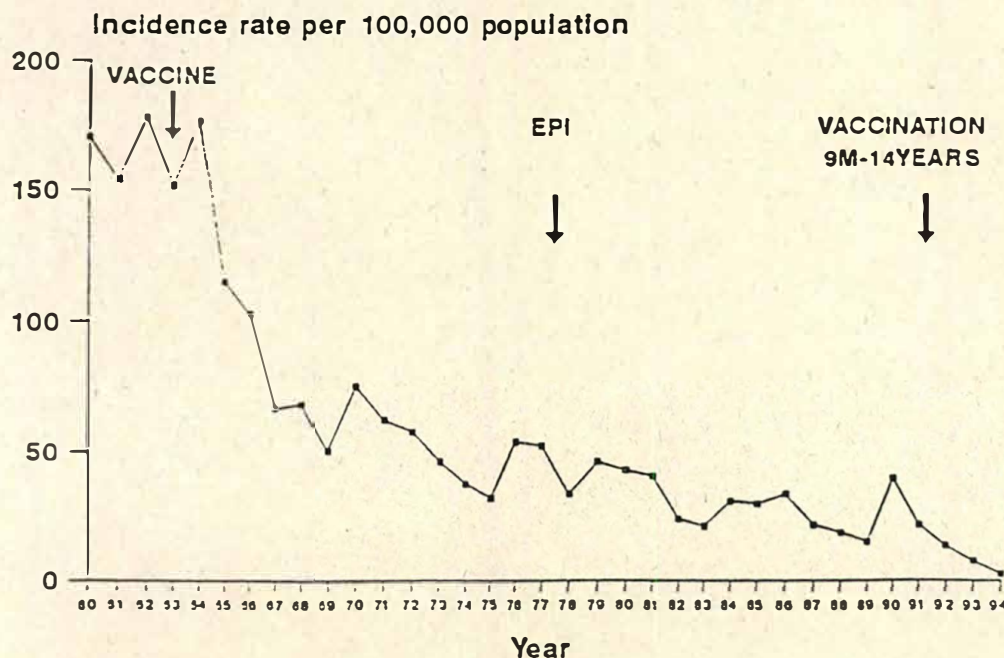
The project has a duration of five years and will cost an estimated \$45.8 million dollars, with PAHO/WHO providing an additional \$6,500,000 above the requirement amount from its regular budget.

3. PROJECT DATA

Since the EPI was launched in the Region of the Americas in 1977, immunization coverages have improved considerably. In 1978, less than 10% of the children under one year of age lived in countries where coverage with the EPI vaccines was at least 50%; by 1993, nearly 80% of the children in this age group lived in countries with coverage of at least 75% for DPT and BCG vaccines, and of over 80% for polio and measles vaccines.

The impact of the high coverage with measles vaccine and the national measles elimination campaigns can be seen in Figure 1, which shows the annual reported incidence of measles in the Region of the Americas during the period 1977-1993, and in Figure 2, which shows the absolute number of cases reported each year during the same period.

Figure 1. Annual reported incidence of measles
(per 100,000 population), Region of the Americas, 1960-1994*

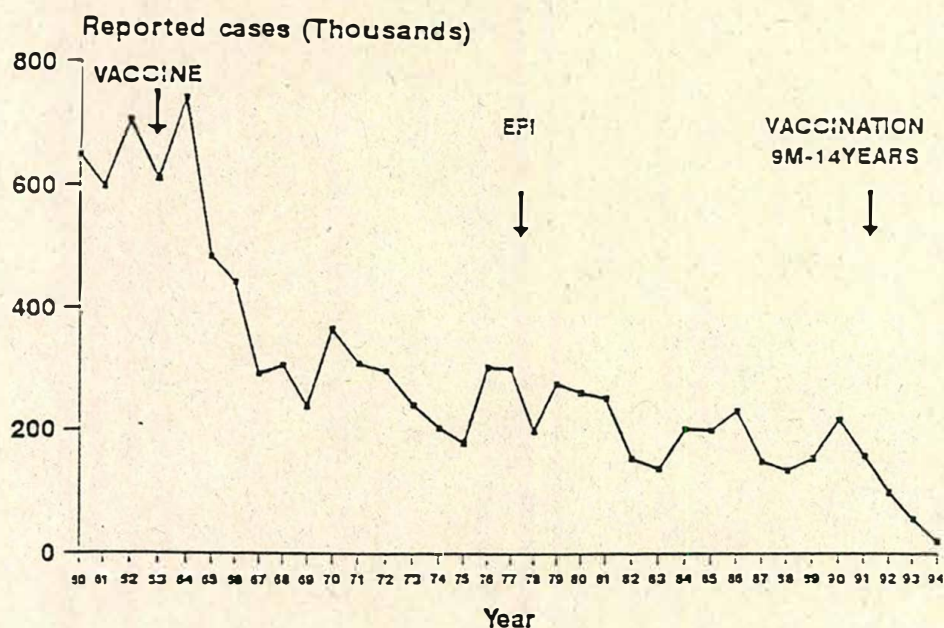


Source: PAHO

*1994 data provisional as of 27 Jan 1995

Figure 2. Annual number of reported cases of measles,
Region of the Americas, 1960-1994

Number of measles cases notified
Region of the Americas, 1960 - 1994*



Source: PAHO

*1994 data provisional as of 27 Jan 1995

Table 1 gives a breakdown of the annual number of reported cases by country between 1977 and 1993. By November 1994, three years had elapsed without measles cases in Cuba and the English speaking Caribbean and two years with no confirmed cases in Chile. During 1994, no importation of

Table 1. Annual number of measles cases, by country.
Region of the Americas, 1983-1994

Country	1983 Cases	1984 Cases	1985 Cases	1986 Cases	1987 Cases	1988 Cases	1989 Cases	1990 Cases	1991 Cases	1992 Cases	1993 Cases	1994 Cases	Total
Bolivia	2,324	1,270	257	144	387	1,793	469	820	2,128	4,337	3,391	0	17,622
Colombia	13,299	12,849	5,572	5,180	20,420	14,101	12,394	12,520	12,392	7,376	9,105	525	124,224
Ecuador	2,556	6,379	1,183	839	1,537	1,234	3,649	1,681	1,812	4,354	3,627	0	26,022
Peru	7,613	13,329	9,393	6,399	6,340	5,795	1,245	418	1,401	22,252	855	0	74,246
Venezuela	11,263	22,832	21,394	14,026	19,262	22,339	10,160	9,862	15,273	12,349	20,244	0	253,223
Brazil	58,239	80,875	75,393	129,126	66,372	26,279	22,853	61,435	42,537	7,334	5,830	15	577,228
Chile	11	4	7	124	224	74	3	23	7	12	2	0	489
Costa Rica	39	12	1	4,334	4,304	158	33	76	6,296	2,261	273	7	17,733
El Salvador	2,407	4,775	1,413	278	405	78	0	0	3	539	37	0	12,811
Guatemala	2,762	3,972	2,372	1,650	400	182	2,413	8,819	209	97	17	204	22,297
Honduras	1,148	5,328	6,476	603	977	619	5,353	8,360	95	58	13	1	28,752
Nicaragua	122	153	956	2,550	792	314	0	3	3	2,332	139	3	7,752
Paraguay	951	158	4,295	4,199	1,885	178	102	1,891	2,430	145	90	3	17,270
Panama	24	3	0	0	0	2	7	15	1	3	0	0	25
Antigua	10	1	1	0	0	0	0	0	0	0	0	0	12
Barbados	2,464	16	26	85	42	23	59	72	0	0	0	0	2,622
Bermuda	6	5	7	2	2	1	2	51	2	0	0	0	78
Cayman Islands	9	5	4	2	3	1	5	0	0	0	0	0	29
Dominica	1	188	64	45	82	10	9	13	6	0	0	0	439
French Guiana	2	0	0	0	0	0	0	0	0	0	0	0	2
Grenada	168	12	7	20	6	4	2	6	2	0	0	0	226
Guadeloupe	0	0	0	0	0	0	0	0	0	0	0	0	0
Jamaica	20	294	87	15	22	317	12	1	12	0	0	0	1,279
Maricao	1,164	136	67	30	17	30	5,724	3,651	109	9	0	0	12,299
Martinique	0	0	0	0	0	0	0	0	0	0	0	0	0
Montserrat	0	0	0	0	0	0	0	0	0	0	0	0	0
Netherlands Antilles	0	0	0	0	0	0	0	0	0	0	0	0	0
Saint Kitts and Nevis	556	2	27	22	22	12	12	80	0	0	0	0	722
Saint Lucia	71	13	9	32	4	4	19	30	2	0	0	0	175
Saint Vincent	63	15	5	2	1	13	1	1	3	0	0	0	98
Suriname	17	40	110	37	5	68	0	35	10	0	0	0	322
Trinidad and Tobago	2,192	3,556	1,549	2,643	441	388	2,170	511	141	0	0	0	13,108
Turks and Caicos	100	6	2	0	0	0	0	2	8	0	0	0	128
British Virgin Islands	6	0	0	0	0	0	162	90	0	0	0	0	264
U.S. Virgin Islands	0	0	0	0	0	0	0	21	0	0	0	0	21
Uruguay	3,287	3,115	2,474	3,312	858	121	12	12	17	12	2	0	13,122
Dominican Republic	2,760	4,429	4,417	501	499	692	1,505	3,477	7,512	7,650	4,637	3	28,282
Haiti	469	2,681	2,112	269	3,230	235	580	1,414	0	0	0	0	12,239
Puerto Rico	0	0	0	0	0	0	0	0	0	0	0	0	0
Mexico	3,168	5,158	23,826	9,824	2,776	3,915	20,381	68,782	5,377	533	169	101	143,310
Canada	0	0	0	0	0	0	0	1	2	0	0	0	3
United States of America	924	4,379	2,816	15,116	2,385	611	11,145	1,033	6,364	2,361	187	503	48,293
Argentina	7,104	21,751	9,240	6,448	6,890	4,816	4,009	1,367	42,393	20,551	5,048	65	143,364
Chile	6,752	4,785	17,101	12,563	2,621	45,279	13,008	1,358	2,098	397	1	0	125,165
Paraguay	1,259	979	666	610	1,742	755	150	1,396	471	864	2,066	122	12,280
Uruguay	18	152	160	198	1,190	76	20	110	2,040	187	16	0	4,257
Total	136,928	200,182	196,328	221,167	146,163	123,403	118,369	218,327	158,185	100,343	56,259	2,480	1,133,734

This impressive, rapid reduction in the disease burden resulting from increased coverage with the measles vaccine and its massive utilization has paved the way for the decision to eliminate indigenous transmission of measles the American Hemisphere by the year 2000.

In keeping with this, on 29 September 1994 the XXIV Meeting of the Pan American Sanitary Conference approved Resolution XVI setting the target of elimination of indigenous transmission of measles in the Americas by the year 2000.

PAHO has emphasized that activities related to the eradication of diseases preventable by immunization must be considered within the context of the national immunization programs.

immunization must be considered within the context of the national immunization programs.

4. PROJECT GOAL

Therefore, the proposed Plan of Action has as its goal:

a) To promote the overall development of the Expanded Program on Immunization in the Region, to speed up the attainment of its objectives.

5. PROJECT PURPOSE

a) To eliminate indigenous transmission of measles in the American Region by the year 2000.

6. PROJECT OUTPUTS

The expected outputs for the project are:

6.1 Elimination of the indigenous transmission of measles by the year 2000.

6.2 Increase EPI vaccine coverage (DPT/Measles/OPV/BCG) to 95% in children < 1 year of age.

6.3 Catch-up campaign carried out in selected countries which have built up a large group of susceptible capable of sustaining measles transmission.

6.4 80% of women, in child bearing age living in high risk areas, will have been vaccinated with 2 doses of T.T. vaccine.

6.5 All countries will incorporate the weekly routine surveillance of fever and rash illnesses from at least 50% of all health establishments into their disease surveillance system.

6.6 Computerized Rash and Fever Illness surveillance software installed all countries for collecting, and analyzing suspect measles cases.

6.7 All countries will develop annual country work plans which show the cost of the different EPI activities by type of cost and source of funding.

6.8 Updated norms and manuals which reflect the development of new vaccine technologies and improved methods for disease control.

6.9 Regional laboratory network for supporting the processing of samples for measles diagnosis.

6.10 Laboratory training manual and trained staff at Regional laboratory network in the latest techniques for measles diagnostics.

6.11 Information exchange meetings of EPI managers: a minimum of 24 sub-Regional meetings and 6 Regional Meetings during the life of the project.

7. STRATEGIES AND TECHNICAL COMPONENTS

The primary prerequisite to achieve the stated objectives will be the level of national political commitment, as expressed by:

- *Approval of the Plan of Action by the Directing Council of PAHO;
- *Availability and allocation of national resources for the effort.
- *Legislative action by member countries, whenever necessary; and,
- *Availability of international resources to support the regional and national initiatives.

In order to meet the goal of elimination of indigenous transmission of measles in the Americas by the year 2000, it will be necessary to intensify all components of the EPI strategies presently being implemented and to adapt many of the EPI approaches. Other essential elements are coordination of international agencies at the Regional and country levels, and availability of sufficient funds from both national and international sources to cover all activities related to this goal.

The key strategies to be adopted in this effort are:

1. Mobilization of national resources supported by international resources where necessary;
2. Achievement and maintenance of vaccine coverage of greater than 95% of the target population in every district of each country and catch-up of older age groups of susceptible in countries that build up a cohort of susceptible;
3. Catch-up campaign carried out in selected countries which have built up a large group of susceptible. since 1994, capable of sustaining measles transmission.
4. To expand the Regional surveillance system that was put in place for polio eradication, to include surveillance of fever and rash illnesses at regional and national levels, so that all suspected cases of measles are immediately investigated and appropriate control measures to stop transmission are rapidly implemented.
5. Laboratory diagnostic services available to all countries, to permit laboratory studies of all reported cases of febrile rash illness that are suspected of being measles;
6. Information dissemination within countries and throughout the Region;
7. Identification of research needs with subsequent funding for execution;
8. Development of a certification protocol to declare the countries and the Region free of indigenous transmission of measles ; and

9. Reduce missed opportunities in all countries that can provide DPT(1) to 90% of the target population but experience drop-out factor of 15% or more.

10. Evaluation of all on going program activities.

For each of the key strategies, a series of technical components/activities are recommended to ensure their success.

8. PROJECT ACTIVITIES

8.1 Mobilization of Country Resources

Recognizing the limited resources available within the Ministries of Health in many of the countries, it will be crucial to concentrate efforts on the mobilization of all country resources to complement those available.

To this end, inter-sectorial coordination and NGO collaboration will be essential to estimate the potential of existing resources and to mobilize the necessary additional resources. The education and agriculture sectors, social security and other organizations will be essential elements in this endeavor.

Finally, communities and community groups will be called on to collaborate and add their resources and talents towards the achievement of the objective. Private voluntary organizations, NGOs, religious groups, and mass media organizations will also be tapped to assist in promotional activities, distribution of supplies and personnel and participation in vaccination activities. Cooperative strategies will be developed for combined actions of several countries and technical cooperation between countries for purposes of planning, implementation and evaluation of programs, particularly in the areas of outbreak investigation and control, as well as laboratory support.

8.2 Immunization Activities

The first essential requirement of the strategy will be to achieve and maintain an immunization coverage among children of at least 95% with potent measles vaccine in every district of every country. Given that all countries have already implemented the mass vaccination with measles vaccine of all children between 9 months and 14 years of age, it is recommended that the age for primary vaccination be at 12 months of age, therefore the primary target age group will be children 12-15 months of age.

The second essential requirement of the strategy will be the identification of all districts with immunization coverage of less than 60% with the EPI antigens. These districts will be labeled as "high risk" districts and will be targeted in the National Work Plan for receiving additional resources.

The third essential requirement is to reduce missed opportunities to vaccinate children when they visit a health establishment for other health care purposes. Countries which can not achieve 90% percent coverage in the target population by 1998, will be ask to evaluate the districts which account for large proportion of the missed opportunities and develop the necessary interventions to correct the problems.

Because many of the cases are now occurring in school age children, countries will be urged to pass legislation making complete vaccination with DPT, Polio and Measles vaccines mandatory vaccination for school entry.

In addition, to the routine vaccination of children, there will be special activities directed at interruption of transmission of measles virus through the achievement of vaccination of 95% of the susceptible population. Therefore, "Catch Up " campaigns may be necessary in selected countries in order to not only prevent an explosive outbreak but also to prevent measles transmission from continuing.

During 1991- 1994, the catchup stage of vaccination activities (vaccination of identified susceptible) all individuals less than fifteen years old were vaccinated. Recognizing that in the early years of EPI activities there may have been deficiencies in the cold chain and also recognizing that there may have been diagnostic errors, all individuals in this age group were vaccinated, irrespective of their vaccination history or reported history of measles infection in prior years.

The success of this strategy required intensive planning of the logistics of both supply and demand. The use of the mass media and professional advertising firms to sell the concept of "measles elimination" and vaccination of older individuals was encouraged. Mobilization of all resources, both intra- and extra-sectorial, and participation of non-governmental sectors in these efforts were essential for success. It is expected that these innovations will be continued with immediate concentration of efforts on the routine vaccination of the childhood population.

8.2.1 Vaccination Tactics

The vaccination tactics recommended to maintain high level of vaccination coverage in all children that complete 12 months of age in every district of every country will vary depending upon each country's level of existing vaccination coverage and health infrastructure.

National immunization days, to be held at least twice a year, will be recommended for countries in which their established health system does not reach all its population. Their success will require intensive planning of the logistics of both supply and demand. The use of the mass media and professional advertising firms to sell the concept of vaccination will be encouraged. Mobilization of all resources, both intra- and extra-sectorial, and participation of non-governmental sectors in these efforts will be essential for success. This tactic should be viewed as an ad hoc measure, to be gradually replaced by regular immunization services performed routinely by health services.

Advantage should be taken of the national immunization days to administer DPT and polio vaccines, as well as Tetanus Toxoid for women of childbearing age in the areas at risk for neonatal tetanus.

As the measles vaccine is not 100% efficacious, even with a very high level of coverage there will be a build up of susceptible in the new cohorts of children, which could fuel an outbreak should the measles virus be introduced. It will be therefore necessary to implement periodic campaigns targeted at eliminating this pool of susceptible. The periodicity and target age group for these periodic "catch-up" campaigns will be determined by epidemiological and coverage data.

8.3 Logistical support

All countries should ensure that the vaccines used in the program meet WHO requirements. Vaccine distribution will be a key component of immunization activities. Efficient distribution systems will be essential to ensure that vaccines are available at the delivery points on the scheduled days. To assist countries in the management of their stocks of vaccines and cold chain equipment, PAHO will introduce warehouse management software to those countries that have problems in managing their stocks of vaccine, supplies, and cold chain equipment and will have requested PAHO's assistance in this matter.

To guarantee that immunization activities will not be interrupted, a stockpile of vaccines will be maintained at the Regional level for use in case of emergency. Manufacturers will be requested to have 10 million doses on hand for emergency use at all times. PAHO will oversee the inventory of these emergency stocks and allocate distribution when needed. Countries are expected to order vaccine supplies as needed on a routine basis, either through the PAHO Revolving Fund for Vaccine Procurement or their own purchasing mechanisms.

PAHO will provide technical cooperation and will also use project funds to provide temporary consultants for assisting countries in identifying equipment needs for solving cold chain deficiencies. As each country prepares its National Work Plan, these cold chain deficiencies and needs will be identified in them. Cooperation from donor agencies should include the procurement and maintenance of necessary cold chain equipment. To address the recognized problems with cold chain equipment maintenance, countries will be encouraged to design cold chain systems that rely upon low-maintenance equipment.

8.4 Training

There will be a major emphasis on training personnel in the additional components of program operations critical for success. To assist in this endeavor, PAHO will ensure that the field guide on the technical basis of measles elimination is broadly available in all member countries. This field guide will serve as a prototype for countries to produce country-specific field guides adapted to local circumstances. PAHO will use project funds to provide temporary technical assistance to the countries for the adaptation of the field guide and for its production and distribution, as well as for the planning and execution of training courses as needed.

As new cold chain technologies become available, such as vaccine heat indicators that will permit that vaccines are taken out of the cold chain and transported without ice until used, PAHO will use project funds to prepare materials for training health care workers in the use of these technologies in order to assure that vaccines remain potent.

8.5 Social Mobilization

In many of the countries, measles is still considered to be a normal childhood occurrence and when the diagnosis is suspected by the mother, the child is kept at home, without seeking the assistance of the health sector. In order to stimulate reporting of the disease, education of the population with respect to the importance of the health sector knowing the existence of measles as soon as possible will be a primary goal. The mass media will be used for this purpose. Families, neighbors and school teachers will be encouraged to report suspected cases to the health sector as early as possible. PAHO, therefore, will use project funds to develop prototype public service announcements, as well as written materials for distribution to the countries for them to adapt or use.

PAHO will also collaborate with all institution in the health sector and with NGOs in all countries to prepare local health education materials and to involve NGOs in social mobilization activities. PAHO will also work with local NGOs in each country to determine the different methods that the community can be mobilized to support disease surveillance and improve preventative health education messages regarding childhood immunizations.

8.6 Epidemiological Surveillance and Outbreak Control

In view of the relatively small number of cases being reported annually in the Region, it is urged that every suspected case be investigated. This is one of the most critical components of the elimination effort. Case and outbreak investigation should be carried out according to the definitions set out in the field guide referred to in section 2.2.4. For operational purposes, the following provisional definitions are proposed:

-Suspected measles case: Any illness with a rash and fever.

-Probable measles case:

- a) Generalized macular-papular rash of 2-3 days duration.
- b) Fever (101°F).
- c) One of the following: cough, coryza or conjunctivitis.

-Confirmed measles case:

Meets the case definition and is epidemiologically linked to another confirmed or probable case or is serologically confirmed.

Confirmed cases will also be classified as indigenous or imported. In the situation of imported cases, cases will be further identified by generation following importation.

8.6.1 Case identification and reporting

Surveillance will be both active and passive. All potential sources of notification of suspected cases of measles in the countries will be contacted and incorporated in the surveillance activities. Weekly calls to all outpatient facilities that might see acute cases should be considered as part of the surveillance mechanism. The types of facilities to be called include: all acute care hospitals (public and private, general and specialized) and outpatient units at the facilities. Once suspected cases are identified, thorough community investigations for additional cases and routes of transmission will be conducted. Each country will telex/fax to PAHO weekly reports of probable and confirmed cases of measles.

Proper containment actions should be taken to prevent spread of measles in the event of a probable case or cases occurring. This will require the immunization of contacts within the population. In addition, a geographical area around the case or cases should be demarcated and containment vaccination performed among the identified target age group. Even those with documentary proof of immunization or history of measles in the past should not be excluded from containment vaccination. The area for containment activities should be determined by an experienced epidemiologist or health worker with a view of preventing the disease from further spread to other communities. It must be borne in mind that some children in the containment area could be incubating the disease during the containment vaccination. A health education message will have to be built into the containment action to make it clear that children immunized during the incubation period will not be protected from measles so that the health workers do not lose credibility.

In the event of an outbreak, defined as one or more probable or confirmed cases, all countries in the subregion will be notified immediately through telex from PAHO/Washington, so that traveller's advisories

can be issued.

PAHO will use project funds to contract international expert personnel are available to help strengthen epidemiological surveillance in the subregion. These personnel will be made available to assist countries in developing or improving surveillance activities in all countries, and to review case records of other diseases included in the differential diagnosis of measles, such as dengue, rubella and roseola.

Another key element in the reinforcement of measles surveillance will be to include key private sector medical doctors. They are often one of the first health related authorities to see a possible case of measles. This is important, as the private sector is a significant provider of health care in many countries of the Region. Therefore, obtaining their participation will be essential. The project will use meeting and direct mailing for contacting and informing them. To determine the best methods for incorporating the private medical doctors, PAHO will use project funds to conduct operational research on incorporating the private sector in public surveillance activities.

Laboratory surveillance of febrile rash illnesses will be a critical activity. PAHO personnel will be available to assist in confirming the validity of the reports. These personnel will also be available to assist in performing evaluations of facilities that are likely to see measles cases, following up reported febrile rash illnesses to ensure the appropriate collection of specimens for laboratory studies, and instituting the reward mechanism for cases found.

In countries where transmission appears to have been interrupted, monetary rewards may be offered to individuals finding a case of measles. PAHO personnel will be available to assist in confirming the validity of the reports. These personnel will also be available to assist in performing evaluations of facilities that are likely to see measles cases, following up diagnosed cases of measles and instituting the reward mechanism for cases found.

8.6.2 Outbreak investigation and control:

The good foundation of a proper surveillance system is the immediate investigation of suspect measles cases. This is one of the most critical components of the elimination effort, and for this purpose adequate means of communication and transport facilities will be provided for logistical support as subsistence allowance. Detailed standardized case investigation forms will be designed and implemented. For operational purposes, the definition of an outbreak is the occurrence of one probable or confirmed case of measles. Upon identification of a probable or confirmed case, the Ministry of Health should make an official announcement alerting all health personnel and the general population to the situation in order to increase public awareness of the need for immunization, and the need to report all suspected cases promptly. PAHO should also be notified immediately.

Once a case is identified prompt control action is needed which requires administrative decentralization of the decision-making process and of the monies. The project will provide at country level the funding necessary to carry out those activities in the most timely manner.

PAHO will offer technical assistance and when necessary use project funds to offer assistance in case investigation and outbreak control by providing investigation teams which will be mobilized within 24 to 48 hours of notification or a case to participate in the investigation of the outbreak, the search for additional (secondary) cases, and implementation of control measures. Thorough investigations into the source of the cases will be conducted.

Adequate stocks of Measles vaccine must be available to the countries to mount control measures immediately. The control measures will aim to provide Measles vaccine to all persons defined as at risk. Due to the rapid and extensive transmission of the measles virus, immunization is recommended not just of the surrounding neighborhood, but also of a wider area. In some of the smaller island countries, country-wide vaccination efforts may be indicated.

Part of outbreak investigation and control will be the rapid identification of measles virus in the community. Upon identification of a probable case, specimens will immediately be collected and sent to the nearest laboratory for serologic studies. In addition, the probable epidemiological classification of the case (indigenous vs. imported) will be determined within 24-48 hours of notification. Measles elimination related surveillance activities will be tagged onto the ongoing acute flaccid paralysis surveillance activities in each of the countries in the Region.

Reports on all outbreaks and case importations will be published and disseminated. When intra-regional importation has occurred, the country of origin of the case will be notified and an investigation team will be available to assist in the investigation.

8.7 Laboratory Support

8.7.1 Support to surveillance activities

A major component of surveillance activities will be laboratory confirmation of probable cases of measles. All probable cases will have specimens collected for serological studies. A Regional network of 7 to 8 laboratories will be created to work in close collaboration and participation with the national laboratories in the serological studies and testing of suspected measles cases. The Regional network of labs will monitor the quality of the work performed by the national laboratory in each country through proficiency testing. The close involvement of the laboratories in the epidemiological evaluation process is imperative. If clinically and epidemiologically compatible cases of measles are identified but serologic studies are either negative or inconclusive, original specimens will be sent to reference laboratories for further study.

8.7.2 Laboratory evaluations:

All countries should have access to laboratory facilities for measles serology studies. PAHO will use project funds to provide laboratory access to all countries for processing of specimens. The project will support a team of internationally recognized virologists who will work under the auspices of PAHO, with the identified laboratories in the Region to ensure standardization of the serological work conducted. Studies on the best serologic tests to be used for confirmation of the acute infection will be conducted by PAHO with project funds. Ideally, Elisa IgM studies will be the most cost effective studies for use as they may permit confirmation of recent measles infection with a single serum specimen taken two weeks following onset of the rash. This process is now being implemented in several of the laboratories of the network.

However, it is critical that a simplified serological test that can be used in the field be developed immediately to facilitate surveillance activities. PAHO will use project funds to support research institutions that are working towards the development of such simplified test.

8.7.3 Development of Regional Laboratory Network:

In keeping with the general PAHO policy of developing networks of national institutions for technical cooperation among developing countries, the Regional laboratory network created for the polio eradication effort will be strengthened to address the issues related to measles diagnosis. This will involve strengthening the necessary logistics system for both the transport of specimens and the distribution of necessary supplies such as reagents.

Therefore, PAHO will use project funds to provide a continual supply of standardized reagents for the serologic studies. The CDC in Atlanta and LCDC in Ottawa will be requested to assist in the strengthening of the laboratory network and to certify laboratories as reference centers.

For countries without laboratories, reference laboratories will be identified for their assistance. The reference laboratories will assist countries to develop in-country virology support. The reference laboratories will confirm the results of the country laboratories. A regional laboratory supervisory system, using project funds, will guarantee consistent, high quality testing and reliability of results.

As part of the development of the laboratory network, a manual will be produced covering: tests to be performed on all suspected cases, testing procedures, appropriate specimens, methods of collection of specimens, shipping procedures, handling of specimens, quality control procedures, data collection and data processing. This manual will be ready by July 1995 and will be distributed to all participating laboratories.

Almost all countries will require that their national staff in their laboratories be trained in measles diagnostic testing. With project funds, PAHO will address these training needs at the various levels through the development of a workshop for participating laboratory personnel in the network. The first course will be held by August 1995.

In addition, to the laboratory studies related to surveillance, there is a need to develop further laboratory support for potency testing of vaccines. This activity will be designated to the Vaccine Quality Control network laboratories designated by the Regional System for Vaccines (SIREVA), which will be used as reference centers for testing of vaccine potency.

8.8 Information Dissemination

8.8.1 Publications

At the Regional and sub-Regional levels, the PAHO EPI Newsletter and the CAREC Surveillance Report will contain a section on measles in all issues. This section will include information on the current epidemiology of measles in the Region; the number of cases reported in the interval since the previous issue, by week of reporting and by country; individual case studies of outbreaks and investigations; issues related to the elimination effort; and topics of interest in measles research. The section on measles activities in the CAREC Surveillance Report will be distributed monthly. It is expected that EPI Newsletter circulation will increase so that all health facilities in the sub-Region will receive copies. Information should also be disseminated through other PAHO publications.

In addition, to the reports on measles activity contained in the EPI Newsletter and CAREC Surveillance Report, the weekly measles report bulletin prepared by PAHO Washington will be widely distributed to all countries in the Region.

Countries will be encouraged to include a section on measles in their national epidemiological bulletin, with distribution to all health care workers in the network.

Both Periodic reviews of the literature on measles and advancements in the field of vaccinology, including the introduction of new vaccines, will be collected, and classified for distribution by PAHO the Region, including NGOs that are collaborating with the EPI.

PAHO will use project funds for implementing a Regional computerized information system regarding the tracking of rash and fever cases in each country. This information system will permit both PAHO and each country collect standardized case information for determining not only the existence of measles but also for evaluating the quality of the surveillance in each country. PAHO will evaluate on a country by country basis the training and hardware requirements.

8.8.2 Information exchange meetings

An essential ingredient in the polio eradication effort from the Western Hemisphere, were the meetings of the EPI program managers. These meetings, sub-Regional and Regional, served as a forum for mutual assistance and information dissemination. As is in the polio eradication effort, these meetings will be decisive in maintaining momentum and facilitating communication in the Region, as well as served as a forum for inter-agency coordination within the Region.

Therefore, the project will continue these meetings of EPI managers for Latin American and English speaking Caribbean countries and will be held as often as necessary to discuss progress made and problems encountered. The meetings will consist of country presentations, discussions related to issues raised during the country presentations, and presentations of updates in the field of immunizations. Attending the meetings will be technical experts to aid in the resolution of problems encountered. NGOs will also be invited to participate at these meetings. Outputs of the meetings will include recommendations of the working groups to the countries on strategies to resolve the problems encountered. Findings and recommendations of the meetings will be published and disseminated in the Region.

8.9 Identification of Research Needs

8.9.1 Advisory group review

Recognizing that questions remain to be addressed in the field of measles elimination, both in technical and operational areas, support for research will be provided. Research needs identified by the EPI Technical Advisory Group (TAG) will be implemented within the first two years of the project. It is also recognized that questions will continue to arise as some problems are solved and others appear in their place. Participation in addressing research needs will be encouraged by all member nations.

The Technical Advisory Group (See section 3.2) will review ongoing activities and identify areas for research. This will include identification of funding sources for grants, review of protocols and review of research results. The mechanism to initiate research once areas have been identified will be facilitated by PAHO.

8.9.2 Possible areas for research

Some of the issues to be addressed immediately include:

- identification of additional target populations for catchup vaccination after the "measles mass elimination campaigns";
- strategies and tactics to achieve optimal coverage during routine vaccination activities;
- reasons for dropouts from vaccination programs and strategies to reduce dropouts (dropouts defined as those children who have had contact with the health sector for one or more doses of vaccine but have not completed the full recommended series);
- optimal surveillance techniques to detect all potential cases;
- reasons for non-reporting among private sector physicians;
- strategies to get the population to report suspected cases to the health sector when medical care is not sought;
- simpler diagnostic methods (such as the IgM Elisa allowing confirmation from a single rather than paired specimen); and
- improved inoculation procedures and equipment for injectable vaccine.

8.10 Evaluation and Certification Procedures

8.10.1 Evaluation

Recognizing the critical nature of evaluation for monitoring success and detecting and resolving problems, there will be a continued emphasis on the EPI evaluation component. The project will carry out a mid-term evaluation in at least one country in each of the sub-Regions in the Western Hemisphere (Andean, Southern Cone, Central America and either Mexico and/or Brazil. International observers will participate in all country evaluations and reports of findings will be widely distributed.

Because of the difficulties inherent in routine information systems, coverage surveys may be performed in some of the countries. Included in the coverage surveys will be questions on reasons for compliance and non-compliance. Knowledge, attitude and practice (KAP) studies related to measles disease and prevention will be part of these studies. Results of these surveys will be used as a basis for modifications of strategies to optimize the efficacy of interventions.

The project will evaluate the laboratory network in each country periodically, at a minimum of every 24 months, to guarantee that the high level of support needed is met. Part of the laboratory evaluation process will include a retesting of original specimens by the reference laboratories, as well as reference specimens sent by the reference laboratories to the country laboratories for testing. The project will send experts to visit both reference and country laboratories as needed or when a certain problem has been identified.

8.10.2 Certification Criteria

The certification of elimination of indigenous transmission of measles from the Americas will be accomplished when the following conditions have been met: (1) Three years have elapsed without identification of any indigenous cases of measles in the Region, in the presence of adequate surveillance; (2) Extensive case search by international investigation team does not identify any indigenous cases having onset in the three years preceding the visit; and (3) In the case of an importation, there are no secondary cases identified within one month of the date of onset of the illness in the imported case.

Using project funds, an international certification commission will review criteria for certification based on findings of studies conducted and the need to include other criteria to detect the measles virus. PAHO will begin planning for the Certification Commission in 1997 and will begin holding meetings in 1998. Vaccination activities should continue until such time as global eradication is achieved.

9. PROJECT LOG FRAME AND INDICATORS.

Appendix VI presents the objectively verifiable indicators and their means of verification.

10. ORGANIZATION AND ADMINISTRATION

10.1 Country Level

10.1.2 National Work Plans and ICC

Each country is strongly urged to include activities related to measles elimination in their overall National Work Plan for the EPI and to sign a letter of agreement with PAHO and other collaborating agencies. As part of this process, all countries will continue to use the Inter-Agency Coordinating Committee (ICC) as the mechanism for coordination of in-puts and program activities.

As each donor agency has its own mandate, the presence of their representatives will ensure that the individual mandates are met and thereby avoid the all too common duplication of efforts that have occurred when there are independent project designs.

The National Work Plans will identify the roles of all of the participating agencies in the country's effort. In the agreement, the National Work Plans should identify additional cooperation needed from PAHO and other participating agencies. All participating agencies in a given country should sign the agreement.

At the time of preparation of the national work plans, participation of other international agencies will be encouraged to ensure the necessary level of donor coordination. In addition, technical cooperation will be provided for the drafting of country work plans. Full inventories of existing resources will be made, with identification of needs to be complemented in order to maximize inputs into the program activities.

All resources necessary to achieve the goal of elimination will be identified in the National Work Plans, with high priority given to the acquisition of these resources.

Those countries that will require long-term technical advisors should approve their placement in the agreement and commit to a prioritization of the effort in terms of resource allocation for supporting the

National Work Plan. The long-term technical advisors (previously deployed for the polio eradication effort) will continue to support the counties in the preparation of the National Work Plans.

It is critical that seed funding be available at the time of design of the plans of action and signing of agreements.

10.1.3 Organization of National EPI

The National EPI unit will: oversee the elimination activities at all levels; ensure that coordination with laboratories is a high priority, that training needs are identified, and that courses addressing these needs are organized. This office will serve as the focal point for identification of all external cooperation and coordination of extra-sectorial assistance.

A member of the central level National EPI unit will be appointed responsible for the national measles elimination activity. This individual, supervised by the EPI country program manager (or may be the same individual), will have full responsibility for all components of the measles elimination efforts, drawing upon resources made available to the EPI unit.

Within each country, all activities in the elimination effort should be under the guidance of the national EPI office to strengthen implementation of the activities and facilitate achievement of the overall EPI objectives. This office will oversee the elimination activities at all levels; ensure that coordination with laboratories is a high priority, that training needs are identified, and that courses addressing these needs are organized. This office will serve as the focal point for identification of all external cooperation and coordination of extra-sectorial assistance.

10.2 External - International Participation

To assist in the guidance of the activities of the elimination effort the EPI Technical Advisory Group (TAG) originally formed with the initiation of polio eradication activities in the Region of the Americas, composed of experts in the field of immunizations, will assume the role of guidance of activities in the sub-Region. The TAG is presently composed of a core of six individuals, and will call on additional experts as needed to address special problem areas. The recommendations for vaccination activities will be reviewed on an annual basis. The TAG will assist in the identification of research needs and oversee the progress of the studies under way, review protocols and results. The TAG will review progress and problems encountered in the measles elimination effort at its regular meetings. Recommendations of the TAG will be published and distributed throughout the Region.

To ensure the Regional coordination of all international agency inputs, EPI Interagency Coordinating Committee (ICC) with representation from all of the international agencies collaborating with the effort (e.g. Spain, CARICOM, UNICEF, Rotary, USAID, IDB, World Bank, CIDA and the Task Force for Child Survival and Development) will follow up the elimination effort. Any additional agencies (such as the French, Swedish, Danish and Dutch cooperation agencies as well as the European Economic Community [EEC], JICA, and the Office for Development Assistance [ODA] of Great Britain), may provide assistance to the effort and will be included in the ICC.

The ICC will secure interagency participation in each country for the planning stage in order to guarantee the coordination of donor inputs into the countries. This Coordinating Committee was created for polio eradication activities and was instrumental in coordinating previous TAG recommended activities in each country. The ICC will assume the additional task of coordinating efforts towards the achievement of the goal of measles elimination.

The Regional ICC will meet as frequently as necessary (quarterly or semi-annually or annually) to review progress and the needs for additional assistance. The first meeting of the ICC that will address issues related to measles elimination will be held by May 1995 to review the Regional Plan of Action and identify the types of assistance each of the agencies can provide in the effort. The PAHO EPI program office serves as the Secretary to both the TAG and the ICC.

As a further step to ensure the coordination of interagency assistance, a letter of agreement between the international agencies and PAHO should be signed after discussion of the Plan of Action. This agreement will define the roles of each participating agency. This pre-identification of each agency's role will greatly facilitate the necessary response when additional needs are required for a country.

10.3 Internal - PAHO

The Regional EPI office will coordinate all activities related to the measles elimination effort. All reports and requests from the field for assistance will go through the EPI office, which will in turn coordinate assistance as needed from other units within PAHO. This is critical to ensure a consistent, coordinated effort in the Regional activities.

Technical cooperation in all areas of program operations will be available through PAHO and its member countries. The project will provide assistance of expert consultants from outside the organization, as needs arise. The assistance required may include epidemiologists, virologists, laboratory technicians, cold chain specialists, mass media experts in health education and economists.

10.3.1 Personnel for Technical Assistance

At the sub-regional level (inter-country), seven epidemiologist post are available (of which five are already available and funded by PAHO, and two to be funded by this project). They serve as technical advisors on an international basis and provide support and supervisory assistance to national country personnel. They assist and cooperate in assessing needs for special intervention in the countries under their jurisdiction; train personnel at all levels; procure vaccines; in design of cold chain systems; preparation of manual for improving supervisory and surveillance system; and in general provide direct technical cooperation when needed. It is planned that the EPI epidemiologists/technical advisors presently posted at inter-country level will also be responsible for several countries from their "base" country and serve as technical advisors on an international basis. They will assist and cooperate in assessing needs for special interventions in the countries under their jurisdiction, and provide direct technical cooperation when needed.

The inter-country level personnel will work closely with counterparts in the MOH in the planning and implementation of the elimination effort activities. A major objective of the advisors will be the strengthening of the surveillance activities in the countries.

In addition, to the inter-country level personnel, there is a need for additional support personnel available to the EPI program office at the central level. This will include support of virologists (with extensive laboratory skills) to assist in the development of the laboratory network in the Region (including training, supervision, supplies and quality control). One additional epidemiologists is also needed to assist in the coordination of activities related to epidemiological surveillance, outbreak investigation, immunization strategy design, and provision of supervisory assistance to the inter-country advisors. They will be based in the EPI Unit in Washington D.C.

The anticipated increase in data collection and processing and the development of a computerized surveillance system will require a computer programmer.

Complementing the country and sub-regional level personnel, additional support personnel will be available to the EPI program office at the Regional level supported by PAHO/WHO.

The project financed administrative officer will assist in the planning, management and implementation of the project, including its budgetary and financial aspects.

The project will also fund the placement of 11 country epidemiologists/technical advisors (generally a host country national) in selected countries to assist the national program manager with planning and implementation of the country Work Plan and activities. These full time persons are responsible for all surveillance activities of the program, case investigation and outbreak control activities, training of national staff in all aspects of EPI, and "mop-up" activities in those districts where measles transmission is detected. Figure 1 (page 24) and Annex I provide the details on personnel assignments and requirements.

11 PROJECT IMPLEMENTATION

11.1 Management Structure

The overall Regional implementation, monitoring, and logistical support to the project will be managed and provided by PAHO/EPI staff, both central level and inter-country staff. For this purpose the project will enable the continuation of two inter-country technical advisors, as well as the continued two administrative/epidemiological posts at the central level for meeting the increased administrative demands expected from this country. PAHO will also provide increased technical support for developing the regional network of laboratory and another epidemiologist for supporting field activities in the countries.

To guide the implementation of the project and assist PAHO in the management of the project, PAHO will convene meetings of national immunization program managers for reviewing progress being made and to ensure that critical activities which necessary for assuring that the goal is met are included in their yearly National Work Plans. At these meetings PAHO will provide technical assistance to countries which request it.

Figure 1 contains an overview of the relationships among PAHO, potential donor(s) and organizational elements of the project. The elements are:

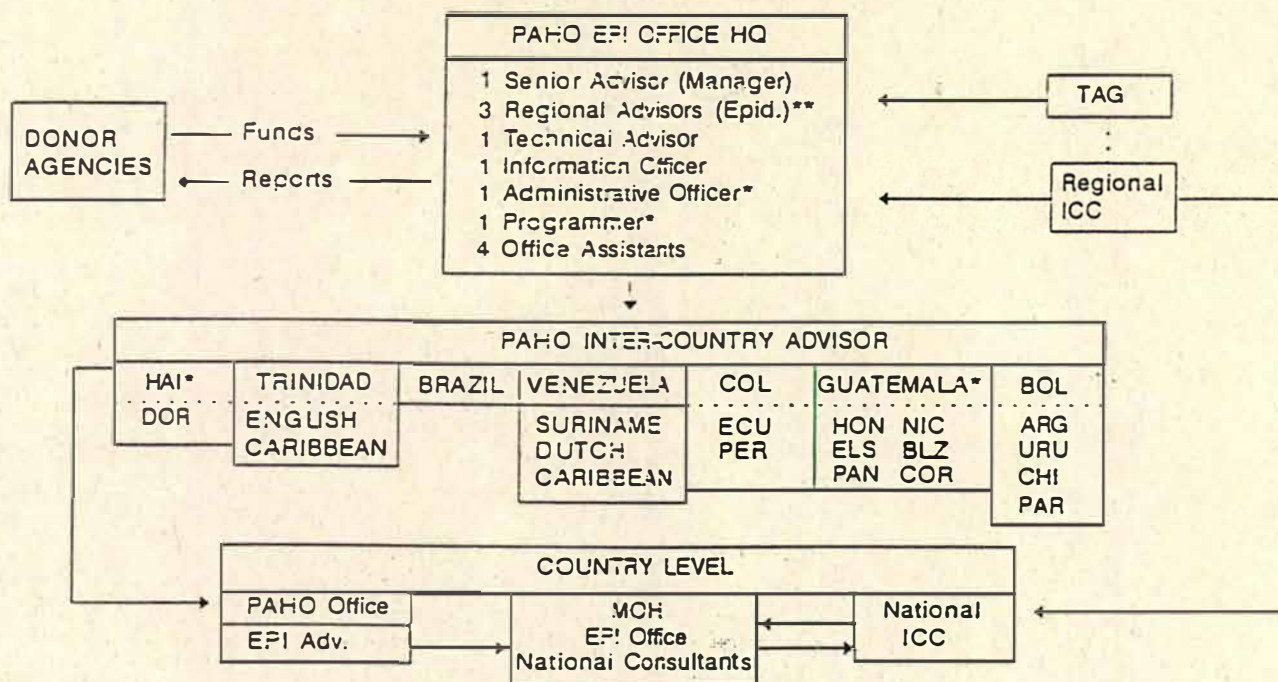
- PAHO's EPI Office in Washington, D.C., to coordinate and manage the program region-wide.
- A Technical Advisory Group.
- An Inter-Agency Coordinating Committee representing donors.
- National EPI offices in the Ministries of Health.
- Donor-Washington Office
- Country Offices
- PAHO Inter-Country Advisors
- PAHO Country Advisors
- Other Donors - Country level

PAHO serves as the Secretariat for both ICC and TAG Committees.

PAHO serves as the Secretariat for both ICC and TAG Committees.

Figure 1

ORGANIZATIONAL CHART
EXPANDED PROGRAM ON IMMUNIZATION (EPI)



* Project Funded

** 2 Project funded

11.2 Coordination

Success of this effort depends upon the participation of every country in the Region and coordination is a key element of the project. Activities at the international, national, and regional levels will be undertaken throughout the life of the project as follows:

PAHO/Washington, D.C.

The regional PAHO/EPI office will coordinate all activities related to the eradication effort. All reports and requests for assistance from the field will go through the EPI office, which will in turn coordinate assistance as needed from other units within PAHO. This is critical to ensure a consistent, coordinated effort in the regional activities.

Technical cooperation in all areas of program operations will be available through PAHO to its Member Countries.

Assistance of expert consultants from outside the Organization will be coordinated by PAHO and provided as need arise.

4. FUNDING AND FINANCIAL COMPONENTS

4.1 Levels of Funding

In order to meet the objective of measles elimination by the year 2000, it is expected that approximately US\$45,875,000 of extra-budgetary resources will be needed to support national programs. These extra-budgetary resources should be managed by PAHO for the regional coordination of the initiative. Approximately, US\$9,500,000 is the cost of extra vaccine and syringes and needles needed for implementation of catch-up vaccination campaigns. This component is expected to be made available either by the countries themselves or by other donors.

Another US \$6,500,000 will be made available by PAHO/WHO from regular sources for supporting personnel, and program activities. Therefore the total cost of the project is estimated to be US \$ 52,375,000. (See Appendix IV).

PROJECTED EXTERNAL COSTS BY COMPONENT, 1996-2000

<u>Component</u>	<u>Total US\$</u>
Personnel	7,750,000
Documentation and Information	1,500,000
Vaccine and syringes	9,500,000
Meetings	1,625,000
Laboratories	2,500,000
Surveillance/Supervision	6,000,000
Social Mobilization/Promotion	4,000,000
Training	2,000,000
Cold Chain/Logistics	2,500,000
Evaluations	1,500,000
Research	2,000,000
Contingency Funds	5,000,000
Total External Funding	<u>\$45.875.000</u>

A more detailed cost breakdown and preliminary financial analysis are presented in Appendices II, III, and IV.

When individual country plans are designed, an economist should participate in costing the program. Cost figure will be identified and will include salaries for additional personnel, transportation costs (including airfares), per diem costs, expected expenditures for investigation of identified suspected cases, vehicles, gasoline, vaccine, cold chain equipment, and laboratory development costs (including costs for reagents, transportation and shipping of specimens). All recurrent and capital expenditures should be taken into account in the program design. Budgets will also include the cost of media time and production of educational materials.

PAHO will coordinate with all participating agencies to procure the necessary funding to guarantee the achievement of this goal, and could serve as the coordinating agency for all of the financial assistance provided to the effort. It is expected that by the time of the Directing Council Meeting in September 1995, commitments to cover estimated needs for at least the first three years of the program will already be identified.

It is important to assure that funds which are committed are allocated and available in a short time to permit rapid implementation of the targeted activities.

APPENDIX I

PROPOSED SUB-REGIONALIZATION FOR MEASLES
ELIMINATION EFFORT AND LOCATION OF SUBREGIONAL ADVISORS

<u>Location of Advisor</u>	<u>Countries in Subregion</u>
Guatemala	Guatemala El Salvador Nicaragua Panama Honduras Costa Rica
Venezuela	Dutch Caribbean Suriname
Haiti	Haiti Dominican Republic
Colombia	Colombia Ecuador Peru
Bolivia	Bolivia Argentina Chile
Brazil	Brazil Uruguay Paraguay
Trinidad and Tobago	English-speaking Caribbean

APPENDIX II

COST COMPONENTS. 1996-2000

<u>Extra Personnel</u>		<u>\$7,750,000</u>
11 National Consultants, local contracts (\$30,000/year/5 years) =	\$1,650,000	
4 Inter-country Epidemiologists x 5 years =	\$3,100,000	
1 Project Administrator and 1 Programmer =	\$ 875,000	
Short term consultants (\$8,500/month x 250 months) =	\$2,125,000	
Documentation and Information		<u>1,500,000</u>
<u>Vaccine and Svringes</u>		<u>\$9,500,000</u>
<u>Meetings</u>		<u>\$1,625,000</u>
SUB-REGIONAL -- 4/Year x 5 years =	\$1,000,000	
TAG -- 1 meeting/year x 5 years =	\$600,000	
ICC -- (Interagency Coordinating Committee)=	\$25,000	
<u>Laboratories</u>		<u>\$2,500,000</u>
Viral diagnostic labs (9 x \$50,000 x 5)	\$2,250,000	
Diagnostic kits (10,000 kits x \$5 x 5)	\$ 250,000	
<u>Surveillance/Supervision</u> (travel and per diem)		<u>\$6,000,000</u>
Social Mobilization/Promotion (media time. radio, TV, press)		<u>\$4,000,000</u>
<u>Training</u>		<u>\$2,000,000</u>
<u>Cold Chain/Logistics</u>		<u>\$2,500,000</u>
<u>Evaluations</u>		<u>\$1,500,000</u>
<u>Research</u>		<u>\$2,000,000</u>
<u>Contingency Funds</u>		<u>\$5,000,000</u>
<u>GRAND TOTAL</u>		<u>\$45,875,000</u>

APPENDIX III External Costs by components and by year, 1996-2000. (In thousands)

BUDGET ITEM	YEAR					
	1996	1997	1998	1999	2000	TOTAL
PERSONNEL						
EPIDEMIOLOGIST- WASHINGTON D.C. (2)	291.8	302.0	313.0	327.2	346.0	1,580.0
EPIDEMIOLOGIST- BOLIVIA (1)	138.2	137.5	142.5	149.0	157.8	725.0
EPIDEMIOLOGIST- HAITI (1)	151.3	150.5	156.4	163.0	173.0	795.0
PROJECT ADMINISTRATOR- WASHINGTON D.C.	91.5	93.4	96.8	101.2	107.1	490.0
PROGRAMMER- Washington D.C.	71.5	73.5	76.3	79.5	84.2	385.0
11 NATIONAL CONSULTANTS	330.0	330.0	330.0	330.0	330.0	1,650.0
SHORT TERM CONSULTANTS	425.0	425.0	425.0	425.0	425.0	2,125.0
SUB-TOTAL	1,499.3	1,512.2	1,540.0	1,575.4	1,623.1	7,750.0
Documentation/Information	300.0	300.0	300.0	300.0	300.0	1,500.0
Meetings:						1,625.0
TAG (1 x \$120.0 x 5)	120.0	120.0	120.0	120.0	120.0	600.0
Sub-Regional (4 x \$50.0 x 5)	200.0	200.0	200.0	200.0	200.0	1,000.0
ICC (1 x \$5.0 x 5)	5.0	5.0	5.0	5.0	5.0	25.0
Laboratories/Diagnostics						2,500.0
Virology Labs (9 x \$50.0 x 5)	450.0	450.0	450.0	450.0	450.0	2,250.0
Diagnostics (100 KITS)	50.0	50.0	50.0	50.0	50.0	250.0
Social Mobilization/Promotion	800.0	800.0	800.0	800.0	800.0	4,000.0
Surveillance/Supervision	1,200.0	1,200.0	1,200.0	1,200.0	1,200.0	6,000.0
Training	400.0	400.0	200.0	400.0	200.0	2,000.0
Cold Chain/Logistics	500.0	500.0	500.0	500.0	500.0	2,500.0
Evaluations	300.0	300.0	300.0	300.0	300.0	1,500.0
Research	400.0	400.0	400.0	400.0	400.0	2,000.0
Vaccines	2,000.0		2,000.0		2,000.0	6,000.0
Syringes/Needles	1,170.0		1,170.0		1,160.0	3,500.0
Contingency	1000.0	1000.0	1000.0	1000.0	1000.0	5,000.0
GRAND TOTAL	10,394.3	7,237.2	10,435.0	7,300.4	10,508.1	45,575.0

APPENDIX IV

External costs, by year, by agency (PAHO, USAID and OTHER Potential Sources), 1996 -2000. (In thousands of US\$)

YEAR	PAHO	OTHER SOURCES	TOTAL
1996	\$1,100.0	\$10,394.3	\$11,494.3
1997	\$1,200.0	\$ 7,237.2	\$ 8,437.2
1998	\$1,300.0	\$10,435.0	\$11,735.0
1999	\$1,400.0	\$ 7,300.4	\$ 8,700.4
2000	\$1,500.0	\$10,508.1	\$12,008.1
TOTAL	\$6,500.0	\$45,875.0	\$52,375.0

APPENDIX V

TERMS OF REFERENCE OF PAHO EPI TECHNICAL ADVISORY GROUP (TAG)

1. According to the Plan of Action for the eradication of indigenous transmission of wild poliovirus from the Americas by 1990, a Technical Advisory Group (TAG) should be formed in 1985 to help the PAHO Secretariat with its implementation.
2. To accomplish the above, an outstanding group of consultants was appointed by the Director in 1985, to advise PAHO on the acceleration of the Expanded Program on Immunization in the Americas and on the efforts to eradicate the indigenous transmission of wild poliovirus from the Region by 1990.

The Technical Advisory Group is composed of six individuals and are assisted by additional consultants and/or study panels for any specific purposes they may require.
3. The Technical Advisory Group:
 - a) Advise the PAHO Secretariat with respect to program priorities of the program;
 - b) Advise and guide the PAHO Secretariat concerning the optimal strategies and tactics to reach the overall goals of the EPI and the maintenance of polio free status in the Americas;
 - c) Monitor the implementation of the Regional Plan of Action to accomplish the above-stated goals;
 - d) Promote understanding and support for the program goals among technical institutions and bilateral, multilateral and private agencies, as well as political leaders; and
 - e) Participate in missions at country level for program reviews and meetings
4. Members of the Technical Advisory Group are appointed by the Director for a period of one year, with extensions to be arranged at his discretion.
5. At least one member of the TAG should also be a member of the GPV Scientific Advisory Group of Experts (SAGE). At least one member of the TAG should also participate in meetings with other agencies and organizations to assure proper coordination and exchange of information.
6. TAG meetings will be convened as required, usually once a year, and a report on each meeting will be prepared and circulated as appropriate.

APPENDIX VI

PROJECT LOGFRAME AND INDICATORS

PROJECT LOG FRAME: VERIFIABLE INDICATORS

Project Title: Accelerated
Immunization Project, Phase III

Life of Project:
From FY 1995 to 2000
Total U.S. Funding \$20,000,000
Date Prepared: 1/30/95

NARRATIVE SUMMARY

Program or Sector Goal: The
Broader objective to which this
project contributes

To reduce morbidity and mortality
among children and women of
childbearing ages from
immunopreventable diseases and
eliminate indigenous transmission of
measles by the year 2000.

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievement:

Mortality Reduction

	<u>1990</u>	<u>2000</u>
Measles	1.0	0.0
Neonatal tetanus	0.5	0
Pertussis	1.0	0.5
Polio	0	0

Morbidity Reduction

Measles	60.0	0.0
Neonatal	0.5	0
Pertussis	50.0	20.0
Polio	0	0

MEANS OF VERIFICATION

Country MOH reports to PAHO

Country MOH reports to PAHO

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal
targets:

1. There are an estimated 5,000
deaths due to Measles, 5,000 due to
Pertussis and 5,000 due to Neonatal
Tetanus per year in Latin America.

2. CFR for Measles 4% and
Pertussis 3%.

3. There are an estimated 100,000
cases of Measles, 200,000 cases of
Pertussis 5,000 cases of Neonatal
Tetanus occurring every year in
Latin America.

Note: Mortality:
Measles, Pertussis and Polio: Deaths per 100,000 population
Neonatal Tetanus: Deaths per 1,000 live births
Morbidity:
Measles, Pertussis and Polio: Cases per 100,000 population
Neonatal Tetanus: Cases per 1,000 live births.
No measles cases in the English-speaking Caribbean by 1995.

PROJECT LOG FRAME: VERIFIABLE INDICATORS

Project Title: Accelerated
Immunization Project, Phase III

Life of Project:
From FY 1995 to 2000
Total U.S. Funding \$20,000,000
Date Prepared: 1/30/95

NARRATIVE SUMMARY

Program or Sector Goal: The
Broader objective to which this
project contributes

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievement:

MEANS OF VERIFICATION

IMPORTANT ASSUMPTIONS

Assumptions for achieving goal
targets:

Sub-Goal

To increase coverage with all EPI
antigens.

Coverage of each EPI antigen (DPT,
Polio, Measles, BCG) increase from
80% in 1995 to 95% in 2000, among
children under one year of age in all
LAC countries.

Women in childbearing years in high
risk areas with 2 dose of TT
increases from 50% in 1990 to 80%
in 1995.

Country MOH reports to PAHO
Coverage surveys (if undertaken)

ditto

1993 Coverage (children < 1 year
old)

DPT(3)	80%
Polio(3)	87%
Measles(1)	85%
BCG(1)	93%

PROJECT LOG FRAME: VERIFIABLE INDICATORS

Project Title: Accelerated
Immunization Project, Phase III

Life of Project:
From FY 1995 to 2000
Total U.S. Funding \$20,000,000
Date Prepared: 1/30/95

NARRATIVE SUMMARY

Project Purpose:

OBJECTIVELY VERIFIABLE INDICATORS

Conditions that will indicate purpose
has been achieved: End-of-Project
status.

MEANS OF VERIFICATION

IMPORTANT ASSUMPTIONS

Assumptions for achieving purpose:

- Improving geographic access to
immunization services

In 75% or more "municipios" DPT1
or OPV1 will increase to 95% by
2000.

Country MOH reports to PAHO

Coverage surveys where conducted

1. Vaccinations will be reported by
dose and district in children under
one year of age and women of
childbearing age.

Expand rash/fever surveillance
system to include 50% of all health
establishments in the Region.

Number of health units reporting
cases of rash/fever including
negative notification.

Weekly reports from MOH to PAHO.

2. Currently PAHO receives 21,500
reports weekly on the occurrence of
AFP.

NOTE: The following is the level of missed opportunities for those countries
that have conducted studies: Bolivia 32%, Colombia 73%, Ecuador
34%, El Salvador 45%, Guatemala 51%, Honduras 45%, Mexico 40%,
Nicaragua 66%, Peru 48%, Paraguay 67% and Venezuela 52%.

PROJECT LOG FRAME: VERIFIABLE INDICATORS

Life of Project::
From FY 1995 to 2000
Total U.S. Funding \$20,000,000
Date Prepared: 1.30.95

Project Title: Accelerated
Immunization Project, Phase III

NARRATIVE SUMMARY

Project Outputs:

Improved norms, training, and
supervision of measles and neonatal
tetanus immunizations, and for
avoiding missed opportunities.

OBJECTIVELY VERIFIABLE INDICATORS

Magnitude of Outputs:

All countries have updated field
guides or manuals with improved
norms on measles and neonatal
tetanus elimination and control and
for avoiding missed opportunities.

All annual country plans show use of
new manuals for training and
supervision.

All ICCs monitor implementation of
training and supervision with new
manuals as planned.

MEANS OF VERIFICATION

Field guides or manuals updated as
needed.

Country Annual Work Plans.

ICC minutes.

IMPORTANT ASSUMPTIONS

Assumptions for achieving outputs:

ICC will meet regularly and monitor
country work plans.

PROJECT LOG FRAME: VERIFIABLE INDICATORS

Life of Project:
From FY 1995 to 2000
Total U.S. Funding \$20,000,000
Date Prepared: 1/30/95

Project Title: Accelerated
Immunization Project, Phase III

NARRATIVE SUMMARY

Project Outputs:

Improved targeting of Immunization
program resources.

Immunization Program is sustained.

OBJECTIVELY VERIFIABLE INDICATORS

Magnitude of Outputs:

All country Annual Work Plans show
that districts which have lower than
average Coverage or higher disease
incidence will receive a proper and
fair share of the resources, not
necessarily proportional to the size
of their population but proportional to
the size of the problem.

National funds cover an increased
proportion of recurrent costs of
immunization programs in all
countries in 1995 compared to 1990.

The number and variety of national
organizations participating in ICCs
meetings increases.

The number of ICCs adopting and
maintaining financial monitoring of
Annual Plans increases.

The number of ICCs increases with:
- published schedules
- open agendas
- consultation on new actions
- minutes published

MEANS OF VERIFICATION

Country Annual Work Plans and
ICC monitoring of expenditures.

Country Annual Work Plans and ICC
monitoring of expenditures

ICC minutes

ICC minutes

ICC records

IMPORTANT ASSUMPTIONS

Assumptions for achieving outputs:

1. Countries will report vaccinations
by age group, dose and district.
2. Surveillance will be decentralized
to district level.
3. MOHs and ICC members will
release periodic reports on
disbursements.

MEASLES ELIMINATION AND IMMUNIZATIONS IN THE AMERICAS

A CALL FOR ACTION

1. INTRODUCTION

The Expanded Program on Immunization (EPI) has its basis in resolution WHA 27.57, adopted by the World Health Assembly in May 1974. General program policies, including the EPI goal of providing immunization services for all children of the world by 1990 (resolution WHA 30.53, 1977) were endorsed by resolution CD 25.27 of the Pan American Health Organization (PAHO) Directing Council in September 1977.

The long-term objectives of the EPI are to:

- reduce morbidity and mortality from diphtheria, whooping cough, tetanus, measles, tuberculosis and maintain the eradication of poliomyelitis by providing immunization services against these diseases for every child in the world by 1990 (other selected diseases may be included when and where applicable);
- promote countries' self-reliance in the delivery of immunization services within the context of comprehensive health services; and
- promote regional self-reliance in matters of vaccine production and quality control.

Supporting EPI long term objectives are goals set forth in the Plan of Action for implementing the World Declaration on the Survival, Protection, and Development of Children on the 1990s, as enunciated by the World Summit for Children. The EPI in the Americas has met the goals set forth in the World Summit for Children in relation to the goals of eradication of indigenous transmission of Poliomyelitis and the virtual elimination of Neo-natal Tetanus. Considerable progress has also been made towards the goal of reduction of morbidity/mortality due to measles.

Resolution XVI, approved by the Ministers of Health of the Region of the Americas, during their meeting of the XXIV Pan American Sanitary Conference, in Washington, D.C. in September 1994, set the target of measles elimination from the Western Hemisphere by the year 2000.

This decision builds on the remarkable completion of the initiative to eradicate poliomyelitis from the Americas and several successful national or multi-country initiatives to eliminate measles.

In August, 1994, at its XIth meeting held in Washington, D.C., the PAHO/EPI Technical Advisory Group (TAG), recommended that "these national measles elimination initiatives would be greatly enhanced if a regional measles elimination initiative was launched in a coordinated effort". This recommendation was then endorsed by the XXIV Pan American Sanitary Conference in September, 1994 in its Resolution XVI.

In December, 1995, during the Summit of the Americas, held in Miami, Florida, disease control initiatives were emphasized as important for the attainment of sustainable development and in January, 1995, at a White House meeting called by the First Lady of the USA, two initiatives in the health area were targeted for follow up of the Summit: Measles Elimination and Reduction of Maternal Mortality.

Previous research has shown that the polio eradication effort had many positive outcomes, one of them being the increased awareness of the benefits of immunization and the importance of preventive health care. Therefore, it is expected that the measles elimination effort will build on this by internalizing the value of preventing diseases through immunization.

The project will have a duration of five years (1996-2000) and will cost an estimated \$46.0 million dollars.

2. PROJECT OBJECTIVE

The Plan of Action will have the following objectives:

- a) Promote the overall development of the Expanded Program on Immunization in the Region, to speed up the attainment of its objectives.
- b) Eliminate indigenous transmission of measles in the American Region by the year 2000.
- c) Strengthen the surveillance of vaccine preventable diseases, which in turn could serve as the basis for surveillance of emerging infections and drug resistance.
- d) Introduce new vaccines (e.g. Hepatitis B, Haemophilus influenzae B) in national immunization programs, whenever warranted by the epidemiological situation and financial feasibility.

3. PROJECT OUTPUTS

The expected outputs for the project are:

- 6.1 Elimination of the indigenous transmission of measles by the year 2000.
- 6.2 Increase EPI vaccine coverage (DPT/Measles/OPV/BCG) to 95% in children < 1 year of age.
- 6.3 80% of women, in child bearing age living in high risks areas, will have been vaccinated with 2 doses of T.T. vaccine.
- 6.4 All countries will incorporate the weekly routine surveillance of fever and rash illnesses from at least 50% of all health establishments into their disease surveillance system.
- 6.5 Computerized Rash and Fever Illness surveillance software installed all countries for collecting and analyzing suspect measles cases.
- 6.6 All countries will develop annual country work plans which show the cost of the different EPI activities by type of cost and source of funding.
- 6.7 Updated norms and manuals which reflect the development of new vaccine technologies and improved methods for disease control.

6.8 Regional laboratory network for supporting the processing of samples for measles diagnosis.

6.9 Laboratory training manual and trained staff at Regional laboratory network in the latest techniques for measles diagnostics.

6.10 Information exchange meetings of EPI managers: a minimum of 24 sub-Regional meetings and 6 Regional Meetings during the life of the project.

6.11 Inter-agency coordination through the Inter-Agency Coordination Committees (ICCs) will be consolidated in every country.

4 STRATEGIES AND TECHNICAL COMPONENTS

The primary prerequisite to achieve the stated objectives will be the level of national political commitment, as expressed by:

- *Approval of the Plan of Action by the Directing Council of PAHO in September 1995;
- *Availability and allocation of national resources for the effort.
- *Legislative action by member countries, whenever necessary; and,
- *Availability of international resources to support the regional and national initiatives.

In order to meet the goal of elimination of indigenous transmission of measles in the Americas by the year 2000, it will be necessary to intensify all components of the EPI strategies presently being implemented and to adapt many of the EPI approaches. Other essential elements are coordination of international agencies at the Regional and country levels, and availability of sufficient funds from both national and international sources to cover all activities related to this goal.

The key strategies to be adopted in this effort are:

1. Mobilization of national resources supported by international resources where necessary;
2. Achievement and maintenance of vaccine coverage of greater than 95% of the target population in every district of each country and catch-up of older age groups of susceptibles in countries that build up a cohort of susceptibles;
3. Catch-up campaigns carried out in selected countries which have built up a large group of susceptibles, since 1994, capable of sustaining measles transmission.
4. Expansion of the regional surveillance system that was put in place for polio eradication, to include surveillance of fever and rash illnesses at regional and national levels, so that all suspected cases of measles are immediately investigated and appropriate control measures to stop transmission are rapidly implemented.

5. Laboratory diagnostic services available to all countries, to permit laboratory studies of all reported cases of febrile rash illness that are suspected of being measles;
6. Information dissemination within countries and throughout the Region;
7. Identification of research needs with subsequent funding for execution;
8. Further reduction of missed opportunities in all countries that can provide DPT(1) to 90% of the target population but experience drop-out factor of 15% or more, and
10. Evaluation of all on going program activities.

For each of the key strategies, a series of technical components/activities will be expelld out in the Plan of Action to ensure their success.

5. FUNDING AND FINANCIAL COMPONENTS

In order to meet the objective of measles elimination by the year 2000, it is expected that approximately US\$ 45,875,000 million of extra-budgetary resources will be needed to support national programs. It is proposed that US\$ 15,000,000 (32%) be financed by USAID. The remaining US\$ 30,875,000 will be financed by PAHO and some other potential partners, such as UNICEF, the Canadian International Development Agency (CIDA), the Inter-American Development Bank, the Japan International Cooperation Agency (JICA), Rotary International, Lions International and European donors will be approached to participate in the project. To ensure appropriate regional coordination, these external resources should be managed by PAHO. It is also expected that some bilateral funding will also occur in several countries. Approximately US\$ 9,500,000 is the cost of extra vaccine and syringes and needles needed for implementation of catch-up vaccination campaigns. This component is expected to be made available either by the countries themselves or by UNICEF and/or other partners.

PROJECTED EXTERNAL COSTS BY COMPONENT. 1996-2000

<u>Component</u>	<u>Total US\$</u>
Personnel	7,750,000
Documentation and Information	1,500,000
Vaccine and syringes	9,500,000
Meetings	1,525,000
Laboratories	2,500,000
Surveillance/Supervision	6,000,000
Social Mobilization/Promotion	4,000,000
Training	2,000,000
Cold Chain/Logistics	2,500,000
Evaluations	1,500,000
Research	2,000,000
Contingency Funds	5,000,000
Total External Funding	<u>\$45,875,000</u>

A more detailed cost breakdown and preliminary financial analysis are presented in Appendices I, II, III and IV.

APPENDIX I

COST COMPONENTS. 1996-2000

<u>Extra Personnel</u>		<u>\$7.750.000</u>
11 National Consultants, local contracts (\$30,000/year/5 years) =	\$1,650,000	
4 Inter-country Epidemiologists x 5 years =	\$3,100,000	
1 Project Administrator and 1 Programmer =	\$ 875,000	
Short term consultants (\$8,500/month x 250 months) =	\$2,125,000	
 Documentation and Information		 <u>1.500.000</u>
 <u>Vaccine and Svringes</u>		 <u>\$9.500.000</u>
<u>Meetings</u>		<u>\$1.625.000</u>
SUB-REGIONAL -- 4/Year x 5 years =	\$1,000,000	
TAG -- 1 meeting/year x 5 years =	\$600,000	
ICC -- (Interagency Coordinating Committee)=	\$25,000	
 <u>Laboratories</u>		 <u>\$2.500.000</u>
Viral diagnostic labs (9 x \$50,000 x 5)	\$2,250,000	
Diagnostic kits (10,000 kits x \$5 x 5)	\$ 250,000	
 <u>Surveillance/Supervision</u> (travel and per diem)		 <u>\$6.000.000</u>
 Social Mobilization/Promotion (media time. radio, TV, press)		 <u>\$4.000.000</u>
 <u>Training</u>		 <u>\$2.000.000</u>
 <u>Cold Chain/Logistics</u>		 <u>\$2.500.000</u>
 <u>Evaluations</u>		 <u>\$1.500.000</u>
 <u>Research</u>		 <u>\$2.000.000</u>
 <u>Contingency Funds</u>		 <u>\$5.000.000</u>
 <u>GRAND TOTAL</u>		 <u>\$45.875.000</u>

APPENDIX II

External Costs by components and by year, 1996-2000. (In thousands)

SUBJECT ITEM	YEAR					
	1996	1997	1998	1999	2000	TOTAL
PERSONNEL						
EPIDEMIOLOGIST- WASHINGTON D.C. (2)	281.3	302.3	313.0	327.2	346.0	1,580.0
EPIDEMIOLOGIST- BOLIVIA (1)	138.2	137.5	142.5	149.3	157.8	725.0
EPIDEMIOLOGIST- HAITI (1)	151.3	150.3	158.4	163.0	173.0	795.0
PROJECT ADMINISTRATOR- WASHINGTON D.C.	91.5	93.4	96.8	101.2	107.1	490.0
PROGRAMMER- Washington D.C.,	71.5	73.5	78.3	79.5	84.2	386.0
11 NATIONAL CONSULTANTS	330.0	330.0	330.0	330.0	330.0	1,650.0
SHORT TERM CONSULTANTS	425.0	425.0	425.0	425.0	425.0	2,125.0
SUB-TOTAL	1,499.3	1,512.2	1,540.0	1,575.4	1,623.1	7,750.0
Documentation/Information	300.0	300.0	300.0	300.0	300.0	1,500.0
Meetings:						1,625.0
TAG (1 x \$120.0 x 5)	120.0	120.0	120.0	120.0	120.0	600.0
2nd-Regional (4 x \$50.0 x 5)	200.0	200.0	200.0	200.0	200.0	1,000.0
ISC (1 x \$5.0 x 5)	5.0	5.0	5.0	5.0	5.0	25.0
Laboratories/Diagnostics						2,500.0
Virology Labs (9 x \$50.0 x 5)	450.0	450.0	450.0	450.0	450.0	2,250.0
Diagnostics (10.0 KITS)	50.0	50.0	50.0	50.0	50.0	250.0
Social Mobilization/Promotion	800.0	800.0	800.0	800.0	800.0	4,000.0
Surveillance/Supervision	1,200.0	1,200.0	1,200.0	1,200.0	1,200.0	6,000.0
Traveling	400.0	400.0	200.0	400.0	200.0	2,000.0
Cold Chain/Logistics	500.0	500.0	500.0	500.0	500.0	2,500.0
Evaluations	300.0	300.0	300.0	300.0	300.0	1,500.0
Research	600.0	400.0	400.0	400.0	400.0	2,000.0
Vaccines	2,000.0		2,000.0		2,000.0	6,000.0
Syringes/Needles	1,170.0		1,170.0		1,160.0	3,500.0
Contingency	1000.0	1000.0	1000.0	1000.0	1000.0	5,000.0
GRAND TOTAL	10,394.3	7,237.2	10,435.0	7,300.4	10,308.1	45,675.0

APPENDIX III DISTRIBUTION OF BUDGET BY ITEM AND BY YEAR FOR USAID FUNDS, 1996-2000.
(IN THOUSANDS OF US DOLLARS)

SUBJECT ITEM	YEAR					TOTAL
	1996	1997	1998	1999	2000	
PERSONNEL						
EPIDEMIOLOGIST- WASHINGTON D.C. (2)	291.8	302.3	313.0	327.2	348.0	1,580.3
EPIDEMIOLOGIST- BOLIVIA (1)	138.2	137.3	142.5	149.0	157.8	725.3
EPIDEMIOLOGIST- HAITI (1)	151.3	150.3	156.4	163.5	173.0	795.3
PROJECT ADMINISTRATOR- WASHINGTON D.C.	91.5	83.4	96.9	101.2	107.1	480.0
PRELIMINER- Washington D.C.	71.5	73.5	78.3	79.5	84.2	367.0
11 NATIONAL CONSULTANTS	-	-	-	-	-	-
SHORT TERM CONSULTANTS	214.0	212.0	212.0	212.0	212.0	1,062.0
SUB-TOTAL	958.3	969.2	997.0	1,032.4	1,080.1	5,137.0
Documentation/Information	-	-	-	-	-	-
Meetings:						1,158.0
TAG (1 x \$120.0 x 5)	120.0	120.0	120.0	120.0	120.0	600.0
Sub-Regional (4 x \$28.5 x 5)	108.0	108.0	108.0	108.0	108.0	540.0
ICG (1 x \$5.0 x 5)	5.0	5.0	5.0	5.0	5.0	25.0
Laboratories/Diagnostics						1,500.0
Virology Labs (6 x \$250.0 x 5)	300.0	300.0	300.0	300.0	300.0	1,500.0
Diagnostics(10.0 Kits)	-	-	-	-	-	-
Social Mobilization/Promotion	-	-	-	-	-	-
Surveillance/Supervision	500.0	500.0	500.0	500.0	458.0	2,458.0
Training	100.0	100.0	100.0	100.0	100.0	500.0
Cold Chain/Logistics	80.0	80.0	80.0	80.0	80.0	400.0
Evaluations	144.0	144.0	144.0	144.0	144.0	720.0
Research	100.0	100.0	100.0	100.0	100.0	500.0
Vaccines	-	-	-	-	-	-
Syringes/Needles	-	-	-	-	-	-
Contingency	100.0	100.0	100.0	100.0	100.0	500.0
10% Administrative Cost	345.2	345.1	346.1	346.1	346.5	1,729.0
GRAND TOTAL	2,358.5	2,363.3	2,997.1	3,032.5	3,042.8	15,000.0

APPENDIX IV

External costs, by year, by agency (PAHO, USAID and OTHER Potential Sources), 1996 -2000. (In thousands of US\$)

YEAR	PAHO	USAID	OTHERS	TOTAL
1996	\$1,100.0	\$ 2,958.5	\$ 6,335.8	\$10,394.3
1997	\$1,200.0	\$ 2,969.3	\$ 3,067.9	\$ 7,237.2
1998	\$1,300.0	\$ 2,997.1	\$ 6,137.9	\$10,435.0
1999	\$1,400.0	\$ 3,032.5	\$ 2,867.9	\$ 7,300.4
2000	\$1,500.0	\$ 3,042.5	\$ 5,965.5	\$10,508.1
TOTAL	\$6,500.0	\$15,000.0	\$24,375.0	\$45,875.0

Declaration of the International Commission for the Certification of Poliomyelitis Eradication (ICCPE)

August 1994

A. Background

1. In May 1985, the Pan American Health Organization (PAHO) proposed the goal of interruption of wild poliovirus transmission in the Western Hemisphere. This proposal was promptly endorsed by all Member Governments and received strong support from several agencies and organizations including UNICEF, the United States Agency for International Development (USAID), Rotary International, the Inter-American Development Bank (IDB), and the Canadian Public Health Association.
2. It has now been three years since the last confirmed case of paralytic poliomyelitis due to wild poliovirus was reported in the Americas. Several factors made it possible for the Region of the Americas to progress towards the goal of poliomyelitis eradication. These include the very high level of political commitment of the Member Governments, the high degree of community participation, the strong collaboration of various agencies and organizations through interagency coordinating committees, and the availability of well managed resources under a strong PAHO leadership.
3. In 1990, PAHO established an independent International Commission for the Certification of Poliomyelitis Eradication in the Americas (ICCPE). Their task has been to oversee the regional poliomyelitis eradication efforts and to determine when the goal has been achieved. Prior to this third meeting of the ICCPE in August 1994, previous meetings were held in July 1990 in Washington, D.C., U.S.A., and in March 1992 in Rio de Janeiro, Brazil.
4. In early 1994, each member country formed an independent National Certification Commission. Their task was to evaluate national data and to recommend to the ICCPE whether or not poliovirus transmission had been interrupted in their respective countries.
5. Information reviewed by the National Certification Commissions included trends in vaccination coverage, data obtained from an extensive Regionwide surveillance system that includes over 20,000 health units that report weekly on the presence or absence of cases of acute flaccid paralysis (suspected poliomyelitis cases), and laboratory results from the testing of stool specimens obtained from suspected poliomyelitis cases and their contacts for the presence of wild poliovirus. Specimens were tested in a highly developed and proficient network of laboratories throughout the Hemisphere.

B. Conclusions

1. During the past six years most countries of the Region have achieved and maintained OPV3 vaccination coverage levels of over 80%. Since the last confirmed case was reported from Peru in August 1991, over 6,000 acute flaccid paralysis cases have been thoroughly investigated and none has been confirmed as paralytic poliomyelitis due to wild poliovirus. Furthermore, over 25,000 stool specimens obtained from these cases and their contacts were negative for wild poliovirus. Finally, there has been constant monitoring of key surveillance indicators, which were, with few exceptions, at acceptable levels in all countries over the last three years.
2. After carefully reviewing these data, **all National Certification Commissions of the Region have recommended that their countries be certified as being polio-free.**
3. The ICCPE has carefully reviewed data that were presented by the Presidents of the National Certification Commissions. The ICCPE recognizes and applauds the extraordinary accomplishments which have been achieved by the countries of the Region. Overall, the quality of the National Certification Commission reports have been excellent; they have taken their responsibilities seriously and responded in exemplary fashion.
4. Based on the impressive evidence presented, the ICCPE concludes that wild poliovirus transmission has been interrupted in the Americas.

C. Recommendations

1. While the ICCPE is quite convinced that poliovirus transmission has been interrupted in the Americas, there remain several areas of concern. Although all National Certification Commissions have concluded that poliovirus transmission has ceased and evidence has been presented to support their conclusion, clear deficiencies exist in a few programs which should be corrected promptly. In particular, **vaccination coverage needs to be increased and surveillance systems need to be strengthened in these countries.** These deficiencies, if not corrected, will increase the risk for the re-establishment of wild poliovirus transmission in these countries, as well as in other countries of the Region, should the virus be introduced.

Since wild poliovirus transmission still occurs in other parts of the world, the ICCPE recognizes that the Americas will remain at risk for the importation of wild poliovirus. If importations occur, the potential exists for polio outbreaks, especially in areas with low vaccine coverage and poor sanitation. Poliovirus has displayed great ingenuity in locating pockets of susceptible persons, even in countries with high levels of vaccination coverage, such as the Netherlands, Canada, and Taiwan.

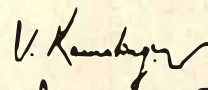
2. **The Region of the Americas will need to maintain high levels of vaccination coverage until the world is certified as being polio-free.** Indeed, it may be easier to eliminate poliovirus from the Americas than to maintain a polio-free status. Being the first region of the world to interrupt wild poliovirus transmission means that these efforts will need to be conducted for as long as wild poliovirus is circulating elsewhere.
3. Ongoing targeted surveillance for cases of acute flaccid paralysis and for the presence of wild poliovirus will be absolutely necessary to assure that the Region of the America remains polio-free. It would be tragic, if after the extraordinary efforts that have been made to free the Americas from polio, we were to let down our guard and allow the poliovirus to become established once again.

4. International communication and collaboration are necessary to assure the rapid detection and timely implementation of control efforts for importations of wild poliovirus.
 5. The ICCPE strongly encourages other regions of the world to accelerate their poliomyelitis eradication activities, since only the global eradication of poliomyelitis will assure that poliovirus infection will not cause paralytic disease in the Americas or the rest of the world. The polio-free countries of the world should realize that it is very much to their benefit to do what they can to facilitate the eradication of poliovirus from polio-endemic countries.
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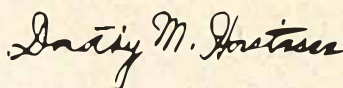
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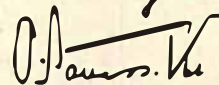
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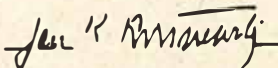
Dr. Dorothy Horstmann



Dr. Olikoye Ransome-Kuti



Dr. Jan Kostrzewski



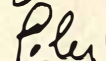
Dr. Frederick C. Robbins
(Chairman)



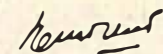
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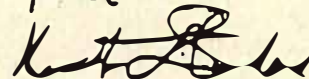
Dr. Guillermo Soberón



Dr. Elsa Morena



Sir Kenneth L. Standard



Dr. Fernando C. Olinto



- Remarks for Mrs. Clinton at the April 7th event will have to be prepared. Her participation will "kick-off" this initiative, making the elimination of measles a more visible goal in the hemisphere. The event will also allow for a public call on the need for political and financial commitment to the measles campaign and generate broad participation by all sectors, including NGOs such as the Lion's Club. Representatives from all the sectors (IFIs, NGOs, donors, etc) will be invited to participate in the April 7 ceremony.
- Through Mrs. Clinton's participation in the Measles ceremony, she should promote the establishment of country level partnerships to promote the elimination of measles.
- Full funding for the \$46 million PAHO-led Measles Elimination Project in the Americas has not been identified. Negotiations are proceeding with the Japanese, USAID and the IDB. Expectations are that the high visibility given to this event through the participation of the First Lady will encourage others to contribute towards this project.

2. International Conference on Maternal Mortality

- The proposed "Plan of Action to Reduce Maternal Mortality in the Americas", prepared by PAHO (dated 3/3/95), was reviewed. The recommendation to hold an international conference on the subject in Honduras to be held late August-early September was discussed.
- Concerns were raised on the relative advantage/impact of holding a separate international conference on this subject. It was noted that in 1990 countries of the region approved the "Regional Plan for the Reduction of Maternal Mortality in the Americas" and Ministers of Health of the region adopted a resolution committing to the implementation of a comprehensive health care policy addressing maternal mortality and morbidity issues. Progress in this area, however, has been very slow. Most countries have national plans of actions, but improvement in the related indicators has been disappointing.
- A Scientific Technical Advisory Committee for the Reduction of Maternal Mortality will meet in Atlanta in April 1995. Countries will present a report and progress will be evaluated. Based on the results, updated plans will be developed and published in July 1995.

- After discussing the proposed conference (cost, usefulness, timing, etc), it was decided that an attempt would be made to add maternal mortality as a topic on the Agenda of the First Ladies' meeting scheduled for October 1995 in Paraguay.
- Consolidating this activity into the agenda of the First Ladies Meeting in Paraguay will reduce logistics, cost and allow for greater participation by the other first ladies. At the meeting, the host (and Mrs. Clinton) can ask for the respective First Ladies to present a status of the problem in their country and discuss the plans that the individual countries have to confront the maternal mortality and morbidity challenges. This will provide an opportunity for the First Ladies to highlight the issue at the national and regional level and to solicit support for a common need identified in the region by the First Ladies at the Miami Symposium. This forum will lend itself to monitoring the progress made towards the targets set in the country Plans.
- Prior to the meeting, Mrs. Clinton and Mrs. Wasmosy could send a Maternal Mortality-specific letter, emphasizing the concerns for the issue in the region and promoting support for this effort -- referring to the goals presented in the National Plans of Action updated during the April 1995 meeting in Atlanta. The First Ladies involvement in this effort can help generate political support for this area at the country level (prior and after the Paraguay meeting). They can also be very influential in creating local-level partnerships supporting this initiative.
- PAHO, through their country level offices, will work with the national counterparts (Ministries, First Ladies' Office, NGOS, Church, etc.) to implement the activities presented in the National Action Plans.

3. International Conference on Girl's and Women's Education

- A note was made to the Girl's and Women's Education Initiative that the Vice President and Mrs. Clinton plan to announce at the World Summit for Social Development in Copenhagen March 6-7.
- Caution was raised to the issue as perceived by the Caribbean countries since girls' attendance rates exceed those of boys. These countries could be invited to present their strategies and lessons learned on how to achieve their high rates --- given the role that girls' education plays in development. This would put these countries in a key role. Strong attendance achievement in the Caribbean is contrasted with low

access for girls to leadership roles. They could help highlight the absence of women in decision-making positions in the Caribbean and the need to focus their countries on the need to link education with employment.

- Concern was raised over the proposed site. Given some human rights issues, Guatemala may not be a possible site to hold the conference. Thought should be given to other countries. Nicaragua was proposed as an alternative because of Mrs. Chamorro's likely participation in such an event.

4. Launching the Partnership for Education Reform in the Americas (PERP)

- More detail is needed on this proposed activity. Once some funding issues are resolved a more fleshed out version of this activity will be prepared for review by the group.
- Interest was expressed in launching the PERA project prior to the Meeting of the First Ladies in Paraguay. Mrs. Clinton could be asked to launch the project by participating in the first education policy meeting under the project. Mrs. Clinton could be asked to address the participants and highlight the importance of educational investment and sound education policy.

General Follow Up Items:

- A letter will be drafted for Mrs. Clinton/Mrs. Wasmosy's signature which links the four areas/activities coming out of the Symposium for follow up within the framework of the Summit of the Americas. It will encourage the First Ladies to engage in these areas by calling for increased broad participation at the country level, increased financial support and political commitment for progress in achieving targets in the these sectoral areas.
- Mrs. Clinton will call Mrs. Wasmosy to walk through the proposed strategy and talk through the contents of a proposed letter to the First Ladies. The Agenda for the First Ladies's Meeting in Paraguay will also be discussed.
- A list of actions for Mrs. Clinton will be drafted to make sure that we are clear on exactly what we are committing her to.
- Work will continue on the preparation, printing and distribution of the Rapporteur's Report.

- A workplan on the "educational reforms" initiative will be prepared and the "Maternal Mortality" initiative will be revised to reflect the changes discussed in the meeting.
- A meeting with the IDB will be scheduled to discuss its participation in the education sector initiatives.

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