Update on Measles in the Americas

The countries of the Americas reported only 5,623 confirmed measles cases in 1995, 2,868 of which were confirmed by laboratory tests. This represents the lowest number of total cases since measles surveillance began, and a dramatic drop over the 1994 total of 23,583. The downward trend has continued in 1996: In the first 20 weeks of this year, only 409 cases were confirmed (340 with laboratory investigation), compared with 731 in the same period in 1995 (150 with laboratory confirmation).

It has been over four years since the last laboratory-confirmed case of measles was reported in the English-speaking Caribbean. Although there is still no formal process for the certification of interruption of measles transmission, all available evidence suggests that the goal established in 1988 by the CARICOM ministers of health of interrupting measles transmission in the English-speaking Caribbean by 1995 has been accomplished. This is the first time that a group of countries has achieved and maintained a measles-free status for such a long period. In addition, no laboratory-confirmed cases have been detected in Chile or in Cuba over the last two and three years, respectively, despite the presence of excellent surveillance systems.

Of the reported confirmed cases in 1995, 2,764 (49%) were confirmed on clinical grounds without an adequate laboratory investigation, representing a failure of the surveillance system. Without laboratory testing, it is impossible to state with certainty whether these cases were truly measles virus infection or were due to another cause. The establishment of a regional measles diagnosis laboratory network, now in the final phase of completion (see Bulletin of PAHO 29(3), 1995, pp. 276–278), is expected to help the countries increase the rate of laboratory investigation.

Over a year has passed since the occurrence of an imported case of measles into the United States of America from Latin America and the Caribbean. This is in great contrast to the period 1990–1992, when an average of over 100 imported cases per year, or over 80% of such importations, came from Latin America and the Caribbean. This information provides further evidence of the extremely high level of measles control that has been achieved in the countries of the Western Hemisphere.

PAHO has developed a comprehensive methodology for evaluating the capacity of national surveillance systems to detect measles cases. This methodology was applied successfully in Mexico in December 1995 and El Salvador in February 1996. No measles virus circulation was detected in those countries at the time these evaluations were performed.

Despite the great progress achieved in the Americas toward the goal of measles elimination, it is important to keep in mind that measles virus still circulates freely in other parts of the world and that importations into this hemisphere are highly likely. Data from country program reviews underscore the fact that, in spite of high levels of vaccination coverage, many children remain susceptible to measles in almost every country in the Region. This is true because vaccine coverage never reaches 100% and vaccine efficacy is approximately 90%. Therefore, every year there are some children who are not vaccinated and some vaccinated children who, for some reason, fail to respond to the vaccine.


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At present, it is estimated that 25% of all children 1–5 years of age in the English-speaking Caribbean are susceptible to measles. In Central America the proportion may be as high as 30%. These high numbers of susceptibles could fuel an outbreak if measles virus were introduced in these areas, especially in population pockets with relatively low vaccine coverage. Therefore, as indicated in the Plan of Action for Measles Elimination in the Americas, approved by the XXXVIII Meeting of the Directing Council in 1995, it is imperative that all countries regularly analyze their accumulation of susceptibles. If this number has reached the threshold indicated in the Plan of Action (equal to or greater than the number of children in one annual birth cohort), the country should implement follow-up vaccination campaigns targeting all children 1–5 years of age, regardless of vaccination status. Such a campaign was carried out by all the countries of Central America in April–May 1996, and similar campaigns have also been implemented in Belize, Brazil, Cuba, and Jamaica. It is expected that other countries will follow suit. If these measures are not carried out, achievement of the elimination goal by the year 2000 will be jeopardized.

FUNDING FOR MEASLES ELIMINATION

The Plan of Action for Measles Elimination estimates that for the period 1997–2001 the total cost of immunization programs in Latin America and the Caribbean, including activities aimed at the elimination of measles, will be on the order of US$ 710 million. Of this total, it is estimated that approximately $53 million (7.5%) will be financed by external resources and $657 million (92.5%) by resources available from the countries. The corresponding percentages for the period 1992–1996 were 8.5% from external sources and 91.5% from national funding. National contributions for immunization programs have increased steadily compared with external resources, ensuring the sustainability of these programs.

Several agencies have been consulted by PAHO about their interest in supporting the program in the coming period, and some have already responded positively. The Spanish Agency for International Cooperation has provided a $650 000 grant to PAHO along with one associate expert. The Kingdom of the Netherlands has also indicated support for this program. In June 1996, during the 118th Meeting of the Executive Committee, PAHO and the United States Agency for International Development (USAID) signed a grant agreement for approximately $8 million. The signing marked the fulfillment of a commitment announced by First Lady Hillary Rodham Clinton at PAHO Headquarters on World Health Day 1995. The Inter-American Development Bank (IDB) has approved a grant of some $2 million to the Organization; IDB and PAHO officials are now negotiating the terms of disbursement and utilization of these resources.

While the collaboration of external agencies is critical for program success, the bulk of resources will have to come from the countries themselves. An excellent example of national commitment is the recent establishment of a budget line for national immunization activities in the budget of Guatemala. Similar laws should be enacted in all countries to ensure the permanence of these programs. PAHO is actively collaborating with legislators in various countries to facilitate this process.

The participation of nongovernmental and private voluntary organizations in immunization programs has increased markedly in recent years. This trend has had a positive effect on the mobilization of national resources in support of immunization programs and their sustainability within the national health infrastructure.

The regional initiatives to eradicate poliomyelitis and now to eliminate measles,
as well as the ongoing efforts to maintain high vaccination coverage levels and to control other communicable diseases, attest to the impact of well-coordinated approaches that require national commitment and allocation of the necessary resources to carry out activities at regional and country levels. Continued national and international commitment will be critical if these challenges are to be met successfully.

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Progress Toward Control of Foot-and-Mouth Disease

BACKGROUND

The prevalence of foot-and-mouth disease (FMD) directly and significantly affects a country’s production of protein of animal origin, such as milk and meat, which is essential for human nutrition. This disease is also the greatest nontariff obstacle to international trade in animals and animal products worldwide.

The Region of the Americas has made enormous headway in controlling foot-and-mouth disease during the last decade under the Hemispheric Plan for the Eradication of Foot-and-Mouth Disease. The Hemispheric Plan was prepared at the request of the V Inter-American Meeting, at the Ministerial Level, on Animal Health (Washington, D.C., 1987), which also approved the creation of the Hemispheric Committee for the Eradication of Foot-and-Mouth Disease and entrusted it with monitoring and supporting the achievement of the Hemispheric Plan’s objectives and goals. The Committee comprises one minister of agriculture and one representative of livestock producers from each subregion of the Americas. The Committee has held five meetings since its creation and has provided essential political and technical support to the program to eradicate foot-and-mouth disease. The Pan American Health Organization, through its Pan American Foot-and-Mouth Disease Center (PANAFTOSA) in Brazil, is mandated to provide technical cooperation to the countries for implementation of the Hemispheric Plan.

Successful fulfillment of the plan requires integrated and coordinated efforts of the public and private sectors through local producers, as well as the effective use of technical components such as information and epidemiologic surveillance systems, ecosystem-specific control activities, potent and effective vaccines, and methods of risk analysis. Participation of the community has also proven to be an important strategy.

CURRENT SITUATION AND ACTIVITIES

The following goals had been achieved by the end of 1995:

- Uruguay was recognized as a FMD-free country without vaccination in 1995 (its status had been FMD-free with vacci-