

## 54th DIRECTING COUNCIL

### 67th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 28 September-2 October 2015

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*Provisional Agenda Item 7.5*

CD54/INF/5  
10 September 2015  
Original: English/Spanish\*

#### PROGRESS REPORTS ON TECHNICAL MATTERS

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\* Original in English: section B. Original in Spanish: sections A, C, D, E, F, and G.

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## **A. IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL**

### **Background**

1. This is a progress report on tobacco control in the Region of the Americas between 30 June 2013 (document CD52/INF/4) (1) and 30 April 2015, in the framework of resolutions CD48.R2 (2008), adopted by the 48th Directing Council of the Pan American Health Organization (PAHO) (2), and CD50.R6 (2010), adopted by the 50th Directing Council (3).

### **Update on Progress Achieved**

2. The number of States Parties to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) increased to 30 in the Region of the Americas with ratification by El Salvador in October 2014. In the last two years, progress has been slow in the implementation of the mandates of the FCTC.

3. With regard to surveillance, a new round of the Global Youth Tobacco Survey was carried out in seven countries and is in preparation in four more. The Global Adult Tobacco Survey was repeated in Mexico and was carried out for the first time in Costa Rica. It should be noted that Argentina, Brazil, and Uruguay have included standardized questions on tobacco in their national surveys.

4. Chile and Venezuela, within the framework of their respective tax reforms, have established measures to make tobacco products more expensive. Honduras has adjusted its specific tax on tobacco to take inflation into account; Dominica and Grenada have raised its special tax on consumption, taking effect in 2015, while Saint Vincent and the Grenadines, and Saint Lucia are making headway with proposals in this regard. There are six Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products, two of which (Nicaragua and Uruguay) belong to the Region.

5. No new legislation on smoke-free environments has been passed, but enabling regulations were issued for the Brazilian law that took effect in December 2014.

6. Jamaica, Suriname, and Trinidad and Tobago have issued enabling regulations for their laws on packaging and labeling of tobacco products, which includes graphic health warnings, while several countries have renewed such images during the biennium. To date, all the Parties that have not yet implemented article 11 of the FCTC have missed the stipulated deadline to do so.

7. Uruguay has joined the four countries that have approved a total ban on tobacco advertising, promotion, and sponsorship (Brazil, Colombia, Panama, and Suriname). At the end of this biennium, the 22 countries that have not yet complied with this article will have missed the deadline for implementation set in the FCTC.

8. The situation of tobacco industry interference against tobacco control policies remains unchanged.

9. The Pan American Sanitary Bureau has continued to lend its technical support, both in the drafting of tobacco control laws and in the process of approving and implementing them, and in the defense against attacks by industry. Assistance to the Parties and to the Secretariat of the Framework Convention has continued through ongoing communications between meetings of the Conference of the Parties. A regional workshop in preparation for the sixth meeting of the Conference of the Parties was organized with financial support from Panama. Finally, the *amicus curiae* submission made by the Secretariat to the International Center for Settlement of Investment Disputes (ICSID), an institution belonging to the World Bank Group, was accepted on 18 March 2015, in the arbitration requested by Philips Morris against Uruguay.<sup>1</sup>

### **Measures Recommended to Improve the Situation**

10. In general, the recommendations made in the 2013 progress report (Document CD52/INF/4) are reiterated, with special emphasis on the following points:

- a) the Parties should consider ratifying the Protocol on Illicit Trade in Tobacco Products, adopted at the fifth meeting of the Conference of the Parties to the WHO-FCTC, if they have not yet done so;
- b) Argentina, Cuba, Dominican Republic, Haiti and the United States of America should consider ratification of the WHO FCTC;
- c) the Member States should consider the possibility of implementing the four “best buys” in tobacco control in order to reach the goal of the Global Tobacco Surveillance System: a 30% reduction in the prevalence of tobacco use by 2025, if they have not yet done so;
- d) the Member States should consider including the subject of tobacco control in the program of all United Nations agencies at the country level, and in all projects of the United Nations Development Assistance Framework (UNDAF)<sup>2</sup> (4, 5).

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

11. The Directing Council is requested to take note of this progress report and to formulate the recommendations it deems relevant.

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<sup>1</sup> <http://www.iareporter.com/>

<sup>2</sup> In compliance with the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, and in compliance with the resolution of the Economic and Social Council (ECOSOC) of July 2012.

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## B. PROPOSED 10-YEAR REGIONAL PLAN ON ORAL HEALTH FOR THE AMERICAS

### Background

1. The purpose of this document is to report to the Governing Bodies of the Pan American Health Organization (PAHO) on progress made toward implementing Resolution CD47.R12, the 10-year Regional Plan on Oral Health for the Americas (“the Plan”), adopted in 2006 (1). The Resolution seeks that Member States recognize that oral health is a critical aspect of general health conditions, due to its weight in the overall burden of disease and association with risk factors for noncommunicable diseases (NCDs), and can be implemented through cost-effective interventions for disease prevention.
2. Resolution CD47.R12 asks Member States to support three goals—the integration of oral health into primary health care (PHC) strategies, greater access to care, and the extension and consolidation of successful programs such as fluoridation and proven cost-effective delivery of oral health care services, for example, Procedures for Atraumatic Restorative Treatment (PRAT<sup>1</sup>). The resolution also asked Member States to work in a multidisciplinary manner with other stakeholders, including those in the private sector, academia, and civil society.
3. To keep the Governing Bodies informed of achievements in the Region toward meeting these goals, it was requested that progress reports be submitted. The current update is provided below, along with a description of the three goals and their complementary objectives.

### Update on Progress Achieved

Goals	Objectives	Status
<b>1. Ensure essential and basic level of access to oral health care for all by addressing gaps in care for the most vulnerable groups</b>	1. Reduce oral infections among vulnerable groups	<ul style="list-style-type: none"> <li>• 56 national oral health surveys indicated a marked decline (35%–85%) in the prevalence of dental caries, attributed mostly to fluoridation programs (2).</li> <li>• 34 Member States had an average DMFT<sup>2</sup> score <math>\leq 3</math> for 12-year-olds (with 23 of the countries scoring <math>\leq 2</math>); only one country</li> </ul>

<sup>1</sup> PRAT (or Procedures for Atraumatic Restorative Treatment) is a simple method for treating dental caries that is considered a cost-effective means of reducing inequities in oral health care services. It involves the removal of soft, demineralized tissue followed by the restoration of the tooth with fluoride-releasing glass ionomer. Known also as Atraumatic Restorative Treatment (ART).

<sup>2</sup> DMFT (decayed, missing, and filled teeth) is a unit of measurement (score) describing the amount of caries in a population. The World Health Organization (WHO) recommends a DMFT score  $\leq 3$  for the population aged 12 years.

Goals	Objectives	Status
	2. Increase access to oral health care for vulnerable groups	received a score >5. The Caries Free Communities Initiative (CFCI), a collaboration of multiple stakeholders launched in 2009, supports cost-effective interventions and increased coverage of services for the most vulnerable populations in the Americas. The CFCI includes 37 country chief dental officers, 17 dental schools, 12 dental associations, and two private health companies. The initiative provides evidence and promotes action to further improve oral health programs at the national and local level throughout the Region (3).
<b>2. Integrate oral health care into primary health care services</b>	1. Integrate oral health programs into primary health strategies	<ul style="list-style-type: none"> <li>• All countries in the Region report having institutional policies to integrate oral health into PHC strategies.</li> <li>• With the inclusion of oral health in the political declaration of the High-level Meeting of the General Assembly on NCDs, further efforts are being made by Member States to sustainably integrate oral health into PHC programs and to define it as a risk factor for NCDs (4-6).</li> <li>• With the support of the private sector, a multicountry plan known as SOFAR<sup>3</sup> is in progress until 2016 in nine countries to further improve oral health for children and to reduce common risk factors for NCDs using multidisciplinary approaches.</li> </ul>
<b>3. Scale up proven cost-effective interventions—multiyear plan for fluoridation programs in the Americas and expansion of oral health coverage with simple technologies</b>	<p>1. Strengthen country capacity to enable scaling-up of fluoridation programs</p> <p>2. Scale up oral health coverage using cost-effective and simple technologies</p>	<ul style="list-style-type: none"> <li>• All countries in the Region have effective fluoridation programs at varying stages of maturity and with different levels of sustainability.</li> <li>• Salt fluoridation has been recognized as a sustainable leading global health case study (7).</li> <li>• In accordance with current salt ingestion guidelines, salt fortification procedures are being reviewed.</li> <li>• The PRAT technique is recognized as a best-practice model by all countries in</li> </ul>

<sup>3</sup> SOFAR (*Salud Oral y Factores de Riesgo* or Oral Health and Risk Factors) encompasses the horizontal integration of oral health into PHC by *a*) promoting and incorporating it as an integral part of PHC areas such as family health and perinatal health (e.g., including fluoride varnish application in a vaccine schedule) and *b*) focusing on poor oral health as a risk factor for general health.

Goals	Objectives	Status
		<p>the Region and has been scaled up in 20 countries.</p> <ul style="list-style-type: none"> <li>• Nearly 126 million people will benefit from the initial scale-up of SOFAR.</li> </ul>

### Challenges

- a) Achieving recognition of oral health as a public health priority remains a challenge despite the demonstrated link between oral health and systemic health, and the cost-effectiveness of oral health interventions.
- b) Incentivizing actions to improve oral health and aligning and integrating it with PHC systems to modify risk factors for NCDs.
- c) Achieving an effective country-level response to the recent trend of increasing human papillomavirus (HPV)-associated oral cancer.

### Actions Necessary to Improve the Situation

4. The following are actions required to improve the situation:
  - a) Recognize that oral health is a priority for and an essential part of general health and has a direct impact on the quality of life of the aging population.
  - b) Continue to strengthen the capacity of PHC workers to improve oral health and to sustainably integrate oral health into PHC.
  - c) Address the implications of the state-of-the-science of HPV-associated oral cancer for future research and public health policy in the Region.
  - d) Prepare a new plan of action, upon the completion of this one, in order to sustain achievements in oral health in the Region.

### Action by the Directing Council

5. The Directing Council is invited to take note of the progress report and to provide pertinent recommendations.

### References

1. Pan American Health Organization. Proposed 10-year regional plan on oral health for the Americas [Internet]. 47th Directing Council of PAHO, 58th Session of the WHO Regional Committee for the Americas; 2006 Sep 25-29; Washington (DC), US. Washington (DC): PAHO; 2006 (Resolution CD47.R12) [cited 2014 Dec 3]. Available from: <http://www1.paho.org/english/gov/cd/CD47.r12-e.pdf>

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## C. PLAN OF ACTION ON ROAD SAFETY

### Background

1. This report considers the progress made in road safety in the Region of the Americas from October 2011 to December 2014, following up on Resolution CD51.R6 of the 51st Directing Council of the Pan American Health Organization (PAHO) (1, 2).

### Progress Report

2. This progress report is based on the Global status report on road safety (3) and includes additional information received from the country offices.

3. There has been an increase in the number of countries that have an agency responsible for coordinating measures to promote road safety. Since the establishment of the 25-country baseline, two additional countries (Colombia and Paraguay) have created a road safety agency in this period.

4. There has been an increase in the number of countries that have passed laws setting the blood alcohol limit for drivers at  $\leq 0.05$  g/dl (concentration of alcohol in the blood). The number of countries that have set this limit has risen from 10 to 15. Chile is one of the countries that have lowered the limit to a maximum of 0.03 g/dl.

5. Compared to the baseline, two countries (Mexico and Panama) have passed laws setting speed limits at  $\leq 50$  km/h in urban areas, while allowing local authorities to set lower limits.

6. Major progress has been observed in the countries as the result of new laws making seatbelt use compulsory for all passengers in vehicles: the baseline figure of 20 countries has risen to 32. Countries that have improved their laws include: Cuba, Ecuador, Guatemala, Honduras, Paraguay, Saint Vincent and the Grenadines, and Venezuela.

7. Progress has been made in terms of passing laws on compulsory helmet use for all motorcycle passengers: there are now 30 countries with such laws, compared to 12 on the 2011 baseline. Argentina, Bolivia, and Nicaragua are among those that have improved their laws.

8. Argentina, Cuba, Ecuador, Peru, and Uruguay have improved their laws on the compulsory use of child restraint systems.

9. There have been improvements in national policies to promote safe public transportation in Argentina, Cuba, Guatemala, Jamaica, Panama, Peru, and Uruguay.

10. The 22 baseline countries that promoted pre-hospital care for victims of traffic injuries have now been joined by three more countries: El Salvador, Jamaica, and Peru, bringing the figure to 25.

11. No improvement was observed in the quality of data on traffic injuries. The Andean, Central American, and Southern Cone subregions have high percentages of deaths classified as “other or unspecified causes” (48%, 34%, and 20%, respectively). There is clearly an urgent need to improve the registry and classification of traffic-related deaths in these subregions.

12. Attention to user mobility and safety is not uniform across subregions; for example, only 14 countries have policies to create separate, safe spaces for cyclists as part of roadway infrastructure in certain cities.

13. No information is available in the PAHO database or in any other regional database to determine whether progress has been made on the technical inspection of the entire vehicle fleet.

14. The majority of the countries have programs to follow up on the provisions of laws related to risk factors and the use of protective equipment, but very few countries consider the level of implementation of these laws to be effective.

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

15. It is again recommended that the countries establish advisory committees or national agencies to coordinate road safety, providing them with the necessary authority and resources to promote, implement, and ensure compliance with the approved road safety laws and measures (4).

16. The Member States should consider establishing a national surveillance system or strengthening the existing ones to improve the quality of data on: the groups and areas at greatest risk of road traffic injuries (4), vehicle fleet inspections, and implementation of legal frameworks, among others.

17. It is important that the Member States ensure that laws and regulations clearly establish how implementation, compliance, and monitoring will be ensured, and which entity is responsible (5).

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

18. The Directing Council is requested to take note of this progress report and to formulate the recommendations it deems relevant.

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## **D. DENGUE PREVENTION AND CONTROL IN THE AMERICAS**

### **Background**

1. In 2001, given the increase in dengue cases in the Americas and since national dengue control programs were predominantly vertical and based on pesticide use, a detailed action plan was prepared and presented to address the situation (1). In 2003 the Integrated Management Strategy for Dengue Prevention and Control in the Americas (IMS-dengue) was implemented. In its early stages it included five components (patient care, epidemiological surveillance, laboratory, integrated vector management, and mass communication) and subsequently incorporated an environmental component (2, 3). IMS-dengue was gradually implemented in each subregion and in 35 countries or territories, and was evaluated in 22 of them (two evaluations were conducted in Brazil and two in Mexico). A technical group of international experts on dengue (GT-Dengue International Task Force) was created to provide technical assistance to countries and territories on each component of IMS-dengue (3). In 2007, Resolution CSP27.R15 was adopted, urging countries and territories to step up implementation of IMS-dengue and systematically evaluate it (4).

2. The epidemiological status of dengue remains extremely complex and unstable. Between 2000 and 2014, 14.2 million dengue cases were registered, with 7,000 deaths. Incidence has continued to rise, due in part to improvements in epidemiological surveillance systems and reporting by the countries of the Region. However, dengue incidence in 2014 (193.7 cases/100,000 population) was 31% lower than the average over the previous five years (282.4 cases/100,000 population) and 57% lower than 2013 (455.9 cases/100,000 population) (5). Brazil, Colombia, and Mexico currently contribute 70% of the Region's dengue cases. The four serotypes of the dengue virus are circulating in the Americas, which increases the risk of severe cases (secondary immunological response) (6-8). However, it should be noted that a reduction has been registered in the proportion of severe cases in the last five years, and particularly in the last two years, reflecting a clear downward trend (5). There is a direct relationship between the reduction in severe cases and improvements in the quality and timeliness of primary medical care (warning signs). This has been confirmed in evaluations conducted in the countries.

### **Update on Progress Made**

3. Implementation of IMS-dengue has provided countries and territories with a sound methodological tool for dengue prevention and control.

4. World Health Organization (WHO) clinical guidelines for the care of dengue patients has been reviewed, updated, adapted, and published for the Americas, accompanied by training given by GT-Dengue experts to physicians and paramedical workers at the different levels of health care in the countries (9, 10).

5. Since implementation of the new clinical guidelines, the dengue case-fatality rate has declined in the Americas; it is estimated that 3,300 deaths were prevented between 2011 and 2014.<sup>1</sup> The second edition (2015) of the clinical guidelines is in the publication process. It includes new information for the management of dengue cases in pregnant women, newborns, and older adults, and for the reorganization of health services during outbreaks, among other elements.

6. A laboratory network was created for dengue diagnosis in the Americas (RELDA), through which technology and capacities are periodically transferred to countries and territories for the implementation of state-of-the-art molecular and serological methods for dengue diagnosis, with the support of the WHO collaborating centers (WHOCCs) for dengue.

7. In the last five years, 50 countries and territories have successfully maintained periodic reporting of dengue data (5). Work is in progress on the development of a generic system for integrated epidemiological surveillance, using standardized definitions and indicators, and integrating entomological and environmental components in the analysis. Surveillance in sentinel areas is also included to better characterize the history and course of the disease and its management in each country's service system. The generic system is in the validation phase in several countries and territories. Work is also underway to estimate the economic burden of dengue in several countries.

8. In May 2014, a review was conducted of the state of knowledge about dengue in the last 10 years (11), with the participation of academia, private industry, WHOCCs, countries, territories, and nongovernmental organizations. This review confirmed that IMS-dengue is the best available strategy and led to a strengthening of its operational model through the WHO Global Strategy for Dengue Prevention and Control 2012-2020 (12).

### **Actions Needed to Improve the Situation**

9. Advance in the consolidation of the IMS-dengue model as a methodological tool for dengue prevention and control in countries and territories.

10. Guarantee political support and financial and human resources for the sustainable implementation of IMS-dengue.

11. Involve other government sectors, ministries, academia, the private sector, communities, and families in an integrated response to the social and environmental determinants involved in transmission, since dengue is not exclusively a problem of the health sector. It has been shown that illiteracy, poor coverage of sanitation and piped drinking water, and poverty in general, are related to the high incidence and transmission of the disease.

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<sup>1</sup> Estimate based on an annual increase of 0.018% in case fatality (increase in case fatality between 2009 and 2010).

12. Continue to promote and foment public policies that act on the social and environmental determinants of dengue transmission in order to minimize the risk of infection by the disease.
13. Improve and strengthen the capacity and quality of medical care in all the countries and territories, focusing on clinical case management at the primary care level in order to prevent the progression to severe cases, since difficulties persist in case management.
14. Develop and implement new operational models for vector control.
15. Accompany the development and evaluation of new technologies for disease control and prevention that can be put into practice, including a dengue vaccine, transgenic mosquitoes, bacteria of the *Wolbachia* genus, and new ovitraps, among others (13-15).

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

16. The Directing Council is requested to take note of this report and formulate the recommendations it deems relevant.

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## **E. CHRONIC KIDNEY DISEASE IN AGRICULTURAL COMMUNITIES IN CENTRAL AMERICA**

### **Background**

1. Over the past two decades, the Central American subregion has reported a growing number of cases of people suffering, and dying, from chronic kidney disease (CKD). Among these cases, a type of CKD has been reported whose etiology is not linked to the most frequent causes of CKD, such as diabetes mellitus and hypertension. The frequency of this type of nontraditional chronic kidney disease, that is, CKD from nontraditional or unknown causes (CKDnT), is higher than that observed in the Region of the Americas overall and exhibits an upward trend (1). Recognizing this situation, the Member States of the Pan American Health Organization (PAHO) adopted Resolution [CD52.R10](#) (2013), Chronic Kidney Disease in Agricultural Communities in Central America,<sup>1</sup> during the 52nd Directing Council (2). This report summarizes progress achieved in implementation of that resolution.

### **Analysis of Progress Made**

2. There have been advances in developing a clinical case definition and an epidemiological case definition of CKDnT, as well as in establishing functional mechanisms to strengthen epidemiological surveillance. PAHO, in collaboration with the United States Centers for Disease Control and Prevention (CDC), the Latin American Society of Nephrology and Hypertension (SLANH), the Executive Secretariat of the Council of Ministers of Health of Central America and the Dominican Republic (SE-COMISCA), and representatives of the health ministries of Central America, has developed a proposal for a case definition to be used in epidemiological surveillance as well as a clinical case definition. Together, these agencies have reviewed the document on harmonization of procedures in order to improve notification and the quality of the registry of deaths from CKD. The Latin American and Caribbean Network for the Strengthening of Health Information Systems (RELAC SIS), of PAHO/WHO, has achieved improvements in the coverage and quality of the information on mortality and in the standardization of definitions, and has developed a proposal for implementation of the new codes that will appear in the International Classification of Diseases, 11th revision (ICD-11).

3. Although there is still no consensus on the formulation of a regional research agenda, the countries have moved forward in conducting studies, publishing articles, incorporating CKDnT into national research agendas, and participating in research. MEDICC Review (International Journal of Cuban Health and Medicine) devoted a special issue to the subject (3). During the period, collaboration has been strengthened between the Pan American Sanitary Bureau (the Bureau) and the PAHO/WHO

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<sup>1</sup> Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

Collaborating Centers in occupational and environmental health,<sup>2</sup> which have incorporated CKDnT into their support activities. A collaboration network was also formed to undertake research on the epidemic: the Consortium for the Epidemic of Nephropathy in Central America and Mexico (CENCAM) (4). To date, although the etiology remains unknown, the scientific community has reached consensus on characterization of the disease, establishing that CKDnT is essentially occupational in character. Therefore it is vital to strengthen environmental and occupational health promotion to prevent this disease.

4. Although advances in environmental and occupational health have been limited, the legal framework for pesticide control has been updated in El Salvador, where the use of 53 highly toxic active ingredients has been prohibited (5), and new national regulations on occupational health and safety have been approved in Guatemala, including measures for the prevention of CKD (6). Guatemala is also working to modify its regulations on the management of domestic pesticides.

5. Countries have held training activities on intersectoral action to address environmental risks, clinical toxicology, and risk assessment methodology. The Bureau, together with the PAHO/WHO Collaborating Centers in occupational and environmental health, is developing protocols for situation analysis and for implementation of preventive and corrective interventions in work environments. The Bureau has also implemented an online tutorial course with regional experts on diagnosis, treatment, and prevention of acute pesticide poisoning (7).

6. There have been some advances in incorporating comprehensive care for CKD into the health services, among them the development of clinical care guidelines for CKD patients at the first level of care, updating of national standards, and development of services for prevention and comprehensive care of CKD, with emphasis on primary care. Two countries, El Salvador and Nicaragua, reported advances in establishment of legal and regulatory frameworks for organ and tissue donation and transplantation.

7. The Bureau has completed a review of essential drugs and technologies for treatment of CKD with a view to their possible inclusion in the product list of the PAHO Strategic Fund (8). PAHO consolidated the demand for these drugs; however, except for insulin, the Member States have not used the Fund to acquire these drugs.

8. The Bureau has continued its technical cooperation efforts to improve access to and coverage of transplants for the treatment of CKD. These activities include the high-level meeting of the Iberoamerican Network/Council of Donation and Transplantation, held in Panama in November 2014, and the meetings of COMISCA

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<sup>2</sup> The Regional Institute for Studies on Toxic Substances (IRET), Costa Rica; the National Public Health Institute of Quebec (INSPQ), Canada; and the United States Centers for Disease Control and Prevention (CDC) and its National Institute for Occupational Safety and Health (NIOSH).

XXXVIII and XL, held in Costa Rica and the Dominican Republic in June 2013 and 2014, respectively.

### **Actions Needed to Improve the Situation**

9. It is important to complete, with urgency, the formulation of the regional agenda for research on this topic, and to identify resources with which to carry out two key types of studies to guide prevention efforts: *a)* etiologic studies, and *b)* operational research studies on the effectiveness of interventions.

10. Once agreement has been reached on case definitions for surveillance of CKDnT (suspected case, clinical case, and mortality coding), it is crucial that countries develop and use a standardized surveillance platform and periodically share agreed information from the surveillance. It is also necessary to continue efforts to develop and strengthen dialysis and renal transplantation registries, and to strengthen environmental and occupational health surveillance.

11. The Member States should urgently analyze the comprehensive response to CKD in light of the agreed commitment to advance toward universal access to health and universal health coverage. This should include analysis of how CKD is incorporated into the package of universal comprehensive services, taking into account not only clinical care of the disease, but also promotion and prevention.

12. Since CKDnT is essentially occupational in character, immediate intersectoral action is required to address the risk factors and social determinants of health clearly related to this problem and to identify environmental and occupational health promotion initiatives that can help prevent the disease.

13. Available estimates show that the cost of treatment for CKD is very high and that the financing and sustainability of health services will be greatly affected by the capacity of countries to implement measures for the prevention of CKD. The estimated cost of dialysis per patient ranges from US\$355<sup>3</sup> to \$2,249 in the public sector (9), and the monthly cost of immunosuppressants per transplant patient ranges from \$725 to \$4,250 (9). In these countries, total health expenditure per capita (public + private) ranges from \$144 to \$951, and per capita government health spending ranges from \$78 to \$710 (10). Cost-benefit studies should be conducted to inform processes aimed at expansion and sustainability of access to treatment, as well as to explore options for negotiating better prices, in the context of country health plans and policies.

14. Steps should be taken to strengthen the local-level response capacity for comprehensive care of CKD, including greater capacity of human resources for management of peritoneal dialysis and hemodialysis, treatment protocols, and mental health interventions, in order to support not only patients but also their families.

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<sup>3</sup> Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

**Action by the Directing Council**

15. The Directing Council is requested to take note of this report and formulate the recommendations that it considers appropriate.

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## F. HEALTH TECHNOLOGY ASSESSMENT AND INCORPORATION INTO HEALTH SYSTEMS

### Background

1. At the 28th Pan American Sanitary Conference (PASC) in September 2012, the Member States were pioneers when they adopted the first resolution on health technology assessment (HTA) and the incorporation of health technologies into health systems. Resolution CSP28.R9 adopted an innovative policy paper that proposes linking HTA with the decision-making processes involved in incorporating these technologies into health systems (1). The resolution has had worldwide impact: in 2013, the countries of SEARO<sup>1</sup> adopted a resolution on HTA (2) and, in 2014, the World Health Assembly adopted resolution WHA67.23 on this same issue (3). Resolution CSP28.R9 also recognizes the importance of the HTA Network of the Americas (RedETSA)—created in 2011 with PAHO acting as its secretariat—and urges the countries to participate actively in this network. This report to the Governing Bodies of PAHO presents the progress achieved in the Region in the implementation of Resolution CSP28.R9.

### Progress Report

2. In recent years there have been clear advances in the institutionalization of HTA in the Region, both at the regional and national levels. Countries that have moved forward on this issue include: *a*) Argentina, with the creation of a national network (RedARETS), the consolidation of a coordinating unit (UCEETS), and the recognition of IECS as a WHO Collaborating Center; *b*) Brazil, with the strengthening of a national commission (CONITEC) and the expansion of a national network (REBRATS) with more than 75 institutions; *c*) Colombia, with the strengthening of a national institute (IETS); and *d*) Chile, with the creation of a national HTA commission.

3. The Region was mapped to determine the status of HTA and information from 28 countries was gathered,<sup>2</sup> revealing clear advances in its use.<sup>3</sup> Twelve countries of the Region have HTA units, commissions, or institutes. The responses from the countries indicate that the Region has 76 institutions that carry out some type of HTA-related activity: 49% of them are governmental and 34% are academic institutions.

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<sup>1</sup> See the list of acronyms at the end of the document.

<sup>2</sup> Mapping was split into two components: diagnosis of HTA capacities and decision-making processes. Interviews were held with key staff members of ministries of health, HTA institutions, and other academic and health institutions between 2014 and early 2015. A total of 147 responses were received from 28 countries.

<sup>3</sup> The survey on decision-making process was prepared as a part of the Advance-HTA project, jointly with EASP, LSE, and NICE. The survey on HTA capacities was prepared by the RedETSA countries, based on a mapping survey carried out in MERCOSUR.

4. Seven countries<sup>4</sup> reported already having laws that require some use of HTA in decision-making processes. Beyond legislation, the actual linkage between decision-making and the conclusions reached through HTA is highly diverse across the Region. On the basis of the responses received, it appears that only in Brazil are the conclusions of HTA always taken into account for decision-making. In contrast, seven countries<sup>5</sup> reported that decisions are made without reference to HTA. The other countries<sup>6</sup> reported different levels of frequency in the use of HTA to support decision-making.

5. Other important findings of the mapping indicate: *a)* significant production of documents<sup>7</sup> on HTA, especially in Argentina, Brazil, Canada, and Colombia; *b)* high use of HTA reports from other countries in decision-making; *c)* widespread use of methodological guides among RedETSA countries and, in contrast, no use in countries outside the Network; and *d)* little consideration of ethical and equity-related aspects as explicit decision-making criteria.

6. Despite the major progress, the results of the mapping show great heterogeneity: although some countries have made important achievements, others have not institutionalized HTA at all. In the countries of the Caribbean, for example, implementation of HTA remains at low levels. Nevertheless, seven Caribbean countries<sup>8</sup> have commissions or structures in charge of selecting products from the essential medicines list, which could serve as the starting point for establishing HTA units.

7. At the regional level, the main limiting factors or obstacles observed in HTA implementation were a lack of skilled human resources, budgetary or financial needs, limited inclusion of HTA as a decision-making tool, and lack of access to databases.

8. Considering the need for training in the Region, the launch of the first course on HTA at the PAHO Virtual Campus represented very significant progress. In September 2014, with the support of IECS (Argentina), the tutored virtual course “Introduction to health technology assessment and economic evaluation” was launched. A total of 352 people from 19 countries requested admission to the course but only 47 participants from 16 countries could be accepted.

9. Networked collaboration plays a key role in the development of HTA. Since its creation, RedETSA has grown (it is currently made up of 26 institutions from 14 countries)<sup>9</sup> and has contributed to strengthening HTA in the Region. In addition to mapping capabilities and decision-making processes, there have been other important

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<sup>4</sup> Bermuda, Bolivia, Brazil, Chile, Colombia, Suriname, and Uruguay.

<sup>5</sup> Barbados, Guatemala, Honduras, Mexico, Panama, Saint Martin, and Trinidad and Tabago.

<sup>6</sup> Argentina, Bermuda, Bolivia, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Jamaica, Paraguay, Peru, Saint Lucia, Suriname, Uruguay, and Venezuela.

<sup>7</sup> The countries reported a production of approximately 3,900 documents on HTA since 2010.

<sup>8</sup> Antigua and Barbuda, Dominica, Grenada, Jamaica, Suriname, and Trinidad and Tobago, and Turks and Caicos Islands

<sup>9</sup> Argentina, Brazil, Bolivia, Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Mexico, Paraguay, Peru, and Uruguay.

achievements: for example, the Network has allowed the development of a forum for the exchange of information by consolidating the PRAIS community of practice,<sup>10</sup> establishing a virtual forum where reports can be shared, subjects of interest addressed, and consultations made on specific technologies; and eight meetings and workshops were held to discuss different issues such as the role of HTA in universal health coverage and the interaction between HTA and regulation in the countries. In November 2014, Mexico City was host to the most recent meeting of RedETSA, organized in collaboration with PAHO and the National Center for Health Technology Excellence (CENETEC), in conjunction with the 10th National Health Technology Forum. Also in recent years, there has been considerable collaboration with other regional HTA networks, such as EUnetHTA and HTAsiaLink, and with the global HTA Network (INAHTA), which has seen a significant increase in affiliation of countries of the Region.<sup>11</sup>

10. Progress has been made in the adoption of an integrated approach to HTA in support of decision-making, which includes assessment, selection, incorporation, and rational use. The first experience in the implementation of this approach was in the Caribbean in 2013. Similarly, Paraguay is in the process of creating an office responsible for HTA and rational use—the first in the Region to integrate both issues. An integrated course in selection, HTA, and rational use is also in being designed at the PAHO Virtual Campus.

11. The rational use of technologies is an essential element in the implementation of an integrated approach, and significant progress has been achieved, such as the adoption of standardized mechanisms for the preparation of clinical practice guidelines in 12 countries.

### **Action Required to Improve the Situation**

12. The most important actions required to reduce the existing gaps and improve the situation in the countries of the Region with regard to the use of HTA as a tool to support decision-making include:

- a) Expansion of RedETSA: Considering the significant gap in the use of HTA in the countries that do not belong to the Network, the countries of Central America and of the Caribbean that are not part of the Network<sup>12</sup> are a priority for expansion. The data obtained in the mapping serve as a baseline to guide this effort.
- b) Preparation of a continuous training strategy: Considering the high demand for training in the Region, a strategy is needed that addresses the different needs of

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<sup>10</sup> Currently, there are 63 participants belonging to the organizations that make up RedETSA, and 150 documents.

<sup>11</sup> INAHTA, created in 1993, currently has 13 member institutions from eight countries of the Region (Argentina, Brazil, Canada, Chile, Colombia, Mexico, the United States, and Uruguay). The institutions from Argentina, Brazil, Colombia, and Uruguay have joined since 2012.

<sup>12</sup> Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Dominican Republic, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, Panama, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, and Venezuela.



the countries, including training in the analysis and preparation of reports on HTA, as well as activities to raise awareness among decision-makers. More space will be made available at the Virtual Campus in order to respond more adequately to this demand.

- c) Strengthening of the links between assessments and decision-making: Currently, the weak links between HTA and decision-making in the Region makes it a priority to implement activities aimed at strengthening the connection, both in legislation and in fact.
- d) Development of tools that support the countries in the application of HTA to their decision-making processes: A set of relevant decision-making tools is now in development,<sup>13</sup> which will be more useful for countries in an early stage of HTA implementation.
- e) Increasing the exchange of information on HTA among the countries of the Region: Despite the progress made in the production of HTA documents, it is necessary to extend their availability to all countries. The RedETSA database is in development and will include reports on HTA and each country's decisions on the incorporation of technologies. A project for short professional exchanges among RedETSA institutions is also being prepared.
- f) Promoting the prioritization of assessments as a function of national and regional needs, taking ethical and equity considerations into account; incorporating these elements will further the adoption of HTA in decision-making.

### Action by the Directing Council

13. The Directing Council is requested to take note of this progress report and to formulate the recommendations it deems relevant.

### List of Acronyms

Acronym	Name
CONITEC	Comissão Nacional de Incorporação de Tecnologias no Sistema Único de Saúde (National Commission on the Incorporation of Technologies into the Unified Health System)
EASP	Escuela Andaluza de Salud Pública (Andalusian School of Public Health)
EUnetHTA	European Network for Health Technology Assessment
HTAsiaLink	Asian Health Technology Assessment Network
IECS	Instituto de Efectividad Clínica y Sanitaria (Institute for Clinical Effectiveness and Health Policy)
IETS	Instituto de Evaluación Tecnológica en Salud (Institute of Health Technology

<sup>13</sup> Prepared by PAHO and other institutions as part of the Advance-HTA project.

Acronym	Name
	Assessment)
INAHTA	International Network of Agencies for Health Technology Assessment
LSE	London School of Economics and Political Science
NICE	UK National Institute for Health and Care Excellence
REBRATS	Rede Brasileira de Avaliação de Tecnologias em Saúde (Brazilian Health Technology Assessment Network)
RedARETS	Red Argentina Pública de Evaluación de Tecnologías Sanitarias (Argentine Public Network for Health Technology Assessment)
RedETSA	Red de Evaluación de Tecnologías en Salud de las Américas (Health Technology Assessment Network of the Americas)
SEARO	WHO Regional Office for South-East Asia
UCEETS	Unidad Coordinadora de Evaluación y Ejecución de Tecnologías en Salud (Coordinating Unit for Health Technology Assessment and Implementation)

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

### **Introduction**

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

### **Background**

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

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

3. To address the convergence of human, animal, and environmental health, PAHO has exercised hemispheric leadership in the sphere of zoonosis, food safety, and food security, through the elimination of foot-and-mouth disease from the Region. PANAFTOSA is uniquely situated in this regard, given its extensive formal and informal network in the public and animal health sectors, which includes government entities, academia, the private and philanthropic sectors, non-profit organizations and international agencies. The Center helps assess the risks posed by animal diseases that could constitute public health events of international importance, thereby contributing to the implementation of the International Health Regulations (2005).

4. The current political and strategic directives for the Organization's technical cooperation in veterinary public health were defined by the "Consensus of Santiago, Chile",<sup>3</sup> a result of political and technical dialogue between health and agriculture/livestock ministries during the 16th Inter-American Meeting at the Ministerial Level on Health and Agriculture (RIMSA 16). Furthermore, when announcing food

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

<sup>2</sup> On this occasion, it was not considered necessary to include information on the Latin American Center for Perinatology and Human Development/Women's and Reproductive Health (CLAP/WR) because no changes have been reported since the last report.

<sup>3</sup> Pan American Foot-and-Mouth Disease Center of the Pan American Health Organization. Consensus of Santiago, Chile [Internet]. 16th Inter-American Meeting at the Ministerial Level on Health and Agriculture, 2012 Jul 26-27; Santiago, Chile. Rio de Janeiro (Brazil): PAHO/PANAFTOSA; 2012 [consulted on 2014 Feb 14]. Available from: [http://ww2.panaftosa.org.br/rimsa16/dmdocuments/RIMSA16\(INF5\)%20Consensus%20ingles.pdf](http://ww2.panaftosa.org.br/rimsa16/dmdocuments/RIMSA16(INF5)%20Consensus%20ingles.pdf)

safety as a theme for World Health Day 2015, the Director-General of the World Health Organization (WHO) emphasized the need for a coordinated, collaborative global effort with the United Nations Food and Agriculture Organization (FAO) and the World Organization for Animal Health (OIE) to ensure food safety in all stages of the food chain.

### ***Recent Progress***

5. PANAFTOSA's technical cooperation is being implemented, as part of the work of the Department of Communicable Diseases and Health Analysis (CHA), by a technical team based in Brazil (Rio de Janeiro and Minas Gerais), two veterinary public health advisors in the Andean and Caribbean subregions, and a senior advisor at the headquarters. Recently, there have been important achievements in the improvement of health with equity, through activities aimed at promoting food safety, food security, the elimination of priority zoonoses and the prevention of mortality and disability resulting from health emergencies. These achievements contribute to categories 1 and 5 of PAHO Strategic Plan 2014-2019.

6. With respect to food safety, the World Health Day 2015 campaign has led to greater participation from leaders and decision-makers, and has made PAHO the institution of reference on this issue. Work is ongoing to strengthen regional networks, and a growing number of institutions in the Region are contributing to regional intersectoral food safety networks for the prevention of foodborne diseases (e.g. the Inter-American Network of Food Analysis Laboratories [INFAL], the Global Foodborne Infections Network [GFN], and the PulseNet network of the Latin America and the Caribbean). There is active collaboration on the five strategic lines of the Global Action Plan on Antimicrobial Resistance, in particular: improving awareness and understanding of antimicrobial resistance, strengthening the scientific base through surveillance and research, and optimizing the use of antimicrobial medicines in animal health.

7. Regarding zoonosis, the Center is implementing a regional action plan to eliminate rabies transmitted by dogs<sup>4</sup> by providing technical cooperation to the countries in the areas of laboratory diagnosis, post-exposure prophylaxis, program management, definition of surveillance indicators, promotion of global rabies elimination, and inclusion of the rabies vaccine for dogs in the PAHO Revolving Fund. In addition to technical cooperation on dog-transmitted rabies, PANAFTOSA provides technical cooperation to the countries for the prevention and control of rabies transmitted by bats.

8. With regard to other zoonoses, the Center collaborates with other PAHO units to strengthen capacities in leptospirosis, leishmaniasis, and yellow fever. The Center also

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<sup>4</sup> Pan American Foot-and-Mouth Disease Center. Action plan to eliminate rabies transmitted by dogs [Internet]. 14th Meeting of Directors of National Programs for Rabies Control in Latin America (REDIPRA 14), Lima (Peru), August 2013. PAHO/PANAFTOSA; 2013 [consulted on 2015 Feb 2]. Available from:  
[http://www.paho.org/panaftosa/index.php?option=com\\_content&view=article&id=795&Itemid=336](http://www.paho.org/panaftosa/index.php?option=com_content&view=article&id=795&Itemid=336)

carries out technical cooperation activities for the surveillance and control of echinococcosis or hydatidosis in five countries. In 2014, the Center began implementing technical cooperation activities for the prevention and control of neurocysticercosis, in collaboration with the WHO Department of Control of Neglected Tropical Diseases and with PAHO's Tropical, Neglected, and Vector-borne Diseases, and Mental Health units.

9. With regard to foot-and-mouth disease (FMD), for the first time since the Center was established in 1951, there has been a three-year period without any reported cases of this disease. This is a historic achievement for all the countries of the Hemisphere and for PAHO/WHO. The challenges now faced are to maintain this accomplishment by moving forward towards an FMD-free Hemisphere without vaccination; to continue supporting the countries, particularly by introducing new surveillance tools, responding to emergencies, and providing mechanisms to address the growing susceptibility of the population to the FMD virus; and to strengthen national policies, strategies, and plans for FMD eradication. The Center continues to provide technical cooperation to strengthen national foot-and-mouth disease programs. As a result, the OIE officially recognized Bolivia and Paraguay as FMD-free countries in 2014, and Ecuador received the same recognition in May 2015.

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

10. The technical cooperation agreement to strengthen Brazil's national health surveillance system and the management capacity of its Unified Health System remains in effect in 2015. The agreement, signed in 2012 by PAHO (through PANAFTOSA) and by the Health Surveillance Secretariat of the Ministry of Health of Brazil, aims to reduce the burden of zoonosis and of vector-borne, waterborne, and foodborne diseases on the human population. Furthermore, other financial and technical cooperation agreements were signed with different institutions, including the Mérieux Foundation (France); the Wellcome Trust (Sanger Institute); the Joint Institute for Food Safety and Applied Nutrition (JIFSAN); the United States Food and Drug Administration and Centers for Disease Control and Prevention; the Standards and Trade Development Facility (STDF) of the World Trade Organization; and the Health Products and Food Branch of Health Canada.

11. PANAFTOSA has been able to mobilize voluntary contributions from sources specifically interested in foot-and-mouth disease eradication in South America, and these contributions support the Center's technical cooperation for regional coordination of the Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA). An example is the National Animal Health Coordinating Association (ACONASA) of Paraguay, which has renewed its financial support for the trust fund established to facilitate financial contributions. In addition, other cooperation agreements have been negotiated with public entities in other Member States, including Ecuador's Agricultural Quality Assurance Agency (*Agrocalidad*) and Paraguay's National Service for Animal Health and Quality (SENACSA). Accordingly, the regular financial resources provided by the Organization to the Center have been channeled toward technical cooperation in the areas of zoonosis and food safety. The generous contribution from the Brazilian

Ministry of Agriculture, Livestock, and Food Supply (MAPA) continues to fully cover the Center's maintenance costs.

***Review of PANAFTOSA Governance***

12. In 2014, the delegation of the Government of Brazil suggested studying the possibility of reviewing the PANAFTOSA governance mechanism. In response to this request, PAHO will initiate a consultation process with Brazil and other Member States in 2015 and will report to the Governing Bodies on the progress and results of this process.

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

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

14. BIREME is assigned to the Knowledge Management, Bioethics, and Research Office (KBR), and there is a specific biennial work plan (2014-2015) for the Center.

***Recent Progress***

15. Progress has been made at the regional level in the development of national capabilities to strengthen scientific and technical health information systems. During the period under review, more than 150 on-site and virtual activities were carried out in the areas of technical cooperation, training, and promotion, including the following events:

- a) Workshop on updating the technological platform of the Virtual Health Library (for professionals from eight countries—Argentina, Brazil, Bolivia, Honduras, Panama, Peru, Uruguay, and Venezuela);
- b) First regional workshop on the ProEthos platform for the management of research ethics committees (for professionals from eight countries—Argentina, Brazil, Colombia, Chile, El Salvador, Guatemala, Honduras, and Peru);
- c) online course on LILACS methodology;
- d) course on scientific communication and writing.

16. The EvIDeNCe portal was developed and launched in cooperation with the Caribbean Public Health Agency (CARPHA), offering scientific evidence on health to Caribbean countries, organized according to the subregion's needs.

17. Technical cooperation between BIREME and PAHO Headquarters was also expanded, including: *a*) bibliographic searches tailored to the needs of the technical and programmatic areas; *b*) new data added to the PAHO Institutional Repository (PAHO-IRIS); *c*) developing and hosting the PAHO/WHO Equity Blog; *d*) support in

defining the conceptual model for the universal health coverage platform; and *e*) regional distance learning courses given through the Virtual Campus for Public Health.

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

18. Since 2010, BIREME's institutional structure has been characterized by the coexistence of a previous institutional framework—the Agreement on Maintenance and Development of the Center, signed by PAHO/WHO and the ministries of Health (MINSAL) and Education (MEC) of Brazil, the Ministry of Health of the State of São Paulo (S-SP) and the Federal University of São Paulo (UNIFESP)—and the new framework established by the Statute of BIREME approved by the 49th Directing Council in September 2009.

19. The Center's physical headquarters is located on the São Paulo campus of UNIFESP in accordance with the Agreement on Maintenance and Development of BIREME, to which the university is a signatory.

20. The Agreement on Maintenance and Development of BIREME expired on 1 March 2015. Although negotiations are in progress to extend it through 31 December 2015, especially with UNIFESP which, in the second semester of 2014, requested a review of its contributions to the Center, no extension has been signed to date.

21. BIREME's governance structure includes the National Advisory Committee (CAN, Portuguese/Spanish acronym), from the previous framework, and the Advisory Committee and Scientific Committee, from the new framework. The three committees are operating normally.

- a) The National Advisory Committee is made up of the signatories to the Agreement on Maintenance and Development of BIREME and meets twice a year. The results of BIREME's technical cooperation with the countries of the Region, and with Brazil in particular, are presented at these meetings. CAN met twice in 2014, on 15 August and on 9 December. MINSAL attended both meetings, while the S-SP only attended the first one, and MEC and UNIFESP did not attend either meeting.
- b) The Advisory Committee has two permanent members: PAHO and Brazil, the latter represented by the Ministry of Health, as well as five nonpermanent members. The 28th Pan American Sanitary Conference selected Cuba, Ecuador, and Puerto Rico for the Advisory Committee, with a three-year mandate (2013-2015). The 53rd Directing Council selected Panama and Trinidad and Tobago for a three-year mandate (2015-2017). The Advisory Committee has met five times since it was established. The latest session was held on 3 December 2014, and the sixth meeting is scheduled for the end of 2015. During its fifth session, the members of the Advisory Committee reaffirmed their ongoing support for the institutional development of the Center, and in particular, the urgency of implementing the new institutional framework and signing the

- Headquarters Agreement in order to ensure the transfer of financial resources from MINSAL for the regular maintenance of BIREME.
- c) The Scientific Committee is made up of five health information experts selected by the Advisory Committee. The Committee is currently comprised of members from Brazil, Canada, Honduras, and Trinidad and Tobago, as well as a representative of the National Library of Medicine of the United States. The members of the Scientific Committee have held two sessions since it was established, one on 27 July 2013 and the other on 14 August 2014. The third session is planned for the second semester of 2015.
22. In order to strengthen implementation of the new Statute of BIREME approved by the Member States, the Office of the Assistant Director coordinated an external evaluation of the Center. The recommendations were submitted to the Director and the Executive Management of the Pan American Sanitary Bureau (PASB) in March 2015.
23. On 19-20 August 2015, PAHO's Director of Administration conducted an administrative review of BIREME that included a comprehensive updating of several of the Center's managerial processes.

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

#### *Headquarters Agreement in Brazil*

24. Negotiations continue between PAHO and the Government of Brazil (through MINSAL) on the Headquarters Agreement called for in the institutional framework for the Center. The lack of a signed Headquarters Agreement limits the transfer of budgeted funds from MINSAL to BIREME, unless the parties agree to a provisional legal instrument.

#### *Facilities and operations agreement*

25. PAHO/WHO has been negotiating with the Administration of UNIFESP since 2014, within the framework of the commitments made by the Government of Brazil to PAHO/WHO, the mandate of the Governing Bodies in accordance with Resolution CD49.R5, and the need to ensure BIREME's technical cooperation with stakeholders in the Member Countries, including UNIFESP.
26. In September 2014, the Administration of UNIFESP notified the Director of PASB that the University was reconsidering its contributions for the maintenance and development of BIREME, especially with regard to: *a*) the immediate restructuring of the physical space occupied by BIREME, which would entail reducing its facilities to a single floor instead of the four floors it currently occupies, in addition to the payment of rent payment; and *b*) the return to UNIFESP of 16 university staff members who had been working in BIREME's administrative and technical areas for many years. These staff members rejoined UNIFESP on 1 April 2015. The interim Director of



BIREME has scheduled a meeting to be held soon with UNIFESP authorities, in particular with regard to point *a)* above.

***Short-term Challenges***

27. Promptly sign the Headquarters Agreement between the Government of Brazil and PAHO for the operation of BIREME in Brazilian territory, which will ensure the transfer of resources necessary for its operation.

28. Define and formalize the future institutional relationship with UNIFESP, especially with regard to BIREME's physical presence on the UNIFESP campus, the negotiation of a facilities and operations agreement, and the redefinition the cooperation objectives with UNIFESP, taking into account the expectations of the scientific and academic community and the international cooperation for which BIREME is responsible.

29. Strengthen the governance of BIREME through the proactive participation of the National Advisory Committee, the Advisory Committee, and the Scientific Committee in their areas of competence.

**Action by the Directing Council**

30. The Directing Council is requested to take note of this progress report and to formulate the relevant recommendations.

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