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PROGRESS REPORTS ON TECHNICAL MATTERS

CONTENTS

A. Strategy and Plan of Action on eHealth: Midterm Review	2
B. Plan of Action on Adolescent and Youth Health	9
C. Plan of Action for the prevention and control of noncommunicable diseases: Midterm Review	17
D. Plan of Action to Reduce the Harmful Use of Alcohol: Midterm Review	39
E. Plan of Action on Psychoactive Substance Use and Public Health: Midterm Review	60
F. Status of the Pan American Centers	67

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

A. STRATEGY AND PLAN OF ACTION ON eHEALTH: MIDTERM REVIEW

Background

1. In May 2005, the 58th World Health Assembly of the World Health Organization (WHO) adopted Resolution [WHA58.28](#) on *eHealth*, the first on this subject (1). Inspired by that resolution, in September 2011, the 51st Directing Council of the Pan American Health Organization (PAHO), through Resolution [CD51.R5](#) (2), adopted the [Strategy and Plan of Action on eHealth](#) to contribute to the sustainable development of health systems in the Member States (3). Furthermore, in response to the need to facilitate the processing and transmission of digital information related to health services delivery worldwide, in May 2013 WHO adopted Resolution [WHA66.24](#) on *eHealth* standardization and interoperability (4), while in September of that same year PAHO established its Program and Budget ([OD346](#)), which included an outcome indicator to promote the implementation of the Regional Strategy and Plan of Action on *eHealth* in the Member States (5).

Update on the Progress Achieved¹

2. The Strategy and Plan of Action on *eHealth* consists of four strategic areas, 13 specific objectives, and a total of 26 indicators. This progress report follows the same structure in order to facilitate a review of the Region's main achievements and challenges with regard to *eHealth*.

Strategic Area 1: Support and promote public policies on eHealth

3. At present, 21 countries and territories² are formulating and adopting a public policy on *eHealth*. In order to support the Member States in this task, WHO and the International Telecommunications Union (ITU) published, in 2012, guidelines known as the [National eHealth Strategy Toolkit](#) (6). National partnerships forged between sectors of civil society, the civil service, and private entities through the creation of national commissions and committees are proving to be key in mobilizing the necessary resources to adopt and implement strategies.

¹ PAHO will soon be publishing an article in the Pan American Journal of Public Health / Revista Panamericana de Salud Pública that will provide more information on PAHO's actions in this field and that can be consulted as a complement to this progress report. Novillo-Ortiz D, D'Agostino M and Becerra-Posada F. El rol de la Organización Panamericana de la Salud en el desarrollo de capacidad en *eSalud* en las Américas: análisis del periodo 2011-2015. Rev Panam Salud Pública. 2016;40(2) (in press).

² Argentina, Barbados, Belize, Bonaire, Brazil, British Virgin Islands, Canada, Chile, Colombia, Costa Rica, Curaçao, Dominican Republic, El Salvador, Guatemala, Jamaica, Mexico, Panama, Peru, Trinidad and Tobago, United States, and Venezuela. Source: PAHO/WHO Observatories.

4. In order to help the Member States to define policy priorities with respect to *eHealth*, PAHO, in coordination with the Statistical Conference of the Americas (Economic Commission for Latin America and the Caribbean, SCA-ECLAC) has led the development of [Methodological recommendations for the measurement of access and use of Information and Communications Technologies \(ICT\) in the Health Sector](#) to determine the advances made in *eHealth* in the countries of the Region of the Americas toward improving the effectiveness and efficiency of public and private health systems (7). Brazil and Uruguay are currently implementing these recommendations. Furthermore, PAHO has a group of experts who have acted as a technical advisory committee on when necessary. The efforts of this network are reflected in [eHealth Conversations: Using Information Management, Dialogue, and Knowledge Exchange to Move Toward Universal Access to Health](#), a project that presents the opinions of specialists on this subject (8).

5. In order to consolidate a regional system for the evaluation and analysis of policies, the [PAHO Regional eHealth Observatory](#) has been in operation since 2012, providing tools that support the implementation of and acting as the regional entity for the [WHO Global Observatory for eHealth](#).

Strategic Area 2: Improve public health through the use of eHealth

6. Improving organizational and technological infrastructure is one of the main challenges in the implementation of *eHealth*, according to a study conducted by WHO with the support of PAHO and ITU (9). In order to collaborate in this task, PAHO has worked with the Member States to develop guidelines that serve as a baseline for a strategy to strengthen and determine basic organizational and technological infrastructure in health services (10).

7. The use of information and communications technology (ICT) can be observed in the Region's epidemiological surveillance services. However, additional research is needed regarding the number of countries using mobile technology in these services. The case of Paraguay is noteworthy, with its community epidemiological telesurveillance system based on free software.

8. Unique patient identification is one of the main components for promoting the sustainable, scalable, and interoperable development of *eHealth*-focused programs and initiatives. The main trends in the Region indicate that the use of live birth records is the access portal to electronic health systems; countries such as Mexico or Peru are examples in this regard. In order to devise a common framework, PAHO and the Organization of American States (OAS), which coordinates the e-government program at the regional level and develops the [Universal Civil Identity Project of the Americas \(PUICA\)](#) [Spanish acronym], will be working on a joint proposal for the Region that integrates all electronic services, not only those related to the health sector.

9. A significant number of countries in the Region are financing projects with public funds at the local and national levels. The most widespread initiatives involve telemedicine and electronic health records. Specifically, 10 countries³ already have a national electronic health records system that immediately provides secure information to authorized users, while 12 countries of the Americas⁴ have a national policy or strategy on telehealth. Big data and e-prescription projects continue to be a challenge for the Region, due to a lack of necessary infrastructure for development and implementation.

Strategic Area 3: Promote and facilitate horizontal collaboration between countries

10. During the first half of the period, intersectoral cooperation has been promoted, as well as the establishment of resource- and experience-sharing mechanisms. Specifically, biennial progress reports have been disseminated on policies in the Member States that participate in the WHO [Global Survey on eHealth](#), and mechanisms have been established for the communication and dissemination of information at the [PAHO Regional eHealth Observatory](#).

11. Unique interoperability in health systems continues to be a challenge for the Region, due to a lack of integration among the existing information systems. Using the experience of the European Union as a reference point for guidelines on unique interoperability with regard to patient data (11) and electronic prescriptions (12), PAHO and the Member States plan to work on devising a common framework for a standard or minimum dataset to facilitate the exchange of information between systems. Furthermore, despite the existence of health institutions that integrate organizational and administrative entities interacting in the provision of medical and health services with a technological component, there has been no observed progress in the Region in terms of developing methodologies to establish such steps and procedures at the national level.

12. The number of legal frameworks supporting the use of ICT in health care and facilitating the exchange of clinical information has increased in the last three years. Specifically, at least 18 countries in the Region⁵ have legislation to protect the privacy of people's personal information; and nine additional countries⁶ report having a legal framework that facilitates the electronic exchange of clinical information at the national level. Taking as an example the projects already initiated in Europe, work will soon be undertaken with the Member States to determine a legal framework that will promote the exchange of clinical information at the regional level.

³ Canada, Chile, Costa Rica, El Salvador, Jamaica, Mexico, Panama, Paraguay, Peru, and Uruguay. Source: WHO Global Observatory for eHealth.

⁴ Argentina, Canada, Colombia, Costa Rica, Cuba, Dominican Republic, Jamaica, Mexico, Paraguay, Peru, United States, and Uruguay. Source: WHO Global Observatory for eHealth.

⁵ Argentina, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, United States, and Uruguay. Source: WHO Global Observatory for eHealth.

⁶ Argentina, Canada, Chile, Colombia, Dominican Republic, Mexico, Paraguay, United States, and Uruguay. Source: WHO Global Observatory for eHealth.

Strategic Area 4: Knowledge management and digital literacy for quality care, promotion of training and health, and disease prevention

13. There has been a considerable increase in the number of countries that have a university-level *eHealth* training plan. Specifically, 16 countries⁷ have training of this kind in some of their universities.

14. During this period, reliable, high-quality information on education for health and disease prevention has been provided to the general public and health professionals. For example, there are now 10 virtual health libraries with information sources and services that address health priorities. Furthermore, there has been an increase in the number of Member States with access and local capacity to produce and use content from the virtual health libraries, while the number of countries with national virtual health libraries has risen from 26 to 30, in addition to the [CARPHA EvIDeNCe](#) initiative in the countries of the English-speaking Caribbean.

15. With regard to certified public health content, PAHO's Latin American and Caribbean Center on Health Sciences Information (BIREME) signed a memorandum of understanding with the University Hospital of Rouen (France), a center specialized in this discipline. This initiative will help achieve significant progress in devising a common framework for the development of portals with certified public health content. It will also increase the number of Member States (currently nine countries⁸) that have policies on access to certified public health content and that are members of the Federated Network of Institutional Repositories of Scientific Publications ([LA Referencia](#)).

16. With regard to the use of social networks to facilitate the dissemination, communication, and sharing of public health information, 18 countries⁹ use social networks, mainly Twitter and Facebook, both in emergencies and as a way to promote health and disease prevention. Nevertheless, additional research is needed to determine whether the Member States have specific strategies in this regard.

Action Necessary to Improve the Situation

17. In light of the advances and challenges described above, the following measures should be considered for the 2016-2017 period:

- a) continue implementing the Strategy and Plan of Action and promote the formulation of national strategies in the countries that do not have them;

⁷ Argentina, Canada, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Honduras, Jamaica, Mexico, Paraguay, Peru, Trinidad and Tobago, United States, and Uruguay. Source: WHO Global Observatory for *eHealth*.

⁸ Argentina, Brazil, Chile, Colombia, Ecuador, El Salvador, Mexico, Peru, and Venezuela. Source: WHO Global Observatory for *eHealth*.

⁹ Argentina, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela. Source: WHO Global Observatory for *eHealth*.

- b) work to include areas where progress has been made in the framework of public health since the approval of the Strategy and Plan of Action, such as the Internet of things, open data, and big data, among others;
- c) strengthen communication and institutional coordination between agencies, donors, and Member States, including key sectors other than the health sector, in order to ensure that strategic, technical, and budgetary components are coordinated and aligned with a single objective, focused on improving the quality of life of the population, and implemented so as to avoid duplication of effort;
- d) promote the generation of evidence and development of guidelines on *eHealth* that favor decision-making and project development in a strategic and sustained manner;
- e) establish a road map for the role of *eHealth* within the framework of the Sustainable Development Goals, specifically objective 3 (“Ensure healthy lives and promote well-being for all at all ages”).

Action by the Directing Council

18. The Directing Council is invited to take note of this report and offer any recommendations it deems relevant.

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B. PLAN OF ACTION ON ADOLESCENT AND YOUTH HEALTH

Background

1. This report summarizes progress in the implementation of the Regional Strategy for Improving Adolescent and Youth Health (1) and the *Plan of Action on Adolescent and Youth Health* (2). PAHO Member States endorsed the regional strategy during the 48th Directing Council (Resolution CD48.R5) in 2008, and the plan during the 49th Directing Council (Resolution CD49.R14) in 2009.

2. The report is based on a program implementation analysis and draws from multiple sources, including data reported to PAHO by Member States, regional stakeholder consultations, and input from adolescents and youth collected through a web-based tool.

Update on the Progress Achieved

3. During 2010-2015, significant progress was made under each of the seven strategic areas of action. The annex provides a summary of progress against the midterm (2014) milestones. While progress was also made towards achievement of some 2014 milestones few were fully achieved, and the mortality rates targeted in three of the milestones (road traffic injuries, homicides and suicides) worsened rather than improved.

4. Beyond the resources provided by the Pan American Sanitary Bureau (PASB), PAHO mobilized close to US\$ 7 million in donor funding to support regional and country-level adolescent and youth health activities. Efforts included:

- a) PASB's support for the development of an adolescent health portal, a virtual platform that provides easy access to regional and country adolescent health data; support to 14 countries for the implementation of adolescent health surveys; technical cooperation for strengthening the collection and analysis of adolescent health data disaggregated by sex, age group, and relevant social determinants.
- b) PASB provided technical cooperation for the review, update, and revision of legal and policy frameworks, and the development of national adolescent health strategies and plans. Currently all but five of the Region's countries are implementing adolescent health strategies and plans, even though not all programs have designated staff and budget. Training on the health of young people and their human rights was provided for national programs and to health care providers and other stakeholders, including judges, legislators, and ombudsmen.
- c) PASB supported the implementation of the Integrated Model for Management of the Adolescent Needs (IMAN) and the promotion of a standards-based approach to health care services for adolescents; guidance was provided for 120 stakeholders from 45 countries on the core elements of the regional Strategy for

- Universal Access to Health and Universal Health Coverage (3) and its implications for child and adolescent health programs and services.
- d) From 2010 to 2015, more than 40 regional, subregional, and country-level capacity-building workshops were organized for adolescent health program managers, health care providers, youth, and other stakeholders, in topics related to adolescent health. PAHO also provided 442 scholarships for health care providers from 14 countries to participate in the diploma program in comprehensive adolescent health and development offered by the Pontifical Catholic University of Chile.
 - e) PAHO continued to support the implementation of community-based models and interventions aimed at strengthening parents and families, including the “Strengthening Families Program” currently being implemented in 13 countries.
 - f) PAHO, in partnership with United Nations Population Fund (UNFPA), World Bank, and other partners, supported and promoted a comprehensive approach towards adolescent sexual and reproductive health, with special focus on pregnancy prevention and HIV/STI. Key actions included: the generation and dissemination of strategic information on adolescent sexual and reproductive health (SRH); training of program managers, service providers, representatives of the judicial system and other stakeholders in human rights instruments; formulation of technical opinions on sexual and reproductive rights; promotion of access of young people to quality health services, including SRH services, and sharing of technical guidance and best practices. Support was provided for development of subregional strategies for prevention of adolescent pregnancy in Central America, the Caribbean and the Andean Region, and mobilization of political support. In 2014, PAHO supported a summit of First Ladies of the Central American Integration System (SICA) member countries, resulting in the signing of the “*Honduras Declaration*”, reaffirming their commitment for the promotion and facilitation of actions aimed at prevention of adolescent pregnancy in their countries. Bilateral opportunities, joint work plans, and joint activities helped build strong partnerships with UN agencies and stakeholders, the World Bank, regional integration mechanisms, the inter-american system, and youth organizations.
 - g) PASB coordinated capacity-building activities on the use of digital media, after which several countries, including Brazil, the Dominican Republic, and Guatemala, implemented actions aimed towards incorporating digital media into adolescent health programs.

Action Necessary for Improving the Situation

5. Considering that the Region has steadily advanced toward reducing adolescent fertility (4), it is recommended that Member States continue to invest in policies and programs that can accelerate this reduction, and focus on early pregnancy in girls younger than 15 years, a growing trend in the Region (5). Ensuring access for adolescents to SRH information, services and commodities will be critical, in particular considering the

limited progress in the reduction of HIV in adolescents and youth (see Annex) and the current Zika virus disease outbreak in the Region, and their implications for the sexual and reproductive health of young persons.

6. Given that adolescent and youth mortality rates are worsening rather than improving, and that homicide, suicide, and traffic fatalities continue to be the leading causes of death among adolescents and youth in the Region (6), Member States are encouraged to:

- a) accelerate the implementation of evidence-based “best buys” for road safety, such as actions for strengthening road safety management and improving legislation and enforcement (speed reduction, seat belt use, child restraints, helmets, and penalties for drunk driving); promote safer roads and the use of sustainable modes of transportation; put in place policies to protect vulnerable road users; increase awareness and strengthen road safety skills among road users; and invest in improving post-crash response and rehabilitation services;
- b) strengthen programs and services for the promotion of mental health and early diagnosis and treatment of mental health conditions in adolescents and youth;
- c) mainstream the human security approach in existing health plans as a mechanism to prevent violence and injuries in accordance with global and regional mandates, and implement evidence-based interventions to empower young people, strengthen families, and prevent all forms of violence, including sexual violence.

7. Considering the regional commitment to universal access to health and universal health coverage, and the persisting barriers that adolescents and youth face in accessing health services, Member States are urged to ensure that adolescents and youth, particularly those in situations of vulnerability, have access, without any discrimination, to comprehensive, appropriate, timely, gender-responsive, and quality health services, including sexual and reproductive health services.

8. Considering that 13 of the Region’s countries report levels of overweight and obesity near or exceeding 25% of adolescents aged 13-15 years, and that tobacco and alcohol use in this age group continue to be significant (7), Member States are urged to implement the PAHO *Plan of Action for the Prevention of Obesity in Children and Adolescents* (8), and to pursue intersectoral partnerships that include the health and education sectors, the private sector, parents, community-based organizations, and youth themselves for the implementation of comprehensive strategies to promote health and wellness, reduce risk factors, and address the social determinants influencing the health and wellness of adolescents and youth.

Action by the Directing Council

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

Annex

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Annex

**Overview of Impact and Objectives Progress in 2014
(for objectives which have 2014 stated targets)**

Impact Targets	2014 Milestones	2014 Status
By 2018, 75% of the countries in Latin America and the Caribbean have an adolescent fertility rate of 75.6 per 1,000 or less.	20 countries	31 countries (Source: UNData. Available from: http://data.un.org/Data.aspx?q=adolescent+fertility&d=WDI&f=Indicator_Code%3aSP.ADO.TFRT)
By 2018, 100% of the countries will have an estimated percentage of adolescents and youth (15-24 years old) living with HIV of under 0.6% in the Caribbean and under 0.4% in Latin America and North America.	Females: 5 Caribbean countries and 20 countries in Latin and North America. Males: 6 Caribbean countries and 12 countries in Latin and North America.	1 Caribbean country (males and females) 16 countries in Latin America and North America (males and females) (Based on the aggregated estimates for males and females available for 23 countries) (Source: UNAIDS, AIDSinfo Online Database. Available from: http://www.aidsinfoonline.org/devinfo/libraries/asp/asp/Home.aspx)
By 2018, 100% of the countries will reduce the current increasing trends in mortality rates due to road traffic injuries among males (15-24).	10%	The regional age adjusted mortality rate due to road traffic injuries among males increased from 34.0 to 37.8 per 100,000 from 2008 to 2012, reflecting an 11.5% increase. 14 countries (27%) reduced the mortality rate due to road traffic injuries among males aged 15-24 years by percentages ranging from 0.7% to 71%. Among these, 10 decreased the rate by > 10%.
By 2018, priority countries ¹ will reduce the current increasing trends in mortality rates due to homicides among males (15-24).	7%	The regional age adjusted mortality rate due to homicides among males aged 15-24 years increased from 50.1 in 2008 to 55.7 per 100,000 in 2012, ² reflecting an 11.3% increase. 9 countries (17.6%) reduced the mortality rate due to homicides among males aged 15-24 years by percentages ranging from 8.6% to 57%, including one priority country, Nicaragua (45%).

¹ The Plan of Action on Adolescent and Youth Health identified Bolivia, Guyana, Haiti, Honduras, and Nicaragua as priority countries.

² Mortality analysis was conducted for 2012, due to incomplete 2013 and 2014 mortality reporting.

Impact Targets	2014 Milestones	2014 Status
By 2018, 75% of the countries will reduce the trends in mortality rates due to suicides (10-24).	8%	<p>The regional age adjusted mortality rate due to suicides in the age group 10-24 years increased from 5.5 to 5.8 per 100,000 from 2008 to 2012,³ reflecting a 5.6% increase.</p> <p>9 countries (17.6%) reduced the mortality rate due to suicide in the age group by percentages ranging from 0.7% to 38.5%. Among these, 8 decreased the rate by > 8%.</p>

Plan of Action Objectives	2014 Targets	2014 Status
Provide technical cooperation to Member States to develop and strengthen their health systems' delivery of timely and effective health promotion, disease prevention, and care for adolescents and youth, using a life-cycle approach and addressing equity gaps.	70% of countries have established national adolescent and youth health objectives that integrate interventions of the main health issues affecting them using promotion and prevention strategies.	<p>72% (37 out of 51)</p> <p>(Sources: country responses to mid-term evaluation survey and country reports to PAHO through the Strategic Plan Monitoring System)</p>
Objective 2.1: Promote and secure the existence of environments that enable adolescent and youth health and development through the implementation of effective, comprehensive, sustainable, and evidence-informed policies (including legal frameworks and regulations).	Priority and high-impact countries ⁴ will have evidence-based policies that integrate the main health issues and determinants affecting adolescents and youth as a way to increase this group's access to health care.	<p>Argentina, Bolivia, Guyana, Honduras, Nicaragua, Brazil, Colombia, Mexico, and Peru reported having policies aimed at increasing access of adolescents and youth to health care. All nine countries have included sexual and reproductive health (SRH), HIV, mental health in these policies, eight have nutrition, physical activity, substance use, violence, seven have tobacco, alcohol, and six have injury prevention included in these policies.</p> <p>(Source: WHO MNCAH Policy Surveys, 2012 & 2014)</p>
Objective 3.1: Improve comprehensive and integrated quality health systems and services to respond to adolescent and youth needs with emphasis on primary health care.	Priority and high-impact countries will have 50% of health centers at the district level applying an integrated package of effective interventions for adolescents and youth (IMAN: Integrated Management of Adolescent Needs).	<p>No data available on the percentage of health centers at district level applying an integrated package of services.</p> <p>PAHO developed and widely disseminated the IMAN manual, and conducted numerous regional and country-level training workshops on IMAN. Currently the majority of the countries have adopted the IMAN manual or incorporated the contents in national clinical guidelines and protocols.</p>

³ Mom bnrtality analysis was conducted for 2012 due to incomplete 2013 and 2014 mortality reporting.

⁴ The Plan of Action on Adolescent and Youth Health identified Argentina, Brazil, Colombia, Mexico, Peru, and Venezuela as high-impact countries for adolescent and youth health interventions.

Plan of Action Objectives	2014 Targets	2014 Status
<p>Objective 5.1: In alignment with PAHO’s Family and Community Health Concept Paper, develop and support adolescent and youth health promotion and prevention programs, with community-based interventions that strengthen families, include schools, and encourage participation and ownership of interventions.</p>	<p>Priority and high-impact countries will have incorporated in their adolescent and youth health promotion and prevention programs, interventions to strengthen families and programs coordinated with schools and communities.</p>	<p>Brazil, Bolivia, Honduras, Nicaragua, Colombia, Peru, and Mexico initiated or expanded the implementation of the Strong Families program (<i>Familias Fuertes</i>), a model program working with parents and adolescents to improve intra-familial communication, improve caring relationships as protective factors, and reduce risk behaviors among adolescents. The program is currently only available in Spanish.</p>

C. PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES: MIDTERM REVIEW

Background

1. This report reviews the status of noncommunicable diseases (NCDs) and their risk factors in the Region, based on the implementation of the Plan of Action for the Prevention and Control of Noncommunicable Diseases (1), adopted by the 52nd Directing Council in 2013, which is aligned with the World Health Organization (WHO) Global action plan for the prevention and control of NCDs 2013-2020 (2).
2. In the Americas, approximately 4.8 million people die each year as a result of NCDs, and 35% of these deaths are premature, occurring among people less than 70 years of age (3). The regional NCD plan of action aims to reduce premature mortality by 15% by 2019 through four overall strategies: implementing national multisectoral NCD policies and plans, reducing NCD risk factors (tobacco use, harmful use of alcohol, unhealthy diets, and physical inactivity), strengthening the health system response to NCDs (cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases), and undertaking systematic surveillance and monitoring, notably for the nine NCD targets and 25 indicators of the NCD Global Monitoring Framework (4).
3. The global Country Capacity Survey on NCDs, conducted by WHO in 2015, provides relevant and current data on NCD policies, health service response, and surveillance capacity. The survey was completed by Ministry of Health focal points in each country using the WHO standardized survey instrument, and responses were subsequently validated with the focal points. In the Americas, PAHO/WHO conducted and validated the survey, and 38 countries and territories provided responses. The results from each National NCD Capacity Survey provide the main data and information used in this report (5).¹

Update on the Progress Achieved

4. Worldwide, premature mortality from NCDs, measured according to the unconditional probability of dying from an NCD between the ages of 30 and 70 years, is lowest in the Region of the Americas, at 15% (6). Almost all countries in the Region show a stable or modest decline in **NCD premature mortality**, and 14 countries and

¹ The 2015 WHO National NCD Capacity Survey was a self-administered, standardized questionnaire completed by Ministry of Health focal points using the global online response system. A total of 38 countries and territories in the Americas provided their responses between July and November 2015, and responses were fully validated by 30 countries between September 2015 and January 2016. The data used in this report were extracted from the WHO database of survey responses (<https://extranet.who.int/ncdccs/RegionHome>). A report on the results of this NCD capacity survey is in process.

territories are on target to meet the overall regional NCD goal of a 15% reduction in premature mortality by 2019². (3).

5. All countries were committed to establishing national NCD plans and national targets by 2015. However, only about half of the countries and territories in the Americas that provided responses (22 of 38, 58%) report having an operational, multisectoral national NCD policy, strategy, or action plan, and only 17 countries (45%) report having set national NCD targets. Of the countries with national NCD plans, 13 have developed them since 2013, the year in which the Regional NCD Plan was adopted (5).

6. NCDs can be adequately addressed only through a whole-of-government and whole-of-society approach, and the regional NCD plan of action calls for countries to establish multisectoral commissions and to implement actions in at least three sectors outside the health sector. Yet, only 12 countries (32%) report having established NCD commissions with several government ministries and civil society; 19 countries (50%) have integrated NCDs into their national development agenda (5).

7. NCDs are largely preventable, and while the Region has made some important advances with respect to NCD risk factor reduction policies, many countries have yet to establish the necessary interventions that will sufficiently reduce tobacco use and harmful use of alcohol and promote healthy diets and physical activity. Although 30 countries have ratified the WHO Framework Convention on Tobacco Control, much more progress is required in its implementation. Only four countries have implemented at least three of the four tobacco demand reduction interventions (taxation policies, smoke-free environments, health warnings, advertising and marketing bans) at the highest level of achievement (6). In addition, only 11 of the 38 countries and territories (29%) report having implemented general policies to reduce harmful use of alcohol; only 8 countries (21%) report policies to reduce the impact on children of marketing of foods and non-alcoholic beverages; 10 countries (26%) report policies to limit saturated fats and eliminate partially hydrogenated vegetable oils in the food supply; three countries (8%) tax sugar-sweetened beverages; and 11 countries (29%) report policies to reduce salt consumption. Also, only seven countries have fully implemented legislation aligned with the International Code of Marketing of Breast-milk Substitutes (7). Twenty-four countries (63%) report having implemented a national public awareness campaign to promote physical activity within the past five years (5).

8. **Overweight and obesity** (body mass index of 25 kg/m² or above) continue to be of major concern, as the Americas has the highest global prevalence of these conditions.

² Data from the PAHO Mortality Database were extracted and analyzed for 2012 to determine, among people 30-70 years of age, premature mortality rates and trends for the four main NCDs in each country where information was available. These data were then used to create projections to the year 2019. Based on this unpublished PAHO analysis, countries and territories that are estimated to be on track to meet the premature NCD mortality reduction goal by 2019 include Argentina, Aruba, Canada, Chile, Colombia, Costa Rica, French Guyana, Guadeloupe, Martinique, Saint Lucia, Trinidad and Tobago, the United States of America, Uruguay, and the U.S. Virgin Islands.

Twenty-seven percent of women and 22% of men are obese (8). Seven percent of children less than 5 years of age and 17% to 36% of adolescents (12-19 years of age) in Latin America and the Caribbean are overweight or obese (9). This situation is compounded by the low rates of physical activity in the Region, where 38% of women and 27% of men report insufficient physical activity (8). The regional Plan of Action for the Prevention of Obesity in Children and Adolescents offers clear direction on how to halt the rise in obesity, and all countries are urged to implement policies and regulatory strategies (10).

9. **Tobacco use**, perhaps the single most important NCD risk factor, continues to be a challenge in the Region, with an estimated 127 million adult smokers. Some advances have been made in implementing tobacco interventions: 17 countries, which represents 49% of the population in the Americas are protected by a national 100% smoke-free law, and 16 countries have appropriate health warnings on tobacco product packaging which covers 58% of the population in the Americas (6).

10. Progress in reduction of **alcohol use** has stalled; 22% of drinkers report heavy episodic drinking, only six countries (16%) have regulations that restrict alcohol availability, and only two countries (5%) have bans on advertising and promotion (5). Of particular concern is that an estimated 3.2% of adult women in the Americas suffer from an alcohol use disorder, a rate higher than that of any other region in the world (11). In addition, between 51% and 94% of children 13-15 years old report initiation of alcohol use before age 14. More information is available in the midterm progress report on the Plan of Action to Reduce the Harmful Use of Alcohol, which is presented as agenda item 7.12-D of the 55th Directing Council.

11. **Cardiovascular diseases** (CVD), including hypertension, continue to be the leading cause of death in almost all countries in the Region (3). In the Americas, 17% of women and 22% of men have elevated blood pressure (systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg) (8). CVD guidelines have been established in 18 countries (47%), but only 10 countries report that these guidelines have been fully implemented (5). Although CVD risk stratification is offered in 20 countries (53%), only five countries report that it is available in more than half of their primary care facilities (5). Essential medicines for CVD—*aspirin, thiazide diuretics, ACE (angiotensin-converting-enzyme) inhibitors, calcium channel blockers, statins, and sulfonylureas*—are reported to be generally available in the public sector in 26 countries (68%) (5).

12. An estimated 62 million people in the Americas have **type 2 diabetes**, with 8% of women and 9% of men reported to have an elevated blood glucose (i.e., a fasting blood glucose level ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose or have a history of diabetes) (8). Guidelines for diabetes management are available but have been fully implemented in only 18 countries (47%), whereas blood glucose measurement is generally available in primary care settings throughout the Region (36 countries and territories, 95%); HbA1c testing is available in 20 countries (53%) (5). With respect to

essential medicines, 34 countries (89%) report that metformin and insulin generally are available in public primary care settings (5).

13. **Cancer** is the second leading cause of death in the Americas, and the most common types are lung, prostate, and colorectal cancer among men and lung, breast, and cervical cancer among women (3). Comprehensive cancer plans that address the continuum of care (primary prevention, secondary prevention, diagnosis, treatment, palliative care) are promoted by WHO and other institutions. About half of the countries in the Region (23 countries, 61%) report having a national cancer policy, strategy or action plan in place, either a stand-alone plan or one integrated into the country's NCD plan (5). Notable progress is being made in cervical cancer prevention, with 20 countries (53%) introducing HPV vaccines and 33 countries (87%) reporting available screening services for breast, cervical, colon and/or prostate cancer; however, only six countries report screening coverage for at least one of these cancer types, at levels that are likely to have an impact (70% coverage or greater) (5). Although 31 countries (81%) report that breast cancer screening is available and 16 (42%) report that mammography is used, only three of these countries have significant screening coverage likely to have an impact (70% coverage or greater) (5).

14. **Chronic respiratory diseases (CRD)**, principally chronic obstructive pulmonary disease, asthma, and occupational lung diseases are responsible for approximately 413,000 deaths in the Americas (3). Tobacco use, air pollution, and occupational chemicals and dusts are the most important risk factors for these diseases, which cannot be cured but for which effective treatment is available. Treatment is reported as generally available in the primary care facilities of the public health sector in the Region: 28 countries (74%) report availability of steroid inhalers and 33 countries (87%) report availability of bronchodilators. Guidelines on the management of CRD, however, are only implemented in 9 countries (24%), and only 8 countries (21%) indicate that they have an operational policy, strategy or action plan specific for CRD (5). Better surveillance to establish the magnitude of CRD, as well as primary prevention to reduce risk factors and strengthening health care for people with chronic respiratory diseases, are urgently needed to improve quality of life for those affected by CRD.

15. As countries work towards universal health coverage, there are opportunities to improve access, coverage, and quality of care for NCDs as well as to address comorbidities, notably depression and other mental health conditions. The chronic care model, an approach promoted by PAHO and other institutions to integrate NCD management into primary care as a means of providing continuous quality improvement and self-management, is being applied in several countries with PASB's technical assistance. These experiences are being documented and shared to stimulate more countries to adopt this approach. Access to essential NCD medicines is being strengthened through PAHO's Revolving Fund for Strategic Public Health Supplies (Strategic Fund), which now includes almost 40 drugs used to treat hypertension, diabetes, and cancer and to manage tobacco cessation; however, very few countries are

using this mechanism, and, as a result, many are paying significantly higher prices for their NCD medicines than the prices available through the fund.

16. Surveillance capacity needs to be improved, especially in the Caribbean and Central America, to enable all countries to measure their progress in meeting NCD targets and indicators; evaluate the impact of their NCD policies, programs, and services; and report progress at the Third UN High-level Meeting on NCDs in 2018. Nonetheless, there has been some progress in this area, with 29 countries reporting either full or partial implementation of NCD risk factor surveys³ and 34 countries reporting mortality data (5).

Challenges and Lessons Learned

17. NCDs, a complex set of four diseases with four shared risk factors, require political will, investments, and concerted actions across all sectors of government and society to address their underlying drivers. There is a great deal of political commitment to NCDs in the Region, as noted in this regional NCD Plan of Action as well as the Global NCD Plan of Action and the 2011 and 2014 UN High-level Meetings on NCDs. Moreover, there have been some important advances, as noted above. Nonetheless, these advances have not yet fully translated to all countries achieving their time-bound commitments to create national NCD plans, establishing multisectoral NCD commissions, setting national NCD targets and indicators, advancing the implementation of stronger regulations and policies to reduce risk factors, improving health services for NCDs, or completing risk factor surveys. Interference from the tobacco, alcohol, and food and beverage industries continues to inhibit countries' progress in attaining the NCD risk factor targets.

18. Multisectoral action is an area that has been particularly challenging for countries to implement, given the complexity of engaging other sectors beyond health, along with civil society, academia, and the private sector, in preventing NCDs. The Sustainable Development Goals, as well as the regional commitments to Health in all Policies, health-related law, prevention of obesity in children and adolescents, call for and support creating multisectoral NCD responses. Therefore, more concerted action is required with sectors beyond health that can intervene in NCD prevention and control.

³ NCD risk factor surveys are considered fully implemented if the country, in the 2015 National Capacity Survey, responded "yes" to each of the following for adults: "Have surveys of risk factors (may be a single risk factor or multiple) been conducted in your country for all of the following:" "Harmful alcohol use" (optional for Member States according to national circumstances), "Physical inactivity," "Tobacco use," "Raised blood glucose/diabetes," "Raised blood pressure/hypertension," "Overweight and obesity," and "Salt/sodium intake?" In addition, for each risk factor, the country must indicate that the most recent survey was conducted in the past five years (i.e., 2010 or later for the 2015 survey responses) and must respond "Every 1 to 2 years" or "Every 3 to 5 years" to the sub-question "How often is the survey conducted?" This indicator is considered partially achieved if the country responded that at least three (but not all) of the above risk factors are covered or that the surveys were conducted more than five years but less than 10 years ago.

19. In this regard, PAHO is leading a regional mechanism for multisectoral cooperation on NCDs through the Inter-American Task Force on NCDs, which was established as a mandate from the VII Summit of the Americas. This regional task force, launched in July 2015, aims to promote and coordinate multisectoral activities with the agencies and associated international institutions within the Inter-American system: the Pan American Health Organization, the Organization of American States, the Inter-American Institute for Cooperation Agriculture, the Inter-American Development Bank, the Economic Commission for Latin America and the Caribbean, and the World Bank. A mapping of each agency's current investments and technical cooperation in NCDs and their risk factors has been conducted, and PAHO is currently analyzing the information to inform potential areas of synergy, gaps, and collaboration. A joint work plan is in the process of being developed, with a focus on the priority topics of tobacco control, obesity prevention in children and adolescents, and cardiovascular disease prevention and control. The elements of the work plan include advocacy and community mobilization, legislation, economic analysis, and capacity building for key interventions for a multisectoral response to NCDs, among others. The Task Force is hosting a side event on NCDs as part of the July 2016 OAS Ministerial Meeting on Social Development to create linkages among social development, social inclusion, and NCDs.

Action Necessary to Improve the Situation

20. The regional NCD Plan of Action should continue to be implemented, and the following actions are highlighted for attention to improve the current NCD situation:

- a) Intensify political, technical, and financial commitments to NCDs, especially in the subregions of Central America and the Caribbean, where progress in NCD prevention and control appears to be lagging.
- b) For those countries that have not yet established their national NCD plan, national targets, or multisectoral commissions, prioritize these actions without further delay.
- c) Accelerate implementation of the WHO Framework Convention on Tobacco Control, notably to put in place the four demand reduction interventions of taxation policies, smoke-free environments, health warnings, and advertising and marketing bans.
- d) Focus on obesity prevention by promoting healthy lifestyles and healthy diets through public awareness campaigns, physical activity promotion, taxation of sugar-sweetened beverages, restrictions on the marketing of foods and non-alcoholic beverages to children, and restrictions on the marketing of breast milk substitutes.
- e) Make alcohol policies a priority within the NCD and health agenda and put in place the demand reduction interventions (taxation policies, regulation of access and availability, and advertising and marketing bans) needed to reduce harmful use of alcohol.

- f) Fully use the PAHO Strategic Fund to increase access to and affordability of NCD essential medicines, particularly medicines to improve blood pressure control and prevent cardiovascular diseases.

Action by the Directing Council

21. The Directing Council is invited to take note of this progress report and consider actions needed to accelerate NCD prevention and control interventions.

Annex

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ANNEX – Midterm progress on the Regional NCD Plan of Action, by specific objective

The table below describes the progress for each specific objective and indicator of the Regional NCD Plan of Action 2013-2019, endorsed at the 2013 meeting of the PAHO Directing Council. It shows the countries that were considered baseline in 2010 and the countries meeting the indicator by 2016, the year for which a midterm progress report is submitted to the Directing Council. Indicators with an asterisk (*) are also included in the WHO Global NCD Action Plan.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
1. Multisectoral policies and partnerships for NCD prevention and control	1.1 Promote integration of NCD prevention in sectors outside of health, at the government level, and conduct activities in partnership with a wide range of non-state actors, as appropriate, such as agriculture, trade, education, labor, development, finance, urban planning, environment, and transportation.	1.1.1 Number of countries with multisectoral NCD prevention policies, frameworks and actions in at least three sectors outside the health sector at the government level, conducted in partnership with a wide range of non-state actors, as appropriate (e.g., agriculture, trade, education, labor, development, finance, urban planning, environment, and transportation).	(5) ARG, BRA, CAN, MEX, USA	(12) ARG, BRA, BRB, CAN, CRI, CUB, GRD, JAM, MEX, PRI, USA, VGB	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015. -This refers to countries with operational multisectoral NCD commissions that include government ministries other than health. The survey question did not probe for number of sectors, so it is not certain if the country has at least three sectors outside health in its national commission.
	1.2 Strengthen or develop national health plans based on multisectoral approaches, with specific actions, targets, and indicators geared to at least the four priority NCDs and the four main risk factors.	1.2.1 Number of countries implementing a national multisectoral plan and/or actions for NCD prevention and control.	(15) ARG, BRA, BRB, CAN, CHL, COL, CUW, DOM, GTM, JAM, MEX, SUR, TTO, USA, VGB	(22) ARG, BLZ, BRA, BRB, VGB, CAN, CHL, COL, CRI, DOM, ECU, GLP, GUY, JAM, KNA, MEX, PAN, PRI, PRY, SUR, USA, VCT	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	1.3 Expand social protection policies in health to provide universal coverage and more equitable access to promotive, preventative, curative, rehabilitative, and palliative basic health services and essential, safe, affordable, effective, quality medicines and technologies for NCDs.	1.3.1 Number of countries with national social protection health schemes that address universal and equitable access to NCD interventions.	(7) BRA, CAN, CHL, COL, CRI, CUB, URY	In progress	-Data to measure progress on this indicator are currently not available. A review and analysis of all social protection schemes of countries in the Region are needed to assess this indicator, and this is in progress and information will be included in the final report.
2. NCD risk factors and protective factors	2.1 Reduce tobacco use and exposure to secondhand smoke.	2.1.1* Number of countries that reduce the prevalence of current tobacco use from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the global target of a 30% relative reduction in current tobacco smoking by 2025 (measured by the age-standardized prevalence of current tobacco use in the population 15 years and over).	0	In progress	-Information on the age-standardized prevalence of current tobacco smoking in adults 15+ (2013) is available for 19 countries in Appendix X of the WHO Report on the Global Tobacco Epidemic, 2015 (available from: http://bit.ly/1gl1YYm). -Data are not yet available that will allow for calculation of the change in the prevalence of tobacco use from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	2.2 Reduce the harmful use of alcohol.	2.2.1* Number of countries that by 2019 achieve a reduction in harmful use of alcohol from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the global target of a 10% relative reduction by 2025.	0	In progress	<p>-Information on alcohol consumption per capita in adults 15+ (2010) is available for the 35 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx). This is one of the three indicators for harmful use of alcohol included in the WHO Global Monitoring Framework. Countries are encouraged to report against as many indicators as possible; however, they may also choose to report against the one most appropriate for their national circumstances.</p> <p>-According to the PAHO/WHO Country Capacity Survey on NCDs, 26 countries report having a recent (≤ 5 years) risk factor survey that includes harmful use of alcohol.</p> <p>-Data are not yet available that will allow for calculation of the change in harmful use of alcohol from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.</p>
	2.3 Promote healthy eating for health and well-being.	2.3.1* Number of countries with policies to reduce the impact on children of marketing of foods and non-alcoholic beverages and foods high in saturated fats, trans-fatty acid, sugar, and salt.	(2) BRA, CAN	(7) BRA, CAN, CHL, COL, CRI, MEX, URY	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.

CD55/INF/12 - C - ANNEX

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		2.3.2* Number of countries with adopted national policies to limit saturated fats and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate within national contexts and national programs.	(6) ARG, BRA, CAN, CHL, CRI, USA	(10) ARG, BRA, CAN, COL, CRI, ECU, JAM, PER, PRI, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.
		2.3.3* Number of countries that by 2019 reduce salt/sodium consumption from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of a 30% relative reduction in population-based intake of salt/sodium, measured by the age-standardized mean population intake of salt (sodium chloride) in grams per day in persons aged 18+ years.	0	In progress	-Based on the PAHO/WHO Country Capacity Survey on NCDs, 14 countries report having a recent (≤ 5 years) risk factor survey that includes salt/sodium intake. PAHO/WHO is providing technical assistance to countries to undertake risk factor surveys that include salt/sodium intake. -Data are not yet available that will allow for calculation of the change in salt/sodium consumption from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.

CD55/INF/12 - C - ANNEX

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	2.4 Promote active living for health and well-being and to prevent obesity.	2.4.1* Number of countries that by 2019 reduce the prevalence of insufficient adult physical activity from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of at least a 10% relative reduction in the prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week or the equivalent).	0	In progress	<p>-Information on the age-standardized prevalence of insufficient physical activity in adults 18+ years (2010) is available for 20 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx).</p> <p>-Based on the PAHO/WHO Country Capacity Survey on NCDs, 24 countries report having recent (≤ 5 years) risk factor surveys that include physical activity.</p> <p>-Data are not yet available that will allow for calculation of the change in insufficient adult physical activity from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.</p>
		2.4.2* Number of countries that by 2019 reduce the prevalence of insufficient physical activity among adolescents from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of at least a 10% relative reduction in the prevalence of insufficiently physically active adolescents (defined as less than 60 minutes of moderate- to vigorous-	0	In progress	<p>-Country-reported data on the prevalence of insufficient physical activity among adolescents aged 11-17 years who are enrolled in school are available for 27 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx).</p> <p>-Based on the PAHO/WHO Country Capacity Survey on NCDs, 21 countries report having recent risk factor surveys that include physical activity measures.</p> <p>-Data are not yet available that will</p>

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		intensity activity daily in school-aged children and adolescents).			allow for calculation of the change in insufficient adolescent physical activity from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
3. Health system response to NCDs and risk factors	3.1 Improve the quality of health services for NCD management.	3.1.1 Number of countries implementing a model of integrated management for NCDs (e.g., Chronic Care Model with evidence-based guidelines, a clinical information system, self-care, community support, multidisciplinary team-based care).	(9) ARG, BRA, CAN, CHL, DOM, JAM, MEX, PRY, USA	(18) ARG, BRA, CAN, CHL, COL, CRI, CUB, DOM, ECU, GRD, MEX, JAM, PAN, PRI, PRY, LCA SUR, USA	-Source: information provided by the PAHO Unit on Noncommunicable Diseases, based on technical cooperation on the implementation of the Chronic Care Model.
	3.2 Increase access to and rational use of essential medicines and technologies for screening, diagnosis, treatment, control, rehabilitation, and palliative care of NCDs.	3.2.1 Number of countries that by 2019 achieve the level of availability of affordable basic technologies and essential medicines (including generics) required to treat the four main NCDs in both public and private facilities, as established by the country for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of 80% availability.	(7) ARG, BRA, CAN, CHL, CRI, CUB, URY	(20) ATG, BRA, BRB, CAN, CHL, COL, CRI, CUB, CYM, DOM, ECU, GRD, GUY, JAM, PAN, PRI, SUR, TTO, URY, USA	-Source: PAHO/WHO National Capacity Survey, conducted July-November 2015. -This includes countries that report having all basic technologies and essential NCD medicines generally available in the public sector. Private sector data were not available for NCD medicines. -The definition of essential medicines and basic technologies is as outlined in the NCD GMF definitions and specifications (available from: http://bit.ly/1KsRizl).
		3.2.2 Number of countries that by 2019 improve access to palliative care, assessed by the increase in morphine equivalent consumption of	0	In progress	-Data on opioid consumption (as measured by morphine equivalence minus methadone in milligrams per capita) are available for 37 countries

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		opioid analgesics (excluding methadone) per cancer death based on 2010 data.			and territories in the Americas, as estimates from the International Narcotics Control Board. -Based on the PAHO/WHO Country Capacity Survey on NCDs, 18 countries report having oral morphine generally available in the public sector. -Data are not yet available that will allow for calculation of the change in morphine equivalent consumption of opioid analgesics (excluding methadone) per cancer death. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.2.3 Number of countries utilizing the PAHO Strategic Fund and Revolving Fund and/or other cost-saving mechanisms to procure essential medicines and health technologies relevant to prevention, control, and palliation for the four leading NCDs, such as chemotherapy drugs, palliation medications, insulin, dialysis and hemodialysis, hepatitis B (HBV) and human papillomavirus (HPV) vaccines, and medications for the treatment of hypertension and diabetes.	0	In progress	-All countries in the Region utilize the PAHO Revolving fund for HBV vaccine, and almost all countries that have introduced HPV vaccines utilize this fund. -The inclusion of NCD medicines in the PAHO Strategic Fund is very recent, and as such countries in the Region have not yet begun to fully utilize this mechanism. Only two countries to date have procured their NCD medicines through the Strategic Fund. PAHO is actively promoting the availability of affordable NCD medicines through this fund to its Member States.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		3.2.4 Number of countries with an official commission that selects, according to the best available evidence and operating without conflicts of interest, NCD prevention and/or treatment and/or palliative care medicines and technologies for inclusion in/exclusion from public sector services.	(6) BRA, CAN, CRI, CUB, URY, USA	In progress	-There are eight countries with commissions that select, according to the best available evidence and operating without conflicts of interest, medicines and technologies. The currently available information does not separate NCD prevention and/or treatment and palliative care medicines and technologies from others, so it is not possible at present to fully report on this indicator.
		3.2.5 Number of countries with a plan in place, as appropriate, to increase access to affordable treatment options for patients affected by chronic kidney disease (CKD), particularly end-stage renal disease.	(5) CHL, CUB, PRI, URY, VEN	(10) ARG, BRA, CHL, COL, CUB, ECU, PRI, PRY, URY, VEN	-Source: González-Bedat et al. Los registros nacionales de diálisis y trasplante renal en América Latina: cómo implementarlos y mejorarlos. Rev Panam Salud Publica. 2015;38(3):254-260.
	3.3 Implement effective, evidence-based, and cost-effective interventions for treatment and control of CVD, hypertension, diabetes, cancers, and chronic respiratory diseases.	3.3.1* Number of countries that by 2019 achieve the level set for raised blood glucose/diabetes from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of a halt in the prevalence of raised blood glucose/diabetes, assessed by the age-standardized prevalence of raised blood glucose/diabetes among adults aged 18+ years (defined as fasting plasma glucose value ≥ 7.0 mmol/L [126 mg/dl] or on medication for raised blood glucose).	(1) USA	In progress	-Information on the age-standardized prevalence of raised fasting blood glucose/diabetes (≥ 7.0 mmol/L or on medication) in adults 18+ (2014) is available for 35 Member States from the WHO Global Health Observatory (available from: http://bit.ly/297Gopx). -Based on the PAHO/WHO Country Capacity Survey on NCDs, 23 countries report having recent (≤ 5 years) risk factor surveys that include blood glucose/diabetes. -Data are not yet available that will allow for calculation of the change in raised blood glucose/diabetes

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
					from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.3.2* Number of countries that by 2019 achieve the level set for adult obesity from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of a halt in the prevalence of adult obesity, assessed through the age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as BMI ≥ 25 kg/m ² for overweight or ≥ 30 kg/m ² for obesity).	0	In progress	<p>-Information on the age-standardized prevalence of obesity (BMI ≥ 30 kg/m²) in adults 18+ years (2014) is available for 35 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx).</p> <p>-According to the PAHO/WHO 2015 Country Capacity Survey, 27 countries report having recent (≤ 5 years) risk factor surveys that include overweight and obesity among adults.</p> <p>-Data are not yet available that will allow for calculation of the change in adult obesity from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.</p>
		3.3.3* Number of countries that by 2019 achieve the level set for adolescent overweight and obesity from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the	0	In progress	<p>-Country-reported data for the prevalence of overweight and obesity ($>+1$SD from the median for BMI) in adolescents 13-15 years of age are available for 18 countries from the Global School Health Survey (available from:</p>

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		2025 global target of a halt in the prevalence of overweight and obesity (defined according to the WHO growth reference for school-aged children and adolescents: overweight as one standard deviation BMI for age and sex and obese as two standard deviations BMI for age and sex).			http://bit.ly/295Ogt6 . –Based on the PAHO/WHO Country Capacity Survey on NCDs, 21 countries report having recent (≤ 5 years) risk factor surveys that include overweight and obesity among adolescents. -Data are not yet available that will allow for calculation of the change in adolescent overweight and obesity from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.3.4* Number of countries that by 2019 achieve the level of drug therapy and counseling set from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of at least 50% of eligible people receiving drug therapy and counseling (including glycemic control) to prevent heart attacks and strokes (eligible people are defined as aged 40 years and over with a 10-year cardiovascular risk greater than or equal to 30%, including those with existing CVD).	(4) BRA, CAN, CHL, CUB	In progress	-The STEPS survey includes questions related to this indicator, but results are not currently available that would enable calculation of this indicator. When data become fully available, this indicator will be calculated and information will be included in the final report.

CD55/INF/12 - C - ANNEX

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		<p>3.3.5* Number of countries that by 2019 reduce the level of prevalence of raised blood pressure from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global goal of at least a 25% relative reduction in the prevalence of raised blood pressure or containing the prevalence of raised blood pressure, expressed by the age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg).</p>	0	In progress	<p>-Information on the age-standardized prevalence of raised blood pressure (systolic blood pressure ≥ 140 or diastolic blood pressure ≥ 90) among adults 18+ (2014) is available for 35 Member States from the WHO Global Health Observatory (available from: http://bit.ly/29djA9W).</p> <p>-Based on the PAHO/WHO Country Capacity Survey on NCDs, 24 countries report having recent (≤ 5 years) risk factor surveys that include blood pressure.</p> <p>-Data are not yet available that will allow for calculation of the change in the prevalence of raised blood pressure from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.</p>
		<p>3.3.6* Number of countries with cervical cancer screening coverage of 70% by 2019 (among women aged 30-49 years, at least once or more often, and for lower or higher age groups according to national policies).</p>	(5) BRA, CAN, CHL, KNA, USA	(7) BRA, CAN, CHL, CUB, ECU, GRD, USA	<p>-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.</p>

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		3.3.7 Number of countries with at least 50% coverage of breast cancer screening in women aged 50-69 years (and other age groups according to national programs or policies) in a three-year period, with effective and timely treatment for all positive cases found during screening.	(4) ARG, BRA, CAN, USA	(7) BRA, CAN, CUB, DOM, ECU, JAM, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.
		3.3.8* Number of countries that provide as appropriate cost-effective and affordable vaccines against HPV according to national programs and policies.	(8) ARG, CAN, COL, MEX, PAN, PER, URY, USA	(21) ARG, BHS, BLZ, BRA, BRB, CAN, CHL, COL, CYM, ECU, GUY, HND, MEX, PAN, PER, PRI, PRY, SUR, TTO, URY, USA	-Source: PAHO/WHO Country Capacity Survey, conducted July-November 2015.
4. NCD surveillance and research	4.1 Improve the quality and breadth of NCD and risk factor surveillance systems to include information on socioeconomic and occupational status.	4.1.1 A 15% reduction in premature mortality from the four leading NCDs by 2019 and 25% by 2025.	0	(14) ABW, ARG, CAN, CHL, COL, CRI, GLP, GUF, LCA, MTQ, TTO, URY, USA, VIR	-Source: analysis of data from the PAHO Mortality Database, 2016.
		4.1.2 Number of countries with high-quality mortality data (based on international criteria for completeness and coverage and percentage of ill-defined or unknown causes of death) for the four main NCDs and other NCDs of national priority (e.g., CKD).	(10) CAN, CHL, CRI, CUB, MEX, SUR, PAN, URY, USA, VEN	(23) ARG, ATG, BHS, BRA, BRB, CAN, CHL, CRI, CUB, DMA, GRD, GUY, KNA, LCA, MEX, MSR, MTQ, PRI, URY, USA, VCT, VEN, VIR	-Source: PAHO Basic Indicators. Health Situation in the Americas, 2016. This includes countries with coverage higher than 90% and percentage of ill-defined causes of death lower than 10%, as defined by WHO in Mathers et al. Counting the dead and what they died from: an assessment of the global status of cause of death data. Bull World Health Organ. 2005;83(3):161-240.

CD55/INF/12 - C - ANNEX

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		4.1.3* Number of countries with quality cancer incidence data, by type of cancer per 100,000 population.	(11) ARG, BRA, CAN, CHL, COL, CRI, ECU, MEX, PER, URY, USA	(18) ARG, BRA, BRB, CAN, CHL, COL, CRI, CUB, CYM, ECU, GTM, GUY, JAM, PAN, PER, PRI, URY, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.
		4.1.4* Number of countries with at least two nationally representative population surveys by 2019 of NCD risk factors and protective factors in adults and adolescents in the last 10 years, including: <ul style="list-style-type: none"> - tobacco use - alcohol use - anthropometry - albumin - blood pressure - fasting glucose and cholesterol - fruit and vegetable intake - creatinine - physical inactivity - sodium intake - disease prevalence - sugar intake - medication use 	(7) ARG, BRA, CAN, CHL, MEX, JAM, USA	In progress	-Based on the PAHO/WHO Country Capacity Survey on NCDs and the definition outlined in WHO progress indicator #3, nine countries report having recent (≤ 5 years) and periodic (at least every 5 years) NCD risk factor surveys in adults covering harmful use of alcohol, physical inactivity, tobacco use, raised blood glucose/diabetes, raised blood pressure/Hypertension, overweight/obesity, and salt intake; 19 countries have NCD risk factor surveys that cover at least three risk factors and were conducted more than 5 years ago but less than 10 years ago. Information on this indicator will be included in the final report.
	4.2 Improve utilization of NCD and risk factor surveillance systems and strengthen operational research with a view to improving the evidence base for planning, monitoring, and	4.2.1 Number of countries that produce and disseminate regular reports with analysis of NCDs and risk factors, including demographic, socioeconomic, and environmental determinants and their social distribution, to contribute to the global NCD monitoring process.	(9) ARG, BRA, CAN, CHL, COL, CUB, MEX, JAM, USA	(22) ARG, BHS, BRA, BRB, CAN, CHL, CRI, CUB, DOM, ECU, GRD, GTM, LCA, MEX, PAN, PRI, PRI SUR, TTO, URY, USA, VCT	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015, and the WHO NCD Progress Monitoring Report. -This refers to countries that have demonstrated a report, or factsheet, that disseminates data on tobacco use, harmful use of alcohol, fruit and

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	evaluation of NCD-related policies and programs.				vegetable consumption, physical inactivity, raised blood pressure/hypertension, and raised blood glucose/diabetes in the past 5 years from STEPs or similar surveys among adults.
		4.2.2 Number of countries that have research agendas that include operational studies on NCDs and risk factors aiming to strengthen evidence-based policies and program development and implementation.	(9) ARG, BRA, CAN, CHL, COL, CUB, JAM, MEX, USA	(11) ARG, BRA, CAN, CHL, COL, CRI, JAM, MEX, PRI, PRY, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015, and the WHO NCD Progress Monitoring Report. -This refers to countries that have an operational policy or plan on NCD-related research.

D. PLAN OF ACTION TO REDUCE THE HARMFUL USE OF ALCOHOL: MIDTERM REVIEW

Background

1. In 2010, the Sixty-third World Health Assembly endorsed the Global Strategy to Reduce the Harmful Use of Alcohol (Resolution WHA63.13) (1). To facilitate implementation of the Global Strategy, in 2011 the Pan American Health Organization (PAHO) adopted the Plan of Action to Reduce the Harmful Use of Alcohol (Resolution CD51.R14) (2). The purpose of the present document is to report on progress made in the implementation of the Plan of Action, five years after its adoption.

Update on the Progress Achieved

2. Progress has been made on many objectives, as described in the Table below. A network of national counterparts and other stakeholders, the Pan American Network on Alcohol and Public Health (PANNAPH), was created; it uses face-to-face meetings and a mailing list to regularly share information on new studies, events, and activities at the regional and global levels. Alcohol use has been included in several regional initiatives, including those on noncommunicable diseases (NCDs), injury prevention, road safety, and the United Nations Sustainable Development Goals, consistent with its importance as a health, social, and political priority. Across the Region, numerous events have been held and technical tools shared. Information is regularly reported by Member States through the World Health Organization (WHO) Global Survey on Alcohol and Health and entered in the Regional Information System on Alcohol and Health of the Americas.¹ The Pan American Sanitary Bureau has developed four self-learning virtual courses, three of them available in both English and Spanish, in which approximately 6,800 people from nearly 60 countries have participated (3).² These courses are recognized as highly valuable and have been adapted by individual countries (e.g., Uruguay and Mexico), and are now being used as models for other regions (e.g., WHO Headquarters and European Region). PAHO has published and disseminated several documents, including the Regional Status Report on Alcohol and Health in the Americas (2015) (4) and the PAHO Meeting on Alcohol Marketing Regulation: Final Report (2016) (5). Activities include building the capacity of the health services to screen for and intervene in patients' harmful use of alcohol and alcohol use disorders, often in coordination with other mental health intervention efforts (6). Technical cooperation was established with 25 countries.³

¹ This system is an interface of the Global Information System on Alcohol and Health.

² The four courses are Alcohol Policy in Public Health (*Políticas sobre alcohol y salud pública*); AUDIT-SBI in Primary Health Care (*Capacitación AUDIT-DIT*); Drug Policy and Public Health (*Políticas sobre drogas y salud pública*); and *Capacitación ASSIST-DIT*.

³ Argentina, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Suriname, Trinidad and Tobago, United States, and Venezuela.

However, limited progress has been made on Objective 3, meant to support cost-effective public health policies to reduce the harmful use of alcohol.

3. Neither the WHO Global Strategy nor the Regional Plan of Action has established indicators to measure reductions in consumption and harmful use of alcohol. Since the adoption of these two resolutions, however, a 10% relative reduction in the harmful use of alcohol has been included as one of the outcome indicators of Category 2 in the PAHO Strategic Plan 2014-2019 (7). In addition, the PAHO Strategy and Plan of Action for the Prevention and Control of Noncommunicable Diseases sets an objective for the number of countries achieving a reduction in the harmful use of alcohol (8), and the Sustainable Development Goals call for stronger prevention and treatment of alcohol use disorders (9).

4. Countries have increased efforts to develop and update national policies, plans, and programs, although the most cost-effective policies have not been fully used to reduce the harmful use of alcohol. Such policies include price increases through taxation policies; limiting the physical availability of alcohol, or banning or effectively regulating alcohol marketing, sponsorship, and promotions. Several collaborations are under way, including in the area of research and program implementation. For example, the International Alcohol Control Policy Evaluation Study is currently being implemented in St. Kitts (with PAHO's collaboration) and in Peru, and emergency room studies have been carried out in several countries of the Region, resulting in a PAHO publication on alcohol-related injuries (10).

5. Despite these efforts, alcohol per capita consumption is still high in the Region, and predicted to increase if no additional measures are taken. Heavy episodic drinking and alcohol use disorders are prevalent in adults and adolescents, and alcohol-specific mortality rates are high (11). Of particular concern is that an estimated 3.2% of adult women in the Americas suffer from an alcohol use disorder, higher than in any other region of the world. Between 51% and 94% of children 13-15 years of age report initiation of alcohol consumption before age 14 (4).

Table: Progress toward Achievement of Each Objective of the Plan of Action

Objective	Indicator	Baseline and Target	Status
1. To raise awareness and political commitment.	Number of regional advocacy events integrating a link with alcohol-related issues.	Baseline: 0 Target: At least 2 events per year until 2021 (road safety; violence; health promotion; workers' health; mental health, human rights, violence against women; world day against drugs; world health day; cancer, cardiovascular disease, diabetes).	<p>2012: PANNAPH meeting; International Men's Day celebration; e-SBI seminar (12-14).</p> <p>2013: Caribbean alcohol policy meeting; alcohol policy, underage drinking prevention, and social change webinar; alcohol control, state systems, and public health webinar; National Alcohol Awareness Month: alcohol and health webinar; International Men's Day celebration webinar; health systems and addiction recovery event; International Day against Drug Abuse and Illicit Trafficking event (15, 16).</p> <p>2014: PANNAPH meeting; alcohol and cancer meeting; changing the practices of the tobacco, alcohol, automotive, and food industries to prevent NCDs webinar; conflicts of interest webinar; alcohol epidemiology in the Americas webinar (17, 18).</p> <p>2015: Regional Conference on Mental Health; Forum of Key Stakeholders on NCDs: Advancing the NCD Agenda in the Caribbean (19, 20).</p> <p>2016: World Cancer Day; 4 PANNAPH webinars (on marketing control, availability, taxes, monitoring indicators).</p>
2. To improve the knowledge base on the magnitude of problems and on	Number of new research studies undertaken with a focus on alcohol	Baseline: Not available Target: At least 10 new studies completed between 2012-2021.	10+ studies undertaken (e.g., 21-34).

Objective	Indicator	Baseline and Target	Status
effectiveness of interventions disaggregated by sex and ethnic group.	and its impact on health.		
3. To increase technical support to Member States.	Number of countries with national and/or subnational alcohol action plans developed with PAHO's technical cooperation.	Baseline: 5 Target: 15 by 2021.	8 (Colombia, Mexico, Paraguay achieved the objective after the adoption of the Plan of Action and have been added to the 5 baseline countries after the adoption of the Plan of Action). More detail on specific national policies, as detailed under Objective 3, can be found in the Annex. Note that this target only includes countries that have received PASB's technical cooperation.
4. To strengthen partnerships.	A regional network of national counterparts with countries and other stakeholders formed and functioning.	Baseline: 0 Target: One network formed in 2012 and regularly functioning throughout the period until 2021.	2012: PANNAPH created; mailing list created (currently 171 subscribers, including PAHO focal points, ministry of health counterparts, collaborating centers, selected researchers, and NGOs); approximately 700 emails sent as of February 2016 (12).
5. To improve monitoring and surveillance systems and dissemination of information for advocacy, policy development, and evaluation.	Number of countries that provide country-specific data to the regional alcohol information system.	Baseline: 35 Target: 35	35 countries (including St. Maarten but not Haiti) responded to the 2012 Global Survey on Alcohol and Health; 30 (all Member States except Argentina, Dominica, Guyana, Haiti, and Paraguay) responded to the 2015 Global Alcohol Policy Survey. All 35 Member States plus Puerto Rico have country profiles with at least partial data in the 2011 and 2014 editions of the Global Status Report on Alcohol and Health (35, 11).

Challenges and Lessons Learned

6. Alcohol is a risk factor for over 200 International Classification of Diseases (ICD) codes, including those related to injuries, violence, mental health, noncommunicable diseases, and communicable diseases. Vertical approaches to reducing alcohol problems have had a limited impact on public health. Therefore, it is a challenge to promote the need for and value of population-based policies, even those recognized as cost-effective, in the absence of an understanding of alcohol consumption as a public health threat.
7. Alcoholic beverages enjoy broad cultural acceptance, and there is limited support in society for reducing overall per capita consumption. There is even a widespread belief that alcohol consumption has net health benefits, when in fact the evidence shows that the positive effects of alcohol are limited and are surpassed by the harms in all countries of the world.
8. Changing such perceptions in order to gain political support for population-based policies would require Member States to invest prohibitively large amounts of financial and human resources in programs to compete with the private sector's alcohol marketing strategies.
9. The limited advocacy and organization carried out by the nongovernmental sector and civil society at regional and national levels competes for political space and influence with a strong, well-organized, and influential alcohol industry that is only weakly regulated.
10. It is important to strengthen the institutional capacity of the health authority to effectively regulate alcohol consumption through improved governance, transparency processes, accountability, and appropriate management of conflicts of interest (36).
11. There are several barriers to wider utilization of evidence-based public policies on alcohol, including a lack of studies on alcohol policy in countries of the Region as well as a lack of standards against which a country can assess the effectiveness of its policies in reducing the harmful use of alcohol.
12. Revenues from increased taxes on alcoholic beverages can help make resources available for health system reforms aimed at achieving universal access to health and universal health coverage. At the same time, a resultant decrease in alcohol consumption can prevent a significant percentage of acute and chronic problems that often threaten to overwhelm health care services.
13. Stricter measures to counter drink-driving have been adopted in several countries with relative success, but experience to date also indicates the need to strengthen enforcement of laws and regulations to make them more effective.

Actions Necessary to Improve the Situation

- a) Give higher priority to alcohol as a public health problem and increase its visibility in the Region across technical areas and sectors.
- b) Convene a task force to review progress made to date on the regional plan, review cost effective policies applicable for the Region, establish appropriate indicators, identify barriers to the implementation of national policies, and recommend further actions that can strengthen technical cooperation to achieve significant progress on reducing the harmful use of alcohol.
- c) Develop and revise national alcohol policies and plans that can lead to a relative reduction in the harmful use of alcohol by at least 10%, which can be best achieved by enacting or updating laws and regulations on alcohol taxes, physical availability, and alcohol marketing control.
- d) Promote alcohol marketing control to protect young people from pressures to drink and change cultural norms regarding alcohol consumption.
- e) Promote fiscal policies as an effective way to reduce the harmful use of alcohol as well as to increase revenues for governments.
- f) Support action at the local or municipal level to reduce alcohol availability as a means to improve public safety and promote healthy environments.
- g) Support advocacy efforts in the Region, particularly focused on young people, social determinants, and gender. Establish a day to raise awareness about the need to reduce alcohol problems and to protect young children from pressures to drink, including from exposure to alcohol marketing. In this respect, the Healthy Caribbean Coalition (a nongovernmental organization in official relations with PAHO) will establish, starting in 2016, a subregional alcohol awareness day.
- h) Promote strengthening of primary health care services to include screening, brief interventions, and management of alcohol use disorders as part of an essential package of primary health care services for achieving universal health coverage.
- i) Improve tools and processes for collecting and using data to inform policies and programs at regional and national levels.
- j) Develop alcohol policy standards that can be adopted by Member States to enable monitoring of progress on reducing the harmful use of alcohol.
- k) Strengthen research on alcohol's impact on health, on policies and programs aimed at reducing alcohol-related harm, and on the net impact of alcohol on the economy, to provide justification for public policies and gain the support of sectors beyond health.

Action by the Directing Council

14. The Directing Council is invited to take note of this progress report and offer any recommendations it deems necessary.

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Annex

Status of national activities undertaken between 2011 and 2014 by Member States¹

Adopted written national policy on alcohol	<u>2011 and after</u> : Colombia, Mexico, Paraguay, United States of America <u>Pre-2011</u> : Argentina, Bahamas, Brazil, Chile, Colombia, Cuba, Venezuela
Under development/not yet approved	Belize, Bolivia, Colombia,* Costa Rica, Dominican Republic, Ecuador, Grenada, Guyana, Honduras, Jamaica, Panama, Suriname, Trinidad and Tobago

*Colombia is updating its national plan.

COUNTRY	YEAR	MILESTONE
Bahamas	2014	Value-added tax introduced (1).
Bolivia	2011	Alcohol law implemented.
Canada	2011	The National Alcohol Strategy Advisory Committee advanced the implementation of recommendations in the priority area of risky drinking by youth. The Canadian Post-Secondary Education Collaborative on Reducing Alcohol-related Harms has been developed by approximately 30 institutions to address binge drinking and related harms on post-secondary campuses across the country. A charter has been developed (pending final approval), as well as a framework and a data measurement framework based on the strategic areas in Canada's National Alcohol Strategy. In addition, the Canadian Centre on Substance Abuse (CCSA) produced materials to increase awareness of the risks of combining alcohol and caffeine, a common practice among youth. Collaborative documents are undergoing final revision and will be available in 2016 (2). To better understand the impact of alcohol-impaired driving, CCSA produced a report comparing drug- and alcohol-related motor vehicle driver fatalities, based on national data. This led to further work on drug-impaired driving and increased engagement with provincial ministries of transport, helping to keep impaired driving on the provincial agenda (3).
Chile	2011	Broad incorporation of the National Health Strategy (4).
		Brief alcohol interventions in primary health care program initiated (5).
	2012	Enactment of legal measures and changes regarding drinking and driving (Zero Tolerance Law and Emilia's Law) (6).
	2014	Enactment of tax reform, increasing alcohol taxes.

¹ The policies outlined here fall under the 10 areas of national activities outlined in Objective 3: a) leadership, awareness, and commitment; b) health services' response; c) community action; d) drinking and driving policies and countermeasures; e) availability of alcohol; f) marketing of alcoholic beverages; g) pricing and/or taxation policies; h) reducing the negative consequences of drinking and alcohol intoxication; i) reducing the public health impact of illicit alcohol and informally produced alcohol; j) monitoring and surveillance.

COUNTRY	YEAR	MILESTONE	
Colombia	2011	National Road Safety Education Act (Law 1503) (7).	
	2012	National Road Safety Plan 2011-2016 adopted (Resolution 1282) (8).	
		Establishment of rules to ensure comprehensive care for psychoactive substance users; creation of national award for an “entity committed to the prevention of psychoactive substance consumption, abuse and addiction” (Law 1566) (9).	
		Establishment of technical regulations on health requirements for the manufacture, processing, hydration, packaging, storage, distribution, transport, marketing, sale, export, and import of alcoholic beverages intended for human consumption (Decree 1686) (10).	
	2013	Guide to the development of strategic plans for promoting responsible alcohol consumption (11).	
		Clinical practice guidelines for health professionals for early detection, diagnosis, and treatment of acute intoxication in patients with alcohol abuse or dependence (12).	
		Clinical practice guidelines for patients and families for early detection, diagnosis, and treatment of acute intoxication in patients with alcohol abuse or dependence (13).	
		Definition, clarification, and update of the Mandatory Health Plan (Resolution 5521) (14).	
		Criminal and administrative sanctions for driving under the influence of alcohol or other psychoactive substances (Law 1696) (15).	
	Costa Rica	2012	New penalties for motorists under the Transit Law (Law 9078), with specifications for novice, general, and professional drivers, including a decrease in the allowable blood alcohol concentration (16).
Unification of laws regulating alcohol sales licensing, hours of operation, and advertising, with penalties for infringement (Law 9047) (17).			
Health sector policy for treatment of people with problems resulting from consumption of alcohol, tobacco, and other drugs (18).			
National Survey on Drug Use in the Secondary Education Population (19).			
2013		Modification of regulation and control of commercial advertising related to the sale of alcoholic beverages (20).	
		Workshop on use of information for developing alcohol policies and programs, in collaboration with PAHO/WHO.	
Cuba		2011	Implementation of Global Plan for the Decade of Action for Road Safety 2011-2020 (Ministry of Public Health Resolutions 28, 29, and 30 to complement Law 109).
		2012	National workshops on implementation of Alcohol Use Disorders Identification Test (AUDIT).
	2013	Master’s in drug prevention offered by University of Havana.	
		National Road Safety Plan.	
2014	Random breath testing for motorists.		

COUNTRY	YEAR	MILESTONE
Dominican Republic	2011	Publication of alcohol and gender survey results.
	2012	Guide and protocol on alcohol and drugs.
		Center opened for comprehensive care of substance dependence in Santo Domingo (21).
		Center opened for substance abuse patients in Barahona.
		Human resources for health training on AUDIT at Hospital Cabral y Baez in Santiago.
	2013	Center opened for substance abuse patients in San Juan hospital.
		Publication of guide for parents on reducing alcohol consumption.
2014	Strengthening of Alcohol Cluster.	
	Development of draft law regulating hours of sale of alcoholic beverages.	
El Salvador	2013-2014	Solidarity Fund for Health (FOSALUD) educational campaign on the health effects of harmful use of alcohol aimed at children and adolescents, health professionals, and risky drinkers (“El alcohol te está ganando la batalla”).
		FOSALUD increases service coverage for addiction prevention and cessation.
	2013-2014	Activity and accountability report (FOSALUD Annual Report) (22).
	2013	Certification of health care providers as therapeutic partners (23).
		Penal Code (Art. 147e) reformed to change the criminal classification from reckless driving to dangerous driving (under the influence of alcohol) and increase the penalty from 3 to 5 years in prison (24).
	New technical guidelines for psychoactive substance abuse prevention services (25).	
Grenada	2011	Alcohol taxes increased.
	2013	Regional Meeting organized by PAHO on policy formulation.
	2014	National Policy on Alcohol drafted.
Alcohol taxes increased.		
Jamaica	2013	Cabinet approval of a National Strategy and Action Plan for Prevention and Control of NCDs, including strategy for addressing harmful use of alcohol (26).
Mexico	2011	National Addiction Survey 2011: Alcohol Report (27).
	2011-2012	Program against alcohol and alcohol abuse: 2011-2012 update (28).
	2013	Amendment to Art. 220 of the general health law, which equates supplying alcohol to minors with the crime of corruption (29).
Nicaragua	2014	Incorporation of reforms to Law 431, regulating vehicular traffic rules and transit breaches (30).
		Strategy for human and citizen security (31).
Panama	2013	New excise tax on alcoholic beverages established.
	2014	Liquor tax law approved by the National Assembly and agreed by the beverage industry, with technical support from the Ministry of Economy and Finance. Law states that a 20% tax will be directed to the Social Security Fund’s Program on Disability, Old Age and Death.
Peru	2014	Mental health control and prevention (PP 131).

COUNTRY	YEAR	MILESTONE
Saint Lucia	2012	Survey on various health indicators, including prevalence of alcohol use among women (Multiple Indicator Cluster Survey) (32).
		Alcohol taxes increased (government tax review and implementation of VAT) (33).
	2014	Survey of secondary school population (Secondary School Standardised Survey).
Suriname	2011	Excise taxes increased on most imported and domestically produced alcohol products (SB 129) (34).
		NCD Action Plan 2012-2016 formalized. Objective 2.1 defined: “Promote and support reduction of risk factors related to tobacco and alcohol use” (Ministry of Health Suriname, National Action Plan for the Prevention and Control of Noncommunicable Diseases, 2012-2016).
	2014	<i>Ya no mi basi!</i> information campaign on dangers of alcohol launched by the Ministry of Health.
Uruguay	2011	Campaign (“La sed sácatela con agua”) implemented for risk and harm reduction aimed at youth and adult audiences (35).
		Program for responsible serving of alcohol implemented as intervention in risk and harm reduction for staff and managers of nightclubs and pubs in two interior states (35).
		Fifth national household survey on drug consumption (36).
	2012	WHO Global School-based Student Health Survey (37).
		Alcohol-related risk and harm management program (“Cuidándote vos, disfrutamos todos”) implemented in nationwide festivities, designed and managed in coordination with El Abrojo, Carnival Museum, National Road Safety Unit (UNASEV), Ministry of the Interior, ANTEL, and Banco de Seguros del Estado (38).
		Review, update, and printing of guide to prevention of alcohol and drug use in the workplace (38).
		Audiovisual program “Consumo cuidado” for use in workshops on risk management for problem drinking (38).
		Training and dissemination of methodology on brief interventions for public and private health care workers (38).
		Training of armed forces health workers and officials working with prisoners on new methodologies in managing drugs (“Intervenciones breves y prosociabilidad”) (38).
		Development of National Strategy to Reduce Problematic Alcohol Use, aimed at strengthening alcohol policy related to regulation, processing controls, distribution and sales, awareness and prevention, creation of a national system of services for problem alcohol users, and clear regulation of advertising; this included a period of consultation with civil society during its drafting (38).
		2013
		Campaign for preventing alcohol and other drug use when driving (“Si tomó no dejes que maneje”) in conjunction with the National Road Safety Unit (UNASEV), National Highway Police (DNPC), Congreso Nacional de Intendentes, and National Drug Board (JND); and the campaign

COUNTRY	YEAR	MILESTONE
		“Disfrutá de principio a fin, si tomó no dejes que maneje” during the noche de la nostalgia (39).
		Summer campaign “Estás aquí, cuidate y disfrutá” launched to raise awareness of the problematic use of alcohol during the tourist season (39).
		Virtual course for primary health care professionals on ASSIST-SBI (brief interventions for alcohol and other psychoactive substances), as part of institutional strengthening actions aimed at construction of a national system of services for clients with problems related to alcohol consumption, held in conjunction with the Ministry of Public Health, PAHO, and WHO (39).
		Campaign “Todo consumo de drogas tiene riesgos” launched in two parts, one dealing with alcohol and the other marijuana (39).
		Studies funded by the International Development Research Centre (IDRC): “Monitoring, Analysis, and Comparison of Corporate Social Responsibility Practices by the Alcohol Industry in Uruguay” and “Public Health Implications of Alcohol Industry Corporate Social Responsibility Programs (Latin America)” (39).
	2014	“First International Symposium on New Approaches to Alcohol Problems” held in Montevideo, organized by JND and University of the Republic Faculty of Medicine (40).
		Inauguration of Alcohol Disorders Unit of the Psychiatric Clinic of the Faculty of Medicine, Medical Clinic “C”, and ASSE National Addiction Treatment Network, under the auspices of JND (40).
		Blended learning course and regional workshops on “AUDIT and ASSIST Brief Interventions and Tools” organized jointly by the Public Health Ministry with the support of PAHO and WHO (40).
		Sixth National Survey on Drug Use in Middle School Students.

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E. PLAN OF ACTION ON PSYCHOACTIVE SUBSTANCE USE AND PUBLIC HEALTH: MIDTERM REVIEW

Background

1. Technical cooperation to address public health problems related to psychoactive substance use in the Region is based on the Strategy on Substance Use and Public Health (1, 2) and the corresponding Plan of Action (3, 4) approved by the Directing Council of the Pan American Health Organization (PAHO) in 2010 and 2011, respectively. Both initiatives are complemented by the Strategy and Plan of Action on Mental Health, also implemented by PAHO in 2009 (5, 6), and the Hemispheric Drug Strategy and the Hemispheric Plan of Action on Drugs, approved in 2010 and 2011, respectively, by the Inter-American Drug Abuse Control Commission (CICAD Spanish acronym) of the Organization of American States (OAS) (7, 8).
2. The role of public health in a comprehensive approach to the global drug problem was emphasized by the Member States in the Declaration of Antigua Guatemala (9), approved in the 43rd General Assembly of the OAS in June 2013. That same year, during the 52nd Directing Council of PAHO, the Member States received an initial report on the progress of the Plan of Action on psychoactive substance use (10). The report recognizes the progress made by the Member States, as well as the actions taken by PAHO, and recommends stepping up support for countries to strengthen the public health approach and promote respect for human rights in their drug-related policies and plans.

Update on Progress Achieved

3. The principal references for the preparation of the following table of progress were the 2015 Report on Public Health Resources to Address Psychoactive Substance Use in the Region of the Americas (11), based on the countries' response to the ATLAS survey,¹ and the Hemispheric Report on the Sixth Round (12) of the OAS-CICAD Multilateral Evaluation Mechanism (MEM).²

¹ In 2014, in collaboration with WHO, the information on resources and programs for the prevention and treatment of alcohol and other substance use disorders was updated, based on the ATLAS-SU 2014 methodology (*Atlas on Resources for the Prevention and Treatment of Substance Use Disorders*), developed by the WHO Department of Mental Health and Substance Abuse (http://www.who.int/substance_abuse/activities/atlas/en).

² The Hemispheric Report covers the period from 2013 to mid-2014 and presents an overview of the performance of Member States' drug control policies. The report was submitted and approved in the 56th regular session of OAS-CICAD in Guatemala in November 2014.

Progress Toward the Targets of the Plan of Action

Objective	Indicator and target	Progress
1.1	By 2021, 16 countries will have policies on psychoactive substance use integrated into their national health plan.	18 countries now identify the health sector (ministry of health) as being responsible for policies on psychoactive substance use (11). The integration of the issue into health policy remains precarious and incomplete. However, 27 countries have included public health-related content in their drug policies (13).
1.2	By 2021, 10 countries will have widely implemented evidence-based programs.	23 countries have comprehensive plans and programs to reduce demand. Information on the implementation and results of these programs is not available (12).
1.3	By 2015, 15 countries will have a documented budget dedicated to health and social services related to disorders caused by psychoactive substance use.	19 countries have specific budget allocations for prevention and 17 have allocations for treatment (11).
2.1	By 2021, 15 countries will be implementing evidence-based, universal, substance use prevention programs and 8 countries will have evaluated these programs.	24 countries offer psychoactive substance use prevention programs for through the mass media, schools, and workplaces; 11 countries have prevention programs that are differentiated according to risk factors; 3 countries have implemented program monitoring and evaluation; and 8 countries have evaluated their programs (12).
2.2	By 2021, 20 countries will have at least one national awareness activity on the subject per year.	With a view to promoting this type of activities in the countries, PAHO organizes an annual webinar to mark the International Day against Drug Abuse and Illicit Trafficking, and disseminates it in the countries. There are no reports on activities of this kind at the country level, which is an area that should be strengthened in the coming years.
3.1	By 2021, 10 countries will be implementing essential, evidence-based interventions based on PAHO/WHO tools and materials.	14 countries are conducting screening and rapid interventions in primary care, using ASSIST and mhGAP ³ materials developed by PAHO/WHO (11).
3.2	By 2021, 5 tools will have been developed to assist countries in the training and certification of professionals,	<i>Quality Rights QR-Tool Kit</i> , ASSIST, and mhGAP are WHO tools that have been translated into Spanish and Portuguese and are available for adaptation and implementation in the countries.

³ Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST); Improving and scaling up care for mental, neurological, and substance use disorders (mhGAP).

Objective	Indicator and target	Progress
	accreditation of services, and the development of norms and standards for care and the appropriate prescription of psychoactive drugs.	Work is underway to validate accreditation standards for prevention and treatment (11).
3.3	By 2021, 5 countries will be utilizing PAHO/WHO technical support and or tools to train unpaid health care providers.	PAHO has developed training on tools for ASSIST-DIT and drug policies through courses given as country support at the Virtual Campus for Public Health; 3,235 participants from 26 countries and territories have registered, with an approval rating of 70.48%. ⁴
3.4	By 2021, 5 countries will have updated curricula for health care professions.	Some incipient progress has been made to incorporate the contents of mhGAP into university programs, but this is an area that needs further development.
3.5	By 2021, 20 countries will have functioning regulatory systems for internationally controlled psychoactive drugs that ensure an adequate provision of such medications while minimizing their non-medical use.	Although these systems do exist in the countries, they function poorly, especially in the case of drugs used to treat opiate use disorders; 10 countries have an approved methadone registry and 7 have a naloxone registry; 6 countries have an available supply of methadone and 3 have a supply of naloxone (11).
4.1	By 2021, 25 countries will be using standardized tools to assess and monitor their responses to substance use problems.	21 countries have approved national standards for the treatment of substance use problems in their public health systems; 3 countries have carried out program monitoring and assessment (12).
4.2	By 2021, 5 countries will have a national health information system that includes indicators of substance use and its impact on health, disaggregated by sex and age.	20 countries report that they have national information systems on substance use, and 11 countries have information systems on service delivery; 29 countries have drug observatories; 14 have relevant data on the magnitude of substance use in the population (12).
4.3	By 2021, 10 new research studies will have been to assess either the nature, dimension, or impact of substance use disaggregated by sex and age group, or studies on the effectiveness of interventions.	Preparations are underway for research studies on different areas of interest: acute psychosis and cannabis use; reducing stigma in health services for substance users; incidence of substance use and other mental disorders.

⁴ Information obtained from the coordinators of the PAHO Virtual Campus for Public Health.

Objective	Indicator and target	Progress
4.4	At least one regional-level publication will be disseminated every two years, with evidence based information on substance use, related problems, and/or effectiveness of interventions.	It is necessary to promote this work with the Member States during the remaining lifespan of the Plan of Action.
5.1	By 2021, 8 joint activities will have been undertaken with other international organizations and partners.	PAHO maintains a regular program of joint activities with the OAS-CICAD, the Cooperation Program on Drug Policies between Latin America and the European Union (COPOLAD), the United Nations Office on Drugs and Crime (ONODC), the Spanish Government Delegation for the National Plan on Drugs, and civil society organizations (RIOD, ICJ, Intercambios), including international seminars and conferences, working groups of experts, training courses and workshops, and preparation of documents.

4. As part of its preparation for the special session of the United Nations General Assembly (UNGASS 2016) on the World Drug Problem, PAHO and the Government of Mexico organized an advisory meeting on drug policies and public health, held on 26-27 October 2015 in Mexico City, with the participation of technical experts from 17 countries and from international organizations (WHO, OAS, and the United Nations Office on Drugs and Crime [ONODC]). PAHO also participated in “Convergence for a comprehensive and sustainable regional drug policy,” a seminar coordinated by the Union of South American Nations (UNASUR) and the United Nations Development Program (UNDP), held in Quito (Ecuador) on 4-5 February 2016.

Challenges and Lessons Learned

5. Having a strategy and plan of action backed by the Pan American Sanitary Bureau (PASB) has helped enable the Member States to adopt a comprehensive, balanced, public health position in drug policy discussion forums and in preparation for UNGASS 2016.

6. It is important to continue to strengthen the ties between PAHO and other international organizations and partners as a way of strengthening intersectoral action for technical assistance to Member States on drugs and public health, especially the social determinants of health and the achievement of Sustainable Development Goals (SDGs).⁵

7. In the political and technical spheres, PAHO has been contributing to regional initiatives such as the Declaration of Antigua Guatemala and the OAS report on the drug

⁵ Specifically, SDG 3.5 refers to strengthening the prevention and treatment of addictive substance abuse.

problem in the Americas, but the health sector is still not prepared to take full part in efforts to reduce the health-related and social impact of this problem.

8. The guaranteed right to health for substance users, especially for the most vulnerable and high-risk groups, is a pending challenge reflected in stigma and exclusion in health services, and in a lack of access to controlled substances for medical and research purposes.

Action Needed to Improve the Situation

9. Continue PASB support for Member States to strengthen the public health approach in their drug policies, plans, and legislation, facilitating the use of technical tools appropriate to their particular conditions and needs.

10. Support joint efforts between PASB and the Member States in the development of health systems, organization of services, and development of human resources in order to bridge the treatment gap and improve the quality of care.

11. Promote resource allocation that is consistent with the identified needs and goals established in plans and programs on public health and substance use, with special attention to high-risk groups.

12. Strengthen information and surveillance systems, improve epidemiological data, increase survey coverage of marginalized populations and other vulnerable groups, and use the social determinants approach to analyze data and programs.

Action by the Directing Council

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

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F. 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. During this period PAHO has created or administered 13 centers¹ 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 Latin American and Caribbean Center on Health Sciences Information (BIREME) and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA).²

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

3. 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 health information, and the sharing of knowledge and evidence that contribute to the ongoing improvement of health systems, education, and research.

4. Within PAHO's organizational structure, BIREME is situated within the Office of Knowledge Management, Bioethics, and Research, and has a specific biennial work plan (BWP) 2016-2017, approved by the Director of the Pan American Sanitary Bureau (PASB).

Institutional Structure of BIREME

5. BIREME's institutional framework was established by the Agreement on Maintenance and Development of the Center ("Maintenance Agreement"), signed by PAHO/WHO and the Ministries of Health and Education of Brazil, the Ministry of Health of the State of São Paulo and the Federal University of São Paulo (UNIFESP) in 2004.³

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

² 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) given that no changes of strategic importance have taken place since the last report.

³ The first agreement was signed on 3 March 1967 and the last one on 2 December 2004.

6. In 2009, recognizing that the institutional framework of BIREME did not adequately meet BIREME's current and future governance, management and financing needs, the 49th Directing Council of PAHO adopted Resolution CD49.R5 approving a new Statute for BIREME and requesting the Director of PASB to undertake negotiations with the Government of Brazil to conclude a new Headquarters Agreement regarding the maintenance of BIREME as well as its privileges and immunities in that country.

7. The above-referenced Maintenance Agreement expired on 1 March 2015.

Current Status of the Institutional Frameworks

Facilities and operations agreement

8. The PASB continues to pursue its negotiations with the Government of Brazil with respect to the basic document referenced by the 49th Directing Council in its Resolution CD49.R5. At the same time, in order to provide BIREME with a legal foundation under which to continue operations in Brazilian territory, the PASB proposed a new agreement ("*Termo de Cooperação*") directly with the Ministry of Health of Brazil and specifically for BIREME. The *Termo de Cooperação* expressly recognizes BIREME's legal status as an integral part of PAHO, functioning under the Organization's basic agreements with the Government of Brazil. The *Termo de Cooperação* ensures necessary financial contributions from the Government of Brazil to maintain BIREME's operations. The *Termo de Cooperação* is currently under consideration by the Government of Brazil.

9. A contingency plan for BIREME is in place during this transition period to guarantee its continued optimal functioning.

10. After being located for almost 40 years on the UNIFESP campus, under the terms of the Maintenance Agreement, the University has notified PAHO that it will be renovating its facilities and that BIREME can no longer maintain its headquarters on the campus. As a result, and after a thorough search and analysis of available options for BIREME's Headquarters, BIREME has relocated its facilities to rental premises located in the city of Sao Paulo. Some renovations of the new premises were necessary. The move took place on 1 April 2016.

Staffing

11. At the end of 2015, 17 UNIFESP employees assigned to work at BIREME returned to the University.

12. During the first quarter of 2016, 19 local employees retired or took early retirement in accordance with Brazilian law. These individuals have not been replaced.

13. The selection process for the position of Director of BIREME has been finalized and the new Director assumed duties on 1 August 2016.

Short-term Challenges for BIREME

14. The upcoming challenges for BIREME include:
- a) finalizing and operationalizing the *Termo de Cooperação* with the Ministry of Health of Brazil;
 - b) structurally and functionally reorganizing BIREME to fit the needs of the BIREME biennial work plan 2016-2017;
 - c) scheduling the 2016 Scientific and Advisory Committee Meetings of the Center.

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

15. PANAFTOSA is a PAHO center located in the Brazilian state of Rio de Janeiro. It was created in 1951 pursuant to an agreement subscribed between the Government of Brazil and PAHO. Its initial purpose was to execute the Hemispheric Program for the Eradication of Foot-and-mouth Disease. In 1998, the zoonotic reference, research, and technical cooperation activities were transferred from the Pan American Institute for Food Protection and Zoonoses (INPPAZ) to PANAFTOSA. With the close of INPPAZ in 2005, the technical cooperation activities on food safety were transferred to PANAFTOSA.

Recent progress at PANAFTOSA

16. The 17th Inter-Ministerial Meeting on Health and Agriculture (RIMSA 17, for its Spanish acronym) was hosted by the Government of Paraguay in Asunción 21-22 July 2016, with the theme “One Health and the Sustainable Development Goals”. The theme emphasized the link between animal health and public health and its contribution to sustainable development, as well as the need for good governance and long-term commitment among all sectors and actors to promote and improve the health of the people of the Americas today and for future generations.

17. RIMSA is an important regional meeting of the Ministers of Agriculture and Health of all Member States of PAHO, where participants address issues, propose actions and coordinate a unified approach to addressing animal health/human health issues. Through RIMSA, PAHO receives political support for its technical cooperation on veterinary public health in the field of food safety, eradication of foot-and-mouth disease in the Americas and prevention and control of zoonotic diseases. In addition, RIMSA supports and articulates issues related to the animal health/human health interface, critical for the prevention and control of emerging and neglected infectious diseases, as well as for the containment and reduction of the impact of antimicrobial resistance. This multisectoral meeting aims to generate high-level support for PAHO’s implementation of plans and projects related to thematic health-related areas as approved by PAHO’s Governing Bodies.

18. RIMSA 17 was attended by delegates of Ministries of Health and Agriculture from 30 countries and numerous representatives of international and regional organizations, academia, nongovernmental organizations and the private sector. Their presence sent a

clear message on the importance of intersectorial action to address the challenges of health and its determinants, in line with the concept of One Health.

19. RIMSAs 17 highlighted the challenges faced by countries to achieve universal health coverage and ensure food safety as a priority for public health and food security, taking also into consideration the crucial role of the Region of the Americas in ensuring food security to the world population. Health and agriculture authorities agreed to establish and/or strengthen intersectoral governance mechanisms and platforms for coordinating regular actions on the management of zoonoses, and for developing and/or strengthening early warning and rapid response mechanisms to the threats of emerging and re-emerging zoonoses. In this regard, RIMSAs 17 requested PAHO to provide technical cooperation for the reinforcement of integrated systems for the surveillance, prevention, control and elimination of endemic and emerging and re-emerging zoonotic diseases, following the One Health approach.

20. With regard to food safety, RIMSAs 17 urged governments: *a)* to strengthen and develop food safety programs based on the “from farm to table” approach in health and agriculture, and *b)* to incorporate other sectors such as environment, tourism and industry, with the active participation of non-governmental organizations, the private sector and consumers.

21. Furthermore, RIMSAs 17 requested PAHO to update and present to the Directing Council a strategy and plan of action for food safety to support countries in the modernization of food control systems using new information communication technologies.

22. On antimicrobial resistance (AMR), RIMSAs 17 highlighted that it is a threat for public health and animal health, and that its containment requires the cooperation of both health and agriculture sectors, including the private sector. Furthermore, RIMSAs 17 urged governments to develop national action plans on AMR, aligned with the WHO Global Action Plan, based on multisectoral interventions, including public and private sectors as well as integrated surveillance mechanisms, and promoting the rational and appropriate use of antimicrobials in health and agriculture through the One Health approach.

23. Ministers of Health and Agriculture, agreed that technical cooperation and intersectoral action are key for this purpose, and requested PAHO to lead and provide priority support to those country initiatives that benefit from a One Health approach, related to the Goals and Targets of the 2030 Sustainable Development Agenda. Furthermore, RIMSAs 17 requested international cooperation agencies in public health, animal health, and the environment, to consolidate and strengthen the coordination of their technical cooperation to the countries in the One Health framework, and to formalize an initiative leading to a strategy and integrated action plan agreed by the countries of the Region.

Action by the Directing Council

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

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