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MID-TERM EVALUATION OF THE HEALTH AGENDA FOR THE AMERICAS

Preliminary Report

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I. Executive Summary

1. Presented below is the preliminary report on the mid-term evaluation of the Health Agenda for the Americas (referred to below as "the Agenda"). The report does not attempt to be conclusive, but rather is being presented for the knowledge and information of countries with the hope of receiving comments and suggestions regarding the report and the evaluation process. The Ministry of Health of Argentina, in its capacity as leader of the working group of countries formed to carry out the evaluation, will receive these contributions, which can also be submitted through the Pan American Health Organization (PAHO) country offices, during the month of October. The comments received will then be incorporated into the final report, to be published in December 2012.

2. On 3 June 2007, in Panama, the ministers and secretaries of health of the Region launched the Health Agenda for the Americas 2008-2017, which is intended to guide collective action aimed at improving the health of the peoples of the Americas. The Agenda establishes the principal areas of action and reiterates the commitments made by countries in international forums with a view to strengthening their responses and enhancing the effectiveness of their actions.

3. During the sixth session of the PAHO Subcommittee on Program, Budget, and Administration, held in March 2012, it was agreed that the mid-term evaluation of the Health Agenda for the Americas (2008–2017) would be carried out, and it was decided that the evaluation would focus on the following components:

(a) Determining the influence of the Agenda in guiding the preparation of national health plans and the strategic plans of all organizations cooperating for health with the countries of the Americas.

(b) Assessing progress in eight areas of action of the Agenda, measured by proxy indicators.

(c) Evaluating the Bureau's response in implementing the Agenda.

4. In order to evaluate components A and B, the Members of the Subcommittee formed a working group, led by Argentina and comprising Brazil, Chile, Costa Rica, El Salvador, Guyana, Panama, Saint Vincent and the Grenadines, the United States of America, and Venezuela (Bolivarian Republic of), with the Pan American Sanitary Bureau (the Bureau) serving as secretariat.

5. The Members of the Subcommittee also decided that component C of the evaluation would be conducted separately and simultaneously by the PAHO Office of Internal Oversight and Evaluation Services (IES).

6. Surveys, interviews, and document reviews were used in conducting components A and B of the mid-term evaluation of the Agenda. The process was led by countries and involved all 35 countries of the Region of the Americas, as well as 5 subregional integration bodies and 19 international organizations working in the health sphere in the Region.

7. This evaluation and its findings, which are highlighted in this report, present and document the progress made in implementing the Agenda and identify challenges and issues in the various areas of action on which further effort is needed on the part of countries and subregions, with support from international cooperation agencies, so that the expected outcomes can be achieved.

8. The first part of the evaluation (component A) analyzes the way in which the Agenda has been used in countries, subregions, and international organizations. Based on the findings, it can be concluded that during the evaluation period the Health Agenda for the Americas has indeed been used in countries to guide the preparation of numerous national health plans, policies, strategies, and other specific health plans. At the subregional level the Agenda has been used to a fair degree, whereas in international organizations its use has been limited.

9. The second part (component B) analyzes the findings, conclusions, and recommendations for each of the eight areas of action in the Agenda. From the analysis of the proxy indicators it can be concluded that significant progress has been made in all the areas of action, although there is cause for concern with regard to some indicators, such as those relating to the maternal mortality ratio, which has not declined as had been expected in recent years; dengue cases, which have increased; rates of tuberculosis, HIV infection/AIDS, and obesity; stagnation of public spending as a percentage of GDP; and the lack of reduction in out-of-pocket spending on health in the Region.

10. The third part (component C) analyzes the Bureau's contribution to the implementation of the Agenda and its areas of action through the PAHO Strategic Plan, biennial work plans, and technical cooperation strategies and looks at how the principles and values set out in Agenda have been applied in PAHO's technical cooperation. The report on this component was prepared by IES. Its main findings and recommendations are presented in Annex II of this report. The full report will be made available to Member States on request.

11. The main recommendations aim to strengthen dissemination and efforts to advocate greater use and ownership of the Agenda at all levels, including the subnational, national, and regional levels and within other sectors and international organizations. The Bureau has a key role to play in this task. Countries are encouraged to step up their efforts in the areas of action in which the least progress has been achieved and, in particular, on the issues that pose the greatest challenges, such as reducing maternal mortality and rates of

dengue, tuberculosis, obesity, and chronic diseases and their risk factors; strengthening social protection systems; and boosting national public spending and reducing out-of-pocket spending on health.

12. It is recommended that for the final evaluation of the Agenda the proxy indicators already identified be used and that 2011 be taken as the baseline. Indicators for which reliable information is not available should be reviewed, and information systems should be strengthened in order to improve health situation analysis and ensure the availability of complete information for decision-making.

13. In keeping with the commitments, statement of intent, and principles and values set out in the Agenda, the findings of this evaluation should be used by countries, subregional integration entities, and international organizations to guide the planning of interventions aimed at improving the health of people. To that end, a work plan should be drawn up with a view to strengthening health planning processes in the Region and addressing the recommendations of the mid-term evaluation of the Agenda. The evaluation findings should also be used in developing WHO's Twelfth General Program of Work 2014-2019 and PAHO's Strategic Plan 2014-2019. The dynamics of the working group and its experience in carrying out this evaluation should also be put to use in developing the next Strategic Plan of PAHO.

II. Introduction

14. On 3 June 2007, the ministers and health secretaries of the Region, meeting in Panama, launched the Health Agenda for the Americas ("the Agenda") 2008–2017, which is intended to guide collective action aimed at improving the health of the peoples of the Americas during that period.

15. The Agenda reflects a decision of all the Governments of the countries of the Americas, which committed themselves to a collective vision of a healthier and more equitable Region and to addressing health determinants and improving access to health services. The Agenda constitutes a commitment of solidarity among countries to meet the health needs of their people and work together from a regional perspective.

16. The Agenda recognizes the common principles and values of the countries of the Region, analyzes the health situation and trends in the Region, identifies the principal areas of action, and reiterates the commitments made by countries in international forums with a view to strengthening their responses in order to act effectively.

17. The eight areas of action set out in the Agenda are:

(a) Strengthening the national health authority

(b) Tackling health determinants

(c) Increasing social protection and access to quality health services

(d) Diminishing health inequalities among countries and inequities within them

(e) Reducing the risk and burden of disease

(f) Strengthening the management and development of health workers

(g) Harnessing knowledge, science, and technology

(h) Strengthen health security

18. The aim of the Agenda is to carry out activities in the above areas of action, guiding the preparation of future national and subregional health plans and the strategic plans of all international organizations engaged in health-related cooperation with countries of the Region of the Americas, including the Pan American Health Organization (PAHO). The Agenda calls for an evaluation examining the progress made in the eight areas of action.

19. As 2012 marks the halfway point in the period covered by the Agenda, during the sixth session of the Subcommittee on Program, Budget, and Administration (the

Subcommittee), held in March 2012, it was agreed that a mid-term the evaluation would be carried out. To that end, a working group was formed comprising 10 countries: Argentina, Brazil, Chile, Costa Rica, El Salvador, Guyana, Panama, Saint Vincent and the Grenadines, United States of America, and Venezuela (Bolivarian Republic of). It was decided that Argentina would be lead the working group and that the Pan American Sanitary Bureau (the Bureau) would serve as secretariat for the process.

20. The evaluation focused on the following components:

(a) Determining the influence of the Agenda in guiding the preparation of national health plans and the strategic plans of all organizations cooperating for health with the countries of the Americas.

(b) Assessing progress in the Agenda's areas of action by evaluating the achievement of goals set in national health plans and the strategic plans of all organizations interested in cooperating for health with the countries of the Americas.

(c) Evaluating the Bureau's response in implementing the Agenda.

21. Components A and B were evaluated by countries and component C was evaluated independently and simultaneously by the Office of Internal Oversight and Evaluation Services (IES) of PAHO.

22. This report presents the findings, conclusions, and recommendations of the evaluation of components A and B. A summary of the principal findings and recommendations emanating from the evaluation of component C is also included (see Annex B).

III. Procedure and Methodology

23. As agreed during the sixth session of the Subcommittee, a working group of countries was formed to carry out the evaluation, under the leadership of the Ministry of Health of Argentina and with support from the Bureau.

24. The working group of countries held its first face-to-face meeting from 25 to 27 April 2012 in Buenos Aires. During this meeting the working group examined and approved: *(a)* the work plan, *(b)* the methodology, and *(c)* the instruments for carrying out the evaluation.

25. From 22 May to 28 June 2012, surveys, interviews, and document reviews were conducted with countries, subregional integration bodies, and international organizations in accordance with the approved methodology. This process was supported by national health authorities and the PAHO/WHO Representative Offices, which served as liaisons for monitoring the process and carrying out the agreed interviews. This process was managed in a flexible manner in order to ensure the participation of all involved entities. On 20 June a progress report on the steps taken in the evaluation process was submitted to the PAHO Executive Committee, which approved adjustments to the original timetable.

26. During the month of July all of the information compiled was processed and a database was constructed, which enabled a rigorous analysis of the evaluation findings. This database was managed centrally and only the working group had access to the data for the analysis of findings.

27. The second face-to-face meeting of the working group was held from 25 to 27 July 2012 in Panama City to analyze the preliminary results of the evaluation and prepare the report to be submitted to the Pan American Sanitary Conference in September 2012.

28. From 24 to 29 August 2012 a consultation with the working group of countries was held in order to approve the report to be submitted to the 28th Pan American Sanitary Conference.

29. On 7 September 2012 the report for the Conference was made available to all countries on the website of the Governing Bodies of PAHO.

30. The methodology used for components A and B of the mid-term evaluation is described below.

Component A: Use of the Agenda in countries, subregions, and international organizations

31. The evaluation sought to determine how the Agenda has influenced the development and implementation of health plans (national plans and other strategic plans

for addressing specific health problems), policies, and strategies in the 35 countries of the Region of the Americas. The information was obtained through surveys sent to countries, interviews with relevant national stakeholders, and a review of key documents (plans, policies, and strategies).

32. At the subregional level the aim was to determine how the Agenda has influenced the development and implementation of health agendas, plans, policies, and strategies of subregional integration organizations. Information was obtained by means of a survey sent to the secretariats of such organizations, interviews with their staff, and a document review.

33. Lastly, the evaluation sought to ascertain how the Agenda has influenced the development and implementation of strategic plans, policies, and strategies of international organizations in the inter-American and United Nations systems and other bilateral and multilateral organizations working on health-related matters in the Region. The information was obtained through a survey sent to each organization, interviews with their staff, and a review of relevant documents of these organizations.

Component B: Progress in each area of action of the Agenda as measured through proxy indicators

34. The evaluation looked at the issues addressed under the areas of action of the Agenda. Since the Agenda does not include baselines or targets, a set of proxy indicators was proposed for measuring the progress made on the various issues (the indicators are included in Section IV: Analysis of Findings) and the results achieved in the implementation of the Agenda up to 2011.

35. The working group of countries reviewed and approved by consensus a set of proxy indicators for each area of action. Is important to note that the aim was to compare regional averages and numbers of countries that had made progress on public health issues before and after the launching of the Agenda. No attempt was made to compare countries or analyze the individual situation of any country.

36. The information used for the evaluation of the Agenda included data from the previous period—i.e., data from 2007 or earlier—which was compared with the information available as of 2011. Both quantitative and qualitative methods were used to collect the information needed to calculate and interpret the proxy indicators, as explained below:

- ***Quantitative*.** The information available from PAHO/WHO was examined with a view to identifying, on the one hand, indicators for which reliable information existed and, on the other, areas where the information available was unreliable or nonexistent. In the case of the former, the indicators were calculated using the available information; in the case of the latter, a survey was designed, to be

answered officially by focal points designated by the health authorities of the 35 countries of the Region. The indicators were analyzed using the information collected, and conclusions and recommendations were formulated on the basis of this analysis.

- ***Qualitative.*** In order to capture experiences and opinions on the implementation of the Agenda, interviews were conducted among a qualified sample of officials from countries, subregions, and international organizations. The aim of the interviews was to identify factors that have hindered or facilitated progress in the implementation of the Agenda, challenges encountered and how they have been addressed, areas of opportunity, and the usefulness of the Agenda in each country, subregion, and international agency. All of this information made it possible to interpret and contextualize the quantitative indicators.

37. The information was complemented by a review of key documents (plans, policies, and strategies) carried out at the country and subregional level and at the regional level for the international organizations.

Instruments

- ***Surveys:*** Surveys were prepared for countries, subregions, and international organizations. The survey was sent by Argentina, in its capacity as leader of the working group of countries, directly to the highest-ranking health authority in each country, subregion, or international organization. Each entity designated a focal point responsible for coordinating the response to the survey, including sources of information and means of verification, where applicable. The completed surveys were sent to the Ministry of Health of Argentina, with copies to the PAHO/WHO Representative Offices.

- ***Interviews:*** Interviews were conducted among key respondents in countries, subregions, and international organizations. PAHO teams were trained in countries and at Headquarters to conduct the interviews.

Countries

38. In countries, key respondents were selected by PAHO/WHO in consultation with national health authorities. The respondents needed to have extensive knowledge of the national health situation. The PAHO/WHO representatives and their teams conducted the interviews in the countries. The number of people interviewed varied depending on the size and characteristics of each country. In general, it was recommended that the following people be interviewed:

- national director of planning of the health authority or the equivalent;
- director of the social security system or the equivalent;
- director of a nongovernmental organization (NGO) working at the national level.

Subregions

39. In the subregions, the executive secretary of the subregional integration mechanism or the official serving as president pro tempore was interviewed. These interviews were conducted in coordination with the PAHO/WHO country office.

International organizations

40. For international organization interviews, the person to be interviewed was identified by staff from the regional level of PAHO/WHO, in coordination with the director of the organization concerned. It was recommended that the respondent be someone who worked directly with and had a comprehensive view of the Region of the Americas.

Document review

41. A checklist was prepared to facilitate this process. The document review in countries was carried out by teams at the PAHO/WHO country offices in coordination with national health authorities. In the case of the subregional integration mechanisms, the document review was carried out by the PAHO/WHO office in the country where the mechanism had its headquarters or in the country holding the pro tempore presidency. A regional PAHO/WHO team carried out the document review in the case of international organizations.

IV. Analysis of Findings

Responses obtained

42. Table 1 shows the responses to the various evaluation instruments obtained from countries, subregions, and international organizations. Altogether, 50 surveys were received and 64 interviews and 35 document reviews were conducted.

43. It is noteworthy that 100% (35) of the countries of the Region answered the evaluation **survey**. The survey was also answered by the principal subregional integration organizations: CARICOM, MERCOSUR, ORAS/ CONHU, SICA/COMISCA, and UNASUR. As to international organizations, the survey was answered by four United Nations agencies (UNDP, UNESCO, UNICEF, and ILO), one organization in the Inter-American system (Inter-American Development Bank); two bilateral agencies (AECID and CIDA); and three other organizations (Church of Latter-Day Saints, APHA, and PAHEF).

44. A total of 64 **interviews** were conducted. Two subregional integration participated in interviews: CARICOM and ORAS/CONHU, as did three United Nations system organizations (World Bank, UNDP and UNFPA), five bilateral agencies (AECID, CDC, FDA, USAID, HHS), and three other organizations (Bill and Melinda Gates Foundation, American Red Cross, and the Seventh Day Adventist Church).

45. In total, 19 international organizations participated in surveys and/or interviews.

46. Of the 35 **document reviews**, the vast majority were of national health plans, strategies and policies.

Table 1. Responses to the various evaluation instruments

Instruments/levels	***Surveys***	***Interviews***	***Document review***
Countries	35	51	31
Subregions	5	2	2
Agencies	10	11	2

Analysis

47. The analysis of the findings of components A and B of the evaluation is presented below.

Component A: Use of the Agenda in countries, subregions, and international organizations

Countries

Findings

(a) During the period 2008–2011, 30 of the 35 countries (86%) developed a national health plan. Of those 30 countries, 20 (67%) said they had used the Agenda in formulating their plans.

(b) Of the 20 countries that used the Health Agenda for the Americas in the formulation of their national health plans, more than 90% incorporated action areas (a), (b), (c), (e), (f), and (g). Areas (d) and (h) were incorporated to a lesser extent—85% and 75%, respectively—as shown in Table 2.

Table 2. Areas of action incorporated by the 20 countries that prepared a national health plan using the Health Agenda for the Americas during the period 2008–2011

Area of action	*Number of countries*
(a) Strengthening the national health authority	20
(b) Tacking health determinants	18
(c) Increasing social protection and access to quality health services	19
(d) Diminishing health inequalities among countries and inequities within them	17
(e) Reducing the risk and burden of disease	19
(f) Strengthening the management and development of health workers	20
(g) Harnessing knowledge, science, and technology	18
(h) Strengthening health security	15

(c) In addition to national health plans, 18 countries (51%) made use of the Agenda in designing other specific health programs.

(d) Eighteen countries used the Agenda to formulate health policies and 18 countries also used it to develop health strategies.

Conclusions

(a) The fact that the majority (67%) of the countries that formulated a national health plan used the Agenda in that process and that, furthermore, they incorporated almost all the areas of action is a clear indication of the importance attached to the Agenda by the countries of the Region.

(b) More than half of the countries in the Region also used the Agenda for the formulation of other specific health plans, policies, and strategies.

(c) All the areas of action were incorporated in the national health plans that drew on the Agenda, although two were incorporated to a lesser extent: (d) diminishing health inequalities and (h) strengthening health security.

(d) In both surveys and interviews, countries mentioned the following factors that hindered greater use of the Agenda:

- Differences in the periods covered by the various planning frameworks; many countries indicated that they had not been able to use the Agenda because they already had plans, policies, or strategies in place when the Agenda was drawn up.

- Countries with federal systems of government had more difficulty in incorporating the Agenda into their plans because it had to be embraced and validated by subnational levels, which had not participated in developing the Agenda and were not always familiar with it.

- Lack of knowledge and limited dissemination of the Agenda, coupled with staff turnover within the national health authorities and lack of ongoing promotion of the Agenda's use, have resulted in lack of a widespread sense of ownership of the Agenda at different levels within countries.

Recommendations

(a) Countries should continue to disseminate the Agenda not only within the ministry or secretariat of health, but in other sectors and also across the country at subnational levels. All health stakeholders in the country should be encouraged to take ownership of the Agenda.

(b) The Agenda should play a bigger part in national planning cycles. Countries with a federal structure should examine how the Agenda might be better used as a frame of reference at the national and subnational levels.

(c) An effort should be made to increase the incorporation of the Agenda areas of action that have been reflected to a lesser extent in national health plans.

(d) In the task of strengthening dissemination of the Agenda in countries, PAHO/WHO should play a more active role as secretariat through its country offices. It also should take advantage of various national and international forums, including meetings of the Governing Bodies of the Organization, to increase dissemination. The Agenda should also be incorporated to a greater extent when priorities are established under country cooperation strategies (CCS).

Subregions

Findings

(a) During the period 2008–2011, two of the five subregions surveyed prepared a subregional agenda using the Agenda.

(b) During the same period, four of the five subregions designed a subregional health plan. Of these four subregions, three used the Agenda:
- The three subregions that designed their health plans drawing, directly or indirectly, on the Agenda incorporated the following areas of action: *(a)* strengthening the national health authority, *(b)* tackling health determinants, *(c)* increasing social protection and access to quality health services, *(e)* reducing the risk and burden of disease and *(f)* strengthening the management and development of health workers. The analysis of the findings in this area revealed that more work ahs been undertaken at the national level than at the subregional level.
- Two subregions incorporated area of action *(d)* diminishing health inequalities among the countries and inequities within them.
- One subregion incorporated areas of action *(g)* harnessing knowledge, science, and technology and *(h)* strengthening health security.

(c) When subregional organizations were asked why they had not incorporated some of the Agenda's areas of action, the following reasons were cited:
- The subregion's priorities and the mandates differed from those of the Agenda.
- Lack of knowledge of the Agenda.
- Impossibility of responding to all the areas of action of the Agenda.

(d) The five subregions all reported having formulated health policies during the period, but only one used the Agenda.

(e) Four subregions reported having developed health strategies, but only one used the Agenda.

48. Analysis of the interviews conducted with subregional organization staff members revealed the following:

(a) Dissemination, knowledge, and use of the Agenda was rated as good to fair. Dissemination has been better when PAHO has taken a more active role in the process.

(b) With regard to implementation of the Agenda, respondents described it as fair. This rating is explained by limitations in mobilizing the resources needed to implement the components of the Agenda, given the changing world financial climate.

(c) Positive effects of the Agenda mentioned by respondents included: strengthening of subregional capacity to address public health needs and coordination of support at regional level, which has served as a basis for the subregion's strategic plan and annual operational plans.

Conclusions

(a) The subregional integration organizations that prepared agendas and subregional plans during the period 2008–2011 used the Agenda as a frame of reference. They also incorporated all the Agenda's areas of action into their subregional programs, plans, policies, and strategies for the period 2008–2011.

(b) Use of the Agenda in the subregions has facilitated prioritization of interventions and coordination between the subregional and regional levels.

(c) Although the Agenda has been disseminated and used in the subregions, opportunities exist to improve knowledge and implementation of it and, thus, to optimize its use.

Recommendations

(a) Dissemination of the Agenda among subregional integration organizations should be strengthened and their ownership of the Agenda encouraged.

(b) The convergence of subregional programs, plans, policies, and subregional strategies with the areas of action of the Agenda should be improved.

(c) The countries serving as executive secretariat or president pro tempore of the subregional integration mechanisms should disseminate the Agenda at their meetings, especially summits, promoting ownership thereof by the subregional integration bloc.

(d) PAHO should strengthen dissemination of the Agenda among subregional integration mechanisms, encouraging greater ownership on their part and better coordination and linkage among the regional, subregional, and national levels.

International organizations

Findings

(a) Of the international organizations that responded to the survey, 10 reported having a strategic plan that guides their work, but only three reported having used the Agenda to design those plans.

(b) The three organizations that used the Agenda did so mainly as a frame of reference to develop substantive aspects of their strategic plans. It was also used as a basis for the specific action program of the organization and influenced its work.

(c) The Agenda was used by three organizations to design other health-related plans (control and prevention of malaria, guides for studying the cost of dengue and maternal, neonatal, and child health); by two organizations to design health-related policies (as a frame of reference for establishing the policies of the organizations or the support that it provides to countries for the design of their health policies); and by five organizations to design health-related strategies (as a frame of reference for determining the strategies of the organization or the support that it provides to countries for the design of their health strategies, for educational campaigns on specific health issues, and for promotion of active and healthy environments, with subsidies to support research and training in priority areas, to design maternal, neonatal, and child health strategies, and to train birth attendants).

(d) With regard to lack of use of the Agenda, the organizations surveyed reported that they had focused their work on specific areas or issues or that the mandates received from their governing bodies were not directly related to the issues addressed under the Agenda. The following reasons were cited for not making greater use of the Agenda, although it is worth noting that the organizations' strategic plans incorporate some of the areas of action of the Agenda:

- lack of knowledge about the Agenda,
- Agenda not considered relevant to their work,

- the organization does not involve third parties in the design of its plans or, given its experience, does not need the Agenda in order to design its plans,
- organization's responsibility to comply directly with the expectations of its member governments,
- disease burden is greater in Africa and Asia; Latin America has greater availability of resources; restrictions of the organization itself.

(e) With respect to incorporation of the Agenda's areas of action, of the organizations surveyed, three reported incorporating all the areas of action and the rest only incorporated them partially.

(f) The areas of action of the Agenda incorporated most frequently by international organizations have been: (b) tackling health determinants, (d) diminishing health inequalities among the countries and inequities within them, and (g) harnessing knowledge, science, and technology. Those incorporated least frequently have been: (a) strengthening the national health authority, (e) reducing the risk and burden of disease, and (h) strengthening health security.

(g) During the period 2008–2011, six of the nine organizations that answered the survey aligned their assistance with the areas of action of the Agenda: two with area (c) increasing social protection and access to quality health services (access to drugs and social protection), two with area (e) reducing the risk and burden of disease (education on health-related matters), and two with area (h) strengthening health security (humanitarian assistance in emergency situations and practices affecting HIV-infected or vulnerable people).

(h) Six of the nine organizations that answered the survey reported that during the period 2008–2011 they had collaborated with national authorities to respond to situations that threatened health security.

(i) Areas in which the organizations provided support included: HIV infection/AIDS, sexual and reproductive health, control of infections (in particular, pandemic (H1N1) 2009), natural disasters and pandemics, vaccination, and access to drugs.

(j) The interviews conducted with staff of international organizations yielded important findings, as shown in Table 3. The majority of the staff interviewed indicated that they had fair knowledge of the Agenda. They identified the following positive impacts of the Agenda, in order of importance: (a) it served as a frame of reference for the organization's planning and priority-setting, (b) it helped countries to better focus their work and implement, and (c) it facilitated collaboration in the organization's priority areas. Three organizations considered the Agenda's positive impacts to be limited and confined to a few areas of action, and three did not believe that the Agenda had had any positive effects.

Table 3. Responses on variables relating to dissemination, knowledge, and use of the Agenda in the international organizations

Variable	***Ratings by respondents (percentages)***		
	Good	Fair	Poor
Dissemination of the Agenda	9%	27%	64%
Knowledge of the Agenda	0%	55%	45%
Implementation of the Agenda	10%	30%	60%
Utilization of the Agenda	11%	22%	63%

Conclusions

(a) Analysis of the data revealed that the work of the international organizations is aligned with the areas of action of the Agenda. Particularly worthy of note is the increase in work aimed at expanding social protection in health and joint initiatives with PAHO/WHO linked to the Strategic Plan for the Region, health issues related to flexibilities in the TRIPS Agreement for facilitating access to drugs, and subjects linked to HIV infection/AIDS.

(b) The findings show that there has not been sufficient dissemination of the Agenda among the international organizations working on health-related matters in the Region. This could explain its limited utilization by these organizations.

Recommendations

(a) Emphasize better dissemination of the Agenda among the international organizations, encouraging greater ownership of the instrument by these organizations, especially those of the United Nations and inter-American systems.

(b) It is urgent that the strategic plans of the international organizations be aligned with the Agenda in order to improve the effectiveness of their interventions aimed at improving the health of the Region's population.

(c) Use of the Agenda should be emphasized when the strategic plans of the international organizations are prepared.

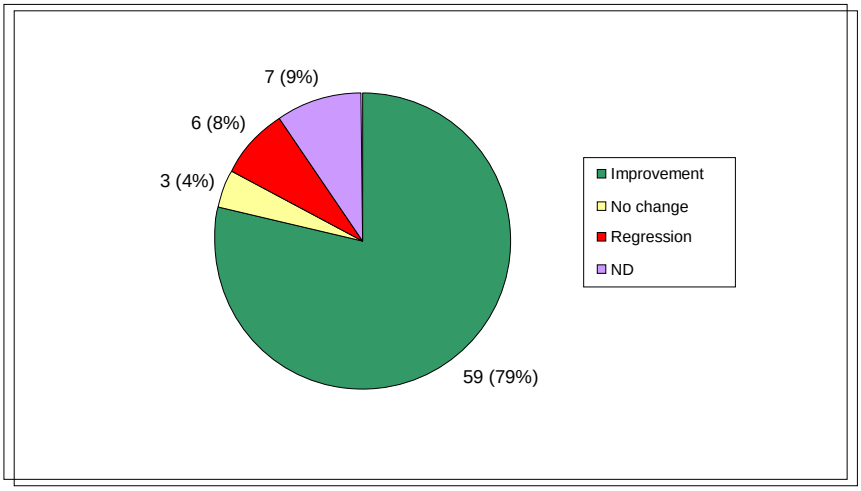
(d) PAHO/WHO should strengthen its role in the dissemination of the Agenda among international organizations, thus enhancing its cooperation with the countries of the

Region. This should be done both at regional and subregional levels and in the countries themselves through the PAHO/WHO country offices.

Component B: Progress in the eight areas of action of the Agenda as measured through proxy indicators

49. Figure 1 shows the summary of the evaluation resulting from the analysis of the 75 proxy indicators that were used to measure progress in the eight areas of action of the Agenda. Generally speaking, there has been progress; 79% of the indicators (59 of the 75) show an improvement in the situation over the period 2007–2011. However, there are still challenges in some areas, as is evident from the number of indicators on which there has been no change or on which ground has been lost: nine (12%) of all the indicators evaluated. For seven of the indicators (9%) no data were available (ND), and it could therefore not be determined what change had occurred during the evaluation period.

Figure 1. Status of the proxy indicators for the eight areas of action of the Agenda, 2007–2011



50. The analysis for each area of action is presented below. [1]

[1] Unless otherwise indicated, the data for the proxy indicators in the columns is for 2007 and 2011, respectively. Where no data were available (ND), the figure for the nearest year was used.

(a) Strengthening the national health authority

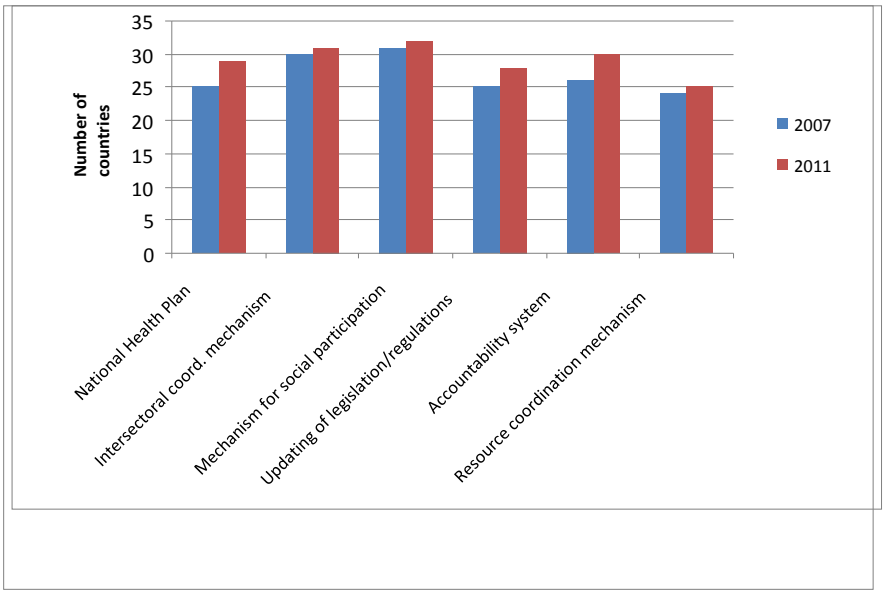
Findings

51. As the evaluation of each proxy indicator below and in Figure 3 shows, improvements have occurred in all seven indicators in this area of action.

Proxy indicators	2007	2011	Source and comments
1. Number of countries that have implemented a national health plan with specific goals and strategies	25	30	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Of the 30 countries, 20 used the Agenda and its various areas of action.
2. Number of countries that have implemented coordination mechanisms for intersectoral work led by the national health authority	30	31	Source: Survey of countries, Evaluation of the Agenda 2012.
3. Number of countries that have implemented mechanisms to promote social participation	31	33	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
4. Number of countries that have updated legislation and regulatory frameworks in the health sector	25	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Increase in the number of countries in which the regulatory framework was updated. Of the regulatory components, the areas in which the most strengthening has occurred are those relating to guidance (23 countries), regulation (28), and performance of the essential public health functions (21).
5. Proportion of mandates in declarations of the Summits of the Americas that reflect health matters	2009: 12/96	2012: 6/44	Source: Declarations of the Fifth and Sixth Summits of the Americas, 2009 and 2012, respectively. Health matters figured relatively prominently at both summits. The Fifth Summit in 2009 established a mandate in relation to chronic noncommunicable diseases, which extended the mandate established by the Heads of Government of the English-speaking Caribbean to the entire Region of the Americas, which in turn served as a policy platform for the High-level Meeting of the United Nations General Assembly on Non-Communicable Diseases in 2011. At the Sixth Summit in 2012 the issue of the use of the

Proxy indicators	2007	2011	Source and comments
			information and communication technologies was placed on the health policy agenda, as was the issue of social determinants of health.
6. Number of countries that have incorporated an accountability system into their health sector management system	25	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
7. Number of countries that have incorporated a mechanism led by the national health authority to plan, manage, and coordinate the use of all international health cooperation resources	24	26	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. In 2011, 20 of the 26 countries had incorporated the management of domestic and international resources, and 5 had partially done so.

Figure 2. Progress in strengthening the national health authority in countries of the Americas, 2007–2011



Conclusions

(a) An improvement has been seen in strengthening the health authority in the majority of the Region's countries, which is confirmed by the increase in the implementation of national health plans, the implementation of coordination mechanisms led by the national health authority, the promotion of social participation, the updating of health sector legislation and regulatory frameworks, and the establishment of national accountability systems.

(b) It should be noted that 26 countries of the Region have already implemented mechanisms led by the health authority in order to align international cooperation resources with national priorities.

(c) The proportion of mandates in declarations of the Summits of the Americas that reflect health issues (which rose from 13% in 2009 to 14% in 2012) shows the great importance that has been attached to health and to priority issues in the policy agenda at the highest level in the Region.

Recommendations

- Continue to strengthen efforts to ensure that all countries have a national health plan and, if they consider it necessary, that they request technical support from PAHO/WHO for the formulation of those plans.
- Countries should evaluate the way in which they are planning and managing international cooperation with a view to ensuring that cooperation plans and national plans are integrated and avoiding overlap and fragmentation of technical efforts and financial resources.

(b Tackling health determinants

Findings

52. As the table below shows, improvements have occurred in 9 of the 13 proxy indicators for this area of action; two have shown no change; the situation of one (maternal mortality ratio) has worsened; and for one it was not possible to determine whether any change had occurred since the introduction of the Agenda, owing to lack of data.

Proxy indicators	2007	2011	Source and comments
1. Number of countries that have implemented interventions to address the recommendations of the Commission on Social Determinants of Health	Period 2008–2011: 29 countries		Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Variables relating to social determinants of health and number of countries that have implemented interventions: Social exclusion: 23 Exposure to risks: 27 Unplanned urban growth: 14 Climate change: 22 Human rights approach: 24 Others: 8
2. Number of countries that have implemented a national health promotion plan, with allocation of national resources	17	21	Source: Survey of countries, Evaluation of the Health Agenda for the Americas 2012.
3. Number of countries that have incorporated a gender perspective in their health services	22	32	Source: Survey of countries, Evaluation of the Health Agenda for the Americas 2012.
4. Number of countries that have implemented a multisectoral national plan for violence prevention	17	25	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. With respect to this increase, it should be noted that countries have also introduced specific measures to address interpersonal violence (increase from 17 to 24 countries in the period 2007–2011) and to address gender-based violence (increase from 11 countries to 22 in the same period).
5. Number of countries that have implemented a national plan to improve the health mothers, newborns, and children	30	32	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
6. Maternal mortality ratio per 100,000 live births	2007: 62.4 per 100,000 live births.	2010: 65.7 per 100,000 live births.	Source: Health in the Americas, 2012. Improvement in records has led to an apparent increase during the period. It should be noted that in 2000, the maternal mortality ratio had was 76.4 per 100,000 live births; in other words, there was a reduction of 14.0% from 2000 to 2010.

Proxy indicators	2007	2011	Source and comments
7. Infant mortality rate	2006: 17.7 per 100,000 live births.	2010: 14.8 per 100,000 live births.	Source: PAHO, Basic Indicators 2007 and 2010.
8. Neonatal mortality	2005: 11 per 1,000 live births.	2010: 9 per 1,000 live births.	Source: UNICEF, World Bank, UNDP, ECLAC, and WHO, 2011. Infant mortality estimates: data and trends. Available at www.childmortality.org.
9. Under-5 child mortality per 1,000 live births	2006: 22.4 per 100,000 live births.	2010: 18.0 per 100,000 live births.	Source: PAHO, Basic Indicators 2007 and 2010.
10. Prevalence of overweight and obesity among children under 5	2005: 6.9%	2010: 6.9%	Source: WHO, 2012. WHO Global Infobase 2012, available at: https://apps.who.int/infobase/Comparisons.aspx
11. Prevalence of low height for age among children under 5	N/D	2010: 3.3% (2 million)	Source: PAHO Family and Community Health Program, 2012.
12. Vaccination coverage at national level (using DPT3 as a marker)	2007: 93%	2010: 93%	Source: PAHO, Basic Indicators 2007 and 2010. The Region has sustained the progress made towards the target of 95% vaccination coverage at national level.
13. Number of countries that have incorporated new vaccines into their national immunization schedules	Period 2008–2011: 22 countries.		Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. New vaccines and number of countries that have incorporated them: HPV: 7 Pneumococcal: 18 Rotavirus: 11 Others: 17 (mainly influenza)

Conclusions

(a) During the period 2008–2011 a significant number of countries (29) in the Region took steps to address the recommendations of the Commission on Social Determinants of Health.

(b) Significant progress has been made with regard to health promotion, gender mainstreaming, social inclusion, addressing risks, climate change, human rights approaches, and violence prevention.

(c) The use of the Agenda at all levels of the health sector and in other relevant social sectors in countries, as well as in subregions and international organizations, will facilitate a health determinants approach in the Region of the Americas.

(d) Significant progress has been made in reducing infant and under-5 child mortality.

(e) The maternal mortality ratio showed a slight increase during the period 2007–2010 (from 62.4 to 65.7 per 100,000 live births). This can be attributed to improvements in vital statistics records in countries. Nevertheless, this slight increase is troubling since the trend of this indicator had been downward since 2000, when the ratio was 79.4 per 100.00 live births. The risk of dying during delivery or the puerperium remains unacceptably high: 12 to 18 times higher than in developed countries.

Recommendations

(a) Countries should continue to promote intersectoral approaches in order to achieve effective interventions that will address social determinants of health.

(b) Intersectoral coordination mechanisms for addressing social determinants of health should be institutionalized.

(c) Progress with respect to global agreements (such as the Framework Convention on Tobacco Control) that affect social determinants of health could be furthered by promoting measures such as healthy diet (reduction of salt, fat, and sugar intake), physical activity, and moderate consumption of alcohol, among others.

(d) The health sector should advocate the incorporation of health in all policies.

(e) Evidence is needed: research, studies, and knowledge of social determinant of health, analyzing the impact of lifestyles and risk factors, the economic burden, inequities and gaps, etc., in order to contribute to policy-making relating to social determinants.

(c) Increasing social protection and access to quality health services

Findings

53. Improvements were seen in all nine proxy indicators in this area of action.

Proxy indicators	2007	2011	Source and comments
1. Number of countries that have implemented public policies to improve social protection	25	31	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Generally speaking, there has been an increase in the number of countries implementing public policies to improve social protection; of the 31 countries that implemented such policies, 100% cover access to health services, 23 countries cover security and solidarity in financing, and 29 include patients' rights.
2. National public expenditure on health as a percentage of gross domestic product	2006: LAC 3.1%	2011: LAC 3.7%	Source: PAHO, Basic Indicators 2011 and 2012, and second progress report on the PAHO Strategic Plan 2008–2012. The data available for 2006 and 2011 are for Latin America and the Caribbean (LAC). In 2008–2009 public spending on health in LAC was 4%. The reduction in 2010–2011 is due to the fact that spending increases were not maintained. It is also important to point out that spending by countries of the Region ranged from 1% to 14%. The figure for the Region as a whole, available for 2011, is 13.1%.
3. Number of countries that had public health insurance coverage	20	21	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
4. Out-of-pocket spending on health, expressed as a percentage of total health spending	2006: LAC 52%	2010: LAC 47%	Source: PAHO, 2012. Basic Indicators and second progress report on the implementation of the PAHO Strategic Plan 2008–2012. Progress has been made in reducing of out-of-pocket spending. In 2008–2009 the level was reduced to 42%, commensurate with the increase in public spending on health. It is worth noting that the target established in the Strategic Plan for 2013 is to reach a level of 40%; in countries of the Organization for Economic Cooperation and Development (OECD) with universal coverage health systems, out-of-pocket spending averages 20% of total health spending.

Proxy indicators	2007	2011	Source and comments
5. Number of countries that have implemented a policy that includes improved access to drugs	26	31	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. A large number of countries already had a drug policy, and number that have implemented a policy has increased.
6. Number of countries that have used PAHO's Regional Revolving Fund for Strategic Public Health Supplies	10	15	Source: PAHO, 2012. Second progress report on the implementation of the PAHO Strategic Plan 2008–2012. The number of countries using the Strategic Fund has increased. The volumes purchased through this fund have also increased significantly, rising from $18.3 million in 2007 to $49 million in 2011, reflecting increased use of this mechanism by countries in the last 5 years.
7. Number of countries that have incorporated the renewed primary health care strategy into their health care model	17	24	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Is an important increase in the use of renewed primary health care in the model of care in countries.
8. Number of countries that have incorporated specific measures to address the needs of indigenous populations into their health systems	17	21	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. The number of countries incorporating specific measures aimed at indigenous populations has increased; however, 10 countries indicated that the question was not applicable to them, possibly because they do not have indigenous populations.
9. Number of countries that have implemented programs aimed at improving quality of care	28	31	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. A significant number of countries already had a program for improving quality of care, and the number of countries implementing such programs has increased.

Conclusions

(a) The majority of countries (31 of 35) are implementing public policies to improve social protection. However, the number of countries with public health insurance coverage has remained constant (21 of 35 in 2011).

(b) National public spending on health as a percentage of GDP has increased only slightly in Latin America and the Caribbean, rising from 3.1% to 3.8% between 2006 and 2011. It should be noted that in 2008–2009 public spending on health reached 4%. The reduction in 2010–2011 was due to the fact that spending increases were not maintained.

(c) Progress has been made in reducing out-of-pocket spending, which fell from 52% in 2007 to 47% in 2011. However, this represents a setback in comparison with the level achieved in 2008–2009, when out-of-pocket expenditure was 42%. It is worth noting that the target established in the Strategic Plan for 2013 is to reach a level of 40%; in countries of the Organization for Economic Cooperation and Development (OECD) with universal coverage health systems, out-of-pocket spending averages 20% of total health spending.

(d) The number of countries that have incorporated primary health care into their health care model has risen from 17 in 2007 to 24 in 2011.

(e) Access to medicines is of key importance, as is evident from the fact that 30 countries have policies aimed at improving such access and by the sizeable increase in the number of countries making use of the PAHO Strategic Fund. The volumes purchased through the Fund by countries of the Region increased from $18.3 million in 2007 to $49 million in 2011. However, it needs to be ensured that supplies are delivered to countries in a more timely manner in order to avoid possible shortages.

Recommendations

(a) Carry out a more in-depth evaluation of countries' social protection systems.

(b) The sector should spearhead efforts aimed at raising public investment in health and reducing out-of-pocket spending.

(c) Focus efforts on increasing social protection in countries, striving to achieve universal coverage, regardless of whether the system is contributory or not.

(d) Continue to promote the PAHO Strategic Fund and other mechanisms aimed at overcoming barriers impeding access to supplies and hindering timely delivery.

(e) The processes and procedures for use of the Strategic Fund should be reviewed with a view to simplifying them and removing bureaucratic barriers that might be limiting use of the Fund.

(d) Diminishing health inequalities among countries and inequities within them

Findings

54. Improvements were noted in 8 of the 11 proxy indicators for this area; for the other three, it could not be determined whether any change had occurred since the introduction of the Agenda owing to lack of data.

Proxy indicators	2007	2011	Source and comments
1. Percentage of deliveries attended by trained health workers	91.3%	95.2%	Source: PAHO, Basic Indicators 2007 and 2011.
2. Number of countries with a national health information system that makes it possible to analyze inequities	24	27	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Of the 27 national plans, 26 include the variables of sex and age and 14 include ethnicity and other variables.
3. Proportion (%) of newborns with low birthweight (<2500g)	8.1%	8.2%	Source: PAHO, Basic Indicators 2007 and 2011. This indicator has remained constant with respect to periods prior to 2007. It should be noted that countries have improved their records, based on analysis of birth certificates.
4. Number of countries with a national development plan	25	27	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Of the 27 development plans, 25 include health and 22 include education and nutrition.
5. Number of new cases of mother-to-child HIV transmission	N/D	3,200	Source: UNAIDS, 2011, figures for 2011; PAHO, 2011, Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and

Proxy indicators	2007	2011	Source and comments
			Congenital Syphilis The estimated transmission rate for 2010 was 15%. The principal barrier to reducing maternal transmission is the low rate of HIV screening among pregnant women. Although screening has increased from 29% to 57% (between 2005 and 2009), this level remains low.
6. Incidence of the mother-to-child transmission of congenital syphilis	N/D	9,828 cases reported by 26 countries and territories	Source: UNAIDS, 2011, figures for 2011; PAHO, 2011, Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis
7. Prevalence of HIV infection (by sex and age group)	N/D	Prevalence in the group aged 15 to 49 years: Caribbean: 1.0 Latin America: 0.4 Canada and United States: 0.6	Source: UNAIDS, 2012.
8. Prevalence of contraceptive use	2006: 11 countries and territories had contraceptive prevalence rates of over 60%	2010: 14 countries and territories had contraceptive prevalence rates of over 60%	Source: UNFPA, 2010. *How Universal is Access to Reproductive Health*.
9. Number of countries that have implemented a national health development program targeting adolescents (10 to 19 years of age) and young adults (15 to 24 years of age)	22	26	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
10. Number of countries that have implemented a national program targeting older adults	22	26	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.

Proxy indicators	2007	2011	Source and comments
11. Percentage of international organizations in the inter-American and United Nations systems that have aligned their assistance with the areas of action of the Agenda	2008–2011: 6 of the 9 that answered the survey		Source: Agency survey, Mid-term evaluation of the Health Agenda for the Americas, 2012.

Conclusions

(a) Countries have made significant progress in increasing in percentage of births attended by trained health workers, which has already reached 95.2% in 2011, thus surpassing the target for 2013 established in the PAHO Strategic Plan. However, it is worrying that the percentage of low-birthweight babies has remained unchanged for several years.

(b) Increasing numbers of countries are formulating integrated development plans that include health goals and targets, and some also include goals relating to education and other social matters.

(c) Countries have progressed in incorporating variables into their national health information systems that make it possible to analyze inequities; 27 countries have now introduced such variables.

(d) Countries are increasingly designing programs with a life course approach, as is evident from the progress made with regard to programs targeting adolescents and older adults. Countries have also made progress with regard to contraceptive use: in 2010, 14 countries had contraceptive prevalence rates of over 60%.

(e) The number of new cases of mother-to-child transmission of HIV continues to be a problem, and although HIV screening has increased from 29% to 57% (between 2005 and 2009), the level remains low.

Recommendations

(a) Although the majority of countries have national development plans that include health and other social components, this type of planning should, ideally, be practiced in all countries of the Region.

(b) Information systems should be strengthened through the incorporation of variables relating to ethnicity and others, in order to make it possible to identify inequities with regard to health throughout the Region.

(c) Although an increase has been recorded in births attended by trained health workers, a study on the subject should be conducted and the impact of skilled attendance at birth on maternal and child mortality should be analyzed.

(d) Countries should continue working to maintain and expand the use of contraceptives, especially those in which the contraceptive prevalence rate remains under 60%.

(e) Reducing the risk and the burden of disease

Findings

55. Improvements were noted in 12 of the 19 proxy indicators for this area; no change was found in one; the situation had worsened with respect to five; and no data were available for one, which made it impossible to compare the situation before and after the introduction of the Agenda.

Proxy indicators	2007	2011	Source and comments
1. Number of countries that have implemented a national program for the prevention and control of chronic diseases	23	31	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. A significant improvement was noted in the number of countries that have and are implementing national programs to address CNCDs. The number of countries that have implemented CNCD risk factor surveillance systems (using the STEPwise approach) has risen from 10 to 21 during the period 2007–2011.
2. Number of countries that have implemented a national mental health program	27	30	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
3. Mortality from diabetes per 100,000 population (adjusted by age and sex)	2008: 27.0 per 100,000 population	2011: 32.8 per 100,000 population	Source: PAHO, Basic Indicators 2008 and 2011. Noticeable increase in mortality, the rate having risen almost 6 points. This may reflect improvements in information systems, but it may also be part of the epidemiological profile (for example: longevity, quality of life). Projections in *Health in the Americas*

Proxy indicators	2007	2011	Source and comments
			(2012) indicate that the number of people with diabetes in the Region will increase from 62.8 million in 2011 to 91.1 million in 2030. In the future, the inclusion of years of life lost to premature death should be considered. CNCD surveillance systems should be strengthened and information on metabolic and endocrine diseases should be disaggregated.
4. Mortality from ischemic heart diseases per 100,000 population (adjusted by age and sex)	2008: 81.0 per 100,000 population	2011: 76.4 per 100,000 population	Source: PAHO, Basic Indicators 2008 and 2011. Reduction of approximately 5 points from the period 2003–2005 to the period 2007–2009, consistent with the regional trend observed in recent years. Is important to note that in 2007 ischemic heart diseases were the second leading cause of death in 30 countries of the Region. Disease disaggregated within the group of diseases of the circulatory system: important to note that the Agenda emphasizes some specific issues.
5. Mortality from cerebrovascular diseases per 100,000 population (adjusted by age and sex)	2008: 42.3 per 100,000 population	2011: 43.1 per 100,000 population	Source: PAHO, Basic Indicators 2008 and 2011. The increase of 0.8 deaths per 100,000 indicates a stable trend for the period considered.
6. Mortality from malignant neoplasms per 100,000 population (adjusted by age and sex)	2008: 116.3 per 100,000 population	2011: 118.8 per 100,000 population	Source: PAHO, Basic Indicators 2008 and 2011. The increase of 2.5 per 100,000 population appears to indicate a stable trend. This is an estimate based on the available data of countries for the period considered. A slight decline has been recorded for the Region as a whole in mortality from all the types of cancer in both sexes since year 2000 (*Health in the Americas*, 2012).

Proxy indicators	2007	2011	Source and comments
7. Mortality from transport accidents per 100,000 population (adjusted by age and sex)	2007: 15.5 per 100,000 population 36 per 100,000 motor vehicles	2010: 14.1 100,000 population 30.2 per 100,000 motor vehicles	Source: PAHO, Basic Indicators 2007 and 2010. The reduction may be attributable to the introduction of and compliance with road safety laws and regulations.
8. Number of countries that have created enabling environments for the promotion of physical activity	19	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Notable increase in the creation of healthy spaces for physical activity.
9. Prevalence of tobacco use	N/D	22% (among adults)	Source: WHO, 2012, and PAHO, 2012. Second interim progress report on the implementation of the PAHO Strategic Plan 2008–2012. The prevalence of tobacco use among adults in the Region is very close to the world average of 24%. The number of countries that have achieved a 10% reduction in tobacco use has increased considerably, rising from 3 in 2007 to 10 in 2011.
10. Number of countries that have implemented the demand reduction measures envisaged in the WHO Framework Agreement for Tobacco Control (FCTC)	18	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Countries of the Region have made significant progress in implementing measures envisaged in the FCTC and in applying all articles of the Convention, especially in Article 8 (smoke-free environments). The implementation of the FCTC mandates is helping to reduce tobacco use in countries.
11. Number of countries that have implemented a national program for the prevention of public health problems caused by harmful use of alcohol or psychoactive substances	24	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Components and number of countries including them in their national programs in 2011: Alcoholic beverages: 25 Drugs and psychoactive substances: 27.

Proxy indicators	2007	2011	Source and comments
12. Number of countries that have implemented a national food and nutrition security program	22	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Components and number of countries including them in their national programs in 2011: - Regulation of advertising: 12 - Regulation of sugar, fat, and salt content: 11 - Communication and education: 28
13. Prevalence of obesity (BMI >25) among adults (15+ years of age) by sex (estimate)	2005: Total: 27.2% Women: 31.0% Men: 23.3%	2010: Total: 32.9% Women: 37% Men: 28.7%	Source: WHO, 2012. Global Infobase, available at: https:/apps.who.int/infobase/Comparisons.aspx. Although projections indicate a rising trend, it is worth noting that the rates are estimates. Strategies should be implemented improve data recording and reporting.
14. Tuberculosis incidence rate per 100,000 population (all forms and sputum-positive).	2007: TB, all forms: 24.0 per 100,000 population Sputum-positive: 13.2 per 100,000 population	2009: TB, all forms: 23.5 per 100,000 population Sputum-positive: 12.1 per 100,000 population	Source: PAHO, Indicators Basic 2007 and 2009, and *Health in the Americas*, 2012. According to *Health in the Americas* (2012), there has been a steady reduction in the incidence of TB since the 1990s, with annual reductions of up to 4% following the introduction of DOTS in 2006. An improvement has also been observed in treatment success rates, which rose from 58% in the cohort of 1997 to 77% in that of 2008. However, challenges have arisen recently with the emergence of multi-drug resistant and extensively drug-resistant cases. Ensuring continued application of the DOTS strategy has also posed a challenge (Second interim progress report on the implementation of the PAHO Strategic Plan 2008–2012).
15. AIDS incidence rate per 100,000 population	2007: 10.5 per 100,000 population	2009: 10.7 per 100,000 population	Source: PAHO, Basic Indicators 2007 and 2009. The available data indicate that the rate has remained stable over the period. According to UNAIDS estimates, in

Proxy indicators	2007	2011	Source and comments
			2010 some 3.2 million people were infected with HIV in the Region of the Americas, 48% (1.5 million) of them in Canada and the United States, 44% (1.4 million) in Latin America, and 8% (240,000) in the Caribbean. Of the total, 57,000 are under 15 years of age.
16. Number of cases of malaria reported annually in the Region	2007: 786,393 (148.7 per 100,000 population)	2010: 680,174 (124.1 per 100,000 population)	Source: PAHO, Basic Indicators 2007 and 2010. The trend of the disease has been downward, which it is consistent with the behavior of the disease since 2000. Malaria remains endemic in 21 countries of the Region.
17. Number of reported cases of dengue	2006: 427,627	2011: 1,699,072	Source: *Health in the Americas*, 2012. In 2009 the definition of dengue hemorrhagic fever was changed to "severe dengue." Despite this change, there has been a significant reduction in case-fatality from severe dengue.
18. Number of countries with certification of interruption of vector transmission of Chagas disease in the 21 endemic countries of the Region	3 of 21 countries in 2006	14 of 21 countries in 2011	Source: PAHO, 2012. Second interim report progress on implementation of the PAHO Strategic Plan 2008–2012. Countries with an infestation index of under 1%. Steady progress has been made towards elimination of this disease.
19. Number of onchocerciasis endemic countries in the Region that have achieved certification of its elimination.	0 of 6 in 2006	1 in process of obtaining certification	Source: PAHO, 2012. Second interim progress report on the implementation of the PAHO Strategic Plan 2008–2012. Colombia in the process of obtaining certification. Endemic countries: Brazil, Colombia, Ecuador, Guatemala, Mexico, Venezuela (Bolivarian Republic of).

Implementation of the various articles of the Framework Agreement on Tobacco Control (FCTC), from 2007 to 2011

Article	**Number of countries per year**	
	2007	2011
***Article 6**: Taxes*	9	16
***Article 8**: Smoke-free environments*	14	28
***Article 11**: Packaging and labeling*	14	23
***Article 13**: Prohibition of advertising, promotion, and sponsorship*	12	20

Conclusions

(a) Of the 19 proxy indicators identified to measure progress in this area, an improvement has been noted in the majority (63%), the exceptions being those related to chronic noncommunicable diseases (for example, diabetes) and risk factors linked to them, such as obesity, dengue, AIDS, and tuberculosis.

(b) The majority of countries have prioritized chronic diseases in their policies, plans, strategies, and programs (increase from 19 to 26 countries in the period evaluated) with an integrated approach that promotes enabling environments for physical activity, and the majority have also prepared programs to address mental health problems; harmful use of alcohol and drugs and psychotropic substances, and food and nutrition security programs.

(c) There has been a substantial increase in the number of countries that have created healthy spaces for physical activity, from 19 in 2007 to 29 in 2011.

(d) In the area of nutrition, 50% of countries have regulations on advertising and on fat, sugar, and salt content in food. In this regard, it should be noted that projections indicate a rising trend in obesity among adults, particularly women.

(e) With regard to prevention of tobacco use, countries have shown progress in the application of the measures contained in all articles of the Framework Convention on Tobacco Control. The greatest progress has been made in the introduction of legislation and regulations on tobacco use (Article 8: Smoke-free environments).

(f) The number of countries with a national program for the prevention of public health problems caused by harmful use of alcohol, drugs, and psychoactive substances has

increased. Of the 29 countries that have a program, more than 90% include components for the prevention of harmful use of alcoholic beverages, drugs, and psychoactive substances.

(g) The incidence of AIDS and tuberculosis has not changed noticeably during the period 2007–2011. In the case of tuberculosis, the increase in multi-drug resistant cases and HIV-tuberculosis coinfection is troubling. Ensuring continued application of the DOTS strategy remains a challenge.

(h) With regard to vector-borne diseases, a favorable trend has been seen in the case of malaria and Chagas disease, which is consistent with the trend of previous periods. However, there has been a worrying increase in reported cases of dengue, the number of which tripled between 2006 and 2011 (rising from 476,627 to 1,699,072 cases). Progress towards onchocerciasis elimination has been made in the six endemic countries, one of which is in the process of obtaining certification.

(i) The indicators of mortality from prevalent chronic noncommunicable diseases (circulatory and neoplastic diseases) show a stable trend during the period evaluated. Mortality from diabetes, on the other hand, has increased. Available estimates indicate a rising trend in the prevalence of obesity, as well, particularly among adult women.

(j) Mortality from injuries caused by transit accidents showed a small reduction during the period 2007–2010, which could be the result of the introduction and enforcement of road safety laws and regulations in countries.

Recommendations

(a) Continue to strengthen the implementation of plans and programs aimed at reducing the risks and burden of chronic noncommunicable diseases, with emphasis on an integrated approach to food and nutrition security and, particularly, with components designed to regulate advertising and the fats, sugar, and salt content of foods.

(b) Prioritize strategies for the prevention and control of HIV/AIDS and tuberculosis transmission.

(c) Pay special attention to integrated interventions for dengue prevention and control.

(d) Improve data capture and recording in chronic disease information systems, including information on risks.

(e) Maintain investment in order to continue progressing towards the elimination of neglected diseases in the Region.

(f) Strengthening the management and development of health workers

Findings

56. All five of the proxy indicators for this area of action have registered significant improvement, as is shown below.

Proxy indicators	2007	2011	Source and comments
1. Number of countries that have implemented national policies to strengthen the health work force	23	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. This indicator improved in all countries; the area showing the greatest improvement was accreditation of training institutions. The area showing the least improvement in absolute terms was bilateral agreements, which is the most neglected area. Substantial improvement was registered in actions within countries.
2. Number of countries with a health work force (physicians, nurses, and midwives) density of 25 per 10,000 inhabitants.	2006: 12	2011: 22	Source: PAHO, 2012. Second interim progress report on of implementation of the PAHO Strategic Plan 2008–2012.
3. Number of countries reporting on monitoring of the 20 regional goals for human resources for health	9	23	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. There has been a sizeable increase in monitoring of the regional goals for human resources for health, but additional work is needed in this area of action.
4. Number of countries that have established learning networks in order to improve the public health competencies of health workers	16	24	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
5. Number of countries that have participated in bilateral or multilateral agreements on migration of health workers	4	11	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.

Conclusions

(a) The issue of human resources for health is being accorded growing prominence and priority in the majority of the countries, as is demonstrated by the fact that 29 countries now have national policies aimed at strengthening the health work force and 22 countries have succeeded in increasing the density their health work force to 25 workers per 10,000 population. In addition, the number of countries that report that they are monitoring the regional goals for human resources for health has increased from 9 in 2007 to 23 in 2011. The prominence of the issue is also evident from the monitoring of the regional goals for human resources for the health 2007–2015, which are organized in accordance with the five critical challenges identified in the Agenda and the Toronto Call to Action.

(b) Is important to note the progress made the creation networks for improving public health competencies, which now exist in 29 countries.

(c) Migration of health workers is an issue of growing importance, as is evident from the increase in bilateral or multilateral agreements on the matter, the number of which rose from 4 in 2007 to 11 in 2011.

Recommendations

(a) Intensify efforts for the management and development of health workers, especially in the area of bilateral or multilateral agreements that address the migration of health workers and monitoring of the regional goals for human resources for the health. In addition, implement a policy of incentives for health workers in order to ensure continuity and quality in the delivery of services.

(b) Continue efforts to expand the health work force with a view to achieving the recommended level in the majority of the countries of the Region.

(g) Harnessing knowledge, science, and technology

Findings

57. Improvements were found in all five of the proxy indicators for this area of action.

Proxy indicators	2007	2011	Source and comments
1. Number of countries with a system or mechanism that facilitates evidence-based decision-making.	21	28	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
2. Number of countries that have implemented a national policy or plan on health research.	13	17	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
3. Number of countries that have formed a national commission designed to monitor compliance with ethical standards in scientific research.	24	28	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.
4. Number of countries that have implemented standards in keeping with international standards on quality, safety, and efficacy of health-related inputs.	25	29	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Of the 29 countries, all have implemented standards for drugs, 22 for other inputs, and 18 for health technologies.
5. Number of countries that have implemented a policy that includes rational use of medicines[2].	22	27	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012.

Conclusions

(a) The countries have made progress in ensuring that their policies are based on scientific evidence; however, progress in formulating national policies on health research appears inadequate, as only 17 countries reported having such policies or plans.

(b) A significant number of countries (27) have institutional mechanisms for monitoring compliance with ethical standards in scientific research.

(c) Noteworthy progress has been made in 29 countries of the Region with regard to the application of standards in keeping with international standards on quality, safety, and efficacy of health-related inputs.

[2] Rational use of medicines is understood to mean correct and appropriate use. Rational use of medicines requires that patients receive appropriate medications in the proper doses for an adequate period of time and at the lowest cost to them and their community.

Recommendations

(a) Redouble efforts to encourage the health authorities of countries to formulate national research policies in order to address key public health problems, in accordance with national priorities. Also, ensure appropriate financing for these policies.

(b) Continue intensifying efforts with regard to the quality, safety, and efficacy of inputs, one of the key factors for health care.

(h) Strengthening health security

Findings

58. Improvements were noted in four of the six proxy indicators for this area; for the other two, it was not possible to compare the situation before and after the introduction of the Agenda owing to lack of data.

Proxy indicator	2007	2011	Source and comments
1. Number of countries that have implemented national plans or programs for emergency and disaster preparedness for the health sector	30	35	Source: Survey of countries, Mid-term evaluation of the Health Agenda for the Americas, 2012. Components and number of countries that had incorporated them into their national plans or programs in 2011: Disasters: 35 Pandemics: 33 Diseases: 30 Others: 6. Improvements were found in all components in comparison with 2007.
2. Number of countries that have put in place the core capacities for surveillance and response as required by the International Health Regulations (2005)	0	July 2012: 6 in progress	Source: PAHO, 2010. Program for Disease Surveillance, Prevention, and Control. As of 18 July 2012, 6 of the 35 countries reported having met the IHR core capacity requirements; 28 of the 35 countries had requested an extension from WHO in order to allow them to meet the IHR requirements by 2014; and one country had not reported its status with regard to the core capacities to WHO.

Proxy indicator	2007	2011	Source and comments
3. Number of countries that have maintained surveillance and take steps to ensure their preparedness to deal with emerging and reemerging zoonotic diseases.	31	33	Source: Survey of organizations, Mid-term evaluation of the Health Agenda for the Americas, 2012. Of the 33 countries that have maintained surveillance and preparedness with regard to zoonotic diseases, 29 have integrated such surveillance into their health information systems.
4. Percentage of public health events of international concern that have been investigated within the timeframe recommended under the International Health Regulations	N/D	100%	Source: PAHO, 2010. Program for Disease Surveillance, Prevention, and Control. Of 196 public health events of potential international concern reported, all were investigated in 2011.
5. Number of international organizations that have collaborated with national authorities in responding to situations that threaten health security	ND	Period 2008-2011: 6 of 9 organiza-tions	Source: Survey of organizations, Mid-term evaluation of the Health Agenda for the Americas, 2012.
6. Number of countries that have formed epidemic and outbreak alert and response teams	30	35	Source: Survey of organizations, Mid-term evaluation of the Health Agenda for the Americas, 2012. As of 2011, all countries had alert and response teams.

Conclusions

(a) All countries reported having plans or programs for disaster and pandemic preparedness. They all also reported having formed preparedness and response teams. This is the result of the concerted effort by countries to prepare for an influenza H5N1 pandemic and the efforts spurred by the H1N1 pandemic of 2009–2010 and the IHRs. Moreover, 100% public health events of potential international concern have been investigated.

(b) With regard to the implementation of the IHRs, only 6 of the Region's 35 countries reported having met the IHR core capacity requirements for surveillance and response. Is important to note that 28 of the 35 countries have requested a two-year extension of the deadline for meeting the IHR requirements (from June 2012 to June 2014).

Recommendations

(a) Countries should accelerate measures aimed at meeting the IHR core surveillance and response capacity requirements. WHO, through its regional offices, should strengthen its cooperation in order to contribute to the strengthening of countries' capacities.

(b) Alert and response capacity for public health events of international concern should be maintained and it should be ensured that the necessary action is taken within the time frame recommended under the IHRs.

V. Comments on the Evaluation Process

(a) The high degree of participation and commitment by countries in this evaluation process is worthy of note. All 35 countries of the Region (100%) answered the survey, and the quality of the responses was very good. It should also be noted that there was participation by individuals in the political, managerial, and technical spheres in countries.

(b) The majority of the subregional integration mechanisms participated in the mid-term evaluation of the Agenda.

(c) A significant number of international organizations (19) also participated in the evaluation process.

(d) The evaluation made it possible to put the Agenda up for public discussion in countries and subregions and in the international organizations. This evaluation thus helped to increase dissemination of the Agenda within these entities, complementing what has been achieved since the launch of the Agenda in 2007.

(e) The mixed qualitative and quantitative methodology made it possible to obtain better explanations of health-related phenomena and their causes. It should be noted that the methodology used for this evaluation focused on measuring its influence, not functions.

(f) The fact that the Agenda does not include targets or indicators hindered the evaluation. The identification of proxy indicators made it possible to measure progress made before (up to and including 2007) and after the Agenda was adopted (from 2007 to circa 2011). These proxy indicators made it possible to evaluate the areas of action and to identify issues on which progress has been made, as well as issues on which it will be necessary to redouble efforts. They also made it possible to identify areas in which international cooperation could be intensified in order to enhance the health of the peoples of the Americas.

(g) The proxy indicators could be used to establish targets for the year 2017, the final year of the period covered by the Agenda, in order to facilitate the final evaluation. They might also be useful to countries for generating their own targets and indicators for monitoring and evaluating their internal processes up to the end of the period covered by the Agenda.

(h) Factors that facilitated the preparation of this evaluation included the support provided throughout the process by PAHO as secretariat, the participation and the direct support provided by the PAHO/WHO country offices, and the active participation of the working group with focal points from 10 countries of the Region.

Limitations of the evaluation process

(a) The Agenda does not include an evaluation model or baselines or targets for evaluating it. Although this problem was partially solved through the identification and measurement of the proxy indicators included in this evaluation, there were cases in which progress could not be measured more precisely owing to lack of data. It is recommended that for similar evaluation processes there should be a baseline so that the changes that have occurred can be compared with the situation before implementation.

(b) It was necessary to work with a limited number of indicators in some areas of action. It should also be noted that there are several issues that are repeated in different areas of action of the Agenda and some areas of action cover the same issues, although they remain separate in different sections. In future evaluations, the complementarity of the issues covered in the various areas of action should be recognized and taken into account in the evaluation of the proxy indicators in each area of action.

(c) The Agenda should have included an evaluation plan and an implementation document, with operational definitions of the various concepts in order to facilitate its implementation in countries.

(d) The period covered by the evaluation (2007–2011) is too short to analyze trends or significant changes in some indicators (maternal mortality, infant mortality, etc.) or in health systems, especially given the delay in implementing its principles in some countries and the fact that they were already part of national plans in some cases. In the latter cases, it was not possible to determine what changes had occurred.

(e) The survey conducted as part of the evaluation of the Agenda took account of the distinct structural features of each country and therefore did include any instructions for answering the questions. However, countries need more guidance in order to better complete the process.

(f) The turnover and temporary nature of health authorities in the countries was not taken into account, which made the evaluation more difficult, since the respondents did not always have sufficient knowledge of the Agenda. That, in turn, made it difficult to carry out some of the surveys and interviews and may also have affected the responses relating to knowledge of the Agenda. Furthermore, it may have limited the participation of some key stakeholders, as occurred in the case of some international organizations.

VI. General Conclusions and Recommendations

Conclusions

(a) The mid-term evaluation of the Agenda was timely for documenting progress in the Agenda's implementation and identifying the challenges and issues within each area of action that require attention.

(b) Participation in the evaluation was excellent on the part of countries (all 35 countries of the Region participated), subregions (5 participated), and international organizations working in the health sphere in the Region (19 participated). Consequently, the information obtained through the evaluation is highly representative of the status of the variables considered therein. The commitment of the countries and of the working group of countries, coupled with the support of the Pan American Sanitary Bureau, contributed to the success of the evaluation.

(c) During the period evaluated, utilization of the Agenda by countries was good. It guided the formulation of numerous national health plans, policies, and strategies and of other specific plans in this sphere. Dissemination of the Agenda among ministries and secretariats of health was good at the time that the Agenda was launched. However, high turnover among national health authorities in some countries may be one reason that hindered greater ownership and, consequently, greater utilization of the Agenda. It should be emphasized that dissemination of the Agenda in other sectors and at the subnational level was limited.

(d) At the subregional level, fair use has been made of the Agenda, which has guided the preparation of two action programs, three strategic plans, one strategy, and one subregional health policy. Its dissemination has been limited in cases in which countries and the Bureau have not taken proactive action to encourage subregional integration mechanisms to embrace the Agenda.

(e) International organizations working in the health sphere in the Region have made limited used of the Agenda, which has guided the formulation of only a few strategic plans and projects. This could be because the Agenda has not been widely disseminated among international organizations and because countries have not drawn on the Agenda when they negotiate cooperation with such organizations. The Bureau could be more proactive in disseminating the Agenda among international organizations.

(f) Significant progress has been made in all the areas of action of the Agenda (especially efforts to strengthen the national health authority, increase social protection and access to health services, reduce the burden of disease, strengthen

the management and development of health workers, and harness knowledge, science, and technology), as measured by proxy indicators, defined by consensus by the working group of countries. However, there is cause for concern regarding the status of some indicators, such as the maternal mortality ratio, which has not declined as expected in recent years. Also worrying are the increases in the number of dengue cases and rates of tuberculosis and HIV infection/AIDS, the rise in obesity, the stagnation of national public spending on health as a percentage of GDP, and the lack of reduction in out-of-pocket spending in the Region. It should be noted that for seven indicators no data were available, and changes during the period of evaluation could therefore not be analyzed. In addition, for three indicators only estimates or projections were used to analyze the health situation.

(g) The Agenda does not include targets or indicators, which hindered the mid-term evaluation. Now that proxy indicators have been identified and there is a baseline for 2011, targets could be established for the Agenda for the year 2017.

Recommendations

(a) Strengthen dissemination of the Agenda in countries, especially in other sectors and at the subnational level. In countries where a change of authorities has occurred, special action should be taken to disseminate the Agenda. The Bureau could play a proactive role in disseminating the Agenda.

(b) Strengthen dissemination of the Agenda among subregional integration mechanisms. Countries and the Bureau should work together to this end.

(c) Strengthen dissemination of the Agenda among all international organizations working in the health sphere in the Region of the Americas. Countries should draw on the Agenda in negotiating cooperation with these organizations. The Bureau should play a more active role in disseminating the Agenda among international organizations.

(d) With regard to the areas of action, countries should intensify their efforts to reduce maternal mortality, cases of dengue and tuberculosis, obesity, and chronic diseases and their risk factors; strengthen social protection systems; and increase national public spending on health and reduce out-of-pocket spending.

(e) Establish targets for the Agenda for the year 2017, based on the proxy indicators established and using the 2011 baseline. This will facilitate the final evaluation of the Agenda. The indicators for which reliable information was not available should be reviewed and information systems should be strengthened in order to improve

analysis of the health situation and ensure complete information for decision-making.

(f) Use the proxy indicators identified for the evaluation of the Agenda as starting point in order to devise the indicators for the future Strategic Plan of PAHO for 2014–2019.

(g) Use the findings of the mid-term evaluation of the Agenda as a contribution to the formulation of the new General Program of Work of WHO.

(h) Recommend that the working group of countries established for the mi-term evaluation of the Agenda form the basis for the technical team of countries that will participate in the formulation of the Strategic Plan of PAHO for 2014–2019, so as to take advantage of the experience and work dynamic already in place.

(i) Recommend that a work plan be developed for the year 2013 in order to strengthen the health planning process in the Region and address the recommendations of the mid-term evaluation of the Agenda. This plan would include specific measures to strengthen dissemination of the Agenda in countries, subregions, and international organizations; focus work on the aspects of the areas of action of the Agenda that need to be strengthened; establish targets for the Agenda for 2017; prepare the new Strategic Plan of PAHO for 2014–2019; and ensure that the results of this evaluation contribute to the new Program Work of WHO, among other aspects. An outline of this plan could be presented to the Executive Committee in September 2012 for approval; it could be implemented in 2013 and, subsequently, the results could be presented to the Directing Council of PAHO that year. The group of countries responsible for implementing the plan would be formed on the basis of the working group of countries that carried out the mid-term evaluation of the Agenda.

ACRONYMS AND ABBREVIATIONS

AECID	Spanish Agency for International Development Cooperation
APHA	American Public Health Association
CARICOM	Caribbean community
CCS	country cooperation strategy
CDC	Centers for Disease Control and Prevention (United States of America)
CIDA	Canadian International Development Agency
CNCDs	chronic noncommunicable diseases
COMISCA	Council of Central American Ministers of Health
DOTS	directly observed treatment, short course
ECLAC	Economic Commission for Latin America and the Caribbean
FCTC	WHO Framework Agreement on Tobacco Control
FDA	Food and Drug Administration (United States of America)
GDP	gross domestic product
HHS	Department of Health and Social Services (United States of America)
IDB	Inter-American Development Bank
IHRs	International Health Regulations
ILO	International Labor Organization
LAC	Latin America and the Caribbean
MDG	Millennium Development Goals
MERCOSUR	Southern Common Market
N/D	No data available
NGO	Nongovernmental organization
OECD	Organization for Economic Cooperation and Development
ORAS/CONHU	Andean Health Agency/Hipólito Unanue Agreement
PAHEF	Pan American Health and Education Foundation
PAHO	Pan American Health Organization
SICA	Central American Integration System
STEPS	WHO STEPwise approach to chronic disease risk factor surveillance
STI	sexually transmitted infection
TCC	technical cooperation among countries
TRIPS	Agremeent on Trade-Related Aspects of Intellectual Property Rights

UNAIDS	Joint United Nations Program on HIV/AIDS
UNASUR	Union of South American Nations
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the High Commissioner of the United Nations for the Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization

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Component C of the Mid-Term Evaluation of the Health Agenda for the Americas: Main Findings and Recommendations

1. This component of the evaluation (c), examined PASB's contribution to the Agenda's work and its achievements. The work was divided into three parts: first, it assessed the extent to which the official documents and meetings of the PASB related to the Agenda incorporated its areas of action; second, it examined the ways in which the principles and values of the Agenda shaped PAHO's technical cooperation; and finally, it analyzed the most relevant contributions to achievements in the region made by PAHO (comprising the Secretariat plus Member States).

2. The Agenda had important implications for the PAHO Strategic Plan 2008-2012 (hereinafter the Strategic Plan) of the Organization since the Agenda contains areas of action which outline the priorities for improving health in the Region; the Strategic Plan responds to the areas of action through its different Strategic Objectives (SOs) and Region-wide Expected Results (RERs). Thus, the Agenda establishes collective priorities for the Region and the Strategic Plan establishes the commitment of the Pan American Sanitary Bureau (PASB) and PAHO Member States to address such priorities through a result-based management approach. According to document CD47/8 (paragraphs 1, 2, and 3); the Agenda belongs to the Member States of PAHO, presents ten-year areas of action for the people of the Americas to achieve the highest possible level of health, and is the primary strategic planning framework for PASB's work. The indicators of the Strategic Plan are the quantifiable measurements of regional progress toward the Agenda's areas of action, and the Plan remains an effective monitoring tool of advancement in the Region for the whole PAHO community.

3. The evaluation's findings show that the PASB has responded to the Agenda by encouraging progress in all areas of action and by endorsing its principles and values in the Region, while, on the other hand, the Agenda has supported multilateralism in the PASB's actions providing a commonly agreed strategic vision to guide its operations. The PASB also promoted internal institutional changes in order to align its operations to the Agenda's objectives (in parallel, the Organization has undertaken major institutional strengthening initiatives, including the establishment of an Ethics Office, an Ombudsman's Office, and an Office of Internal Oversight and Evaluation Services.) The Agenda has been used in the development of strategic documents, including national health plans, regional health plans and sub-regional agendas, as well in the training of personnel.

4. For this evaluation, the Office of Internal Oversight and Evaluation Services (IES) conducted a study - together with the Planning, Budget and Resource Coordination Area (PBR) – which mapped in detail the links between the RERs (foundational bricks of the Strategic Plan's architecture) and the areas of action of the Agenda, as

well as the Biennial Work Plans (BWP) and Country Cooperation Strategies (CCS). This exercise confirmed that the Strategic Plan and the Agenda are closely linked and that the Plan's strategic objectives address the entire Agenda's areas of action, although with different emphases among the various areas. PAHO's strategic objectives also contribute to harmonizing the Agenda with the World Health Organization's (WHO) strategic objectives, and the work of other international organizations in the Region. The mapping exercise between the RERs and the areas of action should provide a platform for continuing management analysis of these linkages.

5. The interviews for this evaluation indicated that many interviewees had little familiarity with the Agenda, whose existence is known to everyone but remains in the background of institutional action. In some cases the regional nature of the Agenda also confines it to a lower priority, as compared to other documents, in the general perception of the respondents. PASB made significant efforts for the dissemination of the Agenda but needs in the future to intensify even further its work for the advocacy of the Agenda (finding opportunities in its internal debate and international *fora* with partners, civil society and government counterparts); to call attention to the fact that the Strategic Plan without the Agenda is not complete; and to highlight the role of health in social development in the Region.

6. While IES found that the PASB had responded adequately to the Agenda, it makes the following recommendations in this report to strengthen efforts to promote it internally and externally in order to improve its implementation:

7. To establish a strategic session within the meetings of the PASB's performance, monitoring and assessment (PMA) process to discuss the Agenda and adapt the Bureau's response to emerging issues like changes in the political and economic scenario, pandemics, climate change, and terrorism;

8. To continue promoting the Agenda with all external funding partners and to include it in collaborative agreements;

9. To include the Agenda as a reference document in PAHO's on-line orientation program and on-line quiz of the orientation program;

10. To use the mapping analysis to monitor the PASB's response to the Agenda and take it forward, creating a group, expressly dedicated to the problem, including representatives of technical areas to complement the results and, in light of developments for the PAHO Strategic Plan for 2014-2019 (currently under development), ensure a systematic monitoring tool and clear alignment of it with the areas of action of the Agenda;

11. To ensure that RERs or any other measures to monitor the progress of the Strategic Plan do not duplicate content and are directly aligned to the areas of action of the Agenda.

12. To create a criteria and glossary with common practices for the development of the CCS, linking it to the Agenda and the PAHO Strategic Plan to facilitate their development and therefore their monitoring and evaluation.

13. To build on the new strategy for resource mobilization with a plan of action to address the funding gap for the present biennium.

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