



Pan American
Health
Organization



World Health
Organization

REGIONAL OFFICE FOR THE
Americas

29th PAN AMERICAN SANITARY CONFERENCE

69th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 25-29 September 2017

Provisional Agenda Item 4.4

CSP29/6, Rev. 3*
25 September 2017
Original: Spanish

SUSTAINABLE HEALTH AGENDA FOR THE AMERICAS 2018-2030: A CALL TO ACTION FOR HEALTH AND WELL-BEING IN THE REGION

* This version contains changes to goal 5.8.

CONTENTS

I. DECLARATION OF MINISTERS AND SECRETARIES OF HEALTH	3
II. FOREWORD BY THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU	4
III. THE HEMISPHERIC VISION	5
About the New Agenda.....	5
Principles and Values.....	5
<i>The right to the enjoyment of the highest attainable standard of health.....</i>	<i>5</i>
<i>Pan American solidarity</i>	<i>6</i>
<i>Equity in health</i>	<i>6</i>
<i>Universality.....</i>	<i>6</i>
<i>Social inclusion.....</i>	<i>7</i>
Vision.....	7
IV. CONTEXT AND SITUATION ANALYSIS.....	8
Context and Background.....	8
<i>Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030).....</i>	<i>8</i>
<i>Health Agenda for the Americas 2008-2017.....</i>	<i>8</i>
<i>The 2030 Agenda and the Sustainable Development Goals</i>	<i>11</i>
Situation Analysis	12
<i>Socioeconomic trends in the Region</i>	<i>13</i>
<i>Demographic trends.....</i>	<i>14</i>
<i>Health situation trends and health system response in the Region.....</i>	<i>15</i>
<i>Environment and health.....</i>	<i>18</i>
<i>Communicable diseases</i>	<i>19</i>
<i>Chronic diseases, mental health, and risk factors for noncommunicable diseases</i>	<i>22</i>
<i>Health systems and services.....</i>	<i>24</i>
V. GOALS AND TARGETS.....	28
VI. IMPLEMENTATION, MONITORING, ASSESSMENT, AND REPORTING.....	42
Implementation	42
Monitoring, Assessment, and Reporting.....	45
Annex A - SDG 3 Targets and Indicators	47
Annex B – Leading causes of death in the Region in the period 2010-2013, by sex.....	52
Annex C – Acknowledgments.....	53

I. DECLARATION OF MINISTERS AND SECRETARIES OF HEALTH

We, the Ministers and Secretaries of Health of the countries of the Region of the Americas unanimously endorse this Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) as the strategic policy instrument that provides direction and political vision for health development in the Region for the next 13 years, and declare our commitment to:

- a) A hemispheric vision of a healthier and more equitable Region of the Americas, in harmony with the global vision and principles established in the 2030 Agenda for Sustainable Development, building on the progress made in the achievement of the Millennium Development Goals (MDGs) and the Health Agenda for the Americas 2008-2017;
- b) The reaffirmation of the right to health, where it is nationally recognized, and the right to the enjoyment of the highest attainable standard of health, Pan American solidarity, equity in health, universality, and social inclusion, as fundamental principles and values that have inspired the countries we represent to improve health outcomes so that our peoples may achieve their fullest potential;
- c) The ongoing work toward universal access to health and universal health coverage, and the development of resilient health systems with capacity to analyze and act on the determinants of health in an intersectoral manner;
- d) Promotion of the Agenda at the highest levels of decision making and the promotion of joint actions with government and nongovernmental actors alike at the regional, subregional, national, and subnational levels, as appropriate, to realize the hemispheric vision of this Agenda in an integrated and collaborative manner;
- e) The implementation, monitoring, and evaluation of this Agenda, and accountability for its realization through established mechanisms, in collaboration with the Pan American Sanitary Bureau.

II. FOREWORD BY THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU

1. The countries of the Americas have come together in an unprecedented fashion to develop and launch this inspirational Sustainable Health Agenda for the Americas 2018-2030, and I applaud them. The Region continues to maintain its role as a trailblazer and global leader in public health, in this case by clearly stating how it will take up the challenges laid out in the 2030 Sustainable Development Goals (SDGs) approved by the United Nations General Assembly in 2015.

2. The Pan American Sanitary Bureau has been an enthusiastic supporter of the countries that worked to build this Agenda, and I firmly commit our full support to carrying it out. This Agenda will be key to the development of PAHO's own strategic plans, and we will actively support its implementation throughout the Region in collaboration with all countries and partners.

3. The evolution of the health sector in the Region has been remarkable: just in the past few decades we have seen major advances in key health indicators such as life expectancy, infant mortality, and vaccine coverage. Recently we eliminated rubella and measles, while many countries have eliminated mother-to-child transmission of human immunodeficiency virus (HIV) and some of the neglected tropical diseases, such as onchocerciasis (river blindness) and Chagas disease. The Region is also well on track toward the elimination of malaria. While progress is being made in curbing noncommunicable diseases and their risk factors, they pose a major threat to the health, well-being, and development of our peoples.

4. I believe that this Agenda will help us to better focus our efforts throughout the third decade of the twenty-first century, so that we will see even greater returns on our investment in health. In the coming years, our focus must be on ensuring equity in health, so that all people may benefit from this major push for universal access to health and universal health coverage.

5. I am confident that this high-level political agenda can help us to keep our "eye on the prize" as we collectively work towards the health goals contained herein. Between now and 2030, political parties may change, economic circumstances may be more or less favorable to investing in health, and yet we can stay focused on the long-term targets that have been set.

6. So please join me in celebrating the labor, vision, and commitment of the countries that have resulted in this Sustainable Health Agenda. At the same time, we must recognize that the hard part starts now: working daily on the myriad initiatives and actions that will ultimately lead us to the vision of equitable health and well-being for all peoples of the Region.

(Signature)

III. THE HEMISPHERIC VISION

About the New Agenda

7. The Sustainable Health Agenda for the Americas 2018-2030 (“the Agenda” or SHAA2030) constitutes the highest level of strategic planning and policy framework in the Americas. It is a call to collective action to achieve higher levels of health and well-being in the Region as a whole and in the Member States, within the new hemispheric and global context. The Agenda is approved by the Pan American Sanitary Conference, the highest authority of the Pan American Health Organization (PAHO), representing all countries in the Western Hemisphere.

8. SHAA2030 represents the health sector’s response to commitments adopted by the PAHO Member States in the 2030 Agenda for Sustainable Development, together with the unfinished business from the MDGs and the Health Agenda for the Americas (HAA) 2008-2017, as well as any future and emerging regional public health challenges that may arise. It will be implemented through the PAHO strategic plans and strategies, as well as through subregional and national health plans.

Principles and Values

9. SHAA2030 seeks to promote the health and well-being of all individuals, families, and communities in the Americas. Acknowledging that the countries of the Region have different needs and approaches to improving health, this Agenda respects and adheres to the following interrelated principles and values.

The right to the enjoyment of the highest attainable standard of health

10. The Constitution of the World Health Organization (WHO) states that “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”¹ In order to make this right a reality, countries should work toward improving access to health care that is timely, available, affordable, and of appropriate quality, as well as the social determinants of health, such as adequate standards of living and healthy food. All of these factors also promote the enjoyment of other human rights, including, among others, the right to education, as well as nondiscrimination, access to information, and social participation.

11. The Agenda is aligned with the commitment of Member States and the Pan American Sanitary Bureau (PASB, or “the Bureau”) to mainstreaming human rights in health programs, and policies at both the national and regional levels, considering the underlying determinants of health as part of a comprehensive approach to health and human rights.

¹ Constitution of the World Health Organization. Available from: http://www.who.int/governance/eb/who_constitution_en.pdf.

Pan American solidarity

12. Based on the history and experience of our Hemisphere, Pan American solidarity—understood to mean the promotion of shared interests and responsibilities, as well as the facilitation of collective efforts to achieve common targets—is essential in order to ensure equitable progress by Member States in the implementation of the Agenda in the Region.

13. Strong bilateral partnerships and South-South cooperation among Member States, as well as multilateral and regional cooperation, along with dynamic integration processes, are basic mechanisms for exchanging effective approaches and experiences, as well as goods and services, in order to achieve common targets and overcome health inequities.

14. Solidarity is also critical for ensuring health security during crises, emergencies, and disasters in the Region.

Equity in health

15. The Agenda reflects the quest for equity in health as part of a collective effort to eliminate all health inequalities that are avoidable, unjust, and remediable among populations or groups within the countries of the Americas and between them. In overcoming health inequalities, it is important to bear in mind that they are rooted in social and environmental determinants that also need to be addressed.

16. WHO has stated that “a human rights-based approach to health provides strategies and solutions to address and rectify inequalities, discriminatory practices and unjust power relations, which are often at the heart of inequitable health outcomes. The goal of a human rights-based approach is that all health policies, strategies and programs are designed with the objective of progressively improving the enjoyment of all people to the right to health. Interventions to reach this objective adhere to rigorous principles and standards, including nondiscrimination [...], availability [...], accessibility [...], acceptability [...], quality [...], accountability [...], universality [...].”²

Universality

17. Human rights, including the right to the enjoyment of the highest attainable standard of health, are universal and inalienable. All people, everywhere in the world, must be able to exercise and enjoy them.

18. Consistent with the 2030 Agenda for Sustainable Development, SHAA2030 adheres to the principle of leaving no individual and no country behind.

² WHO. Health and human rights. Fact sheet 323. December 2015. Available from: <http://www.who.int/mediacentre/factsheets/fs323/en/>.

Social inclusion

19. The Agenda promotes social participation in defining, implementing and assessing the outcomes of health policies. It therefore encourages policy-makers and service providers to take the necessary steps to make health systems more responsive to the people they serve.

20. In the exercise of human rights, including the right to the enjoyment of the highest attainable standard of health, all persons should be included, without discrimination on the basis of race, color, sex, language, religion, political or other opinion, national or social origin, place of birth, or other status.³

21. In the exercise of the right to the enjoyment of the highest attainable standard of health, individuals who belong to ethnic groups, communities, and groups that are culturally different must be included. The Agenda considers the intercultural approach as an expression of an interactive social process of recognition and respect for differences in one or more cultures, which is indispensable for the construction of a just society.⁴

Vision

22. By 2030, the Region as a whole and the countries of the Americas aim to achieve the highest attainable standard of health, with equity and well-being for all people throughout the life course, with universal access to health and universal health coverage, resilient health systems, and quality health services.

23. This vision is in full harmony with the global vision stated in the 2030 Agenda for Sustainable Development,⁵ which defines an overarching framework for social, economic, and environmental development in which health and its determinants are key: “We envisage a world free of poverty, hunger, disease and war, where all life can thrive. We envisage a world free of fear and violence. A world with universal literacy. A world with equitable and universal access to quality education at all levels, to health care and social protection, where physical, mental and social well-being are assured. A world where we reaffirm our commitments regarding the human right to safe drinking water and sanitation and where there is improved hygiene; and where food is sufficient, safe, affordable and nutritious. A world where human habitats are safe, resilient and sustainable and where there is universal access to affordable, reliable and sustainable energy.”

³ United Nations Economic and Social Council: Committee on Economic, Social and Cultural Rights. General Comment No. 20, Non-discrimination in economic, social and cultural rights; 2009. E/C.12/GC/20. Available from: <http://www.refworld.org/docid/4a60961f2.html>.

⁴ OPS. Una visión de salud intercultural para los pueblos indígenas de las Américas, p.11. Available in Spanish at: <http://new.paho.org/hq/dmdocuments/2009/54-VisionSaludInterculturalPI.pdf>.

⁵ United Nations. Transforming our World: the 2030 Agenda for Sustainable Development. Seventieth session of the General Assembly, Resolution A/RES/70/1. Available from: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N15/291/89/PDF/N1529189.pdf?OpenElement>.

IV. CONTEXT AND SITUATION ANALYSIS

Context and Background

Sustainable Health Agenda for the Americas 2018-2030

24. The Agenda represents the health sector response to the commitments adopted by the countries in the 2030 Agenda for Sustainable Development and unfinished business from the Millennium Development Goals (MDGs) and the Health Agenda for the Americas 2008-2017, as well as the commitments of the WHO regional office for the Americas, other global health commitments of the Region, and future public health challenges that may arise in the Region.

25. The PAHO Member States decided to develop SHAA2030 at a special event during the 55th Directing Council, on September 28, 2016. Participants, including several ministers of health, determined that the new Agenda should express the shared vision of the Member States for the development of health in the Region in the context of the United Nations' 2030 Agenda for Sustainable Development. It was further determined that the new Agenda should build on the lessons learned from the Health Agenda for the Americas (HAA) 2008-2017 and the PAHO Strategic Plan 2014-2019, as well as individual initiatives of Member States to make progress in national implementation of the Sustainable Development Goals (SDGs).

26. To develop the Agenda, a Countries Working Group (CWG)⁶ worked in close collaboration with the PASB in virtual and face-to-face meetings from October 2016 to September 2017. Consultations were held with Member States during the 2017 PAHO Governing Bodies meetings and during the World Health Assembly in May 2017. These consultations provided an opportunity to keep Member States informed about progress and to obtain input as the process evolved.

Health Agenda for the Americas 2008-2017

27. The Health Agenda for the Americas 2008-2017⁷ was developed following a "recommendation by the United Nations Joint Inspection Unit, which had pointed out that planning by international organizations should be based on a common vision of their Member States, formulated independently of the secretariat and of the organization's

⁶ The CWG membership was composed of high-level representatives of 16 Member States from all the Americas subregions: North America: United States and Mexico; Caribbean: Antigua and Barbuda, Barbados; Central America: Costa Rica, El Salvador, Honduras, Nicaragua, and Panama; South America: Argentina, Brazil, Chile, Ecuador, Paraguay, Peru, and Uruguay. Ecuador was the president, and Panama and Barbados were vice presidents of the group. The representatives included Ministers and Vice Ministers of Health, chief medical officers, planners, epidemiologists, and international health relations professionals.

⁷ PAHO. Health Agenda for the Americas 2008-2017. Available from:

http://new.paho.org/hq/dmdocuments/2009/Health_Agenda_for_the_Americas_2008-2017.pdf.

governing bodies.”⁸ Additionally, the Health Agenda addressed the mandates of the MDGs and the Eleventh General Program of Work of the World Health Organization, approved in 2006. The HAA 2008-2017 was launched in Panama City in June 2007.

28. The Agenda was recognized as the high-level policy instrument for health in the Americas. It provided orientation for responding to the health needs of the population in the Region and served as a formal commitment to work together in solidarity for health development in the Region. It also served as a guide for the preparation of national health plans and the strategic plans of all organizations interested in health cooperation with the countries of the Americas, including the PASB (Strategic Plans 2008-2013 and 2014-2019).

29. The Health Agenda for the Americas 2008-2017 established eight major areas of action: *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; and *h)* strengthening health security.

30. The mid-term evaluation of the HAA 2008-2017 was presented to the 28th Pan American Sanitary Conference in September 2012. The evaluation acknowledged the significant progress made in the eight areas of action and called attention to specific health concerns where less progress was observed and renewed efforts were necessary: *a)* maternal mortality, *b)* dengue, *c)* tuberculosis, *d)* HIV/AIDS, *e)* obesity, *f)* public expenditure on health, and *g)* out-of-pocket expenditure. During the period reviewed, the Agenda had been put to good use in the countries of the Region, having guided the formulation of national health plans, policies and strategies. Similarly, at the subregional level, the Agenda had been regularly used, guiding the development of action plans, programs, and strategies. However, health agencies and partners in the Region had used the Agenda in a limited way. The lack of targets and indicators had created difficulties in the mid-term evaluation of the Agenda and in effective monitoring and reporting on its implementation. A recommendation was made to set targets for 2017, based on "proxy indicators," defined during the mid-term evaluation of the Agenda.

31. The final evaluation of the HAA 2008-2017, conducted in tandem with the development of the present Agenda, involved the completion of a survey by all Member States, a review of their health plans, and an analysis of the proxy indicators defined in the mid-term evaluation. The preliminary findings of this final evaluation allowed for reporting on the main areas of concern identified in the mid-term evaluation.

32. With respect to the specific areas highlighted, the final evaluation indicated the following:

⁸ Final Report of the 27th Pan American Sanitary Conference (Document CSP27/FR), held on 1-5 October 2007.

- a) Maternal mortality: The estimated maternal mortality ratio (MMR) in the Region⁹ showed significant variations between countries, with a reduction from 67.0 in 2005 to 52.0 per 100,000 live births in 2015. In this latter year, while the median was 63 per 100,000 for the Region as a whole,¹⁰ among the countries below the median it was 27 per 100,000,¹¹ and in those above the median it was 94.¹²
- b) Dengue: Dengue cases increased significantly, from 1,699,072 in 2011 to 8,207,797 accumulated cases in 2015,¹³ and therefore the disease remains a major concern in the Region.
- c) Tuberculosis: There was a reduction in incidence from 24 cases per 100,000 population in 2007 to 23.5 per 100,000 in 2009, and 22.1 per 100,000 in 2014.¹⁴
- d) HIV/AIDS: There was a reduction in the number of cases of mother-to-child transmission of HIV from 3,300 in 2011 to 2,100 in 2015.¹⁵
- e) Obesity: The trend shows an increase in obesity in children under 5 years of age from 6.9% in 2005 to 7.2% in 2012.¹⁶
- f) National public expenditure on health as a percentage of gross domestic product (GDP): There was a gradual increase in Latin American and the Caribbean, from 3.1% in 2006 to 3.7% in 2011 and 4.0% in 2014 (as a simple average).¹⁷
- g) Out-of-pocket expenditure: As a percentage of total health expenditure, out-of-pocket expenditure dropped from 52% in 2006 to 33% in 2014 in Latin America and the Caribbean.¹⁸
33. Consistent with its purpose, the HAA 2008-2017 served PAHO as the main political and strategic instrument for the development and implementation of two strategic plans (2008-2013 and 2014-2019), as well as regional strategies and plans of action, and country cooperation strategies.

⁹ WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Trends in Maternal Mortality: 1990 – 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Available from: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>

¹⁰ Confidence interval 95% (14–229)

¹¹ Confidence interval 95% (7–54)

¹² Confidence interval 95% (64–350)

¹³ Health in Americas 2012 and 2017.

¹⁴ PAHO. Core Health Indicators, 2016.

¹⁵ PAHO. Elimination of Mother-to-Child Transmission of HIV and Syphilis in the Americas. Update 2016.

¹⁶ PAHO. Mid-term Evaluation of the Health Agenda for the Americas, 2012 and PAHO Core Indicators 2016.

¹⁷ PAHO. Mid-term Evaluation of the Health Agenda for the Americas, 2012 and PAHO Core Indicators, 2017.

¹⁸ Idem.

The 2030 Agenda and the Sustainable Development Goals

34. In September 2015, the United Nations General Assembly adopted the Resolution "Transforming our World: the 2030 Agenda for Sustainable Development."¹⁹ The 2030 Agenda contains 17 sustainable development goals (SDGs) and 169 specific development targets.

35. Of the 17 development goals, Goal 3, "Ensure a healthy life and promote the well-being of all at all ages," and its 13 targets are directly relevant to SHAA2030. However, it is important to note the existence of additional health-related targets in other SDGs, symbolic of the intent of the 2030 Agenda to foster an intersectoral approach to development, working towards holistic social, economic, and environmental improvements.

Table 1. SDG 3 Targets²⁰

Number	Targets
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, waterborne diseases and other communicable diseases.
3.4	By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being.
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents.
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination.
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.

¹⁹ United Nations. Transforming our World: the 2030 Agenda for Sustainable Development. Seventieth session of the General Assembly, Resolution A/RES/70/1. Available from: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N15/291/89/PDF/N1529189.pdf?OpenElement>.

²⁰ Prepared with information from United Nations General Assembly Resolution A/RES/70/1: "Transforming our World: the 2030 Agenda for Sustainable Development."

Number	Targets
3.b	Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health and, in particular, provide access to medicines for all.
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

36. Paragraph 26 of the 2030 Agenda emphasizes the critical importance of health: “To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola, and other communicable diseases and epidemics, including by addressing growing anti-microbial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioral, developmental and neurological disorders, which constitute a major challenge for sustainable development.”

Situation Analysis

37. The analysis presented below establishes the context for SHAA2030. It includes a synopsis of socioeconomic and demographic characteristics and trends, together with the epidemiologic profile, health situation trends, and health system response. The information sources are the “World Economic Situation and Prospects 2017” published by the United Nations;²¹ the “Regional Outlook on Health in the Americas,” from the 2017 edition of Health in the Americas;²² and the Report of the End-of-biennium

²¹ United Nations. World Economic Situation and Prospects 2017. Available from: https://www.un.org/development/desa/dpad/wp-content/uploads/sites/45/publication/2017wesp_full_en.pdf. and United Nations. World Economic Situation and Prospects 2017. Update as of mid-2017. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N17/130/50/pdf/N1713050.pdf?OpenElement>.

²² PAHO. Health in the Americas 2017: Economic and social context in the Americas 2010-2015 (publication pending).

Assessment of the PAHO Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019.²³

Socioeconomic trends in the Region

38. The world economy in the last ten years has been characterized by slowdowns with slight rebounds. The slowdown began in September 2008, with its epicenter in the economies of some countries that were experiencing major growth. The Region of the Americas has not been a stranger to this trend, presenting a more pronounced slowdown than the world average.

Economic prospects by subregion

39. The performance of the Region's economies shows varying patterns. The economic outlook for North America (United States and Canada, the first and tenth largest economies in the world) is good, mainly because of increased private consumption, especially of durable goods and real estate; low levels of unemployment; and a slight uptick in wages in the United States. In Canada, economic expansion is expected as a result of plans for fiscal expansion in basic infrastructure, modest increases in commodity prices, and a slight improvement in competitiveness thanks to depreciation of the currency.

40. In South America, after a two-year decline in GDP (reductions of 1.9% in 2015 and 2.6 in 2016), there has been a slow recovery, with projections of 0.6% for 2017 and 2.6% for 2018. Some countries have shown better performance due to increased investments, while others have been burdened by rising unemployment, low productivity growth, poor economic diversification and weak institutional capacity.

41. In Mexico and Central America, average growth is expected to remain modest, with GDP growing by slightly more than 2.0% in 2017 and 2018 amid a climate of uncertainty. In some Central American countries, GDP growth is expected to rise to more than 4% in 2017 and 2018 as a result of vigorous public investment, strong private consumption, and thriving tourism industries.

42. In the Caribbean, the economic situation and the outlook vary widely between the countries, depending on the structural constraints of their economies and their vulnerability to changes in the world economy. However, despite these drawbacks, some countries have seen GDP growth levels of 3% and higher.

43. The United Nations report²⁴ calls for a reorientation of macroeconomic and other policies in order to more effectively promote investment in physical and human capital

²³ PAHO. Report of the End-of-biennium Assessment of the Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019. 55th Directing Council, 68th Session of the Regional Committee of WHO for the Americas, 26-30 September 2016 (Document CD55/5). Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=35900&Itemid=270&lang=en.

and strengthen capacity for innovation across the Region. There are significant risks to the economic outlook. The medium-term growth outlook for many Latin American and Caribbean economies is clouded by persistent structural weaknesses, including a high dependence on commodities and low productivity growth. A prolonged period of weak growth could pose a threat to the social achievements of the past decade and complicate the Region's path toward achievement of the Sustainable Development Goals. For this reason, the report recommends increasing public investment and improving tax collection to break the vicious cycle of low investment paired with low economic growth.

Demographic trends

44. The region of the Americas has witnessed important epidemiological and demographic transitions. In 2015 the Region's population reached 992 million—a 12% increase since 2005. In general, between 2010 and 2015 there was a 1.48% reduction in the under-15 population and a 14.06% increase in the population over age 79.²⁵

45. Life expectancy at birth at the global level increased by three years between 2000-2005 and 2010-2015 (from 67.1 to 70.5 years). In the Americas, life expectancy also increased by 3.2 years, from 73.7 in 2000 to 76.9 years in 2015. The regional life expectancy average hides inequalities between and within subregions and countries. For instance, life expectancy in 2015 in Latin America and the Caribbean was 74.5 years, while in North America was 79.2 years, and at the country level it ranged from 63.5 in Haiti to 82.2 in Canada.²⁶

46. Half the countries in the Region have fertility rates below 2.1 children per woman, which means that they have started to enter the demographic phase of “population without replacement,” as well as a progressive aging process. Although fertility rates have diminished, fertility rose among adolescents (15–19 years of age), with an estimated regional fertility rate of 49.5 per 1,000, ranging from 8.2 to 96.1. While the current trend has been stable, adolescent mothers account for 20% of the 15 million births in the Region each year.²⁷

47. It is worth noting that, without exception, Latin American countries have an advantageous demographic situation in terms of economic development: the so-called

²⁴ United Nations. World Economic Situation and Prospects 2017. Available from: https://www.un.org/development/desa/dpad/wp-content/uploads/sites/45/publication/2017wesp_full_en.pdf. and United Nations. World Economic Situation and Prospects 2017. Update as of mid-2017. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N17/130/50/pdf/N1713050.pdf?OpenElement>

²⁵ WHO. Global Health Observatory. Available from: http://www.who.int/gho/publications/world_health_statistics/2017/en/

²⁶ CEPAL. Los impactos de las tendencias demográficas. En: CEPAL. *Panorama social de América Latina 2015*. Santiago de Chile: CEPAL; 2015. Available from: http://repositorio.cepal.org/bitstream/handle/11362/39965/S1600175_es.pdf

²⁷ Pan American Health Organization/World Health Organization, Communicable Diseases and Health Information and Analysis. Health Situation in the Americas: Basic Indicators 2017. Washington, D.C., 2017.

“demographic dividend.” In general, the countries of Latin America are in the so-called second phase of the demographic dividend. In this second (most favorable) phase, a country’s dependency ratio reaches its lowest level—less than two dependent people for every three active people—and remains constant at that level. This phase began at the beginning of the 21st century and is expected to last through the end of the 2011-2020 decade. The third phase will extend into the early years of the 2041-2050 decade.

48. In 2015, Latin America and the Caribbean had 26% of the world's children (0-14 years old), 17% of the adolescent population (15-24 years), and 14.6% of the over-60 population. The over-80 population represented 3.8% of the world’s total in North America and 1.6% in Latin America. However, the rate of teenage pregnancies in Latin America and the Caribbean was the second highest in the world in 2010-2015 (66.5 live births per 1,000 females aged 15-19).

49. In 2014, the countries with the highest proportions of people living in urban areas in the world were found in North America (82% of the population living in urban areas), Latin America and the Caribbean (80% of the population), and Europe (73%). In contrast, Africa and Asia remained mainly rural. It should be noted that the Region of the Americas has three of the world’s six megacities (Mexico City, New York, and São Paulo).

Health situation trends and health system response in the Region

Health inequities

50. In the last decade, the growth experienced by the countries in the Region of the Americas has not uniformly benefited its diverse social groups, resulting in poor household quality of life and low availability of social services, including health and education, for millions of people. This situation is reflected in major variations in the health indicators, both between and within countries in the Region.

51. The variations indicate huge inequalities between and within countries, with health outcomes in the countries reflecting such factors as wealth, education, geographical location, gender, ethnicity, and/or age. For instance, in 2013 the countries in the Americas with the lowest income levels had an infant mortality rate (IMR) 4.5 times higher than the countries with the highest income levels, while for women the risk of dying of maternal causes was 5.5 times higher in countries with the lowest mean years of schooling than in countries with the highest mean years of schooling. Similarly, even within countries, the subnational units with the poorest quintile of household wealth had the highest under-5 child mortality rates, while those with the lowest levels of education had up to three times the risk of premature death than those with higher levels of education, regardless of age or sex. When considering race or ethnic origin, life expectancy among indigenous inhabitants tends to be 7 to 8 years lower than among

non-indigenous populations.²⁸ Indigenous women tend to have a lower probability of receiving prenatal care that meets standards of care,²⁹ higher rates of maternal mortality, and a lower likelihood of receiving delivery care in a health facility during childbirth compared with non-indigenous women.³⁰ When age groups are disaggregated and compared with non-indigenous and non-black people, proportional mortality in children under 5 is greater, and there are more deaths from accidents and violence among blacks and indigenous youths.³¹ Below are other examples of inequalities within and between countries:³²

- a) Countries with the largest rural populations still face inadequate prenatal care coverage compared to the most urbanized quintiles, with an absolute gap of 11.9 percentage points in 2013 (that is, countries in the quintile with the largest rural population had 78.4% adequate coverage compared to 90.3% in more urban countries).
- b) Countries with the lowest levels of schooling in 2013 had an absolute inequality gap of 16.7 premature deaths related to noncommunicable diseases per 100,000 population compared with countries with the highest levels of schooling (that is, countries in the quintile with the lowest level of schooling in 2013 had a premature mortality rate of 280 deaths per 100,000 population compared with 263.3 in the quintile of countries with the highest level of schooling).
- c) The incidence of dengue is far higher in countries in the lowest quintiles of per capita GDP.
- d) Countries in the lowest quintile for mean years of schooling have a significantly higher homicide rate than the rest of the countries in the Region, as well as higher adolescent homicide rates than all other quintiles combined.

52. During 2014-2015, institutional capacity to quantify and analyze social inequalities in health was strengthened in 19 countries through the production of health

²⁸ Instituto Nacional de Estadística y Censo (INEC), Fondo de Población de las Naciones Unidas (UNFPA), Panamá: Diagnóstico de la población indígena de Panamá con base en los Censos de Población y Vivienda 2010. Available from:

https://www.contraloria.gob.pa/inec/Publicaciones/Publicaciones.aspx?ID_SUBCATEGORIA=59&ID_PUBLICACION=657&ID_IDIOMA=1&ID_CATEGORIA=13

²⁹ Dansereau E, McNellan CR, Gagnier MC, Desai SS, Haakenstad A, Johanns CK, Palmisano EB, Ríos-Zertuche D, Schaefer A, Zúñiga-Brenes P, Hernandez B, Iriarte E, Mokdad AH. Coverage and timing of antenatal care among poor women in 6 Mesoamerican countries. *BMC Pregnancy and Childbirth*. 2016 Aug 19; 16:234. DOI: 10.1186/s12884-016-1018-5

³⁰ Colombara DV, Hernández B, Schaefer A, Zyznieuski N, Bryant MF, Desai SS, Gagnier MC, Johanns CK, McNellan CR, Palmisano EB, Ríos-Zertuche D, Zúñiga-Brenes P, Iriarte E, Mokdad AH. Institutional Delivery and Satisfaction among Indigenous and Poor Women in Guatemala, Mexico, and Panama. *PLoS ONE*. 2016 Apr 27; 11(4): e0154388. doi: 10.1371/journal.pone.0154388

³¹ Ministerio da Saúde, Racismo e desigualdades na saúde, *Epidemiologia e Análise em Saúde*, 2014. Personal Communication, Dr. Fatima Marinho.

³² Results of an analysis conducted by the Health Information and Analysis Unit of PAHO, based on data from PLISA (PAHO Platform for Health Information and Analysis).

equity profiles addressing the social, economic, and environmental dimensions of sustainable development.

53. Consistent with the countries' commitment to the SDGs, there is a need to establish national priorities and development goals for the upcoming years, considering current health inequalities both between and within countries in the Americas. It is vital that these priorities and goals reflect the needs of the most vulnerable populations and are based on current evidence. In order to generate evidence that reflects current health inequities both between and within countries, it is important for countries to include data collected at the subnational level in their health inequalities analyses.

Leading causes of death

54. The overall age-adjusted mortality rate declined slightly from 5.6 per 1,000 population in 2005 to 5.3 in 2013. The mortality profile of the Americas is dominated by noncommunicable diseases. In 2013, among nearly six million deaths, 78% were due to noncommunicable diseases; 9%, to communicable diseases; 10%, to external causes; and 3%, to ill-defined causes.

- a) The top ten causes of death in the Region of the Americas during 2010-2013 are shown in the following table.

Table 2. Leading Causes of Death in the Region in the period 2010-2013³³

Causes (ICD-10)	Deaths	Age-adjusted rate per 100,000 population	% of total deaths
Ischemic heart diseases (I20-I25)	2,792,698	76.4	14.1
Cerebrovascular diseases (I60-I69)	1,423,762	38.9	7.2
Diabetes mellitus (E10-E14)	1,098,085	30.0	5.5
Dementia and Alzheimer's disease (F01, F03, G30)	1,017,617	27.8	5.1
Chronic lower respiratory diseases (J40-J47)	1,013,061	27.7	5.1
Malignant neoplasm of trachea, bronchi, and lungs (C33, C34)	958,356	26.2	4.8
Influenza and pneumonia (J10-J18)	814,175	22.3	4.1
Hypertensive diseases (I10-I15)	700,591	19.2	3.5
Cirrhosis and other diseases of the liver	544,217	14.9	2.7
Assault (homicide) (X85-Y09)	543,815	14.9	2.7

Source: PAHO Mortality Information System for the Region of the Americas.

³³ Adjusted by age and based on the categories in the WHO standardized list for international comparisons of the leading causes of death, from WHO: Becker R, Silvi J, Fat D, L'Hours A, Laurenti R: A method for deriving leading causes of death; Bull of the WHO 2006; 84: 297-304.

- b) In both sexes, the mortality profile is dominated by chronic noncommunicable diseases, accounting for eight of the top 10 causes among women and seven of the top 10 causes in men. Among men, the deaths not related to noncommunicable disease were due to external causes such as assault, homicide, and land transport accidents (see Annex B).
- c) By age groups, the leading causes of death in the Region were as follows (the figures in parentheses refer to rates per 100,000 population): in the 10-24 years age group, homicide (20.4), land transport accidents (13.4), and suicide (5.3); in the 25-64 age group, ischemic heart diseases (35.9), diabetes mellitus (19.1), and homicide (18.3); among those over 65, ischemic heart diseases (620.6), cerebrovascular diseases (327.5), and dementia and Alzheimer's disease (292.8).
- d) As mentioned previously, between 2002-2005 and 2010-2013 the maternal mortality ratio (MMR) saw a decrease at the regional level (from 68.4 to 58.2 per 100,000 live births), with significant variations within the Region. Of the total number of maternal deaths, 66.4% were related to direct obstetric causes, such as heavy bleeding (usually puerperal), infections, hypertensive pregnancy disorders (usually eclampsia), obstructed labor, and complications of abortion.
- e) The Region's infant mortality rate (children under 1 year) declined from 17.9 per 1,000 live births to 13.6 per 1,000 live births between 2002-2005 and 2010-2013. Of the total deaths, more than 70% occurred during the neonatal period. The main specific cause of neonatal death in the Americas was respiratory distress in newborns.

Environment and health

55. In terms of the modern conception of the relationship between environment and human health,³⁴ preventable environmental risks contribute about one quarter of global deaths. In the Americas, deaths attributable to environmental risks are estimated to range between 8% and 23% of total deaths, with the highest burden in Haiti, followed closely by Honduras, Nicaragua, and Paraguay (20%).³⁵ It is striking to see that the largest fraction of these deaths (46% in Haiti, followed by 26% in Guatemala, and 18% in

³⁴ This concept of environment and health considers the analysis of all physical, chemical, and biological factors external to the person and their related behavior patterns, excluding those natural environments that cannot reasonably be modified. The concept includes contamination of the air, water, and soil with chemical or biological agents; ionizing and ultraviolet radiation; electromagnetic fields; noise; occupational hazards, including physical, chemical, biological, psychosocial, and occupational hazards; built environments (housing, workplaces, land use, roads); agricultural practices; and behaviors related to environmental factors, such as the availability of safe water for human consumption and support for physical activity through improved urban designs.

³⁵ World Health Organization. Preventing diseases through healthy environments: A global assessment of the burden of disease from environmental risks http://www.who.int/quantifying_ehimpacts/publications/preventing-disease/en/ (See Global Health Observatory data).

Bolivia) is caused by chronic noncommunicable diseases (NCDs) that could be prevented with healthy environments.³⁶

56. Globally, preventable environmental risks contribute about one third of disability-adjusted life years (DALYs) associated with key NCDs, such as lower respiratory infection (35%), cardiovascular disease (31%), chronic obstructive pulmonary disease (COPD) (35%), asthma (44%), and cancer (20%). Globally, air pollution (ambient and indoor) is the greatest environmental risk and accounts for about 6.5 million deaths per year, 11.6% of the global total, with 94% due to NCDs. Priority hazardous chemical risks, such as exposure to highly toxic pesticides, lead or mercury, and tend to disproportionately impact children, and contribute to NCDs throughout the life-course, and to chronic health conditions such as neurodevelopment and congenital defects and diseases associated with endocrine disruption.³⁷

Communicable diseases

57. The Region has made steady progress in the elimination of communicable diseases, with landmark achievements such as: *a*) declaration of the Region of the Americas as the first WHO region to be free from endemic measles transmission; *b*) certification of the elimination of rubella and congenital rubella syndrome (the first and only region of the world that has achieved this goal); *c*) elimination of mother-to-child transmission (EMTCT) of human immunodeficiency virus (HIV) and congenital syphilis in Cuba, Anguilla, Montserrat, Bermuda and the Cayman Islands; and *d*) elimination of onchocerciasis in Colombia, Ecuador, Guatemala, and Mexico, and trachoma in Mexico. Additionally, six countries of the Organization of Eastern Caribbean States (OECS) are in the process of obtaining validation for EMTCT of HIV and congenital syphilis by the Regional Validation Committee (Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, and Saint Vincent and the Grenadines). In addition, Argentina and Paraguay are in the process of certifying the elimination of malaria. With regard to interruption of the transmission of *Trypanosoma cruzi*, new areas of Colombia and Paraguay were certified and Chile was recertified.

58. Annual cases of influenza averaged 116,590 over the last five years. Since 2009, the main seasonal influenza viruses circulating in the Americas have been influenza A (H1N1) pdm09, influenza A (H3N2), and influenza B (Victoria and Yamagata lineages).

59. Between 2011 and 2016, only five countries (Brazil, Bolivia, Colombia, Ecuador, and Peru) reported cases of yellow fever. In December 2016, an outbreak was reported in Brazil, with 448 confirmed severe cases and a fatality rate of 32%.

³⁶ Prüss-Ustün A, Wolf J, Corvalán C, Bos R, Neira M. Preventing diseases through healthy environments: A global assessment of the burden of disease from environmental risks. World Health Organization, 2016. http://apps.who.int/iris/bitstream/10665/204585/1/9789241565196_eng.pdf

³⁷ World Health Organization. Preventing diseases through healthy environments: A global assessment of the burden of disease from environmental risks http://www.who.int/quantifying_ehimpacts/publications/preventing-disease/en/ (See Global Health Observatory data).

60. In 2010, Haiti reported 179,379 cases of cholera and 3,390 deaths. As a result of that outbreak, between 2010 and 2013, cases were reported in Cuba (469 cases and three deaths), the Dominican Republic (32,778 cases and 488 deaths) and Mexico (203 cases and one death).

HIV and sexually transmitted infections

61. In 2015, an estimated 2 million people were infected with HIV in Latin America and the Caribbean, of whom 58% were 15 years of age or older. That year, the estimated prevalence of HIV infection among 15- to 49-year-olds in Latin America and the Caribbean was around 0.5% [0.4-0.6%], particularly affecting the Caribbean population, which had a prevalence of 1%. In Latin America, the epidemic has mainly affected males, who represent 68% of people with HIV, while in the Caribbean, 52% of people with HIV are females.

62. An estimated annual 64 million new cases of curable sexually transmitted infections (STIs)—*Chlamydia trachomatis*, *Neisseria gonorrhoeae*, syphilis, and *Trichomonas vaginalis*—affect people in the 15-49 age group. Human papillomavirus (HPV) infection is the most common viral infection of the genital tract, with 70 million cases in the region. The estimated prevalence of HPV in Latin America and the Caribbean is 16.1%. It is important to bear in mind that the magnitude of the problem is not accurately known because of underreporting of STIs.

63. The HPV vaccine was introduced in the Region less than a decade ago. As of 2016, 19 countries and territories had introduced the vaccine into a comprehensive control program for the reduction of cervical cancer in women³⁸. Cost-effectiveness modelling for a period of 10 years indicates that if low- and middle-income countries achieve full vaccine coverage, plus one-time cervical cancer screening for women over 35 years old, approximately 5.2 million cervical cancer cases and 3.7 million deaths can be avoided. The net cost of this intervention for 50 low- and middle-income countries would be \$3.2 billion over the 10-year period.³⁹

Tuberculosis

64. Tuberculosis mortality rates decreased from 4.3 to 2.5 per 100,000 population during the period from 2000 to 2015. HIV co-infection remains one of the major risk factors for prolonging this disease and contributing to its mortality in the Americas. In 2015, 218,700 tuberculosis cases were diagnosed and reported (22.1 per 100,000 population). In 2015, 4,508 cases of multidrug resistant tuberculosis were reported in the Region of the Americas.

³⁸ PAHO/WHO Immunizations Technical Unit.

³⁹ Campos, N. G., Sharma, M., Clark, A., Lee, K., Geng, F., Regan, C., Kim, J. and Resch, S. (2017), The health and economic impact of scaling cervical cancer prevention in 50 low- and lower-middle-income countries. *Int J Gynecol Obstet*, 138: 47–56. doi:10.1002/ijgo.12184

Vector-borne diseases

65. Malaria and dengue continue to occur in the Region. The situation of vector-borne diseases has been aggravated by the introduction of the chikungunya and Zika viruses. In December 2013, the first local cases of chikungunya were diagnosed in Saint Martin (French territory). During 2016, 361,312 suspected cases were reported and 157,288 cases were confirmed in the Region.

66. Transmission of the Zika virus was first documented in the Region of the Americas in February 2014. From April 2015 through January 2017, a total of 714,636 suspected cases of Zika were reported, of which 178,297 (29%) were confirmed. During the same period, 2,530 confirmed cases of congenital syndrome associated with Zika virus infection were reported.

67. Between 2000 and 2015, cases of malaria in the Americas decreased by 62% (from 1,181,095 to 451,242 cases). In 2015, however, increases were seen in Colombia, Dominican Republic, Ecuador, Guatemala, Honduras, Nicaragua, Peru, and Venezuela. The increase in this last country, from 90,708 to 136,402 cases, was 50% greater than had been expected. During the same period, malaria-related deaths decreased by 76%, from 410 to 98 deaths. Of this total, 77% were reported by Brazil, Peru, and Venezuela.

68. Between 2011 and 2015, a cumulative total of 8,207,797 cases of dengue were reported in the Region. Of these cases, 118,837 (1.4%) were severe, with 5,028 deaths (0.06%).

Neglected tropical and zoonotic diseases

69. The Region continued to make progress in the elimination of neglected infectious diseases, verifying the elimination of onchocerciasis in Colombia, Ecuador, Guatemala, and Mexico. Only one focus of onchocerciasis (shared by two countries in South America) remains for this disease to be eliminated from the Region.

70. Of the 21 countries in which Chagas disease is endemic, 17 continued to maintain interruption of domiciliary transmission by vectors, insects of the Triatominae subfamily (reduviid bugs) carrying the parasite *Trypanosoma cruzi*, with a household infestation index of 1% or less in the country or its endemic areas.

71. Between 2010 and 2014, new reported cases of leprosy in Latin America and the Caribbean declined from 37,571 to 33,789. Brazil accounted for 92% of all reported cases.

72. With regard to dog-transmitted human rabies, the trend in confirmed cases between 2013 and 2016 remained in the range of 10 to 12 per year. The challenge continues, however, as cases of human rabies transmitted by other animals are rising, with an increase from 12 in 2013 to 23 in 2016.

Vaccine-preventable diseases

73. In 2015, the Region interrupted the endemic transmission of rubella and was also declared free of measles. According to data reported by the countries that same year, coverage in the Region of the Americas with the third dose of the vaccine against diphtheria, pertussis, and tetanus (DPT) and the vaccine against poliomyelitis in children under 1 year of age was 91% and 92%, respectively. For vaccination against measles and rubella in 1-year-olds, the figure was 93%.

74. In 2015, of the nearly 15,000 municipalities in Latin America and the Caribbean, 8,456 (56%) reported that vaccination coverage with the third dose of DPT was lower than 95%.

Antimicrobial resistance

75. Since 1996, a rising trend has been documented in the resistance of major human pathogens to antimicrobial drugs both at the community and hospital levels. The spread of emergent mechanisms of resistance in the Region, including carbapenems⁴⁰ against *Klebsiella pneumoniae* (KPC-type), is being reported in almost all the Latin American countries, with up to 50% fatality from infectious outbreaks in intensive care units.

Chronic diseases, mental health, and risk factors for noncommunicable diseases*Mortality from noncommunicable diseases*

76. Noncommunicable diseases (NCDs) are responsible for nearly four out of five deaths in the Americas, and this number is expected to increase in the coming decades. In 2015, a 30 year-old person in the Region had a 14.7% chance of dying from one of the four major NCDs before reaching the age of 70. This was a lower probability of death compared with other regions, considering that the world average was 18.8%.

77. In 2013, cardiovascular diseases were the leading cause of death in the Region. With 1,644,738 deaths (144.9 per 100,000 population), it accounted for 28.8% of all deaths from noncommunicable diseases. That same year, the Region had 1,087,047 deaths from cancer (102.4 per 100,000 population) and 278,034 deaths from diabetes mellitus, causing 19.0% and 6.3%, respectively, of the deaths in this disease group.

⁴⁰ Carbapenems are broad-spectrum β -lactamic antibiotics with action and resistance to β -lactamase. They are highly effective against Gram-negative and -positive bacteria.

Chronic kidney disease

78. Chronic kidney disease is a growing public health problem in all of the countries of the Americas, and Latin America has the highest mortality rate in the world,⁴¹ In the last two decades, Central America has reported a growing number of cases of chronic kidney disease of nontraditional causes in male agricultural workers, mainly associated with improper use of agrochemicals, working conditions in intense heat, insufficient hydration, and other determinants of health. In El Salvador, mortality from this cause increased from 18.7 deaths per 100,000 population in 1997 to 47.4 deaths per 100,000 in 2012, and in Nicaragua, from 23.9 deaths per 100,000 in 1997 to 36.7 deaths per 100,000 in 2013.

Mental health

79. Mental, neurological, and substance use disorders are the main factors contributing to morbidity, disability, injury, premature mortality, and increased risk for other health conditions. The estimated 12-month prevalence of these disorders ranges between 18.7% and 24.2% in the Americas (anxiety disorders, between 9.3% and 16.1%; affective disorders, between 7.0% and 8.7%; and substance use disorders, between 3.6% and 5.3%).

Main risk factors

80. The four major modifiable behavioral risk factors⁴² for noncommunicable diseases are: *a*) tobacco use; *b*) excessive consumption of alcohol; *c*) unhealthy diet; and *d*) physical inactivity, not to mention physiological and metabolic changes such as high blood pressure, overweight and obesity, elevated blood glucose, and high levels of cholesterol.

81. Modifiable environmental risk factors, especially exposure to air pollution (ambient and indoor) and to priority hazardous chemicals, are another category of NCD risk factors. The proportion of environmental risk factors relative to behavioral risk factors is lower for the Americas than for Asia, North Africa and the Middle East.⁴³

82. In the Region, average annual alcohol consumption per person over age 15 years was 8.4 liters.

⁴¹ Wang H, Naghavi M, Allen C, et al. GBD 2015 Mortality and Causes of Death Collaborators. Global, Regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980-2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet* 2016;388:1459-1544.

⁴² WHO Noncommunicable Diseases Fact Sheet (Updated June 2017); available from: <http://www.who.int/mediacentre/factsheets/fs355/en/>

⁴³ GBD Risk Factors Collaborators, "Global, regional, national comparative risk assessment of 79 behavioral, environmental and occupational, and metabolic risks or clusters of risk, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015, *Lancet* 2016; 388:1659-724 (Oct. 2016).

83. In 2013, the estimated age-standardized prevalence of current tobacco use among persons aged 15 years and over in the Americas was 17.5%. Among 13- to 15-year-old students, the prevalence of current tobacco use was 13.5% (14.7% for males and 12.3% for females).

84. In 2010, approximately 81% of school-aged adolescents (11 to 17 years old) were not doing enough physical activity, with girls being less active than boys.

85. In 2014, the standardized prevalence of high blood pressure in the Region was 18.7%. Furthermore, 15% of the population over 18 years of age was living with diabetes.

86. The obesity rate (BMI over 30 kg/m²) in the Americas was more than double the global average (26.8% vs. 12.9%), with a higher prevalence among females (29.6%) than males (24.0%). The prevalence of overweight in children under 5 years of age was 7.2% in 2012.

Injuries due to traffic accidents, violence, and homicide

87. In the Americas in 2013, 121,383 people died from traffic-related injuries (13.1 per 100,000 population).

88. With regard to violence, 18 of the 20 countries with the highest homicide rates in the world are in Latin America and Caribbean, associated with criminal gang activities and organized crime. The homicide rate in the Region in 2013 was 14.6 per 100,000 population. Males experience higher levels of lethal violence (26.0 per 100,000 population) than females (3.1 per 100,000), with the group aged 10 to 29 years being the most affected. However, in the case of women, 38% of violent deaths are caused by an intimate partner or ex-partner.⁴⁴ A large proportion of children aged 0 to 7 years suffer physical, sexual, or emotional abuse every year (58% in Latin America and the Caribbean, and 61% in North America).⁴⁵

Health systems and services

Universal access to health and universal health coverage

89. Significant progress continues to be made in the implementation of the Strategy for Universal Access to Health and Universal Health Coverage approved by the

⁴⁴ WHO: Global and regional estimates of violence against women, 2013. Available from: <http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>

⁴⁵ Hillis S, Mercy J, Amobi A, Kress H. Global Prevalence of Past-year Violence Against Children: A Systematic Review and Minimum Estimates. *Pediatrics* 2016; 137(3):e2015407.

PAHO Member States in 2014.⁴⁶ At the end of 2015, 10 countries were implementing plans of action and/or road maps toward universal health; 11 countries had developed regulatory frameworks for universal health; and 15 had established and were implementing financial frameworks for universal health.⁴⁷

90. Between 2014 and 2015, levels of health services coverage were high across the countries, with 98% in Chile, 95% in Colombia, 90% in the United States, 80% in Mexico, and 73% in Peru. Levels of coverage were, however, lowest in the poorest households, particularly for the United States, with 14 percentage points less coverage for poor households, and Peru with a 12 percentage point difference.⁴⁸

Access to health services and quality of care

91. Between 2013 and 2014, more than 1.2 million deaths could have been avoided in the Region with health care systems offering accessible, quality, and timely health care. At the end of 2015, 12 countries had implemented national strategies and/or plans for improving quality of care and patient safety. Additionally, 23 countries had implemented the integrated health service delivery network strategy. The regional mortality rate from causes preventable through health care has been declining, with an estimated decrease from 118.6 per 100,000 population in 2014 to 108.1 per 100,000 in 2019 (a reduction of 8.9%).⁴⁹

Health investment and expenditure

92. In 2014, total health spending accounted for an average of 14.2% of GDP in the Region of the Americas. Five countries (Canada, Costa Rica, Cuba, United States, and Uruguay) allocated 6% or more of their GDP to public expenditure in health. In most countries in the Region, health services development and investments have largely focused on hospitals and highly specialized and costly technology.

93. Public expenditure on health increased in 22 countries between 2010 and 2014. Despite these improvements, however, the percentage increases were smaller compared with the 2005-2010 period except in Bolivia, Peru, and Uruguay.

⁴⁶ PAHO. Strategy for Universal Access to Health and Universal Health Coverage. 53rd Directing Council, 66th Session of the Regional Committee of WHO for the Americas (Document CD53/5, Rev. 2). Available from:

http://www2.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=27312&Itemid=270&lang=en.

⁴⁷ PAHO. Report of the End-of-biennium Assessment of the Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019. 55th Directing Council, 68th Session of the Regional Committee of WHO for the Americas, 26-30 September 2016 (Document CD55/5). Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=35900&Itemid=270&lang=en; and Health in the Americas 2017.

⁴⁸ Analysis based on information obtained from the websites of national statistics agencies, and available in Health in the Americas, 2017.

⁴⁹ PAHO: Core Indicators 2017; confidence interval 95% (8.9% -12.1%).

94. Out-of-pocket expenditure as a percentage of total health expenditure in Latin America and the Caribbean decreased from 52% in 2006 to 33% in 2014.⁵⁰

Preventive health services

95. Available data for 2011-2015 show high levels of inequality and diverse levels of utilization of preventive health care services across the Region. In Peru, 21% of the population had at least one annual preventive visit in 2015 or the most recent year, compared with 24% in the United States and Chile, 68% in Colombia, and 76% in Mexico. The percentage of households reporting access barriers was highest in the poorest households, particularly in Peru (66%), followed by the United States (37%), Colombia (29%), Mexico (20%), and Chile (7%). Disparities have been reduced in most countries, indicating improvements in equity.⁵¹

Reproductive health

96. In 2015, most countries in the Region reached universal (100%) or almost universal ($\geq 93\%$) coverage of key reproductive and maternal health interventions, though with important gaps between the wealthiest and poorest countries. Coverage by skilled birth attendants ranged from 100% (or nearly 100%) in most countries, to a low of 50% in Haiti, followed by Guatemala (67%) and Bolivia (74%).

Pharmaceutical policy, regulatory capacity, and use of medicines

97. In 2014, only 13 of the 28 countries that responded to the survey on pharmaceutical policy, regulatory policy, and use of medicines had a national pharmaceutical policy (46%), while 18 of the 35 countries in the Region had a national blood policy (51%). At the end of 2015, 10 countries had developed institutional development plans for medicines.

Human resources for health

98. In 2015, the Region of the Americas ensured the minimum recommended availability of health personnel, with an average of 70 physicians and nurses per 10,000 population, and all 35 countries reached the target of 25 doctors and nurses per 10,000 population. The main challenge is the distribution of the health workforce:

- a) The percentage of physicians in the Region is up to 80 percentage points higher in urban as opposed to rural (non-metropolitan) areas.
- b) On average, there were 48.7 nurses per 10,000 population in the Americas in 2015. North America had by far the highest density of nurses—more than seven

⁵⁰ PAHO. Mid-term Evaluation of the Health Agenda for the Americas, 2012 and PAHO Core Indicators 2016.

⁵¹ Analysis based on information obtained from the websites of national statistics agencies

times higher than in Latin America and the Caribbean (110.9 vs. 13.6 per 10,000 population).

99. At the end of 2015, at least 17 countries had human resources for health action plans aligned with the policies and needs of their health services delivery system.

Information Systems for Health and health research

100. Countries in the Americas have made significant progress in the implementation of information systems for health. However, due to the rapid evolution of internet and information and communication technologies, they continue to experience challenges, particularly related to data management, adoption of new technologies and development of new skills, the need for interoperability among databases and systems, and sustainability of investments. Preconceptions about information systems are mainly focused on software development, electronic health records, or vital statistics. However, information systems should be conceived as an integrated mechanism for interconnected and interoperable systems and processes that ensure the convergence of data, information, knowledge, standards, people, and institutions. These preconceptions do not consider the current context of the information society and the data revolution; therefore, they cannot provide a realistic general framework for policy development and decision-making.

101. The renewed framework for information systems for health developed by PAHO seeks to define and implement strategies, policies, and standards for interoperable and interconnected systems, and best practices in health data management for improving decision-making and well-being under the framing of four overarching strategic approaches: 1) universal access to health and universal health coverage; 2) health in all policies; 3) eGovernment; and 4) open and big data initiatives. This proposal is taking into consideration existing projects, systems, and structures; therefore, it is based on the assumption of incremental improvements.

Emergency and disaster response capacity

102. In the Region of the Americas, 682 disasters occurred between 2010 and 2016, (21% of all disasters globally), with 277,037 injuries and 12,954 deaths. The economic cost of these disasters has been estimated at \$360 billion, representing 32.8% of the total cost of global damages. The earthquakes registered in 2010 in Haiti and Chile and in Ecuador in 2016 caused considerable damage in the health sector.⁵²

103. Countries' capacity to respond more effectively and efficiently to emergencies and disasters from all types of hazards has increased over the last few years, as evidenced by the efforts to respond to Zika and Ebola virus disease outbreaks, and to a number of earthquakes, hurricanes, and severe floods and droughts that impacted the Region.

⁵² EM-DAT. International database, Center for Investigation on Disaster Epidemiology (CRED). Available from: <http://www.emdat.be/database>.

V. GOALS AND TARGETS

104. In order to achieve its vision of the highest attainable standard of health with equity and well-being for all people in the Region in the next 13 years, taking into account the national context and priorities, SHAA2030 sets the following interrelated goals and targets. These goals are consistent with the Agenda's previously mentioned principles, vision, and purpose.

- Goal 1: Expand equitable access to comprehensive, integrated, quality, people-, family-, and community-centered health services, with an emphasis on health promotion and illness prevention.
- Goal 2: Strengthen stewardship and governance of the national health authority, while promoting social participation.
- Goal 3: Strengthen the management and development of human resources for health (HRH)⁵³ with skills that facilitate a comprehensive approach to health.
- Goal 4: Achieve adequate and sustainable health financing with equity and efficiency, and advance toward protection against financial risks for all persons and their families.⁵⁴
- Goal 5: Ensure access to essential medicines and vaccines, and to other priority health technologies, according to available scientific evidence and the national context.
- Goal 6: Strengthen information systems for health to support the development of evidence-based policies and decision-making.
- Goal 7: Develop capacity for the generation, transfer, and use of evidence and knowledge in health, promoting research, innovation, and the use of technology.
- Goal 8: Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks, and emergencies and disasters that affect the health of the population.
- Goal 9: Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders.
- Goal 10: Reduce the burden of communicable diseases and eliminate neglected diseases.
- Goal 11: Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health.

⁵³ Includes HRH talent management.

⁵⁴ This aligns with SDG 3.8 and, in particular, with strategic line 3 of the Strategy for Universal Access to Health and Universal Health Coverage (document CD53/5, Rev. 2 [2014]), which establishes: Increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service.

105. These goals take into account the health situation of the Region; pending issues related to the MDGs; the areas of action of Health Agenda for the Americas 2008-2017; the impact goals and outcomes of PAHO strategic plans, global and regional strategies and plans of action; and the regionally adjusted health targets of SDG3 and other health-related targets in the 2030 Agenda.

106. Each of the goals contains a scope, highlighting key components and interventions required for its achievement, and a selected set of targets that will enable monitoring and assessing progress in implementation of the Agenda. The targets describe the expected result (at the impact or outcome level, in most cases) that Member States aim to achieve by 2030. The targets were defined mainly based on the existing commitments at the global or regional level and express the aspirations of the Member States, individually and collectively, consistent with the goals and vision of the Agenda.⁵⁵

107. The following table includes the 11 goals of this Agenda, with their respective scope and targets.

Table 3. SHAA2030 Goals, Scopes, and Targets

<p>Goal 1: Expand equitable access to comprehensive, integrated, quality, people- family- and community-centered health services, with an emphasis on health promotion and disease prevention</p>
<p>Scope: Consistent with the commitment of the Member States to advance toward the achievement of universal access to health and universal health coverage, the attainment of this goal requires strengthening or transforming the organization and management of health services through the development of people-, family-, and community-centered models of care, taking into consideration the following:</p> <ul style="list-style-type: none"> • implementation of strategies for universal access to health and universal health coverage; • provision of comprehensive health services according to the demographic, epidemiological and cultural profile of the population, with due attention to the differentiated and unmet needs of all people and the specific needs of groups in conditions of vulnerability; • implementation of models of care, including organization and management of health services, by level of complexity and based on the needs of the population, through increased resolution capacity of the first level of care and integrated health services networks; • ensuring quality of care and improved performance of the health services (e.g., reduction of waiting times); • empowerment of people and communities so that they can make informed decisions.

⁵⁵ Details on the methodology used to define the targets are available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=13680&Itemid=42425&lang=en

Targets for 2030:

- 1.1 Reduce by at least 50% the regional mortality amenable to health care rate (MAHR)⁵⁶ (updated from PAHO Strategic Plan impact goal 4.1).
- 1.2 Reduce the regional maternal mortality ratio (MMR) to less than 30 per 100,000 live births⁵⁷ in all population groups, including those at greatest risk of maternal death (i.e. adolescents, women of over 35 years of age, and indigenous, Afro-descendent, Roma, and rural women, among others, as applicable in each country) (adapted SDG target 3.1).
- 1.3 Reduce the neonatal mortality rate to less than 9 per 1,000 live births⁵⁸ in all population groups, including those most at risk (indigenous, Afro-descendent, Roma, and rural population, among others, as applicable in each country), and under-5 mortality to less than 14 per 1,000 live births⁵⁹ (adapted from SDG target 3.2).
- 1.4 Ensure universal access to sexual and reproductive health care services, including for family planning⁶⁰, information, and education, and the integration of reproductive health into national strategies and programs. (SDG target 3.7).
- 1.5 Increase resolution capacity of the first level of care as measured by a 15% reduction in hospitalization that can be prevented with quality ambulatory care (updated PAHO Strategic Plan outcome 4.2).
- 1.6 Organize health services into integrated health service delivery networks with high resolution capacity at the first level of care (updated PAHO Strategic Plan outcome 4.2).

Goal 2: Strengthen stewardship and governance of the national health authority, while promoting social participation

Scope: The achievement of this goal requires strengthening of the essential public health functions, establishment or strengthening of mechanisms for social participation, and dialogue for the development and implementation of inclusive policies, accountability, and transparency. The following are key for the achievement of this goal:

⁵⁶ This rate is used as a quality indicator and as an outcome indicator for the health system.

⁵⁷ This target was set based on the analysis of the reduction of MMR in the countries of the Region between 2010 and 2015, and considering the methodology of the Maternal Mortality Estimation Inter-Agency Group (WHO, 2015); http://apps.who.int/iris/bitstream/10665/153540/1/WHO_RHR_15.03_eng.pdf. Additional information on this target can be found in the technical note available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=13680&Itemid=42425&lang=en.

⁵⁸ This target is based on the estimates of the Every Newborn Action Plan (WHO and UNICEF, 2014): http://www.healthynewbornnetwork.org/hnn-content/uploads/Every_Newborn_Action_Plan-EXECUTIVE_SUMMARY-ENGLISH_updated_July2014.pdf and the PAHO Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: Final Report (CD55/INF/11).

⁵⁹ Based on the PAHO Core Health Indicators 2016 and data reported by the countries of the Americas, the Regional under-5 mortality rate was 15.9 per 1,000 live births. Available from: <http://iris.paho.org/xmlui/bitstream/handle/123456789/31289/CoreIndicators2016-eng.pdf?sequence=1&isAllowed=y>

⁶⁰ In no case should abortion be promoted as a method of family planning. (Report of the International Conference on Population and Development [1994]). Available from: <http://www.un.org/popin/icpd/conference/offeng/poa.html>.

- leadership of the national health authority in the formulation, monitoring, and evaluation of policies, plans, and programs, with mechanisms that facilitate social participation and accountability;
- national legal and regulatory frameworks consistent with the commitment of countries to universal access to health and universal health coverage;
- competencies and capacities for the regulation of service delivery;
- mechanisms for coordination with other sectors (public, social security, private, nongovernmental) and geographical units (subnational, state, provincial, municipal);
- comprehensive management of international cooperation⁶¹ to ensure alignment with national health priorities.

Targets for 2030:

- 2.1 Achieve universal access to health and universal health coverage, according to the national context (adapted from SDG target 3.8 and PAHO Strategy on Universal Health Access and Universal Health Coverage, document CD53/5, Rev. 2 [2014]).
- 2.2 Perform the essential public health functions according to established standards (Core competencies for public health: A regional framework for the Americas, PAHO, 2013).⁶²
- 2.3 Strengthen stewardship, governance, and transparency, including policies, plans, rules, and processes for health system organization and mechanisms for monitoring and evaluation (PAHO Strategy on Universal Health Access and Universal Health Coverage, document CD53/5, Rev. 2 [2014]).⁶³
- 2.4 Develop and strengthen mechanisms, as applicable, for the regulation of health service delivery in order to expand access and improve quality (PAHO Strategy on Universal Health Access and Universal Health Coverage, document CD53/5, Rev. 2 [2014]).
- 2.5 Increase the participation of all stakeholders, including civil society and communities, in the policy-making and evaluation process relating to Health in All Policies to reduce health inequities (PAHO Plan of Action on Health in All Policies, document CD53/10, Rev. 1 [2014]).

⁶¹ Essential Public Health Function #5, measurement parameter 5.4. Public Health in the Americas, 2002. Available from: <http://iris.paho.org/xmlui/handle/123456789/2748>

⁶² PAHO. Core Competencies for Public Health: A Regional Framework for the Americas, 2013. Available from: http://www2.paho.org/hq/index.php?option=com_content&view=article&id=9267&Itemid=40548&lang=en Note: The PAHO Essential Public Health Functions Framework is being updated. New measurements/standards will be provided when the updated framework becomes available.

⁶³ The Strategy for Universal Access to Health and Universal Health Coverage posits the need to strengthen stewardship through the exercise of essential public health functions.

Goal 3: Strengthen the management and development of human resources for health with skills that facilitate a comprehensive approach to health

Scope: Attainment of the goal requires: *a)* strengthening and consolidating governance and leadership in human resources for health (HRH); *b)* developing the conditions and capacity to expand access to health and health coverage with equity and quality; and *c)* partnering with the education sector to respond to the needs of health systems in the transformation toward universal access to health and universal health coverage. Increased public spending and financial efficiency is needed to foster quality education and employment in order to increase the availability of human resources for health, motivate health teams, and promote retention. The following are key components for this goal:

- comprehensive HRH policies that include planning, recruitment, training, retention, and distribution of health personnel;
- improvement of employment conditions, including adequate remuneration;
- strong HRH information systems to inform planning and decision-making, taking into account the health system approach and possible change scenarios, modeling and forecasting, and performance monitoring;
- partnerships with the education sector at the highest levels to strengthen governance in the planning and regulation of health education;
- policies for mobility and migration of health personnel.

Targets for 2030:

- 3.1 Ensure adequate availability of a health workforce⁶⁴ (44.5 health workers per 10,000 population) that is qualified, culturally and linguistically appropriate, and well distributed (adaptation of SDG target 3.c and PAHO Strategic Plan outcome 4.5).⁶⁵
- 3.2 Develop HRH policies and intersectoral coordination and collaboration mechanisms between health and education, as well as other social actors, to address the requirements of the health system and the health needs of the population (PAHO Strategy on Human Resources for Universal Health Access and Universal Health Coverage, document CE160/18 [2017]).
- 3.3 Strengthen the quality of professional health education in collaboration with the education sector, through evaluation systems and the accreditation of training institutions and degree programs⁶⁶ (adaptation of the PAHO Strategy on Human Resources for Universal Access to Health, CE160/18 [2017]).
- 3.4 Develop working conditions that foster the attraction and retention of health personnel, as well as their participation in and commitment to health management, including through collaboration with organizations representing health workers (unions and syndicates) and other social actors (adapted from SDG target 3.c and PAHO Strategic Plan outcome 4.5).

⁶⁴ WHO defines health workers as all those “engaged in action whose primary intent is health” and collates data based on the International Standard Classification of Occupations, excluding some lower-skill cadres (e.g. personal care workers).

⁶⁵ The analysis leading to the 44.5 threshold is available from: <http://www.who.int/hrh/resources/health-observer17/en/>.

⁶⁶ Standards should prioritize technical and scientific knowledge, together with the social competency criteria of graduates, and the development of contextualized learning programs.

Goal 4: Achieve adequate and sustainable health financing with equity and efficiency, and advance toward protection against financial risks for all persons and their families⁶⁷

Scope: This goal aims at increasing and improving health financing with equity and efficiency as a necessary condition to advance toward universal health, addressing the following components in coordination and collaboration with financial authorities:

- financing for universal access to health and universal health coverage;
- increase public expenditure on health and improve quality of the expenditure, as necessary;
- elimination of direct payments that constitute a barrier to access at the point of service;
- protection against financial risks due to health events that cause catastrophic expenditure;
- regulation and oversight of organisms that administer health funds;
- efficient organization of health systems;
- investment in health (infrastructure, equipment, training of personnel), prioritizing the first level of care;
- use of pooling arrangements based on solidarity;
- development of systems of purchase and payment to suppliers which promote efficiency and equity in the allocation of strategic resources.

Targets for 2030:

- 4.1 Achieve a level of public expenditure in health of at least 6% of GDP⁶⁸ (updated PAHO Strategic Plan outcome 4.1).
- 4.2 Reduce out-of-pocket expenditure on health⁶⁹ in collaboration with the financing authorities (PAHO Strategy for Universal Access to Health and Universal Health Coverage, document CD53/5, Rev. 2 [2014]).
- 4.3 Develop and strengthen policies and strategies to reduce the segmentation of health system financing (PAHO Strategy on Universal Health Access and Universal Health Coverage, document CD53/5, Rev. 2).
- 4.4 Implement policies and/or strategies to develop systems of purchase and payment to providers, which promote efficiency and equity in the allocation of strategic resources (PAHO Strategy on Universal Health Access and Universal Health Coverage, document CD53/5, Rev. 2 [2014]).
- 4.5 Develop and strengthen strategies to reduce segmentation and improve the mechanisms for health financing, in collaboration with relevant decision-makers and actors, that promote efficiency and equity in the allocation of resources (PAHO Strategy on Universal Health Access and Universal Health Coverage, document CD53/5, Rev. 2 [2014]).

⁶⁷ This aligns with SDG 3.8 and, in particular, with strategic line 3 of the Strategy for Universal Access to Health and Universal Health Coverage (document CD53/5, Rev. 2 [2014]), which establishes: Increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service.

⁶⁸ Public expenditure on health equivalent to 6% of GDP is a useful benchmark in most cases and is a necessary, though not sufficient, condition to reduce inequities and increase financial protection.

⁶⁹ In the Strategy for Universal Access to Health and Universal Health Coverage (CD53.R14), the PAHO Member States committed to move toward the elimination of **direct payments** at the time services are provided, which becomes an access barrier. **The corresponding regional indicators will be defined in PAHO's strategic plans, based on technical assessments to estimate sustained regional reductions.**

Goal 5: Ensure access to essential medicines and vaccines, and to other priority health technologies, according to available scientific evidence and the national context

Scope: The attainment of this goal requires improving equitable access to priority and quality medicines, vaccines, and other health technologies, according to available scientific evidence, which is important for universal access to health and universal health coverage. The availability of these health technologies and their rational use involve the following considerations:

- timely and affordable access to safe, quality, effective medicines and other health technologies;
- a national essential medicines list and a priority health technologies list;
- a strong national immunization program;
- sustainable mechanisms for public procurement and strengthening of the supply chain for medicines and vaccines;
- promotion of a competitive environment and transparent and efficient practices in the management of medicines, vaccines, and other health technologies, including the optimization of regional and subregional mechanisms and funds;
- innovation, health technology assessment (HTA) and health technology management in accordance with the needs of the population;
- development of innovative medicines in accordance with needs of the population;
- management of intellectual property to promote innovation.

Targets for 2030:

- 5.1 Ensure timely access to medicines on the national essential medicines list, and to priority health technologies, without any payment at the point of care, service, or dispensing of the medicine, according to the national context (revised PAHO Strategic Plan outcome 4.3).
- 5.2 Reach 95% vaccination coverage⁷⁰ in children under 5 years of age, through national vaccination programs (revised PAHO Strategic Plan outcome 1.5).
- 5.3 Have in place a national regulatory authority for medicines rated at level-3 capacity based on the WHO global benchmarking tool.⁷¹ (Adapted from PAHO Strategic Plan outcome 4.3).
- 5.4 Implement health technology assessment methodologies in the decision-making processes for incorporation in health systems⁷² (PAHO Report: Health Technology Assessment and Incorporation into Health Systems, document CSP28/11 [2012]).
- 5.5 Implement the requirements of the international Basic Safety Standards in diagnostic and therapeutic services that use radiation health technologies (Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards, PAHO document CSP28/17, Rev. 1 [2012]).

⁷⁰ Coverage is measured using DPT3 (Diphtheria, pertussis, and tetanus) as a tracer.

⁷¹ “National regulatory authority that is competent and efficient, which shall improve performance of certain health regulation functions recommended by PAHO/WHO in order to guarantee the safety, efficacy, and quality of medicines”: <http://www.who.int/medicines/regulation/rss/en/>.

⁷² The processes for the HTA-based prioritization and incorporation of health technologies contribute to universal access by: improving the quality of health care; evaluation of genuine therapeutic innovations; increased efficiency of expenditures; expanding access to technologies that are effective, safe, cost-effective, and that form part of the right to health; and rational use of technologies. (CSP28/11)

- 5.6 Promote only and exclusively non-remunerated, repeated, voluntary blood donations, and discourage remunerated and family/replacement donations except where protected by the national regulatory system (Plan of Action for Universal Access to Safe Blood, PAHO resolution CD53.R6 [2014]).
- 5.7 Strengthen national, subregional and regional mechanisms for negotiation and purchasing to improve the capacity of countries to obtain more affordable and equitable prices for medicines, vaccines, and other health technologies (Policy on Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies, PAHO document CD55/10, Rev. 1 [2016]).
- 5.8 Taking into account public health perspectives, strengthen the capacity to implement intellectual property policies and health policies that promote research and development of medicines, vaccines and other health technologies for communicable and noncommunicable diseases that primarily affect developing countries and that promote access to affordable medicines, vaccines, and other health technologies (adapted from SDG target 3.b and Policy on Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies, PAHO document CD55/10, Rev. 1 [2016]).

Goal 6: Strengthen information systems for health to support the development of evidence-based policies and decision-making

Scope: This goal aims at improving information systems for health (IS4H),⁷³ which are essential in order to improve health policy and decision-making, as well as to measure and monitor health inequalities in the population, and progress toward the achievement of universal access to health and universal health coverage. Strong and comprehensive IS4H are also essential in order to strengthen the leadership and stewardship role of Ministries of Health. Key elements for these systems include:

- analysis of the level of maturity of the countries' IS4H, as a first step to identify gaps and needs;
- data management and governance;
- information and communication technologies;
- knowledge management for health;
- national capacity-building for human resources and strengthening of infrastructure for data management and analysis;
- information systems for health, including electronic medical records and civil registries, that facilitate interconnectivity and interoperability through data integration processes in a systematic and routine manner.

⁷³ Information Systems for Health (IS4H) is an integrated effort for the convergence of interconnected and interoperable systems, data (including health and vital statistics), information, knowledge, processes, standards, people, and institutions, supported by information, and communication technologies that interact (or help) to generate, identify, collect, process, store, and make free and publicly available, quality data and strategic information for better policy- and decision-making processes in public health systems.

Targets for 2030:

- 6.1 Develop a national policy for interoperable⁷⁴ information systems for health to generate, identify, collect, process, analyze, store, and make quality data and strategic information free and publicly available for better policy- and decision-making in public health and health planning (combined SDG target 17.18 and PAHO Strategy on Information Systems for Health, proposed).⁷⁵
- 6.2 Strengthen information systems for health to support the assessment of the national health system performance, as well as the monitoring and reporting on progress toward achievement of national, regional, and global health objectives, including the health-related SDGs, and SHAA2030 targets, among others.
- 6.3 Strengthen capacity for analysis and the use of information for decision-making at the national and subnational levels (adapted from PAHO Strategic Plan outcome 4.4 and SDG target 17.18).

Goal 7: Develop capacity for the generation, transfer, and use of evidence and knowledge in health, promoting research and innovation, and the use of technology

Scope: This goal aims at strengthening the capacity of countries to conduct relevant and appropriate research on public health matters, and to generate, transfer, and use evidence and knowledge to inform public health policy and resource allocation for health development while promoting research, innovation and the use of technology. This goal also seeks to promote innovation and the use of affordable applications for eHealth, telemedicine, mHealth, and eLearning, which offer opportunities to address health challenges and improve health outcomes. The following are essential components of this goal:

- research governance, including national health research policies, agendas, and systems aimed at addressing the principal health problems faced by the population;
- research, development, and innovation in health to facilitate the development of new health technologies, expanding coverage of existing tools to contribute to economic growth;
- institutional capacities for public health research;
- promotion of the dissemination and translation of knowledge;
- training of human resources for research and innovation in health;
- exchange of knowledge, communities of practice and networks;
- governance for innovation and digital health.

⁷⁴ The term “interoperability” refers to communication between different technologies and software applications for the efficient, accurate, and sound sharing and use of data. This requires the use of standards, i.e., rules, regulations, guidelines, or definitions with technical specification to make the integrated management of health systems viable at all levels. Source: <http://iris.paho.org/xmlui/bitstream/handle/123456789/7663/CD51-13-e.pdf?sequence=1&isAllowed=y>

⁷⁵ PAHO. The Caribbean Information System for Health Project: Advancing Public Health in the Caribbean Region. Washington, D. C. November 22, 2016.

Targets for 2030:

- 7.1 Develop health research policies that lead to funding of at least 2% of the health budget for public health research⁷⁶ (adapted from the PAHO Policy on Research for Health, document CD49/10 [2009]).
- 7.2 Develop institutional capacities, infrastructure, technology, and qualified human resources for public health research and its dissemination, in accordance with national health policy (adapted from the PAHO Policy on Research for Health, document CD49/10 [2009]).
- 7.3 Develop and strengthen strategies and plans on digital health (eHealth) (PAHO Strategy and plan of action of eHealth, document CD51/13 [2011]).

Goal 8: Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks and emergencies and disasters that affect the health of the population

Scope: This goal aims to reduce mortality, morbidity, and societal disruption resulting from emergencies and disasters through the prevention, detection, management, and mitigation of high-threat pathogens, together with all-hazards risk reduction, preparedness, response, and early recovery. The health sector should have adequate, nationally led, sustained capacity to ensure sufficient resilience to protect the physical, mental, and social well-being of their communities and rapidly recover from all outbreaks, emergencies, and disasters. The following components are key for this goal:

- building and strengthening resilience of health systems and services and application of a multisectoral approach to contribute to health security and cope with emergencies and climate change;
- monitoring, assessment, and strengthening of core capacities to comply with the International Health Regulations (IHR);
- prevention, alert, and control strategies for high-threat infectious hazards;
- national, subregional, and regional capacity to respond to disasters and emergencies caused by any hazard;
- emergency preparedness and disaster risk management, including training and raising of awareness of the population on risk reduction;
- health sector strengthening in countries in situations of high vulnerability to emergencies and disasters, including human resources, safe health facilities and national preparedness plans;
- timely and appropriate response to health emergencies.

⁷⁶ Expert recommendation based on observation of how much countries invest in developing sustainable capacities to produce and use health research. This recommendation has been supported technically and politically since 1990 and is reflected in the PAHO Policy on Research for Health and WHO Resolution WHA60.15. The Policy indicates that the Bureau will “foster an appreciation, at the political level, of the value of research in accelerating health improvements and development, and seek political commitment to national health research aiming for the allocation of at least 2% of the budgets of ministries of health to research and research capacity strengthening, in order to reach funding levels proposed in WHA resolutions, expert committees, ministerial forums and strategic plans.” (PAHO Policy on Research for Health, document CD49/10)

Targets for 2030:

- 8.1 Reduce the number of cases of death, disability, and illness, with emphasis on protection of the poor and vulnerable populations affected by emergencies and disasters (combination of the SDG target 11.5 and PAHO Strategic Plan impact goal 9).
- 8.2 Bolster essential public health functions in order to strengthen resilience and adaptability to climate and other hazards in the health sector (SDG target 13.1).
- 8.3 Meet and sustain the critical capacities for health emergencies, including the IHR core capacities (revised PAHO Strategic Plan outcome 5.2).⁷⁷
- 8.4 Have critical capacity in place to respond to any type of emergency or disaster (early warning systems, emergency operation centers, risk communication, and safe hospitals) (revised PAHO Strategic Plan outcome 5.2).

Goal 9: Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders

Scope: This goal aims to reduce the burden of noncommunicable diseases, including cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, and mental health disorders, as well as disability, violence, and injuries. This can be achieved through health promotion and risk reduction, and the prevention, treatment, and monitoring of noncommunicable diseases and their risk factors with emphasis on the following:

- cardiovascular diseases, cancer, diabetes, chronic obstructive pulmonary disease, and chronic kidney disease;
- tobacco consumption, alcohol abuse, unhealthy diet, salt consumption, physical inactivity, and obesity;
- disabilities and rehabilitation;
- injuries caused by traffic accidents;
- violence, with emphasis on violence against girls, women, and older persons;
- mental health disorders and the use of psychoactive substances;
- suicide;
- malnutrition;
- promotion of health and well-being throughout the life course to prevent diseases and reduce mortality, disability, and morbidity;
- illness and deaths caused by environmental exposures, particularly exposure to air pollution.

Targets for 2030:

- 9.1 Reduce premature mortality from noncommunicable diseases⁷⁸ by one-third through prevention and treatment, and promote mental health and well-being (SDG target 3.4).
- 9.2 Apply the WHO Framework Convention on Tobacco Control (FCTC) according to the national context (adapted from SDG target 3.a).

⁷⁷ Includes the results derived from the WHO emergency reform and its application in PAHO.

⁷⁸ Mainly for cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.

- 9.3 Ensure access to comprehensive habilitation/rehabilitation services, including access to assistive technologies and support services for all those in need, and promote implementation of the community-based rehabilitation strategy,⁷⁹ among others (adapted from the PAHO Plan of Action on Disability and Rehabilitation, document CD53/7, Rev. 1 [2014]).
- 9.4 Contribute to the significant reduction of violence and its impact on health, in collaboration with other government and nongovernmental actors (adapted from SDG targets 16.1, 3.6 and 5.2).
- 9.5 Reduce by half the number of deaths and injuries caused by road traffic accidents (adapted from SDG target 3.6).
- 9.6 Increase universal access to mental health services, including the promotion of emotional well-being and its favorable conditions, prevention of psychosocial problems and mental disorders, and mental recovery in all stages of life, with a gender, intercultural, and community approach, through the integration of mental health care into primary care (adapted from the PAHO Plan of Action on Mental Health, document CD53/8, Rev. 1 [2014]).
- 9.7 Contribute to ending all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and addressing the nutritional needs of adolescent girls, pregnant and lactating women, and older persons (adapted from SDG target 2.2).

Goal 10: Reduce the burden of communicable diseases and eliminate neglected diseases

Scope: This goal aims to reduce mortality, morbidity, and stigma associated with some of the world's most devastating communicable and neglected diseases that exacerbate poor health, poverty, and inequities in the Americas. In the context of universal health access and universal health coverage, effective interventions to prevent, control, treat, and eliminate these diseases, such as education, water and sanitation, and labor, extend beyond the health sector and strive to reach populations in conditions of vulnerability to address the underlying social determinants of health. Emphasis will be on the following:

- HIV/AIDS and sexually transmitted infections;
- viral hepatitis;
- tuberculosis;
- vector-borne diseases (malaria, dengue, Zika, chikungunya, yellow fever, and Chagas disease);
- neglected, tropical and zoonotic diseases;
- vaccine-preventable diseases;
- antimicrobial resistance surveillance;
- food safety risks (biological and chemical risks).

⁷⁹ The CBR strategy offers a conceptual and operational model for coordinating the specialized resources of the various care levels and the organized community. It also facilitates ties and strengthens the main services, along with access to specific interventions. (CD53/7, Rev.1)

Targets for 2030:

- 10.1 End the AIDS epidemic (SDG target 3.3).⁸⁰
- 10.2 End the tuberculosis epidemic (adapted from SDG target 3.3).
- 10.3 Eliminate mother-to-child transmission of HIV and congenital syphilis (PAHO Strategic Plan impact goal 8.1).
- 10.4 Combat waterborne diseases and other communicable diseases (adapted from SDG target 3.3).
- 10.5 Halt the transmission of viral hepatitis and accelerate the reduction of chronic infections and deaths from hepatitis to eliminate viral hepatitis as a major public health threat in the Region of the Americas (adapted from the WHO Global Health Sector Strategy on Viral Hepatitis 2016-2021, document A69/32 [2016]).
- 10.6 Eliminate local malaria transmission between Member States and prevent possible reestablishment of the disease (adapted from the PAHO Plan of Action for Malaria Elimination 2016-2020, document CD55/13 [2016]).⁸¹
- 10.7 Eliminate neglected infectious diseases⁸² as public health problems (adapted from the PAHO Plan of Action for the Elimination of Neglected Infectious Diseases and Post-Elimination Actions 2016-2022, document CD55/15 [2016]).
- 10.8 Treat and prevent infectious diseases, including the responsible and rational use of safe, effective, accessible, and affordable quality-assured drugs (adapted from the PAHO Plan of Action on Antimicrobial Resistance, document 54/12, Rev. 1 [2015]).
- 10.9 Mitigate food safety risks (outcome 1.7 of the PAHO Strategic Plan).
- 10.10 Control the transmission of dengue, chikungunya, Zika, and yellow fever with an integrated and intersectoral approach (Strategy for the Control of Arboviral Diseases, CD55/16 [2016] and WHO report on global vector control response, document A70/26/Rev. 1 [2017]).

⁸⁰ The indicators for this target will be defined in the PAHO Strategic Plan and will include measurement of the reduction in new HIV infections, in accordance with SDG indicator 3.3.1.

⁸¹ The elimination of malaria is feasible in the endemic countries of the Americas and in the long term is possible as a regional goal. In the last 15 years, the transmission of malaria has been dramatically reduced in several countries of the Region. In 2016, Argentina and Paraguay, respectively, completed 6 and 5 years without reports of autochthonous cases, and Costa Rica, El Salvador, and Belize, respectively, reported 4, 13, and 4 autochthonous cases. In South America, Suriname has had a major impact in controlling transmission, with 64 autochthonous cases in 2016, after having reported 16,003 cases in 2001. The drastic reduction in the number of cases in these countries is the main evidence in favor of the feasibility of eliminating malaria from the Americas in transmission conditions with the use of currently available interventions. In terms of sustainability, the countries of the Region and PAHO also have the support and commitment of multiple strategic partners in the implementation of interventions to eliminate transmission of malaria and avoid possible reestablishment.

⁸² Mainly leishmaniasis, leprosy, lymphatic filariasis, onchocerciasis, trachoma, and schistosomiasis.

Goal 11: Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health

Scope: This goal is important for addressing the persistent inequities in health in the Region. Consistent with the principles of this Agenda and the 2030 Agenda for Sustainable Development of leaving no one behind, this goal considers multisectoral strategies for reducing inequities in health by promoting health and well-being through actions on the social and environmental determinants of health, including social protection, to address gender, ethnic, and human rights issues. The following are essential in this regard:

- strengthening the capacity of countries to measure, monitor, and systematically analyze health inequalities;
- implementing the Health in All Policies strategy for intersectoral action to address the social and environmental determinants of health;
- promoting healthy environments and access to health services equitably to improve health and well-being and to reduce preventable deaths and the burden of diseases throughout the life course, while preventing any disproportionate impacts on public health among disadvantaged populations or communities, including displaced populations, refugees, and migrants.⁸³

Targets for 2030:

- 11.1 Demonstrate a marked reduction health inequity gaps as measured by any of the following equity stratifiers: place of residence (rural/urban), race , ethnicity, occupation, gender, sex, age, education, and socioeconomic status using simple inequality measures (absolute and relative gap) (WHO Handbook on Health Inequality Monitoring).
- 11.2 Reduce substantially the number of deaths and diseases caused by hazardous chemicals and by pollution and air, water, and soil pollution, especially where environmental risk may be disproportionately impacting disadvantaged populations or communities (adapted from SDG target 3.9).
- 11.3 Reduce significantly inequities related to water quality and sanitation by moving forward with the responsible sectors on access to water and sanitation services and the safe management thereof (SDG targets 6.1 and 6.2).
- 11.4 Generate policies that incorporate the safe and healthy mobility and migration of people (SDG target 10.7 and PAHO Policy on Health of Migrants, document CD55/R13 [2016]).
- 11.5 Promote healthy, safe, and risk-free working environments for workers, including migrant workers and persons in precarious employment, (adapted from PAHO Strategic Plan outcome 3.5 and Plan of Action of Workers' Health, document CD54/10, Rev. 1 [2015]).

⁸³ PAHO. Health of Migrants. (Document CD55/11, Rev. 1 [2016])

VI. IMPLEMENTATION, MONITORING, ASSESSMENT, AND REPORTING

108. In keeping with the goals and targets stated above, the Member States should implement this Agenda in accordance with its established mechanisms and, together with the Pan American Sanitary Bureau, they should present reports. The implementation should be realized through collaborative efforts among countries, the Pan American Sanitary Bureau and other strategic actors and partners at the national, subregional, and regional levels.

Implementation

109. SHAA2030 will have PAHO Strategic Plans and country cooperation strategies as well as subregional and national plans developed by Member States, as the principal means for its implementation, monitoring, and evaluation. At the same time, multiple actors in health must be engaged in order to achieve the goals and targets established here. Table 4 shows the main actors and partners at the different levels.

Table 4. Main strategic actors and partners, by level

Level	Strategic actors and partners
National	<ul style="list-style-type: none"> • Ministry/Secretariat of Health • National SDG coordination mechanisms • Executive, legislative, and judicial bodies • Government sectors (education, finance, foreign affairs, environment, agriculture and livestock, work/labor, and others) • Municipal or local governments • PAHO/WHO • UN agencies • National and international civil society organizations • International cooperation agencies • Academic and scientific sectors • Private sector
Subregional	<ul style="list-style-type: none"> • Subregional integration mechanisms and, where applicable, their health-focused bodies • Subregional mechanisms from other related sectors • PAHO/WHO subregional offices
Regional	<ul style="list-style-type: none"> • Epidemiology, statistics, planning, international health relations networks, and others • PAHO/WHO • United Nations Development Group for Latin America and the Caribbean (UNDG LAC) • PAHO/WHO Collaborating Centers • Economic Commission for Latin America and the Caribbean (ECLAC) • Organization of American States (OAS)

Level	Strategic actors and partners
	<ul style="list-style-type: none"> • World Bank, Latin America and the Caribbean Region • Inter-American Development Bank (IDB) and other development banks • Other international agencies

110. The implementation of SHAA2030 at the country and subregional levels requires the political commitment of health authorities in the Member States and subregional integration mechanisms, which should be reflected in their national and subregional plans, and the Bureau's support through adjustments to country cooperation strategies and subregional plans. Furthermore, major national and international partners working for health development should consider the goals and targets set forth in this Agenda when developing their own strategic and operational plans.

111. The countries in the Region of the Americas concur on the adoption of several key **strategic approaches** for implementing this agenda, as follows:

- a) **National accountability for results.** The Ministries and Secretariats of Health are expected to promote and lead the process for establishing national goals and targets that contribute to the collective regional achievement of the Agenda. The Ministries and Secretariats also are expected to take measures to raise the profile of the health priorities established in this Agenda and in their national health plans, and to promote action jointly with the executive, legislative and judiciary bodies.
- b) **Advocacy and coordination of multisectoral actions.** The Ministers and Secretaries of Health of the Americas recognize that achieving the goals of this Agenda, as well as the SDGs, will require concerted intersectoral action far beyond the health sector. Therefore, they plan to work with all sectors relevant to social development at both national and international levels. This advocacy role includes not only addressing the determinants of health, but also demonstrating to other sectors the advantages that health development brings to them, not least through increased economic productivity and reduced expenditure on treatment, with a Health in All Policies approach.
- c) **National interagency coordination and cooperation.** The situation varies greatly across the countries of the Americas, but those that receive significant international support have coordination mechanisms in place that bring together all international agencies working in development, including cooperation on health. It is critical for national authorities to take the lead with these mechanisms.
- d) **South-south cooperation for health development.** All countries in the Americas have knowledge and expertise that are important to share and benefit all countries. With the support of the Pan American Sanitary Bureau, health authorities in the Region will capitalize on this opportunity as they seek innovative ways to improve the health of their populations.

- e) **Regional interagency coordination.** PAHO will actively coordinate with the Forum of the Countries of Latin America and the Caribbean on Sustainable Development,⁸⁴ the regional mechanism for monitoring implementation of the 2030 Agenda for Sustainable Development, including the SDGs and their means of implementation, and the Addis Ababa Action Agenda on financing for development, by contributing regional health information relevant to monitoring and evaluating the 2030 Agenda.
- f) **Strategic communication.** To facilitate the adoption and implementation of this Agenda, and based on the findings of the final evaluation of the Agenda 2008-2017, PASB, in coordination with the health authorities of the Region, according to national context, will promote and build awareness about SHAA2030, its commitments, and how the achievement of the goals in this Agenda by the Region will contribute to the 2030 Agenda for Sustainable Development. PASB, jointly with the Ministries and Secretariats of Health and other strategic partners, will develop a communications strategy and plan to disseminate information about the goals and targets of the Agenda at the policy, strategic, and technical levels. The strategy and plan should take into account experiences and lessons learned from health promotion and should be closely articulated with other national efforts to implement the 2030 Agenda for Sustainable Development. It is essential to document progress at each step and communicate the essential role and specific benefits of the 2030 Agenda for achieving the highest attainable standard of health and well-being for all people of the Americas. PAHO should actively promote the 2030 Agenda to raise awareness among the entities in the Region that are working on the commitments and monitoring the goals and targets presented here. The communication strategy for the SHAA2030 should outline what should be done by the countries and PASB, summarized below:
- i. Countries: The process of communication and awareness carried out by the countries is of great importance given that the implementation of the SHAA2030 depends on the leadership of the Ministries and Secretariats of Health, and on the commitment and active participation of various actors. In this regard, the Ministry/Secretariat of Health, as the national health authority, should identify different opportunities that exist within the country (Councils, Commissions, intersectoral forums) to raise awareness about the agenda. In addition, it is necessary to create other spaces such as seminars, workshops, and others, where the key social actors for the scope of agenda are convened. It is also important that the Ministries/Secretariats of Health take advantage of the subregional forums (of Ministers of Health and the health sector, among others) to share and raise awareness on the importance of the agenda and their role in its dissemination and implementation. This

⁸⁴ Economic Commission for Latin America and the Caribbean: Thirty-sixth session of ECLAC, 2016. <http://periododesesiones.cepal.org/36/en/news/authorities-establish-forum-countries-latin-america-and-caribbean-sustainable-development>.

component should be developed by the first half of 2018 so that countries can have the necessary guidance and tools.

- ii. PASB: The Bureau has a very important role in positioning the SHAA2030 and raising awareness about it. First, within PASB itself, all staff members should be informed and committed to its implementation. There should be a process of awareness-raising and ongoing communication with the country representatives to ensure that the representative offices adopt the Agenda and define jointly with the countries the mechanisms for its implementation, including the technical cooperation needed by each country to implement it. As a member of the United Nations system, PAHO should ensure that all relevant UN agencies are aware of and committed to supporting the successful achievement of the goals and targets set out in the SHAA2030. PAHO should also identify other spaces and forums of key players who can support the implementation of the Agenda. Furthermore, PASB will, by various means, provide implementation mechanisms (i.e. strategic plan, a monitoring and assessment system) to accompany the implementation of the Agenda with Member States and other key players. These actions should be carried out in parallel with communication and awareness-raising on the part of the Member States.

Monitoring, Assessment, and Reporting

112. Commitment by the Member States, PASB, and partners is fundamental to the accountability for implementation of this Agenda. This requires the utilization of established reporting mechanisms and the strengthening of joint monitoring and assessment mechanisms related to the PAHO Strategic Plan and other PAHO strategies and plans of action.

113. The goals and targets defined in SHAA2030 should become integral parts of health planning at the regional, subregional, and country levels and should guide the establishment of specific indicators that serve as benchmarks for monitoring and assessing progress toward achieving the goals of the Agenda.

114. For PAHO, the targets should guide the development of indicators in the strategic plans of the Organization for 2020-2025 and 2026-2031, in the regional strategies and plans of action, and should be considered in country cooperation strategies developed between 2018 and 2030.

115. At the regional level, there should be coordinated monitoring, assessment, and reporting of the SHAA2030 targets via the established mechanisms and through the assessment reports of the PAHO strategic plans and programs and budgets. In addition, monitoring, assessment, and reporting should be linked to the periodic review and analysis conducted as part of the Health in the Americas process, and to the global SDG monitoring requirements.

116. Collaboration should be strengthened with agencies of the United Nations and Inter-American systems, particularly the Inter-Agency and Expert Group on SDG indicators and ECLAC, to optimize the use of existing platforms for monitoring SDG 3 and other health-related targets (see Annex A).

117. The monitoring and assessment of SHAA2030 should be harmonized with existing monitoring and reporting mechanisms. Efforts will be made to strengthen and integrate information systems to facilitate measurement and monitoring of the SHAA2030 targets along with other health indicators.

118. Similarly, at the subregional and country levels, it is expected that subregional entities and Member States adopt and adapt the SHAA2030 goals and targets for implementation, monitoring, assessment, and reporting. Efforts will be made to enable national information systems to assess and report with respect to the goals set in the Agenda. PASB will provide the necessary support to Member States, if requested.

119. A midterm assessment should be conducted in 2025 to assess progress in the adoption and implementation of SHAA2030 across all levels, to document lessons learned, and to inform corrective actions where necessary. Finally, in 2031 there should be a final evaluation of SHAA2030 in conjunction with the global efforts to review the achievements made toward the commitments in the 2030 Agenda for Sustainable Development.

120. To the extent possible, based on existing reporting mechanisms, the Bureau should monitor and assess the implementation of SHAA2030 through PAHO statutory reports to Governing Bodies, incorporating a gender-sensitive analysis of lessons learned and best practices.

Annexes

Annex A - SDG 3 Targets and Indicators

Source: Report of the Inter-Agency and Expert Group on Indicators of the Sustainable Development Goals (SDGs) – United Nations Economic and Social Council¹

Goal 3. Ensure healthy lives and promote well-being for all at all ages

TARGET	INDICATOR
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio 3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-five mortality rate 3.2.2 Neonatal mortality rate
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations 3.3.2 Tuberculosis incidence per 100,000 population 3.3.3 Malaria incidence per 1,000 population 3.3.4 Hepatitis B incidence per 100,000 population 3.3.5 Number of people requiring interventions against neglected tropical diseases
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular diseases, cancer, diabetes or chronic respiratory disease 3.4.2 Suicide mortality rate
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries

¹ Report of the Inter-agency and Expert Group on Sustainable Development Goal Indicators: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N16/441/96/PDF/N1644196.pdf?OpenElement>

TARGET	INDICATOR
<p>3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes</p>	<p>3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods</p> <p>3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group</p>
<p>3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all</p>	<p>3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)</p> <p>3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income</p>
<p>3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</p>	<p>3.9.1 Mortality rate attributed to household and ambient air pollution</p> <p>3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)</p>
<p>3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate</p>	<p>3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older</p>
<p>3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all</p>	<p>3.b.1 Proportion of the target population covered by all vaccines included in their national programme</p> <p>3.b.2 Total net official development assistance to medical research and basic health sectors</p> <p>3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis</p>

TARGET	INDICATOR
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1 Health worker density and distribution
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture²

TARGET	INDICATOR
2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	<p>2.2.1 Prevalence of stunting (height for age < -2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age</p> <p>2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)</p>

Goal 5. Achieve gender equality and empower all women and girls³

TARGET	INDICATOR
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	<p>5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age</p> <p>5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence</p>

² Ibid, p. 16

³ Ibid, p. 21

Goal 6. Ensure availability and sustainable management of water and sanitation for all⁴

TARGET	INDICATOR
6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all	6.1.1 Proportion of population using safely managed drinking water services
6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water

Goal 10. Reduce inequality within and among countries⁵

TARGET	INDICATOR
10.7 Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies	10.7.1 Recruitment cost borne by employee as a proportion of yearly income earned in country of destination 10.7.2 Number of countries that have implemented well-managed migration policies

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable⁶

TARGET	INDICATOR
11.5 By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations	11.5.1 Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population

Goal 13. Take urgent action to combat climate change and its impacts⁷

TARGET	INDICATOR
13.1 Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries	13.1.1 Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population

⁴ Ibid, p. 22⁵ Ibid, p. 26⁶ Ibid, p. 27⁷ Ibid, p. 30

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels⁸

TARGET	INDICATOR
<p>16.1 Significantly reduce all forms of violence and related death rates everywhere</p>	<p>16.1.1 Number of victims of intentional homicide per 100,000 population, by sex and age</p> <p>16.1.2 Conflict-related deaths per 100,000 population, by sex, age and cause</p> <p>16.1.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months</p> <p>16.1.4 Proportion of population that feel safe walking alone around the area they live</p>

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development⁹

TARGET	INDICATOR
<p>17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts</p>	<p>17.18.1 Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics</p> <p>17.18.2 Number of countries that have national statistical legislation that complies with the Fundamental Principles of Official Statistics</p>

⁸ Ibid, p. 34

⁹ Ibid, p. 36

Annex B – Leading causes of death in the Region in the period 2010-2013, by sex¹

Women			
Causes (ICD-10)	Deaths	Age-adjusted rate per 100,000 population	Percentage of total deaths
Ischemic heart diseases (I20-I25)	1,223,202	66.2	13.2
Cerebrovascular diseases (I60-I69)	766,684	41.5	8.3
Dementia and Alzheimer's disease (F01, F03, G30)	692,653	37.5	7.5
Diabetes mellitus (E10-E14)	570,892	30.9	6.2
Chronic lower respiratory diseases (J40-J47)	498,929	27.0	5.4
Influenza and pneumonia (J10-J18)	410,659	22.2	4.4
Malignant neoplasm of trachea, bronchi, and lungs (C33, C34)	396,957	21.5	4.3
Hypertensive diseases (I10-I15)	377,043	20.4	4.1
Malignant neoplasm of breast (C50)	317,456	17.2	3.4
Diseases of the genitourinary system (N00-N39)	270,689	14.6	2.9

Men			
Causes (ICD-10)	Deaths	Age-adjusted rate per 100,000 population	Percentage of total deaths
Ischemic heart diseases (I20-I25)	1,569,496	86.8	14.8
Cerebrovascular diseases (I60-I69)	657,078	36.3	6.2
Malignant neoplasm of trachea, bronchi, and lungs (C33, C34)	561,399	31.0	5.3
Diabetes mellitus (E10-E14)	527,193	29.1	5
Chronic lower respiratory diseases (J40-J47)	514,132	28.4	4.9
Assault (homicides) (X85-Y09)	485,817	26.9	4.6
Land transport accidents (V01-V89)	404,929	22.4	3.8
Influenza and pneumonia (J10-J18)	403,516	22.3	3.8
Cirrhosis and other diseases of the liver (K70-K76)	377,185	20.9	3.6
Dementia and Alzheimer's disease (F01, F03, G30)	324,964	18.0	3.1

¹ Adjusted by age and based on the categories in the WHO standardized list for international comparisons of the leading causes of death, from WHO: Becker R, Silvi J, Fat D, L'Hours A, Laurenti R: A method for deriving leading causes of death; Bull of the WHO 2006; 84: 297-304.

Annex C – Acknowledgments

The following members of the Countries Working Group and the Pan American Sanitary Bureau are recognized for their contributions to preparation of the Agenda.

Country	Participants/Contributors
Antigua and Barbuda	Rhonda Sealy-Thomas Chief Medical Officer, Ministry of Health
Argentina	Rubén Nieto Secretary, National and International Relations, Ministry of Health Miguela Pico Undersecretary for Institutional Relations, Ministry of Health National Directorate of International Health Relations, Ministry of Health
Barbados	John Boyce Minister of Health Joy St. John Chief Medical Officer Reeshemah Cheltenham-Niles Chief Health Planner Danny Gill Director, Projects Unit, Ministry of Health
Brazil	Fátima Marinho Director of Epidemiology, Ministry of Health Diogo Alves Advisor, International Relations, Ministry of Health
Chile	Matilde Maddaleno Director, International Health Relations Odette Urrutia Planner, Department of National Health Strategy, National Health Planning Division
Costa Rica	Rosibel Vargas Gamboa Director, Planning and Institutional Development, Ministry of Health
Ecuador	Verónica Espinosa Minister of Public Health Jakeline Calle National undersecretary for Public Health Governance Peter Skerrett Director, National and International Cooperation in Health

	<p>Cristina Luna Ministerial Advisor</p> <p>Angela Cáceres Cooperation and Multilateral International Relations Coordinator</p> <p>Fernando Cornejo Former Vice Minister of Governance, Ministry of Public Health</p>
El Salvador	<p>Marina Estela Avalos López Director of Planning, Ministry of Health</p>
Honduras	<p>Janethe Aguilar Director, Planning and Management Evaluation, Secretariat of Health</p> <p>Fanny Mejía Vice Minister of Projects and Investments, Secretariat of Health</p>
Mexico	<p>Luis Adrián Ortiz Blas Assistant Director, Policy and International Cooperation , Secretariat of Health</p> <p>Martha Caballero Director, Bilateral and Regional Cooperation, General Office for International Affairs, Secretariat of Health</p>
Nicaragua	<p>Alejandro Solís Martínez Director of Planning, Ministry of Health</p> <p>Carlos José Sáenz Torres General Secretary, Ministry of Health</p>
Panama	<p>Miguel Antonio Mayo Di Bello Minister of Health</p> <p>Reina Roa Director of Planning, Ministry of Health</p> <p>Natasha Dormoi Director of International Relations, Ministry of Health</p> <p>Iritzel Santamaría Deputy Director of Planning, Ministry of Health</p>
Paraguay	<p>María Antonieta Gamarra Mir Director, International Health Relations</p> <p>Patricia A. Giménez León Director General, Planning and Evaluation, Ministry of Health</p>
Peru	<p>Sofía del Pilar Velásquez Portocarrero Adviser, Office of the Vice Minister of Public Health</p>

<p>United States of America</p>	<p>Cristina Rabadan-Diehl Director of the Office of the Americas Office of Global Affairs, U.S. Department of Health and Human Services</p> <p>Maya Levine Senior Global Health Officer, Office of Global Affairs, U.S. Department of Health and Human Services</p> <p>Allison O’Donnell Global Health Officer, Office of Global Affairs, U.S. Department of Health and Human Services</p>
<p>Uruguay</p>	<p>Gilberto Ríos Director, International Health Relations</p>
<p>Pan American Sanitary Bureau</p>	<p>Carissa F. Etienne, Director</p> <p>Dean Chambliss, Rony Maza, Victor Cuba, and Travis High, Department of Planning and Budget</p> <p>Gina Tambini and Patricia Alvarado, PAHO/WHO Office in Ecuador</p> <p>Godfrey Xuereb, PAHO/WHO Office in Barbados</p> <p>Gerardo Alfaro and Hilda Leal, PAHO/WHO Office in Panama</p> <p>Gerardo De Cosio, Jose Escamilla, and Antonio Sanhueza, Health Information and Analysis Unit</p> <p>Kira Fortune, Agnes Soares, Julietta Rodríguez and Daniel Buss, Special Program on Sustainable Development and Equity</p> <p>James Fitzgerald, Amalia Del Riego, Fernando Menezes, Analia Porras, Camilo Cid, Juan Pablo Pagano and Candelaria Aráoz, Department of Health Systems and Services</p> <p>Luis Andrés De Francisco, Suzanne Serruya, Pablo Guirotane, Betzabe Burtrón, Cuauhtémoc Ruiz, and Anna Coates, Department of Family, Gender and Life Course</p> <p>Anselm Hennis and Raphaele Dambo, Department of Noncommunicable Diseases and Mental Health</p> <p>Marcos Espinal, Luis Gerardo Castellanos, and Massimo Ghidinelli, Department of Communicable Diseases and Health Analysis</p> <p>Ciro Ugarte, Sylvain Aldighieri, Roberta Andraghetti, and Nicole Wynter, Department of Health Emergencies</p>

	<p>Francisco Becerra, Luis Gabriel Cuervo, and David Novillo, Office of Knowledge Management, Bioethics, and Research</p> <p>Teófilo Monteiro, Decentralized Regional Team on Water and Sanitation (ETRAS)</p> <p>Kevin Cook, Donna Eberwine, Leticia Linn, Bola Oyeleye, and Harold Ruiz Perez, Department of Communications</p> <p>Gabriel Listovsky, Coordinator, PAHO Virtual Campus for Public Health</p> <p>All PAHO country office, subregional, and regional teams who supported the development of the Agenda since its inception in 2016.</p>
<p>Also, the teams from the various Ministries and Secretariats of Health who provided their invaluable support in the development of this Agenda.</p>	

- - -