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PRELIMINARY VERSION OF THE FINAL EVALUATION OF THE HEALTH AGENDA FOR THE AMERICAS 2008-2017

Final report

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I. EXECUTIVE SUMMARY

1. The purpose of this report is to document and describe the process, results, and conclusions of the final evaluation of the Health Agenda for the Americas 2008-2017 (hereinafter, "HAA2008-2017" or "the Agenda"). The final evaluation of HAA2008-2017 employed the model used in the mid-term evaluation carried out in 2012 and reviewed the progress made by the countries and the Pan American Sanitary Bureau (hereinafter "PASB") in implementing the Agenda's eight areas of action through three components: *a)* use of the Agenda by the countries; *b)* progress in its eight areas of action, measured through proxy indicators; and *c)* evaluation of the Bureau's contribution to the implementation of the Agenda. Following the guidance from Member States, existing information was used to report on the evaluation of the indicators.

2. HAA2008-2017, promoted by the ministers and secretaries of health, inspired and created an opportunity for independent action that complemented the functions of the Governing Bodies of the Pan American Health Organization (PAHO) and PASB, strengthening their capacities in the formulation of the Organization's policies and strategic plans. It likewise promoted and boosted the Member States' participation in the formulation of PAHO policies, strategies, and plans at all levels (regional, subregional, and country), pursuant to the purpose of the Agenda and the recommendations of the mid-term evaluation.

3. The results also reveal significant progress and important targets achieved by the countries across the Agenda's areas of action, in reference to indicators linked with the following aspects: *a)* reduction of maternal, neonatal, infant, and under-5 mortality; *b)* reduction of mortality from ischemic heart and cerebrovascular diseases; *c)* existence of programs for health promotion, care for adolescents and older persons, and violence prevention; and *d)* drafting of policies and legislation on social protection and health coverage. However, the results also reveal the following negative developments: *a)* an increase in mortality from diabetes and road traffic injuries; *b)* an increase in overweight among adults; *c)* an increase in the number of dengue cases; *d*) an increase in infections with the human immunodeficiency virus (HIV); and *e)* stagnation in public health financing.

4. Concerning use of the Agenda, the results of the final evaluation show that it has lost visibility as a reference for planning in the countries in recent years. This may be due to the time that has passed since its approval in 2007 and the growing importance of other frameworks, such as the United Nations Sustainable Development Goals (SDGs), the World Health Organization's (WHO) General Programmes of Work, and the PAHO Strategic Plans. Nevertheless, the evaluation shows that the Agenda served as a regional policy instrument that contributed a health policy vision for the Region and reaffirmed the countries' commitment to people's health.

5. During the formulation, implementation, and evaluation of the Agenda, important lessons have been learned related to the development of a shared vision for the Region, the search for equity in policies, and the countries' participation and leadership in the

formulation and evaluation of the Organization's policies and strategies. It should be pointed out that the lessons from the formulation, implementation, and evaluation of HAA2008-2017 were applied in the preparation of the new Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030), whose execution will be guided by the results of this evaluation.

II. INTRODUCTION

6. The purpose of this report is to document and describe the process, results, and conclusions of the final evaluation of the Health Agenda for the Americas 2008-2017 ("HAA2008-2017" or "the Agenda"). This report also provides an evaluation of the Agenda as a whole that underscores its importance as a regional guide for development in terms of the eight areas of action in the countries and for the Pan American Sanitary Bureau (PASB), highlighting the key role of the stakeholders, practices that have been adopted, and lessons learned. It should be noted that a preliminary report on the final evaluation of this Agenda was included in the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030), approved by the 29th Pan American Sanitary Conference. It indicated that the final report would be submitted to the Governing Bodies of the Pan American Health Organization (PAHO) in 2018.

7. Concerning its scope, the final evaluation covered the 35 Member States, 16 territories, and PASB. Given the time that has passed (10 years) since publication of the Agenda, the regional and global changes that occurred in the period, and the turnover in management teams of subregional and international organizations in the health sector, it was considered inappropriate to assess the Agenda's influence on the subregions and international organizations, as was done in the mid-term evaluation.

8. The HAA2008-2017 did not establish goals, targets, or indicators for direct assessment of impacts and outcomes. The Agenda's statement of intent explicitly says: "The Agenda will guide the preparation of future national health plans, as appropriate, and the strategic plans of all organizations interested in cooperating for health with the countries of the Americas, including that of the Pan American Sanitary Bureau. Assessment of progress in the areas of action outlined in this Agenda will be done by evaluating the achievement of goals set in these plans."

9. The final evaluation of the HAA2008-2017 follows the model used in the mid-term evaluation, with a general assessment of progress by countries and the Bureau in the areas of action outlined. It also follows the recommendations issued in the Agenda's mid-term evaluation report.

III. BACKGROUND

10. **October 2007.** HAA2008-2017 was "the result of 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 its Member States, formulated independently of the secretariat and of the organization's governing bodies."[1] The Agenda also addressed the mandates of the Millennium Development Goals (MDGs) and the World Health Organization's Eleventh General Programme of Work, approved in 2006, proposing eight areas of action.[2] HAA2008-2017 was presented in Panama City in June 2007 and recognized as the highest-level health planning instrument in the Region of the Americas and as a guide for the preparation of national health plans and the strategic plans of international agencies cooperating in health in the Region. The final report of the 27th Pan American Sanitary Conference (Document CSP27/FR) of October 2007 informed the Member States of its roll-out.

11. **September-October 2008.** The PAHO Strategic Plan 2008-2012 (Official Document 328), approved by the 48th Directing Council of PAHO (2008), was developed taking into account the areas of action outlined in the HAA2008-2017. The Plan "defines the Bureau's contribution to the countries' call for action in the Health Agenda," as stated in the document itself. The Strategic Plan contained 16 regional strategic objectives that were explicitly harmonized with the Agenda's eight areas of action.[3]

12. **September 2012.** The Mid-term Evaluation of the Health Agenda for the Americas (Document CSP28/6), presented to the 28th Pan American Sanitary Conference in September 2012, was a preliminary report describing the outcomes associated with use of the Agenda in the countries, subregions, and international organizations (component A), country progress with respect to the Agenda's eight areas of action (component B), and PASB's contribution to its implementation (component C). It offered specific recommendations for improving use of the Agenda in a manner consistent with its statement of intent.

a) With regard to component B, it highlighted the significant progress made in all the Agenda's areas of action (especially the efforts to strengthen the health authority, increase social protection and access to health services, reduce the burden of disease, strengthen the management and development of health workers, and

[1] Pan American Health Organization. Final Report [Internet]. 27th Pan American Sanitary Conference, 59th Session of the Regional Committee of WHO for the Americas; 1-5 October 2007; Washington, DC. Washington, DC: PAHO; 2007 (Document CSP27/FR) [accessed 18 May 2017]. Available from: http://www1.paho.org/english/gov/csp/csp27-fr-e.pdf

[2] The Health Agenda for the Americas established eight 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.

[3] PAHO Strategic Plan 2008-2012 Amended, pg. 15, paragraph 59.

harness knowledge, science, and technology), measured through proxy indicators.[4] However, it expressed concern about the status of some of the indicators, including: *a)* the maternal mortality ratio, which had not declined as expected in recent years; *b)* dengue cases, which had increased; *c)* the increase in the rates of tuberculosis and HIV infection/AIDS; *d)* the rise in obesity; *e)* the stagnation of public health expenditure as a percentage of GDP; and *f)* the lack of reduction in out-of-pocket expenditure in the Region. It should be noted that for seven indicators, no data were available, and changes during the evaluation period therefore could not be analyzed. Furthermore, for three indicators, only estimates or projections were used to analyze the health situation.

b) With regard to component C, the evaluation's results showed that in response to the Agenda, PASB had made progress in the following lines of work: *a)* it had encouraged progress in all the areas of action and endorsed the Agenda's principles and values in the Region; *b)* it had supported multilateralism in its actions; *c)* it had provided a commonly agreed strategic vision to guide operations; *d)* it had promoted internal institutional changes in order to align its operations with the Agenda's objectives; and *e)* it had used the Agenda in the preparation of strategic documents, including national and regional health plans and subregional agendas, and in the training of personnel. In addition, the Office of Internal Oversight and Evaluation Services (IES) and what was then the Planning, Budget, and Resource Coordination Area (PBR) conducted a study that mapped in detail the links between the region-wide expected results (RERs, the foundational bricks of the Strategic Plan's architecture) and the Agenda's areas of action, as well as the Biennial Work Plans and Country Cooperation Strategies. This exercise confirmed that: *a)* the Strategic Plan and the Agenda were closely linked and that the Plan's strategic objectives addressed the entire Agenda's areas of action, although with different emphases among the various areas; *b)* the strategic objectives of PAHO also contributed to harmonizing the Agenda with WHO's strategic objectives and the work of other international organizations in the Region; and *c)* mapping of the links between the region-wide expected results and the areas of action would provide a platform for continuing management analysis of these linkages. The following recommendations were issued: *a)* promote the Agenda with all external funding partners and include it in collaborative agreements; b) in view of the progress made in the preparation the PAHO Strategic Plan 2014-2019 (in progress at the time), ensure a systematic monitoring tool and its clear alignment with the areas of action of the Agenda; *c)* ensure that the RERs or any other measures to monitor the progress of the Strategic Plan do not duplicate content and are directly aligned with the Agenda's areas of action; *d)* create criteria and a glossary with common practices for development of the country cooperation strategies (CCS), linking them to the Agenda and the PAHO Strategic Plan to facilitate their development and therefore their monitoring and evaluation; and *e)* build on the new strategy for

[4] The proxy indicators were defined by the country working group for the Mid-term Evaluation of the HAA2008-2017.

resource mobilization with a plan of action to address the funding gap for the 2012-2013 biennium in progress at the time.

13. **September 2012.** The Program and Budget 2010-2011 End-of-biennium Assessment/Second Interim PAHO Strategic Plan 2008-2012 Progress Report (Document CSP28/8), presented to the 28th Pan American Sanitary Conference (2012), reported on the results of the assessment in terms of its 16 strategic objectives, 90 region-wide expected results, and the progress toward achieving the targets and indicators. It stated that the Region had made great progress toward achieving the targets for 2013.

14. **September-October 2013.** The PAHO Strategic Plan 2014-2019 (Official Document 345), approved by the 52nd Directing Council of PAHO (2013), stated that the plan had been prepared in response to regional and global mandates, indicating that its strategic agenda represented a balance between PAHO's response to the regional priorities set in HAA2008-2017, other regional mandates established by the PAHO Member States, the collective national priorities identified in PAHO's country cooperation strategies, and programmatic alignment with the WHO General Programme of Work. This new PAHO Strategic Plan contained nine impact goals and six programmatic categories (with 30 program areas) that incorporated the Agenda's eight areas of action, as in the Strategic Plan 2008-2012.

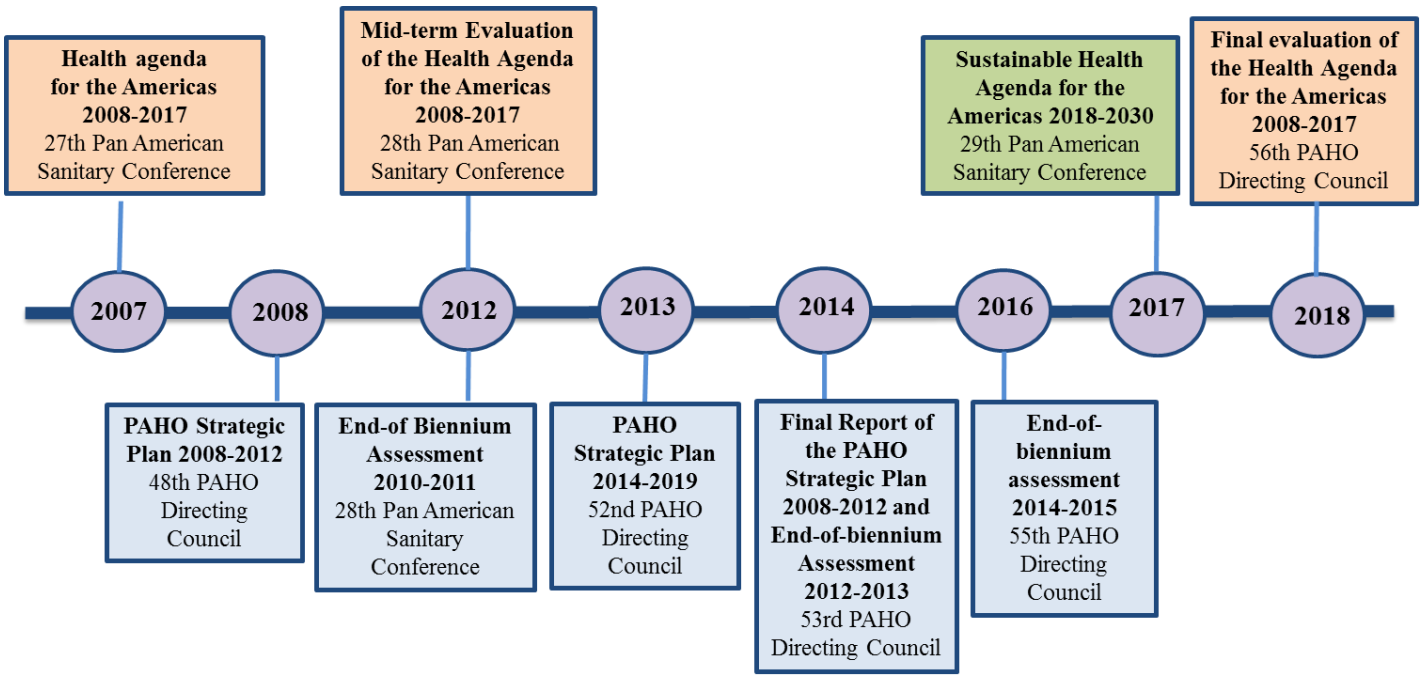
15. **September-October 2014.** The Final Report of the PAHO Strategic Plan 2008-2013 and End-of-biennium Assessment of the Program and Budget 2012-2013 (Official Document 348), presented to the 53rd Directing Council of PAHO (2014), discussed the results of the assessment, which indicated that the Organization had maintained a consistent implementation rate throughout the three bienniums covered by the Strategic Plan 2008-2013. The report stated that despite significant progress and accomplishments, several challenges remained: *a)* the slow reduction in the maternal mortality rate; *b)* the need to expand and coordinate multisectoral action in the fight to prevent noncommunicable diseases and their risk factors and to address the social determinants of health; *c)* the need to augment national core capacities in line with the requirements of the International Health Regulations to ensure adequate detection, response, and management of public health emergencies of international concern; *d)* the need for health systems and services to be better organized and managed in order to achieve progressive realization of universal health coverage and address inequities in health, particularly as they affect vulnerable population groups; and *e)* the need to address the difficulties with information systems and data reliability that hinder countries and the Region from fully assessing the health situation and making informed decisions to address key health problems and their determinants.

16. **September 2016**. The Report of the End-of-biennium Assessment of the Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019 (Document CD55/5), presented to the 55th Directing Council of PAHO (2016), showed steady progress toward achieving the targets for 2019, with 90% of the outcome indicators on track and achievements in 114 output indicators. Significant progress had been made in improving health and well-being across the Region in terms of impact goals, outcomes, and outputs. The report also noted the persistence of key challenges and gaps in certain

areas, such as noncommunicable diseases and their risk factors, maternal health, health financing, maintaining and strengthening core capacities for emergency and crisis response, and increasing the resilience of health systems.

17. **September 2017**. Sustainable Health Agenda for the Americas 2018-2030: A Call to Action for Health and Well-being in the Region (Document CSP29/6, Rev. 3.), approved by the 29th Pan American Sanitary Conference (2017), contained a preliminary report on the final evaluation of HAA2008-2017, previewing some results in connection with the recommendations issued by the Pan American Sanitary Conference during the presentation of the mid-term evaluation report in specific areas such as maternal mortality, dengue, tuberculosis, HIV/AIDS, obesity, national public health expenditure, and out-of-pocket expenditure.

Figure 1. Chronology of the Health Agenda for the Americas 2008-2017



IV. PROCEDURE AND METHODOLOGY

Procedure

18. In this evaluation, both the recommendations of the 28th Pan American Sanitary Conference in 2012 in regard to the mid-term evaluation report and those of the Member States that participated in the working group tasked with preparing SHAA2030 in 2017 were taken into account. In order to focus the evaluation on the relevant and priority aspects of the Agenda, after filtering out those with lower priority, 70 of the 75 proxy indicators used during the mid-term evaluation of HAA2008-2017 were ranked and organized as follows: *a)* 18 indicators on health status; *b)* five on risk factors; *c)* four on service coverage; and *d)* 43 on health systems.[5]

19. Information on components A and B was obtained through a questionnaire sent to ministry and secretariat of health personnel in the countries in May 2017, as well as a series of other sources, as indicated in the next paragraph. This information was used to construct proxy indicator tables similar to those used in the mid-term evaluation. For the evaluation of component C, a review of the documents approved by the PAHO Governing Bodies since 2008 was conducted in March 2018, along with a review of PAHO's country cooperation strategies. The Bureau was responsible for compiling, organizing, and reviewing the available information, providing relevant commentary, and preparing the report for presentation to the 162nd Session of the Executive Committee in June 2018.

20. With regard to sources, the following documents approved by the Organization's Governing Bodies served as important references for the final evaluation: the Health Agenda for the Americas 2008-2017; the PAHO Strategic Plan 2008-2012; the Mid-term Evaluation of the HAA2008-2017; the End-of-biennium Assessment 2010-2011; Health in the Americas, 2012 and 2017 editions; the PAHO Strategic Plan 2014-2019, the Final Report of the PAHO Strategic Plan 2008-2013 and End-of-biennium Assessment 2012-2013; the End-of-biennium Assessment 2014-2015; [6]and the Sustainable Health Agenda for the Americas 2018-2030. Data from Core Indicators 2017 were also used, especially those related to the health status, risk factor, and health coverage indicators. When

[5] Following the recommendations of the country working group, the following indicators of the Mid-term Evaluation were not considered in this evaluation:

a) Number of countries that have created a mechanism headed by the national health authority for planning, managing, and coordinating the use of external cooperation resources for health.
b) Number of countries that have a national development plan.
c) Percentage of international organizations in the Inter-American and United Nations system that have harmonized their aid with the areas of action of the Health Agenda for the Americas 2008-2017.
d) Number of countries that have created suitable environments for the promotion of physical activity.
e) Number of international organizations that have collaborated with the national authorities to respond to situations that pose a threat to health security.

[6] It should be noted that the indicators of the PAHO Strategic Plan 2014-2019, specifically those corresponding to outcomes (OCM) and outputs (OPT), were measured as of 2015. These data will be updated with the end-of-biennium 2016-2017 results in the final version of this report, currently under review by the Member States. In the use of this source, the utmost effort was made align its indicators with those used in the evaluation of the Agenda.

supplementary information was needed, the Health Information Platform for the Americas (PLISA) was used, among other sources. The information on sources is summarized below by type of indicator:

a) The 18 indicators on *health status* were taken from PAHO's Core Indicators 2017 (eight indicators), Health in the Americas 2017 (five indicators), the Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 (Document CD55/15) (two indicators), the UNAIDS Spectrum estimates for 2017 (two indicators), and the UNAIDS and WHO country reports (one indicator).

b) The five indicators for *risk factors* were taken from the PAHO Core Indicators 2017 (two indicators), the publication Joint Child Malnutrition Estimates. Levels and Trends in Child Malnutrition. Key findings of the 2018 edition (two indicators), and data from the WHO Global Health Observatory (one indicator).

c) The four indicators for *service coverage* were taken from PAHO's Core Indicators 2017 (three indicators) and the Report of the End-of-biennium Assessment of the Program and Budget 2014-2015 of PAHO (one indicator).

d) The 43 indicators for *health systems* were taken from the Report of the End-of-biennium Assessment of the Program and Budget 2014-2015 of PAHO (26 indicators), the survey for the final evaluation of the HAA2008-2017 (five indicators), information from WHO (two indicators), Preliminary Report of the End-of-biennium Assessment of the PAHO Program and Budget 2016-2017 (two indicators), Regional Goals for Human Resources for Health 2007-2015: Final Report (one indicator), and Health in the Americas 2017 (one indicator). Information available to PASB was used for three indicators. The assessment of three indicators is to be determined.

Methodology

Component A: Use of the Agenda in the countries

21. The responses to the survey sent to the 35 Member States were reviewed and recorded in a table. An assessment was then conducted and comments on the results were prepared.

Component B: Progress in the areas of action

22. The indicators for each area of action were organized according to the classification established. The 2017 data were compared with those reported by the same source in 2011 (during the mid-term evaluation of the Agenda) and rated as "progress" and "no progress," based on the changes that had occurred between the two cut-off points. In the case of the indicators for health systems, the proxy indicators were standardized with those of the End-of-biennium Assessment 2014-2015, the results were assessed in terms the target for 2015, and they were described as "exceeded," "achieved," "progress," and "no progress."

Component C: Contribution of the Pan American Sanitary Bureau to the implementation of the Agenda

23. The documentary information on the contribution of the Bureau and PAHO's Governing Bodies in this regard was reviewed, following the recommendations of the Mid-term Evaluation of the HAA2008-2017.

V. RESULTS

24. This section presents the main results of each component, which have been organized in tables with descriptions and comments.

Component A: Use of the Agenda in the countries

25. Table 1 shows the country responses to two of the six questions from the survey for the final evaluation of Agenda.[7] Since planning is a function of health systems, all Member States are expected to have sector plans corresponding to their political and administrative structures. The response to the first question simply confirms this generic fact.

Table 1. Use of the Agenda in the countries

Questions	Number of countries (2017)
a. Countries that have prepared national plans for the health sector	19 of the 20 that responded
b. Use of HAA2008-2017 by the countries in the design of national plans for the health sector	13 of the 20 that responded

Component B: Progress in the eight areas of action

Area of action a*: Strengthening the national health authority*

26. As seen in Table 2, all six proxy indicators (indicators for health systems) were evaluated.

Table 2. Indicators for area of action *a* (health systems)

Indicator	Rating
1. Number of countries and territories that have a national health sector plan or strategy with targets and objectives that have been reviewed in the past five years (OPT 4.1.1)	**Exceeded** Achieved in 22 and progress in 6 (2015)[a]
2. Number of countries that have implemented intersectoral coordination mechanisms headed by the national health authority	**Progress** 19 of the 20 that responded (2017)[b]
3. Number of countries that have implemented mechanisms to promote social participation	**Progress** 19 of the 20 that responded (2017)[b]
4. Number of countries and territories that have legislative or regulatory frameworks that support universal health coverage (OPT 4.1.3)	**Exceeded** Achieved in 21 and progress in 2 (2015)[a]

[7] Twenty of the 35 Member States responded to the survey.

Indicator	Rating
5. Number of countries and territories that have analyzed or reported progress toward universal access to health and universal health coverage using the monitoring and evaluation framework[8]	**Progress** 13 (2017)[c]
6. Proportion of mandates in Summit of the Americas declarations that reflect health issues	**Progress** 8/48 (2015)[a]

Sources:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015
b) Country survey for the final evaluation, 2017
c) Health in the Americas, 2017

27. As of 2015, major progress had been made in terms of the number of countries and territories with legislative frameworks that support universal health coverage. In all, 21 countries and territories had achieved the indicator, exceeding the target, and two more partially achieved it. Worth noting are the approval of the tobacco law in Mexico (2008), Colombia (2009), El Salvador (2011), and Jamaica (2013); the mental health law in Guatemala; the law for the Promotion and Protection of the Right to Equality of People with HIV or AIDS and their Family Members in Venezuela; the criminal code of the Dominican Republic in the context of maternal health and reproductive rights; and the reform of the civil code in Argentina with respect to the legal status of persons with disabilities.

28. At the Seventh Summit of the Americas in Panama in 2015, after successful negotiation by PAHO, leaders of the Americas agreed to address public health priorities. These included commitments to work for universal access to health and universal health coverage, in line with the strategy approved in 2014; to prevent, detect, and respond to outbreaks of emerging infectious diseases and other public health emergencies; and to make progress in the areas of NCDs, water and sanitation, food and nutrition, and reduction of maternal and child mortality. Following up on the commitments made at the Fifth Summit of the Americas in 2009, leaders also called for the establishment of an Inter-American Task Force on NCDs, led by PAHO.

Area of action **b***: Tackling health determinants*

29. As seen in Tables 3-6, all 13 proxy indicators were evaluated (four on health status, two on risk factors, two on coverage, and five on health systems).

Table 3. Indicators for area of action *b* (health status)

Indicator	2011	2017	Rating
1. Maternal mortality ratio (MMR) per 100,000 live births	65.7 (2010)[a]	52 (2015, estimated)[c]	**Progress**

[8] No current information exists on the indicator used in the mid-term evaluation: "Number of countries that have incorporated an accountability system into their health sector management system." This indicator is used as a proxy for it.

Indicator	2011	2017	Rating
2. Infant mortality rate (children under 1) per 1,000 live births	14.8 (2010)[b]	13 (2017)[c]	**Progress**
3. Neonatal mortality rate per 1,000 live births	9 (2010)[b]	8 (2017)[c]	**Progress**
4. Under-5 mortality rate per 1,000 live births	18 (2010)[b]	15.8 (2017)[c]	**Progress**

Sources:
a) PAHO, Health in the Americas, 2012
b) PAHO, Basic Indicators 2010
c) PAHO, Core Indicators 2017

30. As of 2015, the Region had made real progress in reducing maternal mortality (52 per 100,000 live births), infant mortality (children under 1) (13 per 1,000 live births), neonatal mortality (8 per 1,000 live births), and mortality in children under 5 (15.8 per 1,000 live births). Although the reduction in maternal mortality was significant, the Region was unable to meet the respective Millennium Development Goal (MDG) (Goal 5, "Improve maternal health"). However, it had achieved MDG 4, on the reduction of under-5 mortality. Concerning this progress, mention should be made of the countries' efforts to improve and expand maternal and child services, increasing the coverage of prenatal care and delivery attended by trained health workers.[9] Concerning the data reported at the regional level, it should be noted that the regional averages should not be used to conceal the significant differences in the data from the different subregions.

a) In the case of maternal mortality, North America,[10] had 13 deaths per 100,00 live births; the Andean Area,[11] 87; Brazil, 44; the Latin Caribbean,[12] 187; the non-Latin Caribbean,[13] 107; the Southern Cone,[14] 54; the Central American Isthmus,[15] 95; and Mexico, 38.

b) In the case of under-5 mortality, North America had 6.7 deaths per 1,000 live births; the Andean Area, 22.1; Brazil, 17.0; the Latin Caribbean, 48.7; the non-Latin Caribbean, 20.8; the Southern Cone, 11.1; the Central American Isthmus, 23; and Mexico, 15.1.

[9] PAHO, *Health in the Americas+, 2017 edition. Summary: Regional Outlook and Country Profiles*.
[10] Bermuda, Canada, and the United States of America.
[11] Bolivia, Colombia, Ecuador, Peru, and Venezuela.
[12] Cuba, Dominican Republic, French Guiana, Guadalupe, Haiti, Martinique, and Puerto Rico.
[13] Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Curaçao, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Sint Maarten (the Netherlands), Suriname, Trinidad and Tobago, Turks and Caicos Islands, Virgin Islands (UK), and Virgin Islands (USA).
[14] Argentina, Chile, Paraguay, and Uruguay.
[15] Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

Table 4. Indicators for area of action *b* (risk factors)

Indicator	2011	2017	Rating
1. Prevalence of overweight and obesity in children under 5[16]	7.6% (2011)[a]	7.2% (2017)[b]	**Progress**
2. Prevalence of low height-for-age in children under 5	8.2% (2011)[a]	6.3% (2017)[b]	**Progress**

Sources:

a) UNICEF/WHO/World Bank. Joint Child Malnutrition Estimates. Levels and Trends in Child Malnutrition. Key findings of the 2012 edition

b) UNICEF/WHO/World Bank. Joint Child Malnutrition Estimates. Levels and Trends in Child Malnutrition. Key findings of the 2018 edition

31. As of 2017, there had been a slight decrease in the prevalence of overweight in children under 5 in the Region: 7.2%, in contrast to 7.6% in 2011. The subregional data paint an unequal picture: North America, 6%; the Andean Area 6.6%; the Latin Caribbean 7.9%; the non-Latin Caribbean, 7%; the Central American Isthmus, 5.3%; and Mexico, 9.0% (there were no data for Brazil and the Southern Cone). It should be noted that the increase in this indicator is generally attributable to poor diet, limited physical activity, and economic and social factors, especially policies in agriculture, transportation, urban planning, the environment, education, and food processing, distribution, and marketing.[17]

32. As of 2017, there had been a reduction in the prevalence of low height-for-age in children under 5 in the Region, reported as chronic malnutrition in that group: 6.3%, compared to 8.2% in 2011. The subregional data paint an unequal picture: North America, 2.1%; the Andean Area, 15.5%; the Latin Caribbean, 12.9%; the non-Latin Caribbean, 7.4%; the Central American Isthmus, 30.1%; and Mexico, 13.6% (there were no data for Brazil and the Southern Cone). The prevalence of malnutrition in children is considered one of the expressions of inequity in the developing countries, with serious consequences for children in these countries. It should be recalled that the Region reported having achieved MDG 1, "Eradicate extreme poverty and hunger," whose target 1.C was "to halve, between 1990 and 2015, the proportion of people who suffer from hunger", and as indicator 1.8 "Prevalence of underweight children under 5." The immediate causes of chronic malnutrition are not enough food, inadequate care, and disease; underlying them is the lack of access to food, lack of health care, and lack of water and basic sanitation, within the broader context of limited schooling for mothers, poverty, and inequality.[18]

[16] In *Core Indicators 2017*, this indicator is defined as "Overweight in children aged < 5 years."

[17] WHO, *Global strategy on diet, physical activity, and health.* Available from: http://www.who.int/dietphysicalactivity/childhood_why/en/

[18] UNICEF. La desnutrición infantil: Causas, consecuencias y estrategias para su prevención y tratamiento. Madrid: UNICEF España; 2011.

Table 5. Indicators for area of action *b* (service coverage)

Indicator	2011	2017	Rating
1. Vaccination coverage at the national level (using the third dose of the diphtheria, pertussis, and tetanus vaccine [DPT3] as a marker)	93% (2010)[a]	91% (2016)[c]	**No progress**
2. Number of countries that have introduced new vaccines in their national immunization schedule	22 (2011)[b]	Achieved in 26 and progress in 8 (2015)[d]	**Progress**

Sources:
a) PAHO, Basic Indicators 2010
b) Country survey, Mid-term Evaluation of the HAA2008-2017, 2011
c) PAHO, Core Indicators 2017
d) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015

33. As of 2016, national vaccination coverage had fallen in the Region (using the third dose of the diphtheria, pertussis, and tetanus [DPT3] vaccine as a marker), with a regional figure of 91% (weighted average of all the countries), compared to 93% in 2010. The subregional data paint a diverse picture; for example, North America had 95% coverage, but Latin America and the Caribbean had 89%.

34. As of 2015, progress was "underway" in the Region in terms of the number of countries that had introduced one or more new vaccines, and 26 of the 35 countries had achieved the target. With PAHO support, the following vaccines had been introduced: the human papillomavirus vaccine (HPV), the conjugate pneumococcal vaccine, the rotavirus vaccine, and the inactivated polio vaccine (IPV). The Revolving Fund had negotiated with manufacturers to substantially lower the price of HPV vaccines, and the countries had collaborated with PAHO to introduce new vaccines in their national vaccination plans.

Table 6. Indicators for area of action *b* (health systems)

Indicator	Rating
1. Number of countries and territories that are implementing health promotion strategies to reduce inequalities in health and increase community participation (OPT 3.4.3)	**Progress** Achieved in 13 and progress in 7 (2015)[a]
2. Number of countries and territories that have an institutional response that addresses inequities in health, gender, ethnicity, and human rights (OCM 3.3.1)	**Progress** Achieved in 21 and progress in 16 (2015)[a]
3. Number of countries and territories that use a public health perspective in an integrated approach to violence prevention (OCM 2.3.2)	**Progress** Achieved in 5 and progress in 6 (2015)[a]
4. Number of countries and territories that have implemented a national plan to improve maternal, newborn, and child health (OPT 3.1.1)	**Progress** Achieved in 12 and progress in 4 (2015)[a]

Indicator	Rating
5. Number of countries that have implemented interventions in response to the recommendations of the Commission on Social Determinants of Health[19]	**Progress** 35 countries (2017)[b]

Sources:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015
b) Information available to PASB

35. As of 2015, progress was "underway" in terms of the number of countries and territories in which a public health approach is part of an integrated approach to violence prevention. Five countries and territories had achieved the goal and six more had partially done so. The countries had adopted measures related to this indicator or were in the process of doing so. For example, El Salvador had developed the "Safe El Salvador" plan which includes a public health approach. Ecuador was implementing a violence prevention plan with an integrated public health strategy as a component of its National Plan for Good Living. Trinidad and Tobago was working to meet the target, and the United States and Canada had been using this approach for several years.

36. As of 2017, most countries had addressed the recommendations of WHO´s Commission on Social Determinants of Health, as the recommendations of the Commission are very broad. Progress made between 2011 and 2017 includes the development of equity profiles, actions on Health in All Policies, which speaks to governance, and the measurement of health inequalities.

Area of action* c*: Increasing social protection and access to quality health services

37. As seen in Table 7, all nine proxy indicators (all of them on health systems) were evaluated.

Table 7. Indicators for area of action *c* (health systems)

Indicator	Rating
1. Number of countries that have implemented public policies to increase social protection	**Progress** 19 of 20 that responded (2017)[a]
2. Number of countries and territories that have financing strategies to achieve universal health coverage (OPT 4.1.2)	**Progress** Achieved in 16 and progress in 5 (2015)[b]
3. Current public expenditure in health as a percentage of gross domestic product	**Progress** Latin America and the Caribbean: 3.5% (2015)[c]

[19] The indicator refers to WHO´s Commission on the Social Determinants of Health, and as such it is important to bear in mind that a Commission on Equity and Health Inequalities in the Americas was established in May 2016. Recommendations will be issued in 2018.

Indicator	Rating
4. Out-of-pocket health expenditure as a percentage of total health expenditure	**Progress** Latin America and the Caribbean: 31.5% (2015)[c]
5. Number of countries and territories with national policies on access, quality, and use of medicines and other health technologies updated in the last five years (OPT 4.3.1)	**Exceeded** Achieved in 13 and progress in 13 (2015)[b]
6. Number of countries that have adopted specific measures for the care of indigenous populations	**Progress** 17 of 20 that responded (2017)[a]
7. Number of countries and territories implementing national strategies or plans for quality care and patient safety (OPT 4.2.2)	**Progress** Achieved in 10 and progress in 11 (2015)[b]
8. Number of countries that have used the Regional Revolving Fund for Strategic Public Health Supplies	**Progress** 33 countries (2017)[d]
9. Number of countries that have used the renewed primary health care strategy in their model of care	**Progress** 25 (2017)[d]

Sources:
a) Country survey for the final evaluation, 2017
b) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015
c) WHO
d) Information available to PASB

38. As of 2017, progress had been made in terms of the number of countries and territories that had implemented public policies to increase social protection (19 of the 20 countries that had responded to the survey reported progress). It should be noted, moreover, that, within the framework of these policies, the countries of the Region had made progress in eliminating economic and social barriers, increasing access to public health insurance, delivering quality health services, and expanding services to marginalized indigenous populations.

39. As of 2015, progress had been made with respect to the number of countries and territories with financing strategies to achieve health insurance coverage under the public system. Sixteen countries and territories had achieved the goal and five more were in the process of doing so. At the end of 2015, 10 countries were implementing plans of action or roadmaps toward universal health, 11 had developed regulatory frameworks for universal health, and 15 had created and were implementing financial frameworks for universal health.[20]

40. In 2015, current public expenditure in health as a percentage of the gross domestic product in Latin America and the Caribbean had increased to 3.5%, compared to 3.2% in 2011. In 2014, the subregional data and differences by country were as follows: North America, 8.2%; the Andean Area, 3.9%; Brazil, 3.8%; the Latin Caribbean, 5.1%; the non-Latin Caribbean, 3.1%; the Southern Cone, 3.3%; the Central American Isthmus, 4.1%; and Mexico, 3.3%. The Region has been marked by economic contraction in Latin America

[20] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2014-2015*.

and the Caribbean for two consecutive years (2015 and 2016), with an estimated 1% contraction in the gross domestic product in 2016. However, a recovery is projected for 2017 and 2018, with a 1.1% increase in the gross domestic product in 2017 and a 2.5% increase in 2018. This modest recovery is expected to continue thanks to higher external demand, an increase in raw material prices, and a certain monetary easing in South America in the context of lower inflation.[21]

41. As of 2015, progress had been made in terms of out-of-pocket health expenditure as a percentage of total health expenditure in Latin America and the Caribbean, putting the figure at 31.5%, in contrast to the 33.3% reported in 2010. In 2015, the subregional data and differences by country are as follows: North America, 11.3%; the Andean Area, 34.0%; Brazil, 25.5%; the Latin Caribbean, 19.9%; the non-Latin Caribbean, 31.3%; the Southern Cone, 31.9%; the Central American Isthmus, 40.0%; and Mexico, 44.0%. Notwithstanding this progress, this percentage is still considered very high. Out-of-pocket health expenditure is the health expenditure with the heaviest impact on household budgets and can be catastrophic for families. It also plays a key role in the decision to seek health care and is the most inequitable and least efficient source of financing.[22]

42. As of 2015, progress had been made with respect to the number of countries and territories that had implemented a policy that includes an improvement in access to medicines. Thirteen countries and territories had achieved the target and other 13 had partially done so. Most of the countries had implemented national policies to guarantee access to essential medicines and other priority health technologies, and the subregional mechanisms made significant progress in terms of access to high-priced medicines. MERCOSUR, for example, had held joint negotiations for the procurement of antiretrovirals and drugs for hepatitis C.

43. As of 2017, progress had been made in terms of the number of countries that had adopted specific measures for the care of indigenous populations: 17 out of the target of 20 (85%), according to the survey returned by the countries. Similarly, as of 2015, progress had been made with respect to the number of countries or territories that are implementing health plans, policies, or laws for ethnic or racial groups.[23] Ten countries and territories had achieved the indicator, and nine had partially done so. Two regional technical consultations with the ministries of health had been held, with extensive participation by the countries of the Region. These initiatives have been key to giving ethnicity a more prominent place in national and regional health programs. In the case of Honduras, efforts were underway to prepare a health profile for indigenous and Afro-descendant populations. Peru and Mexico had made progress in achieving the output indicator, as reflected in its country assessments. Nevertheless, challenges remain, given the complexity of the issues involved.

[21] United Nations. *World economic situation and prospects as of mid-2017*. Available from: https://documents-dds-ny.un.org/doc/UNDOC/GEN/N17/130/50/pdf/N1713050.pdf?OpenElement

[22] C. Cid and L. Prieto, "Gasto de bolsillo en salud de los hogares: el caso de Chile, 1997 y 2007". *Rev Panam Salud Publica*, 2012, 31 (4): 310-316.

[23] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2014-2015* (OPT 3.3.5).

44. As of 2015, progress had been made with respect to the number of countries that had implemented programs to improve the quality of care. Ten countries and territories had achieved the target, and 11 countries and territories had partially done so.

45. Currently, 33 countries have signed an agreement to use the services provided by the Regional Revolving Fund for Strategic Public Health Supplies. The volumes purchased were $40.4 million[24] in 2012 and $90.4 million in 2017.

46. As of 2017, based on a review of the implementation of the mandates of the Strategy for Universal Access to Health and Universal Health Coverage, 25 countries have a model of care based on primary health care and/or have developed Integrated Health Service Delivery Networks.

Area of action *d*: Diminishing health inequalities among countries and inequities within them

47. As seen in Tables 8-11, nine proxy indicators were evaluated (three for health status, one for risk factors, two for coverage, and three for health systems).

Table 8. Indicators for area of action *d* (health status)

Indicator	2011	2017	Rating
1. Number of new cases of mother-to-child HIV transmission	Americas: 4,300 LAC: 4,100 (2011)[a]	Americas: 2,700 LAC: 2,600 (2016)[a]	**Progress**
2. Incidence of mother-to-child congenital syphilis transmission	9,828 cases reported by 26 countries and territories (2011)[b]	23,609 cases reported by 37 countries and territories (2016)[c]	**No progress**
3. HIV prevalence (by sex and age group)	Ages 15-49: Americas: 0.5% Caribbean: 1.2% Latin America: 0.4% (2011)[a]	Ages 15-49: Americas: 0.5% Caribbean: 1.2% Latin America: 0.5% (2016)[a]	**No progress**

Sources:
a) UNAIDS, Spectrum Estimates, 2017
b) UNAIDS report, 2011, 2012, 2016
c) UNAIDS/WHO, 2017 Global AIDS monitoring, country reports

48. Concerning mother-to-child HIV and congenital syphilis transmission, it is important to bear in mind what PAHO, WHO, and UNICEF have reported:[25]

a) As of 2015, 22 countries in the Region of the Americas had reported data consistent with achieving the targets for the elimination of mother-to-child HIV transmission.

[24] Unless otherwise indicated, all monetary figures in this document are expressed in United States dollars.
[25] PAHO, *Elimination of mother-to-child transmission of HIV and syphilis in the Americas: Update 2016.*

The transmission rate in Latin America and the Caribbean had fallen by 55% between 2010 and 2015, from 15% to 8%.

b) In children aged 0 to 14 years, the number of new HIV infections in Latin America had fallen by 29% between 2010 and 2015, declining from 2,440 to 1,730; and by 83% in the Caribbean, plummeting from 2,280 to 400. Thus, between 2010 and 2015 some 28,000 HIV infections had been prevented in Latin America and the Caribbean, thanks to interventions for the prevention of mother-to-child transmission.

c) As of 2015, there had been an increase in the incidence rate of mother-to-child transmission of congenital syphilis to up to 1.7 cases per 1,000 live births, compared to the 1.0 case per 1,000 live births reported in 2011. That year, 20 countries had reported data consistent with the elimination of congenital syphilis (two countries more than in the previous year).

d) As of 2015, 18 countries in the Region of the Americas had provided data consistent with the elimination of the two diseases.

49. As of 2016, there had been a slight uptick in HIV prevalence (by sex and age group) in the 15-49 age group in Latin America, increasing from 0.4 in 2011 to 0.5% in 2016. The regional prevalence had held steady at 0.5% between 2011 and 2016. The same situation had been reported in the Caribbean, where the prevalence rate had remained at 1.2% for five years. In 2015, an estimated two million people were living with HIV infection in Latin America and the Caribbean, 98% of them 15 years of age or older. In Latin America, the epidemic has mainly affected men, who represent 68% of the people living with HIV, while in the Caribbean, 52% of the people with HIV are women.[26] In this regard, it is important to consider what UNAIDS reported in 2017:[27]

a) Latin America: In 2016, there were 1.8 million (1.4-2.1 million)[28] people living with HIV, with an estimated 97,000 (79,000-120,000) new HIV infections (the number of new HIV infections did not vary between the 2010 and 2016). Some 36,000 (28,000-45.000) people died of AIDS-related illnesses (between 2010 and 2016, the number of AIDS-related deaths fell by 12%). Treatment coverage was 58% (42-72%) of all people living with HIV. There were some 1,800 (1,300-2,400) new HIV infections in children.

b) Caribbean: In 2016, there were 310,000 (280,000-350,000) people living with HIV, with an estimated 18,000 (15,000-22,000) new HIV infections. Some 9,400 (7,300-12,000) people died of AIDS-related illnesses (between 2010 and 2016, the number of AIDS-related deaths fell by 28%). Treatment coverage was 52% (41-60%) among people living with HIV. There were less than 1,000 new HIV infections among children.

[26] PAHO, *Health in the Americas+, 2017 edition. Summary: Regional Outlook and Country Profiles*, p. 21.
[27] UNAIDS, *Fact sheet: World AIDS Day 2017.* Available from: http://www.unaids.org/en/resources/fact-sheet.
[28] The intervals in parentheses show the confidence intervals in the UNAIDS estimates.

Table 9. Indicators for area of action *d* (risk factors)

Indicator	2011	2017	Rating
1. Proportion of low birthweight (<2,500 g)	8.2% (2011)[a]	8% (2016)[b]	**Progress**

Sources:
a) PAHO, Basic Indicators 2011
b) PAHO, Core Indicators 2017

50. As of 2016, the Region had made progress in terms of the proportion of newborns with low birthweight (<2,500 g): 8%, compared to 8.2% in 2011. The subregional data are as follows: North America, 7.9%; the Andean Area, 8.5%; Brazil, 8.4%; the Latin Caribbean, 10.1%; the non-Latin Caribbean, 10.1%; the Southern Cone, 6.9%; the Central American Isthmus, 10.5%; and Mexico, 5.8%. Here, it is important to consider what WHO has stated: "The low birth weight rate in a population is a good indicator of a public health problem that includes long-term maternal malnutrition, ill health and poor health care. On an individual basis, low birth weight is an important predictor of newborn health and survival."[29]

Table 10. Indicators for area of action *d* (service coverage)

Indicator	2011	2017	Rating
1. Percentage of hospital births[30]	94.1% (2015)[a]	94.8% (2016)[a]	**Progress**
2. Prevalence of contraceptive use	63% (2011)[a]	69% (2017)[a]	**Progress**

Sources:
a) PAHO, Basic Indicators 2011 and Core Indicators 2016, 2017

51. As of 2016, the percentage of hospital births in the Region had risen to 94.8%, compared to 94.1% in 2015. The subregional data for 2016 are as follows: North America, 98.1%; the Andean Area, 93.2%; Brazil, 98.4%; the Latin Caribbean, 79.2%; the non-Latin Caribbean, 96.4%; the Southern Cone, 99.4%; the Central American Isthmus, 79.7%; and Mexico, 94.2%. Institutional pregnancy and delivery care and the increase in obstetric interventions have significantly lowered maternal mortality.

52. As of 2017, progress had been made with respect to the prevalence of modern contraceptive use in the Region: 69%, compared to 63% in 2011. The subregional data for 2017 are as follows: North America, 69%; the Andean Area, 63%; Brazil, 75%; the Latin Caribbean, 59%; the non-Latin Caribbean, 58%; the Southern Cone, 68%; the Central American Isthmus, 61%; and Mexico, 70%. The United Nations Population Fund (UNFPA) reports a 70% prevalence for Latin America and the Caribbean in 2017, together

[29] WHO. World Health Statistics 2005. Geneva: WHO; 2005.

[30] Since 2015, PAHO has used hospital deliveries as a proxy indicator of deliveries attended by trained health workers, assuming that these births are attended by trained health workers. PAHO first published the data reported by the countries on hospital deliveries in 2016 as part of the Core Indicators. For this reason, the indicator previously reported as "Percentage of deliveries attended by trained health workers" has been replaced.

with other indicators, such as a 10% prevalence of unmet family planning needs among women aged 15-49, with 83% of the demand for modern family planning methods met in women aged 15-49.

Table 11. Indicators for area of action *d* (health systems)

Indicator	Rating
1. Number of countries and territories that biennially monitor the health situation, health trends, and health determinants (OPT 4.4.1)	**Exceeded** Achieved in 18 and progress in 7 (2015)[a]
2. Number of countries and territories implementing national health-related policies or plans on comprehensive adolescent health (OPT 3.1.5)	**Progress** Achieved in 15 and progress in 13 (2015)[a]
3. Number of countries and territories that have incorporated strategies to promote active and healthy aging or access to an integrated continuum of care in their national plans (OPT 3.2.1)	**Achieved** Achieved in 11 and progress in 9 (2015)[a]

Sources:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015

53. The Region has intensified capacity-building activities for data management and health situation trend monitoring in health information systems. However, implementing more robust information systems capable of generating timely and quality data for measuring progress in health is still a challenge.

54. As of 2015, the Region had reported significant progress in several priority countries, such as Bolivia, Guatemala, Suriname, and Haiti, in terms of the formulation or updating of their national adolescent health policies or plans.

55. As of 2015, the countries of the Region had reported the adoption of strategies for active and healthy aging in the population. For example, Mexico had developed a national plan to promote healthy aging, the National Development Plan 2007-2012. Argentina, in turn, had had a major leadership role in the process surrounding the new Inter-American Convention on Protecting the Human Rights of Older Persons and the global consultation on the Global Strategy and Plan of Action on Aging and Health.

Area of action* e*: Reducing the risk and burden of disease

56. As seen in Tables 12-14, 17 of the 18 proxy indicators were evaluated, 11 of which were on health status, two on risk factors, and five on health systems.

Table 12. Indicators for area of action *e* (health status)

Indicator	2011	2017	Rating
1. Mortality from diabetes per 100.000 population (adjusted by age and sex)	32.8 (2011)[a]	Total: 33.6 Women: 31.4 Men: 36.3 (2015)[b]	**No progress**

Indicator	2011	2017	Rating
2. Mortality from ischemic heart disease per 100,000 population (adjusted by age and sex)	76.4 (2011)[a]	62.8 (2015)[b]	**Progress**
3. Mortality from cerebrovascular disease per 100,000 population (adjusted by age and sex)	43.1 (2011)[a]	34.8 (2015)[b]	**Progress**
4. Mortality from road traffic injuries per 100,000 population (adjusted by age and sex)	14.1 (2011)[a]	15.9 (2013)[a]	**No progress**
5. Incidence rate of tuberculosis per 100,000 population (all forms and positive sputum smear)	All forms: 23.5 Positive sputum smear: 12.1 (2009)[a]	To be determined	**Progress**
6. Incidence rate of AIDS per 100.000 population	10.7 (2009)[a]	HIV diagnosis rate: 13.7 (2016)[a] [1]	**No progress**
7. Number of malaria cases reported annually in the Region	680,174 (124.1 per 100.000 population) (2010)[a]	454,311 (2015)[a] [2]	**Progress**
8. Number of reported dengue cases	1,699,072 (2011)[b]	2,276,803 (2016)[b]	**No progress**
9. Number of countries with Chagas disease vector transmission interrupted in the 21 endemic countries in the Region	14/21 (2012)[c]	17/21 (2016)[d]	**Progress**
10. Number of endemic countries in the Region with onchocerciasis elimination certification	1 in the process of obtaining certification (2012)[c]	4 (2016)[d]	**Progress**
11. Mortality from malignant neoplasms per 100.000 population (adjusted by age and sex)	109.6 (2011)[a]	105.3 (2015)[a]	**Progress**

Sources:

a) PAHO, Basic Indicators, 2009, 2010, 2011, and 2012, and Core Indicators 2017

b) PAHO, Health in the Americas, 2012 and 2017

c) PAHO, Second Interim PAHO Strategic Plan 2008-2012 Progress Report

d) PAHO, Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 (Document CD55/15)

Note [1]: The methodology used in calculating the incidence rate of AIDS per 100,000 population changed after 2012. Therefore, the update provided here is for a different measurement, consistent with the PAHO Core Indicators.

Note [2]: Includes both imported and autochthonous cases reported from 21 endemic countries and imported cases reported from 15 non-endemic countries and territories for 2015. Data for 12 non-endemic countries and territories for different years was also used: 2014 data for the United States of America and Canada; 2013 data for Antigua and Barbuda, Anguilla, Jamaica, Montserrat, Saint Kitts and Nevis, and US Virgin Islands; and 2012 data for Bermuda, Cayman Islands, Dominica, Sint Maarten, and Saint Vincent and the Grenadines. 2016 data was used for Chile and Cuba.

57. As of 2015, there had been an increase in mortality from diabetes to 33.6 per 100,000 population (adjusted by age and sex), compared to 32.8 in 2011. More than 15% of the Region's population over the age of 18 had diabetes, a figure three times higher than 10 years earlier, while the prevalence of elevated blood glucose had risen from 5% in 1980 to 8.5% in 2014. In 2014, the age-adjusted mortality for type 2 diabetes in the Region differed slightly between men and women: 35.6 versus 31.6 per 100,000 population, respectively.[31] The obesity rate (Body Mass Index [BMI] equal to or greater than 30 kg/m^2) in the Region stood at 26.8%—more than double the world average (12.9%), with a higher prevalence in women (29.6%) than in men (24%).

58. As of 2016, the Region had made progress in reducing mortality from ischemic heart disease to 62.8 per 100,000 population (adjusted by age and sex), compared to 76.4 in 2011. While mortality from this cause had been steadily declining in the majority of countries in the Region, with an overall reduction of 19% between 2000 and 2010, it was still the main cause of death.[32]

59. As of 2016, the Region had made progress in terms of reducing mortality from cerebrovascular disease: 34.8 per 100,000 population (adjusted by age and sex), compared to 43.1 in 2011.

60. As of 2013, the Region had reported mortality of 15.9 per 100,000 population from road traffic injuries, up from 14.1 for 2011. The rates varied widely from country to country, from six deaths per 100,000 population in Canada to 29.3 in the Dominican Republic. Road traffic injures had taken the lives of 154,089 people in 2013 and accounted for 12% of all the deaths from this cause worldwide; this figure represents a 3% increase over the 149,357 deaths reported in 2010. Deaths from this cause were more common in the middle-income countries (73% of the total of deaths from this cause) than in the high-income countries (26%). Furthermore, a disproportionately high percentage of these deaths were related to the degree of motorization, with 37% of the total deaths occurring in the middle-income countries and 63% in the high-income countries.[33]The age- and sex-adjusted rate in 2015 was 25.4 deaths for men and 6.6 for women.[34]

61. As of 2016, the Region recorded an incidence rate of HIV infection of 13.7 per 100,000 population. The 2009 AIDS incidence rate (used in the HAA2008-2017 mid-term evaluation) was 10.7 per 100,000 population (there is no updated data on this indicator). In 2016 there were 1.8 million (1.4-2.1 million) people in Latin America living with HIV, and it is estimated that 97,000 (79,000-120,000) people acquired new infections—1,800 (1,300-2,400) of them children (the number of new infections did not change between 2010 and 2016). Some 36,000 (28,000-45,000) people died from AIDS-related diseases in 2016, 12% less than in 2010. In 2016 treatment coverage was 58% (42-72%). For the Caribbean, which had 310,000 (280,000-350,000) people living with HIV in 2016, there were an

[31] PAHO, *Health in the Americas +, 2017 Edition. Summary: Regional Outlook and Country Profiles.*
[32] *Ibidem*.
[33] PAHO, *Health in the Americas +, 2017 Edition. Summary: Regional Outlook and Country Profiles*.
[34] PAHO, *Core Indicators 2017.*

estimated 18,000 (15,000-22,000) new infections that year (fewer than 1,000 new infections among children). Nearly 9,400 (7,300-12,000) people died of AIDS-related diseases, 28% less than the deaths recorded in 2010. Treatment coverage in 2016 was 52% (41-60%).[35]

62. As of 2015, the Region had made progress in reducing the number of cases of malaria reported annually. Between 2000 and 2015, the number of malaria cases in the Region fell by 62% (from 1,181,095 to 454,311 cases). During the same period, malaria-related deaths declined by 76%, from 410 to 98. Of the total number of cases, 77% were reported by Brazil, Peru, and Venezuela. At the end of 2015, malaria was endemic in 21 countries of the Region. All the endemic countries, except for Haiti and Venezuela, have reduced their morbidity since 2000. However, in recent years (2016-2017) malaria mortality and morbidity has increased.[36]

63. As of 2016, there was an increase in the number of cases of dengue reported in the Region: 2,276,803 compared to 1,699,072 in 2011. Between 2011 and 2015 a cumulative total of 8,207,797 cases of dengue were reported, which represents a 58% increase over the 2006-2010 period. Of these, 118,837 (1.4%) were cases of severe dengue and there were 5,028 deaths (0.06%)—a 93% increase over the previous period.[37]

64. As of 2016, the Region had made progress with the number of countries that had certified the interruption of vector-borne transmission of Chagas disease: 17 out of 21 endemic countries—three more than the 14 certified by 2012. It is important to recall that the elimination of transmission of Chagas disease corresponds to impact target 8.3 of the PAHO Strategic Plan 2014-2019. In this regard, the Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 (Document CD55/15) includes objective 1.2: "accelerate actions to interrupt domiciliary transmission of Chagas disease by the principal vectors."

65. As of 2016, the number of countries in which onchocerciasis is endemic that had certified its elimination increased to four—three more than in 2011. These countries were Colombia, Ecuador, Guatemala, and Mexico. Onchocerciasis elimination corresponds to impact goal 8.2 of the Strategic Plan 2014-2019. The Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 (Document CD55/15) includes objective 2.2: "eliminate NIDs that are targeted for preventive chemotherapy, including collection of evidence to support elimination," and raises the target for 2022 to six countries.

66. A decline in mortality was recorded for the Region for all types of cancer in both sexes since the year 2000, with an estimated reduction of 7.9% between 2008 (114.3 per 100,000 population) and 2015 (105.3 per 100,000 population).

[35] UNAIDS, *Fact Sheet. World Aids Day 2017*.
[36] PAHO, *Health in the Americas+ 2017. Summary: Regional Outlook and Country Profiles*.
[37] *Ibid*.

Table 13. Indicators for area of action *e* (risk factors)

Indicator	2011	2017	Rating
1. Prevalence of overweight and obesity in people 18 years of age or older (defined as BMI ≥ 25 kg/m^2) (estimate)[38]	59.8 (58.3-61.3) (2011)[a]	62.5 (60.5-64.5) (2016)[a]	**No progress**
2. Prevalence of smoking	22% in adults (2012)[b]	Adults: 16.3% Adolescents: 13% (2014)[c]	**Progress**

Sources:
a) WHO, Global Health Observatory, available from: http://www.who.int/gho/en/
b) PAHO, Second Progress Report of the PAHO Strategic Plan 2008-2012
c) PAHO, Health Situation in the Americas: Core Indicators 2017

67. As of 2016, the Region reported an increase in the prevalence of overweight and obesity (BMI >25kg/m ^{2}) in adults (18 years of age or older) (estimate): 62.5% (60.5-64.5) compared to 59.8% (58.3-61.3) in 2011. The Region of the Americas is the WHO region with the highest prevalence of overweight and obesity.[39]

68. The Region has made progress in reducing the prevalence of smoking (16.3% for adults and 13% for adolescents) since 2011 (22% in adults). In 2013, the age-standardized prevalence of current estimated tobacco consumption among people 15 years of age or older in the Region was 17.5%; among students 13 to 15 years old it was 13.5% (14.7% in males and 12.3% in females).[40]

Table 14. Indicators for area of action *e* (health systems)

Indicators	Rating
1. Number of countries and territories implementing multisectoral national action plans for the prevention and control of noncommunicable diseases and risk factors (OPT 2.1.1)	**Progress** Achieved in 16 and in progress in 12 (2015)[a]
2. Number of countries and territories that have a national policy or plan for mental health in line with the Regional Strategy for Mental Health and the Global Mental Health Action Plan 2013-2020 (OPT 2.2.1)	**Progress** Achieved in 21 and in progress in 13 (2015)[a]
3. Number of countries implementing policies, strategies or laws in line with the FCTC (OPT 2.1.6)	**Progress** Achieved in 4 and in progress in 7 (2015)[a]

[38] In the mid-term evaluation the following indicator was used incorrectly: "Prevalence of obesity (BMI >25) in adults (15 years of age or older), by sex (estimate)." Obesity requires a BMI >30. This evaluation defines overweight and obesity by the same parameter used in the Strategic Plan 2014-2019.
[39] PAHO, *Health in the Americas+ 2017*, Overweight and Obesity. Health status of the population.
[40] PAHO, Sustainable Health Agenda for the Americas 2018-2030.

Indicators	Rating
4. Number of countries and territories with a national alcohol policy or a plan for the prevention and treatment of alcohol use disorders in line with the Regional Plan of Action/Global Strategy to Reduce the Harmful Use of Alcohol (OPT 2.2.3)	**Progress** Achieved in 7 and in progress in 12 (2015)[a]
5. Number of countries that have implemented a national nutrition and food security program	To be determined

Sources:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015

69. Countries faced challenges in implementing their multisectoral national action plans for the prevention and control of noncommunicable diseases (NCDs) and their risk factors. Multisectoral action to address the fundamental causes of NCDs with a health-in-all-policies approach continues to be difficult in all countries.

70. As of 2015, the Region had shown progress in implementation of the WHO Framework Convention on Tobacco Control (FCTC). Brazil, Chile, Panama, and Uruguay have laws on the books aligned with the FCTC. However, the Region faces challenges in applying public-health based alcohol policies, such as societal acceptance of alcohol use, a lack of awareness of its negative impact, and a weak political commitment to reducing harmful alcohol consumption.

Area of action* f*: Strengthening the management and development of health workers

71. As is shown in Table 15, all five proxy indicators related to health systems were evaluated.

Table 15. Indicators for area of action *f* (health systems)

Indicator	Rating
1. Number of countries and territories with an HRH action plan aligned with the policies and needs of their health care delivery system (OPT 4.5.1)	**Progress** Achieved in 7 and in progress in 10 (2015)[a]
2. Number of countries and territories with at least 25 health workers (physicians, nurses, and midwives) per 10,000 population (OCM 4.5.1)	**Progress** Achieved in 27 (2015)[a]
3. Number of countries and territories that have established a node of the Virtual Campus for Public Health or equivalent e-learning network (OPT 4.5.4)	**Progress** Achieved in 11 and in progress in 8 (2015)[a]
4. Number of countries that have participated in bilateral or multilateral agreements that address the migration of health workers	**Progress** 13 of the 20 that responded (2017)[b]
5. Number of countries that report monitoring of the 20 regional goals on HRH	**Progress** 20 countries (2013-2015)[c]

Source:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015
b) Survey of countries for the final evaluation, 2017
c) PAHO, Regional Goals for Human Resources for Health 2007-2015: Final Report

72. As of 2015, progress had been made in terms of the number of countries implementing national policies to strengthen the health workforce. Seven countries and territories achieved the indicator and 10 more partially achieved it.

73. As of 2015, progress had been made in the number of countries with a density of health workers (physicians, nurses, midwives) of 25 professionals per 10,000 population, and a total of 27 countries and territories had achieved that target. The main challenge is the distribution of the health work force. The percentage of physicians is up to 80 percentage points higher in urban areas than in rural (or non-metropolitan) ones. In 2015 the regional average was 48.7 nurses per 10,000 population. But North America had by far the highest nurse density with more than seven times that of Latin America and the Caribbean (110.9 compared to 13.6 per 10,000 population).[41]

74. As of 2015, there had been an increase in the number of countries that had established learning networks to improve the public health competencies of health workers. Eleven countries and territories achieved this target, while eight more did so partially.

75. As of 2017, there had been an increase in the number of countries participating in bilateral or multilateral agreements to address the migration of health workers: 13 of 20 countries, compared to the 11 reported in 2011, according to country responses to the survey.

76. The final report on Regional Goals for Human Resources for Health 2007-2015 was presented at the 54th PAHO Directing Council in 2015. Information was gathered between 2013 and 2015, with the participation of 20 countries. A progress report was presented at the 28th Pan American Sanitary Conference, for which information was collected between 2009 and 2010 with the participation of 24 countries.

Area of action* g*: Harnessing knowledge, science, and technology

77. As is shown in Table 16, five proxy indicators related to health systems were evaluated.

Table 16. Indicators for area of action *g* (health systems)

Indicator	Rating
1. Number of countries and territories integrating scientific evidence into practice, programs, or policies using standardized methodologies (OPT 4.4.5).	**Progress** Achieved in 9 and in progress in 6 (2015)[a]
2. Number of countries and territories implementing the regional Policy on Research for Health (OPT 4.4.4).	**Progress** Achieved in 14 and in progress in 15 (2015)[a]

[41] PAHO, Sustainable Health Agenda for the Americas 2018-2030.

Indicator	Rating
3. Number of countries and territories with accountability mechanisms to review research or incorporate ethics into public health (OPT 4.4.6).	**Exceeded** Achieved in 12 and in progress in 3 (2015)[a]
4. Number of countries and territories with national policies on access, quality, and use of medicines and other health technologies updated within the last five years (OPT 4.3.1).	**Exceeded** Achieved in 13 and in progress in 13 (2015)[a]
5. Number of countries and territories with mechanisms for health technologies assessment and evidence-based incorporation, selection, management, and rational use of medicines and other health technologies (OPT 4.3.4).	**Exceeded** Achieved in 13 and in progress in 14 (2015)[a]

Source:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2014-2015

78. As of 2015, progress had been made in the number of countries with a system or mechanism to facilitate evidence-based decision-making. Nine countries and territories achieved this target, while six more did so partially.

79. As of 2015, progress had been made in the number of countries implementing a national health research policy or plan. Fourteen countries and territories had achieved the target and 15 more did so partially.

80. As of 2015, progress had been made in the number of countries that formed a national commission designed to monitor compliance with ethical standards in scientific research. Twelve countries and territories achieved the target, and three more did so partially.

81. As of 2015, there was progress in the number of countries that had enacted rules to comply with international standards on the quality, safety, and efficacy of health sector inputs. Thirteen countries achieved this indicator, exceeding the target, and thirteen more did so partially.

82. As of 2015, progress had been made in the number of countries with a policy on the rational use of drugs. Thirteen countries and territories achieved this indicator, exceeding the target, and fourteen more did so partially.

Area of action *h*: Strengthening health security

83. As is shown in Table 17, four of five proxy indicators on health systems were evaluated.

Table 17. Indicators for area of action *h* (health systems)

Indicator	Rating
1. Number of countries and territories implementing a national preparedness plan for major epidemics and pandemics (OPT 5.2.1).	**Progress** Achieved in 27 and in progress in 1 (2017)[a]
2. Number of countries that have acquired the basic skills for surveillance and response to comply with the International Health Regulations (2005).	**Progress** 22 (2017)[b]
3. Proportion of public health emergencies of international concern for which information is made available to IHR National Focal Points in the Region within the first 48 hours of completing the risk assessment (OPT 5.1.2).	**Progress** 60% (2017)[b]
4. Number of countries that have formed alert and response teams for outbreaks and epidemics.	**Progress** 35 (2017)[a]
5. Number of countries that have maintained surveillance and preparations to cope with emerging and reemerging zoonotic diseases.	To be determined

Source:
a) Information available to PASB
b) Draft Report of the End-of-biennium Assessment of the Program and Budget 2016-2017 (subject to review with results of the joint assessment)

84. As of 2017, progress had been made in the number of countries implementing national plans or programs to prepare the health sector for emergencies or disasters. Twenty-seven countries and territories had achieved this indicator and one more did so partially.

85. As of 2017, progress had been made in the number of countries incorporating core competencies for surveillance and response in compliance with the International Health Regulations (2005): 22 out of 35 Member States.

86. In the 2016-2017 biennium, information was made available to IHR National Focal Points within the first 48 hours of completion of the risk assessment for a total of 109 out of 181 (60%) potential public health emergencies of international concern.

Component C: Implementation of the Agenda by the Pan American Sanitary Bureau

87. The recommendations formulated during the mid-term evaluation regarding responsibilities of PASB for implementation of the Agenda can be summarized as follows: *a)* evaluate the extent to which the Strategic Plan 2014-2019 and its monitoring and evaluation tools are aligned with the areas of action of the Agenda; *b)* evaluate the extent to which the Agenda and the Strategic Plan 2014-2019 promoted the preparation of official documents aligned with the vision and areas of action of the Agenda; and *c)* evaluate the extent to which the country cooperation strategies were aligned with the Agenda and the Strategic Plan 2014-2019.

Recommendation a: Evaluate the extent to which the Strategic Plan 2014-2019 and its monitoring and evaluation tools are aligned with the areas of action of the Agenda.

88. The PAHO Strategic Plan 2014-2019 (Official Document 345), originally approved by the 52nd PAHO Directing Council held from 30 September to 4 October 2013, was formulated in light of the regional priorities defined in the Agenda, regarded as the main reference point in PAHO's planning framework (Figure 2). The nine impact goals and the six categories (with 30 program areas) incorporate the eight areas of action of the Agenda, as had already been done in the PAHO Strategic Plan 2008-2013 (see Tables 18 and 19).

Figure 2. PAHO/WHO Planning Frameworks

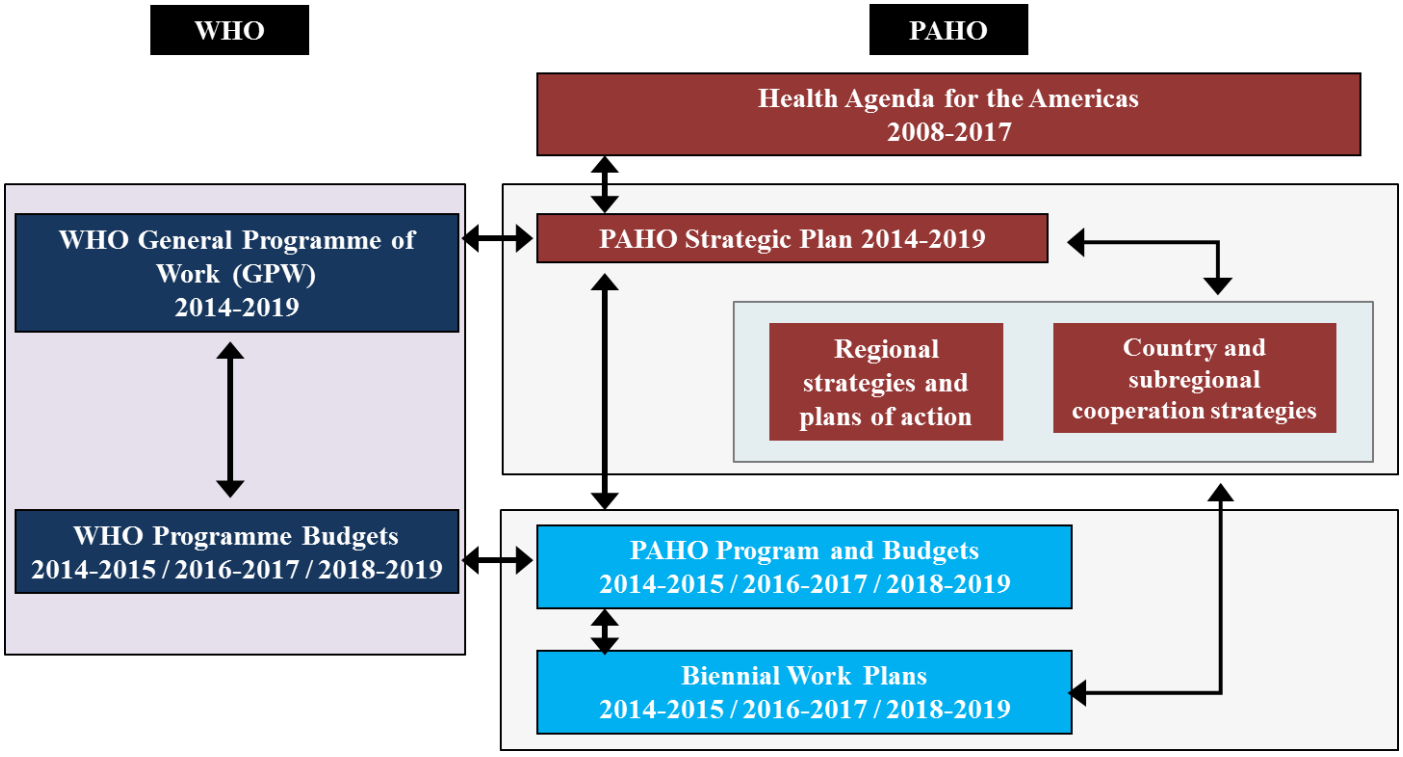


Table 18. Relationship between the areas of action and the impact goals of the PAHO Strategic Plan 2014-2019

Areas of Action of the Agenda	Impact Goals of the Strategic Plan
b) Tackling health determinants	Goal 1: Improve health and well-being with equity
d) Diminishing health inequalities among countries and inequities within them	Goal 2: Ensure a healthy start for newborns and infants Goal 3: Ensure safe motherhood Goal 4: Reduce mortality due to poor quality of health care
e) Reducing the risk and burden of disease	Goal 5: Improve the health of the adult population with an emphasis on NCDs and risk factors.

Areas of Action of the Agenda	Impact Goals of the Strategic Plan
	Goal 6: Reduce mortality due to communicable diseases. Goal 7: Curb premature mortality due to violence, suicides, and accidents among adolescents and young adults (15 to 24 years of age) Goal 8: Eliminate priority communicable diseases in the Region
h) Strengthening health security	Goal 9: Prevent deaths, illnesses, and disabilities arising from emergencies

Table 19. Relationship between the areas of action and the categories and program areas of the PAHO Strategic Plan 2014-2019

Areas of action of the Agenda	Categories and program areas of the Strategic Plan
a) Strengthening the national health authority	**Category 4. Health systems** 4.1 Health governance and financing; national health policies, strategies, and plans.
b) Tackling health determinants	**Category 3. Determinants of health and promoting health throughout the life course** 3.3 Gender, equity, human rights, and ethnicity 3.4 Social determinants of health 3.5 Health and the environment
c) Increasing social protection and access to quality health services	**Category 4. Health systems** 4.2 People-centered, integrated, quality health services 4.3 Access to medical products and strengthening of regulatory capacity
d) Diminishing health inequalities among countries and inequities within them	**Category 3. Determinants of health and promoting health throughout the life course** 3.1 Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health 3.2 Aging and health
e) Reducing the risk and burden of disease	**Category 1. Communicable diseases** 1.1 HIV/AIDS and sexually transmitted infections 1.2 Tuberculosis 1.3 Malaria and other vector-borne diseases (including dengue and Chagas disease 1.4 Neglected, tropical, and zoonotic diseases 1.5 Vaccine-preventable diseases (including maintenance of polio eradication).
	Category 2. Noncommunicable diseases and risk factors 2.1 Noncommunicable diseases and risk factors 2.2 Mental health and psychoactive substance use disorders 2.3 Violence and injuries 2.4 Disability and rehabilitation 2.5 Nutrition

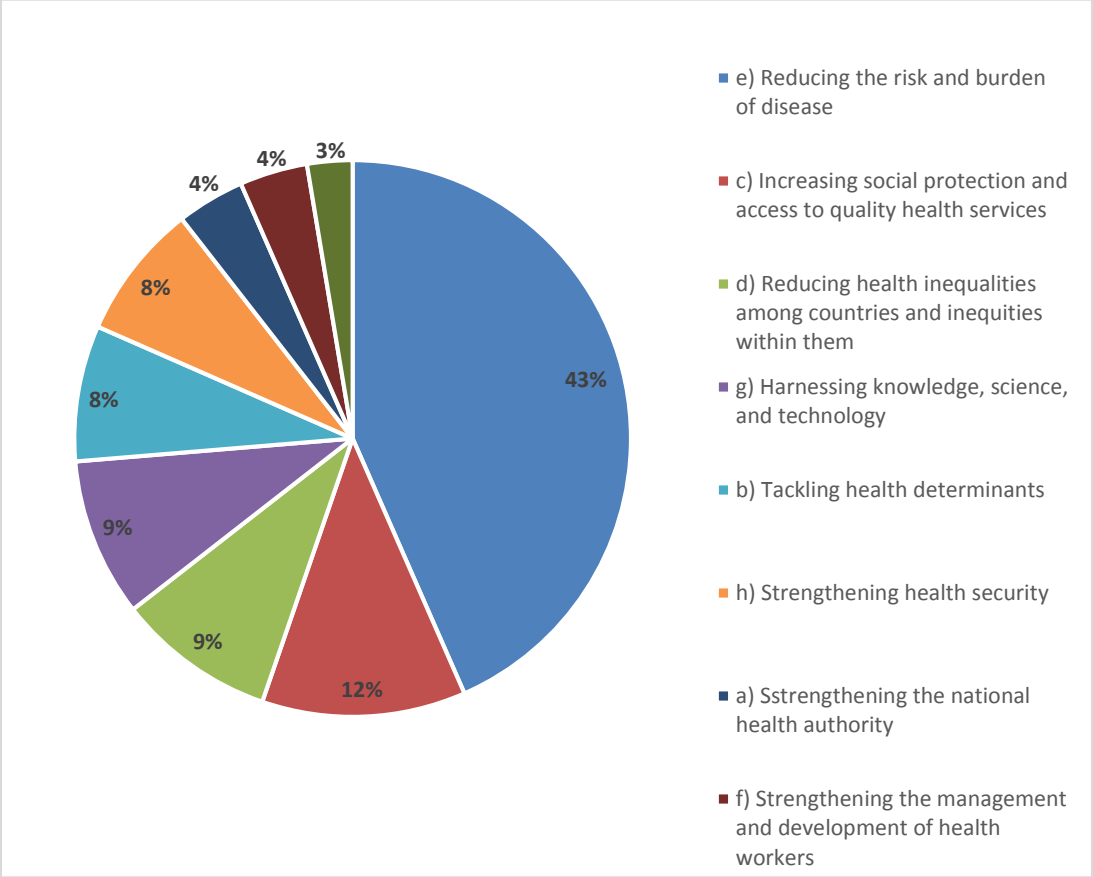
Areas of action of the Agenda	Categories and program areas of the Strategic Plan
f) Strengthening the management and development of health workers	**Category 4. Health systems** 4.5 Human resources for health
g) Harnessing knowledge, science, and technology	**Category 4. Health systems** 4.4 Health systems information and evidence
h) Strengthening health security	**Category 5. Preparedness, surveillance, and response** 5.1 Alert and response capacity (for IHR) 5.2 Epidemic- and pandemic-prone diseases 5.3 Emergency risk and crisis management 5.4 Food safety 5.5 Outbreak and crisis response

89. In the Report of the End-of-biennium Assessment of the Program and Budget 2014-2015, presented in September 2016, information was provided on implementation of the Strategic Plan. It was noted that continuous progress was being made toward achievement of the targets set for 2019, advances had been made toward 90% of the outcome indicators, and 114 output indicators were either fully or partially achieved—all linked to the areas of action of the Agenda.

Recommendation b: Evaluate the extent to which the Agenda and the Strategic Plan 2014-2019 promoted the preparation of official documents aligned with the vision and areas of action of the Agenda.

90. In the 2014-2017 period, the PAHO Governing Bodies approved a significant number of documents related to the areas of action of HAA2008-2017 (see Annex B). The interconnections between the areas of action and the topics outlined in PAHO documents are summarized in Figure 3. It should be noted that most of the 76 documents reviewed (33-43%) are related to area of action *e*, followed by areas *c* (9-12%) and *d* and *g* (7-9% each). In particular, it should be noted that the PAHO documents include topics that cover different areas of action.

Figure 3. Summary of the links between the areas of action and policy documents, strategies, and plans of action (2008-2017, in order of frequency)



Recommendation c: Assess the extent to which country cooperation strategies are linked to the Agenda and to the PAHO Strategic Plan

91. Both before and after the mid-term evaluation of the Agenda, the country cooperation strategies were consistent with it, as can be seen with the cooperation strategies for Argentina (2012-2016), Aruba (2014-2017 proposal), Bolivia (2011-2015), Brazil (2008-2012), Chile (2011-2014), Colombia (2011-2014), Costa Rica (2010-2014), Cuba (2012-2015), Ecuador (2010-2014), El Salvador (2012-2015), Guatemala (2013-2017), Guyana (2010-2015), Jamaica (2010-2015), Mexico (2015-2018), Panama (2014-2017), Paraguay (2010-2014), Peru (2014-2019), Puerto Rico (2013-2016), Dominican Republic (2013-2017), Suriname (2012-2016) and Uruguay (2012-2015), among others.[42]

[42] PAHO, Country Cooperation Strategy (CCS). Available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=2126%3A2009-country-cooperation-strategy-ccs&catid=1762%3Aabout&Itemid=1849&lang=en

VI. GENERAL OBSERVATIONS ON THE RESULTS OF THE EVALUATION

Component A

92. The evaluation of this component shows that the HAA2008-2017 was not used to guide planning in most of the technical teams at the Ministries and Secretariats of Health that completed the survey. As was touched on in the mid-term evaluation, this may be explained by the time lag between publication of the Agenda, its implementation through other instruments (strategic plans, policy documents, strategies, and action plans on specific subjects addressed in the Agenda), and staff turnover in the technical and management teams at the Ministries and Secretariats of Health.

Component B

93. Data on the 70 indicators evaluated in this component reveal, with few exceptions, significant strides made by the countries and territories of the Region in the eight areas of action of the Agenda during the 2011-2017 period, continuing the similar progress reported for the 2007-2011 period. The evaluation of this component was preliminarily reported through the SHAA2030 document, updating on the progress and challenges in critical areas reported in the mid-term evaluation in 2012. These included: *a)* maternal mortality; *b)* dengue; *c)* tuberculosis; *d)* HIV/AIDS; *e)* obesity; *f)* national expenditure allocated to health, as a percentage of GDP; and *g)* out-of-pocket expenditures, as a percentage of total expenditures on health.

Component C

94. The evaluation of this component focused on three recommendations formulated during the mid-term evaluation of the Agenda. The strategic plans of the Organization; the policy papers, strategies and action plans; and the country cooperation strategies were all found to be consistent with the areas of action of the Agenda.

VII. CONCLUSIONS

95. The final evaluation of HAA2008-2017 confirmed its role as a regional policy instrument that provided a health policy vision for the Region. It reaffirmed the commitments of countries and territories to the health of their populations and provided programmatic guidance for the strategic planning process in Member States and in PAHO. As a call to action, HAA2008-2017 placed the critical health issues of the Region on the agenda, including: the social determinants of health and health inequalities among and within countries, social protection, access to health services, and strengthening of the national health authority.

96. HAA2008-2017 guided the formulation of the PAHO Strategic Plan 2008-2013 and the PAHO Strategic Plan 2014-2019, which incorporated the areas of action of the Agenda. This enabled its implementation and evaluation within the institutional framework of the Organization, as was proposed in the statement of intent of the Agenda. It also guided the country cooperation strategies, giving them a clear direction. Finally, the Agenda served as a benchmark for the preparation of national health policies, strategies, and plans, although its importance decreased over the course of the decade as other regional and global policy frameworks were introduced.

97. HAA2008-2017, promoted by the Ministers of Health, inspired and created an opportunity for independent action to complement the role of the Governing Bodies and PASB, and strengthened policy-making and strategic planning in the Organization. It likewise promoted and stimulated the participation of Member States in the formulation of PAHO programs and policies, carried out both in Headquarters and in the countries, through the active involvement of working groups and advisory groups comprised of country representatives, with support from PASB in its role as secretariat.

98. The lessons learned from the formulation, implementation, and evaluation of HAA2008-2017 are summarized in the following recommendations:

a) Make greater efforts to reach consensus on a shared vision for the Region, organized around regional and global mandates, promoting health interventions in the countries, based on the available evidence.

b) Provide the greatest possible degree of direction for health policies in the Region, incorporating an equity-based approach and reflecting this in measurable goals and targets.

c) Foster the active participation of the most senior authorities and technical teams at the Ministries and Secretariats of Health of the countries in the development and evaluation processes for PAHO policies and strategies. Commitment and empowerment can be encouraged by means of working groups comprised of country representatives and supported by PASB in its role as secretariat, and by holding side events during Directing Council and Pan American Sanitary Conference sessions.

d) Establish appropriate levels of coordination among regional policy-making, implementation, and evaluation mechanisms, tapping into PAHO's institutional capacity (governance, technical capacity, resources, and logistics) to achieve the agreed goals and targets.

e) Provide a governance mechanism and a communications plan to coordinate and monitor activities in these frameworks with all the key stakeholders.

f) Recognize the value of establishing clear goals and targets to measure the impact of the Agenda.

99. The lessons learned from the process of formulating, implementing, and evaluating the Health Agenda for the Americas 2008-2017 were incorporated into the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030). Efforts must be directed toward their application in the execution and evaluation of SHAA2030.

Annex

VIII. ANNEX

Links between the areas of action and policy papers, strategies, and action plans (2008-2017)

Area of action **HAA2008-2017**	**29th Pan American Sanitary Conference** **(25 to 29 September 2017)**
b) Tackling health determinants	Policy on Ethnicity and Health (Document CSP29/7, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action for the Sustainability of Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Americas 2018-2030 (Document CSP29/8)
e) Reducing the risk and burden of disease	Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018-2022 (Document CSP29/11)
f) Strengthening the management and development of health workers	Strategy on Human Resources for Universal Access to Health and Universal Health Coverage (Document CSP29/10)
g) Harnessing knowledge, science, and technology	Plan of Action for the Strengthening of Vital Statistics 2017-2022 (Document CSP29/9)
Cross-cutting	Sustainable Health Agenda for the Americas 2018-2030 (Document CSP29/6, Rev.3)
Area of action **HAA2008-2017**	**55th Directing Council** **(26 to 30 September 2016)**
b) Tackling health determinants	Health of Migrants (Document CD55/11, Rev. 1)
c) Increasing social protection and access to quality health services	Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies (Document CD55/10, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action for Malaria Elimination 2016-2020 (Document CD55/13)
e) Reducing the risks and burden of disease	Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021 (Document CD55/14)
e) Reducing the risks and burden of disease	Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 (Document CD55/15)
e) Reducing the risks and burden of disease	Strategy for Arboviral Disease Prevention and Control (Document CD55/16)
h) Strengthening health security	Resilient Health Systems (Document CD55/9)
h) Strengthening health security	Plan of Action for Disaster Risk Reduction 2016-2021 (Document CD55/17, Rev. 1)
Area of action **HAA2008-2017**	**54th Directing Council** **(28 September to 2 October 2015)**
a) Strengthening the national health authority	Strategy on Health-related Law (Document CD54/14, Rev. 1)
b) Tackling health determinants	Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (Document CD54/9, Rev. 2)
b) Tackling health determinants	Plan of Action on Workers' Health (Document CD54/10, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action on Immunization (Document CD54/7, Rev. 2)
e) Reducing the risks and burden of disease	Strategy and Plan of Action on Dementias in Older Persons (Document CD54/8, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action for the Prevention and Control of Tuberculosis (Document CD54/11, Rev. 1)

e) Reducing the risks and burden of disease	Plan of Action on Antimicrobial Resistance (Document CD54/12, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action for the Prevention and Control of Viral Hepatitis (Document CD54/13, Rev. 1)
Area of action HAA2008-2017	**53rd Directing Council (29 September to 3 October 2014)**
a) Strengthening the national health authority	Strategy for Universal Access to Health and Universal Health Coverage (Document CD53/5, Rev. 2)
a) Strengthening the national health authority	Plan of Action on Health in All Policies (Document CD53/10, Rev. 1)
c) Increasing social protection and access to quality health services	Plan of Action for Universal Access to Safe Blood (Document CD53/6)
e) Reducing the risks and burden of disease	Plan of Action on Disabilities and Rehabilitation (Document CD53/7, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action on Mental Health (Document CD53/8, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action for the Prevention of Obesity in Children and Adolescents (Document CD53/9, Rev. 2)
e) Reducing the risks and burden of disease	Plan of Action for the Prevention of Blindness and Visual Impairment (Document CD53/11)
h) Strengthening health security	Plan of Action for the Coordination of Humanitarian Assistance (Document CD53/12)
Area of action HAA2008-2017	**52nd Directing Council (30 September to 4 October 2013)**
c) Increasing social protection and access to quality health services	Social Protection in Health (Document CD52/5)
e) Reducing the risks and burden of disease	Plan of Action for the Prevention and Control of Noncommunicable Diseases (Document CD52/7, Rev.1)
f) Strengthening the management and development of health workers	Human Resources for Health (Document CD52/6)
Area of action HAA2008-2017	**28th Pan American Sanitary Conference (23 to 27 September 2012)**
c) Increasing social protection and access to quality health services	Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards (Document CSP28/17, Rev. 1)
d) Diminishing health inequalities among countries and inequities within them	Strategy and Plan of Action for Integrated Child Health (Document CSP28/10)
e) Reducing the risks and burden of disease	Strategy for the Prevention and Control of Noncommunicable Diseases (Document CSP28/9, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome (CRS) Elimination in the Region of the Americas (Document CSP28/16)
g) Harnessing knowledge, science, and technology	Health technology Assessment and Incorporation into Health Systems (Document CSP28/11)
g) Harnessing knowledge, science, and technology	Strategy and Plan of Action on Knowledge Management and Communication (Document CSP28/12, Rev. 1)
g) Harnessing knowledge, science, and technology	Bioethics: Toward the Integration of Ethics in Health (Document CSP28/14, Rev. 1)
h) Strengthening health security	Coordination of International Humanitarian Assistance in Health in Case of disasters (Document CSP28/13)

Area of action HAA2008-2017	**51st Directing Council (26 to 30 September 2011)**
d) Diminishing health inequalities among countries and inequities within them	Strategy and Plan of Action on Urban Health (Document CD51/5)
d) Diminishing health inequalities among countries and inequities within them	Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Morbidity (Document CD51/12)
e) Reducing the risks and burden of disease	Plan of Action on Road Safety (Document CD51/7, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action to Reduce the Harmful Use of Alcohol (Document CD51/8, Rev. 1)
e) Reducing the risks and burden of disease	Plan of Action on Psychoactive Substance Use and Public Health (Document CD51/9)
e) Reducing the risks and burden of disease	Strategy and Plan of Action on Epilepsy (Document CD51/10, Rev. 1)
e) Reducing the risks and burden of disease	Strategy and Plan of Action on Malaria (Document CD51/11)
g) Harnessing knowledge, science, and technology	Strategy and Plan of Action on *eHealth* (Document CD51/13)
h) Strengthening health security	Strategy and Plan of Action on Climate Change (Document CD51/6, Rev. 1)
Area of action HAA2008-2017	**50th Directing Council (27 September to 1 October 2010)**
b) Tackling health determinants	Health and Human Rights (Document CD50/12)
b) Tackling health determinants	Strategy and Plan of Action for the Reduction of Chronic Malnutrition (Document CD50/13)
b) Tackling health determinants	Health, Human Security, and Well-being (Document CD50/17)
d) Diminishing health inequalities among countries and inequities within them	Strategy and Plan of Action for the Elimination of the Mother-to-child Transmission of HIV and Congenital Syphilis (Document CD50/15)
e) Reducing the risks and burden of disease	Strategy and Plan of Action for Chagas Disease Prevention, Control, and Care (Document CD50/16)
e) Reducing the risks and burden of disease	Strategy for Substance Use and Public Health (Document CD50/18, Rev. 1)
f) Strengthening the management and development of health workers	Strategy for Health Personnel Competency Development in Primary Health-care Based Health Systems (Document CD50/11)
h) Strengthening health security	Plan of Action on Safe Hospitals (Document CD50/10)
Area of action HAA2008-2017	**49th Directing Council (28 September to 2 October 2009)**
b) Tackling health determinants	Plan of Action for Implementing the Gender Equality Policy (Document CD49/13)
c) Increasing social protection and access to quality health services	Policy Framework for Human Organ Donation and Transplantation (Document CD49/14)
c) Increasing social protection and access to quality health services	Health and Tourism (Document CD49/15)
c) Increasing social protection and access to quality health services	Integrated Health Services Delivery Networks Based on Primary Care (Document CD49/16)

c) Increasing social protection and access to quality health services	Family and Community Health (Document CD49/20)
d) Diminishing health inequalities among countries and inequities within them	Plan of Action on Adolescent and Youth Health (Document CD49/12)
e) Reducing the risks and burden of disease	Elimination of Neglected Diseases and Other Poverty-Related Infections (Document CD49/9)
e) Reducing the risks and burden of disease	Strategy and Plan of Action on Mental Health (Document CD49/11)
e) Reducing the risks and burden of disease	Plan of Action for the Prevention of Avoidable Blindness and Visual Impairment (Document CD49/19)
g) Harnessing knowledge, science, and technology	Policy on Research for Health (Document CD49/10)
Area of action HAA2008-2017	**48th Directing Council (29 September to 3 October 2008)**
c) Increasing social protection and access to quality health services	Improving Blood Availability and Transfusion Safety in the Americas (Document CD48/11)
d) Diminishing health inequalities among countries and inequities within them	Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn and Child Care (Document CD48/7)
d) Diminishing health inequalities among countries and inequities within them	Regional Strategy for Improving Adolescent and Youth Health (Document CD48/8)
e) Reducing the risks and burden of disease	Population-based and Individual Approaches to the Prevention and Management of Diabetes and Obesity (Document CD48/5)
e) Reducing the risks and burden of disease	Regional Strategy and Plan of Action for Cervical Cancer Prevention and Control (Document CD48/6)
e) Reducing the risks and burden of disease	Toward the Elimination of Onchocerciasis (River Blindness) in the Americas (Document CD48/10)
e) Reducing the risks and burden of disease	WHO Framework Convention on Tobacco Control: Opportunities and Challenges for its Implementation in the Americas (Document CD48/12)
e) Reducing the risks and burden of disease	Integrated Vector Management: A Comprehensive Response to Vector-borne Diseases (Document CD48/13)
g) Harnessing knowledge, science, and technology	Regional Plan of Action for Strengthening Vital and Health Statistics (Document CD48/9)

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