Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

56th DIRECTING COUNCIL

70th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 23-27 September 2018

Provisional Agenda Item 8.1

CD56/INF/1
10 August 2018
Original: English

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

Final Report

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I. EXECUTIVE SUMMARY

1. This report presents the final evaluation of the Health Agenda for the Americas 2008-2017 (HAA2008-2017), using a similar methodology to that employed in the mid-term evaluation carried out in 2012. This document provides a final assessment of how the countries and the Pan American Sanitary Bureau (PASB) implemented the Agenda's eight areas of action through: *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. As per guidance from Member States, existing information was used to report on the evaluation of the indicators.

2. HAA2008-2017 was approved by the ministers and secretaries of health of the Region at a meeting in Panama City on 3 June 2007. The Agenda was intended to guide the work of all stakeholders in the Region of the Americas seeking to improve the health of people in the Americas. The Agenda was intended as a high-level political instrument and was meant to guide the development of future regional and national health plans.

3. The results of this final evaluation reveal significant achievements by countries across the Agenda's areas of action, as measured by indicators linked to: *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, among others. 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 and obesity among adults; *c)* an increase in the number of dengue cases; *d)* minimal progress in reducing the prevalence of human immunodeficiency virus (HIV) infection; *e)* increased incidence of mother-to-child transmission of congenital syphilis; *f)* policies on access, quality, and use of medicines and other health technologies; and *g)* minimal progress in expanding DPT3 vaccination coverage.

4. Concerning use of the Agenda, the results of the final evaluation show that it has lost visibility as a reference for planning in 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 general programs of work of the World Health Organization (WHO), as well as PAHO's own Strategic Plans. Nevertheless, the evaluation shows that the Agenda served as a regional policy instrument that contributed to health policy vision for the Region and reaffirmed the countries' commitments to health.

5. During the formulation, implementation, and evaluation of the Agenda, 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 policies and strategies. These lessons were applied in the preparation of the new Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030), whose execution will be partly guided by the results of this evaluation.

6. This evaluation underscores the Agenda's importance as a regional guide for health development. It should be noted that a preliminary report on the final evaluation of this Agenda was included in the SHAA2030, approved by the 29th Pan American Sanitary Conference.

7. This final evaluation covers PAHO's 35 Member States, 17 territories, and PASB itself. Given the time that has passed (10 years) since the 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. HAA2008-2017 did not establish goals, targets, or indicators for direct assessment of health 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."*

II. CHRONOLOGICAL BACKGROUND

9. **June and 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 Program of Work, approved in 2006. The Agenda, which proposed eight areas of action,[2] was presented and approved in Panama City in June 2007 and recognized as the highest-level health planning instrument in the Region of the Americas. The final report of the 27th Pan American Sanitary Conference (Document CSP27/FR) of October 2007 informed the Member States of its roll-out.

10. **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 in 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]

11. **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, provided a preliminary report on 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) Regarding component A, the evaluation found that of the 30 countries with national health plans in effect during the period of 2008-2011, 20 had considered the Agenda in the development of said plans, particularly incorporating areas of action A, B, C, E, F, and G and, to a lesser extent, D and H. In addition, two of the five subregions developed a subregional agenda using the Agenda as a reference and three

[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.

developed a plan that considered it. Finally, three of the ten international organizations that responded to a survey reported using the Agenda.

b) With regard to component B, the mid-term evaluation highlighted the significant progress made in all of 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 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 (TB) 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.

c) With regard to component C, the evaluation's results showed that in response to the Agenda, the 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

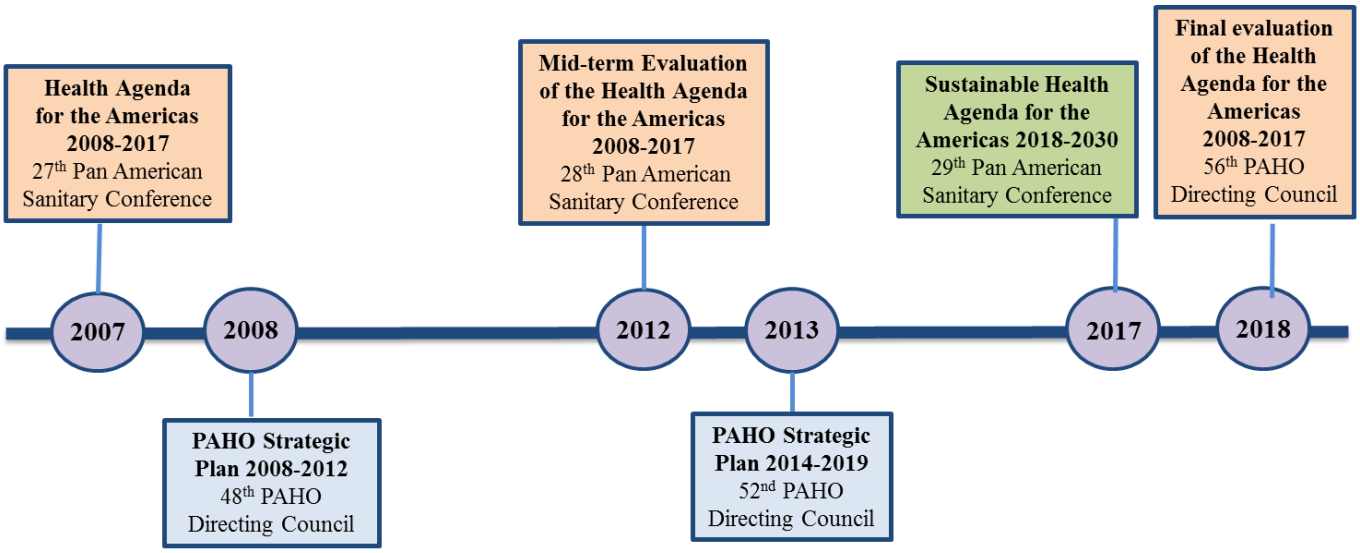
[4] The proxy indicators were defined by the country working group for the Mid-term Evaluation of HAA2008-2017.

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

12. **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 PAHO Member States, the collective national priorities identified in PAHO's country cooperation strategies, and programmatic alignment with the WHO general program 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, thus becoming the main instrument for implementation of the Agenda.

13. **September 2017**. The 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.

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



III. PROCEDURE AND METHODOLOGY

Procedure

14. In this evaluation, both the recommendations made in 2012 by the 28th Pan American Sanitary Conference regarding the mid-term evaluation report and those made by the Member States that participated in the working group tasked with preparing SHAA2030 in 2017 were taken into account. 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]

15. 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.

16. 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 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 Assessments for 2014-2015 and 2016-2017;[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.

[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 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.

When supplementary information was needed, the Health Information Platform for the Americas (PLISA) was used, among other sources.

Methodology

Component A: Use of the Agenda in the countries

17. 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

18. 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 2016-2017. The results were assessed in terms of the targets for 2017, and they were described as "exceeded," "achieved," "progress," or "no progress."

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

19. 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 HAA2008-2017.

IV. RESULTS

Component A: Use of the Agenda in the countries

20. 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

21. As shown in Figure 2, of the 70 indicators that were assessed, 61 (88%) showed progress or exceeded their targets during the period of the Agenda, while eight (12%) showed no progress. One indicator was not considered for this report due to the lack of comparable data. Areas with no progress included: *a)* expanding vaccination coverage of DPT3; *b)* policies on access, quality, and use of medicines and other health technologies*; c)* reducing HIV prevalence; *d)* reducing incidence of mother-to-child congenital syphilis transmission; *e)* reducing mortality from diabetes; *f)* reducing mortality from road traffic injuries; *g)* dengue cases; and *h)* reducing the prevalence of overweight and obesity in adults.

22. Figure 3 shows that progress was made in each area of action; however, area of action E, reducing the risk and burden of disease, had the most indicators showing a lack of progress. The analysis that follows surveys the situation with regard to the 70 indicators; further details are provided in Annex A.

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

Figure 2. Overview of indicator status, 2017 (or most recent year)

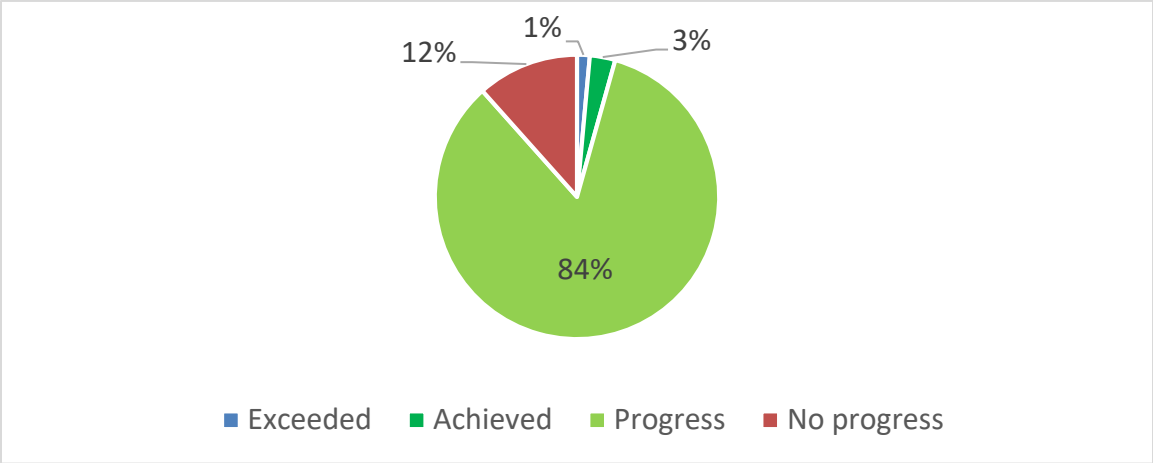
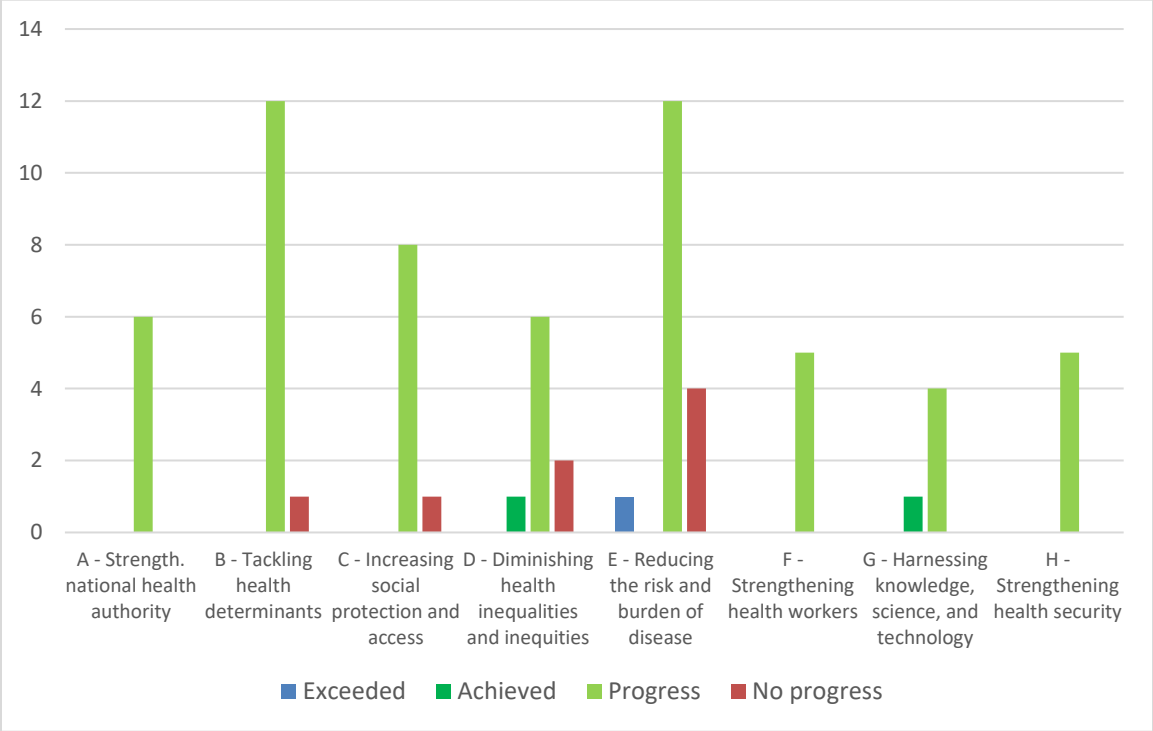


Figure 3. Indicator status by area of action, 2017 (or latest available year)



Area of action A: Strengthening the national health authority

23. In HAA2008-2017 Member States recognized the institutional capacity of the health sector as one of the key building blocks for undertaking a response to the health challenges faced in countries. With the six proxy indicators showing progress, the Region has made significant progress in strengthening the national health authority and putting

governance, leadership, and accountability mechanisms in place to achieve greater levels of health and well-being. Future areas of work under this Member State priority have been laid out under Goal 2 of SHAA2030.

24. As of 2017, 27 countries had made progress on developing comprehensive national health policies, strategies and/or plans, and 22 countries made progress on establishing legislative or regulatory frameworks to support universal health.[8] Worth noting are the approval of tobacco legislation in Mexico (2008), Colombia (2009), El Salvador (2011), and Jamaica (2013); mental health legislation 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 updating of 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. In addition, 13 countries had mechanisms for analyzing and/or reporting on progress toward universal health using a monitoring and evaluation framework.[9]

25. Of the 20 countries that responded to the questionnaire for this evaluation, 19 reported having implemented intersectoral coordination mechanisms headed by the national health authority. Examples of intersectoral coordination mechanisms include intersectoral councils, commissions and other consultative processes, including for coordination with subnational jurisdictions. Some countries have coordinating entities for specific issues, such as nutrition, sports, vaccination, cancer, food safety, radiation, water and sanitation, among others. It is also important to note intersectoral policies related to marginalized groups, such as indigenous peoples, Afro-descendants, women, and older adults, among others. In addition, 19 countries reported having mechanisms for promoting social participation; examples include national health forums, health councils, and dialogues on specific issues or proposals.

26. Member States and the Secretariat have also advocated for the inclusion of health as a priority within regional forums. 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 noncommunicable diseases (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.

[8] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5)*.

[9] Ibid.

Area of action B: Tackling health determinants

27. The Region of the Americas has been a trailblazer in its recognition of the role of social and environmental determinants of health in determining health outcomes, particularly among populations in conditions of vulnerability. All but one of the 13 indicators in this area showed progress during recent years. As of 2017, most countries had made progress in addressing the very broad recommendations of WHO´s Commission on Social Determinants of Health. Progress made between 2011 and 2017 includes the development of equity profiles, actions on Health in All Policies, and the measurement of health inequalities.

28. Looking to the future, by including health determinants in one of the eleven Goals in SHAA2030, Member States have sent a clear message that addressing determinants of health through "intersectoral, multisectoral, regional and subregional approaches" is fundamental to reducing health inequalities and inequities and achieving the health-related Sustainable Development Goals. As of 2017, 22 countries had begun implementing health promotion strategies to reduce health inequities and increase community participation through health-promoting networks, and 32 countries had improved the institutional response to inequities in health, as reflected in work on gender, equity, human rights and ethnicity. Most recently, 15 countries have been participating in the Commission on Equity and Health Inequalities in the Americas.[10]

29. As of 2015, the Region had made real progress in reducing maternal mortality (estimated at 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).[11] 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 did achieve MDG 4, on the reduction of under-5 mortality. As of 2017, ten countries were implementing an integrated plan for maternal and perinatal mortality in line with the regional plans of action on maternal mortality and neonatal health, and eight had made progress on this indicator.[12] Countries have increased efforts to improve and expand maternal and child services, increasing the coverage of prenatal care and delivery attended by trained health workers.

30. Concerning the data reported at the regional level, it should be noted that there are significant variations in the different subregions.

a) In the case of maternal mortality, North America,[13] had 13 deaths per 100,000 live births; the Andean Area,[14] 87; Brazil, 44; the Latin Caribbean,[15] 187; the non-Latin

[10] Ibid.
[11] PAHO, *Core Indicators 2017.*
[12] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*
[13] Bermuda, Canada, and the United States of America.
[14] Bolivia, Colombia, Ecuador, Peru, and Venezuela.
[15] Cuba, Dominican Republic, French Guiana, Guadalupe, Haiti, Martinique, and Puerto Rico.

Caribbean,[16] 107; the Southern Cone,[17] 54; the Central American Isthmus,[18] 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.

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.[19] 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.[20]

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.[21] 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 lack of access to food, lack of health care, and lack of water and basic sanitation, within a broader context of social, economic, and political factors, including poverty, inequality, and limited schooling for mothers.[22]

[16] 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).

[17] Argentina, Chile, Paraguay, and Uruguay.

[18] Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

[19] United Nations Children's Fund (UNICEF), World Health Organization, International Bank for Reconstruction and Development/The World Bank. Levels and trends in child malnutrition: Joint Child Malnutrition Estimates. Geneva: World Health Organization; 2012 and 2018. Key findings of the 2012 and 2018 editions. Available from: http://www.who.int/nutgrowthdb/estimates/en/.

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

[21] UNICEF/WHO/World Bank, ibid.

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

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.[23] 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 2017, 35 countries and territories had achieved the outcome target of having introduced one or more new vaccines into their routine immunization schedules, and six were in progress.[24] 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.

35. As of 2017, three countries had achieved the target of employing a public health approach as part of an integrated approach to violence prevention.[25] 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 *Buen Vivir* (the right or good way of living).

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

36. This area aimed to expand financing and social protection through insurance coverage, as well as to increase access to medicines and health technologies, with a primary health care approach. With all proxy indicators showing progress in this final evaluation, it can be said that the Region has made important strides in increasing protection and access, in line with the resolutions Strategy for Universal Access to Health and Universal Health Coverage (CD53.R14) and Access and Rational Use of Strategic and High-cost Medicines and Other Health Technologies (CD55.R12). Under SHAA2030, it is expected that countries will continue to show progress under this area, with specific goals related to expanding access to health services (Goal 1), achieving adequate and sustainable health financing (Goal 4), and ensuring access to essential medicines and vaccines, and to other priority health technologies (Goal 5).

37. 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). Countries reported policies aimed at addressing issues such as population aging, care for persons with disabilities, health care and nutrition for children's development, reduction of barriers to access, and

[23] PAHO, *Core Indicators 2017* and *Basic Indicators 2010.*

[24] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*

[25] Ibid.

mobile care programs to reach marginalized groups. Many policies are carried out by the national health authority in partnership with other ministries, such as ministries of social development. It should be noted, moreover, that within the framework of these policies the countries of the Region 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.

38. This area of action recognized that universal access to health and universal health coverage are "determined by the availability of financing". As of 2017, 16 countries and territories had achieved the target for having financial strategies for universal health, and three had partially done so.[26] Health financing studies conducted with the support of PASB and collaborative work between ministries of health and ministries of finance and other financial institutions have yielded evidence to support the conclusion that increased financing for health is necessary.

39. 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.[27] 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%. Despite progress made, reaching the target of public expenditure in health in excess of 6% of GDP[28] will be a challenge for many countries in the Region, with just six of the 20 target countries having achieved the target in 2017 and 10 more in the 4-5% range.[29] The Region has been marked by economic contraction in Latin America 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.[30]

40. 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%;

[26] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*

[27] WHO.

[28] This target is consistent with Target 4.1 of SHAA2030 and Outcome Indicator 4.1.2 of the PAHO Strategic Plan 2014-2019. Public expenditure on health equivalent to 6% of GDP is a useful benchmark in most cases and is a necessary, though not sufficient, condition to reduce inequities and increase financial protection.

[29] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*

[30] 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.

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.[31]

41. As of 2017, ten countries and territories had achieved the target for implementing a policy for access to medicines, and another two had partially done so.[32] 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.

42. 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. For example, among other measures, Guatemala created a health care unit for indigenous peoples that employs an intercultural approach, and other countries created special programs or directorates. In addition, 23 countries and territories achieved the indicator for implementing health plans, policies, or laws to address ethnicity.[33] Regional technical consultations with the ministries of health have been held, with extensive participation by the countries of the Region. Important advances have been made in the recognition of traditional medicine by some countries. The Andean countries have made progress in implementing the Andean Health Plan for Afro-descendants 2017-2021. These initiatives have been key to giving ethnicity a more prominent place in national and regional health programs. Nevertheless, challenges remain, given the complexity of the issues involved.

43. As of 2017, nine countries and territories had achieved the target for implementing strategies and/or plans to improve quality of care and patient safety, and ten countries and territories had partially done so.[34] In addition, 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.

44. 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[35] in 2012 and $90.4 million in 2017.

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[31] 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.

[32] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5)*.

[33] Ibid.

[34] Ibid.

[35] Unless otherwise indicated, all monetary figures in this document are expressed in United States dollars.

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

45. Equity in health was one of the main principles of HAA2008-2017 and has continued as one of the principles for SHAA2030. This area of action aimed to improve the health of the most marginalized groups, including through recognition of the importance of promoting health throughout the life course and sexual and reproductive health as priorities for the Region. Equity gaps persist throughout the Region, both between and within countries. Under the theme of "Championing Health: Sustainable Development and Equity," the PAHO Strategic Plan 2014-2019 has sought to address these gaps. However, preliminary results and projections reported in the End-of-biennium Assessment Report for 2016-2017, which are also being reported to the 56th Directing Council, show that progress can be slow. According to that assessment, several equity gap reduction targets were projected to be "at risk" of not being achieved by 2019.[36]

46. This evaluation has shown similar results; while there was progress on other seven of the nine proxy indicators, two showed no progress (HIV prevalence and incidence of mother-to-child congenital syphilis transmission). The ongoing challenges faced by countries in reducing health inequalities and inequities suggest that the Organization will need to accelerate efforts between now and 2030.

47. Concerning mother-to-child HIV and congenital syphilis transmission, it is important to bear in mind what PAHO, WHO, and UNICEF have reported:[37]

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. 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.

[36] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*

[37] PAHO, *Elimination of mother-to-child transmission of HIV and syphilis in the Americas: Update 2016.*

48. 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.[38] In this regard, it is important to consider what UNAIDS reported in 2017:[39]

a) Latin America: In 2016, there were 1.8 million (1.4-2.1 million)[40] 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.

49. 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.[41] 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."[42]

50. As of 2016, the percentage of hospital births in the Region had risen to 94.8%, compared to 94.1% in 2015.[43] 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,

[38] PAHO, *Health in the Americas+, 2017 edition. Summary: Regional Outlook and Country Profiles*, p. 21.
[39] UNAIDS, *Fact sheet: Global HIV & AIDS statistics.* Available from: http://www.unaids.org/en/resources/fact-sheet.
[40] The intervals in parentheses show the confidence intervals in the UNAIDS estimates.
[41] PAHO, *Core Indicators 2017* and *Basic Indicators 2011*.
[42] WHO. World Health Statistics 2005. Geneva: WHO; 2005.
[43] PAHO, *Core Indicators 2017, 2016* and *Basic Indicators 2011*.

79.7%; and Mexico, 94.2%. Institutional pregnancy and delivery care and the increase in obstetric interventions have significantly lowered maternal mortality.

51. 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.[44] 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 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.

52. With regard to reducing inequalities throughout the life course, as of 2017, progress had been made in 21 countries in the formulation or updating of national adolescent health policies or plans. In addition, 15 countries advanced toward the adoption of plans that explicitly include actions to address the health needs of older people in alignment with the WHO Global Strategy and Action Plan on Aging and Health.[45] For example, Mexico developed a national plan to promote healthy aging, the National Development Plan 2007-2012. Argentina, meanwhile, 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.

53. To improve policy- and decision-making and targeting of interventions to address equity gaps, it is important to strengthen information systems. The Region has intensified capacity-building activities for data management and health situation trend monitoring in health information systems. As of 2017, six countries had achieved the indicator for having produced a comprehensive situation and trend assessment during the 2016-2017 biennium, with another 29 in progress. This led to the successful completion of the Organization-wide flagship publication and project *Health in the Americas*+, 2017 edition.[46] However, implementing more robust information systems capable of generating timely and quality data for measuring progress in health is still a challenge.

Area of action E: Reducing the risk and burden of disease

54. This area aimed both to address the rising challenge of preventing and controlling noncommunicable diseases and to combat communicable diseases that remain a challenge for the Region. During the period of the Agenda, many important achievements were registered in this area, including declaration of the elimination of endemic transmission of rubella and congenital rubella syndrome and of measles in the Region of the Americas; certification of seven countries and territories by WHO as having achieved the targets for

[44] Ibid.

[45] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5)*.

[46] Ibid.

the elimination of mother-to-child transmission of HIV and congenital syphilis; verification of the elimination of onchocerciasis in Colombia, Ecuador, Guatemala and Mexico; verification of the elimination of trachoma as a public health problem in Mexico; advances toward the elimination of malaria, leprosy, and dog-transmitted rabies; and reduction of premature mortality and tobacco use.

55. In terms of the proxy indicators, progress has been noted on both communicable and noncommunicable diseases, with 13 of the proxy indicators showing progress; however, four showed no progress. One indicator could not be assessed. The Organization will continue its efforts during the period of SHAA2030, which, in order to provide greater focus, sets separate goals for communicable and noncommunicable diseases.

56. 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 with 32.8 in 2011.[47] 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.[48] 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%).

57. 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 with 76.4 in 2011.[49] 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.[50] 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.[51] Mortality from all types of cancer has fallen in both sexes in the Region since the year 2000, with an estimated reduction of 7.9% occurring between 2008 (114.3 per 100,000 population) and 2015 (105.3 per 100,000 population).

58. 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.[52] The rates varied widely from country to country, from six deaths per 100,000 population in Canada to 29.3 in the Dominican Republic.[53] Road traffic injures claimed 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-

[47] PAHO, *Core Indicators* and *Basic Indicators.*
[48] PAHO, *Health in the Americas +, 2017 Edition. Summary: Regional Outlook and Country Profiles*.
[49] PAHO, *Core Indicators* and *Basic Indicators.*
[50] PAHO, *Health in the Americas +, 2017 Edition. Summary: Regional Outlook and Country Profiles*.
[51] PAHO, *Core Indicators* and *Basic Indicators.*
[52] *Ibid.*
[53] PAHO, *Health in the Americas +, 2017 Edition. Summary: Regional Outlook and Country Profiles*.

income countries (26%).[54] The age- and sex-adjusted rate in 2015 was 25.4 deaths for men and 6.6 for women.[55]

59. As of 2016, the Region showed an increase in the prevalence of overweight and obesity (BMI >25kg/m ^{2}) in adults (18 years of age or older): estimated at 62.5% (60.5-64.5) compared with 59.8% (58.3-61.3) in 2011.[56] The Region of the Americas is the WHO region with the highest prevalence of overweight and obesity.[57]

60. The Region has made progress in reducing the prevalence of smoking (16.3% among adults and 13% among adolescents) since 2011 (22% among adults).[58] 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% among males and 12.3% among females).[59]

61. As of 2017, 21 countries reported having developed national multisectoral action plans for the prevention and control of noncommunicable diseases and their risk factors with the goal of reducing premature mortality from NCDs, while another five made progress.[60] However, multisectoral action to address the fundamental causes of NCDs with a health-in-all-policies approach continues to be difficult in all countries. In addition, 18 countries and territories developed national action plans consistent with the WHO Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition. The area with the slowest rate of progress is the allocation of the necessary human and economic resources needed to implement nutritional interventions.

62. As of 2017, the Region had shown progress in implementing the WHO Framework Convention on Tobacco Control (FCTC). Four of the seven target countries had achieved the indicator, while another three had partially done so. The Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018-2022 was approved by the 29th Pan American Sanitary Conference with the objective of accelerating the implementation of the FCTC. In addition, five countries achieved the indicator for having a national alcohol policy, while another six had partially done so. However, the Region faces challenges in applying public health-based alcohol policies, such as societal acceptance of alcohol use, a lack of awareness of the negative impact of alcohol use, and a weak political commitment to reducing harmful alcohol consumption. Multisectoral engagement is key to working beyond the health sector to address NCDs and risk factors and requires sustained political commitment.[61]

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[54] PAHO, *Health in the Americas +, 2017 Edition. Summary: Regional Outlook and Country Profiles*.
[55] PAHO, *Core Indicators 2017.*
[56] WHO, Global Health Observatory, available from: http://www.who.int/gho/en/.
[57] PAHO, *Health in the Americas+ 2017*, Overweight and Obesity. Health status of the population.
[58] PAHO, *Core Indicators 2017.*
[59] PAHO, Sustainable Health Agenda for the Americas 2018-2030.
[60] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*
[61] *Ibid*.

63. Regarding mental health, 32 countries and territories have an approved policy or plan, with emphasis on the development of community-based mental health care. The integration of mental health into primary health care is being carried out through the implementation of the WHO Mental Health Gap Action Program (mhGAP).[62]

64. As of 2016, the incidence of HIV infection in the Region was 13.7 per 100,000 population.[63] The 2009 AIDS incidence rate (used in 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 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%).[64]

65. The reported incidence rate of tuberculosis has had a slow declining trend in recent years. This suggests that, despite TB prevention and control efforts by countries, there is continued transmission of the disease, with new cases continuing to be detected and diagnosed. The slow decline could also reflect the effect on TB diagnosis of the introduction and increasing use of new rapid diagnostic molecular tests, which are more accurately detecting cases that previously were not detected using smear microscopy. The current challenge in order to reach the milestones and targets set by the End TB strategy and the SDGs for TB is to increase the rate of decline.

66. 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 Americas fell by 62% (from 1,181,095 to 454,311 cases).[65] 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.[66]

67. As of 2016, there was an increase in the number of cases of dengue reported in the Region: 2,276,803 compared with 1,699,072 in 2011.[67] Between 2011 and 2015 a

[62] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*
[63] PAHO, *Core Indicators 2017.*
[64] UNAIDS, *Fact Sheet. World Aids Day 2017*.
[65] PAHO, *Core Indicators 2017.*
[66] PAHO, *Health in the Americas+ 2017. Summary: Regional Outlook and Country Profiles*.
[67] PAHO, *Core Indicators 2017.*

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.[68]

68. 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 is impact target 8.3 of the PAHO Strategic Plan 2014-2019. In addition, 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."

69. As of 2016, the number of countries in which onchocerciasis had been endemic but that had certified its elimination increased to four—three more than in 2011. These countries were Colombia, Ecuador, Guatemala, and Mexico. Onchocerciasis elimination is 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 neglected infectious diseases that are targeted for preventive chemotherapy, including collection of evidence to support elimination," and raises the target for 2022 to six countries.

Area of action F: Strengthening the management and development of health workers

70. The Region of the Americas has led global efforts to ensure an adequate health workforce, including it as a priority in the PAHO Strategic Plan 2014-2019. This evaluation shows that the commitment of countries to address this area is yielding fruit; all five indicators show progress. Looking forward, Member States showed continued support and enthusiasm for the area by including it under Goal 3 in SHAA2030; the regional Strategy on Human Resources for Universal Access to Health and Universal Health Coverage (Resolution CSP29.R15) and the proposed Plan of Action (Document CD56/10) aim to accelerate efforts in this regard.

71. The final report on Regional Goals for Human Resources for Health (HRH) 2007-2015 (Document CD54/INF/1) was presented to the 54th Directing Council of PAHO in 2015. Information was gathered between 2013 and 2015, with the participation of 20 countries. A progress report had been presented to the 28th Pan American Sanitary Conference (Document CSP28/INF/3), for which information was collected between 2009 and 2010 with the participation of 24 countries. As of 2017, eight countries and territories had achieved the indicator for having an HRH action plan or strategy in line with universal health policies, and five more had partially achieved it.[69]

[68] PAHO, *Health in the Americas+ 2017. Summary: Regional Outlook and Country Profiles*.

[69] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*

72. As of 2017, 26 countries had achieved the target of having a density of health workers (doctors, nurses, midwives) of 25 professionals per 10,000 population, while two countries made progress. PASB is working with countries identified as at risk of not achieving this indicator by 2019.[70] The main challenge is the distribution of the health workforce. 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 with 13.6 per 10,000 population).[71]

73. As of 2017, there had been an increase in the number of countries that have continuing education programs for staff, either through a node on the PAHO Virtual Campus for Public Health or through an equivalent e-learning network. Thirteen countries and territories had achieved this target, while five more had done so partially. Around 100,000 professionals take self-learning courses on the Virtual Campus each year.[72]

74. 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 with the 11 reported in 2011, according to country responses to the survey. For example, Argentina has procedures in place to validate degrees with several Latin American countries. Work is also being done through MERCOSUR to harmonize regulations for the recognition of qualifications of health professionals in various fields. Ecuador participates in a training program with Cuba and has a "Yo Retorno" ("I'm Coming Back") program to provide an option for Ecuadorian health professionals living abroad to return.

Area of action G: Harnessing knowledge, science, and technology

75. This area focused on the use of knowledge and evidence in decision-making, strengthening capacity for research and surveillance at all levels, ensuring the application of best practices in bioethics, and exercising the regulatory role of the national health authority. Significant progress has been made, with the 2015 targets under three of the associated indicators having been exceeded and the other two achieved. Work under this area of action will continue with the implementation of SHAA2030 Goals 5, 6, and 7.

76. As of 2017, seven countries and territories had a system or mechanism to facilitate evidence-based decision-making, while four more partially achieved the target. PASB played an active role in the generation of evidence in 12 countries to strengthen essential public health guidance and actions to prevent and limit the impact of Zika virus disease and its complications. Progress was also made in the number of countries implementing a

[70] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*

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

[72] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).*

national health research policy or plan. Nine countries and territories achieved the target, while another nine had partially done so. In addition, 11 countries and territories had accountability mechanisms to review research or incorporate ethics into public health.[73]

77. Regarding medicines, 12 countries and territories were implementing mechanisms for health technology assessment and evidence-based incorporation, selection, management, and rational use of medicines and other health technologies, exceeding the target. Five more partially achieved the indicator. Moreover, countries made progress on the assessment of regulatory functions, with 16 countries having achieved the indicator and four more partially achieved. In 2016, the 55th Directing Council approved a policy document on access to and rational use of strategic and high-cost medicines and other health technologies, which called on Member States to strengthen regulatory systems to ensure the quality of medicines.[74]

Area of action H: Strengthening health security

78. During the period of the Agenda, the Region responded to multiple outbreaks (including the H1N1 pandemic, Zika virus disease, and Chikungunya), as well as a number of emergencies and disasters with an impact on health. With the collaboration of PASB, countries also stepped up efforts to increase preparedness and disaster management capacity, and all five proxy indicators showed important progress. In 2016 the Region of the Americas established the new PAHO Health Emergencies Program, consistent with Decision WHA69(9) and Document A69/30 of the World Health Assembly.

79. As of 2017, progress had been made with regard to 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. Progress was also made in the number of Member States incorporating core competencies for surveillance and response in compliance with the International Health Regulations (2005), with 22 out of 35 Member States meeting the criteria. During 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.[75]

80. Over the last decade, countries in the region have been making sustained progress toward surveillance and preparedness for emerging and reemerging zoonotic diseases. Laboratory networks and integrated health information systems have been supported and strengthened, contributing significantly towards preventing the introduction or dissemination of emerging zoonotic diseases of public health importance, such as avian influenza, and ensuring a timely response to reemerging threats, such as arbo-zoonoses and hematophagous bat-transmitted rabies. Despite these advances, Haiti, for example, requires

[73] *Ibid*.

[74] Document CD55/10, Rev.1 and Resolution CD55.R12 (2016).

[75] PAHO, *Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5)*.

further and closer support to be prepared for the challenges of emerging and reemerging zoonotic diseases. Sharing of best practices and experiences among countries in the Region is an important means of maintaining and improving preparedness for zoonotic diseases.

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

81. 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.

82. 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 2 and 3).

Figure 4. PAHO/WHO Planning Frameworks

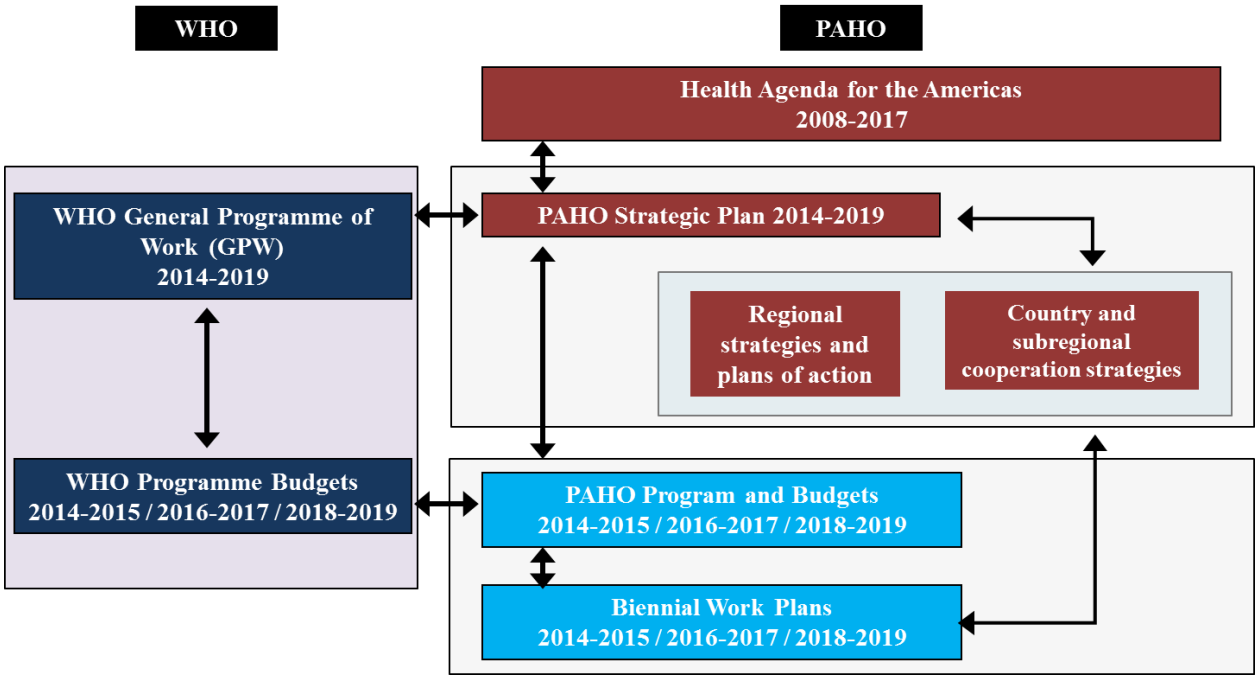


Table 2. Relationship between the areas of action of the Agenda and the impact goals of the PAHO Strategic Plan 2014-2019

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. 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 3. Relationship between the areas of action of the Agenda 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

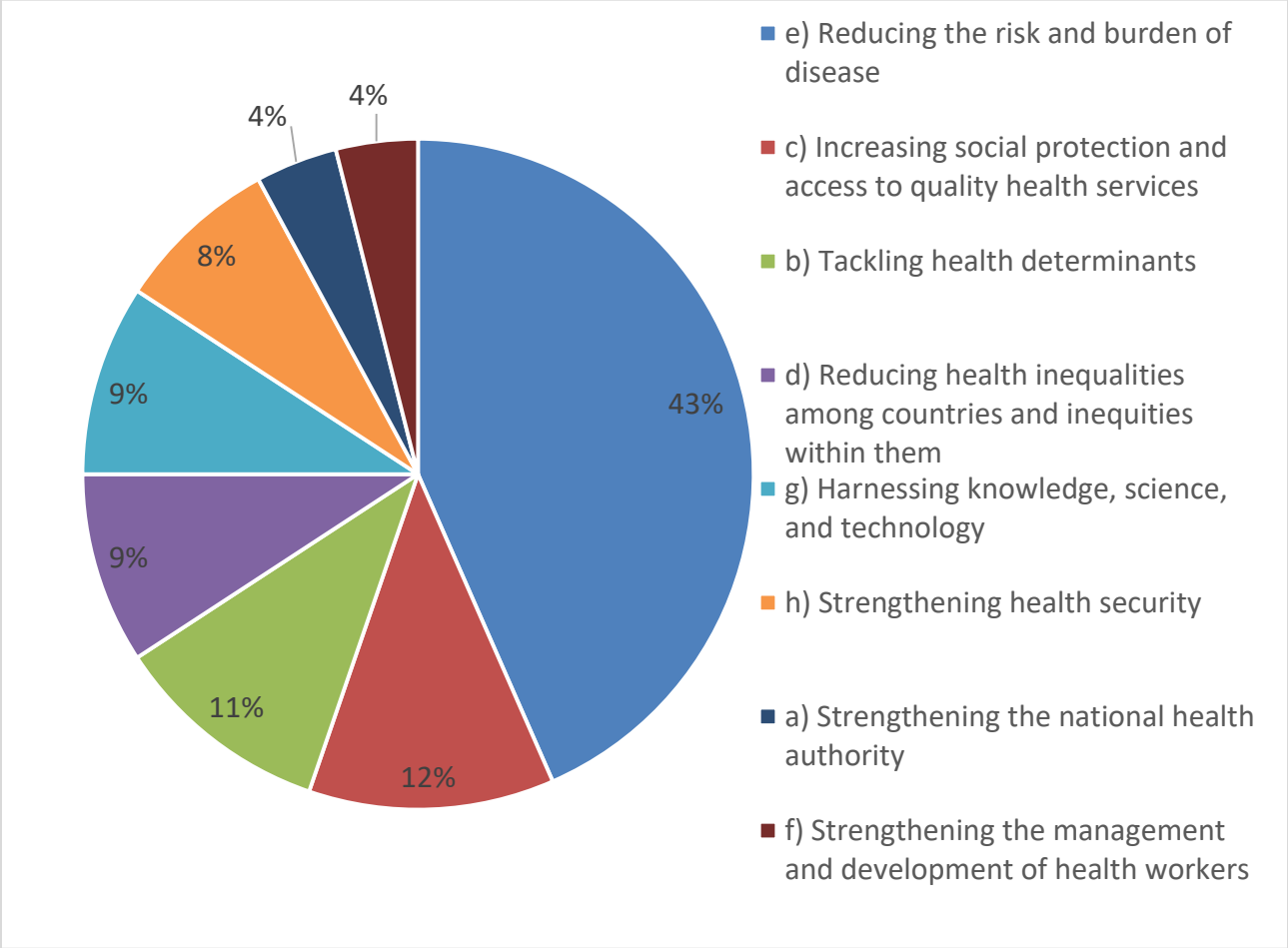
Areas of action of the Agenda	Categories and program areas of the Strategic Plan
	1.4 Neglected, tropical, and zoonotic diseases 1.5 Vaccine-preventable diseases (including maintenance of polio eradication).
	Category 2. Noncommunicable diseases and risk factors 2.1 Noncommunicable diseases and risk factors 2.2 Mental health and psychoactive substance use disorders 2.3 Violence and injuries 2.4 Disability and rehabilitation 2.5 Nutrition
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

83. 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.

84. 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%), B (8-11%), 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 5. 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

85. Both before and after the mid-term evaluation of the Agenda, the country cooperation strategies were consistent with it, as can be seen in 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.[76]

[76] 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

V. GENERAL OBSERVATIONS ON THE RESULTS OF THE EVALUATION

Component A

86. The evaluation of this component shows that 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

87. 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

88. 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 examined were all found to be consistent with the areas of action of the Agenda.

VII. CONCLUSIONS

89. The final evaluation of HAA2008-2017 confirmed its role as a regional policy instrument that provided a strategic vision for health in the Region. It reaffirmed the commitments of countries and territories to the health of their populations, and provided guidance for strategic planning processes in Member States and in the PASB. As a call to action, HAA2008-2017 promoted critical health issues in the Region, 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.

90. 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. The Agenda also 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. The lack of a results-based management framework, including targets and indicators, however, hindered the effective implementation of the Agenda and the monitoring and assessment of its impact.

91. HAA2008-2017 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.

92. 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 available evidence.

b) Provide the greatest possible degree of direction for health policies in the Region, incorporating an equity-based approach and reflecting these 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 PAHO Governing Body meetings.

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 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.

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

Annexes

VIII. ANNEXES

Annex A: Detailed Assessment of Indicators by Area of Action

Area of action A: Strengthening the national health authority

Table 1. 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 defined goals/targets that have been reviewed in the last five years (OPT 4.1.1)	**Progress** Achieved in 22 and progress in 5 (2017)[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 access to health and universal health coverage (OPT 4.1.3)	**Progress** Achieved in 17 and progress in 5 (2017)[a]
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[77]	**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, Reports of the End-of-biennium Assessment of the Program and Budget 2014-2015 and 2016-2017.
b) Country survey for the final evaluation, 2017.
c) Health in the Americas, 2017.

Area of action B: Tackling health determinants

Table 2. 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**
2. Infant mortality rate (children under 1) per 1,000 live births	14.8 (2010)[b]	13 (2017)[c]	**Progress**

[77] 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
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.

Table 3. Indicators for area of action B (risk factors)

Indicator	2011	2017	Rating
1. Prevalence of overweight and obesity in children under 5[78]	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.

Table 4. 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 one or more new vaccines (OCM 1.5.3)	22 (2011)[b]	Achieved in 35 and progress in 6 (2017)[d]	**Progress**

Sources:
a) PAHO, Basic Indicators 2010.
b) Country survey, Mid-term Evaluation of HAA2008-2017, 2011.
c) PAHO, Core Indicators 2017.
d) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).

Table 5. Indicators for area of action B (health systems)

Indicator	Rating
1. Number of countries and territories implementing health promotion strategies to reduce health inequities and increase community participation of health promoting networks (OPT 3.4.3)	**Progress** Achieved in 15 and progress in 5 (2017)[a]

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

Indicator	Rating
2. Number of countries and territories that have an institutional response that addresses inequities in health, gender, equity, human rights, and ethnicity (OCM 3.3.1)	**Progress** Achieved in 19 and progress in 13 (2017)[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 3 (2017)[a]
4. Number of countries and territories implementing an integrated plan for maternal and perinatal mortality in line with regional plans of action on maternal mortality and neonatal health (OPT 3.1.1)	**Progress** Achieved in 10 and progress in 8 (2017)[a]
5. Number of countries that have implemented interventions in response to the recommendations of the Commission on Social Determinants of Health[79]	**Progress** 35 countries (2017)[b]

Sources:

a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).

b) Information available to PASB.

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

Table 6. 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 financial strategies for universal access to health and universal health coverage (OPT 4.1.2)	**Progress** Achieved in 16 and progress in 3 (2017)[b]
3. Current public expenditure in health as a percentage of gross domestic product	**Progress** Latin America and the Caribbean: 3.5% (2015)[c]
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 within the last five years (OPT 4.3.1)	**No progress** Achieved in 10 and progress in 2 (2017)[b]
6. Number of countries that have adopted specific measures for the care of indigenous populations	**Progress** 17 of 20 that responded (2017)[a]

[79] The indicator refers to WHO´s Commission on the Social Determinants of Health. It is important to bear in mind that a Commission on Equity and Health Inequalities in the Americas was established in May 2016. It will issue recommendations in 2018.

Indicator	Rating
7. Number of countries and territories implementing national strategies and/or plans for quality of care and patient safety (OPT 4.2.2)	**Progress** Achieved in 9 and progress in 10 (2017)[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 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).
c) WHO Global Health Observatory.
d) Information available to PASB.

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

Table 7. 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.

Table 8. 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.

Table 9. Indicators for area of action D (service coverage)

Indicator	2011	2017	Rating
1. Percentage of hospital births[80]	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.

Table 10. Indicators for area of action D (health systems)

Indicator	Rating
1. Number of countries that have produced a comprehensive health situation and trends assessment during 2016-2017 (OPT 4.4.1)	**Progress** Achieved in 6 and progress in 29 (2017)[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 6 (2017)[a]
3. Number of countries with national health plans (policies, strategies, plans) that explicitly include actions to address the health needs of older people (OPT 3.2.1a)	**Achieved** Achieved in 12 and progress in 3 (2017)[a]

Sources:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).

Area of action E: Reducing the risk and burden of disease

Table 11. 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**
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**

[80] Since 2015, PAHO has used hospital deliveries as a proxy indicator of deliveries attended by trained health workers, as it is assumed that hospital 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.

Indicator	2011	2017	Rating
5. Incidence rate of tuberculosis per 100,000 population	23.5 (2009)[a]	22.4 (2016)	**Progress**
6. Incidence rate of AIDS per 100.000 population	10.7 (2009)[a]	HIV diagnosis rate: 13.7 (2016)[a] [1]	**N/A**
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 Canada and the United States of America; 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.

Table 12. 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)[81]	59.8 (58.3-61.3) (2011)[a]	62.5 (60.5-64.5) (2016)[a]	**No progress**

[81] 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.

Indicator	2011	2017	Rating
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, Core Indicators 2017.

Table 13. Indicators for area of action E (health systems)

Indicators	Rating
1. Number of countries and territories implementing national multisectoral action plans for the prevention and control of noncommunicable diseases and risk factors (OPT 2.1.1a)	**Progress** Achieved in 21 and in progress in 5 (2017)[a]
2. Number of countries and territories that have a national policy or plan for mental health in line with the Regional Strategy on Mental Health (OPT 2.2.1)	**Exceeded** Achieved in 32 (2017)[a]
3. Number of countries implementing policies, strategies or laws in line with the Framework Convention on Tobacco Control (FCTC) (OPT 2.1.2e)	**Progress** Achieved in 4 and in progress in 3 (2017)[a]
4. Number of countries with a national alcohol policy that includes at least one population based policy measure in line with the Regional Plan of Action/Global Strategy to reduce harmful use of alcohol (OPT 2.1.2a)	**Progress** Achieved in 5 and in progress in 6 (2017)[a]
5. Number of countries and territories that are implementing national action plans consistent with the comprehensive implementation plan on maternal, infant, and young child nutrition (OPT 2.5.1)	**Progress** Achieved in 18 (2017)[a]

Sources:
a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).

Area of action F: Strengthening the management and development of health workers

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

Indicator	Rating
1. Number of countries and territories with a human resources for health (HRH) action plan or strategy aligned with universal access to health and universal health coverage policies (OPT 4.5.1)	**Progress** Achieved in 8 and in progress in 5 (2017)[a]
2. Number of countries and territories with at least 25 health workers (doctors, nurses, and midwives) per 10,000 population (OCM 4.5.1)	**Progress** Achieved in 26 and in progress in 2 (2015)[a]
3. Number of countries and territories that have continuing education programs for staff through a node of the Virtual	**Progress** Achieved in 13 and in progress in 5 (2017)[a]

Indicator	Rating
Campus for Public Health or equivalent e-learning network (OPT 4.5.4)	
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 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).
b) Survey of countries for the final evaluation, 2017.
c) PAHO, Regional Goals for Human Resources for Health 2007-2015: Final Report.

Area of action G: Harnessing knowledge, science, and technology

Table 15. 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 4.4.6)	**Progress** Achieved in 7 and in progress in 4 (2017)[a]
2. Number of countries and territories implementing the regional Policy on Research for Health (OPT 4.4.5)	**Progress** Achieved in 9 and in progress in 9 (2017)[a]
3. Number of countries and territories with accountability mechanisms to review research or incorporate ethics into public health (OPT 4.4.4)	**Achieved** Achieved in 11 (2017)[a]
4. Number of countries and territories that have conducted an assessment of their regulatory functions for at least three of the following: medicines, medical devices, radiation safety, blood safety, and organ transplantations (OPT 4.3.3)[82]	**Progress** Achieved in 16 and in progress in 4 (2017)[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)	**Progress** Achieved in 12 and in progress in 5 (2017)[a]

Source:

a) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).

[82] This indicator is being used as a proxy to report on the following indicator from the midterm evaluation: Number of countries that have implemented standards in keeping with international standards on quality, safety, and efficacy of health-related inputs.

Area of action H*: *Strengthening health security

Table 16. 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	**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 potential public health emergencies of international concern for which information is made available to the International Health Regulations (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	**Progress** 34 (2017)[a]

Source:

a) Information available to PASB.

b) PAHO, Report of the End-of-biennium Assessment of the Program and Budget 2016-2017/Second Interim Report of the PAHO Strategic Plan 2014-2019 (Document CD56/5).

c) PASB technical cooperation with countries and Maxwell MJ, Freire de Carvalho MH, Hoet AE, Vigilato MAN, Pompei JC, Cosivi O, et al. (2017). *Building the road to a regional zoonoses strategy: A survey of zoonoses programmes in the Americas*. PLoS ONE 12(3): e0174175. https://doi.org/10.1371/journal.pone.0174175.

Annex B: Links between the areas of action of the Agenda 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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