



**Pan American  
Health  
Organization**



**World Health  
Organization**  
REGIONAL OFFICE FOR THE  
**Americas**

## **160th SESSION OF THE EXECUTIVE COMMITTEE**

*Washington, D.C., USA, 26-30 June 2017*

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*Provisional Agenda Item 4.4*

CE160/14, Rev. 1  
12 June 2017  
Original: English

### **SUSTAINABLE HEALTH AGENDA FOR THE AMERICAS 2018-2030: A CALL TO ACTION FOR HEALTH AND WELLBEING IN THE AMERICAS**

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\* Revision needed to ensure accuracy of the text in Annex A.

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## **I. DECLARATION OF COMMITMENT**

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

- a) A hemispheric vision of a healthier and more equitable Region of the Americas, in harmony with the global vision and principles established in the 2030 Agenda for Sustainable Development, building on the progress made in the achievement of the Millennium Development Goals (MDGs) and the Health Agenda for the Americas 2008-2017.
- b) The reaffirmation of the right to the enjoyment of the highest attainable standard of health, Pan American solidarity, equity in health, universality and social inclusion, as fundamental principles and values that have inspired the countries we represent to improve health outcomes so that our people can develop to their fullest potential.
- c) The ongoing work toward universal access to health and universal health coverage, and the development of resilient health systems with capacity to address the determinants of health.
- d) Advocacy at the highest level for the use of this Agenda and the promotion of joint actions with government and non-government actors alike at the regional, subregional, national, and subnational levels to realize the hemispheric vision.
- e) The implementation, monitoring, and evaluation of this Agenda, and accountability for its realization through the mechanisms developed in collaboration with the Pan American Sanitary Bureau (PASB).

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

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

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

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

4. I believe that this Agenda will help us focus our efforts throughout the 2020s, so that we will see even greater returns on our investment in health. In the coming years, our focus must be on ensuring equity in health, so that all people can benefit from the major push for universal access to health and universal health coverage.

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

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

(Signature)

### **III. THE HEMISPHERIC VISION**

#### **About the new Agenda**

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

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

#### **Principles and values**

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

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

10. The Constitution of the World Health Organization (WHO) states that “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” In order to make this right a reality, countries should work towards improving access to timely, acceptable, affordable, high quality health care and the availability of health services, as well as an adequate standard of living and nutritious food that promote health. All of these factors are closely related to other human rights, including the right to an education, non-discrimination, access to information, and social participation.

11. The Agenda is aligned with PAHO’s commitment to mainstreaming human rights into health programs and policies at both the national and regional levels, considering the underlying determinants of health to be part of a comprehensive focus on health and human rights.

### ***Pan American solidarity***

12. Based on the history and experience of our Hemisphere, Pan American solidarity is needed to ensure equitable progress of Member States in the implementation of the Agenda in the Americas.

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

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

### ***Equity in health***

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

16. WHO has stated: “A human rights-based approach to health provides strategies and solutions to address and rectify inequalities, discriminatory practices and unjust power relations, which are often at the heart of inequitable health outcomes. The goal of a human rights-based approach is that all health policies, strategies and programs are designed with the objective of progressively improving the enjoyment of all people to the right to health. Interventions to reach this objective adhere to rigorous principles and standards, including non-discrimination [...], availability [...], accessibility [...], acceptability [...], quality [...], accountability [...], universality [...].”<sup>1</sup>

### ***Universality***

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

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

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<sup>1</sup> WHO. Health and human rights. Fact sheet N°323. December 2015. Available at: <http://www.who.int/mediacentre/factsheets/fs323/en/>.

### ***Social inclusion***

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

20. In the exercise of human rights, including the right to health, all persons should be included, without discrimination on the basis of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or other status, for example, disability, age, marital and family status, sexual orientation and identity, health status, place of residence, or economic and social situation.<sup>2</sup>

21. In the exercise of the right to health, individuals, ethnic groups, communities, and groups that are culturally different must be included. The Agenda takes into account the intercultural approach as an expression of an interactive social process of recognition and respect for differences in one or more cultures, which is indispensable for the construction of a just society.<sup>3</sup>

### **Vision**

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

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

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<sup>2</sup> United Nations Economic and Social Council: Committee on Economic, Social and Cultural Rights. General Comment No. 20, Non-discrimination in economic, social and cultural rights; 2009. E/C.12/GC/20. Available at: <http://www.refworld.org/docid/4a60961f2.html>.

<sup>3</sup> PAHO. Una visión de salud intercultural para los pueblos indígenas de las Américas, p. 11. Available in Spanish at: <http://new.paho.org/hq/dmdocuments/2009/54-VisionSaludInterculturalPI.pdf>.

## IV. CONTEXT AND SITUATION ANALYSIS

### Context and background

#### *The Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030)*

24. The Agenda represents the health sector response to the commitments adopted by the countries in the 2030 Agenda for Sustainable Development, unfinished business from the MDGs, and the Health Agenda for the Americas 2008-2017, and other emerging public health challenges in the Region.

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

26. To develop the Agenda, a Countries Working Group (CWG)<sup>4</sup> worked in close collaboration with the PASB in virtual and face-to-face meetings from October 2016 to September 2017. Consultations were held with Member States during the 2017 PAHO Governing Bodies meetings and during the World Health Assembly in May 2017. These consultations provided an opportunity to keep Member States informed about progress and to obtain input as the process evolved.

#### *The Health Agenda for the Americas 2008-2017*

27. The HAA 2008-2017<sup>5</sup> was developed following a “recommendation by the United Nations Joint Inspection Unit, which had pointed out that planning by international organizations should be based on a common vision of their Member States, formulated independently of the secretariat and of the organization’s governing bodies.”<sup>6</sup> Additionally, the Health Agenda addressed the mandates of the MDGs and the Eleventh

<sup>4</sup> The CWG membership was composed of high-level representatives of 16 Member States from all the Americas subregions: North America: United States and Mexico; Caribbean: Antigua and Barbuda, Barbados; Central America: Costa Rica, El Salvador, Honduras, Nicaragua, and Panama; South America: Argentina, Brazil, Chile, Ecuador, Paraguay, Peru, and Uruguay. Ecuador was the president, and Panama and Barbados were vice presidents of the group. The representatives included Ministers and Vice Ministers of Health, Chief Medical Officers, Planners, Epidemiologists, and international health relations professionals.

<sup>5</sup> Health Agenda for the Americas 2008-2017. Available at: [http://new.paho.org/hq/dmdocuments/2009/Health\\_Agenda\\_for\\_the\\_Americas\\_2008-2017.pdf](http://new.paho.org/hq/dmdocuments/2009/Health_Agenda_for_the_Americas_2008-2017.pdf).

<sup>6</sup> Final Report of the 27th Pan American Sanitary Conference (Document CSP27/FR), held between October 1 and 5, 2007.



General Program of Work of the World Health Organization, approved in 2006. The HAA 2008-2017 was launched in Panama City in June 2007.

28. The Agenda was recognized as the high-level policy instrument for health in the Americas. It oriented the response to the health needs of the population in the Region and was a formal commitment to work together in solidarity for health development in the Region. The HAA 2008-2017 guided the elaboration of national health plans, and the strategic plans of all organizations interested in health cooperation with the countries of the Americas, including the PASB (Strategic Plans 2008-2013, 2014-2019).

29. The HAA 2008-2017 set out eight major areas of action: *a)* strengthening the national health authority; *b)* tackling health determinants; *c)* increasing social protection and access to quality health services; *d)* reducing health inequalities among countries and inequities within them; *e)* reducing the risk and burden of disease; *f)* strengthening the management and development of health workers; *g)* harnessing knowledge, science and technology; and *h)* strengthening health security.

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

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

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

- a) Maternal mortality: There has been an important reduction in the mortality rate from 62.4 per 100,000 live births in 2007 and 65.7 per live births in 2010, to 46.8 per 100,000 live births (reported, versus 51 estimated) in 2016.<sup>7</sup>

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<sup>7</sup> PAHO Core Health Indicators, 2016.

- b) Dengue and obesity: The results continue along the lines of the trend evidenced in the mid-term evaluation, and therefore remain a concern.
- c) Tuberculosis: There has been a reduction in the incidence rate from 24.0 per 100,000 population in 2007 and 23.5 per 100,000 population in 2009 to 22.1 per 100,000 population in 2014.<sup>8</sup>
- d) HIV/AIDS: There has been a reduction of the number of cases of mother-to-child transmission of HIV from 3,300 in 2011 to 2,100 in 2015.<sup>9</sup>
- e) National public expenditure on health as a percentage of gross domestic product (GDP): There was a slight improvement in Latin American and the Caribbean, reaching 3.1% in 2006, 3.7% in 2011, and 4.0% in 2014 (as a simple average).
- f) Out-of-pocket spending: As a percentage of total health spending, out-of-pocket expenditure dropped to 52% in 2006, 47% in 2010, and 33.1% in 2014.

33. Consistent with its purpose, the HAA 2008-2017 served PAHO as the main political and strategic instrument for the development and implementation of two strategic plans (2008-2013 and 2014-2019), as well as regional strategies and plans of action, and country cooperation strategies.

### ***The 2030 Agenda and the Sustainable Development Goals***

34. In September 2015 the UN General Assembly adopted the Resolution "Transforming our World: the 2030 Agenda for Sustainable Development".<sup>10</sup> The 2030 Agenda contains 17 sustainable development goals (SDGs) and 169 specific development targets.

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

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<sup>8</sup> Ibid.

<sup>9</sup> PAHO. Elimination of Mother-to-Child Transmission of HIV and Syphilis in the Americas. Update 2016.

<sup>10</sup> United Nations. Transforming our World: the 2030 Agenda for Sustainable Development. Seventieth session of the General Assembly, Resolution A/RES/70/1. Available from: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N15/291/89/PDF/N1529189.pdf?OpenElement>.

**Table 1. SDG 3 Targets**

No.	Targets
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, waterborne diseases and other communicable diseases.
3.4	By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being.
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents.
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination.
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.
3.b	Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health and, in particular, provide access to medicines for all.
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

36. Paragraph 26 of the 2030 Agenda emphasizes the critical importance of health: “To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis,

hepatitis, Ebola, and other communicable diseases and epidemics, including by addressing growing anti-microbial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioral, developmental and neurological disorders, which constitute a major challenge for sustainable development.”

### **Situation analysis**

37. The analysis presented below establishes the context for SHAA2030. It includes a synopsis of socioeconomic and demographic characteristics and trends, and of the epidemiologic profile, health situation trends, and the health system response. The information sources are the United Nations’ “World Economic Situation and Prospects 2017”, the “Regional Outlook on Health in the Americas” from the 2017 edition of Health in the Americas (with input from Member States), and the Report of the End-of-biennium Assessment of the PAHO Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019.<sup>11</sup>

### ***Socioeconomic trends in the Region***

38. According to the United Nations’ “World Economic Situation and Prospects 2017” (WESP) report, Latin America and the Caribbean (LAC) will return to positive growth in 2017. The Region’s recovery will however be relatively shallow amid persistent external and internal headwinds.<sup>12</sup>

### ***World economic situation***

39. The world gross product grew by just 2.2% in 2016, marking the slowest pace of expansion since the Great Recession of 2009. Global growth is projected to improve moderately to 2.7% in 2017 and 2.9% in 2018, but this is more an indication of economic stabilization than a signal of a robust revival of global demand.

40. There are significant risks to the global and the regional outlook. Among other issues, there is a high degree of uncertainty in the international policy environment and elevated foreign currency-denominated debt levels as key downside risks that may derail global growth.

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<sup>11</sup> PAHO. Report of the End-of-biennium Assessment of the Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019. 55th Directing Council, 68th Session of the Regional Committee of WHO for the Americas, 26-30 September 2016 (Document CD55/5). Available from: [http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=35900&Itemid=270&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=35900&Itemid=270&lang=en).

<sup>12</sup> United Nations. World Economic Situation and Prospects 2017. Available from: [https://www.un.org/development/desa/dpad/wp-content/uploads/sites/45/publication/2017wesp\\_full\\_en.pdf](https://www.un.org/development/desa/dpad/wp-content/uploads/sites/45/publication/2017wesp_full_en.pdf).

*Situation in the Americas*

41. The economy of LAC is expected to return to positive growth in 2017, after contracting for two consecutive years, but significant external and internal headwinds will persist. GDP in LAC is expected to grow by 1.3% in 2017 and 2.1% in 2018, following an estimated contraction of 1% in 2016. The modest recovery is expected to be supported by a pickup in external demand, an increase in commodity prices, and some monetary easing in South America amid lower inflation.

42. The economies of the United States and Canada continue to show markedly different characteristics compared to the rest of the Region, given that they include the largest economy in the world (United States of America) and the tenth largest (Canada). In the United States of America the GDP grew by 1.9% in 2016 and in the same year, Canada grew by 2.6%.

*Economic prospects by subregion*

43. South America's GDP contracted by an estimated 2.3% in 2016 as the economies of Argentina, Brazil, Ecuador, and the Bolivarian Republic of Venezuela experienced deep recessions. This subregion is expected to see a mild economic recovery over the next two years. Growth is forecast at 0.9% in 2017 and 2% in 2018, with Argentina and Brazil, the sub region's largest economies, expected to emerge from recession. The recovery is, however, projected to be relatively shallow, especially in Brazil, as rising unemployment, continuing fiscal consolidation and growing indebtedness continue to weigh on domestic demand.

44. In Mexico and Central America, average growth is expected to remain modest, with GDP forecast to expand by 2.3% in 2017 and 2.2% in 2018 amid significant uncertainty. In the face of low oil prices, sluggish industrial production in the United States, and tight monetary and fiscal policy, Mexico's economy grew by only about 2% in 2016. The relatively weak performance of the Mexican economy contrasts with robust growth in parts of Central America. Costa Rica, Nicaragua, and Panama are forecast to see GDP growth of more than 4% in 2017-2018 amid buoyant public investment, strong private consumption and dynamic tourism industries.

45. In the Caribbean, the economic situation and prospects vary widely across countries. The Dominican Republic and Guyana are expected to remain the strongest performers in the subregion. The outlook is less favorable in the Bahamas, Cuba, and Trinidad and Tobago—countries with deep-rooted structural impediments and high vulnerability to external developments.

46. Although North America economies have performed unevenly in recent years, the outlook is relatively positive in Canada and the USA. Private consumption has been spurred by jobs growth, slightly higher wages, housing price gains, and higher exports of goods and services.

47. The UN report calls for a reorientation of macroeconomic and other policies to more effectively promote investment in physical and human capital and strengthen innovative capacities across the Region. There are significant risks to the economic outlook:

- a) For LAC, major risk factors are a sharper-than-expected slowdown in China, the potential adoption of protectionist measures by the new Administration in the United States and renewed financial market turbulences. The latter could, for example, be triggered by a faster-than-expected pace of interest rate hikes in the United States.
- b) The medium-term growth outlook for many Latin American and Caribbean economies is clouded by persistent structural weaknesses, including a high dependence on commodities and low productivity growth. A prolonged period of weak growth could pose a threat to the social achievements of the past decade and complicate the Region's path towards the achievement of the SDGs.

### ***Demographic trends***

48. The population of the Americas grew from 886 million people in 2005 to 992 million in 2015, a 12% rise, constituting 13% of the world's population that year. Life expectancy increased by three years between 2000-2005 and 2010-2015 (from 67.1 to 70.5).

49. Half of the countries in the Region have fertility rates below 2.1 children per woman, which means that they have started the demographic phase of "population without replacement", as well as a progressive aging process. Despite this and without exception, Latin American countries have an advantageous demographic situation in terms of economic development: the so-called "demographic dividend". In general, the countries of Latin America are in the so-called second phase of the demographic dividend. In this second (most favorable) phase, the ratio of dependency in a country reaches its lowest level—less than two dependent people for every three active people—and remains constant at that level. This phase began at the beginning of the 21st century and is expected to last through the end of the decade 2011-2020. The third phase will extend into the early years of the decade 2041-2050.

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

51. The Region has the highest percentage of urbanization (81%) in the world, including three of the six global megalopolises (Mexico City, New York, and São Paulo).

***Health situation trends and health system response in the Region******Health inequities***

52. In the past decade, most economies in the countries of the Americas have grown at a rapid pace, which has allowed approximately 70 million people to rise out of poverty<sup>13</sup> and some 50 million to join the middle class. Unfortunately, this growth has not benefited everyone in the Region, resulting in low household living standards and availability of social services, including health and education, for millions of people. This, in turn, is reflected in major variations in health indicators, both between and within countries in the Region.

53. The variations indicate huge inequalities between countries, with health outcomes reflecting factors such as wealth, education, geographical location, gender, ethnicity and/or age. For instance, the countries in the Americas with the lowest income levels had an infant mortality rate (IMR) 4.5 times higher than the countries with the highest income levels in 2013, while for women the risk of dying of maternal causes was 5.5 times higher in countries with the lowest mean years of schooling than in countries with the highest mean years of schooling. Similarly, even within countries, the subnational units with the poorest quintile of household wealth had the highest under-5 child mortality rates, while those with the lowest levels of education had up to three times the risk of premature death than those with higher levels of education, regardless of age or sex. Furthermore, infant mortality rates in indigenous communities were up to twice as high as in non-indigenous communities.<sup>14</sup> Other examples of inequalities within and between countries are:

- a) Countries with the highest rural populations still face inadequate prenatal care coverage compared to the most urbanized quintiles, with an absolute gap of 11.6 percentage points in 2013.
- b) Countries with the lowest education levels in 2013 had an absolute inequality gap of 16.7 premature deaths related to noncommunicable diseases (NCDs) per 100,000 population compared to countries with the highest education levels.
- c) Incidence of dengue is far higher in countries in the lowest quintiles of per capita GDP and with the lowest levels of sanitation and education.
- d) Countries in the lowest quintile for mean years of schooling have a significantly higher homicide rate than the rest of the countries of the Region, and adolescent homicide rates that are higher than all other quintiles combined.

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

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<sup>13</sup> USAID. Extreme Poverty Possibilities. Ending extreme poverty by 2030. Available at: <http://www.usaid.gov/endextremepoverty>.

<sup>14</sup> Montenegro, R. and Stephens, C. Indigenous health in Latin America and the Caribbean. *The Lancet* 2006; 367:1859-69. Available at: [http://www.who.int/social\\_determinants/resources/articles/lancet\\_montenegro.pdf](http://www.who.int/social_determinants/resources/articles/lancet_montenegro.pdf).

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

55. Consistent with countries commitment to the SDGs, there is a need to establish national priorities and development goals for the upcoming years, considering current health inequalities both between and within countries in the Americas. It is vital that these priorities and goals reflect the needs of the most vulnerable populations and are based on current evidence. In order to generate evidence that reflects current health inequities both between and within countries, it is essential that countries first start collecting, analyzing, and monitoring data at the subnational level.

*Leading causes of mortality*

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

- a) Between 2010 and 2013, the top ten causes of death in the Region of the Americas were:

**Table 2. Leading Causes of Death in the Region, 2010-2013**

<b>Causes</b>	<b>Deaths</b>	<b>Rate<sup>15</sup></b>	<b>%</b>
Ischemic heart diseases	2,792,698	76.4	14.1
Cerebrovascular diseases	1,423,762	38.9	7.2
Diabetes mellitus	1,098,085	30.0	5.5
Dementia and Alzheimer's disease	1,017,617	27.8	5.1
Chronic lower respiratory diseases	1,013,061	27.7	5.1
Malignant neoplasm of trachea, bronchi, and lungs	958,356	26.2	4.8
Influenza and pneumonia	814,175	22.3	4.1
Hypertensive diseases	700,591	19.2	3.5
Heart failure and complications and ill-defined heart disease	700,421	19.2	3.5
Cirrhosis and other diseases of the liver	544,217	14.9	2.7

- b) According to age groups, between 2010 and 2013, the leading causes of death in the Region were: Among 10-24 year olds, homicides (20.4 per 100,000 pop.), land transport accidents (13.4 per 100,000 pop.) and suicide (5.3 per 100,000 pop.); in 25-64 year-olds, ischemic heart disease (35.9 per 100,000 pop.), diabetes (19.1/100,000 pop.) and homicides (18.3 per 100,000 pop.); in those over 65, ischemic heart disease (620.6 per 100,000 pop.), cerebral vascular disease (327.5

<sup>15</sup> Per 100,000 population.



- per 100,000 pop.), and dementia and Alzheimer's disease (292.8 per 100,000 pop.).
- c) Between 2002-2005 and 2010-2013, the maternal mortality ratio (MMR) decreased from 68.4 to 58.2 per 100,000 live births (lb), with the Latin Caribbean being the subregion with the highest MMR (192.2 per 100,000 lb) and North America the lowest (13.5 per 100,000 lb). Of total maternal deaths, 66.35% were from direct obstetric causes.
  - d) The infant mortality rate in the Region declined from 17.9 per 1,000 lb to 13.6 per 1,000 lb between 2002-2005 and 2010-2013, of which more than 60% were neonatal deaths. The main specific cause of neonatal death in the Americas was respiratory distress in newborns.

### ***Communicable diseases***

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

58. During the last five years, there was an average of 116,590 annual cases of influenza and, since 2009, the main seasonal influenza viruses circulating in the Americas are influenza A (H1N1) pdm09, influenza A (H3N2), and influenza B (lineage Victoria and Yamagata).

59. Between 2011 and 2016, only five countries (Brazil, Bolivia, Colombia, Ecuador, and Peru) reported cases of yellow fever. In December 2016, an outbreak was reported in Brazil, with 448 confirmed cases and 144 deaths (32% fatality).

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

*HIV and sexually transmitted infections*

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

62. An estimated annual 64 million new cases of curable sexually transmitted infections (*Chlamydia trachomatis*, *Neisseria gonorrhoeae*, syphilis, and *Trichomonas vaginalis*) affect people in the 15-49 age group. Human papillomavirus (HPV) infection is the most common viral infection of the genital tract. The estimated prevalence of HPV in LAC is 16.1%.

*Tuberculosis*

63. Tuberculosis mortality rates have decreased from 4.3 to 2.5 per 100,000 population, while HIV co-infection remains one of the major risk factors for the prolonging of this disease and mortality from this cause in the Americas. In 2015, 218,700 tuberculosis cases were diagnosed and reported (22.1 per 100,000 pop.) In 2015, 4,508 cases of MDR-TB were reported in the Region of the Americas.

*Vector-borne diseases*

64. Malaria and dengue continue to occur in the Region, and this situation was made worse by the introduction of the chikungunya and Zika viruses. In December 2013, the first local cases of chikungunya were diagnosed in Saint Martin (French territory). During 2016, 361,312 suspected cases were reported and 157,288 cases were confirmed in the Region.

65. Between 2000 and 2015, the number of malaria cases in the Americas decreased by 62% (from 1,181,095 to 451,242 cases). In the same period, malaria-related deaths decreased by 76% (from 410 to 98 deaths), of which 77% were reported by Brazil, Peru, and Venezuela. Between 2014 and 2015, malaria cases in Venezuela increased by 50% (90,708 to 136,402 cases).

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

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

*Neglected tropical and zoonotic diseases*

68. The Region continued to make progress in the elimination of neglected infectious diseases, verifying the elimination of onchocerciasis in Ecuador, Guatemala, and Mexico, and trachoma in Mexico. Only one focus of onchocerciasis (in South America) stands in the way of achieving elimination of this disease in the Region.

69. Of the 21 Chagas-endemic countries, 17 continued to maintain interruption of vector-borne domiciliary transmission by the main vector, as reflected by a household infestation index of less than or equal to 1% in the country or in endemic areas.

70. During 2010-2014, new reported cases of leprosy in LAC declined from 37,571 to 33,789 cases. Brazil accounted for 91.9% of all reported cases.

71. In 2015 there were 17 reported cases of human rabies, 12 of which were transmitted by dogs.

*Vaccine-preventable diseases*

72. In 2015, the Region interrupted the endemic transmission of rubella and declared itself free from measles. According to data reported by countries in 2015, coverage in the Region of the Americas for DPT3 and the third dose of polio vaccine in children under 1 year of age was 91% and 92%, respectively. For vaccination against measles and rubella in 1-year-olds, the figure was 93%.

73. In 2015, of the almost 15,000 municipalities in LAC, 8,456 (56%) reported coverage of DPT3 vaccination below 95%.

*Antimicrobial resistance*

74. Since 1996, increasing trends in the resistance of major human pathogens have been documented. The spread of emergent mechanisms of resistance in the Region has been documented, including KPC-type carbapenems in almost all Latin American countries, with up to 50% mortality in outbreaks in intensive care units.

***Chronic diseases, mental health, and NCD risk factors***

*Mortality from noncommunicable diseases (NCDs)*

75. NCDs are responsible for nearly 4 out of 5 deaths in the Americas and are expected to increase in the coming decades, as a result of population growth, aging, urbanization, and exposure to environmental and other risk factors. In 2012, a 30-year-old living in the Region had a 15.4% chance of dying from any of the four major NCDs before reaching the age of 70.

76. In 2013, cardiovascular disease (CVD) was the leading cause of death in the Region, with 1,644,738 deaths (144.9 per 100,000 pop.), accounting for 28.8% of deaths from NCDs. For the same year, 1,087,047 deaths from cancer occurred in the Region (102.4 per 100,000 pop.), representing 19% of deaths due to NCDs, and there were 278,034 deaths directly caused by diabetes, representing 6.3% of deaths due to NCDs.

#### *Chronic kidney disease*

77. Over the last two decades, Central America has reported a growing number of cases of chronic kidney disease (CKD) of a non-traditional etiology among male agricultural workers, associated mainly with improper use of agrochemicals and labor conditions involving high temperatures and insufficient water intake. In El Salvador, mortality increased from 18.7 deaths per 100,000 population in 1997 to 47.4 deaths per 100,000 in 2012, and in Nicaragua, from 23.9 deaths per 100,000 in 1997 to 36.7 deaths per 100,000 in 2013.

#### *Mental health*

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

#### *Main risk factors*

79. Regarding the main risk factors for NCDs in the Americas, the average annual alcohol consumption per person over age 15 years was 8.4 liters.

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

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

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

83. The obesity rate (BMI > 30 kg/m<sup>2</sup>) in the Americas was more than double the global average (26.8% vs. 12.9%), with a prevalence among women (29.6%) higher than the men (24.0%). The prevalence of overweight in children under 5 years of age was 7.2% in 2012.

*Injuries due to traffic accidents, violence, and homicides*

84. In the Americas in 2013, 121,383 people died due to injuries caused by traffic accidents (13.1 per 100,000 inhabitants).

85. With regard to violence, LAC has 18 of the 20 countries with the highest homicide rates in the world, associated with criminal gang activities and organized crime. The homicide rate in the Region in 2013 was 14.6 per 100,000 population. Men experience higher levels of lethal violence (26.0 per 100,000 pop.) than women (3.1 per 100,000 pop.), with the 10-29 age group being the most affected.

86. A significant proportion of children ages 0 to 7 suffer physical, sexual, or emotional abuse every year (58% in LAC and 61% in North America).

*Health systems and services*

*Universal access to health and universal health coverage*

87. Significant progress continues to be made in the implementation of the Strategy for Universal Access to Health and Universal Health Coverage approved by PAHO Member States in 2014.<sup>16</sup> At the end of 2015, 10 countries were implementing plans of action and/or road maps toward universal health, 11 countries had developed regulatory frameworks for universal health, and 15 had established and were implementing financial frameworks for universal health.

88. Between 2014 and 2015, levels of health services coverage were high across the countries, with 98% in Chile, 95% in Colombia, 86% in the United States, 80% in Mexico, and 73% in Peru. Levels of coverage were, however, lowest in the poorest households, particularly for the United States, with 14 percentage points less coverage for poor households, and Peru with a 12 percentage point difference.

*Quality of care*

89. Between 2013 and 2014, more than 1.2 million deaths could have been avoided in the Region with health care systems offering accessible, quality, and timely health care. At the end of 2015, 12 countries had implemented national strategies and/or plans for improving quality of care and patient safety. Additionally, 23 countries had implemented the integrated health service delivery network strategy.

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<sup>16</sup> PAHO. Strategy for Universal Access to Health and Universal Health Coverage. 53rd Directing Council, 66th Session of the Regional Committee of WHO for the Americas (Document CD53/5, Rev. 2). Available at: [http://www2.paho.org/hq/index.php?option=com\\_docman&task=doc\\_download&gid=27312&Itemid=270&lang=en](http://www2.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=27312&Itemid=270&lang=en).

*Health investment and expenditure*

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

91. Public expenditure on health increased in 22 countries in the Region between 2010 and 2014. Despite improvements, percentage increases were smaller compared to the 2005-2010 period, with the exception of Bolivia, Peru, and Uruguay.

92. Out-of-pocket expenditure as a percentage of total health expenditure in LAC decreased from 47% in 2010 to 33.1% in 2014.

*Preventive health services*

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

*Reproductive health*

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

*Pharmaceutical policy, regulatory capacity, and use of medicines*

95. In 2014, only 13 of 28 countries had a national pharmaceutical policy (46%), while 18 of the 35 countries in the Region had a national blood policy (51%). At the end of 2015, 10 countries had developed institutional development plans for medicines. Furthermore, in collaboration with the Council for Human and Social Development (COHSOD), pharmaceutical policies in the Caribbean were strengthened. Price negotiations for high-cost medicines resulted in significant reductions in the price of medicines for HIV/AIDS and hepatitis C.

*Human resources for health*

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

- a) The percentage of physicians is up to 80 percentage points higher in urban areas than in rural (non-metropolitan) areas.
- b) On average, there were 48.7 nurses per 10,000 population in the Americas in 2015. North America had by far the highest density of nurses—more than seven times higher than in LAC (110.9 vs. 13.6 per 10,000 population).

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

*Health information systems and health research*

98. The Region has made notable progress in strengthening health information systems, adopting new technologies and strategies for research and evidence-gathering, and incorporating ethics into health research. Countries have recognized the centrality of information systems for health (IS4H) and are working to further strengthen capacities in this area to better support informed policy and decision-making as they move toward universal health and the implementation of the SDG commitments.

*Emergency and disaster response capacity*

99. In the Region of the Americas, between 2010 and 2016, 803 disasters occurred (21% of disasters globally), with 861,232 injuries and 146,578 deaths. The economic cost of these disasters has been estimated at \$361 billion, representing 35.5% of the total cost of global damages. The earthquakes registered in 2010 in Haiti and Chile and in Ecuador in 2016 caused considerable damages in the health sector.

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

## V. GOALS AND TARGETS

101. SHAA2030 sets the following interrelated goals and targets to achieve its vision of the highest attainable standard of health with equity and well-being for all people in the Region in the next 13 years. These goals are consistent with the Agenda's principles, vision and purpose.

- Goal 1: Expand equitable access to comprehensive, integrated, quality, people-, family- and community-centered health services, with an emphasis on health promotion and illness prevention.
- Goal 2: Strengthen stewardship and governance of the national health authority, while promoting social participation.
- Goal 3: Strengthen the management and development of human resources for health (HRH)<sup>17</sup> with skills that facilitate a comprehensive approach to health.
- Goal 4: Achieve adequate and sustainable health financing with equity and efficiency, and ensure protection against financial risks for all persons and their families.<sup>18</sup>
- Goal 5: Ensure access to essential medicines and vaccines, and to other health technologies.
- Goal 6: Strengthen information systems for health to support the development of evidence-based policies and decision-making.
- Goal 7: Develop capacity for the generation, transfer, and use of knowledge and technology in health, promoting research and innovation.
- Goal 8: Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks and health emergencies and disasters.
- Goal 9: Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders.
- Goal 10: Reduce the burden of communicable diseases and eliminate neglected diseases.
- Goal 11: Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health.

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<sup>17</sup> Including HRH talent management.

<sup>18</sup> This aligns with SDG 3.8 and with one of the strategic lines of the Strategy for Universal Access to Health and Universal Health Coverage (CD53/5, Rev. 2 [2014]): *Increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service.*



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

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

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

**Table 3. SHAA2030 Goals, Scopes, and Targets**

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

**Targets for 2030:**

- a) The Region will reduce by at least 50% the regional mortality amenable to health care rate (MAHR) (updated from PAHO Strategic Plan impact goal 4.1).<sup>19</sup>
- b) The Region will reduce the regional maternal mortality ratio (MMR) to less than 27 per 100,000 live births in all population groups most at risk of maternal death (including adolescents, women of advanced age, indigenous, Afro-descendent, Roma, and rural women) (adapted SDG target 3.1).
- c) The Region will reduce neonatal mortality to less than 10 per 1,000 live births in all population groups including those most at risk (indigenous, Afro-descendent, Roma, and rural population), and under-5 mortality to less than 14 per 1,000 live births (adapted SDG target 3.2).
- d) All countries will increase resolution capacity of the first level of care as measured by a 15% reduction in hospitalization that can be prevented with quality ambulatory care (updated PAHO Strategic Plan outcome 4.2).
- e) All countries will have organized health services into integrated health service delivery networks with high resolution capacity at the first level of care (updated PAHO Strategic Plan outcome 4.2).

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

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

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

**Target for 2030:**

- a) All countries will achieve universal access to health and universal health coverage (adapted SDG target 3.8).
- b) All countries will perform the essential public health functions according to established standards (PAHO Essential Public Health Functions Framework).<sup>20</sup>

<sup>19</sup> MAHR is used as a quality indicator and as an outcome indicator for the health system.

<sup>20</sup> Note: The PAHO Essential Public Health Functions Framework is being updated. New

- c) All countries will have accountability systems that include governance structures, rules and processes for health sector organization, and mechanisms for independent oversight, monitoring, and evaluation (Source to be confirmed).
- d) All countries will have mechanisms for the regulation of health service delivery, and health financing functions of the health system (Source to be confirmed).
- e) All countries will have formal mechanisms to enable participation of citizens in the development of health policies (adapted from the PAHO Strategy for Universal Access to Health and Universal Health Coverage and PAHO's Plan of Action on Health in All Policies).

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

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

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

**Targets for 2030:**

- a) All countries will have adequate availability of a health workforce<sup>21</sup> (44.5 health workers per 10,000 population) that is qualified, culturally appropriate, well-regulated, and well-distributed (adaptation of SDG target 3.c and PAHO Strategic Plan outcome 4.5).
- b) All countries will have HRH policies and intersectoral coordination and collaboration mechanisms between health, education, and other sectors to address the needs of the health system (PAHO Strategy on HRH, proposed).
- c) All countries will regulate the quality of professional health education through evaluation systems and the accreditation of training institutions and degree programs<sup>22</sup> (PAHO Strategy on Human Resources for Universal Access to Health, proposed).

measurements/standards will be provided when the updated framework becomes available.

<sup>21</sup> WHO defines health workers as all those “engaged in action whose primary intent is health” and collates data based on the International Standard Classification of Occupations, excluding some lower-skill cadres (e.g. personal care workers).

**Goal 4: Achieve adequate and sustainable health financing with equity and efficiency, and ensure protection against financial risks for all persons and their families<sup>23</sup>**

**Scope:** This goal aims at increasing and improving health financing with equity and efficiency as a necessary condition to advance toward universal health, addressing the following:

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

**Targets for 2030:**

- a) All countries will reduce out-of-pocket expenditure by half (adapted from the PAHO Strategy for Universal Access to Health and Universal Health Coverage).
- b) All countries will have public expenditures in health of at least 6% of GDP<sup>24</sup> (revised PAHO Strategic Plan outcome 4.1).
- c) All countries will have implemented policies and/or strategies to reduce the segmentation of the health financing system (PAHO Strategy on Universal Health Access and Universal Health Coverage).
- d) All countries will have implemented policies and/or strategies to develop systems of purchase and payment to suppliers, which promote efficiency and equity in the allocation of strategic resources (PAHO Strategy on Universal Health Access and Universal Health Coverage).

**Goal 5: Ensure access to essential medicines and vaccines, and to other health technologies**

**Scope:** The attainment of this goal requires equitable access to medicines, vaccines, and other health technologies which is essential for universal access to health and universal health coverage. The availability, accessibility, acceptability, and affordability of these health technologies and their rational use require the following:

- improved access to safe, quality, effective, efficient, and cost-effective medicines and other health technologies;

<sup>22</sup> Standards should prioritize technical and scientific knowledge, together with the social competence criteria of graduates, and the development of contextualized learning programs.

<sup>23</sup> This aligns with SDG 3.8 and with one of the strategic lines of the Strategy for Universal Access to Health and Universal Health Coverage (CD53/5, Rev. 2 [2014]): *Increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service.*

<sup>24</sup> Public expenditure on health equivalent to 6% of the GDP is a useful benchmark in most cases and is a necessary, though not sufficient, condition to reduce inequities and increase financial protection.

- national essential medicines list and priority health technologies list;
- national immunization program;
- public procurement of high-cost medicines and vaccines;
- price and market transparency, and promotion of a competitive environment and efficient procurement practices, including the optimization of regional mechanisms and funds;
- health technology assessment (HTA) and health technology management;
- development of innovative medicines in accordance with public health needs.

#### **Targets for 2030:**

- All countries will ensure access to medicines on the national essential medicines list, and to priority health technologies, without any payment at the point of care/service/dispensing (revised PAHO Strategic Plan outcome 4.3).
- All countries will reach 95% vaccination coverage through their national vaccination programs (revised PAHO Strategic Plan outcome 1.5).
- All countries will have national regulatory agencies at level-3 capacity on the global benchmarking tool.<sup>25</sup>
- All countries will apply health technology assessment methodologies in the selection and incorporation of health technologies in their health systems (Resolution CSP28.R9 [2012]).
- All countries will apply requirements on radiation safety in the health sector based on the international Basic Safety Standards (BSS) (PAHO Resolution CSP28.R15 [2012]).
- All countries will ensure self-sufficiency in the supply of safe blood and blood products through 100% voluntary non-remunerated donations (PAHO Resolution CD53.R6 [2014]).

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

**Scope:** This goal aims at improving the Information Systems for Health (IS4H),<sup>26</sup> which are essential to improve health policy and decision-making, as well as to measure and monitor health inequalities in the population, and progress toward the achievement of universal access to health and universal health coverage. Strong and comprehensive IS4H are also essential to strengthen the leadership and stewardship role of the Ministries of Health. Key elements for IS4H include:

- assessment of the state of the countries' IS4H, as a first step to identify gaps and needs;
- data management and governance;

<sup>25</sup> National regulatory authority that is competent and efficient, which shall improve performance of certain health regulation functions recommended by PAHO/WHO in order to guarantee the safety, efficacy, and quality of medicines. [http://www2.paho.org/hq/index.php?option=com\\_content&view=article&id=1615%3A2009-sistema-evaluacion-autoridades-reguladoras-nacionales-medicamentos&catid=1267%3Aquality-drug-regulation&Itemid=1179&lang=en](http://www2.paho.org/hq/index.php?option=com_content&view=article&id=1615%3A2009-sistema-evaluacion-autoridades-reguladoras-nacionales-medicamentos&catid=1267%3Aquality-drug-regulation&Itemid=1179&lang=en)

<sup>26</sup> Information Systems for Health (IS4H) is an integrated effort for the convergence of interconnected and interoperable systems, data (including health and vital statistics), information, knowledge, processes, standards, people, and institutions, supported by information, and communication technologies that interact (or help) to generate, identify, collect, process, store, and make free and publicly available, quality data and strategic information for better policy- and decision-making processes in public health systems.

- Information and Communication Technologies;
- knowledge management for health;
- national capacity building for human resources and infrastructure for data management and analysis;
- interoperable IS4H systems at national level.

**Targets for 2030:**

- All countries will have a national policy for interoperable information systems for health to generate, identify, collect, process, store, and make free and publicly available quality data and strategic information for better policy- and decision-making in public health (combined SDG 17.18 and PAHO Strategy on Information Systems for Health, proposed).<sup>27</sup>
- All countries will have interoperable information systems in place to measure and monitor the performance of the health system and services, and to progress toward achievement of national, regional, and global health objectives (including the health-related SDGs and reducing inequalities in health) (PAHO Strategy on Information Systems for Health, proposed).

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

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

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

**Targets for 2030:**

- All countries will have health research policies and allocate 2% of the health budget for public health research, linked to their national health policies (adapted from the PAHO Research Policy).
- All countries will have institutional capacities, infrastructure, technology, and qualified human resources for public health research and its dissemination, in accordance with the nation health policy (adapted from the PAHO Research Policy).

<sup>27</sup> Under development by PASB.

c) All countries will have implemented policies or plans on digital health (eHealth) (Source to be confirmed).

**Goal 8: Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks, emergencies, and disasters**

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

- building resilience and application of a multi-sectoral approach to contribute to health security and cope with climate change;
- International Health Regulations (IHR) assessment and critical core capacities;
- prevention, alert, and control strategies for high-threat infectious hazards;
- national, subregional, and regional capacity to respond to disasters and emergencies caused by any hazard;
- emergency preparedness and disaster risk reduction;
- health sector strengthening in countries in situations of high vulnerability to emergencies and disasters;
- timely and appropriate response to health emergencies.

**Targets for 2030:**

- a) All countries will reduce death, disability, and illness, and the number of people affected by emergencies and disasters, with a focus on protecting the poor and vulnerable (combined SDG target 11.5 and PAHO Strategic Plan impact goal 9).
- b) All countries will strengthen resilience and adaptability to climate and other hazards in the health sector through reinforcement of the essential public health functions (SDG target 13.1).
- c) All countries will meet and sustain the IHR core capacities (revised PAHO Strategic Plan outcome 5.2).
- d) All countries will have critical capacity in place to respond to any type of emergency or disaster (early warning systems, emergency operation centers, risk communication and safe hospitals) (revised PAHO Strategic Plan outcome 5.2).

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

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

- cardiovascular disease, cancer, diabetes, lung disease, and chronic kidney disease;
- tobacco consumption, alcohol abuse, unhealthy diet, salt consumption, physical inactivity, and obesity;



- disabilities and rehabilitation;
- injuries caused by traffic accidents;
- violence;
- mental health disorders and the use of psychoactive substances;
- nutrition.

**Targets for 2030:**

- a) The Region will reduce premature mortality from noncommunicable diseases by one third through prevention and treatment, and by promoting mental health and well-being (SDG target 3.4).
- b) All countries will apply the WHO Framework Convention on Tobacco Control (FCTC) according to their national context (adapted SDG target 3.a).
- c) All countries will achieve equitable access to affordable habilitation/rehabilitation services, including assistive technology, assistance and support services, and community-based rehabilitation for all those who need it (adapted from the PAHO Plan of Action on Disabilities and Rehabilitation 2014-2019).
- d) All countries will reduce significantly all forms of violence and related death rates by 5% (SDG target 16.1).
- e) The Region will reduce by 2/3 the number of deaths caused by traffic accidents (adapted SDG target 3.6).
- f) The Region will significantly increase universal access to mental health services, including the promotion of emotional well-being and its favorable conditions, prevention of psychosocial problems and mental disorders and mental recovery, in all stages of life, with a gender, intercultural, and community approach, through the integration of mental health care into primary care (adapted from the PAHO Plan of Action on Mental Health).
- g) All countries will eliminate all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and halting by 2020 the rise in diabetes and obesity in all age groups (adapted from SDG target 2.2 and the Global NCD Plan of Action target 7).

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

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

- HIV/AIDS and sexually transmitted infections;
- viral hepatitis;
- tuberculosis;
- vector-borne diseases (malaria, dengue, Zika, chikungunya, Chagas);
- neglected, tropical and zoonotic diseases;
- vaccine-preventable diseases;



- antimicrobial resistance surveillance;
- food safety risks (biological and chemical risks).

**Targets for 2030:**

- All countries will eliminate the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and combat hepatitis, waterborne diseases, and other communicable diseases (SDG target 3.3).
- All countries will halt the transmission of viral hepatitis and accelerate the reduction of chronic infections and deaths from hepatitis to eliminate viral hepatitis as a major public health threat in the Region of the Americas (adapted from the WHO Global Health Sector Strategy on Viral Hepatitis 2016-2021).
- The Region will eliminate tuberculosis (adapted from the PAHO Plan of Action for the Prevention and Control Tuberculosis).
- The Region will eliminate local malaria transmission among Member States and prevent the possible reestablishment of the disease (adapted from the PAHO Plan of Action for Malaria Elimination 2016-2020).
- All countries will eliminate neglected infectious diseases (NIDs) as public health problems (adapted from the PAHO Plan of Action for the Elimination of Neglected Infectious Diseases and Post-Elimination Actions 2016-2022).
- All countries will have the capacity to treat and prevent infectious diseases, including the responsible and rational use of safe, effective, accessible, and affordable quality-assured drugs (adapted from the PAHO Plan of Action on Antimicrobial Resistance).
- All countries will have the capacity to mitigate food safety risks (SDG target 1.7).

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

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

- strengthening countries' capacity to measure, monitor, and analyze health inequalities;
- implementing the Health in All Policies Strategy for intersectoral action to address the social and environmental determinants of health;
- promoting healthy environments to improve health and well-being, and reduce preventable deaths and the burden of diseases throughout the life course.

**Targets for 2030:**

- a) All countries will demonstrate a marked reduction in the health inequity gap as measured by any of the following equity stratifiers: place of residence (rural/urban), race or ethnicity, occupation, gender, education, and socio-economic status using simple inequality measures, including (absolute and relative gap) (WHO Handbook on Health Inequality Monitoring).
- b) All countries will substantially reduce the number of deaths and diseases caused by hazardous chemicals and by pollution and air, water, and soil pollution (SDG target 3.9).
- c) All countries will significantly reduce inequalities on quality of water and sanitation by having progressed on the access to safely managed services on water and sanitation (SDG targets 6.1 and 6.2).
- d) All countries will have policies that incorporate the safe and healthy mobility and migration of people (SDG target 10.7).
- e) All countries will protect labor rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment (SDG target 8.8).

## VI. IMPLEMENTATION, MONITORING, ASSESSMENT, AND REPORTING

105. In keeping with the commitments stated above, the Member States undertake to implement and report on this Agenda. These tasks will be realized through collaborative efforts with the Pan American Sanitary Bureau and other partners at the national, subregional, and regional levels.

### Implementation

106. SHAA2030 will have PAHO's Strategic Plans, as well as subregional and national plans as the principal means for its implementation, monitoring, and evaluation. At the same time, multiple actors in health must be engaged in order to realize its ambitious goals and targets. The following matrix illustrates the main actors and partners and collaborating mechanisms at different levels:

Level	Partners in health	Main means for collaboration
National	<ul style="list-style-type: none"> <li>• Ministry of Health (supported by PAHO country office)</li> <li>• Ministries from contributing sectors (education, environment, agriculture, etc.)</li> <li>• National NGOs and civil society organizations</li> <li>• International cooperation agencies</li> <li>• Academia</li> <li>• Private sector</li> </ul>	<ul style="list-style-type: none"> <li>• National and subnational coordination mechanisms</li> </ul>
Subregional	<ul style="list-style-type: none"> <li>• Subregional integration mechanisms (e.g. CARICOM, SICA, UNASUR) and where applicable, their health-focused bodies (e.g. CARPHA, ISAAGS, COMISCA)</li> <li>• Subregional mechanisms for contributing sectors (e.g. RIMSA, FOCARD)</li> <li>• PAHO Subregional Offices</li> </ul>	<ul style="list-style-type: none"> <li>• Subregional integration meetings and related fora</li> </ul>
Regional	<ul style="list-style-type: none"> <li>• Ministries of Health, Epidemiology, Statistics, and Planning, and International Health Relations networks</li> <li>• PAHO Governing Bodies and reference centers</li> <li>• UN Development Group for Latin America and the Caribbean (UNDG LAC)</li> <li>• Economic Commission for Latin America and the Caribbean (ECLAC)</li> <li>• Organization of American States (OAS)</li> <li>• World Bank LAC</li> <li>• Inter-American Development Bank (IADB)</li> <li>• International bilateral agencies (CIDA Canada, USAID, SEGIB, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Summit of the Americas and other relevant OAS meetings and conferences</li> <li>• PAHO Governing Bodies meetings</li> <li>• Forum of the Countries of Latin America and the Caribbean on Sustainable Development (ECLAC)</li> <li>• UNDG LAC meetings (UNDP)</li> <li>• Other relevant regional development fora with an impact on health</li> </ul>

107. The implementation of SHAA2030 at the subregional and country levels requires the political commitment of subregional governing bodies and Member States' health authorities, reflecting this in their subregional and national plans, and PAHO's support through the adjustments of country cooperation strategies and subregional plans. Furthermore, major national and international partners working for health development should consider the goals and targets set in this Agenda when developing their own strategic and operational plans.

108. The countries of the Americas agree on a several key **strategic approaches** for implementing this agenda. These approaches are as follows:

- a) **National accountability for results.** Ministries of Health will lead the process for establishing national goals and targets that will contribute to the collective regional achievement of the Agenda. The ministries will also work to raise the profile of health priorities established in this Agenda and their national health plans, promoting action at the presidential level and through legislative bodies.
- b) **Multisectoral advocacy and coordination.** The Ministers of Health of the Americas recognize that, similar to the SDGs, achieving the goals of this Agenda will require concerted action well beyond the health sector. Therefore, they undertake to work with all sectors relevant to social development, at the national and international levels. This advocacy role includes not only addressing the social and economic determinants of health, but also demonstrating to other sectors the advantages that health development brings to them, not least through increased economic productivity and reduced expenditure on treatment. Lessons learned from the health-in-all-policies approach and advocating for health determinants can provide valuable insights for countries seeking success through multisectoral work.
- c) **National inter-agency coordination and cooperation.** The situation varies greatly across the counties of the Americas, but those that receive significant international support have coordination mechanisms that bring together all international agencies working in development and, frequently, those that work in health development. It is critical that the national authorities lead these mechanisms.
- d) **South-south cooperation for health development.** All countries in the Americas have knowledge and expertise worth sharing, and all countries can benefit from the help of their peers. Supported by PASB, health authorities in the Americas will capitalize on this opportunity as they seek innovative ways to improve the health of their populations.

- e) **Regional interagency coordination.** PAHO will actively coordinate with the Forum of the Countries of Latin America and the Caribbean on Sustainable Development,<sup>28</sup> which is a regional mechanism to monitor the implementation of the 2030 Agenda for Sustainable Development, including the SDGs, their means of implementation, and the Addis Ababa Action Agenda on financing for development, in order to contribute with regional health information relevant to monitoring and evaluating the 2030 Agenda.
- f) **Strategic communication.** Ensuring uptake and implementation of this Agenda will require active communication by national authorities, supported by PASB. Coherent communications strategies at the country, subregional, and regional levels, for each of these goals, will help advance the Agenda overall by linking public policy with specific health advances, documenting progress at each step, and communicating the essential role and specific benefits of the Agenda for achieving the highest attainable standard of health and well-being for all people of the Americas.

### **Monitoring, Assessment, and Reporting**

109. The commitment of Member States, PAHO, and contributing partners is fundamental for accountability for the implementation of this Agenda. This requires the development and or strengthening of mechanisms for joint monitoring and assessment.

110. The goals and targets defined in the SHAA2030 will become integral parts of health planning at the regional, subregional, and country levels and will guide the establishment of specific indicators that will serve as benchmarks to monitor and assess progress towards the SHAA2030 goals.

111. For PAHO, the targets will guide the development of indicators in PAHO Strategic Plans for 2020-2025 and 2026-2031, regional strategies and plans of action, as well as country cooperation strategies developed during 2018-2030.

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

113. Monitoring and assessment of SHAA2030 will be harmonized with existing monitoring and reporting mechanisms. Efforts will be made to strengthen and integrate information systems to facilitate measurement and monitoring of the SHAA2030 targets along with other health indicators. Collaboration will be strengthened with UN agencies, particularly the Inter-Agency and Expert Group on SDG indicators and ECLAC, to

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<sup>28</sup> Economic Commission for Latin America and the Caribbean: Thirty-sixth session of ECLAC, 2016. <http://periododesesiones.cepal.org/36/en/news/authorities-establish-forum-countries-latin-america-and-caribbean-sustainable-development>.

optimize the use of existing platforms for monitoring SDG3 and health-related indicators (see Annex A).

114. Similarly, at the subregional and country levels, it is expected that subregional entities and Member States will adopt and adapt the SHAA2030 goals and targets for implementation, monitoring, assessment, and reporting. National information systems should enable measurement and reporting against targets set in the Agenda.

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

Annexes

### Annex A - SDG3 Targets and Indicators

Source: Report of the Inter-Agency and Expert Group on Indicators of the Sustainable Development Goals (SDGs) – United Nations<sup>1</sup>

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

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

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

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



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

### Annex B - Acknowledgements

The following members of the Countries Working Group and PASB listed below are recognized for their contributions in the development of the Agenda.

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And the teams from the various ministries of Health, who provided their invaluable support in the development of this Agenda.

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