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C. PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES: MIDTERM REVIEW

Background

1. This report reviews the status of noncommunicable diseases (NCDs) and their risk factors in the Region, based on the implementation of the Plan of Action for the Prevention and Control of Noncommunicable Diseases *(1)*, adopted by the 52nd Directing Council in 2013, which is aligned with the World Health Organization (WHO) Global action plan for the prevention and control of NCDs 2013-2020 *(2)*.

2. In the Americas, approximately 4.8 million people die each year as a result of NCDs, and 35% of these deaths are premature, occurring among people less than 70 years of age *(3)*. The regional NCD plan of action aims to reduce premature mortality by 15% by 2019 through four overall strategies: implementing national multisectoral NCD policies and plans, reducing NCD risk factors (tobacco use, harmful use of alcohol, unhealthy diets, and physical inactivity), strengthening the health system response to NCDs (cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases), and undertaking systematic surveillance and monitoring, notably for the nine NCD targets and 25 indicators of the NCD Global Monitoring Framework *(4)*.

3. The global Country Capacity Survey on NCDs, conducted by WHO in 2015, provides relevant and current data on NCD policies, health service response, and surveillance capacity. The survey was completed by Ministry of Health focal points in each country using the WHO standardized survey instrument, and responses were subsequently validated with the focal points. In the Americas, PAHO/WHO conducted and validated the survey, and 38 countries and territories provided responses. The results from each National NCD Capacity Survey provide the main data and information used in this report *(5)*.[1]

[1] The 2015 WHO National NCD Capacity Survey was a self-administered, standardized questionnaire completed by Ministry of Health focal points using the global online response system. A total of

Update on the Progress Achieved

4. Worldwide, premature mortality from NCDs, measured according to the unconditional probability of dying from an NCD between the ages of 30 and 70 years, is lowest in the Region of the Americas, at 15% *(6)*. Almost all countries in the Region show a stable or modest decline in **NCD premature mortality**, and 14 countries and territories are on target to meet the overall regional NCD goal of a 15% reduction in premature mortality by 2019[2] *(3)*.

5. All countries were committed to establishing national NCD plans and national targets by 2015. However, only about half of the countries and territories in the Americas that provided responses (22 of 38, 58%) report having an operational, multisectoral national NCD policy, strategy, or action plan, and only 17 countries (45%) report having set national NCD targets. Of the countries with national NCD plans, 13 have developed them since 2013, the year in which the Regional NCD Plan was adopted *(5)*.

6. NCDs can be adequately addressed only through a whole-of-government and whole-of-society approach, and the regional NCD plan of action calls for countries to establish multisectoral commissions and to implement actions in at least three sectors outside the health sector. Yet, only 12 countries (32%) report having established NCD commissions with several government ministries and civil society; 19 countries (50%) have integrated NCDs into their national development agenda *(5)*.

7. NCDs are largely preventable, and while the Region has made some important advances with respect to NCD risk factor reduction policies, many countries have yet to establish the necessary interventions that will sufficiently reduce tobacco use and harmful use of alcohol and promote healthy diets and physical activity. Although 30 countries have ratified the WHO Framework Convention on Tobacco Control, much more progress is required in its implementation. Only four countries have implemented at least three of the four tobacco demand reduction interventions (taxation policies, smoke-free environments, health warnings, advertising and marketing bans) at the highest level of achievement *(6)*. In addition, only 11 of the 38 countries and territories (29%) report having implemented general policies to reduce harmful use of alcohol; only 8 countries (21%) report policies to reduce the impact on children of marketing of foods and non-

38 countries and territories in the Americas provided their responses between July and November 2015, and responses were fully validated by 30 countries between September 2015 and January 2016. The data used in this report were extracted from the WHO database of survey responses (https://extranet.who.int/ncdccs/RegionHome). A report on the results of this NCD capacity survey is in process.

[2] Data from the PAHO Mortality Database were extracted and analyzed for 2012 to determine, among people 30-70 years of age, premature mortality rates and trends for the four main NCDs in each country where information was available. These data were then used to create projections to the year 2019. Based on this unpublished PAHO analysis, countries and territories that are estimated to be on track to meet the premature NCD mortality reduction goal by 2019 include Argentina, Aruba, Canada, Chile, Colombia, Costa Rica, French Guyana, Guadeloupe, Martinique, Saint Lucia, Trinidad and Tobago, the United States of America, Uruguay, and the U.S. Virgin Islands.

alcoholic beverages; 10 countries (26%) report polices to limit saturated fats and eliminate partially hydrogenated vegetable oils in the food supply; three countries (8%) tax sugar-sweetened beverages; and 11 countries (29%) report policies to reduce salt consumption. Also, only seven countries have fully implemented legislation aligned with the International Code of Marketing of Breast-milk Substitutes *(7)*. Twenty-four countries (63%) report having implemented a national public awareness campaign to promote physical activity within the past five years *(5)*.

8. **Overweight and obesity** (body mass index of 25 kg/m^2 or above) continue to be of major concern, as the Americas has the highest global prevalence of these conditions. Twenty-seven percent of women and 22% of men are obese *(8)*. Seven percent of children less than 5 years of age and 17% to 36% of adolescents (12-19 years of age) in Latin America and the Caribbean are overweight or obese *(9)*. This situation is compounded by the low rates of physical activity in the Region, where 38% of women and 27% of men report insufficient physical activity *(8)*. The regional Plan of Action for the Prevention of Obesity in Children and Adolescents offers clear direction on how to halt the rise in obesity, and all countries are urged to implement policies and regulatory strategies *(10)*.

9. **Tobacco use**, perhaps the single most important NCD risk factor, continues to be a challenge in the Region, with an estimated 127 million adult smokers. Some advances have been made in implementing tobacco interventions: 17 countries, which represents 49% of the population in the Americas are protected by a national 100% smoke-free law, and 16 countries have appropriate health warnings on tobacco product packaging which covers 58% of the population in the Americas *(6)*.

10. Progress in reduction of **alcohol use** has stalled; 22% of drinkers report heavy episodic drinking, only six countries (16%) have regulations that restrict alcohol availability, and only two countries (5%) have bans on advertising and promotion *(5)*. Of particular concern is that an estimated 3.2% of adult women in the Americas suffer from an alcohol use disorder, a rate higher than that of any other region in the world *(11)*. In addition, between 51% and 94% of children 13-15 years old report initiation of alcohol use before age 14. More information is available in the midterm progress report on the Plan of Action to Reduce the Harmful Use of Alcohol, which is presented as agenda item 7.12-D of the 55th Directing Council.

11. **Cardiovascular diseases** (CVD), including hypertension, continue to be the leading cause of death in almost all countries in the Region *(3)*. In the Americas, 17% of women and 22% of men have elevated blood pressure (systolic blood pressure $\geq$ 140 mmHg or diastolic blood pressure $\geq$ 90 mmHg) *(8)*. CVD guidelines have been established in 18 countries (47%), but only 10 countries report that these guidelines have been fully implemented *(5)*. Although CVD risk stratification is offered in 20 countries (53%), only five countries report that it is available in more than half of their primary care facilities *(5)*. Essential medicines for CVD—aspirin, thiazide diuretics, ACE (angiotensin-converting-enzyme) inhibitors, calcium channel blockers, statins, and

sulfonylureas—are reported to be generally available in the public sector in 26 countries (68%) *(5)*.

12. An estimated 62 million people in the Americas have **type 2 diabetes,** with 8% of women and 9% of men reported to have an elevated blood glucose (i.e., a fasting blood glucose level ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose or have a history of diabetes) *(8)*. Guidelines for diabetes management are available but have been fully implemented in only 18 countries (47%), whereas blood glucose measurement is generally available in primary care settings throughout the Region (36 countries and territories, 95%); HbA1c testing is available in 20 countries (53%) *(5)*. With respect to essential medicines, 34 countries (89%) report that metformin and insulin generally are available in public primary care settings *(5)*.

13. **Cancer** is the second leading cause of death in the Americas, and the most common types are lung, prostate, and colorectal cancer among men and lung, breast, and cervical cancer among women *(3)*. Comprehensive cancer plans that address the continuum of care (primary prevention, secondary prevention, diagnosis, treatment, palliative care) are promoted by WHO and other institutions. About half of the countries in the Region (23 countries, 61%) report having a national cancer policy, strategy or action plan in place, either a stand-alone plan or one integrated into the country's NCD plan *(5)*. Notable progress is being made in cervical cancer prevention, with 20 countries (53%) introducing HPV vaccines and 33 countries (87%) reporting available screening services for breast, cervical, colon and/or prostate cancer; however, only six countries report screening coverage for at least one of these cancer types, at levels that are likely to have an impact (70% coverage or greater) *(5)*. Although 31 countries (81%) report that breast cancer screening is available and 16 (42%) report that mammography is used, only three of these countries have significant screening coverage likely to have an impact (70% coverage or greater) *(5)*.

14. **Chronic respiratory diseases (CRD)**, principally chronic obstructive pulmonary disease, asthma, and occupational lung diseases are responsible for approximately 413,000 deaths in the Americas (*3*). Tobacco use, air pollution, and occupational chemicals and dusts are the most important risk factors for these diseases, which cannot be cured but for which effective treatment is available. Treatment is reported as generally available in the primary care facilities of the public health sector in the Region: 28 countries (74%) report availability of steroid inhalers and 33 countries (87%) report availability of bronchodilators. Guidelines on the management of CRD, however, are only implemented in 9 countries (24%), and only 8 countries (21%) indicate that they have an operational policy, strategy or action plan specific for CRD *(5)*. Better surveillance to establish the magnitude of CRD, as well as primary prevention to reduce risk factors and strengthening health care for people with chronic respiratory diseases, are urgently needed to improve quality of life for those affected by CRD.

15. As countries work towards universal health coverage, there are opportunities to improve access, coverage, and quality of care for NCDs as well as to address

comorbidities, notably depression and other mental health conditions. The chronic care model, an approach promoted by PAHO and other institutions to integrate NCD management into primary care as a means of providing continuous quality improvement and self-management, is being applied in several countries with PASB's technical assistance. These experiences are being documented and shared to stimulate more countries to adopt this approach. Access to essential NCD medicines is being strengthened through PAHO's Revolving Fund for Strategic Public Health Supplies (Strategic Fund), which now includes almost 40 drugs used to treat hypertension, diabetes, and cancer and to manage tobacco cessation; however, very few countries are using this mechanism, and, as a result, many are paying significantly higher prices for their NCD medicines than the prices available through the fund.

16. Surveillance capacity needs to be improved, especially in the Caribbean and Central America, to enable all countries to measure their progress in meeting NCD targets and indicators; evaluate the impact of their NCD policies, programs, and services; and report progress at the Third UN High-level Meeting on NCDs in 2018. Nonetheless, there has been some progress in this area, with 29 countries reporting either full or partial implementation of NCD risk factor surveys[3] and 34 countries reporting mortality data *(5).*

Challenges and Lessons Learned

17. NCDs, a complex set of four diseases with four shared risk factors, require political will, investments, and concerted actions across all sectors of government and society to address their underlying drivers. There is a great deal of political commitment to NCDs in the Region, as noted in this regional NCD Plan of Action as well as the Global NCD Plan of Action and the 2011 and 2014 UN High-level Meetings on NCDs. Moreover, there have been some important advances, as noted above. Nonetheless, these advances have not yet fully translated to all countries achieving their time-bound commitments to create national NCD plans, establishing multisectoral NCD commissions, setting national NCD targets and indicators, advancing the implementation of stronger regulations and policies to reduce risk factors, improving health services for NCDs, or completing risk factor surveys. Interference from the tobacco, alcohol, and food and beverage industries continues to inhibit countries' progress in attaining the NCD risk factor targets.

[3] NCD risk factor surveys are considered fully implemented if the country, in the 2015 National Capacity Survey, responded "yes" to each of the following for adults: "Have surveys of risk factors (may be a single risk factor or multiple) been conducted in your country for all of the following:" "Harmful alcohol use" (optional for Member States according to national circumstances), "Physical inactivity," "Tobacco use," "Raised blood glucose/diabetes," "Raised blood pressure/hypertension," "Overweight and obesity," and "Salt/sodium intake?" In addition, for each risk factor, the country must indicate that the most recent survey was conducted in the past five years (i.e., 2010 or later for the 2015 survey responses) and must respond "Every 1 to 2 years" or "Every 3 to 5 years" to the sub-question "How often is the survey conducted?" This indicator is considered partially achieved if the country responded that at least three (but not all) of the above risk factors are covered or that the surveys were conducted more than five years but less than 10 years ago.

18. Multisectoral action is an area that has been particularly challenging for countries to implement, given the complexity of engaging other sectors beyond health, along with civil society, academia, and the private sector, in preventing NCDs. The Sustainable Development Goals, as well as the regional commitments to Health in all Policies, health-related law, prevention of obesity in children and adolescents, call for and support creating multisectoral NCD responses. Therefore, more concerted action is required with sectors beyond health that can intervene in NCD prevention and control.

19. In this regard, PAHO is leading a regional mechanism for multisectoral cooperation on NCDs through the Inter-American Task Force on NCDs, which was established as a mandate from the VII Summit of the Americas. This regional task force, launched in July 2015, aims to promote and coordinate multisectoral activities with the agencies and associated international institutions within the Inter-American system: the Pan American Health Organization, the Organization of American States, the Inter-American Institute for Cooperation Agriculture, the Inter-American Development Bank, the Economic Commission for Latin America and the Caribbean, and the World Bank. A mapping of each agency's current investments and technical cooperation in NCDs and their risk factors has been conducted, and PAHO is currently analyzing the information to inform potential areas of synergy, gaps, and collaboration. A joint work plan is in the process of being developed, with a focus on the priority topics of tobacco control, obesity prevention in children and adolescents, and cardiovascular disease prevention and control. The elements of the work plan include advocacy and community mobilization, legislation, economic analysis, and capacity building for key interventions for a multisectoral response to NCDs, among others. The Task Force is hosting a side event on NCDs as part of the July 2016 OAS Ministerial Meeting on Social Development to create linkages among social development, social inclusion, and NCDs.

Action Necessary to Improve the Situation

20. The regional NCD Plan of Action should continue to be implemented, and the following actions are highlighted for attention to improve the current NCD situation:

a) Intensify political, technical, and financial commitments to NCDs, especially in the subregions of Central America and the Caribbean, where progress in NCD prevention and control appears to be lagging.

b) For those countries that have not yet established their national NCD plan, national targets, or multisectoral commissions, prioritize these actions without further delay.

c) Accelerate implementation of the WHO Framework Convention on Tobacco Control, notably to put in place the four demand reduction interventions of taxation policies, smoke-free environments, health warnings, and advertising and marketing bans.

d) Focus on obesity prevention by promoting healthy lifestyles and healthy diets through public awareness campaigns, physical activity promotion, taxation of

sugar-sweetened beverages, restrictions on the marketing of foods and non-alcoholic beverages to children, and restrictions on the marketing of breast milk substitutes.

e) Make alcohol policies a priority within the NCD and health agenda and put in place the demand reduction interventions (taxation policies, regulation of access and availability, and advertising and marketing bans) needed to reduce harmful use of alcohol.

f) Fully use the PAHO Strategic Fund to increase access to and affordability of NCD essential medicines, particularly medicines to improve blood pressure control and prevent cardiovascular diseases.

Action by the Directing Council

21. The Directing Council is invited to take note of this progress report and consider actions needed to accelerate NCD prevention and control interventions.

Annex

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ANNEX – Midterm progress on the Regional NCD Plan of Action, by specific objective

The table below describes the progress for each specific objective and indicator of the Regional NCD Plan of Action 2013-2019, endorsed at the 2013 meeting of the PAHO Directing Council. It shows the countries that were considered baseline in 2010 and the countries meeting the indicator by 2016, the year for which a midterm progress report is submitted to the Directing Council. Indicators with an asterisk (*) are also included in the WHO Global NCD Action Plan.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
1. Multisectoral policies and partnerships for NCD prevention and control	1.1 Promote integration of NCD prevention in sectors outside of health, at the government level, and conduct activities in partnership with a wide range of non-state actors, as appropriate, such as agriculture, trade, education, labor, development, finance, urban planning, environment, and transportation.	1.1.1 Number of countries with multisectoral NCD prevention policies, frameworks and actions in **at least three sectors outside the health sector** at the government level, conducted in partnership with a wide range of non-state actors, as appropriate (e.g., agriculture, trade, education, labor, development, finance, urban planning, environment, and transportation).	(5) ARG, BRA, CAN, MEX, USA	(12) ARG, BRA, BRB, CAN, CRI, CUB, GRD, JAM, MEX, PRI, USA, VGB	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015. -This refers to countries with operational multisectoral NCD commissions that include government ministries other than health. The survey question did not probe for number of sectors, so it is not certain if the country has at least three sectors outside health in its national commission.
	1.2 Strengthen or develop national health plans based on multisectoral approaches, with specific actions, targets, and indicators geared to at least the four priority NCDs and the four main risk factors.	1.2.1 Number of countries implementing a national multisectoral plan and/or actions for NCD prevention and control.	(15) ARG, BRA, BRB, CAN, CHL, COL, CUW, DOM, GTM, JAM, MEX, SUR, TTO, USA, VGB	(22) ARG, BLZ, BRA, BRB, VGB, CAN, CHL, COL, CRI, DOM, ECU, GLP, GUY, JAM, KNA, MEX, PAN, PRI, PRY, SUR, USA, VCT	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	1.3 Expand social protection policies in health to provide universal coverage and more equitable access to promotive, preventative, curative, rehabilitative, and palliative basic health services and essential, safe, affordable, effective, quality medicines and technologies for NCDs.	1.3.1 Number of countries with national social protection health schemes that address universal and equitable access to NCD interventions.	(7) BRA, CAN, CHL, COL, CRI, CUB, URY	In progress	-Data to measure progress on this indicator are currently not available. A review and analysis of all social protection schemes of countries in the Region are needed to assess this indicator, and this is in progress and information will be included in the final report.
2. NCD risk factors and protective factors	2.1 Reduce tobacco use and exposure to secondhand smoke.	2.1.1* Number of countries that reduce the prevalence of current tobacco use from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the global target of a 30% relative reduction in current tobacco smoking by 2025 (measured by the age-standardized prevalence of current tobacco use in the population 15 years and over).	0	In progress	-Information on the age-standardized prevalence of current tobacco smoking in adults 15+ (2013) is available for 19 countries in Appendix X of the WHO Report on the Global Tobacco Epidemic, 2015 (available from: http://bit.ly/1gl1YYm). -Data are not yet available that will allow for calculation of the change in the prevalence of tobacco use from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	2.2 Reduce the harmful use of alcohol.	2.2.1* Number of countries that by 2019 achieve a reduction in harmful use of alcohol from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the global target of a 10% relative reduction by 2025.	0	In progress	-Information on alcohol consumption per capita in adults 15+ (2010) is available for the 35 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx). This is one of the three indicators for harmful use of alcohol included in the WHO Global Monitoring Framework. Countries are encouraged to report against as many indicators as possible; however, they may also choose to report against the one most appropriate for their national circumstances. -According to the PAHO/WHO Country Capacity Survey on NCDs, 26 countries report having a recent (≤5 years) risk factor survey that includes harmful use of alcohol. -Data are not yet available that will allow for calculation of the change in harmful use of alcohol from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
	2.3 Promote healthy eating for health and well-being.	2.3.1* Number of countries with policies to reduce the impact on children of marketing of foods and non-alcoholic beverages and foods high in saturated fats, trans-fatty acid, sugar, and salt.	(2) BRA, CAN	(7) BRA, CAN, CHL, COL, CRI, MEX, URY	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		2.3.2* Number of countries with adopted national policies to limit saturated fats and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate within national contexts and national programs.	(6) ARG, BRA, CAN, CHL, CRI, USA	(10) ARG, BRA, CAN, COL, CRI, ECU, JAM, PER, PRI, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.
		2.3.3* Number of countries that by 2019 reduce salt/sodium consumption from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of a 30% relative reduction in population-based intake of salt/sodium, measured by the age-standardized mean population intake of salt (sodium chloride) in grams per day in persons aged 18+ years.	0	In progress	-Based on the PAHO/WHO Country Capacity Survey on NCDs, 14 countries report having a recent (≤5 years) risk factor survey that includes salt/sodium intake. PAHO/WHO is providing technical assistance to countries to undertake risk factor surveys that include salt/sodium intake. -Data are not yet available that will allow for calculation of the change in salt/sodium consumption from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	2.4 Promote active living for health and well-being and to prevent obesity.	2.4.1* Number of countries that by 2019 reduce the prevalence of insufficient adult physical activity from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of at least a 10% relative reduction in the prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week or the equivalent).	0	In progress	-Information on the age-standardized prevalence of insufficient physical activity in adults 18+ years (2010) is available for 20 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx). -Based on the PAHO/WHO Country Capacity Survey on NCDs, 24 countries report having recent (≤5 years) risk factor surveys that include physical activity. -Data are not yet available that will allow for calculation of the change in insufficient adult physical activity from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
		2.4.2* Number of countries that by 2019 reduce the prevalence of insufficient physical activity among adolescents from the level established at the national baseline to the level established for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of at least a 10% relative reduction in the prevalence of insufficiently physically active adolescents (defined as less than 60 minutes of moderate- to vigorous-	0	In progress	-Country-reported data on the prevalence of insufficient physical activity among adolescents aged 11-17 years who are enrolled in school are available for 27 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx). -Based on the PAHO/WHO Country Capacity Survey on NCDs, 21 countries report having recent risk factor surveys that include physical activity measures. -Data are not yet available that will

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		intensity activity daily in school-aged children and adolescents).			allow for calculation of the change in insufficient adolescent physical activity from baseline to the level established for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
3. Health system response to NCDs and risk factors	3.1 Improve the quality of health services for NCD management.	3.1.1 Number of countries implementing a model of integrated management for NCDs (e.g., Chronic Care Model with evidence-based guidelines, a clinical information system, self-care, community support, multidisciplinary team-based care).	(9) ARG, BRA, CAN, CHL, DOM, JAM, MEX, PRY, USA	(18) ARG, BRA, CAN, CHL, COL, CRI, CUB, DOM, ECU, GRD, MEX, JAM, PAN, PRI, PRY, LCA SUR, USA	-Source: information provided by the PAHO Unit on Noncommunicable Diseases, based on technical cooperation on the implementation of the Chronic Care Model.
	3.2 Increase access to and rational use of essential medicines and technologies for screening, diagnosis, treatment, control, rehabilitation, and palliative care of NCDs.	3.2.1 Number of countries that by 2019 achieve the level of availability of affordable basic technologies and essential medicines (including generics) required to treat the four main NCDs in both public and private facilities, as established by the country for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of 80% availability.	(7) ARG, BRA, CAN, CHL, CRI, CUB, URY	(20) ATG, BRA, BRB, CAN, CHL, COL, CRI, CUB, CYM, DOM, ECU, GRD, GUY, JAM, PAN, PRI, SUR, TTO, URY, USA	-Source: PAHO/WHO National Capacity Survey, conducted July-November 2015. -This includes countries that report having all basic technologies and essential NCD medicines generally available in the public sector. Private sector data were not available for NCD medicines. -The definition of essential medicines and basic technologies is as outlined in the NCD GMF definitions and specifications (available from: http://bit.ly/1KsRizl).
		3.2.2 Number of countries that by 2019 improve access to palliative care, assessed by the increase in	0	In progress	-Data on opioid consumption (as measured by morphine equivalence minus methadone in milligrams per

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		morphine equivalent consumption of opioid analgesics (excluding methadone) per cancer death based on 2010 data.			capita) are available for 37 countries and territories in the Americas, as estimates from the International Narcotics Control Board. -Based on the PAHO/WHO Country Capacity Survey on NCDs, 18 countries report having oral morphine generally available in the public sector. -Data are not yet available that will allow for calculation of the change in morphine equivalent consumption of opioid analgesics (excluding methadone) per cancer death. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.2.3 Number of countries utilizing the PAHO Strategic Fund and Revolving Fund and/or other cost-saving mechanisms to procure essential medicines and health technologies relevant to prevention, control, and palliation for the four leading NCDs, such as chemotherapy drugs, palliation medications, insulin, dialysis and hemodialysis, hepatitis B (HBV) and human papillomavirus (HPV) vaccines, and medications for the treatment of hypertension and diabetes.	0	In progress	-All countries in the Region utilize the PAHO Revolving fund for HBV vaccine, and almost all countries that have introduced HPV vaccines utilize this fund. -The inclusion of NCD medicines in the PAHO Strategic Fund is very recent, and as such countries in the Region have not yet begun to fully utilize this mechanism. Only two countries to date have procured their NCD medicines through the Strategic Fund. PAHO is actively promoting the availability of affordable NCD medicines through this fund to its Member States.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		3.2.4 Number of countries with an official commission that selects, according to the best available evidence and operating without conflicts of interest, NCD prevention and/or treatment and/or palliative care medicines and technologies for inclusion in/exclusion from public sector services.	(6) BRA, CAN, CRI, CUB, URY, USA	In progress	-There are eight countries with commissions that select, according to the best available evidence and operating without conflicts of interest, medicines and technologies. The currently available information does not separate NCD prevention and/or treatment and palliative care medicines and technologies from others, so it is not possible at present to fully report on this indicator.
		3.2.5 Number of countries with a plan in place, as appropriate, to increase access to affordable treatment options for patients affected by chronic kidney disease (CKD), particularly end-stage renal disease.	(5) CHL, CUB, PRI, URY, VEN	(10) ARG, BRA, CHL, COL, CUB, ECU, PRI, PRY, URY, VEN	-Source: González-Bedat et al. Los registros nacionales de diálisis y trasplante renal en América Latina: cómo implementarlos y mejorarlos. Rev Panam Salud Publica. 2015;38(3):254-260.
	3.3 Implement effective, evidence-based, and cost-effective interventions for treatment and control of CVD, hypertension, diabetes, cancers, and chronic respiratory diseases.	3.3.1* Number of countries that by 2019 achieve the level set for raised blood glucose/diabetes from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of a halt in the prevalence of raised blood glucose/diabetes, assessed by the age-standardized prevalence of raised blood glucose/diabetes among adults aged 18+ years (defined as fasting plasma glucose value ≥7.0 mmol/L [126 mg/dl] or on medication for raised blood glucose).	(1) USA	In progress	-Information on the age-standardized prevalence of raised fasting blood glucose/diabetes (≥7.0 mmol/L or on medication) in adults 18+ (2014) is available for 35 Member States from the WHO Global Health Observatory (available from: http://bit.ly/297Gopx). -Based on the PAHO/WHO Country Capacity Survey on NCDs, 23 countries report having recent (≤5 years) risk factor surveys that include blood glucose/diabetes. -Data are not yet available that will allow for calculation of the change in raised blood glucose/diabetes

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
					from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.3.2* Number of countries that by 2019 achieve the level set for adult obesity from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of a halt in the prevalence of adult obesity, assessed through the age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as BMI ≥25 kg/m^2 for overweight or ≥30 kg/m^2 for obesity).	0	In progress	-Information on the age-standardized prevalence of obesity (BMI ≥30 kg/m^2) in adults 18+ years (2014) is available for 35 Member States in the WHO Global Status Report 2014 (available from: http://bit.ly/1CeE0Vx). -According to the PAHO/WHO 2015 Country Capacity Survey, 27 countries report having recent (≤5 years) risk factor surveys that include overweight and obesity among adults. -Data are not yet available that will allow for calculation of the change in adult obesity from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.3.3* Number of countries that by 2019 achieve the level set for adolescent overweight and obesity from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the	0	In progress	-Country-reported data for the prevalence of overweight and obesity (>+1SD from the median for BMI) in adolescents 13-15 years of age are available for 18 countries from the Global School Health Survey (available from:

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		2025 global target of a halt in the prevalence of overweight and obesity (defined according to the WHO growth reference for school-aged children and adolescents: overweight as one standard deviation BMI for age and sex and obese as two standard deviations BMI for age and sex).			http://bit.ly/295Ogt6). –Based on the PAHO/WHO Country Capacity Survey on NCDs, 21 countries report having recent (≤5 years) risk factor surveys that include overweight and obesity among adolescents. -Data are not yet available that will allow for calculation of the change in adolescent overweight and obesity from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.3.4* Number of countries that by 2019 achieve the level of drug therapy and counseling set from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global target of at least 50% of eligible people receiving drug therapy and counseling (including glycemic control) to prevent heart attacks and strokes (eligible people are defined as aged 40 years and over with a 10-year cardiovascular risk greater than or equal to 30%, including those with existing CVD).	(4) BRA, CAN, CHL, CUB	In progress	-The STEPS survey includes questions related to this indicator, but results are not currently available that would enable calculation of this indicator. When data become fully available, this indicator will be calculated and information will be included in the final report.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		3.3.5* Number of countries that by 2019 reduce the level of prevalence of raised blood pressure from the national baseline to the level set for interim reporting to the WHO Global Monitoring Framework, thus contributing to the 2025 global goal of at least a 25% relative reduction in the prevalence of raised blood pressure or containing the prevalence of raised blood pressure, expressed by the age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg).	0	In progress	-Information on the age-standardized prevalence of raised blood pressure (systolic blood pressure ≥140 or diastolic blood pressure ≥ 90) among adults 18+ (2014) is available for 35 Member States from the WHO Global Health Observatory (available from: http://bit.ly/29djA9W). -Based on the PAHO/WHO Country Capacity Survey on NCDs, 24 countries report having recent (≤5 years) risk factor surveys that include blood pressure. -Data are not yet available that will allow for calculation of the change in the prevalence of raised blood pressure from the national baseline level to the level set for WHO GMF interim reporting. When these data become available, this indicator will be evaluated and information will be included in the final report.
		3.3.6* Number of countries with cervical cancer screening coverage of 70% by 2019 (among women aged 30-49 years, at least once or more often, and for lower or higher age groups according to national policies).	(5) BRA, CAN, CHL, KNA,USA	(7) BRA, CAN, CHL, CUB, ECU, GRD, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
		3.3.7 Number of countries with at least 50% coverage of breast cancer screening in women aged 50-69 years (and other age groups according to national programs or policies) in a three-year period, with effective and timely treatment for all positive cases found during screening.	(4) ARG, BRA, CAN, USA	(7) BRA, CAN, CUB, DOM, ECU, JAM, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.
		3.3.8* Number of countries that provide as appropriate cost-effective and affordable vaccines against HPV according to national programs and policies.	(8) ARG, CAN, COL, MEX, PAN, PER, URY, USA	(21) ARG, BHS, BLZ, BRA, BRB, CAN, CHL, COL, CYM, ECU, GUY, HND, MEX, PAN, PER, PRI, PRY, SUR, TTO, URY, USA	-Source: PAHO/WHO Country Capacity Survey, conducted July-November 2015.
4. NCD surveillance and research	4.1 Improve the quality and breadth of NCD and risk factor surveillance systems to include information on socioeconomic and occupational status.	4.1.1 A 15% reduction in premature mortality from the four leading NCDs by 2019 and 25% by 2025.	0	(14) ABW, ARG, CAN, CHL, COL, CRI, GLP, GUF, LCA, MTQ, TTO, URY, USA, VIR	-Source: analysis of data from the PAHO Mortality Database, 2016.
		4.1.2 Number of countries with high-quality mortality data (based on international criteria for completeness and coverage and percentage of ill-defined or unknown causes of death) for the four main NCDs and other NCDs of national priority (e.g., CKD).	(10) CAN, CHL, CRI, CUB, MEX, SUR, PAN, URY, USA, VEN	(23) ARG, ATG, BHS, BRA, BRB, CAN, CHL, CRI, CUB, DMA, GRD, GUY, KNA, LCA, MEX, MSR, MTQ, PRI, URY, USA, VCT, VEN, VIR	Source: PAHO Basic Indicators. Health Situation in the Americas, 2016. -This includes countries with coverage higher than 90% and percentage of ill-defined causes of death lower than 10%, as defined by WHO in Mathers et al. Counting the dead and what they died from: an assessment of the global status of

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
					cause of death data. Bull World Health Organ. 2005;83(3):161-240.
		4.1.3* Number of countries with quality cancer incidence data, by type of cancer per 100,000 population.	(11) ARG, BRA, CAN, CHL, COL, CRI, ECU, MEX, PER, URY, USA	(18) ARG, BRA, BRB, CAN, CHL, COL, CRI, CUB, CYM, ECU, GTM, GUY, JAM, PAN, PER, PRI, URY, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015.
		4.1.4* Number of countries with at least two nationally representative population surveys by 2019 of NCD risk factors and protective factors in adults and adolescents in the last 10 years, including: - tobacco use - alcohol use - anthropometry - albumin - blood pressure - fasting glucose and cholesterol - fruit and vegetable intake - creatinine - physical inactivity - sodium intake - disease prevalence - sugar intake - medication use	(7) ARG, BRA, CAN, CHL, MEX, JAM, USA	In progress	-Based on the PAHO/WHO Country Capacity Survey on NCDs and the definition outlined in WHO progress indicator #3, nine countries report having recent (≤5 years) and periodic (at least every 5 years) NCD risk factor surveys in adults covering harmful use of alcohol, physical inactivity, tobacco use, raised blood glucose/diabetes, raised blood pressure/Hypertension, overweight/obesity, and salt intake; 19 countries have NCD risk factor surveys that cover at least three risk factors and were conducted more than 5 years ago but less than 10 years ago. Information on this indicator will be included in the final report.
	4.2 Improve utilization of NCD and risk factor surveillance systems and strengthen operational research	4.2.1 Number of countries that produce and disseminate regular reports with analysis of NCDs and risk factors, including demographic, socioeconomic, and environmental	(9) ARG, BRA, CAN, CHL, COL, CUB, MEX, JAM, USA	(22) ARG, BHS, BRA, BRB, CAN, CHL, CRI, CUB, DOM, ECU, GRD,	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015, and the WHO NCD Progress Monitoring Report.

Strategic line of action	Specific objective	Indicator	Baseline (2010)	Status (2016)	Notes about status (2016)
	with a view to improving the evidence base for planning, monitoring, and evaluation of NCD-related policies and programs.	determinants and their social distribution, to contribute to the global NCD monitoring process.		GTM, LCA, MEX, PAN, PRI, PRI SUR, TTO, URY, USA, VCT	-This refers to countries that have demonstrated a report, or factsheet, that disseminates data on tobacco use, harmful use of alcohol, fruit and vegetable consumption, physical inactivity, raised blood pressure/hypertension, and raised blood glucose/diabetes in the past 5 years from STEPs or similar surveys among adults.
		4.2.2 Number of countries that have research agendas that include operational studies on NCDs and risk factors aiming to strengthen evidence-based policies and program development and implementation.	(9) ARG, BRA, CAN, CHL, COL, CUB, JAM, MEX, USA	(11) ARG, BRA, CAN, CHL, COL, CRI, JAM, MEX, PRI, PRY, USA	-Source: PAHO/WHO Country Capacity Survey on NCDs, conducted July-November 2015, and the WHO NCD Progress Monitoring Report. -This refers to countries that have an operational policy or plan on NCD-related research.

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