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110 Years of Pan American Progress in Health

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From the Director

To the Member States:

In accordance with the provisions of the Constitution of the Pan American Health Organization, I have the honor to present the 2008-2012 quinquennial report on the work of the Pan American Sanitary Bureau, Regional Office of the World Health Organization for the Americas. The report highlights the Bureau's major work in providing technical cooperation during this period within the framework of the 2008–2012 Strategic Plan of the Pan American Health Organization, defined by the Governing Bodies of the Pan American Health Organization.

Mirta Roses Periago
Director

For 110 years, Pan Americanism has been a powerful force for health progress, leading to achievements that few could have imagined a century ago. As we celebrate those achievements, we also set our goals higher, toward bridging the persisting health gaps across and within countries. For that we need to build political will and mobilize all of society to overcome the historic health determinants that hamper our path to human security and sustainable development. Our shared dream is that, sooner rather than later, our hemisphere will be able to announce the realization of "Health for All."

Mirta Roses Periago
Director

CHAPTER I

THE AMERICAS IN THE NEW MILLENNIUM

1. The first decade of the new millennium was a period of significant, if mixed, progress for health and development in the Americas. At the regional level, life expectancy gained 4 years between 2000 and 2010, rising from 72.2 to 76.2 years. Mortality fell 11%, despite (and certainly contributing to) a rapidly aging population.

2. Despite the economic downturn toward the end of the decade, the number of people living in poverty in the Region declined by 44 million between 2002 and 2011, and the number living in extreme poverty fell by 27 million. This was largely the result of sustained economic growth during the earlier part of the decade, but it also reflected targeted anti-poverty policies pursued by a number of the countries.

3. In terms of political development, the positive trends of the 1990s carried over into the 2000s, with the continued consolidation of democracy and the rule of law, increased political and administrative decentralization, and greater citizen participation in local governance. Threats to democratic order did occur but were few and did not alter the regional pattern of deepening democracy. Indeed, Latin America and the Caribbean rated highest among developing regions on the Economist Intelligence Unit's "Democracy Index" during this decade, behind only Europe and North America.

4. Contributing to these positive trends was the ongoing revolution in use of information technologies, which exponentially increased communication and information-sharing in countries. The growing use of Web-based and social media gave rise to new social as well as interest-based networks, including new "communities of practice," many of which focused on issues related to health. These media have clearly

helped mobilize and channel new and growing demands for social inclusion and participation and for accountability by governments, organizations, and corporations.

5. Although progress toward more democratic and participatory governance was made in many of the Region's countries, others faced significant challenges in this regard, especially those most affected by the drug trade and organized crime. By the end of the decade, successes in controlling drug trafficking in countries such as Colombia and Mexico had the effect of shifting drug transit routes and related violence to other countries, particularly Central America. This shift focused new attention on the need for regional and subregional approaches to these problems and spurred calls to broaden the international policy debate to consider new options, including decriminalization and increased, innovative action on prevention and demand reduction in high-consumption areas such as Europe and the United States.

6. In economic terms, countries increased their participation in the global economy during the decade while continuing to pursue development models adapted to their own needs and realities. A particularly noteworthy trend was the continued advancement of regional and subregional integration. Established mechanisms such as the Southern Common Market (MERCOSUR), the Andean and Caribbean communities, and the Central American Integration System (SICA) were supplemented by new entities: the Union of South American Nations (UNASUR), the Community of Latin American and Caribbean States (CELAC), the Bolivarian Alliance for the Peoples of Our America (ALBA), and the Pacific Alliance (Chile, Colombia, Mexico, and Peru). These initiatives not only helped expand intraregional trade and regional exports but also increased Pan American cooperation in a number of areas: from infrastructure development and energy security to harmonization of sanitary regulations and access to essential medicines (see also Chapter II). Through its membership in the BRICS group, Brazil began to explore similar cooperation opportunities with the world's leading emerging economies, while 12 PAHO Member States are participating in meetings of the Group of 20 (G20) developing nations: Argentina, Bolivia, Brazil, Chile, Cuba, Ecuador, Guatemala, Mexico, Paraguay, Peru, Uruguay, and Venezuela.

7. Despite important economic and social progress during the decade, however, the Americas did not overcome its status as the most unequal region in the world. As measured by the Gini index, income inequality improved a scant 6.5% over the decade (from 0.46 in 2000 to 0.43 in 2010). In 2010, the richest 20% of the Region's population earned 49.6% of total income, while the poorest 20% earned only 5.6%.

8. This inequality was also evident in key social determinants of health and development, including access to water and sanitation and exposure to environmental contaminants. Two particularly poignant examples of such inequality were Haiti's cholera epidemic and the unexplained epidemic of renal failure in Central American countries, which claimed more than 18,000 lives during the decade, providing an

alarming reminder of the potential effects of environmental risks on vulnerable groups, in this case predominantly rural families.

9. The continuing inequities and vulnerabilities in poorer countries and population groups were also clear from the impact of numerous natural disasters that struck the Region during the decade. These disasters ranged from flooding and droughts that affected tens of thousands of rural Central Americans to the January 2010 earthquake in Haiti, which is estimated to have claimed over 200,000 lives. The catastrophic impact of Haiti's 7.0-magnitude quake contrasted starkly with the lesser impact of the 8.8-magnitude quake and tsunami that struck Chile a few weeks later, in part due to Haiti's greater vulnerability.

10. For public health, two overarching demographic and epidemiological trends defined the decade: the Region's aging population and the rising burden of chronic noncommunicable diseases (NCDs). Between 2000 and 2009, the number of people over age 60 increased from 92 million to almost 120 million. This increase created special challenges for health systems, which in most countries have proven under-equipped financially and organizationally to deal with the rapid rise in NCDs and other health aspects of aging. The trend has also increased pressures on families and particularly women, who provide most of the care for aging adults. However, the impact has been greatest on the elderly themselves, many of whom suffer not only from age-related health problems but also from poverty and lack of social protection.

11. Other key trends that influenced health and social development included the Region's continued and largely unplanned urbanization, international migration and internal displacement, and climate change, all of which increased exposure to health risks among vulnerable groups. Nevertheless, the Region on balance registered important gains in human development over the decade. The following section describes some of the important public health processes that contributed to these regional achievements.[1]

Public Health Interventions and Achievements

12. The 2000 Millennium Declaration and the subsequent Millennium Development Goals (MDGs) and targets confirmed a growing consensus at the global and regional levels that health is an essential component of economic and social development as well as of basic human well-being. In the Region of the Americas, this consensus was reflected in major new investments and initiatives and in the significant progress made toward public health goals during the decade.

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[1] Additional details and analysis of recent health and development trends in the Region of the Americas are provided in the 2012 edition of PAHO's quinquennial report *Health in the Americas* published concurrently with this report.

13. Overall public spending on health grew over the decade from US$ 212.8 billion (in 2000) to US$ 304.2 billion (in 2010), a 43% increase in constant dollar terms. (During the same period, private health spending declined 6.7%, from US$ 282.1 billion to US$ 263.1 billion.) Most of this increase occurred during the first half of the decade. From 2000 to 2005, public health spending increased 8.6% per year, well above economic growth, rising from 3.1% to 4.0% of gross domestic product (GDP). In contrast, during the second half of the decade, public health spending failed to keep pace with economic growth and declined from 4.0% to 3.7% as a percentage of GDP.

14. The increased spending on health in the early part of the decade was due in part to rising health care costs, but it also reflected countries' renewed determination to address problems that health reforms in the late 1980s and 1990s had failed to resolve. These included fragmented health systems, large numbers of people without social and health care protection, as well as the closely related problems of poverty, social exclusion, and other social determinants of health inequality.

15. In 2006, PAHO's Member States began work on a regional approach to these challenges that would eventually culminate in one of the most important regional public health initiatives of the decade: the Health Agenda for the Americas 2008-2017. Developed through a broad consultation and consensus-building process, the agenda represents the highest-level political and strategic vision for health in the Americas. It is intended to provide guidance for collective action by all health stakeholders, including national health planners, technical cooperation agencies, and other health partners in the Region.

16. The development of the agenda started in March 2006 and was led by a special working group made up of representatives of 10 countries (Argentina, Brazil, Chile, Costa Rica, El Salvador, Guyana, Panama, St. Vincent and the Grenadines, the United States of America, and Venezuela [Bolivarian Republic of]), with the Pan American Sanitary Bureau (PASB) serving as secretariat. During a year-long process, inputs were received from all the Region's countries as well as from United Nations and other technical cooperation agencies, academic institutions, and nongovernmental organizations. The final document was launched in June 2007 before the 37th General Assembly of the Organization of American States (OAS) in Panama City, accompanied by a declaration signed by health authorities from all PAHO Member States.

17. The Health Agenda for the Americas 2008-2017 is grounded in the shared principles of health as a human right, health equity, universality, access and inclusion, social participation, and Pan American solidarity. It presents a situation analysis that reflects a shared vision of the common public health challenges facing the Region's countries and the actions that are needed to confront them. The agenda sets out seven key areas for action: strengthening national health authorities; tackling health determinants; increasing social protection and access to quality health services; diminishing health

inequalities among and within countries; reducing the risk and burden of disease; strengthening the management and development of health workers; harnessing knowledge, science and technology; and strengthening health security.

18. One of the most important regional processes contributing to the Region's advances toward the MDGs and the goals of the Health Agenda for the Americas was the expansion of social protection, in health as well as in such critical social determinants of health as income security and access to essential services, in line with the U.N. Social Protection Floor initiative.

World Conference on Social Determinants of Health

One of the most important achievements of global health advocacy during the first decade of the 2000s was a higher political profile for the social determinants of health (SDH). The 2008 Final Report of the Commission on Social Determinants of Health: *Closing the Gap in a Generation* demonstrated successfully that social determinants—where people are born, grow, live, work, and age, and their access to health services—are the major factors underlying inequities in health status among people around the world.

To build support for action on these issues, the World Health Organization (WHO) convened the World Conference on Social Determinants of Health in Rio de Janeiro, Brazil, in October 2011. Hosted by the Government of Brazil, the conference was organized by the Ministry of Health, the Ministry of Foreign Affairs, and the Oswaldo Cruz Foundation (FIOCRUZ), in close coordination with WHO and PAHO.

In preparation for the conference, PAHO organized three consultations aimed at formulating regional recommendations, including a meeting of Member States, a virtual consultation with 300 civil society organizations (followed by a smaller face-to-face meeting to synthesize its results), and a virtual consultation with members of the PAHO Equity, Health, and Human Development listserv aimed at reaching additional stakeholders. The recommendations that emerged from these consultations were documented and widely distributed.

A highlight of the world conference, which drew more than 1,000 people plus 19,000 virtual participants, was the presentation of seven case studies from the Americas illustrating the systematic and practical aspects of implementing the SDH approach at the country level.

The Rio Political Declaration on Social Determinants of Health was subsequently endorsed by WHO's 65th World Health Assembly, along with measures to support its five priority areas of action: governance to tackle the root causes of health inequities, promotion of participation and community leadership, the role of the health sector in reducing inequities, action among global partners and stakeholders, and monitoring of progress.

In June 2012, the United Nations Conference on Sustainable Development (Rio+20) further reinforced the SDH approach in calling for "action on the social and environmental determinants of health, both for the poor and the vulnerable and the entire population...to create inclusive, equitable, economically productive, and healthy societies."

19. During the first decade of the 2000s, average public health spending in Latin America and the Caribbean peaked at 4.1% of GDP in 2008-2009, and health spending in individual countries was in many cases significantly lower during the decade. The World Health Report 2010, *Health* systems *financing: the path to universal coverage,* presents evidence that no country has reached universal health coverage with public health spending of less than 5-6% of GDP. Nevertheless, a number of countries expanded health coverage by increasing the proportion of the population covered or the level of services offered, by reducing out-of-pocket costs for individuals and families, or a combination of all three.

20. Brazil's *Sistema Único de Saúde* ("Unified Health System") was originally created in 1988 and had expanded to cover 80% of the country's nearly 200 million inhabitants by the end of the decade. Mexico's voluntary public plan, *Seguro Popular* ("Popular Insurance"), established in 2004, was able by the end of the decade to reach some 50 million people in 32 states who were not covered by other social security institutions. Chile's *Régimen de Garantías Explícitas en Salud* (AUGE) ("Universal Access with Explicit Guarantees") program, established in 2005, strengthened the country's already existing universal health care system by providing guaranteed coverage within specific timeframes for 70 high-burden health conditions. Uruguay's *Sistema Nacional Integrado de Salud* ("National Integrated Health System"), created in 2007, increased the quality and sustainability of the country's universal health care system through financing reforms, a guaranteed package of services, and improved distribution of beneficiaries between private and public providers, regardless of capacity to pay. In the United States, the Patient Protection and Affordable Care Act of 2010 seeks to progressively expand health insurance coverage while also improving health care delivery and reducing costs, and represents the most significant U.S. health reform effort since the 1960s.

21. Health care coverage also expanded as part of a growing number of targeted anti-poverty programs that required beneficiaries to receive health interventions as conditions for cash transfers. By the end of the decade, some 3.1 million families in Brazil were receiving health and other benefits from the *Bolsa Familia* ("Family Breadbasket") program, while some 5.8 million families were benefitting from Mexico's *Oportunidades* ("Opportunities") program, and 1.1 million people were benefitting from *Chile Solidario* ("Solidary Chile"). Other countries—including Colombia, Ecuador, and Peru—initiated important efforts to advance the national debate about universal health coverage.

22. Governments' growing emphasis on meeting health and social development commitments also led to the increasing use of legislation, budgetary authority, and constitutional law to reform health and social protection systems and to expand government action into areas related to the social determinants of health. Continuing a process that began in the 1990s, Bolivia, the Dominican Republic, and Ecuador were among countries that adopted new constitutions that explicitly guarantee the right to

health and include mandates for legal reforms that strengthen the steering role of the national health authority and increase participation, transparency, and accountability in the health sector.

23. In addition to these constitutional provisions, other countries developed new legal frameworks for the health sector, including legislation to create new or consolidate existing regulatory agencies. Argentina, Guatemala, and Panama were among countries that drafted new national health laws and launched national dialogues on the proposed legislation led by national health authorities and parliamentary health commissions. Panama's proposed legislation seeks to create a new drug regulatory authority, while the Dominican Republic proposes to create a new agency to manage public sector health services. Paraguay is considering proposed new regulations to guide the implementation of its 1996 law (No. 2.319) establishing the functions and competencies of the national health authority.

24. Related to these developments was the growing use of international treaties and other accords as instruments for collective action to protect population health from common threats. The most important of these was the WHO Framework Convention on Tobacco Control (FCTC), adopted by the World Health Assembly in 2003 as the world's first international treaty related to health. By 2012, 29 of 35 countries in the Americas were parties to the treaty, including most recently seven countries—Bahamas, Colombia, Costa Rica, Nicaragua, St. Kitts and Nevis, St. Vincent and the Grenadines, and Suriname—all of which ratified the treaty during the past five years.

25. During 2008 to 2012, a number of the Region's countries made significant progress in implementing the FCTC. Twelve passed new laws banning smoking in public indoor spaces and workplaces, joining Uruguay, which was the Region's first country to implement such a ban in 2005. By 2012, Canada had smoke-free laws in place at the subnational level that effectively protected 90% of the population. In addition, 14 countries passed legislation on packaging and labeling of tobacco products, most of which was consistent with FCTC provisions on the size of health warnings, the use of graphic warnings, and prohibitions on the use of misleading terms (e.g., "light" cigarettes). These were achieved despite aggressive efforts by the tobacco industry to undermine progress in tobacco control.

26. In 2011, PAHO/WHO Member States endorsed similar measures targeting alcohol as part of the regional Plan of Action to Reduce the Harmful Use of Alcohol (CD51.R14). The plan proposes measures including increased taxes on alcoholic beverages; restrictions on age, type of outlets, and hours for the sale and purchase of alcohol; and limits on marketing, particularly aimed at young people. As with tobacco, the alcohol industry has responded with active efforts to prevent the implementation of such measures.

27. In line with these efforts and contributing to expanded health coverage was a growing, if incipient, emphasis on public health action based on human rights, gender equality, and cultural diversity. In all the Region's countries, these issues were the subject of new legislation, policies, or mechanisms designed to protect and promote "health for all." Particularly noteworthy were efforts among and within countries to define multisector state and civil society responses to complex public health inequalities and challenges, including violence against women, access to HIV treatment and care, gender identity, and reproductive and sexual rights.

28. These efforts led to such achievements as new gender equality policies in the health sector, mental health reforms that incorporate human rights protections, the decriminalization of sexual orientation behaviors, criminalization of violence against women, the creation of intercultural ministries or high-level offices within governments, subregional commitments on gender and ethnic equality in health, and the establishment of technical governmental groups to advocate for health equity in regional, subregional, and national health agendas. Many of these processes embraced universal or regional treaties, conventions, or resolutions that commit countries to protecting health and human rights.

29. The Region's determination to address the growing epidemic of NCDs mounted over the decade and was reflected in a number of new regional initiatives and commitments. These ranged from the above-mentioned efforts to implement the FCTC to first ladies' initiatives targeting childhood obesity—for example, "Let's Move!" in the United States and "Choose to Live Healthy" in Chile—and laws and regulations on marketing of foods to children and serving junk foods in schools—such as in Chile, Costa Rica, and Mexico.

30. The Caribbean was a regional leader in these efforts, holding the first Regional Summit on Chronic Non-communicable Diseases in Trinidad and Tobago in 2007. The final Declaration of Port-of-Spain: "Uniting to Stop the Epidemic of Chronic NCDs" pushed chronic diseases to the top of the Caribbean health agenda and pledged a series of policies and actions based on a multisectoral, "all-of-society" framework. These included health education and health promotion initiatives, expanded programs for NCD screening and management, incentives and resources to improve nutrition and increase physical activity in schools and other settings, full implementation of the FCTC, mandates for labeling of the nutritional content of foods, and agricultural and trade policies that promote indigenous products and counteract the negative effects of globalization on the food supply.

31. In 2010, Caribbean countries sponsored a resolution at the U.N. General Assembly calling for a high-level meeting to raise awareness of the burden of NCDs around the world and to spur new commitments to tackling the problem. The U.N. High-Level Meeting on Chronic Non-communicable Diseases took place in New York on 19-

20 September 2011 and was only the second such U.N. meeting focused on health, after the 2001 special session on the HIV/AIDS epidemic. The final declaration echoed the Port-of-Spain agreement in calling for multisectoral policies and actions to address NCDs and their risk factors and in urging implementation of WHO's global strategies on diet, physical activity, and health and as well as accelerated implementation of the FCTC.

32. The Region's aging population and the related rise of chronic noncommunicable diseases have created new challenges for health systems but have not eliminated the need to face longer-standing problems such as infectious diseases and diseases related to poverty. In some countries, such as Bolivia, Guatemala, and Paraguay, communicable diseases continue to contribute most to the overall burden of disease. Other countries face a "double" (or even "triple") epidemiological burden in which infectious diseases continue to account for a significant share of illnesses and deaths while chronic diseases are rapidly increasing, and external causes, particularly injuries and violence, also contribute a large share to the burden of illness.

33. While other developing regions face similar epidemiological landscapes, Latin America and the Caribbean have surpassed other regions in one key regard: reducing the burden of vaccine-preventable diseases. As of 2010, basic vaccination coverage averaged over 92% among children under age 1 in the Americas. Thanks to these high coverage rates, the Region was able to consolidate such important achievements as the elimination of endemic measles and rubella (both in process of verification) and the lowest child mortality rates of any developing region. In addition, nearly all the countries have eliminated neonatal tetanus as a public health problem. The exception, Haiti, made history in early 2012 with intensified immunization efforts that reached some 3 million children with vaccines against polio, measles, and rubella, achieving coverage of over 98% for all age groups. Introduction of the pentavalent vaccine was scheduled to take place in Haiti by the end of September 2012.

34. In addition to progress against vaccine-preventable diseases, the Region also made important inroads against a number of so-called neglected diseases and diseases of poverty. By the end of the decade, every country of the Region except Brazil had eliminated leprosy at the national level (with less than 1 case per 10,000 inhabitants), and the 21 countries with endemic Chagas disease had interrupted domestic vector transmission. As of 2007, the Region had eliminated blindness due to onchocerciasis, and transmission of the disease was interrupted or eliminated in various foci in Colombia, Ecuador, Guatemala, Mexico, and Venezuela. By 2011, Costa Rica, Suriname, and Trinidad and Tobago had interrupted transmission of lymphatic filariasis. However, the disease remained a problem in Brazil, the Dominican Republic, Guyana, and Haiti. Other diseases of poverty that remained problems in the Region included geohelminth infections, tracoma, schistosomiasis, leptospirosis, and leishmaniasis, the latter being one of the few infectious diseases to increase during the decade.

35. The adoption of the new International Health Regulations (IHR) in 2005 marked a key public health milestone at the global level and also in the Americas, and gave rise to a process of strengthening epidemiological alert and response capacities that is ongoing. PAHO/WHO's technical cooperation programs supported this and other key public health processes and achievements during the decade. Chapter II provides highlights of this work.

CHAPTER II

PAHO: A PARTNER FOR THE NEW CENTURY

36. The complex health challenges facing the Americas at the start of the new millennium, coupled with the changing landscape of international development cooperation, led to a broad-reaching review of PAHO/WHO's technical cooperation programs, its organizational and managerial models, and its relations with Member States and other stakeholders.

37. Part of this process was led by a special Working Group on PAHO in the 21st Century, made up of Argentina, Barbados, Costa Rica, Cuba, and Peru, with the collaboration of Canada, Guatemala, Haiti, and the United States. Following a process of consultations with other Member States, the group issued a report analyzing the challenges and opportunities facing the Organization and making recommendations for its technical cooperation programs and internal reform.

38. The group's recommendations were incorporated into a major reorganization effort that had already been launched by PAHO's Executive Management in 2003. The combined processes produced changes in PAHO's program structure, resource allocation, human resources management, and interactions with Member States and other partners.

39. The *Report of the Working Group on PAHO in the 21st Century* reiterated three overarching mandates bestowed on PAHO/WHO by its Member States at the beginning of the 2000s: (*a*) to support countries' progress on the health-related Millennium Development Goals (MDGs) by incorporating them into its technical cooperation programs, policies, and operations and by helping countries integrate them into their national health policies; (*b*) to support countries in redoubling their efforts to guarantee expanded social protection in health; and (*c*) to ensure that all the Organization's technical programs are grounded in the principles of primary health care.

40. In addition, the working group identified a number of key functions for PAHO/WHO in the changing landscape of international health cooperation. These included (*a*) providing leadership, coordination, and technical orientation for the growing number of health actors in the Region; (*b*) mobilizing resources; (*c*) promoting partnerships and networks for health; (*d*) facilitating the exchange of knowledge, technology, and technical capability; (*e*) developing systems and mechanisms for accountability and transparency; and (*f*) working to ensure consistency between strategies and actions at the national, regional, and global levels.

41. This chapter presents highlights of the Organization's technical cooperation in these areas, with emphasis on the past five years. Chapter III details the institutional

changes carried out in response to the *PAHO in the 21st Century* report and other mandates from the Member States.

The Achievement of the MDGs and the Renewal of Primary Health Care

42. As noted in Chapter I, the Region of the Americas advanced significantly toward the health-related and other MDGs during the first decade of the 2000s, although progress varied across countries, and in all countries there were communities and groups that did not share fully in the resulting benefits.

43. PAHO/WHO technical cooperation contributed to MDG progress through both ongoing programs and initiatives launched specifically to advance the MDGs. These included programs and projects to reduce child and maternal mortality, improve nutrition, fight HIV and other infectious diseases, promote access to safe drinking water and sanitation, strengthen health systems, and expand social protection in health.

44. To advance the MDGs at the local level, PAHO/WHO created the Faces, Voices, and Places initiative, which promotes an integrated and participatory approach to health and development in vulnerable communities. The initiative works through multisectoral and inter-agency partnerships to provide technical cooperation that empowers communities to address the social determinants of health. By 2012, the initiative had grown to include more than 50 communities in 23 countries and four transnational territories.

45. This and other PAHO/WHO technical cooperation efforts in support of the health-related MDGs are presented in detail in the 2011 Annual Report of the Director, *Health and the Millennium Development Goals: From Commitment to Action* (CD51/3 [2011]).

46. One of the most important regional health efforts of the decade, one that contributed significantly to advancing the MDG agenda, was the process of "Primary Health Care Renewal," launched in 2003 on the 25th anniversary of the 1978 International Conference on Primary Health Care ("Alma Ata"). At the request of Member States, PASB organized a series of activities to commemorate the legacy of Alma Ata and its call for "Health for All." During consultations held at the regional, subregional, and country levels, Member States examined experiences with the adoption of the primary health care (PHC) strategy over the previous 25 years and analyzed their relevance for making current health systems more efficient, effective, and equitable. These activities led to the publication in 2007 of *Renewing Primary Health Care in the Americas*, a PAHO position paper that laid out strategic lines of action for developing and strengthening health systems based on primary health care.

47. This renewed vision of PHC was endorsed by the 2007 international conference "Buenos Aires 30/15: From Alma Ata to the Millennium Declaration," was incorporated

into the Health Agenda for the Americas 2008-2017, and was reinforced at the global level in the 2008 World Health Report *Primary Health Care, Now More than Ever.*

48. The PHC strategy guided PAHO/WHO's work in the area of health systems strengthening for much of the decade. The renamed Area of Health Systems Based on Primary Health Care (HSS), together with other PAHO/WHO areas, provided technical cooperation aimed at making health systems more efficient, equitable, inclusive, and effective. Key programmatic areas included integrated health services delivery networks (IHSDN), human resources for health, quality and acceptability of care, access to medicines and health technologies, gender equality and multiculturality, policymaking, and research. Examples of this work included:

(a) National consultations organized in 10 countries—Argentina, Belize, Brazil, Chile, Cuba, Ecuador, Mexico, Paraguay, Trinidad and Tobago, and Uruguay—on IHSDN as a strategy to increase efficiency and quality in fragmented health systems. Participants included representatives of ministries of health, social security institutes, private insurers and health providers, academia, civil society organizations, and professional associations.

(b) Efforts to strengthen the organization and management of emergency medical services (EMS) through reviews of existing legislation, publication of a manual on triage in emergency rooms, and the development of a regional situation analysis on EMS with a focus on pre-hospital care. To date, case studies have been completed in 14 countries: Bolivia, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, Honduras, Guatemala, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela.

(c) Support for the development, revision, and implementation of pharmaceutical policies in 12 countries: Barbados, Belize, Colombia, Ecuador, El Salvador, Haiti, Nicaragua, Panama, Paraguay, St. Lucia, Suriname, and Uruguay.

(d) Strengthening of national drug regulatory authorities (NRAs) through the Pan American Network for Drug Regulatory Harmonization (PANDRH), created in partnership with NRAs throughout the Region to advance pharmaceutical regulatory harmonization.

(e) Support for national evaluations of radiotherapy services in 11 countries—Bahamas, Costa Rica, the Dominican Republic, El Salvador, Guyana, Honduras, Nicaragua, Panama, Paraguay, Suriname, Trinidad and Tobago—and of imaging services in Guyana, Suriname, and Trinidad and Tobago.

(f) Evaluation and improvement plans for radiological safety regulation in Argentina, Colombia, Costa Rica, Honduras, Nicaragua, Panama, and Paraguay, and a plan of action for member countries of CARICOM.

(g) Support for national evaluations of mental health systems in 32 countries of Latin America and the Caribbean using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS), to provide evidence for national health planning.

(h) Collaboration in most Latin American and Caribbean countries in the development and dissemination of national policies on research for health.

(i) Development of detailed collaboration plans for 10 countries—Bolivia, Colombia, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Paraguay, Peru, and Suriname—to incorporate gender equality into the health sector.

(j) Support for six countries—Bolivia, Chile, Colombia, Ecuador, Peru, and Venezuela—in creating national commissions to address the special health needs of Afro descendants.

(k) Impetus for the establishment of a Caribbean working group on access of key groups—especially sex workers, men who have sex with men, and transgender persons—to quality services for HIV prevention, treatment, and care.

49. In addition to these efforts aimed at strengthening health systems, PAHO/WHO also carried out a number of initiatives to strengthen the PHC approach itself. These included a partnership with New York University to collect baseline data for monitoring PHC progress in the countries of Latin America and the Caribbean and a partnership with Johns Hopkins University to develop an analytical framework and methodology for measuring health system performance from a PHC perspective. The 2009 Annual Report of the Director, *Advancing toward "Health for All": Progress in Primary Health Care in the Americas,* provides further details on PAHO/WHO's efforts to advance PHC.

50. As noted in Chapter I, one of the most significant health achievements of the Region during the first decade of the 2000s was progress toward universal access to health care, a central goal of the PHC approach. Expanding access to health care has required countries to seek innovative approaches to financing and managing their health systems in order to increase efficiency and sustainability. Argentina, Bolivia, and Colombia are among a number of countries that have improved management and training of human resources to ensure that the distribution, composition, and skills of the health care workforce are aligned with priority health needs. Other countries have increased sustainability and efficiency through decentralization, such as in Brazil's Unified Health System, which is partly managed and funded by states and municipal governments. Other countries, such as Mexico, have focused on the development of IHSDN to improve both the efficiency and the quality of health services. PAHO/WHO has supported and promoted these approaches at both the national and regional levels.

51. The Organization also has worked closely with ministries of health to improve their capacity to produce and analyze information for health planning, economics, and

financing of health systems and to improve both efficiency and equity in the allocation and use of available resources.

52. Using a methodology developed by PAHO/WHO, seven countries—Brazil, Canada, Chile, Colombia, Jamaica, Mexico, and Peru—completed a first set of studies on the evolution over the past 10-15 years of equality in the utilization of health services. The results showed reductions in inequality in four of the countries, no change in two, and increased inequality in one.

53. An initiative with the Andean Commission of Economics and Health (CASE) and the U.N. Economic Commission for Latin America and the Caribbean (ECLAC) seeks to harmonize health expenditure data in the Andean countries. PAHO/WHO has also begun developing a new common framework for analyzing the economic impact of the growing burden of noncommunicable diseases in the Region to support the formulation of policies within a framework of multisectoral action.

54. PAHO/WHO's ProVac initiative, supported by the Bill & Melinda Gates Foundation, helped countries gather and analyze evidence for decision-making about the introduction of new vaccines and also provided guidance in planning the effective and sustainable incorporation of new vaccines into their national immunization plans.

55. In contrast to earlier decades, when the Region's lower-income countries lagged significantly behind the United States and Canada in introducing newly available vaccines, 24 Latin American and Caribbean countries and territories introduced the new pneumococcal conjugated vaccine, and 16 introduced the rotavirus vaccine between 2002 and 2012. A number of countries were also successful in increasing uptake of seasonal influenza vaccine, and many, with PAHO technical and procurement support through the PAHO Revolving Fund, successfully implemented the 2009 pandemic H1N1 vaccine, despite considerable regulatory, logistical, and public relations challenges.

10 Years of Vaccination Week in the Americas

A major regional health milestone was the celebration in 2012 of the 10th anniversary of Vaccination Week in the Americas (VWA), the Region's largest Pan American health initiative. Including 44 million men, women, and children targeted in 45 countries and territories in 2012, VWA is estimated to have reached a total of more than 400 million people in its 10-year lifespan. Thanks in large part to interest generated by VWA and to active outreach by its supporters, a growing number of WHO regions launched their own vaccination weeks during the decade. The culmination of all these efforts—and the realization of a global health dream—was the participation of more than 180 countries and territories from all six WHO regions in the first-ever World Immunization Week in 2012.

56. PAHO's Revolving Fund and Strategic Fund played a key role in efforts to improve efficiency in health systems, by procuring vaccines, medicines, and other public health supplies at lower prices through bulk purchases but also by linking their acquisition to technical processes in planning and programming. Annual expenditures on behalf of PAHO Member States by the Revolving Fund increased from US$ 105.3 million in 2000 to US$ 505.3 million in 2011 and for the Strategic Fund from US$ 3.5 million in 2004 (its first year of full operations) to US$ 49.7 million in 2011. With over 24 countries now participating in the Strategic Fund, it has been used by Member States to triple the amount of medicines available for Chagas treatment since 2008, while helping to lower prices for medicines to treat HIV/AIDS, tuberculosis, and malaria.

Leaders in International Health Program

As part of efforts to strengthen human resources for health, PAHO/WHO in 2008 launched a new, decentralized version of its training program for professionals in international health, originally established in 1985. The new "Edmundo Granda Ugalde" Leaders in International Health Program (LIHP) targets mid- to high-level managers and directors in decision-making positions in ministries of health, development, finance, foreign affairs, and others, as well as from academia, NGOs, PAHO/WHO country offices, and other international agencies. Each nine-month session includes a series of problem-based virtual learning experiences using the Virtual Campus for Public Health. In addition, participants become members of inter-sectoral country teams that develop and implement projects based on country needs and priorities, in cooperation with PAHO/WHO country offices, national authorities, and other national and international partners. Since its launch in 2008, more than 200 professionals from 32 countries have participated in the redesigned program, contributing to more than 90 country projects and, in some cases, to the transformation of PAHO/WHO technical cooperation models.

Combating Chronic Diseases

57. In the early 2000s, chronic noncommunicable diseases (NCDs) emerged as the leading cause of death and illness in nearly all PAHO/WHO member countries. The Organization supported efforts to confront the epidemic at the regional, subregional, and country levels through advocacy and policymaking, surveillance, health promotion and prevention, and integrated disease management.

58. Guiding this work were the Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet, Physical Activity, and Health, as well as specific strategies on diabetes and obesity, cervical cancer, and nutrition in development. The countries made significant progress in implementing these strategies and other initiatives targeting NCDs throughout the decade.

59. In Argentina, the Organization supported the creation of a new Department of Health Promotion, Prevention, and Control of NCDs; a new National Cancer Institute; a

new program for prevention and control of cervical cancer; and improvements in information systems related to cancer. It also supported initiatives to reduce dietary salt, increase fruit and vegetable consumption, eliminate trans-fats from industrially processed foods, and promote tobacco control legislation.

60. In Aruba, PAHO/WHO partnered with the Ministry of Health to organize the first and second Pan American Conference on Obesity (PACO) in 2011 and 2012. The conferences brought together ministers of health, education, agriculture, development, transportation, and others, as well as representatives of local governments and civil society to examine the causes of obesity and to promote multisectoral action to prevent and address the problem.

61. In Belize, PAHO/WHO partnered with the Food and Agriculture Organization (FAO), the Institute of Nutrition of Central America and Panama (INCAP), and the Caribbean Food and Nutrition Institute (CFNI) to support the development of food-based dietary guidelines known as the Belize Food Basket. The approach converts scientific information on nutritional requirements and food composition into easily understandable guidelines to encourage healthy food choices and promote prevention. The new Food Basket was launched in 2012 by the ministries of health, education, and agriculture.

62. In Brazil, the Organization supported efforts by the National Tobacco Control Program to implement provisions of the Framework Convention on Tobacco Control (FCTC). These included the approval of a law on smoke-free public spaces, new restrictions on tobacco advertising, requirements for health warnings on packages, and new taxes on tobacco products. The Bloomberg Family Foundation supported these efforts as well as a similar one in Mexico as part of the Bloomberg Global Initiative.

63. In Colombia, PAHO/WHO partnered with the Ministry of Health to strengthen implementation of the country's tobacco control laws, to establish norms for healthy meals in schools, and for a pilot project to transform the ministry as well as PAHO/WHO's country office into "healthy workplaces."

64. In December 2009, the Organization held a special Partners' Forum against Non-communicable Diseases,[2] attended by representatives of civil society organizations, member governments, and the private sector. The initiative was re-launched in 2012 as the new Pan American Forum for Action on Non-communicable Diseases. It brings health professionals who are members of the Collaborative Action for Risk Factor

[2] Members and supporters include the World Economic Forum, the International Business Leaders Forum, the Inter-American Heart Foundation, Consumers International Latin American branch, 5-a-Day, the Healthy Caribbean Coalition, McGill University, the World Diabetes Foundation, the Public Health Agency of Canada, CDC, AECID, Kraft Foods, Unilever, Nestlé, Pepsi-Cola, Grupo Bimbo, Coca-Cola, Pfizer, GSK, Merck, Medtronic, Sanofi, and Johnson & Johnson.

Prevention and Effective Management of NCDs (CARMEN) network together with representatives of academic institutions and the private sector, with the goal of advancing strategic cross-sector collaboration and innovation to generate policies and campaigns for the prevention and control of chronic diseases.

65. A partnership with the World Economic Forum led in September 2011 to the first Wellness Week in New York City, on the eve of the United Nations High-Level Meeting on Non-communicable Diseases. Originally inspired by Caribbean Wellness Day (celebrated every September 13 in the Caribbean), Wellness Week 2011 sought to raise awareness of the importance of healthy settings in reducing risk factors for noncommunicable diseases and in promoting prevention. In New York, other partners included the Greater Harlem Chamber of Commerce, the New York Academy of Medicine, and the City College of New York. The week was also celebrated in other countries, including Argentina, Costa Rica, Cuba, Ecuador, El Salvador, Nicaragua, Peru, and Spain.

PAHO Priority Countries

66. Five countries—Bolivia, Guyana, Haiti, Honduras, and Nicaragua—were identified in PAHO's 2003-2007 and 2008-2012 strategic plans as "key countries" that faced health and equity challenges requiring special consideration in technical cooperation programs and resource mobilization. These five key countries have received higher allocations from the PAHO budget as well as priority consideration for inclusion into major grants and proposals that address their respective health needs. Four of the five key countries were among the first to have a Country Cooperation Strategy (CCS), a tool of PAHO's Country Focus Policy that seeks to strengthen relations with the country's Ministry of Health, align technical cooperation priorities with national needs, and coordinate efforts with other development partners working in these countries. (In the case of Haiti, political and emergency conditions made it necessary to adopt an Interim Cooperation Framework instead of the more comprehensive CCS.)

Highlights of recent PAHO/WHO technical cooperation and achievements in the five key countries include:

In Bolivia:

(a) Support for the development of a new law to establish a Unified Health System as well as a new model for Family and Intercultural Health Care (SAFCI) that incorporates gender, ethnicity, and human rights.

(b) Establishment of social protection measures for vulnerable groups, including women of childbearing age (SUMI) and seniors (SSPAM), which are being adjusted for inclusion into the Unified Health System, with universal coverage as the ultimate goal.

(c) Implementation of community surveillance models in both urban and rural areas to reduce maternal mortality, with a focus on community involvement and empowerment as part of SAFCI. In addition, strengthening of the maternal and perinatal health records and information system. This includes the use of geo-referential software and databases by the Ministry of Health to analyze health services network functionality to provide evidence for changes or adjustments.

(d) The development and implementation of a new national policy on human resources in health (HRH), strengthening of the HRH information system, and training on management and use of the SAFCI model.

(e) Consolidation of a unified medicine and medical supplies acquisition and supply system, based on updated information in 81% of public health care systems. Implementation of a strategy on the rational use of medicines, with measures to promote efficiency, transparency, and accountability.

(f) Introduction of new vaccines—rotavirus (in partnership with GAVI), seasonal influenza, H1N1, and DPT and polio boosters—into the National Immunization Plan; implementation of diverse strategies to maintain vaccine coverage rates; and progress toward certification of the country as being free of measles and rubella.

(g) Massive deworming campaigns in endemic areas of La Paz for almost 400,000 inhabitants.

(h) Development of the first national plan on noncommunicable diseases and integration of its variables into the national health information system.

In Guyana:

(a) In-service training for health personnel in emergency obstetric and neonatal care, in collaboration with the U.N. Population Fund (UNFPA) and the U.N. Children's Fund (UNICEF).

(b) Development of a strategic plan for the sanitation sector.

(c) Reductions in adult HIV prevalence over the last five years.

(d) Strengthened primary health care through the expansion of the Integrated Management of Adolescent and Adult Illness (IMAI) program, under the Disease Control Program of the Ministry of Health. This program was recognized when Guyana won the Sergio Arouca Award in 2011.

(e) A 50% reduction in malaria cases between 2000 and 2009 as a result of efforts including the decentralization and integration of the Malaria Information System into primary health care services (with support from the Amazon Malaria Initiative, the Amazon Network for Surveillance of Anti-malarial Drug Resistance, and PAHO) and the adoption of an integrated vector control management strategy, including the establishment of a vector control network.

(f) Implementation of a patient monitoring system for HIV care and treatment, which has been documented as a best practice.

(g) Introduction of rotavirus and pneumococcal vaccines (in partnership with GAVI).

In Haiti:

(a) Training in case management and strengthening of surveillance during the cholera outbreak.

(b) The development and expansion of Free Obstetric Care (SOG) and Free Child Care (SIG), which offers free access to health services for children under 5.

(c) Implementation of the first Perinatal Information System in real time, which will facilitate evidence-based decision making.

(d) Reinitiation of the national childhood immunization program through the development of the Strategic Plan of the Expanded Program on Immunization for 2010-2015. (This was in addition to the post-disaster vaccination campaign conducted in the departments and municipalities most affected by the earthquake.)

(e) Development of a national protocol for the treatment of acute malnutrition and its adaption to the post-disaster situation.

In Honduras:

(a) A strategy to accelerate reductions in maternal and child mortality, including the institutionalization of the Perinatal Information System.

(b) The introduction of new vaccines for rotavirus and pneumococcus (in partnership with GAVI).

(c) Strengthening of epidemiological surveillance and a database (SISLOC) that has substantially improved surveillance of communicable diseases.

(d) A national strategic plan for the control and prevention of cancer for 2009-2013.

(e) A strategic plan for the prevention, care, control, and elimination of neglected diseases for 2012-2015.

(f) A country-wide evaluation that certified the interruption of Chagas disease transmitted by *Rhodnius prolixus*.

(g) Development of an integral malaria intervention model in the municipality of Wampusirpi. The project was selected as one of the Malaria Champions of the Americas for 2011.

(h) Progress in addressing the determinants of health, with policy development in drinking water, sanitation, and waste management, and strengthening of legal and institutional frameworks that facilitate timely intervention.

(i) As part of a Faces, Voices, and Places initiative, strengthening of health services for adolescents and improvement of water quality and waste management for the Misquito population in the department of Gracias a Dios.

(j) With the support of the Secretary of State for Development of Indigenous Peoples and Afro-Hondurans, training of nursing assistants selected by communities.

In Nicaragua:

(a) A 26% reduction in maternal mortality between 2006 and 2010, from 90 to 67 deaths per 100,000 live births.

(b) Annual declines of 6% in under-5 mortality in recent years, putting the country on track to reach its goal of 24 per 1,000 live births by 2015.

(c) Introduction of the rotavirus vaccine in 2006 and pneumococcal vaccine in 2011 (in partnership with GAVI).

(d) An increase in the percentage of municipalities with over 95% vaccination coverage, from 16% in 2006 to 58% in 2011.

(e) Reduced prevalence of mother-to-child transmission of HIV and syphilis.

(f) Guaranteed universal access to free, quality health services within the framework of the Family and Community Care Model (MOSAFC), which encourages a national culture of health promotion and protection based on renewed primary health care.

(g) Improved access to medicines, with a focus on quality and rational, effective, and safe use, through the implementation of the National Strategic Plan for the Promotion of Rational Use of Medicines (PENPURM).

(h) Achievement of 100% voluntary blood donation in the national blood supply.

(i) Progress in malaria control that earned recognition by the 2011 Malaria Champions of the Americas awards and that has advanced Nicaragua into the pre-elimination phase.

(j) International certification of the country as having interrupted vertical transmission of Chagas disease.

Partnering for Health

67. Given the growing number of health actors in the Region over the past decade, an important focus for PAHO/WHO was expanding its political, technical, and resource

mobilization partnerships and networks. Bilateral partners including Canada (CIDA), Norway (NORAD), Spain (AECID), Sweden (SIDA), and the United States (USAID) all continued to support the Organization's technical cooperation programs through multiyear agreements. In addition, Canada, France, and Spain augmented PAHO/WHO's technical staff by seconding their own experts to Headquarters in Washington, D.C., as well as to several PAHO/WHO Representative Offices in the countries.

68. PAHO/WHO served as an implementing agency for projects in Latin America and the Caribbean supported by the MDG Achievement Fund (Spain), the U.N. Trust Fund for Human Security (Japan), the U.N. Trust Fund to Eliminate Violence against Women (multi-donor), and the Rural Development Joint Program in Guatemala (Sweden). PAHO also supported health authorities and NGOs in developing and implementing projects submitted to the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

69. Initiatives resulting from these partnerships included, among others, projects to improve drinking water, sanitation, and housing in Ecuador, El Salvador, Nicaragua, and the Chaco region of Paraguay, financed through the MDG Achievement Fund and carried out in partnership with other U.N. agencies. Joint projects in Ecuador, El Salvador, Guatemala, Nicaragua, and Paraguay focused on prevention of violence, particularly intra-family and gender-based violence, and improved treatment of victims by health services and law enforcement.

Partnerships for Sexual and Reproductive Health

A key area for PAHO/WHO's collaboration with other international partners during the first decade of the 2000s was the promotion of a comprehensive approach to sexual and reproductive health, including access to contraception, improved obstetric care, and attention to vulnerable groups such as adolescents, sex workers, and people with HIV. Among the many activities and alliances in this area were:

- Support for the Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity (CD51.R12 [2011]), which is being implemented in all the countries of Latin America and the Caribbean. It emphasizes prevention of adolescent pregnancies, quality perinatal care, and a rights- and equity-based approach to access to comprehensive services. The plan is supported by the multi-partner Regional Task Force for the Reduction of Maternal Mortality (GTR).[3]
- Participation in the U.N. Development Group for Latin America and the Caribbean (UNDG-LAC) working group on Information and Accountability on Women's and Children's Health

[3] Members include PAHO/WHO, UNICEF, UNFPA, USAID, the World Bank, the IDB, the Population Council, Family Care International (FCI), the Latin American Federation of Societies of Obstetrics and Gynecology (FLASOG), the Pan-American Federation of Nursing Professionals (FEPPEN), and the International Confederation of Midwives (ICM).

(the Commission), which seeks to optimize the impact of resources for maternal and child health. PAHO serves as technical secretariat for the group.

- Support for efforts to eliminate mother-to-child transmission of HIV and congenital syphilis in the Americas, the first WHO region to aim for dual elimination. With support from PAHO/WHO, UNICEF, and other partners, 32 countries are implementing action plans, and the Region has achieved the highest coverage of services to prevent mother-to-child transmission of any developing region.
- A study of sexual and reproductive health and HIV among indigenous youths in Bolivia, Ecuador, Guatemala, Nicaragua, and Peru, with support from Spain and Norway.
- Training on prevention and care for female sex workers, gay men and other men who have sex with men, and/or transgender persons for peer educators from Argentina, Bolivia, Brazil, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama, Paraguay, and Uruguay, in collaboration with the World Association for Sexual Health (WAS) and USAID (AIDStar One).
- Technical and financial support for the new Observatory in Sexual and Reproductive Health in Argentina, with UNICEF, UNFPA, the National Academy of Medicine, the Center for Studies on the State and Society (CEDES), and the Rosarino Center for Perinatal Studies (a PAHO/WHO Collaborating Center).

70. Other partnerships with U.N. sister agencies, international professional associations, faith-based organizations, and other civil society organizations were essential to PAHO/WHO's work and to the Region's public health achievements during the decade. These included the GTR, the Newborn Health Alliance for Latin America and the Caribbean,[4] the Safe Motherhood Initiative,[5] and the Pan American Alliance for Nutrition and Development (PAND).[6] Other organizations with which the Organization worked closely included the GAVI Alliance, the Sabin Vaccine Institute, Rotary International and the Rotary Foundation, the United Nations Foundation, the Council of the Americas, Save the Children, Enfants du Monde, the Latin American Episcopal Conference (CELAM), the Church of Jesus Christ of Latter-day Saints, the General Conference of Seventh-day Adventists, Brothers of Charity, Partners in Health, RAD-AID International, and the American, Canadian, and international Red Cross organizations, among others.

71. In the private sector, PAHO worked with organizations and programs including the International Business Leaders Forum (IBLF), the Global Business Forum (GBF), the Pfizer Global Health Fellows, the GSK Pulse Program, the Oral Health Partnership (with

[4] Members include PAHO/WHO, UNICEF, USAID, ACCESS, BASICS, CORE Group, Plan USA, University Research Co./Center for Human Services (URC/CHS), Save the Children/Saving Newborn Lives, the Latin American Association of Pediatrics (ALAPE), ICM, and FLASOG.

[5] Members include the members of the GTR as well as the OAS and the La Caixa Foundation of Spain.

[6] Members include PAHO/WHO, UNDP, UNICEF, ECLAC, UNFPA,ILO, WFP, UNDOC, UNAIDS, UN Women, and UNOPS.

Colgate), and the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA).

72. As a member of the inter-American system, PAHO/WHO advocated for public health issues on the regional political agenda through its participation in the Summit of the Americas Working Group, meetings of the Summit Implementation Review Group (SIRG), and briefing sessions for the Permanent Council of the Organization of American States (OAS). Along with the World Bank and the Inter-American Development Bank (IDB), the Organization also participated in the OAS-led Friends of Haiti group, a forum for information exchange and coordination of political and technical support by countries and organizations involved in Haiti.

73. PAHO/WHO also participated in U.N. reform efforts with other U.N. agencies through the U.N. Country Teams (UNCTs) and the Common Country Assessment/U.N. Development Assistance Framework (CCA/UNDAF), as well as thought its membership in the regional U.N. Development Group for Latin America and the Caribbean (UNDG-LAC).

74. At the subregional level, the Organization continued partnering with traditional regional integration bodies while also working with new entities. These partnerships led to a number of new subregional health initiatives. In South America and the Andean region, PAHO's collaboration led to country-to-country cooperation on HIV surveillance in MERCOSUR border areas, a collective framework for assessing health technologies, the development of pharmaceutical services in countries of the Andean community, a comprehensive five-year work plan to promote access to medicines within UNASUR, and the creation of an Andean Network of Observatories of Human Resources in Health. In addition, PAHO collaborated with the Amazon Cooperation Treaty Organization (OTCA) to advance the health goals of its Strategic Agenda.

75. In Central America and the Dominican Republic, PAHO coordination led to the development of a strategic subregional plan to reduce vertical transmission of HIV and congenital syphilis, agreements with COMISCA (Council of Ministers of Health) and COMMCA (Council of Ministers of Women's Affairs) on multisectoral health action, pooled procurement of vaccines and other medicines, and the formation of subregional technical commissions on essential medicines, human resources for health, noncommunicable diseases, health surveillance, and information systems.

76. In the Caribbean, PAHO/WHO collaborated with the new Caribbean Public Health Agency (CARPHA) and CARICOM's Council for Human and Social Development (COHSOD) in the areas of chronic diseases, health promotion, adolescent health, and crime prevention, among others. This included support for the integration of nutrition and health into agricultural and food safety policies, in follow-up to the Port-of-Spain Declaration and the U.N. High-Level Meeting on NCDs. Other efforts helped

improve disease surveillance, strengthen laboratories (including in the use of polymerase chain reaction), and create a new framework for laboratory accreditation by PAHO's Caribbean Epidemiology Center (CAREC).

77. These subregional activities were supported by a special allocation in the Organization's program budget, as was the work of the Caribbean Food and Nutrition Center (CFNI), and the Office of Caribbean Program Coordination (CPC).

78. In June 2012, PAHO/WHO launched the Regional Coalition for Water and Sanitation to Eliminate Cholera from the Island of Hispaniola, which seeks to mobilize financial resources, technical expertise, and political commitment to ensure investments in water and sanitation infrastructure that are needed to eventually eliminate cholera from Haiti and the Dominican Republic. In addition to PAHO/WHO, initial members of the coalition include the OAS, the U.S. Centers for Disease Control and Prevention (CDC), UNICEF, AECID, the Inter-American Association of Environmental Health Engineers (AIDIS), the IDB, the National Health Foundation of Brazil (FUNASA), USAID, and the Haitian Association of Medical Physicians Abroad.

79. All these partnerships were in addition to PAHO/WHO's ongoing collaboration at the country level with professional, academic, charitable, faith-based, and other civil society organizations and its coordination with national, departmental, and local authorities from sectors including health, education, agriculture, development, environment, and women's and indigenous affairs.

Promoting Public Health Networks

80. In its capacity as a catalyst for regional and subregional collaboration in public health, PAHO/WHO helped to create or expand networks linking people and institutions to share knowledge and mobilize expertise, resources, and action toward common goals. Some of these networks sponsor periodic meetings or workshops for members, while others are virtual networks that take advantage of the opportunities presented by growing access to the Internet and other information technologies throughout the Region. Examples of these physical and virtual networks include:

(a) The Collaborative Network for Primary Health Care, formed in partnership with the Ministry of Health of Brazil and the School of Public Health of Andalusia (Spain) to promote exchange of knowledge and best practices based on the PHC approach.

(b) The Regional Network of Pharmaceutical Procurement and Supply Management Authorities (CARIPROSUM), created with the participation of national procurement authorities of Caribbean countries to promote the continuous availability of safe, effective, and affordable pharmaceutical products for the public health sector.

(c) The Regional Network for Health Technology Assessment, which helps Member States access and analyze evidence to determine the comparative value-added of new medicines, medical products, and health interventions within health systems.

(d) CARMEN (Collaborative Action for Risk Factor Prevention and Effective Management of NCDs), a network of countries, organizations, and institutions working to reduce the burden of chronic diseases and their risk factors in the Americas.

(e) Health Research Web/Americas, created with the Council on Health Research for Development (COHRED), to help countries and individuals establish policies and priorities for health research, increase the relevance of research, and improve skills for research by providing information resources and facilitating country-to-country exchanges.

(f) Red Salud ("Health Network"), which links 2,500 health journalists and was created in partnership with the Communication Initiative and the Iberoamerican New Journalism Foundation to help improve media coverage of public health issues.

(g) The Americas' Network for Chronic Disease Surveillance (AMNET), supported by the U.S. CDC and Environmental Protection Agency (EPA), Health Canada, the Ministry of Health of Finland, and the ministries of health of other PAHO member countries.

(h) The Water Safety Plan Network for Latin America and the Caribbean (WSP/LAC NETWORK), formed in partnership with the CDC and EPA to support and promote the implementation of water safety plans in cities in Latin America and the Caribbean. The Inter-American Sanitary and Environmental Engineering Association (AIDIS), the International Water Association (IWA), and UN-HABITAT are also members.

(i) The Amazon Network for the Surveillance of Antimalarial Drug Resistance (RAVREDA), organized with Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname, and Venezuela to monitor antimalarial drug resistance in the Amazon.

(j) The Amazon Malaria Initiative (AMI), created in partnership with USAID and supported by the CDC, Management Sciences for Health, and United States Pharmacopeia.

(k) The BiVaPad network, a joint effort with the Andean Community, the Regional Disaster Information Center for Latin America and the Caribbean, the International Strategy for Disaster Reduction, and partner organizations of the Andean Committee for Disaster Prevention and Relief (CAPRADE) to facilitate information-sharing on risk management and mitigation of emergencies and disasters.

(l) The Inter-American Coalition for Violence Prevention, organized in partnership with the OAS, other U.N. agencies, USAID, and the CDC.

81. The Organization's most far-reaching effort to capitalize on expanding Internet access was the Virtual Campus for Public Health, a networked learning initiative that links individuals and organizations to share information, knowledge, and educational opportunities in public health. Since 2003, the Virtual Campus has grown from a pilot project with 13 partner institutions to a network of 144 institutions in 11 countries. In the past five years, more than 5,300 users have benefitted from over 150 courses offered by the network, and its interoperability with BIREME's Virtual Health Library provides virtual access to some 3,600 additional educational resources. The Virtual Campus is supported by the governments of Canada, Cuba, and Spain and is part of PAHO/WHO's efforts to strengthen human resources for health.

82. One of the Organization's newest networking initiatives is the Regional Platform on Access and Innovation for Health Technologies (PRAIS), launched in 2012 with support from Brazil and the U.S. Food and Drug Administration (FDA). Part of efforts to promote access to essential medicines and technologies, the initiative links networks, information resources, and communities of practice to promote technology transfer and to improve capacity and governance in the pharmaceutical development sector.

83. A similar virtual networking initiative, the Cooperation among Countries for Health Development portal on the PAHO website, promotes South-South knowledge-sharing, cooperation, and partnerships.

84. The Organization's commitment to seizing the opportunities presented by new information and communication technologies (ICT) led to the development of a new Strategy and Plan of Action on *eHealth*, approved by the 51st Directing Council in 2011 (CD51.R5). It seeks to use ICT tools and methodologies to improve public and veterinary health in such areas as health administration, human resources, coordination and delivery of health services, and the production and dissemination of scientific and technical knowledge.

85. Practical applications of ICTs in health that are highlighted in the *eHealth* strategy include personal health cards, digital clinical histories, electronic prescriptions, online appointments, telemedicine, distance learning and continuing education, health blogs and portals, call centers, databases for risk management and patient safety, social networking tools for disasters and emergencies, and the digitalization of clinical and administrative documentation. Potential users include health workers, patients, and the public in general.

Promoting Preparedness

86. The first decade of the 21st century brought a series of emergencies and disasters to the Region of the Americas. Unlike in much of the previous century, however, most of the Region's countries today have the capacity to respond to minor or even moderate events without international assistance. PAHO/WHO has played a role in this progress through its work with ministries of health to establish and strengthen disaster and emergency response programs and to develop regional strategies for reducing the health impact of disasters.

87. Levels of preparedness vary widely across countries, however, and the severity of hazardous events in some cases has far exceeded countries' capacities to respond. The most tragic recent case was the 2010 earthquake in Haiti, which claimed more than 200,000 lives and affected most of the Haitian population. As in most disasters, Haitians themselves saved hundreds of lives and attended to thousands of injured and homeless, with support from their closest neighbors starting with the Dominican Republic and followed by Cuba and other Caribbean countries. However, the support of the broader international community was also crucial for the longer-term response and recovery.

88. PAHO/WHO played a critical role in these efforts as head of the Health Cluster, which provided coordination for hundreds of organizations working in health, and as co-administrator with the Haitian government of the national pharmaceutical warehouse, PROMESS. The Organization also oversaw quality control of drinking water at chlorination sites, helped restore operations at the National Public Health Laboratory, and helped develop a database and maps of the locations of existing health facilities and health partners working in the country. (This support is described in greater detail in the Annual Report of the Director 2010: *Promoting Health, Well-being, and Human Security in the Americas.*)

89. Health partnerships that were strengthened following Haiti's January 2010 earthquake were again critical for the response to the cholera epidemic that began in October of the same year. The response was complicated by continuing weaknesses in the country's health system and the fact that health workers had little or no experience with a disease that had not been seen in Haiti in more than a century. PAHO/WHO and other partners helped health authorities establish cholera treatment centers and mobilized resources and expertise in areas including case management, provision of essential medicines and supplies, disease surveillance and early warning, training and guidelines, prevention messages, and environmental health.

The 2009 H1N1 Influenza Pandemic

90. The first influenza pandemic of the new millennium began in the Americas and spread throughout the world within months. While it was considerably less severe than

initially feared, it claimed thousands of lives and revealed important weaknesses in countries' health systems. The large numbers of cases, coupled with people's uncertainty about the virulence of the virus, put a strain on hospitals and health facilities in a number of countries, and some governments responded by adopted ineffective and unnecessary restrictions on people's movements. This highlighted the need for greater investments in public health in general, and for strengthening primary health care in particular, as well as the importance of evidence-based public policy.

91. The 2009 H1N1 influenza pandemic also served as a test for preparedness efforts that PAHO/WHO had promoted in the Region following the 2003 SARS outbreak and concerns about the growing threat of H5N1 influenza. A review meeting by Member State representatives in late 2009 concluded that these efforts had paid off, but that most countries' pandemic preparedness plans had been insufficiently operational, particularly at the local level. The review called for better coordination with the private health sector as well as greater clarity about information flows and the resources needed for implementing enhanced surveillance.

92. In addition to these preparedness efforts, PAHO/WHO played a key supporting role throughout the 2009 H1N1 influenza pandemic, which had a significant impact on the entire Region (see also Chapter I). Immediately following Mexico's notification of the outbreak, PAHO/WHO activated its Emergency Operations Center and through the WHO Global Outbreak Alert and Response Network (GOARN) began mobilizing international experts in epidemiology, emergency management, laboratories, communication, health services, health promotion, and immunization, among others. As the epidemic spread, PAHO/WHO supported countries by coordinating the purchase of antivirals (oseltamivir), personal protective gear, and laboratory equipment and materials, and also provided training in the use of polymerase chain reaction to detect the pandemic virus. Once the pandemic vaccine became available, the PAHO Revolving Fund helped procure more than 20 million doses for 23 countries.

93. The pandemic also provided a test of the new International Health Regulations (IHR), which have been a major focus of PAHO/WHO technical cooperation in outbreak alert and response to help countries fully comply with the regulations. The 2009 regional pandemic review meeting concluded that IHR, through its national focal points, had proven to be an effective mechanism for alerting and informing Member States, had helped inform recommendations by health authorities, and had increased the latter's credibility by promoting transparency. However, the pandemic had also revealed a lack of harmonization in countries' surveillance systems and gaps in national legal frameworks that impede full compliance with IHR.

CHAPTER III

AN EVOLVING ORGANIZATION

94. As noted in Chapter II, the recommendations of the Working Group on PAHO in the 21st Century prompted changes in PAHO's collaboration with Member States and other stakeholders as well as in its program structure, resource allocation, and human resources management. These changes were implemented as part of a major reorganization aimed at making PAHO more efficient, more effective, and fully accountable to its stakeholders. They included new policies, strategies, models, and modalities as well as new procedures, instruments, technologies, and infrastructure. This chapter highlights the major components of the Organization's institutional development over the past decade.

Budget Policy and Results-based Management

95. One of most far-reaching contributors to PAHO's transformation during the decade was the development and implementation of the new PAHO Regional Program Budget Policy. The Organization's first such policy and one of the first in the U.N. System, the Regional Program Budget Policy was developed through a Member State-driven process aimed at ensuring a more equitable distribution of resources.

96. The overall goal of the budget policy is to support countries in achieving programmatic targets agreed upon collectively by Member States as part of the PAHO Strategic Plan, in a way that also ensures equitable resource distribution. The policy allocates funds to three levels—regional, subregional, and country—and uses needs-based criteria to rank countries according to their relative health status and levels of inequality. These new allocation criteria have resulted in a significant shift of budgetary resources toward lower-income countries and from PAHO Headquarters to the country and subregional levels.

97. The first Regional Program Budget Policy was approved by the 45th Directing Council in 2004 for the 2006-2007 biennium, with revisions made at the request of Member States in subsequent biennia. The latest revision of the policy, for the 2014-2015 biennium, was led by a working group composed of Brazil, Chile, Grenada, Peru, the United States of America, and Venezuela (Bolivarian Republic of), with Argentina as an observer, and is being presented to the 28th Pan American Sanitary Conference in September 2012.

98. An equally important change during the decade was PAHO's decisive shift to results-based management and programming, aimed at improving the Organization's performance in pursuit of the goals defined by its Member States. Though a focus on results was not entirely new, PAHO's adoption of a formal Results-based Management

(RBM) Framework paralleled similar developments at WHO and other agencies of the U.N. system.

99. The RBM Framework defines clear objectives, selects indicators to measure progress toward those objectives, sets targets for each indicator, and provides for the collection, analysis, and reporting of results, allowing for objective assessment of the Organization's performance. The RBM Framework has significantly changed the way the Organization operates, making results and performance the central orientation of all work.

100. The implementation of the RBM Framework has been a participatory process, particularly through the Performance Assessment System, and has been supported by a mandatory RBM e-learning course for all staff. A recent externally conducted gap analysis confirmed that PAHO has become a leader in RBM within the U.N. system. Nevertheless, as a process, RBM inherently requires continued implementation as well as adaption to ensure it continues to enhance the Organization's work.

101. The new RBM Framework was incorporated into the Organization's highest-level planning instrument, the PAHO Strategic Plan 2008-2012. The plan defines the Organization's contributions to the fulfillment of the Health Agenda for the Americas 2008-2017 and the MDGs, and is aligned with WHO's 11th General Programme of Work and Medium-Term Strategic Plan. It contains 16 Strategic Objectives that are directly aligned with those of WHO and defines Region-wide Expected Results (RERs) and indicators based on the Region's current priority public health concerns while also allowing for the emergence of new issues and threats. PAHO's RERs contribute to WHO's Organization-wide Expected Results (OWERs), and their indicators aggregate to the global level.

Decentralization

102. In addition to the RBM Framework, one of the most far-reaching changes in the decade was the adoption of a Decentralized Technical Cooperation model. In conjunction with the new Regional Program Budget Policy, this new model progressively transferred the Organization's competencies, functions, and resources from Headquarters to the subregional, national, and subnational levels. The goals were to increase efficiency in the use of human, technical, and financial resources; foster closer collaboration with country and subnational counterparts; and strengthen decision-making at the local level as part of the ongoing decentralization taking place in the countries.

103. The implementation of the Decentralized Technical Cooperation model advanced significantly during the decade. A number of regional technical programs formerly based at Headquarters were transferred to the countries, including programs on dengue (Costa Rica), Chagas disease (Uruguay), disabilities (Argentina), leprosy and leishmaniasis (Brazil), ocular health (Colombia), and indigenous health (Panama), among others. In

addition, the Area of Family and Community Health (FCH) decentralized its technical team on women and reproductive health to the Latin American Center for Perinatology and Human Development (CLAP) in Uruguay, and the Area of Health Surveillance and Disease Prevention and Control (HSD) transferred its veterinary public health activities to the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) in Rio de Janeiro, Brazil.

104. The Area on Emergency Preparedness and Disaster Relief (PED) has established three offices that cover different geographical areas: Ecuador/Colombia for South America, Barbados for the Caribbean, and Panama for Central America. In addition, Canada, Cuba, Mexico, and the United States are covered from the Regional Office in Washington, D.C. Each office has an Emergency Preparedness Advisor and support staff. The office in Barbados also has a Disaster Risk Reduction Specialist. This decentralization ensures not only technical cooperation that is close to the actual needs, facilitating interaction and diminishing costs, but also a quicker response in case of a disaster. In addition, PAHO has decentralized the Senior Regional Response Advisor to Barbados. There is also PED staff in Colombia and in Haiti.

105. In addition, as mentioned in Chapter II, new subregional technical cooperation programs, mandated by the Governing Bodies and in compliance with the recommendations of the PAHO in the 21st Century Working Group, were established to respond to the health priorities of the subregional integration systems. The following programs were established: for Central America, vis-à-vis the Council of Ministers of Health (COMISCA) and the Health Sector Meeting of Central America and the Dominican Republic (RESSCAD); for the Caribbean, vis-à-vis CARICOM's Council for Human and Social Development (COHSOD) and the Caribbean Ministers of Health Caucus; for the Andean region, vis-à-vis the Andean Health Agency/Hipólito Unanue Agreement (ORAS/CONHU) and the Andean Community of Nations (and in accordance with the resolutions of the Meeting of Ministers of Health of the Andean Region, REMSAA); and for the Southern Cone, vis-à-vis MERCOSUR (Working Subgroup #11) and intergovernmental health commissions. The technical cooperation program for the U.S.-Mexico border continues to be carried out from the office in El Paso, Texas, which celebrated its 70th anniversary in 2012.

106. Various country offices underwent a further decentralization of their technical cooperation programs, in response to priorities established in the PAHO Strategic Plan and in agreement with national and subnational counterparts. For example, the country offices in Bolivia, Brazil, Colombia, Mexico, and Nicaragua established decentralized technical cooperation at the subnational level, in some cases with the permanent presence of PAHO staff. In the case of Ecuador, technical cooperation on communicable diseases is provided from a sub-office in Guayaquil, due to the fact that the main counterpart is in the coastal zone. In the case of the Eastern Caribbean countries, a decision was made to establish PAHO's permanent presence in the islands via country program specialists who

interact with their national counterparts on a daily basis while program teams located in Barbados provide specialized technical cooperation.

107. Paralleling the decentralization of PAHO's technical cooperation programs were changes in the administration of several of its specialized Pan American Centers. Since the 1950s, PAHO had created or managed 13 such Centers responsible for carrying out research, providing technical cooperation, and building capacity in areas of priority to the Member States. During this time, PAHO's Governing Bodies urged PASB to reexamine the Centers periodically and consider alternatives in cases where national institutions are capable of providing ongoing technical cooperation services in the Centers' areas of specialization for their countries and for other PAHO Member States.

108. In response, PASB undertook a review in the early 2000s examining each Center's operations, financing, and alignment with PAHO regional and subregional policies, while also exploring alternative structures, agreements, and funding sources that might be more efficient and effective for addressing the issues within each Center's area of specialization.

109. As a result, in 2005, the Pan American Institute for Food Protection and Zoonoses (INPPAZ), based in Argentina, was closed, and a specialized food safety technical team was established at the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) in Brazil. Subsequently, in 2010, the Institute of Nutrition of Central America and Panama (INCAP) was transferred to its Directing Council, with PAHO remaining as a member along with the institute's eight Member States. The same year, the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) in Peru was closed, its laboratories were transferred to the Peruvian government, and a Regional Technical Team on Water and Sanitation (ETRAS) was established through an agreement with Peru to provide continuing technical cooperation in water and sanitation.

110. In the Caribbean, the two Pan American Centers, the Caribbean Epidemiology Center (CAREC) and the Caribbean Food and Nutrition Institute (CFNI), are in the process of transitioning to the Caribbean Public Health Agency (CARPHA). CFNI will be decommissioned at the end of 2012, and functions carried out by CAREC will be transitioned to CARPHA. Work over the past 10 years has focused on consolidating and strengthening the operations of these two centers to facilitate a smooth transition.

111. CARPHA became a legal entity on 4 July 2011, when Heads of Government of the Caribbean signed an intergovernmental agreement for its establishment. The agency is scheduled to become fully operational in January 2013. An Executive Board has been established, and an interim team has been developing a resource mobilization strategy and sustainability plan, a social marketing and communications plan, and a work plan focused on laboratory services, surveillance, and health analysis.

112. PAHO/WHO Collaborating Centers (CCs) continued to play an important role in the Organization's work by carrying out research that supports its technical programs, helping to expand the Organization's networks, and contributing to national and regional capacity-building in the areas of information, services, research, and training.

113. During the decade, PAHO significantly increased its involvement in the designation of new CCs. While traditionally most centers in the Americas were initiated by WHO Headquarters, from 2002 to 2012, this trend was reversed: 60 new CCs were initiated by PAHO/AMRO and 32 by WHO Headquarters. Thirty-seven of the 92 new CCs in the Region are in Latin America and the Caribbean, including the first-ever CCs in Bolivia and Uruguay. For the first time since the 1980s, three new centers were designated in Costa Rica.

114. In addition, a new category of relationship was created for National Institutions Associated with PAHO in Technical Cooperation, with procedures for identifying, designating, and monitoring such institutions. The process is aimed at strengthening in-country technical cooperation while also building national capacity, ensuring intersectoral collaboration, and promoting public-private initiatives and collaboration with civil society institutions.

New Models and Entities

115. To support the RBM Framework, PASB created a number of new entities during the decade. In addition to the Decentralized Technical Cooperation model, a new horizontal team-oriented organizational model was approved that uses teams, standardized collaborative groups, and networks rather than traditional organizational units. The goal is to bring people from different backgrounds and competencies together working toward a common purpose in a results-based culture. The model allows for organizational adjustments in each new planning cycle in response to Member States' changing needs. It also defines a process for delegation of authority that helps clarify roles and responsibilities for results defined in the PAHO Strategic Plan.

116. To support the implementation of the RBM Framework and culture, PAHO also created a new project team for Organizational Effectiveness and Development (IDU) in 2010 within the Area of Planning, Budget, and Resource Coordination (PBR). Its mandate is to strengthen PAHO's capacity to make innovative, efficient, and effective use of its resources in fulfilling its vision and mission. The team is staffed with experts on institutional effectiveness and development with both regional and global experience.

117. Among IDU's contributions to PAHO's transformation in the 2000s have been ensuring approval by the Governing Bodies of the new RBM Framework, facilitating the transition of the Pan American Centers, supporting the new PAHO Management Information System (PMIS), overseeing the development of PAHO operations and

management manuals, and ensuring the systematic use of online dashboards for programming and budgeting.

118. The most senior new entity formed to support the RBM Framework was the Executive Management Team (EXM), made up of the Director, the Deputy Director, the Assistant Director, and the Director of Administration, with a Chief of Staff who serves as liaison, coordinator, and secretary. Established in 2003 to enhance PAHO's management practices, EXM improved transparency in decision-making at all levels of the Organization.

119. EXM is responsible for developing PAHO's strategic direction, priorities, and policies and for coordinating planning and implementation of Organization-wide initiatives, including cross-cutting priorities and policies. The team is also responsible for defining the Organization's resource requirements and overseeing resource mobilization. In addition, EXM fosters information-sharing, communication, collaboration, and accountability at all levels of the Organization with the overarching goal of improving effectiveness and transparency.

120. As part of the participatory management model, a Permanent Managers' Forum was created with a view to achieving effectiveness, efficiency, and synergy in the work of the Organization. It allows EXM and PASB Managers to exchange information and discuss topics of importance, enhancing and facilitating open dialogue, teamwork, and consensus-building. The forum includes a bi-annual face-to-face meeting.

Workplace Policies and Processes

121. The PAHO Strategic Plan 2008-2012 established six cross-cutting priorities—gender, ethnicity, human rights, primary health care, health promotion, and social protection in health—and called for prioritizing and mainstreaming these in all of PAHO's technical cooperation programs.

122. One of these priorities, gender, led to the development and implementation of the PAHO Gender Equality Policy, which was approved by the 46th Directing Council in 2005 (CD46.R16). In addition to calling for mainstreaming gender into health planning, programming, and interventions by the countries and in PAHO's technical cooperation programs, the policy and its Plan of Action called on PASB itself to strive for parity between the sexes in recruitment and career development.

123. A 2009 U.N. report showed that PAHO had already achieved sex parity among professionals at Headquarters, ahead of many other U.N. agencies. However, in the Organization's country offices, women were underrepresented among professional staff and among long-term and new appointees. Yearly progress reports since the gender

policy's adoption have shown increased recruitment of women both at Headquarters and in PAHO country offices and at both the professional and the administrative levels.

124. In 2004, PAHO adopted its first policy addressing harassment in the workplace. Aimed at fostering a respectful work environment through prevention and prompt resolution of harassment, the policy covered two types of workplace harassment—personal and sexual—and explained how to use informal and formal resolution processes to deal with conduct that might constitute harassment.

125. In 2012, the policy was expanded to include bullying, abuse of authority, and a hostile work environment as other forms of harassment. Other changes included eliminating peer review in the formal complaint process and setting time limits to ensure prompt resolution of allegations.

126. In May 2006, PAHO established an independent Ethics Office, which reports directly to the Governing Bodies through the PAHO Executive Committee. Its mandate is to promote a culture of ethics and integrity in the Organization by providing guidance, advice, and training to help staff make the right ethical decisions in compliance with PAHO's Code of Ethical Principles and Conduct, implemented in January 2006. It is also responsible for investigating allegations of misconduct, including harassment, as well as suspected violations of the PAHO ethics code.

127. The Ethics Office is accessible to all PASB staff, family members, clients, stakeholders, and vendors. In June 2007, an Ethics Help Line was implemented to enable people both inside and outside the Organization to report suspected wrongdoing or to ask questions about issues that could have ethical implications. The Help Line is administered by an external vendor and allows callers to remain anonymous if they wish.

128. In 2005, the Organization launched a new Ombudsman Office to provide conflict management and dispute resolution services for staff members with concerns, problems, or challenges related to their work. The office follows practices and procedures that are consistent with the Standards of Practice and the Code of Ethics of the International Ombudsman Association. Its work is based on four principles—confidentiality, impartiality, independence, and informality—and it is an advocate of PAHO's core values—equity, excellence, solidarity, respect, and integrity.

129. The Ombudsman Office supports PAHO's mission by promoting fairness in organizational processes. It places priority on addressing employee concerns at the earliest opportunity with the goal of preventing, managing, limiting, or resolving conflicts before they escalate. Its services are available to anyone working in any PASB workplace, including at PAHO Headquarters, in country offices, and Centers, regardless of the person's contract status. During the past five years, more than 750 employees have consulted the Ombudsman Office with questions or concerns. Visitors have consistently

reflected the demographic profile of the Organization in terms of location, gender, and contract status. The office also acts as an observer and forecaster, providing timely feedback to PAHO's Administration and Managers in an effort to prevent avoidable harm to individuals or the Organization.

130. In October 2007, PAHO launched an Integrity and Conflict Management System (ICMS). The ICMS incorporates all internal resources that handle integrity and conflict resolution issues into a coherent system so they can be more accessible, effective, and easily understood by PASB staff. These resources include the Ombudsman Office, the Ethics Office, the Legal Office, the Information Security Office, Human Resources Management, the PAHO/WHO Staff Association, the Office of Internal Oversight and Evaluation Services (IES), and the Board of Appeal. In November 2011, PAHO for the first time appointed an external chairperson for its Board of Appeal.

131. Each of these resources plays a distinct role, and the ICMS provides clear information about the mandate, scope of work, authority and decision-making ability, reporting relationships, accessibility, level of confidentiality, independence and accountability, and access to officials and records of each individual resource.

132. Since its inception, the ICMS has been the catalyst for the development of a number of important institutional initiatives related to good governance, including a Confidentiality Declaration program (2007), a policy on Protecting People who Report Wrongdoing or Cooperate in an Investigation or Audit (2009), and a Protocol for Conducting Investigations in the Workplace (2010).

133. To promote staff health and well-being, PASB created a Wellness Committee as an advisory body to the Director. It provides a forum for discussion and recommendations about issues related to health in the PASB workplace. The committee has also spearheaded an effort known as "Green PAHO" aimed at reducing the Organization's carbon footprint.

Competencies and Learning

134. In 2003, PAHO established a Working Group on Human Capital (WGHC) whose responsibility was to analyze and make recommendations on the staff competencies and skills seen as necessary for the Organization's effective performance. The group produced a first draft of a Competencies Map, consisting of 20 competencies divided into three sections: (*a*) general competencies, (*b*) technical competencies for professionals involved with technical cooperation, and (*c*) competencies for staff associated with administrative support services. The initial map was reviewed and revised by the Area of Human Resources Management (HRM) in 2006 as part of PAHO's Strategic Assessment and Resources Alignment (SARA) initiative and again in 2007. Changes included the addition of levels and descriptions of desired behaviors associated with different

competencies. In 2007, the map was again revised and subsequently validated by an outside consulting firm.

135. The Competencies Map was part of a larger effort to implement competency-based human resources management. This effort has also included the use of interviews and psychometric tests based on competencies in the staff selection process and the alignment, updating, and improvement of post descriptions through the incorporation of requirements based on the Competencies Map.

136. Starting in 2004, PASB launched a major effort to strengthen itself as a learning organization, to ensure that the skills and knowledge of its staff grow and evolve in tandem with new technological, scientific, policy, and organizational advances.

137. To guide this process, the Learning Board was created and assigned the responsibilities of evaluating priority learning needs, spearheading initiatives that address those needs, and ensuring that such initiatives are aligned with PAHO's business needs, corporate policies, and the objectives of the PAHO Strategic Plan.

138. Since 2004, the Learning program has developed regional and global learning plans focused on eight "learning tracks": induction and updating, PAHO fundamentals, leadership and managerial excellence, project management, technical excellence, administrative excellence, administrative skills, and support skills. All staff are required to take a mandatory induction course, a course on PAHO's Code of Ethical Principles and Conduct, and two courses (basic and advanced) on Security in the Field. Starting in 2012, each PASB staff member is also required to include 10 days/80 hours of learning activities in their personal work plans (see also below).

E-Manual and Country-Level Operations Manual

139. An important initiative to support and codify PAHO's institutional development was the new PAHO/WHO E-Manual. The E-Manual is a unified instrument that directs PAHO personnel in carrying out their responsibilities toward the achievement of the Organization's Strategic Objectives. It incorporates the rules, regulations, policies, and procedures of the WHO E-manual as well as specific PAHO variances from WHO policies, as established by the PASB Director and permitted by the Organization's separate legal status vis-à-vis WHO. Developed over a five-year period and made fully operational in mid-2012, the PAHO/WHO E-Manual is now the sole repository of mandatory PAHO policies, which had previously been distributed in various sites across the Organization.

140. Currently the Organization is also developing an operational management manual for PAHO country offices and specialized Centers. This new manual will provide guidance for country-level managers in all areas of management, including the

development of Country Cooperation Strategies, Biennial Work Plans, and institutional development plans. The manual will also highlight how these processes interrelate. An electronic version will provide users with links to documents and E-manual policies related to each process.

141. The PAHO/WHO E-Manual and country-level manuals will have a dedicated intranet site through which all proposed variances to WHO policies or changes to current PAHO policies will be made. Draft proposals, comments, edits, and written communications will be developed, transmitted, approved, and published using this E-manual system. The PAHO E-Manual Standing Committee, composed of the Director of Administration and the PAHO Legal Counsel, will approve all proposed policy variances.

142. Both the PAHO/WHO E-manual and the Country-Level Operations Manual contribute to the achievement of Strategic Objective 16 and to PAHO's development as a learning organization.

Transparency, Accountability, and Oversight

143. In line with recommendations of the Working Group on PAHO in the 21st Century, the PASB instituted a number of changes aimed at increasing transparency and accountability in PAHO's work. These included the adoption of the first specific rules governing the election of the PASB Director. Based on the recommendations of a special Working Group on Streamlining the Governance Mechanisms of PAHO, the new rules included criteria for use by the Member States in selecting their nominees, a timeline and procedures for nominations and for holding the election, and the establishment of a new Candidates' Forum, timed to coincide with meetings of the Executive Committee, to allow candidates to present their platforms and answer questions from Member States.

144. The rules also included specific regulations regarding candidates who are PAHO or WHO staff members as well as oversight mechanisms related to contracting delegates from Member States participating in the election and the use of certain funds of the Organization before and after the election.

145. In 2009, WHO instituted a new global process for selecting Heads of WHO Country Offices (HWCOs), also known as PAHO/WHO Representatives (PWRs). The process seeks to guarantee the leadership qualities and skills of PWRs/HWCOs through a competitive selection process, continuing education, and a rigorous assessment of performance, combined with proper induction, mentoring, and coaching, as well as responsive back-up and support.

146. The new process includes a Global Roster of pre-qualified candidates from which all PWRs/HWCOs are to be selected. The Global Roster Assessment Committee, made

up of senior officers from the six Regional Offices and WHO Headquarters, ensures that applicants meet the minimum essential requirements for the post and that the assessment process has complied with institutional norms. The process includes a written test to assess candidates' knowledge of fundamental aspects of public health and the values of the United Nations and WHO, as well as interviews and simulations to assess their political skills in situations commonly faced by PWRs/HWCOs.

147. For PWR (AMRO) vacancies, candidates from the Global Roster are reviewed by the PAHO Senior Selection Committee, which proposes one candidate to the WHO Director-General. Appointments proceed on the basis of mutual agreement with the host government.

148. In addition to these changes, PASB also decided to modify the process for selecting PAHO's External Auditor. Over a 30-year period prior to the 2008-2009 biennium, the National Audit Office of the United Kingdom of Great Britain and Northern Ireland (NAO) had been appointed by the Governing Bodies to serve as PAHO's External Auditor. In an effort to improve transparency in oversight processes, PASB adopted the procedure used by WHO, in which nominations are requested for an External Auditor who serves for no more than two successive biennia. In 2008, the NAO was the sole nominee and was again selected as External Auditor for two biennia. In 2011, the Member States appointed the Spanish Court of Audit for the 2012-2013 and 2014-2015 biennia after a competitive process.

149. Several other new entities and processes were established to enhance governance through improved oversight, risk management, and evaluation. These included the new Office of Internal Oversight and Evaluation Services (IES), established in 2009 and headed by the PAHO Auditor General. IES is responsible for conducting internal audits and evaluations, identifying risk and internal control issues, making recommendations, and following up on their implementation. IES acts independently of management and provides advisory services on an ad-hoc basis.

150. A related development was the creation of the PAHO Audit Committee, which met for the first time in 2010. Made up of experienced professionals who operate independently of both the Member States and PASB, the committee contributes to enhanced institutional governance, risk management, and internal control processes by conducting internal audits and evaluations and providing advice to PASB management. Its members also participate in meetings of the ICMS, the Asset Protection and Loss Prevention (APLP) committee, and the PMIS modernization project, among others.

151. The new Standing Committee on Asset Protection and Loss Prevention (APLP) was established in 2009 to make recommendations on policies and measures to prevent the loss, misuse, or theft of PAHO resources and assets. One of its first recommendations, implemented in 2010, was that all reports of suspected theft, loss, or misconduct should

be reported to one focal point in the Organization, namely the Ethics Office. In 2012, a new policy was issued under the auspices of the APLP committee to hold staff accountable when property or equipment belonging to the Organization is lost or stolen due to negligence or misconduct.

152. PAHO instituted other new processes aimed at ensuring integrity, transparency, and accountability in carrying out its mandates. As of 2005, staff members at certain grade levels and in relevant positions are required to submit a Declaration of Interest disclosing any financial, professional, or other interests that could potentially give rise to a conflict of interest. The declaration also requires disclosure of any relevant interests of immediate family members.

153. Starting in 2010, the Organization adopted the International Public Sector Accounting Standards (IPSAS) in its accounting and financial reporting; previously it had used the U.N. System Accounting Standards (UNSAS). PAHO was one of eight U.N. system organizations that succeeded in implementing the new standards by 2010.

Institutional Response Framework and EOC

154. The 2009 H1N1 influenza pandemic and the 2010 earthquake in Haiti proved to be among the largest and most complicated response operations since PAHO's emergency program was created in 1976. As a result of these experiences and the considerable demands they placed on the Organization, PAHO began modifying its own disaster management and response operations.

155. This process involved extensive consultations within and outside the Organization with experts from a variety of disciplines, including emergency management specialists, first responders, epidemiologists, and administrators, among others. The result was a new Institutional Response to Emergencies and Disasters Framework aimed at improving the Organization's capacity to respond with adequate speed, agility, and effectiveness to Members States' needs in times of emergency.

156. As part of the new framework, the space formerly occupied by the Library in the Headquarters building was adapted to host the new Emergency Operations Center (EOC) and Knowledge Center, with interconnected and flexible work spaces to allow different technical areas within the Organization to collaborate in a public health response. The EOC plays a coordinating role, connecting all points of operations to ensure a timely and effective response to urgent public health events. Its integration with PAHO's Library and Information Networks (KMC/LI) and the International Health Regulations' Alert and Response and Epidemic Diseases (HSD/IR) team allows better collaboration between the Area on Emergency Preparedness and Disaster Relief (PED), Knowledge Management and Communications (KMC), Health Surveillance and Disease Prevention and Control (HSD), and other technical and administrative areas. The new EOC/Knowledge Center

space was inaugurated during the 150th Session of the Executive Committee in June 2012.

Information and Communication Technologies

157. Complementing the new institutional response framework and contributing to business continuity and operational efficiency were new efforts to improve the Organization's information and communications infrastructure.

158. The basic framework for these efforts was the new PAHO ICT Strategy, which articulates the consensus on the needs of the PAHO community and its partner base and presents a comprehensive vision of where ICT in PAHO needs to be in the medium term. A draft of the policy was developed through a region-wide consultation involving 13 focus groups and the participation of more than 100 PASB staff.

159. Based on a five-year planning horizon, the ICT Strategy assimilates near-term industry trends in virtualization, cloud computing, standardization, consolidation, and service management. As the Organization continues its progressive shift to the use of mobile services and devices, these approaches and technologies are expected to improve the agility and capacity of ICT to respond to the evolving needs of PAHO and its communities.

160. The PAHO ICT Strategy emphasizes positioning the Organization as a leader in electronic health information as well as in collaboration and networking. It reflects PAHO's Country Focus and stresses increased network connectivity to ensure equitable access for all, in support of PAHO's Strategic Objectives.

161. Projects included in the strategy have been implemented collaboratively by the Information Technology Services (ITS) team with the Area of Knowledge Management and Communications (KMC) to ensure integration with the KMC conceptual model and interoperability with the PAHO Intranet/Extranet 2.0, the WHO Global Institutional Repository, and the Virtual Campus of Public Health.

162. Major ICT projects have included:

(a) The Desktop Technology Refresh Project, which provides a common desktop experience for staff at Headquarters, in the country offices and Pan American Centers, and on multiple devices. It facilitates single-instance management of desktop software configuration, improves standardization, and simplifies local proximity support.

(b) The Email Modernization Project, which has progressively upgraded the email systems of PAHO's country offices and Centers, while migrating many offices to the WDC Datacenter to consolidate hardware and improve business continuity.

As part of the PAHO Business Continuity Plan, ITS also implemented a new Email Management System (EMS) that includes alternate email infrastructure in case of an outage on PAHO's core email systems.

(c) The PAHO Server Virtualization Project, which has provided a stronger and more flexible server infrastructure at Headquarters and has allowed faster response to business continuity demands.

163. As part of its efforts to improve organizational communications, PAHO undertook a major effort to improve connectivity between the country offices, the Pan American Centers, and Headquarters. Formerly these entities were linked through a patchwork of often unreliable local connections confined by inadequate bandwidth and high costs, and prone to outages and poor performance.

164. To remedy this situation the Organization instituted a new PAHO Private Network (PPN), a telecommunications infrastructure that provides the required connectivity at all PAHO locations through added communications capacity, bandwidth, security, and reliability.

165. The PPN supports virtual meeting capabilities, increased knowledge-sharing, social networking focused on health, voice-over-Internet protocol (VoIP) telephony, real-time communications, and a videoconferencing capability. The network also provides a foundation for the future direct involvement of Member States in the activities of PASB as well as connectivity to extend systems in health institutions.

166. As part of the PPN implementation, PAHO has updated most of its telephone systems in the Region and is utilizing state-of-the-art technologies to ensure a seamless communications system for all staff.

Knowledge Management and Communications Strategy and Web 2.0

167. In 2011, PAHO approved its first corporate strategy aimed at integrating knowledge management and communications. The strategy's development involved contributions from 13 different working groups and the incorporation of elements of a previous Knowledge Management Strategy and an existing strategy for Human Resources and Information Technology.

168. The new Knowledge Management and Communications Strategy provides guidance for the planning of knowledge management and communications policies, identifying strategic goals in areas including collaboration, learning, networks, and health communication. The strategy is being implemented throughout the Organization under the primary responsibility of the Area of Knowledge Management and Communications (KMC).

169. A major change instituted as part of the Knowledge Management and Communications Strategy was a shift to the Web 2.0 model of online presence. In contrast to traditional web models, Web 2.0 implies interaction and collaboration among users who are able to create and generate content as members of a virtual community, rather than users essentially being passive recipients of content created for their consumption.

170. The Organization's embrace of Web 2.0 has opened up new opportunities for information-sharing, networking, interaction, interoperability, and content generation. PAHO's implementation of the model has emphasized:

(a) Standards for information management that allow for joint evolution among different users.

(b) Interoperability to allow the consolidation of internal and external information flows.

(c) Targeting of user groups in content production and sharing.

(d) Expanding networks for dissemination of information and innovation, including through communities of practice and the use of social media.

(e) Creation of new functional forms to prepare for mobile devices and access.

(f) Preservation of knowledge, expertise, and historical memory.

171. The implementation of Web 2.0 has strengthened PAHO's presence as an authoritative source of scientific and technical information in public health, expanded multilingual publishing in an open-access environment, promoted strategic and functional alignment with WHO's website, improved interoperability between internal and external public health information sources, and made PAHO's content more accessible to indexers, web browsers, portals, and other web services as well as directly to end users.

172. A related ICT development that supported the Knowledge Management and Communications Strategy was the PAHO Domain Consolidation Project, which consolidated 35 PAHO country office and Center Internet domains into a single "paho.org" domain to present a consistent Organizational identity throughout the Americas. The project has greatly reduced infrastructure complexity, simplified administration, and allowed for future single-instance approaches and cloud computing initiatives.

173. The Organization also took advantage of new platforms available for virtual conferencing and collaboration, which facilitated a dramatic increase in collaborative interaction while also providing major cost savings. Between 2006 (the first year virtual collaboration tools were fully implemented) and 2011, the annual number of virtual meetings and events hosted by the Organization increased from 687 to over 30,000. By

mid-2012, PAHO was hosting nearly 1,000 dedicated virtual collaboration spaces for its staff, their external collaborators, and other stakeholders.

174. In 2011, PAHO launched the first phase of a new PAHO Intranet designed to provide access to key corporate information while providing a comprehensive platform for knowledge management and communication. The second phase, currently under development, includes the implementation of a new information architecture intended to make storage and retrieval of information faster, more intuitive, and more reliable.

175. Since its inception, the new PAHO Intranet has published a large number of news items and features of interest to employees covering topics such as management practices and human resources, and including a number of staff profiles.

PASB Management Information System

176. In 2010, PASB launched a multiyear project to modernize its management information system, formerly known as the Corporate Management System (CMS) and more recently renamed the PASB Management Information System (PMIS). PMIS provides critical support for PAHO's technical cooperation programs by automating the information needed for planning, program management, budgeting, finance, human resources management, payroll, procurement, and evaluation, among others.

177. A special PMIS Committee analyzed the Organization's business processes, developed a set of guiding principles, and identified various options for modernization along with their advantages, disadvantages, and estimated costs. The committee's report, approved by PAHO's 50th Directing Council (CD50/7 and CD50/7, Corr.1) in 2010, called for modernizing the PMIS to align with the WHO Global Management System while taking into account PAHO's separate legal status and ensuring that neither the authority of PAHO's Governing Bodies nor levels of service to PAHO Members States are compromised.

178. In line with the PMIS Committee's recommendations, the PMIS modernization effort seeks to enhance accountability and transparency, collaboration, human resources management, support for emergency operations, and operational efficiency. It also seeks to streamline administrative processes; facilitate multilingual operations at the country, subregional, and regional levels; and ensure that information management helps strengthen management at all levels of PASB.

Procurement, Hiring, and Performance

179. PAHO has dramatically increased its procurement activity in recent years, in large part due to increased use by Member States of the PAHO Revolving Fund and the Strategic Fund. From 2000 to 2011, total procurement grew nearly fivefold, from US$ 105 million to US$ 505 million. To better respond to this growing demand, the

Organization undertook a major Procurement Transformation Project, informed by both external and internal assessments, aimed at streamlining processes for efficiencies and alignment of organizational structures for strategic effectiveness.

180. Among the most significant changes in procurement practices during the past 10 years was increased delegation of authority at both Headquarters and the country level. This trend was in line with other efforts to streamline and decentralize functions in the Organization and is part of a longer-term effort to institute a new procurement model based on "centralized control with decentralized execution."

181. To improve performance in procurement by both internal and external stakeholders, PAHO instituted the use of digital dashboards, or digital interfaces that: (*a*) present performance information in a graphic format that allows users to quickly identify performance issues and assist in their correction, (*b*) deliver more timely information by moving away from manually intensive methods of integrating and disseminating information, and (*c*) facilitate the analysis and management of procurement processes with respect to key goals and objectives. The dashboards make use of key performance indicators (KPI) to measure efficiency and effectiveness of procurement activity and facilitate corrective actions to better meet organizational targets and goals.

182. PAHO's Area of Human Resources Management (HRM) also implemented changes to streamline and clarify its contracting modalities, primarily to reduce recruitment times and facilitate rapid deployment. These changes have included:

(a) Harmonization of PAHO's contracting modalities with those of the U.N. Common System to ensure consistency and inter-agency mobility.

(b) Development of automated systems to address urgent needs and funding challenges, such as short-term funding.

(c) Delegation of authority to allow managers to make hiring decisions without extensive HRM involvement in certain situations (e.g., hiring non-U.N. staff as temporary advisors and consultants).

(d) Development of general services rosters to facilitate rapid hiring of personnel for project or program support.

183. HRM also implemented measures to shorten the duration of the recruitment process for full-time posts (FTPs). These measures included:

(a) A Human Resources Tracking System (HRT) to facilitate better follow-up of hiring requests.

(b) An *E-Select* tool that automates most of the steps for documenting the recruitment process and allows managers more control over the timeline of each phase.

(c) Reconfiguration of the Advisory Selection Panel (ASP) to permit better programming of the selection process.

184. These measures have shorted the duration of the recruitment process on average by three months.

185. HRM also improved its Performance Planning and Evaluation System (PPES) through a new electronic tool that allows staff at Headquarters and in the country offices to complete their work plans and evaluations online. Implemented in early 2010, the new e-PPES is available in all four official languages of the Organization, along with an online course on its use. The system also has reporting capabilities that allow managers to monitor compliance, promoting greater accountability.

CHAPTER IV

FUTURE PROGRESS IN PUBLIC HEALTH

Consolidating Achievements

186. The countries of the Americas have much to celebrate with respect to health advances during the first decade of the 2000s. The Region has achieved meaningful gains in life expectancy, social protection in health, reorganization of health systems, and the treatment, control, or elimination of many infectious diseases (see Chapter I).[7] Contributing to these advances was a less tangible but equally important accomplishment: the consolidation of health as a basic human right on the political agendas of nearly every country, including incorporation of this right into many national legal frameworks. Even on the Region's most historically intractable problem—inequity—there was progress during the decade, although this area is where the greatest challenges remain. This chapter discusses what is needed to consolidate and sustain these achievements, examines key health goals that have not been fully met, and points to some of the major emerging challenges the Region faces in the near term.

187. As noted in Chapter I, public health spending in the Americas grew during most of the first decade of the 2000s, although it did not reach the levels generally considered necessary to achieve universal health coverage. A major challenge will be to ensure the sustainability of expanded social protection in health by increasing health and social budgets sufficiently or developing innovative new financing mechanisms, or both. The process of defining new financing mechanisms should recognize that universal coverage cannot be achieved if all coverage is linked to formal employment, and that coverage for a segment of the population will need to be subsidized. It is also important that new mechanisms contribute to reducing the segmentation (and resulting inequities) of health systems, for example, by incorporating additional groups into existing systems of health care rather than relegating them to separate and often lower-quality care or reduced coverage packages. Countries that have achieved unified national health systems can offer valuable lessons in this regard.

188. Ongoing PAHO/WHO technical cooperation to support expanded health coverage focuses on policies and mechanisms for financing social protection and health systems as well as studies on the evolution of health system inequalities, including analyses of the progressivity of health financing and of impoverishment resulting from catastrophic out-of-pocket expenditures.

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[7] See also the 2012 edition of *Health in the Americas*, published concurrently with this report, for details and analysis of recent health and development trends in the countries of the Americas.

189. Continued progress in reforming and reorganizing health systems based on primary health care (PHC) is also critical to the sustainability of expanded health protection. Efforts in this area have advanced more in some countries than in others, but PHC strategies have proven their worth in making systems more efficient while improving the delivery of care.

190. A key component of the PHC strategy, essential to both sustainability and quality of health systems, is the implementation, strengthening, and expansion of integrated health services delivery networks (IHSDN). For countries that have begun implementing IHSDN, further progress will require the progressive integration of different providers as well as the collaborative participation of health authorities at the national, provincial, and local levels. In implementing IHSDN, it is important also to overcome what are often excessively hierarchical relations among different categories of health professionals, promoting instead collaborative teamwork and mutual respect.

191. Access to affordable medicines remains a key requisite for sustaining and expanding health protection. Over the past decade, countries have had to adjust their pharmaceutical policies in response to important changes in this sector. Despite increased research and development worldwide, the rate of pharmaceutical innovation has declined over the period, and the relative benefits of new medicines have been more limited. At the same time, continued globalization has led to a *de facto* harmonization of intellectual property protection measures, resulting in patents of longer duration (15 to 20 years). The result has been higher prices for newer medicines for both the public and private sectors.

192. Traditional pharmaceutical policies and tools that have helped Latin American and Caribbean countries increase access to medicines remain useful. These include developing and updating lists of essential medicines and health technologies, use of generic medicines, regulation of quality and safety, and promotion of rational use. However, as demand for universal coverage and access to health care services has increased, so has the political willingness of a growing number of governments to promote biomedical and pharmaceutical innovation, a trend that PAHO/WHO supports. Continuing improvements in both regulatory and delivery systems are also needed to ensure equitable access to and quality of pharmaceutical and biomedical products.

193. Another critical element for consolidating health system reforms is improved management models, including models for managing health facilities within public health networks as well as improved strategies for management and development of human resources in health.

194. Many countries still have shortages of health workers, and a number of Caribbean countries, in particular, continue to experience significant emigration of nurses. But many more countries have skewed distribution of health personnel of different skills sets and levels of specialization. Throughout the Region, urban areas continue to have higher rates

of health personnel per population than rural and remote ones. Health systems based on PHC require adequate numbers and distribution of physicians, dentists, psychologists, nursing staff, and others. Appropriate training and educational opportunities, more rational distribution, effective incentive structures, and favorable working conditions—including measures to protect health workers from occupational hazards—are needed for health personnel at all levels to ensure that reorganized health systems meet the heterogeneous needs of different economic, social, cultural, and geographical groups. This also implies increased collaboration and coordination between the health, education, and labor sectors.

195. Sustaining gains in health systems also requires adequate professional capacity and retention in public health management and leadership positions. For this reason, ensuring the availability, attractiveness, and stability of a public health career track should be a key goal of human resources strategies. This includes providing avenues for professionals to acquire competencies in specific fields related to the PAHO/WHO-recommended essential public health functions[8] of national health authorities. In recent years, country-to-country cooperation and networking—for example, through the Pan American Network for Drug Regulatory Harmonization (PANDRH)—have been effective ways of supplementing training and education programs that are available within countries. It is also essential to have public health professionals who can advocate for the health sector and collaborate in the development of legislation, for example, to build legal frameworks to consolidate national health systems and strengthen national health authorities.

196. Other areas of health systems that require continued strengthening include blood and radiological safety, patient safety and patient-provider relations, evaluation and implementation of medical infrastructure and technologies, quality control and enhancement, oral and ocular health services, health information systems, health services accreditation systems, and hospitals safe in disasters.

197. As noted in Chapter I, the Region of the Americas has been a leader in the control and elimination of vaccine-preventable diseases. It was the first WHO region to eradicate smallpox and polio, has since eliminated endemic transmission of measles and rubella, and has reduced neonatal tetanus such that it is no longer a public health problem in any country except Haiti.

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[8] (*1*) Monitoring, evaluation, and analysis of health status; (*2*) surveillance, research, and control of the risks and threats to public health; (*3*) health promotion; (*4*) social participation in health; (*5*) development of policies and institutional capacity for public health planning and management; (*6*) strengthening of public health regulation and enforcement capacity; (*7*) evaluation and promotion of equitable access to necessary health services; (*8*) human resources development and training in public health; (*9*) quality assurance in personal and population-based health services; (*10*) research in public health; (*11*) reduction of the impact of emergencies and disasters on health.

198. Maintaining these impressive achievements will require sustaining the Region's high levels of immunization coverage as well as continued surveillance of vaccine-preventable diseases and monitoring of coverage rates. Countries must remain vigilant given the ongoing risk of imported measles cases and must bridge the coverage gaps that continue to exist in hard-to-reach and vulnerable communities. Vaccination Week in the Americas is an important initiative for addressing this latter problem. At the national level, countries must continue building public support and consolidating political commitment to ensure sustainable financing for their expanded immunization programs.

199. Though the Region as a whole has been a leader among developing regions in adopting new vaccines, a number of countries have not yet introduced important new vaccines such as pneumococcal and HPV. Taking advantage of the technical cooperation and joint procurement services of the PAHO/WHO Revolving Fund and the ProVac initiative can help countries make sound, evidence-based decisions about new vaccines as well as the wider use of underutilized vaccines, particularly for influenza. It is also important that countries with the capacity to produce vaccines engage in technology transfer to those with unrealized potential in this area.

200. Other challenges for consolidating immunization achievements include, for some countries, strengthening the cold chain, fully implementing nominal immunization registries, and certifying the elimination of measles and rubella. Surveillance for events supposedly attributable to vaccination or immunization (ESAVI) also needs to be strengthened.

201. Another area in which Latin America and the Caribbean have led the developing world is expanding access to antiretroviral treatment (ART) for people with HIV. As of 2010, 63 percent of those needing ART—521,000 people—were receiving it in the two subregions combined. Coupled with a decline in new infections, expanding ART coverage contributed to a declining number of HIV deaths in Latin America and the Caribbean between 2000 and 2010. Nevertheless, more than one in three people who need ART went without it, and in some countries the treatment gap remains much larger. This is despite policies in all the countries that support free access to ART as a basic human right.

202. Overcoming these treatment gaps will require improvements in early diagnosis, referrals, and monitoring of HIV patients, as well as more efficiency in the procurement and use of ART. PAHO's 2012 report *Antiretroviral treatment in the spotlight: a public health analysis in Latin America and the Caribbean* recommends that countries reduce the number of ART regimens to only those with the highest effectiveness; phase out obsolete, and especially toxic, drugs; increase their use of international procurement mechanisms such as the PAHO Strategic Fund; adopt new service delivery models based on strategic information and patient-centered care; expand and ensure early diagnosis of

HIV infection; and strengthen monitoring of patient viral loads and CD4, among other measures.

203. Other challenges for the response to HIV include mobilizing national resources to reduce dependency on external financing for ART, accelerating innovation-transfer programs, ensuring the appropriate use of rapid tests and simplified diagnostic algorithms, implementing adherence-support measures, and using web-based monitoring platforms for strategic commodities and drugs.

204. A larger challenge still facing many countries is to fully integrate HIV prevention into sexual and reproductive health strategies and primary health care, with special attention to the most vulnerable groups. This includes HIV testing of pregnant women, provision of ART to mothers and infants, and early diagnosis of exposed infants, in line with the Regional Initiative for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. Integrating HIV into primary health care and other programmatic areas can have the added benefit of reducing stigma and discrimination as well as addressing dependence on external funding for activities related to HIV. Better coordination of tuberculosis and HIV care is also needed to address the problem of HIV/TB coinfections.

Addressing the Unfinished Agenda

205. As noted in Chapter I, the Region's impressive health gains over the past decade have not benefitted all countries or population groups equally. Significant disparities exist across and within countries on such basic indicators as life expectancy, maternal and child mortality, malnutrition, access to clean water and sanitation, and access to health services.[9] Reducing these inequities has been and remains the Americas' greatest public health challenge.

206. Nowhere are these disparities more apparent than in maternal mortality, one of the MDGs the Region is not currently on track to meet. Disparities in access to comprehensive, quality sexual and reproductive health services—including skilled care at birth and contraception—are major reasons for the Region's failure to make sufficient progress toward MDG-5.[10]

207. At the regional level, efforts are under way to accelerate progress in reducing maternal and infant mortality. These include the Regional Task Force for the Reduction of Maternal Mortality (GTR), the Newborn Health Alliance for Latin America and the Caribbean, the Safe Motherhood Initiative, and PAHO regional strategies on maternal

[9] See the 2012 edition of *Health in the Americas* for further data and analysis of health inequalities in the Region.

[10] Improve maternal health.

mortality and morbidity (CSP26.R13 [2002]) and neonatal health (CD48.R4 [2008]). These initiatives and PAHO/WHO's technical cooperation in this area emphasize evidence-based interventions within a continuum of maternal, newborn, and child care and with special attention to vulnerable women such as indigenous women, adolescents, and women in poor communities.

208. At the country level, important areas that need to be reinforced include basic obstetric care and referral systems for women in remote areas, early detection and management of obstetric complications in hospitals, perinatal information systems, and maternal mortality surveillance based on case-finding of deaths among women of childbearing age.

209. Comprehensive sexual and reproductive health services must include prevention, treatment, care, and support services for HIV and other sexually transmitted infections as well as access to contraception and sex education—including family counseling services and parent education programs—to prevent adolescent and unwanted pregnancies that contribute to high fertility rates and put women at unnecessary risk. In many countries, contraception and sex education that could help protect the health and lives of adolescents of both sexes are opposed by vocal segments of society. Overcoming the barriers to full exercise of women's sexual and reproductive rights (including the rights of pregnant and nursing women in the workplace) is a major item on the unfinished agenda and requires legal protections as well as individual empowerment and education, and awareness raising in families, communities, and the health sector itself.

210. A related challenge is the broader incorporation of gender, ethnicity, and human rights approaches into the health sector. A gender perspective is crucial not only for women's health equality but also for men's health and well-being. Men and women have different health needs and profiles that must be taken into account for health policies and interventions to be effective. A key area of gender and ethnicity mainstreaming is collecting disaggregated data to facilitate reporting and analysis of health outcomes and trends that are different for men and women and for members of ethnic groups.

211. In general, addressing these and other social determinants requires strengthening health information systems at both the national and subnational levels to produce quality, timely, and disaggregated data that can be analyzed, reported, and used to develop policies, strategies, and plans that contribute to reducing health inequities. PAHO/WHO is supporting capacity building in these areas while working to ensure these principles are fully incorporated into its own work.

212. As with gender and ethnicity mainstreaming, a great deal remains to be done in the Region in the area of health and human rights. Though the principle of health as a basic right is accepted in the vast majority of the Region's countries and has been enshrined in several countries' constitutions, generally speaking, legislation, policies, and

plans related to health do not incorporate basic human rights principles, such as the right to freedom from discrimination or the right to privacy and informed consent. There is also an urgent need to raise awareness of the human rights of groups in situations of vulnerability, including women, children, adolescents, individuals of divergent sexual or gender orientation (LGTBI persons), people with HIV, older adults, and people with disabilities, among others. Discrimination against members of vulnerable groups is high in the Region, is closely linked to violence, and has serious repercussions on both physical and mental health. Better mechanisms are needed for monitoring, identifying, investigating, prosecuting, and penalizing violations of human rights in vulnerable groups, particularly in health services. There is also great need to strengthen the capacity of magistrates, public health personnel, prison staff, congressional delegates, police officers, and union members to deal effectively with human rights issues among these groups. In addition, training is needed on the American Convention on Human Rights, the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Finally, mechanisms are needed to monitor compliance with these and other human rights instruments in health services, prisons, and long-term care facilities for older persons, among other institutions.

213. Violence against women and children continues to be a major public health problem in the Region, with serious consequences for health, well-being, and behavior throughout the life cycle. Some progress has been made in improving the response to this violence, for example, through legal reforms and improved services for survivors. However, less has been accomplished in the area of prevention, despite an emerging body of evidence on effective approaches. PAHO/WHO technical cooperation in this area includes online training and capacity building seminars on primary prevention of violence against women and children, as well as the development of policy and clinical guidelines for the health sector response.

214. Mental health also remains a pressing issue on the Region's unfinished agenda. Mental and neurological disorders represent some 21% of the total burden of disease in Latin America and the Caribbean, yet the resources available to address this burden are insufficient, inequitably distributed, and at times inefficiently used. The estimated proportion of people with mental disorders who need care and do not receive treatment (the treatment gap) is about 65%. Continuing stigma, social exclusion, and human rights violations significantly compound human suffering from mental disorders. Priority areas for action are the elimination of involuntary institutionalization and reorienting mental health services toward community-based care that is integrated into primary health care.

215. Despite major reductions in the burden of infectious diseases in the Americas, these diseases continue to disproportionately affect poorer countries and population groups. This inequity is most evident in the so-called "neglected diseases" or "diseases of poverty," which together account for a greater share of the total burden of disease in the Region than malaria or tuberculosis. Addressing these diseases requires improving

prevention, diagnosis, and treatment in primary health care services in at-risk areas as well as better epidemiological surveillance and adequate supplies of the necessary medicines at the local level. PAHO/WHO has joined with the Global Network for Neglected Tropical Diseases and the IDB in an initiative to eliminate 10 neglected diseases by 2015 by supporting and promoting such measures in affected countries.

216. Malnutrition also remains a problem in poorer groups, particularly indigenous and remote rural communities where educational levels are low. Chronic malnutrition affects an estimated 9 million children in Latin America, with a significant impact on both physical and cognitive development. Addressing this issue requires better surveillance and monitoring of malnutrition in children under 5 as well as guaranteed access to micronutrients for pregnant women and indeed all women of childbearing age. Also needed are information and health education strategies to raise awareness of the risks of malnutrition. Promotion of breastfeeding also remains a key intervention for preventing malnutrition.

217. In addition to malnutrition, environmental health conditions in rural and peri-urban areas continue to be an important unmet challenge. Indoor air pollution from open cook stoves is a major contributor to respiratory diseases among the rural poor. As noted in Chapter I, the Region as a whole is on track to meet the MDG target for drinking water, but 38 million people still lack access to improved water sources, while 117 million lack access to basic sanitation. Continued population growth and unplanned urbanization complicate efforts to reduce these numbers. Needed interventions include programs for monitoring of water quality, capacity building at the local level in potable water and solid waste management, promotion of clean water as a basic human right, and the dissemination of appropriate and acceptable technologies for waste disposal.

Emerging Challenges

218. Addressing the "unfinished agenda" in health is critical to overcoming inequities that have prevented millions of people in the Americas from contributing fully to their countries' development or sharing fully in its benefits. Yet new health and development challenges are also emerging that must be addressed to ensure a safe and healthy future for current and new generations.

219. The most pressing of these emerging challenges is the rise of chronic noncommunicable diseases, which only a generation ago were considered diseases of the rich. NCDs are now recognized as a major threat to both health and development in developing as well as in developed countries. The 2011 U.N. High-Level Meeting on Chronic Non-communicable Diseases put a spotlight on the problem, but much work remains to be done to ensure that governments follow up on their commitments in this area.

220. NCDs present enormous challenges for health systems, due to their chronic nature and the rapidly growing population group most at risk: older people. NCDs are also especially challenging due to the complexity and multiplicity of their risk factors and consequently the wide scope of action needed to address them. The silver lining in the NCD cloud is that these diseases are largely preventable through the modification of a handful of risk factors, chief among them tobacco, alcohol, poor diet, and physical inactivity. However, such prevention requires behavior change, which presents its own challenges.

221. PAHO/WHO and a growing number of partners are working to address NCDs through a life course approach, with interventions starting before conception, continuing through infancy and early childhood into adolescence and young adulthood, through middle age and into old age. Also critical to addressing NCDs are multisectoral strategies and a heath-in-all-policies approach.

222. For health systems, coping with NCDs will require continued strengthening of primary health care models, including integrated health services delivery networks, and a strong focus on health promotion and prevention to eliminate or reduce risk factors. This includes promotion of breastfeeding and nutrition education and counseling. Continued expansion of health protection systems is also critical, particularly to cover the growing numbers of older persons but also to reduce the costs of NCDs by promoting early detection through routine care and screening.

223. Population-wide interventions are known to be the most cost-effective interventions for NCDs. These include measures called for by the Framework Convention on Tobacco Control (FCTC), which all but one of the Region's countries have signed and most have ratified. The countries have made notable progress in areas such as tax and price increases on tobacco products, smoking bans in indoor public spaces, and packaging and warning labels. Fewer countries have implemented the treaty's recommendations on advertising and sponsorship. Continued implementation of FCTC provisions should be a top priority and will require countering (and when possible, exposing) efforts by the tobacco industry to undermine tobacco control.

224. PAHO's regional Plan of Action to Reduce the Harmful Use of Alcohol calls for measures similar to those in the FCTC as well as others to reduce consumption of alcohol, which is a leading risk factor not only for NCDs but for mental disorders, injuries, domestic and interpersonal violence, youth mortality, HIV, and STIs. Population-level interventions are also needed to reduce salt consumption (to prevent hypertension), reduce consumption of sugar-sweetened beverages, and encourage increased consumption of fruits and vegetables.

225. External causes also remain a significant contributor to mortality and disabilities in the Americas. More than 1 million people in the Region were victims of homicide over

the past decade, with males at eight times higher risk than females, and 15- to 24-year-olds at greater risk than other age groups. Another 1 million died from traffic injuries, in part because of continuing rapid urbanization without the necessary infrastructure and policies for prevention. Suicide rates are also high in the Americas, accounting for some 12% of all deaths from external causes. A public health approach is essential to reducing deaths and injuries from all these causes.

226. While the burden of chronic noncommunicable diseases has risen precipitously, infectious diseases have by no means disappeared from the epidemiological landscape of the Americas. The 2009 H1N1 influenza pandemic, while much milder than many had feared the next flu pandemic might be, suggested how difficult it would be for most health systems to cope with a more virulent novel influenza strain, much less some new disease as virulent and contagious as was SARS. Investments in countries' public health systems are an essential component of societal preparedness.

227. Continuing globalization and expanding international travel will only increase the likelihood of a future outbreak in one country becoming a threat to others. It will be critical for countries to continue strengthening their core capacities for epidemic alert and response, as they have been doing as part of PAHO-supported efforts to comply with the International Health Regulations (IHR).

228. While the number of older people is growing rapidly, the number of young people currently living in the Region is the highest in history. Protecting and promoting the health of children and youths must be a top priority to ensure they develop to their fullest potential, become and remain productive citizens, enjoy equal or higher quality of life than their parents, and avoid or delay illness and the need for long-term medical care.

229. The MDGs reflected the growing international consensus on the importance of health to development and human well-being. Health is likely to play a central role in the next generation of international development goals, the proposed Sustainable Development Goals (SDGs), as well. As was true with the MDGs, it will be critical for public health advocates to promote the new goals on countries' national agendas, to help identify the most effective and efficient policies and interventions, and to mobilize new and existing constituencies to hold governments accountable for reaching the goals.

230. It is also imperative that policymakers, lawmakers, planners, and others in positions of responsibility recognize that the decisions and the investments they make today will affect the health and well-being of future generations, just as the decisions and investments over the past century made possible the remarkable public health achievements we celebrate today.

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