PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

46th DIRECTING COUNCIL
57th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2005

Provisional Agenda Item 4.4

CD46/8 (Eng.)
30 August 2005
ORIGINAL: ENGLISH

MIDTERM ASSESSMENT OF THE IMPLEMENTATION
OF THE STRATEGIC PLAN 2003-2007 FOR THE PAN AMERICAN SANITARY
BUREAU

CONTENT

Executive Summary

1.	This document presents the Midterm Assessment of the Implementation of the *Strategic Plan for the Pan American Sanitary Bureau, 2003-2007* (CSP26/10; hereinafter "SP 03-07") to the 46th Directing Council. In keeping with the overall results-based approach that has characterized the organization's work and reporting to its governing bodies, the Secretariat[1] has been as rigorous as possible in assessing progress, using quantitative data wherever possible to support qualitative information.

2.	The Secretariat has assembled progress information for every objective contained in the SP 03-07 (including the Special Groups and Key Countries orientations, 46 technical cooperation objectives, and eight organizational development goals). While the nature of the information varies based on the technical area, timing and availability of reporting data, and other factors, the overall assessment presents what the Secretariat believes to be a comprehensive picture of the situation as of mid-2005.

3.	The orientations of Special Groups and Key Countries have been fully integrated into the programs and initiatives of the Secretariat, and progress has been achieved throughout the Secretariat's programs, as well as within the countries themselves.

4.	As per its mandate from Member States, the Secretariat has worked to achieve the SP 03-07 technical cooperation objectives while recognizing that virtually all of these reflect the impact of activities of various players in the health sector, not the Secretariat alone. The Secretariat's role in achieving these objectives has consisted mainly in: support for data generation, monitoring and analysis; dissemination of recommended policies and communications to address issues; and implementation of targeted programs and initiatives. With this in mind, this assessment has determined that 41% of the technical objectives are on track to be achieved by 2007, 41% are uncertain to be achieved, and 18% will probably not be achieved. These percentages reflect the ambitious nature of the objectives. Means for addressing those objectives that are not expected to be achieved are examined in the implications section of this document.

5.	The organizational development objectives, further elaborated in the *Managerial Strategy for the Work of the Pan American Sanitary Bureau in the Period 2003-2007* (CD 44/5; hereinafter the "Managerial Strategy") are being addressed on an ongoing basis. Progress has been significant, and will be reported on in detail in the working document *Update on the Process of Institutional Strengthening within the Pan American Sanitary Bureau* (CD46/15), and the information document, *Actions Taken in 2004-2005 to Strengthen the Pan American Sanitary Bureau* (CD46/INF/3, Rev. 1), which are also being submitted to the 46th Directing Council.

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[1]	In this document, the terms "Secretariat" and "Pan American Sanitary Bureau" (or "PASB") are used interchangeably.

6.   While performing this Assessment, the team responsible made several observations that may assist in the preparation of the next Strategic Plan for the period 2008-2012. These are presented in the final section of the document. It is hoped that, in addition to providing feedback on the Assessment itself, Member States will address these points in their comments as a part of the ongoing effort to improve the quality of the Secretariat's planning, monitoring and reporting efforts.

Introduction

7.   Resolution CSP26.R18 of the 26th Pan American Sanitary Conference adopted the SP 03-07 and requested the Director of Pan American Sanitary Bureau (PASB) to monitor and evaluate its implementation as appropriate.

8.   The purpose of this Assessment, conducted at the mid-point in the planning period, is to:

(a) Assess coherence among the SP 03-07 and the programs and initiatives implemented by PASB since the approval of the plan;

(b) Assess the extent to which the priorities of the SP 03-07 have been addressed, and evaluate progress toward the objectives set out in the SP 03-07 for organizational development and technical cooperation; and

(c) Analyze the implications of progress in implementing the SP 03-07 in terms of possible adjustments to the plan's objectives for the remainder of the planning cycle, as well as to future planning exercises.

9.   This document will hopefully not only provide useful (albeit interim) programmatic and organizational results information to the Directing Council, but also serve as a catalyst for debate and suggestions as to the appropriateness and relevance of the current SP 03-07 for the remaining 2005-2007 period that it covers. The Secretariat welcomes this discussion, both in terms of current issues and lessons learned from the current Strategic Plan that may inform the development of its successor.

10.   The SP 03-07 laid out the values, vision and mission of the Secretariat, examined the context in which it operates, and specified the following operational priorities:

• Focus on four special groups (later expanded to five – the full list is included here): the poor, indigenous populations, women, children and the elderly.

• Lead collaborative efforts in five key countries: Bolivia, Haiti, Honduras, Guyana, and Nicaragua.

- Focus efforts on eight areas of technical cooperation, including the achievement of specific objectives (detailed below in the section "Progress towards Technical Cooperation Objectives in the Priority Areas" and in Annex):

  (1) Prevention, Control, and Reduction of Communicable Disease,

  (2) Prevention and Control of Noncommunicable Diseases,

  (3) Promotion of Healthy Lifestyles and Social Environments,

  (4) Healthy Growth and Development,

  (5) Promotion of Safe Physical Environments,

  (6) Disaster Preparedness, Management and Response,

  (7) Ensuring Universal Access to Integrated, Equitable and Sustainable Health Systems, and

  (8) Promotion of Effective Health Input Into Social, Economic, Environment, and Development Policies.

- Improve operational capacity through organizational development as per six goals:

  (1) Communicate quality information in a timely manner to enhance process and impact of technical cooperation;

  (2) Generate and use strategic intelligence to anticipate and increase proactive responses to future challenges and to reap the benefit of opportunities;

  (3) Become a valued member of mainstream scientific and technological networks, harnessing knowledge to address regional health development;

  (4) Become a recognized leader in transnational and global issues that affect regional and national health;

  (5) Foster a creative, competent, and committed work force that is rated exceptional by its clients, and

  (6) Be a high-performance organization and set benchmarks for similar international health agencies.

11.   The United Nations Millennium Development Goals (MDGs) were considered in the SP 03-07; however, at the time the SP 03-07 was drafted, the MDGs and targets were still being finalized. Subsequent organizational activities have incorporated the MDGs as an integral part of PAHO's work.
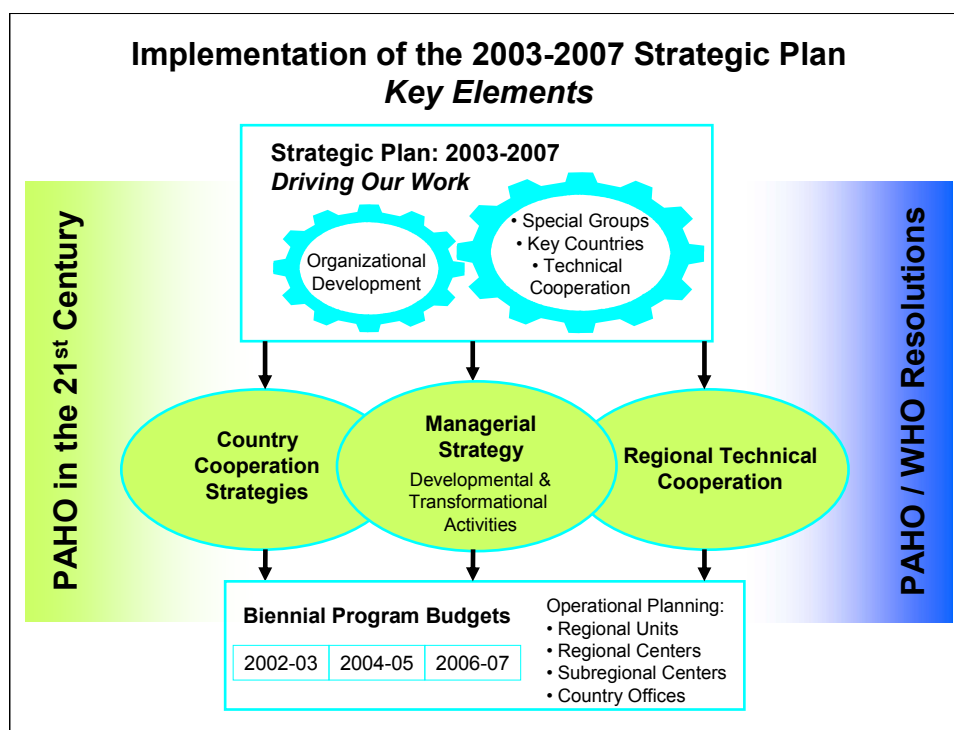
Midterm Assessment Methodology

12.   Given the time constraints and interim nature of this assessment, the methodology adopted was time-sensitive and high-level, while being as comprehensive as possible:

- A team was chosen from among Planning, Program Budget and Project Support (PPS) staff to conduct the assessment and prepare this document.

- Key objectives in the areas of technical cooperation and organizational development were identified in the Strategic Plan 2003-2007.

- For the technical cooperation objectives, PASB technical units were requested to provide information on progress against objectives. The responses are collated and presented in their entirety in the Annex, and summarized in the section "Progress towards Technical Cooperation Objectives in the Priority Areas" of this document.

- For organizational development objectives, the PPS team conducted an analysis of ongoing organizational initiatives and projects that 'operationalized' the objectives. The results of this analysis appear in the section "Progress towards Organizational Development Goals and Objectives" of this document.

- This document presents both progress towards specific objectives, as well as the organizational context and operational linkages to facilitate the understanding of how the SP 03-07 has been implemented, what progress has been achieved, and where adjustments are needed.

Background and Context: Linking Strategic Plan Objectives to Programs and Initiatives

13.   The goals and objectives described in the SP 03-07 are being implemented through the Biennial Program Budget (BPB) and a series of initiatives and operational plans and programs. This diagram depicts the interrelationships among these activities, which are described in greater detail in the text that follows:

Implementation of the 2003-2007 Strategic Plan
Key Elements

Strategic Plan: 2003-2007
Driving Our Work

Organizational Development

• Special Groups
• Key Countries
• Technical Cooperation

PAHO in the 21st Century

PAHO / WHO Resolutions

Country Cooperation Strategies

Managerial Strategy
Developmental & Transformational Activities

Regional Technical Cooperation

Biennial Program Budgets

2002-03	2004-05	2006-07

Operational Planning:
• Regional Units
• Regional Centers
• Subregional Centers
• Country Offices

Biennial Program Budget Exercises

14.   The Biennial Program Budget (BPB) is the Secretariat's main operational planning mechanism, and as such is the key document for implementing the objectives of the Strategic Plan, as well as other organizational priorities.

15.   The BPB for the period 2002-2003 initially supported the Strategic and Programmatic Orientations (the previous medium-term framework from 1999-2002). It was notably modified at the operational level at mid-biennium to begin implementation of the SP 03-07 and to reflect the organizational realignment of March 2003. The BPB for the period 2004-2005 and the proposal for 2006-2007 have fully integrated SP 03-07 objectives, as well as a number of other organizational priorities. A budget by Area of Work (AoW) was introduced organization-wide, PAHO AoWs were structured to strengthen alignment with WHO in order to facilitate resource coordination and to ensure consistency.

16.   In the 2004-2005 and proposed 06-07 BPBs, the five Special Groups are frequently explicit at the area of work level; the five Key Countries have been identified for priority attention in areas of work that are closely related to their national health priorities; and all of the objectives for the priority technical areas are identifiable in the area of work goals or objectives and/or among the expected results.

17.   In summary, the BPB content, format, and development process has been adjusted to better implement the SP 03-07 objectives, as well as other organizational objectives, including alignment with WHO's Areas of Work.

Managerial Strategy

18.   Resolution CSP26.R18, cited above, also requested that the Director "present an analysis of the existing organizational characteristics and those required for the implementation of the Plan."   In September 2003 the Secretariat presented the Managerial Strategy to the 44th Directing Council. The Managerial Strategy describes major organizational development components and objectives for the period 2003-2007, and thus is both an extension of and a tool for implementing the SP 03-07.

19.   The Managerial Strategy, which was endorsed by the Directing Council, took into consideration the organizational development goals of the Strategic Plan for the period 2003-2007, as well as data and information gathered from various analytic exercises on processes in the Secretariat.

20.   The following table illustrates the linkages between the organizational development goals from the SP 03-07, the Managerial Strategy, the Strategic Objectives for Organizational Change, and the Transformational Projects:

STRATEGIC PLAN 2003-2007 Organizational Development Goals	MANAGERIAL STRATEGY Corporate Objectives of Organizational Change (by end 2007)	5 Strategic Objectives for Organizational Change (by 2008)	11 Transformation Projects (started May/June 2005)
1. Communicate quality information in a timely manner to enhance process and impact of technical cooperation.	(c) PASB will be recognized as the Region's premier source of health information and there will be increased networking and sharing of knowledge inside the Organization and between the Organization and its environment. (d) Priorities will be addressed through innovative approaches to technical cooperation and strategic management of the Secretariat's resources.	iii. Become a learning, knowledge-based organization. v. Enhance management practices.	4. Information and Knowledge Management Strategy (IKM) implementation. 11. External communication.
2. Generate and use strategic intelligence to anticipate and increase proactive responses to future challenges and to reap the benefit of opportunities.	(d) Priorities will be addressed through innovative approaches to technical cooperation and strategic management of the Secretariat's resources.	iv. Foster innovation modalities of technical cooperation.	6. Regional programs.
3. Become a valued member of mainstream scientific and technological networks, harnessing knowledge to address regional health development.	(b) The Organization will be in the mainstream of health-related policy debate at all levels. (c) PASB will be recognized as the Region's premier source of health information and there will be increased networking and sharing of knowledge inside the Organization and between the Organization and its environment.	ii. Establish a regional forum iii. Become a learning, .knowledge-based organization.	3. Regional forum.
4. Become a recognized leader in transnational and global issues that affect regional and national health.	(a) The central focus of the Secretariat's work will be in and with countries, while achieving a closer relationship between the national, subregional, regional, and corporate planning processes.	i. Respond better to country needs.	1. Country focused cooperation. 2. CSU organization review.
5. Foster a creative, competent, and committed work force that is rated exceptional by its clients.	(d) Priorities will be addressed through innovative approaches to technical cooperation and strategic management of the Secretariat's resources.	iii. Become a learning, knowledge-based organization. v. Enhance management practices.	5. Leadership development and learning. 8. Human resources strategy. 10. Communication strategy for organizational mobilization.
6. Be a high-performance organization and set benchmarks for similar international health agencies.	(d) Priorities will be addressed through innovative approaches to technical cooperation and strategic management of the Secretariat's resources.	v. Enhance management practices.	7. Resource mobilization strategy. 9. Standards of accountability and transparency.

21.   The Secretariat has undertaken a series of initiatives and projects to effectively implement the organizational development goals set out in the SP 03-07. For the most part these efforts are ongoing, and have been reported on to the governing bodies at regular intervals through the Director's updates on institutional change. This Assessment summarizes these efforts, shows them as a cohesive whole and demonstrates how they address the objectives set out in the SP 03-07 and the subsequent Managerial Strategy. The section titled Progress towards Organizational Development Goals and Objectives provides this information.

22.   The process of organizational transformation is well under way, with planned phases being completed as scheduled (see Document CD46/15 *Update on the Process of Institutional Strengthening within the Pan American Sanitary Bureau*).

Progress towards Strategic Plan 2003-2007 Objectives

Special Groups

23.   In the SP 03-07, the Secretariat proposed to *"focus on low income and poor populations, ethnic and racial groups, especially indigenous people, women, and children."* During discussion by the Conference, the group "elderly" was added to this list.

24.   The Secretariat has made significant progress in directing programs and changing policies to assist these special population groups.

Poor:

25.   Prior to the inclusion of the poor as a Special Group in the SP 03-07, the 32nd Session of the Subcommittee on Planning and Programming in 1999, reviewed and endorsed PAHO's approach to this issue in Document SPP32/8 *Health and its Contribution to Poverty Alleviation*. The work in support of the attainment of the Development Goals of the Millennium Declaration would subsequently become an important framework for focusing on poor populations (see http://www.paho.org/english/gov/cd/CD45-08-e.pdf and the corresponding resolution http://www.paho.org/english/gov/cd/CD45.r3-e.pdf for further information). The SP 03-07 objective to focus on the poor has been articulated with the Secretariat's approach to support Member States' efforts to attain the health-related MDGs.

Studies and Policies

26.   PAHO conducted a series of studies based on household surveys in twelve countries, which were published in the Pan American Journal of Health in May 2002. Further studies on inequities in health care provision to the poor have been carried out in Brazil, Bolivia, Peru, Colombia and Nicaragua, and the results will be published later in 2005.

27.   PASB is in the process of elaborating a comprehensive institutional policy on health and poverty reduction for submission to the Governing Bodies in 2006. This policy will include an examination of the feasibility and usefulness of collecting disaggregated health data to demonstrate disparities based on economic status. It will also emphasize the definition of specific inputs from the different technical areas and Pan American Centers, as well as country offices, to poverty reduction initiatives undertaken by Member States.

Technical Cooperation

28.   Beginning in 2003, cooperation has been emphasized in the Key Countries (see the relevant section below), notably to determine which investments in the health sector will most benefit the poor. The Poverty Reduction Strategy Papers (PRSPs) have been the main planning tools for this effort – see the WHO paper on the relevance of PRSPs to the health sector for more information on this process: http://www.who.int/hdp/en/prspsig.pdf. Other, non-Key Countries are taking a similar approach, and the results should be evident by 2007.

29.   Country Cooperation Strategies include poverty-related objectives, again largely in the context of the MDGs and the link between poverty and poor health care.

Indigenous:

30.   Significant progress has been realized in the 24 countries in Latin America and the Caribbean (LAC) with indigenous populations.

31.   As of the end of 2002, 10 countries had units addressing indigenous issues in their Ministries of Health and 22 countries included information on indigenous peoples in their *Health in the Americas* report; the majority had little information on programs developed to identify and address indigenous needs.

32.   By 2004, based on information received from 20 out of 24 countries, the following milestones have been reached:

- 10 are developing information systems incorporating ethnicity and health.

- 19 have indigenous units in their Ministries of Health, and related national projects.

- 20 have indigenous-specific policies to address the needs of indigenous groups.

- 16 have national networks promoting indigenous issues.

- 6 have research programs in indigenous health issues.

33.   The achievements as of 2004 reflect progress in spite of obstacles, including the lack of continuity in policies with changes in government, and irregular funding at national level.

34.   In 2004 the PAHO Health of Indigenous Peoples Initiative became the Health of Indigenous Peoples Regional Program, and in 2005 PAHO established a full time regular funded position for indigenous health.

Women:

35.   In the last decade Member States have committed themselves to advance gender equity in health. The commitments on gender equity established at the International Conference on Population and Development (1994), the Fourth World Conference on Women (1995) and the World Summit on Social Development (1995) were reaffirmed in the United Nations Millennium Declaration adopted by the UN in 2000. PAHO has promoted policies and programs at local, national, subregional and regional level to fulfill those commitments through strategies on research, data collection, communication, policy development, models of intervention, norms and protocols, as well as human resources training.

Research, data collection, and communication

36.   PAHO has integrated a gender perspective in the collection and dissemination of health statistics at regional and national levels in order to promote the formulation of evidence-based programs, and the monitoring of progress toward gender equity in health. This process has included the collaboration of different technical areas, as well as coordination with other UN agencies. At the national level – with the participation of various government sectors, civil society, academia, and other entities – working groups charged with institutionalizing these processes have been established in six countries.

37.   The information obtained through research initiatives has been used to develop policies and interventions around critical issues for gender equality in health. In order to support the analysis of gender inequities in health, inter-sectoral national networks and

working groups were trained and are producing and analyzing gender sensitive statistical information in seven countries. The tasks of these networks have been facilitated by PAHO guidelines on "Basic Indicators for Analyzing Gender Equity in Health" that were published and disseminated throughout the Region. A regional profile "Gender Equity and Health in the Americas, Elements for a Situational Background" was published and widely disseminated throughout the Region. It includes three booklets:

(a)   Socio-economic inequalities between women and men in Latin America,

(b)   Gender equality in health in the Americas: legal framework, and

(c)   Gender equity and health in the Americas at the beginning of XXI Century.

38.   In addition, the first biennial regional statistical brochure on "Gender, health, and development in the Americas 2003" was published and disseminated throughout the Region.

39.   Gender- and health-related resources, publications, courses, and activities have been disseminated through the "GenSalud" Listserver that reaches over 1000 subscribers globally. Over 300 participants in 22 countries from ministries of health, women's health organizations, academia, NGOs, and international organizations have participated in the two virtual forums.

40.   In the area of gender-based violence (GBV), the institutional response to sexual violence in Central America was analyzed. Also, a research protocol on violence against women during pregnancy was prepared and funds are being sought for its execution.

Policy Setting

41.   Significant progress has been achieved in the construction and testing of a participatory model for mainstreaming gender equity in health policies. The lessons learned at the regional level and in a model in Chile (see below) are beginning to be applied in Central America. These lessons underscore: (a) the need to create evidence to support advocacy and capacity building processes; (b) the crucial importance of strengthening networks with the active participation of stakeholders (government and civil society) to advance changes and foster ownership; and (c) the need to institutionalize participatory policy development and social auditing mechanisms. In support of the policy design process conceptual frameworks were developed to analyze gender equity in health sector reform (HSR).

42.   In order to facilitate the monitoring and evaluation process, a guide to monitor and analyze gender equity in health policy was developed and validated in six countries.

A model of accountability mechanisms with social participation was developed in Chile, the Observatory of Gender Equity in Health Policy. The Observatory is based in the University of Chile, includes participants from research and civil society organizations, and is funded by the Ford Foundation.

43.   To promote the sustainability of gender equity programs, forums for policy dialogue on gender equity in health sector reform have been developed between government, civil society, academia, and scientific associations in Chile and Central America. This strategy also included a regional training program on health sector reform and sexual and reproductive health in collaboration with UNFPA and the World Bank. Two major regional courses were facilitated and national teams from seven countries participated in each course.

Models of Intervention

44.   The 'operationalization' of gender equity requires the development of models that can be used as programmatic frameworks. PAHO has expanded integrated and comprehensive models for gender-based violence developed in ten Latin American countries during the last decade to new localities and countries. The related framework on policies and legislation has widened the regional and national agendas on GBV, and has promoted new legal and programmatic instruments for improving the social response to GBV, such as:

- Proposals for monitoring GBV policies in Costa Rica,
- Promoting municipal policies and protection measures for GBV victims in the Dominican Republic,
- Reforming penal code in Honduras, and
- Creating a comprehensive proposal on domestic violence law in Brazil.

45.   The WHO's protocol for medico-legal care of sexual violence was validated in Nicaragua, and will be validated in El Salvador, Guatemala, and Honduras. The first virtual course on domestic and sexual violence in LAC was validated with participants from ministries of health, women's affairs offices, NGOs, universities and community groups of 17 countries. The course will be replicated in Chile (2005) for providers of the primary care centers at national level.

46.   A new intervention model for reproductive health with male participation has been implemented in Central America with the support of GTZ and PAHO.

Gender mainstreaming in PAHO

47.   In 2004 the Secretariat developed a gender policy draft and a strategic approach to mainstream gender issues within the organization and the Member States (see Document CD46/12 *Proposed PAHO Gender Policy* for further information). Its goal is to integrate gender equity and equality concerns into all PAHO programs, projects and policies. This goal will be met by activities concentrated in 3 areas:

(a)   Governing Bodies approval of a PAHO gender equality policy,

(b)   Participatory development of a gender equality plan of action, and

(c)   Knowledge generation, tool development and capacity building on gender and health among HQ staff, country offices, regional centers and country counterparts.

Children:

48.   The international focus on children drives PAHO's work to improve children's health. The following are key UN-wide mandates:

- MDG 4 – Reduce child mortality – Target: reduce the under-five mortality rate by two-thirds (annual reduction of 4.3%); and

- Convention on the Rights of the Child, particularly Article 24, with regards to ensure children and adolescents the enjoyment of the highest attainable quality of life and the right to facilities for the treatment of illness and rehabilitation of health.

49.   WHO/PAHO have adopted these into health-specific mandates:

- In 1995's resolution WHA48.12 the World Health Assembly integrated management of childhood illness in a cost-effective health sector and community-based strategy that supports and complements other global initiatives to promote child survival, growth and development.

- In 2002, the Pan American Sanitary Conference's Resolution CSP26.R10 supported effective implementation of the Integrated Management of Childhood Illness (IMCI) to improve the health status of children.

- PAHO's 44th Directing Council (June 2003) adopted IMCI as an instrument for improvement of child health care; to empower families and communities through the promotion of the key family practices; and for neonatal care.

Research and data collection

- 23 baseline surveys have been conducted to provide baseline information that will facilitate measurement of behavior changes after community IMCI interventions.

- Cost analysis and other economic studies and surveys are being conducted.

Policy setting

- PAHO has disseminated information regarding low-cost, effective interventions to avoid/prevent at least two thirds of neonatal deaths and to improve the health of children – see the 2003 *Lancet* series on child survival, and 2005 *Lancet* series on neonatal health. The latter was launched in Spanish in June of that year.

- Most recently, the Minister of Health of Peru signed an official declaration to institutionalize the IMCI strategy in that country's health policies. In addition, a Declaration between the Ministry of Health, PAHO and the Peruvian Society of Pediatrics was signed to promote the IMCI strategy and the neonatal component in country plans and activities.

- Integrated strategies for child health (i.e., IMCI) have been incorporated into basic child health policies and programs in most countries in the region.

Primary health care for child health

- Two major Partnerships (Catholic Medical Mission Board-CMMB, Bristol-Meyer Squibb Foundation-BMSF; and American Red Cross and United Nations Foundation) with the Pan American Health Organization are working in twelve countries (including the five PAHO Key Countries). These projects aim to implement and scale-up the three components of the IMCI strategy (especially the family and community component), provide essential drugs, and promote prevention of mother-to-child transmission of HIV/AIDS. Indigenous children are specifically targeted for services. Extensive technical cooperation at the regional and country level is prioritized.

    o The CMMB/BMSF Partnership is working with the Catholic health-care network and Ministries of Health in 36 dioceses, 292 community sites, and 468 health facilities. The total number of Partnership beneficiaries is 6,257,667, including 938,649 children less than five years of age. As of July 2005, 109,532 children less than five years of age were seen at health facilities for an IMCI consultation in the Partnership countries.

o   The key ARC/UNF Partnership element is supporting community IMCI activities implemented by Red Cross Operating National Societies (ONSs) and ministries of health (MOH) with support from community leaders, NGOs, families, and other local actors and institutions. Over 300 community-based organizations and institutions, international agencies, and NGOs, are collaborating in the implementation of community projects and expansion plans.

- Ministries of health and ONSs have increased capacity to provide quality, sustainable community services to children in vulnerable communities. Some notable examples:

o   The Peruvian ONS participates regularly in the National Coalition to Fight against Poverty (*Mesas de Concertación de Lucha contra la Pobreza*) and the National Health Promotion Coalition (M*esa Nacional de Promoción de la Salud*).

o   The Bolivian ONS has assumed a leadership role in the creation of a *National IMCI Coalition,* participating regularly in these meetings and playing a critical role in setting the child health agenda in the country. Also in Bolivia, the mayor of the El Alto city, serving almost one million people, is requesting funds from the Belgian Cooperation to implement community IMCI activities using the Partnership methodology.

o   In Nicaragua, the *Movimiento Comunal Nicaraguense*, a renowned grassroots Nicaraguan organization, is adopting the community IMCI methodology.

o   In Honduras, local municipalities are organizing themselves under the Regional Environmental Council (*Consejo Regional Ambiental*) and forming *Mancomunidad de Municipios*, working with the community IMCI methodology.

- Extensive technical guidelines, documents, and materials have been developed and distributed to Member States.

Elderly:

50.   In April 2002 the Second World Assembly on Aging met in Madrid and produced the U.N. International Plan of Action on Aging. The 2002 Pan American Sanitary Conference endorsed this Plan in Resolution CSP26.R20 *Health and Aging.* In November 2003, a regional conference was held to elaborate a regional strategy to

implement the Madrid Action Plan. All of this set the stage for PAHO's focus on the elderly, which had three key elements during the 2003-2005 period: research and data collection, policy setting, and improving primary health care (PHC) for the elderly.

Research and data collection

- As of 2004, the Secretariat completed situation analyses for all countries in Central America, most of South America, and about half in the Caribbean. Work is ongoing to complete analyses for all countries.

- As of 2004, the database of the Survey on Aging, Health and Wellbeing (better known in the Region as SABE) and the SABE survey methodology was made available for researchers in the region.

- The Network for Research on Aging in Latin America and the Caribbean (REALCE, www.realce.org) was established with assistance form PAHO and the U.S. National Institute on Aging.

Policy setting

- Based on the situation analyses and other inputs, the Secretariat has disseminated its findings to stimulate research and databases within countries. Included in this effort is a toolkit for conducting surveys and assessments as a means to inform policy regarding the elderly. As Key Countries, Bolivia, Honduras and Nicaragua received added technical cooperation to assist in this effort .

- By 2004 over 90% of countries in the region had a MoH focal point for health of the elderly. Still much work remains to be done, since many countries lack sufficient funding for elderly programs.

- TCC in this area has been facilitated between Canada and Mexico in 2002, and Canada and the Southern Cone countries in 2004.

Primary health care for the elderly

- The Secretariat supported the establishment of the Latin American. Academy of Medicine of Older Adults (ALMA), a network that promotes public health and geriatric forum; regional specialized courses for teachers of geriatrics and work with primary health care providers to improve care of the elderly.

- 12 countries have participated in ALMA and over six countries have been assisted to establish geriatric public health training programs.

- A demonstration project for those teaching geriatrics in Primary Health Care Centers has been implemented in El Salvador, and will be replicated this year in Peru.

- A major challenge is to prove that appropriate primary health care for older adults can be provided in poorer countries, and that good practice is often less expensive than uninformed practice.

Key Countries

51.   The PASB planned to *"lead strategic collaborative efforts among countries and partners and maximize wider development initiatives like the PRSPs to accelerate the health improvements in Bolivia, Haiti, Honduras, Guyana, and Nicaragua."*

52.   Four of the Key Countries (KCs) were singled out for special attention in the SP 03-07 due to their status as "Highly Indebted Poor Countries (HIPC)," where the rate of debt payment leaves little national income for increasing expenditure in the development of the social sectors. In the case of Haiti, while not an HIPC, its maternal and infant mortality rates, two of the most sensitive health development indicators, are the highest in the Region and among the highest in the world." Haiti is also the only Least Developed Country (LDC) in the Region.

53.   The Director established a KCs Working Group in 2003, which identified the key elements of the KCs Strategy:

- Redefinition of the nature of TC through development of a strategic agenda;

- Harmonization of TC with the efforts of other development agencies and partners;

- Integration of the redefined TC into PAHO's managerial processes; and

- Appropriate reprofiling of PAHO/WHO's country presence.

54.   The main vehicle for implementing these elements on a country-by-country basis is the Country Cooperation Strategy (CCS), which applies the priorities in the Strategic Plan to national health policies, taking into account PAHO/WHO's strategic role in a given country. To date four KCs have completed CCSs, with Haiti's Interim Cooperation Framework substituting the CCS on a temporary basis. These help focus the efforts at all levels of PAHO on the highest priorities in the KCs.

55.   Resource mobilization was also identified as a critical activity for KCs:

- Resources were mobilized for the KCs from the WHO Department of Country Focus (CCO) to support the development of CCSs, placement of the Program Officers (only in KCs), and enhanced connectivity in Guyana and Haiti;

- The placement of "3 by 5"[2] technical advisors in Guyana and Haiti;

- Countries were assisted with proposals to the Global Fund for HIV/AIDS, TB and Malaria in Guyana and Haiti; and

- Support was obtained from the European Commission/WHO Partnership, for health in development, making pregnancy safer, epidemic alert and response, and supporting country cooperation in Guyana and Haiti.

56.   The KCs' CCSs (or in Haiti's case the Interim Cooperation Framework) have resulted in enhanced partnerships and increased resources going to the KCs, above and beyond their normal allocation under the Regional Program Budget Policy (see Document CE136/INF/1).

Future Challenges

57.   The Secretariat has incorporated the Key Country orientation in its operations. However, there are several challenges, including:

- Issues of governance and security in some of the countries which challenge the capacity for planning and achieving sustainable results from TC programs.

- Continued mobilization of resources to support the implementation of the CCS and other mechanisms to provide enhanced TC to the Key Countries is difficult. For example, the Guyana Country Office faces the prospect of losing key human resources because of the short-term nature of the current extrabudgetary resource commitments – mobilization of resources to support their renewal will be critical.

- Problems ensuring adequate staffing in the KCs.

Progress towards Technical Cooperation Objectives in the Priority Areas

58.   Many of the technical cooperation objectives set out in the Plan are at the macro-level and measure the impact of efforts of multiple organizations working in the health field in addition to the Secretariat, including but not limited to national ministries of health, the multilateral lending institutions, civil society and private sector entities. The factors that lead to shifts in macro-level health indicators can be difficult to assess and

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[2] "3 by 5" is the global target to provide 3 million people living with HIV/AIDS in low- and middle-income countries with antiretroviral treatment by 2005.

often require many years of coordinated efforts. Nonetheless, the Pan American Sanitary Conference approved these objectives for the 2003-2007 period as ambitious goals toward which the Secretariat's own efforts should contribute.

59.	There also exists a major complicating factor in assessing progress towards the objectives: the lack of data availability, even for baselines. Many of the objectives implicitly or explicitly suggest indicators for which there is no or partial data available, or the data collection lags by so many years that it is not useful for measuring short-term progress.

60.	Even with the limitations noted above, it is possible to assess that of the 46 technical cooperation objectives included in the SP 03-07, 41% (19 objectives) have already been achieved or are on target to be achieved by 2007. A further 41% (19 objectives) may or may not be achieved, and 18% (8 objectives) are unlikely to be achieved due to a variety of factors, including the lack of data to measure achievements.

61.	The narrative section that follows is a summary of the detailed information contained in the Annex of this document. The Annex consists of a matrix showing achievements by Priority Area objectives. Each objective is classified in a "stoplight" system:

- "Green" objectives have been met or on track to be met by the end of 2007 (the end of the planning period).

- "Yellow" objectives are uncertain to be met (this category includes objectives for which data is unavailable, but where an alternative measurement has been proposed).

- "Red" objectives are unlikely to be met (this includes objectives were data is unavailable and no alternative indicator has been proposed).

62.	While the quality and reliability of data varies, the Secretariat believes the overall assessment of progress to be accurate.

Priority Area 1: Prevention, Control, and Reduction of Communicable Disease

63.	Overall, progress thus far in this Area is mixed.

Green

64.	The following objectives will likely be met or exceeded:

- *Reduce morbidity due to TB, to malaria, and to dengue fever.*

- *Reduce mortality and morbidity* due to childhood diseases (including diarrheal and respiratory infections) among children under 5 years of age in all countries by 10% of the 2002 level.* (*Note: data on morbidity is not universally available; however, data on mortality indicates that the objective will be reached by 2007.)

- *Extend the number of FMD-free countries and/or areas and reduce morbidity and mortality from common zoonotic diseases.*

Yellow

65.   The objective *"eliminate measles and at least two other selected vaccine-preventable or targeted "eliminatable" diseases"* will likely not be met in its entirety by the end of 2007. The incidence of indigenous measles has indeed been reduced to zero cases as of 2004. However, for the two other diseases PAHO has focused on, rubella and congenital rubella syndrome (CRS), the goal of elimination has had to be revised to 2010. Accordingly, a revised objective is proposed (please note all proposed revisions to objectives are contained in one table in the section "Progress towards Organizational Development Goals and Objectives" of this Assessment).

66.   The objective *"In all countries, decrease the incidence of new AIDS cases and of at least one other STI and* reduce *mother-to-child transmission of HIV"* has had mixed results so far. The number of reported AIDS cases from 2002 to 2003 has gone down (2004 figures are as yet incomplete), however UNAIDS estimates that the incidence of new HIV/AIDS cases has risen. Data regarding mother-to-child transmission is not complete or systematic enough to judge progress. The other STIs are gonococcal infections and syphilis, for which progress has been satisfactory. A revised objective is proposed below.

67.   Progress against the objective *"All national systems monitoring key diseases, anti-microbial resistance, and food- and water-borne disease outbreaks, and the information is shared in real time"* is mixed. Monitoring systems exist in virtually all countries for the principle diseases. The quality of these systems is not, however, uniform, either in terms of coverage or accuracy. Much work remains to be done, especially in terms of information being available "real time" as specified in the objective.

Red

68.   The objective *"Ensure that all transfused blood meets the minimum standards"* will probably not be met. As noted in the Annex, difficulty was encountered in

monitoring compliance with minimum standards for all transfused blood in all countries. Nonetheless, based on our best estimates, as yet only 89% of transfused blood meets minimum standards where such information is available (information for several countries is not available). At the same time, the strategic goal is still valid, and PASB will consider it in the next iteration of the Strategic Plan.

Priority Area 2: Prevention and Control of Non-communicable Diseases

69.   Overall progress is mixed, and some objectives in this Area may not be reached by 2007.

Green

70.   This objective is on track to be met or exceeded:

- *Increase surveillance, at national and regional levels, of NCDs, risk factors and injuries.*

Yellow

71.   Given that the objective *"In all countries, integrated prevention of NCDs established through application of community-based initiative to reduce risk factors (CARMEN)"* requires 100% of countries to participate, it is uncertain whether the objective will be reached. Nonetheless, significant progress has been made: as of 2004, 20 countries/territories (up from five in 2002) are members of the CARMEN Network, and thus are implementing integrated NCD prevention and control actions.

72.   PAHO is addressing the objective *"Improve quality of chronic care in at least five countries"* through projects in several countries, however none of these had 2002 baseline data against which to measure progress for this somewhat imprecise goal.

73.   Data is not yet available in all countries for 2004 for the objective *"In 50% of the countries reduce mortality due to motor vehicle accidents by 20%."* However, based on initial data, the Secretariat has proposed revising the objective.

74.   Data is not available in all countries for 2004 for the objective *"Increase reporting of domestic violence by 200%."* The Secretariat has proposed an alternative objective, against which progress is good.

Red

75.   It is at this time impossible to measure progress against the objective *"In all countries, at least 60% of women between the ages of 35 and 59 would have been screened and treated for cervical cancer"*.   The specific data needed to determine progress is not yet available on a region-wide basis. A revised objective is proposed.

Priority Area 3: Promotion of Healthy Lifestyles and Social Environments

76.   With some exceptions, *the* objectives in this Area are likely to be reached.

Green

77.   These objectives are on track to be met or exceeded:

- *Increase by 30% the number of countries that have undertaken at least two of the following: creating smoke-free spaces, eliminating advertising of tobacco and increasing the taxes on tobacco.*

- *Mental health systems reformed in twelve more countries to protect the human rights of the mentally ill and to increase provision of community-based, primary mental health care.*

- *Increase the number of countries in which all commercial flour is fortified with bioavailable iron.*

- *In the 11 high-risk countries, increase the coverage of at least three doses of Vitamin A supplementation to at least 50% of children less than 3 years.*

- *Increase by 30% the number of countries undertaking surveillance to identify trends in behavior and social conditions that influence lifestyles.*

Yellow

78.   In the objective *"Increase by 30% the number of countries with policies and incentives for the reduction in consumption of alcohol and in substance use"* defining and monitoring what constitutes "policies and incentives" is a challenge. For this reason the Secretariat has focused on PAHO-specific achievements in this area, which have made significant progress in various countries (as with other objectives, please see the matrix in the Annex for details).

79.   For the objective *"In 80% of the countries, increase the availability of life skills education programs to at least 50% of* secondary *schools"* PAHO programs are still at the proposal level – it is too early to measure significant progress.

80.   In 2002, 15 countries had physical education programs, although it is not known if they were mandatory. Thus, measurement of progress against the objective *"Increase by 25% the number of schools at the primary and at the secondary levels in which physical education is mandatory throughout the school life"* is imprecise. Nonetheless, the regional Health-Promoting Schools (HPS) initiative has made good progress in this area, and a survey in 2006 will provide more concrete data. The HPS regional meeting held in Puerto Rico in July 2004 with participants from 26 countries was a significant milestone in establishing strategies and plans for the HPS initiative.

Red - none

Priority Area 4: Healthy Growth and Development

81.   It is unknown if most of the objectives in this Area will be achieved by 2007 due to insufficient data to measure progress.

Green - none

Yellow

82.   Maternal mortality data is generally two to four years old before it is reported. Thus progress against the objective *"Reduce the maternal mortality to no more than 100 per 100,000 live births or 20% of the 2000 level"* is difficult to determine. Surveillance systems have been strengthened in the Region, but timely reporting is still a challenge.

83.   The objective *"Increase the percentage of pregnant women seeking care in the first trimester by 30% and the deliveries by skilled attendants to 90%"* presents measurement challenges, including the disparity of data collection among the rich vs. poor and urban vs. rural populations, and the lack of region-wide reporting on those "seeking care". The Secretariat has proposed alternative indicators, against which progress is incremental but measurable:

- Proportion of pregnant women attended by trained *personnel* during pregnancy, and

- % of deliveries *attended* by skilled personnel.

84.   There is insufficient data to measure results for the objective *"Reduce perinatal mortality to 10% of the 2002 level."* The neonatal mortality rate is proposed as a substitute indicator, since it is available for 2002, and is proposed to be included in the PAHO core database beginning in 2005.

85.   For the objective *"Reduce the adolescent fertility rate (15-19 years of age) to 20% of the 2002 level"* the data available indicates a 2.5% reduction from 2002 to 2004. As of 2004, it is uncertain if this objective will be achieved.

Red

86.   Data is not available for the objective *"Increase the number of countries carrying out developmental screening in preschool-aged children by 25%."* It is not expected that this will change before the end of the planning period for 2007, therefore it is recommended to drop the objective.

Priority Area 5: Promotion of Safe Physical Environments

87.   The results thus far in this Area are mixed, and it is unlikely three of the objectives will be reached.

Green

88.   These objectives are on track to be met by 2007

• *At least 15* countries *will have effective implementation of sanitary surveillance of pesticides and have made improvements in the operational regulations for the importation and use of pesticides.*

• *Increase by 50% the number of countries undertaking risk assessment of environmental conditions of workers on a routine basis and in each country, increase by 30% the number of registered workplaces with programs for the promotion and protection of workers' health.*

Yellow

89.   For the objective *"Towards* the *United Nations Millennium Development Goals and Vision 21 of Water for People, reduce by 25% the gaps in universal coverage and quality of potable water and in sanitation services identified in the PAHO/WHO/UNICEF Regional Evaluation 2000"* data is inconsistent between survey years, and is generally at least two years old. Nonetheless, based on U.N. Joint Monitoring Program (JMP) definitions of improved water and sanitation, on average LAC countries are on track to

achieving gap reduction in water access but are not fulfilling their objective to reduce the gap in access to sanitation.

Red

90.   With respect to the objective *"All countries will have established national policies, and local plans for the capitals and medium-sized cities* [200,000 to 500,000 population] *for the effective management of solid waste"* progress is measurable (10 countries have national policies, while 25 have local/city policies).   The Secretariat considers the objective to be unreachable, and suggests revising the objective.

91.   The objective *"All countries-at-risk will have established programs for improving outdoor air quality in urban areas prone to air pollution, and/or indoor air quality in poor housing affected by the improper home use of fuel for cooking, heating, and cottage industries"* again seeks 100% compliance.   As of 2004, four countries could be considered to have "established programs" meeting the criteria of this objective; it is highly unlikely that by 2007 100% of countries will have done so, and therefore a revised objective is proposed.

92.   Towards the objective *"In all countries, integrated food safety programs ensure as a minimum that all major commercial establishments practice hazard analysis critical control point (HACCP) or other modern food safety approaches to handling of food"* as of 2004, five countries had integrated food safety programs and 15 had HACCP systems. Due to a lack of prioritization and political will on the part of countries to establish integrated food safety programs, it is highly unlikely the goal of all countries will be met by 2007, thus a revised objective is proposed.

Priority Area 6: Disaster Preparedness, Management and Response

93.   Progress towards the four objectives in this Area has been mixed.

Green

94.   The objective *"Increase the national and* intersectoral *capacity for preparedness for and response to natural and manmade disasters"* is on track to be achieved by 2007.

Yellow

95.   As with many of the objectives specifying 100% compliance, it is uncertain whether the objective *"Building codes and other mitigation features for construction of new health and utilities infrastructure* operational *in all at-risk countries"* will be

reached. While significant progress has been made, and the issue is a priority for a number of countries, data collection is a challenge and concrete steps that will be taken by national governments are as yet uncertain.

96.   PAHO has played an active role in reaching the objective *"In all disaster situations, human, technological, and financial resources mobilized and coordinated at the national and regional levels within 24 hours"* and at the regional level, progress is good However, due to 100% compliance specified at the national level, it is uncertain whether this objective will be reached by 2007. It should be noted that this objective is consistent with the Hyogo Declaration from the World Conference on Disaster Reduction, held in Kobe, Hyogo, Japan in January 2005.

Red

97.   Due to competing priorities in countries where terrorism is perceived as a low risk and to a lack of donor funding, it is unlikely this objective will be achieved: *"In all countries, plans and programs to address biological, chemical and radiological (BCR) terrorism incorporated into national disaster plans."* Consequently, the objective needs to be revised. Work is ongoing in this area: some countries have conducted simulation and training activities, and PAHO has provided relevant information and support to MoHs.

Priority Area 7: Ensuring Universal Access To Integrated, Equitable and Sustainable Health Systems

Green

98.   Four out of the five objectives for this Area are well on track to be achieved by the end of 2007:

- *In all countries, the reform of the health sector is reoriented to strengthen the steering role of health authorities, and the essential public health functions.*

- *New manpower management approaches contribute to increased coverage and/or effectiveness and /or efficiency of the health services at national and institutional levels.*

- *More effective technology management and evaluation in one third of the countries; and increased access of the poor to selected services through the use of telemedicine programs in at least half of these.*

- *Increase connectivity among information systems that support health management and planning at local, national, and subregional levels.*

Yellow - None

Red

99.   The objective *"In all countries, social protection in health extended to the informal labor sector"* is unlikely to be achieved. As of 2004 eight countries had performed studies of the issue, but action in all of these countries, much less in others in the Region, is unlikely in the near future. A revised objective is proposed below.

Priority Area 8: Promotion of Effective Health Input Into Social, Economic, Environment, and Development Policies

100.   Where indicator data is available, the objectives in this Area are on track for 2007; however, there exist some significant data gaps.

Green

101.   The following objectives are on target to be achieved:

- *Increase the number of countries able to demonstrate inclusion of health priorities in sustainable human development plans and/or in the negotiation and implementation of trade and integration agreements at regional, subregional, and national levels.*

- *Double the number of countries with effective legislation for effective control of selected health risks and equitable safeguard of health as a human right.*

- *All countries of the Region utilize analysis of national health expenditures and other key financial measures in formulation, monitoring and evaluation of health policies and plans.*

Yellow

102.   The availability of gender-disaggregated health data has improved greatly in the past decade. PAHO has several ongoing initiatives to facilitate the collection of disaggregated health data, and publications to disseminate such data. This progress notwithstanding, data to assess progress against these objectives is lacking for gender and ethnicity:

- *Increase availability of information on the impact of policies adopted by the health sector and other development sectors on health inequities related to poverty, gender, and ethnicity.*

- *At least half of the countries report routinely on surveillance of inequities in health, as well as in access to and financing of health care initiatives related to poverty, gender, and ethnicity at national and sub-national levels.*

103. The poverty-focused parts of the objectives are being largely addressed by the PRSPs and related data-collection efforts. Revised objectives are proposed, in which the poverty section remains the same, but the gender and ethnicity sections focus on information collection rather than impact.

Red - None

Progress towards Organizational Development Goals and Objectives

104. The Secretariat has undertaken a series of developmental actions and initiated transformational projects to effectively implement the organizational development goals set out in the SP 03-07. Progress to date towards individual organizational development goals has been achieved through the developmental actions that began in 2003 with the new administration. These actions are reported below. The transformational projects are in their initial stage and will be implemented from 2005-2007. The relationship between the SP 03-07organizational goals and the transformational projects was summarized in the chart in paragraph 13.

105. An additional resource that may deepen understanding of the various recommendations and initiatives contributing to PAHO's ongoing organizational development is the "Comparative Matrix of Recommendations from PAHO Processes" (http://www.paho.org/english/gov/ce/matrix-e.pdf), made available by the Executive Committee Chair shortly after that Committee's meeting in June 2005. The matrix clarifies the complementarity of the following processes, which share the common goal of institutional strengthening:

- PAHO in *the* 21st Century,

- *Recommendations* on the External Auditor's Special Report, 2004,

- Report on the Activities of the Internal Oversight Services, and

- Institutional Change within the Pan American Sanitary Bureau.

106. Unlike the technical cooperative objectives, attainment of which (or failure to do so) will be the result of inputs from various actors, the organizational development goals and objectives are the sole responsibility of the Secretariat. The achievements listed

under each goal are not meant to be comprehensive, but rather summaries and examples of key developmental activities to date.

Goal 1: *Communicate quality information in a timely manner to enhance process and impact of technical cooperation.*

Objectives:

- *Customized and timely access to information and knowledge meets the needs of staff and key stakeholders.*

- *Communication strategies incorporated to support execution of technical cooperation and policy level decision-making.*

- *Public health information and information about the Secretariat targeted to a wider range of publics.*

Progress

107.   The organizational Area of Information and Knowledge Management (IKM) was established in 2003 and charged with improving the organizational environment where information, knowledge sharing, and collaborative work are recognized as key functions of PAHO's technical cooperation activities.

108.   In 2004, after a detailed analysis of the situation a strategy was approved for information and knowledge sharing in the Organization. The focus is on enhancing the organization's role in the provision of information and knowledge relevant to public health development needs at national, regional, and global levels. The IKM strategy predated WHO's Global Level Strategy and is aligned to it. It also seeks to contribute to the Country Focus Initiative (CFI) and to the Organization's support for achievement of the MDGs, and monitoring such achievement. Some key accomplishments include:

- Establishment of Knowledge Management (KM) Development Working Groups to address issues related to policies, standards, and procedures.

- Detailing of organization-wide implementation plan, leveraging the existing infrastructure, and recruiting and training the Area staff.

- Development of a training program on KM methodologies, processes, and tools for PAHO staff.

- Use of Communities of Practice that explicitly recognize the importance of the less formal knowledge sharing that occurs between peers, and within small groups.

- Proposal of IT/IKM governance for policies, standards and services.

- Structured corporate knowledge sharing in the area of staff mission reports and consultant reports.

109.   Information technology (IT) based internal connectivity and knowledge sharing has been improved through:

- Increased Information Communication Technology (ICT) support to countries and centers (including six ICT assessments at country level, and installation of broadband Internet connections in the remaining six country offices that did not already have them.

- Establishment of a web casting facility.

- Upgrading of the AMPES system to facilitate the development of one program budget and improve program and financial management through information sharing.

- Automation of PAHO-wide workflow processes to improve access to management information and reduce transaction time.

110.   PAHO has had a pivotal role in informing the public – and the Secretariat itself – about key health issues and concern, not only in the Western Hemisphere but around the world. Examples of important health issues information that found wide echo throughout the Americas and beyond included the following:

- In the wake of the December 2004 Tsunami PAHO reports made clear that, contrary to popular belief, cadavers do not lead to catastrophic outbreaks of diseases nor cause epidemics. These PAHO reports were picked and reproduced by literarily hundreds of media outlets throughout the world.

- A PAHO report helped put into perspective the reports of a confirmed case of mad cow disease in Canada by making clear that it was isolated case and did not represent a threat to the food chain.

- During the crisis in Haiti in February 2004, PAHO reported that health conditions in Haiti were becoming increasingly difficult, especially for the poorest people in the country. PAHO officials on the scene received a positive response to their request that all factions to respect the neutrality of hospitals and health centers.

- PAHO has also helped to orient public opinion in areas pertaining to obesity, HIV/AIDS, violence, and the health-related MDGs.

Goal 2: *Generate and use strategic intelligence to anticipate and increase proactive responses to future challenges and to reap the benefit of opportunities.*

Objectives:

- *Analyses of trends and events, their relationships, and possible implications for PASB and public health communicated systematically to staff and clients.*

- *The development of technical and organizational priorities, plans, policies and strategies benefits from increased application of foresight approaches and tools.*

Progress:

111.   Virtually all of the work conducted by the organizational Area for Health Analysis and Information Systems (AIS) contribute to this goal, especially the first objective. This includes the publication of the Health Situation in the Americas Basic Indicators, and the web-based Regional Core Data Initiative in Health, also used for the analysis and monitoring of the Millennium Development Goals (MDG).

112.   The Health in the Americas publication, currently being revised and updated for publication in 2007, provides data and analysis of the health trends and issues affecting the Americas. The publication is a major resource for policy-makers and academics throughout the Region. PAHO disseminates Health in the Americas in various forms, including provision of country- and theme-specific sections of the publication as requested. Internally, it is both an information source and a tool for prioritizing the Secretariat's plans and operations.

113.   Health Statistics from the Americas, 2005 Edition, is planned for publication in December 2005. The main topic is Leading Causes of Death in Countries of the Americas, which provides evidence for determining the major cause groupings of death by age and sex, and formulation of public health interventions for their reduction.

114.   Validation of mortality data from Member States provides feedback to improve the coding of underlying causes of death and vital registration records. The increased quality of mortality data leads to better evidence-based analyses by many players in the health sector. In this context, it is essential to guarantee the adequate use of the International Classification of Diseases (ICD) and other classifications from the WHO's Family of International Classification, both in the Secretariat and at country-level. The ICD-10 has been implemented for mortality in all countries of the Region. Assessments of the vital registration systems and implementation of recommendations has led to improved coverage and completeness for vital events.

115.   Both at the country level and in the Secretariat, there have been increases in the use of technology for the dissemination of timely information and updating country profiles. Support has been provided to countries through training in epidemiological statistics (courses in Spanish and via internet) and geographic information systems for public health applications.

116.   The development of country cooperation strategies (CCSs) is a key opportunity for analyzing trends and developing plans and priorities. 6 CCSs were completed in 2004, and 10 will have been completed during 2005. Similarly, the Common Country Assessment / UN Development Assistance Framework (CCA/UNDAF) process is being completed in seven countries in LAC in 2005. PAHO is participating at the country level in all these processes, and is coordinating the Regional Quality Support Assurance process in two countries (El Salvador and the Dominican Republic).

117.   The Observatory of Human Resources in Health was launched in 1999 as a major initiative of PAHO/WHO to raise awareness of the importance of integrating human resources in the health policy agenda, and to support the participatory development of appropriate human resources policies. During the planning period the work of the Observatory has continued and expanded as a major strategic priority of the organization.

Goal 3: *Become a recognized leader in transnational and global issues that affect regional and national health*.

Objectives:

- *Health-relevant transborder and global issues are identified, understood, and communicated to target audiences.*

- *Member States and partners consider valuable the role of PASB in the mobilization of political, financial, and technical resources to address transborder and global issues.*

Progress:

118.   The International Health Regulations (IHR) provide an essential legal framework for the sharing of urgent epidemiological information on transboundary spread of infectious diseases. Their revision is another important step in strengthening the world's collective defenses against the infectious disease threat. The subregional and regional consultations that contributed to the revised IHR, ratified by the World Health Assembly in May of this year, serve as a prime example of the leadership role of PAHO/WHO in this in this area. During this process, PAHO issued frequent updates to Ministers of Health in a highly collaborative process.

119.	PASB has increased its role in the mobilization of political, financial, and technical resources to address transborder and global issues, as illustrated by the following:

- Technical areas, units and Pan American centers have become increasingly aware of and involved with the implications of integration and trade agreements for the topics under their responsibility, such as access to pharmaceuticals, vaccines and medical equipment; food safety; migration of health personnel; access to health services; e-health and telemedicine; tobacco control; environmental hazards; and health sector regulation.

- Country Offices and Technical Areas have actively supported Member States for the negotiation and implementation of health-related decisions and initiatives adopted by subregional integration bodies.

- Regional and subregional support has been provided for the analysis and management of health personnel migration.

120.	Another example of progress towards this goal is the Diabetes Initiative in Central America (CAMDI) launched in 2002 in collaboration with the Centers for Disease Prevention and Control (CDC) and ministries of health, scientific societies, and diabetes associations of the seven Central American countries.

Goal 4: *Become a valued member of mainstream scientific and technological networks, harnessing knowledge to address regional health development.*

Objectives:

- *Active participation and recognized role of PAHO as a promoter of science and technology forums relevant to health development;*

- *Science and technology counterparts are included in essential junctions of the technical cooperation process; ethical, scientific, and technological research and deployment are included in priority health areas; and*

- *Science and technology capacities become fundamental for the Secretariat's human resource development.*

Progress:

121.   Technical Advisory Groups (TAGs) – PAHO continues to capture and share knowledge on the latest scientific policies and practices in different areas through meetings of regional experts from Member States, universities, and other organizations specializing in the following topics:

- Immunizations,
- Vaccine-Preventable Diseases,
- Integrated Management of Childhood Illness, and
- HIV/AIDS.

122.   Partnerships with technical societies – PAHO has established or strengthened relations with scientific and technical societies in multiple Areas of Work. Some examples follow.

123.   PAHO has recently launched a consultative group of technical experts to respond to the introduction – sometime in mid-2006 – of a vaccine to immunize against the human papilloma virus, or HPV, which is associated with cervical cancer. An HPV vaccine is now under development, but it is expected to be costly and require negotiations with producers in order to ensure access for all.   The consultative group is working on a unified PAHO position and organizational response to the future introduction of these HPV vaccines against cervical cancer.

124.   PAHO has established or strengthened relations with scientific and technical societies for improved health and medical instrumentation, facilitating the exchange of technological information with professionals from Latin America and the Caribbean. Organizations that are part of the network of institutions include the:

- Association for the Advancement of Medical Instrumentation (AAMI),
- American Collage of Clinical Engineering (ACCE),
- Institute of Electrical and Electronic Engineering (IEEE) /Engineering in Medicine and Biology (EMBS), and
- International Certification Commission (ICC) for Clinical Engineering and Biomedical Maintenance Technicians.

Goal 5: *Foster a creative, competent, and committed work force that is rated exceptional by its clients.*

Objectives:

- *Strategic Plan for human resource development (HRD) complements the Bureau's Strategic Plan and promotes appropriate mix of skills to bring multidisciplinary perspectives to address health needs;*

- *Work designs, staff development, and rewards support creative thinking, technical excellence, and teamwork; and*

- *Level of staff satisfaction and well-being increased from levels of 2001 ROAD exercise.*

Progress:

125.   Progress in this area was reported to the 136th Executive Committee in Document CE136/INF/7 *Pan American Sanitary Bureau: Human Resources 2004-2005 Annual Report.*

126.   The following are some *highlights* of achievements and activities that are completed and ongoing towards the achievement of this goal, divided into four broad categories:

(1) Improving selection and recruitment of staff:
- Competency mapping to determine staffing needs to meet programmatic requirements,
- Competency-based interview training conducted for managers at headquarters and in the field,
- Adoption of WHO's eRecruitment system completed in September 2004, and
- Simplification and standardization of post descriptions.

(2) Improving the efficiency and effectiveness of PAHO's workforce:
- Increase in number of staff transfers and reassignments to country offices (part of country focus),
- Partnering with DC-based multilaterals institutions to share knowledge and best practices related to organizational development and staffing issues,
- 62 senior managers (over 95%) have completed WHO's Global Leadership and Management Development Program,
- Learning Board established (chaired by the Assistant Director) to orient and advise on learning issues,

- Electronic Performance Planning and Evaluation System (PPES) has been developed and is being piloted; full implementation expected in 2006, and
- Work groups coordinated by the change management team have fostered creative and innovative approaches to human resource solutions.

(3) Providing a supportive work environment:
- Staff survey conducted in 2004 to obtain more detailed information on staff needs and issues, building on the 2001 ROAD exercise,
- New harassment policy instituted, and
- Grievance Panel established.

(4) Improving the quality and usefulness of information:
- Online learning available and promoted at HQ and in PWRs, and
- New online induction process for new staff

Goal 6:   *Be a high-performance organization and set benchmarks for similar international health agencies.*

Objectives:

- *Increase the overall performance of PASB from the level obtained through the Rapid Organizational Assessment and Diagnosis (ROAD) in 2001; and*

- *Report performance regularly through expanded range of performance indicators/criteria and foster use of internal and external bench marking.*

Progress:

127.   This goal is a theme that runs throughout most of the recent years' institutional change efforts, including PAHO in the 21st Century. All five of the Strategic Objective for Organizational Change contribute to the achievement of this goal and objectives. The Roadmap for Institutional Transformation and its associated projects are the means through which PAHO is implementing this goal. Other actions taken in the planning period to improve performance are summarized here.

Budget alignment and reporting:

- Areas of Work (AoWs) aligned with WHO, resulting in improved coordination of the organization's work through linkages between the organization-wide expected results and the region-wide expected results;

- The budget has been restructured to reflect AoWs; and

- The Regional Program Budget Policy reflects the country focus in budgetary terms and was introduced in the 2006-2007 Biennial Program Budget.

Reducing costs:

- Reduction of 48 international posts since 2004, resulting in approximately $5.3 million reduction in net costs;

- Revised travel policy and reduction of travel unit costs; and

- Reductions in office space costs in headquarters and in country offices.

Maximizing resources:

- For the 2004-5 biennium, $190 million extra-budgetary funds, including $25.8 from WHO, through July 2005 (compared to $12.5 million from WHO in 2002-3); and

- $1.5 million mobilized form WHO to support Key Country presence.

Coordination and alliances to leverage resources:

- The Director of PASB has helped revitalize the UN Regional Directors Group.

- The Secretariat has worked with its development partners to strengthen the coordinating role of ministries of health

Working more effectively, efficiently, and transparently:

- A new project review process is in place, being implemented by a new unit to ensure improved design and implementation of projects funded form extra-budgetary sources.

- New PAHO Working Groups started on HIV/AIDS, essential medicines, renewal of primary health care, and family and community health.

- Inter-programmatic joint missions carried out in Guyana, Haiti, Nicaragua, and Peru.

- Automation of processes:
    - Pension system,
    - Payroll system,
    - Purchasing cards (expense control),
    - Leave tracking system, and
    - Registration of correspondence.

- Extensive upgrading of computer network, workstations, and software.

- Improved availability of financial information through AMPES/OMIS improvements.

- Assessed contributions status reports posted on the PAHO internet.

- Internal Audit team fully staffed and connected to WHO.

- Plans for follow-up to the recommendations of the External Auditor's Special Report developed and submitted to the Governing Bodies, and key activities initiated (the 46th Directing Council will consider this separately).

128.   The practice of Results-Based Management in the Secretariat has been evaluated by the Joint Inspection Unit (JIU) of the United Nations.   *The Review of the Implementation of Results-based Management in the Pan American Health Organization* will be presented to the 46th Directing Council in September 2005.

Implications of this Assessment

Implications for the Current Strategic Plan 2003-2007

129.   As detailed above and in the matrix in the Annex to this document, overall there has been progress towards the objectives set out in the 2003-2007 Strategic Plan. The Secretariat does not recommend any macro-level strategic shifts from the SP 03-07, and for the most part considers the goals and objectives in the plan to be valid through the remainder of the planning period, i.e. the end of 2007.   Nonetheless, there are implications from this Assessment for the SP 03-07:

- Some of the technical cooperation objectives are not useful or measurable, and the Secretariat has proposals to address these cases.

- The MDGs were not emphasized at the time the SP 03-07 was prepared, whereas they are currently one of the highest programmatic priorities for the organization. Progress in achieving the health-related MDGs was most recently presented by the Director on 1 July 2005. The MDGs are part of the Unfinished Agenda in the Framework for Technical Assistance, described below, and as such will form a key part of the next iteration of the Strategic Plan for 2008-2012.

- The recommendations made thus far by the Working Group on PAHO in the 21st Century fit well into the six organizational development goals discussed above (which were elaborated well before the Working Group made any recommendations). However, the recommendations have been specifically and directly incorporated into planning mechanisms through 2007, notably the

Biennial Program Budget 2006-2007.   Other planning mechanisms for the remainder of the planning period will also ensure that the recommendations of the Working Group and of the External and Internal Audits are acted upon.

- In order to ensure that the final assessment of the SP 03-07 is complete and reflects achievements, data collection systems must be improved as a part of the operational BPBs for the 2006-2007 biennium.

- Efforts must continue to ensure that the SP 03-07 is used as a principal reference in elaboration of operational plans and CCSs.

Technical Cooperation Objectives – Issues and Proposed Solutions

130.   There are several objectives, classified as "red" in the stoplight system for technical cooperation, that the Secretariat expects will not be reached due to a variety of factors, not least of which is the lack of data to measure progress. Some of the objectives classified as "yellow" may or may not be reached, but nonetheless an alternative objective or indicator has been proposed by the Secretariat. The following table lists all objectives in these two categories and proposes a solution for each one.

SP 03-07 problematic objective (Red, or Yellow requiring modification of objective)	Progress / comments	Proposed solution
(Yellow) *Eliminate measles and at least two other selected vaccine-preventable or targeted "eliminatable" diseases.*	The other two diseases chosen were rubella and congenital rubella syndrome (CRS). In 2004 there were 0 indigenous measles cases, 3103 rubella cases, and 12 CRS cases. Elimination efforts are ongoing.	REVISE OBJECTIVE: *Sustain measles elimination and develop verification criteria by 2007. Eliminate rubella and congenital rubella syndrome by 2010.*
(Yellow) *In all countries, decrease the incidence of new AIDS cases and of at least one other STI and reduce mother-to-child transmission of HIV.*	The number of reported AIDS cases has decreased during the period 2002-2004. It is, however, notable that UNAIDS estimates that new HIV/AIDS cases have risen significantly during this same period (from 242,000 to 293,000). Data for mother to child transmission are not systematically available in the Region. Progress for two other STIs, gonococcal infections and syphilis, will meet the objective.	REVISE OBJECTIVE: *In all countries, decrease the incidence of new AIDS cases and of at least one other STI.*
(Red) *Ensure that all transfused blood meets minimum standards*	While this objective will probably not be reached by 2007 (see matrix for details) significant progress has been made, the objective is valid and it should be kept in place. The objective is implicit in the *Regional Initiative for Blood Safety and Plan of Action* (Document CD46.16).	While recognizing that the objective will not be reached by 2007, maintain it and track progress.

SP 03-07 problematic objective (Red, or Yellow requiring modification of objective) (cont.)	Progress / comments (cont.)	Proposed solution (cont.)
(Red) *In all countries, at least 60% of women between the ages of 35 and 59 would have been screened and treated for cervical cancer.*	Data is not available for measurement of progress. Suggested shift in focus to data collection.	REVISE OBJECTIVE: *At least five additional countries will have organized data collection mechanisms for providing information on screening and treatment for cervical cancer.*
(Yellow) *In 50% of the countries reduce mortality due to motor vehicle accidents by 20%.*	Data for all countries not yet available. Based on some initial data, the Secretariat recommends revising the objective.	REVISE OBJECTIVE: *In 30% of LAC countries reduce mortality due to motor vehicle accidents by 15%.*
(Yellow) *Increase reporting of domestic violence by 200%.*	Data is not available to measure progress against the objective, thus achievement will be uncertain. The Secretariat suggests using the alternative (see matrix for progress notes).	REVISE OBJECTIVE: *Inter-sectoral models to address gender based-violence (GBV) consolidated and expanded in terms of formulation and monitoring of policies and legislation, development of norms and protocols of care, capacity building and research development.*
(Red) *Increase the number of countries carrying out developmental screening in preschool-aged children by 25%.*	Data to measure progress against this specific indicator/objective is not available for the current planning period 2003-2007. The Secretariat suggests developing an alternative indicator for next SP.	DROP OBJECTIVE
(Red) *All countries will have established national policies, and local plans for the capitals and medium-sized cities for the effective management of solid waste.*	Focus has been at national level and in capital cities, not medium-sized cities: - 10 countries established national policies for solid waste management - 25 countries established national and local plans for capitals	REVISE OBJECTIVE: *50% of the countries will have established national policies, and local plans for the capitals for the effective management of solid waste. 25% of countries will have plans for at least 50% of their medium-sized cities.*
(Red) *All countries-at-risk will have established programs for improving outdoor air quality in urban areas prone to air pollution, and/or indoor air quality in poor housing affected by the improper home use of fuel for cooking, heating, and cottage industries.*	As of 2004, four countries had established programs. The objective is strategically valid, but will not be achieved by 2007, and should be revised for this planning period. There is also no definition of "at risk" countries. NOTE: Activities carried out under this objective contribute to MDG Indicator 29: Proportion of population using solid fuels.	REVISE OBJECTIVE: *Eight countries will have established programs for improving outdoor air quality in urban areas prone to air pollution, and/or indoor air quality in poor housing affected by the improper home use of fuel for cooking, heating, and cottage industries.*

SP 03-07 problematic objective (Red, or Yellow requiring modification of objective) (*cont*.)	Progress / comments (*cont*.)	Proposed solution (*cont*.)
(Red) *In all countries, integrated food safety programs ensure as a minimum that all major commercial establishments practice hazard analysis critical control point (HACCP) or other modern food safety approaches to handling of food.*	5 countries (14%) with integrated food safety programs and 15 (43%) with HACCP system. It will not be possible to reach 100% (all countries) for this objective. The Secretariat recommends revising the objective.	REVISE OBJECTIVE: *85% of LAC countries will have hazard analysis critical control point (HACCP) system implemented.*
(Red) *In all countries, plans and programs to address biological, chemical and radiological (BCR) terrorism incorporated into national disaster plans.*	Due to the slow pace of activity in this area by Member Countries (the United States and Canada excepted), it is unlikely this objective will be reached. Thus, while the Secretariat will report on progress in this area, the objective should be significantly revised.	REVISE OBJECTIVE: *In countries that have made the issue a priority, plans and programs to address biological, chemical and radiological (BCR) terrorism incorporated into national disaster plans.*
(Yellow) *In all countries, social protection in health extended to the informal labor sector.*	Countries have just begun to measure the extent of social protection in health, thus it is not realistic to expect that this objective will be reached by 2007, and it should be revised to focus on data collection.	REVISE OBJECTIVE: *Fifteen countries with strategies and/or schemes to extend social protection in health to the informal labor sector under implementation.*
(Red) *In all countries, social protection in health extended to the informal labor sector.*	Countries have just begun to measure the extent of social protection in health, thus is it not realistic to expect that this objective will be reached by 2007, and it should be revised to focus on strategies.	REVISE OBJECTIVE: *Ten countries with data available to measure social protection in health in the informal labor sector.*
Increase availability of information on the impact of policies adopted by the health sector and other development sectors on health inequities related to poverty, gender, and ethnicity.	REGARDING GENDER AND ETHNICITY ONLY (poverty is on track): Data is unavailable to monitor the objective for gender, and even less available for ethnicity. PROGRESS AGAINST PROPOSED REVISED OBJECTIVE: One country currently has information available (target for 2007 is three countries).	REVISE OBJECTIVE: *a) Increase availability of information on the impact of policies adopted by the health sector and other development sectors on health inequities related to poverty. b) Increase the number of countries with available information on gender inequities in health polices.*

SP 03-07 problematic objective (Red, or Yellow requiring modification of objective) (*cont.*)	Progress / comments (*cont.*)	Proposed solution (*cont.*)
At least half of the countries report routinely on surveillance of inequities in health, as well as in access to and financing of health care initiatives related to poverty, gender, and ethnicity at national and subnational.	REGARDING GENDER AND ETHNICITY ONLY (poverty is on track): Data not available. Most countries are not tracking this indicator at this time; PAHO is supporting the collection and availability of gender-disaggregated health data, but this will not address the specific indicator, which will likely not be measurable.	REVISE OBJECTIVE: *At least half of the countries report routinely on surveillance of inequities in health, as well as in access to and financing of health care initiatives related to poverty at national and subnational levels.*

Recommendations based on this Assessment for the next Strategic Plan 2008-2012

131.   During this Assessment, several issues have been identified that can be addressed in the next Strategic Plan. This is not meant to be an outline of the substance of the SP 08-12, but rather a series of observations gleaned from analysis of the progress made thus far.   Member States' feedback on these recommendations is requested, keeping in mind the timeline for development of the SP 08-12: the 40th Session of the SPP, in March 2006, will discuss the Strategic Plan development process, and the March 2007 SPP will receive the first draft of the SP 08-12.

132.   Framework for Technical Cooperation – Introduced at the 2004 PAHO Annual Manager's Meeting and subsequently presented to the governing bodies, this Framework classifies Areas of Work and expected results into three categories: Addressing the Unfinished Agenda, Facing Challenges and Protecting Achievements. These categories should be used in developing the next Strategic Plan to help determine strategic priorities.

133.   Accountability for achievement of objectives – The issue of what PASB is responsible or accountable for in terms of objectives has arisen in various discussions, including in the Governing Bodies. In order to address this issue, future planning documents will contain two sets of linked objectives and indicators: one for the Secretariat's manageable interests, the other for the organization (including Member States) and its partners (including multilaterals, etc). It should always be evident how the PASB-specific objectives will contribute clearly and directly to the achievement of the higher-level, organization-wide objectives.

134.   Setting the level of objectives and indicators – In order to clearly differentiate between the Strategic Plan and the Biennial Program Budget/Operational Plans, Strategic Plan objectives should all be at the goal (impact) level, whereas BPB and Operational Plan objectives should be set at the output or outcome level. Related to the previous point, the Strategic Plan will set PAHO-wide objectives, whereas the BPBs and Operational plans will include PASB-specific objectives (with links to the previously-established SP objectives) that fall within the Secretariat's manageable interests, i.e. for which it will be accountable.

135.   Data availability to measure achievements – To avoid situations where objectives are impossible to measure due to the fact that progress data for indicators (i.e. baseline data and ongoing monitoring) is not available, in future planning documents no objectives/indicators will be used that are not already available at the start of the planning period (from the Basic Health Indicators, Human Development Report, Economic Commission for Latin America and the Caribbean or other sources), or which cannot be instituted subject to immediate verification. All objectives/indicators will contain baselines.

136.   Relevance for countries and PAHO/WHO country offices – To ensure future Strategic Plans are highly relevant and easily "operationalized" by countries and PWRs, the link between strategic and operational planning will be strengthened and made more explicit.

137.   Strategic relevance and completeness – Future strategic plans should include analyses of all programmatic functions to determine continuing relevance to the overall strategic direction and goals of the Organization. This includes emergency response and support functions (e.g. human resources, information technology, finance/accounting, etc).

138.   Resources – In order to ensure the SP 08-12 is realistic and achievable, it should include resourcing strategies, i.e. an analysis of funding sources and levels needed to meet strategic objectives. This analysis may also explore new and innovative funding sources, as deemed strategically appropriate by governing bodies. This analysis should include an examination of whether resources are being used in the most efficient and effective manner.

139.   Cooperation and leveraging of resources for high impact – To ensure that PAHO leverages its limited resources and achieves the greatest impact in the health sector, the organization's strategic role and objectives should be elaborated in the context of the activities of other players in the health sector in the Americas, including a rigorous analysis of PAHO's core competencies, maximum value-added, and avoidance of

potential duplication.   Future PAHO planning documents should be developed in the context of WHO's General Program of Work (GPW) and Medium Term Strategic Plan (MTSP), and in coordination with the planning departments of the following institutions, in addition to the ministries of health in Member States:

- UN sister agencies,

- The Organization of American States,

- International financial institutions such as the Inter-American Development Bank and the World Bank,

- Bilateral development agencies including USAID and CIDA, and

- NGOs working in related fields.

140.   Inclusion of major findings and recommendations –   The next Strategic Plan should build on the current work to strengthen PAHO as an institution (much of which is cited in this document), in keeping with Resolution CE136.R3, adopted by the Executive Committee at its 136th session in June 2005, requesting the Director to "take into account the findings of the report and recommendations of the Working Group on PAHO in the 21st Century, the institutional changes within the Pan American Sanitary Bureau, and the recommendations of the Special Report of the External Auditor, when preparing the next Strategic Plan for the work of the Pan American Sanitary Bureau."

141.   The recommendations above build on the significant progress already achieved in previous SPOs, the SP 03-07 and current relevant initiatives, and would continue to expand and strengthen PAHO's accountability and effectiveness in the context of a results-based approach.

Action by the Directing Council

142.   The Directing Council is requested to review this document and to endorse the proposed revisions to the technical cooperation objectives in the Strategic Plan 2003-2007 and the recommendations for improving the next Strategic Plan for the period 2008-2012.

List of Acronyms

AMPES – American Region Planning and Evaluation System
AoW – Area of Work
BPB – Biennial Program Budget
CCS – Country Cooperation Strategy
CO – Country Office
CSP – Pan American Sanitary Conference
GTZ – Gesellschaft für Technische Zusammenarbeit (German cooperation enterprise)
IKM – Information and Knowledge Management
JIU – United Nations Joint Inspection Unit
KC – Key Country
LAC – Latin America and the Caribbean
MDG – U.N. Millennium Development Goal
MoH – Ministry of Health
NGO – Non-Governmental Organization
PASB – Pan American Sanitary Bureau
PRSP – Poverty Reduction Strategy Paper
PWR – PAHO/WHO Representative
RBM – Results-Based Management
SP – Strategic Plan
SPP – Subcommittee on Planning and Programming
SPO – Strategic and Programmatic Orientations
TAG – Technical Advisory Group
TC – Technical Cooperation
TCC – Technical Cooperation among Countries
WHA – World Health Assembly

Annex

ANNEX
TECHNICAL COOPERATION MATRIX

Notes:

- Unless otherwise specified, objectives & indicators are for all countries in the region

- Unless otherwise specified, all objectives are assumed to be against 2002 baseline

Color coding

Green = Target met or on track to be met by end-2007

Yellow = Uncertain if target will be met by end-2007

Red = Probable or definite target will NOT be met

Technical Cooperation					
Priority Area 1. Prevention, Control, and Reduction of Communicable Disease					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
Reduce morbidity due to TB, malaria, and dengue fever.	a) % reduced TB b) % reduced malaria c) % reduced dengue	a) 233,650 cases of TB, or 27 for every 100,000 people b) 884,744 cases reported in the entire Region for 2002 c) In 2002 in the Americas, there were 1,015,420 cases of dengue reported.	a) If DOTS coverage continues as in 2003, a reduction of 6,000 cases per year. The expansion of DOTS in Brazil could improve this reduction. b) Reduce the number to no more than 741,213 cases by 2007 (16.22% reduction relative to 2002; 35% reduction relative to 2000, the baseline year for the Roll Back Malaria Decade. c) End-2007 reduction of 40 %.	a) 2004 information is n/a, in 2003 there was a reduction of 6,099 TB cases (2.6% less than 2002). b) 871,965 malaria cases reported in 2004 (1.44% reduction relative to 2002 baseline) c) At the end of 2004, 267,050 cases of dengue were reported (74% reduction from 2002).	a) TB: All information is for 2003 (WHO Report 2005). PAHO in 2005 hopes to detect 70% of cases and cure 85% of those detected. This is in line with PAHO's objectives under the MDGs. PAHO should meet its objectives by the end of 2007. b) Malaria: • While the decrease relative to the 2002 baseline is rather small (1.44%), the 2004 figure represents a 23.54% reduction from the 2000 baseline which serves as the main reference for the Malaria Program in assessing the Region's progress towards the Roll Back Malaria Objective. • The 23.54% reduction noted in 2004 is actually more than the target for the year, which is a decrease of 20%. • These figures mean that we are, at present, slightly above our overall regional targets for malaria. c) Dengue reduction is well on track to meet the goals established.

Technical Cooperation					
Priority Area 1. Prevention, Control, and Reduction of Communicable Disease (*cont*.)					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
Eliminate measles and at least two other selected vaccine-preventable or targeted "eliminatable" diseases.	# indigenous cases of measles, rubella, and congenital rubella syndrome (CRS).	2,579 measles cases. *1,921 rubella cases. 22 CRS* cases. *Surveillance was not fully implemented in 2002.	0 cases of indigenous measles, rubella, and CRS.	0 indigenous measles cases. 3,103 rubella cases. 12 CRS cases.	Measles and rubella campaigns are ongoing. Consolidation of measles elimination will be achieved by 2007. Eradication of rubella and CRS has been revised to 2010. **REVISE OBJECTIVE: *Sustain measles elimination and develop verification criteria by 2007. Eliminate rubella and congenital rubella syndrome by 2010.***
Reduce mortality and morbidity due to childhood diseases (including diarrheal and respiratory infections) among children under 5 years of age in all countries by 10% of the 2002 level.	a) % mortality b) % morbidity	a) 34.9 /1,000 (LAC region) b) info n/a	a) 10% below 2002 (31.41/1,000) b) info n/a	a) 33.2 /1,000 b) info n/a	a) 33.2 Progress on mortality is on track and if the estimated trend is sustained the figure by the end of 2007 would be 30.1, quite below the target defined in the strategic plan. However, this trend will be contingent upon sustained country actions and regional advocacy efforts to strengthen the country response in the context of the MDGs, particularly in the area of neonatal mortality. Please note that these estimates are based on the World Population Prospects 2004, which are being used by AIS to construct the PAHO Basic Indicators. We suggest that indicators on morbidity should be excluded from this matrix as many countries in the Region do not have reliable data on morbidity. Hence, it would be very difficult to provide a solid assessment of progress on this indicator.

Priority Area 1. Prevention, Control, and Reduction of Communicable Disease (*cont*.)

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
In all countries, decrease the incidence of new AIDS cases and of at least one other STI and reduce mother-to-child transmission of HIV.	a) # reported AIDS cases b) reported cases for gonococcal infections and syphilis b) % HIV transmission	a) 57,571 reported cases b) gonococcal infections – 1,877 syphilis – 1,807 c) n/a	a) any reduction b) any reduction c) any reduction	a) 24,071 for 2004*; 51,138 for 2003 b) gonococcal infections – 1,344, syphilis – 998 c) n/a * The 2004 figure reflects incomplete reporting by countries (as of mid-2005); therefore, the 2003 figure is more useful for determining the trend.	The number of reported AIDS cases has decreased during the period 2002-2004. It is, however, notable that UNAIDS estimates that new HIV/AIDS cases have risen significantly during this same period (from 242,000 to 293,000).Data for mother-to-child transmission are not systematically available in the Region. **REVISE OBJECTIVE:** *In all countries, decrease the incidence of new AIDS cases and of at least one other STI.*
Ensure that all transfused blood meets the minimum standards.	% meeting minimum standards	86.70%	100%	89.19%	It is difficult to construct an indicator that summarizes all "the minimum standards." Since this objective is listed under communicable diseases, we calculated the proportion of blood units that are screened for HIV, HBsAg, HCV, syphilis, and, in Latin America, *T. cruzi*. The data for 2004 do not include Chile, Peru, and seven Caribbean countries, since we have not received the information for last year. The objective will not be met in 2007. Mexico has not officially adopted the norm to screen for *T. cruzi*, and five Caribbean countries do not screen for HCV at all. The rest of the nonscreened units are associated with lack of voluntary donors which implies that the availability of testing kits will not assure 100% screening. The objective has been included in the plan of action for 2006-2010. It is strategically not appropriate to reduce the goal to less that 100%.
All national systems are monitoring key diseases, anti-microbial resistance, and food- and water-borne disease outbreaks; and the information is shared in real time.	% monitoring	n/a	100%	Monitoring systems exist in virtually all countries for principle diseases. The quality of these systems is not, however, uniform, and much work remains to be done, especially in terms of information being available in "real time".	

Technical Cooperation					
Priority Area 1. Prevention, Control, and Reduction of Communicable Disease (*cont*.)					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
Extend the number of FMD-free countries and/or areas and reduce morbidity and mortality from common zoonotic diseases.	a) # of countries without the diseases b) % of countries with surveillance	**FMD:** 32% of South America; 43% of the bovine herds and 52% of population free of FMD. **Rabies:** # of countries that need to eliminate the diseases: 8 # of countries with surveillance: 17 **BSE:** # of countries free of diseases: 33 # of countries with risk analyses: 5	**FMD:** 95% of South America, as well as herds and bovine population free of FMD. **Rabies:** # of countries that need to eliminate the diseases: 3 # of countries with surveillance: 22 **BSE:** # of countries free of diseases: 33 # of countries with risk analyses: 9	**FMD:** 53% of South America; 59.3% of the bovine herds and 78.6% of the bovine population free of FMD. **Rabies:** # of countries that need to eliminate the diseases: 6 # of countries with surveillance: 17 **BSE:** # of countries free of diseases: 33 # of countries with risk analyses: 5	FMD: Indicators are expressed in percentages due to the fact that FMD eradication is achieved with a zoning strategy, instead of a whole country strategy. Rabies: Because the number of cases of human rabies transmitted by dogs are currently small, it is better to use the number of countries without the diseases than mortality rates. BSE: The goal for 2007 is the absence of clinical disease, consistent with a final goal of achieving freedom from the disease by 2009.

Priority Area 2. Prevention and Control of Noncommunicable Diseases					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
In all countries, integrated prevention of NCDs established through the application of community-based initiative to reduce risk factors (CARMEN).	# countries	5 countries	100%	20 countries/territories are members of the CARMEN (Initiative for Integrated Noncommunicable Disease Prevention) Network, and are implementing integrated NCD prevention and control actions. It is uncertain whether all countries in the Region will implement such efforts by 2007.	Initiatives developed to date:-CARMEN School project (capacity building for NCD prevention) in partnership with CDC-CARMEN Policy Observatory and Dialogue (analysis and development of NCD prevention policies) in partnership with the Public Health Agency of Canada-Pan American Cardiovascular Initiative –PACI (promotion of heart health) in partnership with the NHLBI/NIH
Increase surveillance, at national and regional levels, of NCDs, risk factors, and injuries.	surveillance	n/a	any increase	5 countries in Central America conducted NCD and risk factor surveys in the capital cities. 3 CARMEN intervention areas have structured their NCD and risk factor local surveillance system (Bucarmanga, Colombia; Concepción, Chile; and Firminopolis, Brazil).	The CAMDI project in collaboration with CDC will implement surveys in two other CA countries in 2005. The local NCD surveillance system was created to continuously monitor the advances on NCD prevention in CARMEN areas (CDC grant).
In all countries, at least 60% of women between the ages of 35 and 59 would have been screened and treated for cervical cancer.	% women screened and treated	n/a	60%	Data for this specific service-related indicator is not systematically available.	PAHO has devoted significant resources to improve screening and treatment of cervical cancer; however, regionwide monitoring of progress in this area is not yet in place. **REVISE OBJECTIVE:** *At least five countries will have organized data collection mechanisms for providing information on screening and treatment for cervical cancer.*
Improve quality of chronic care in at least five countries.	# countries	n/a	5 above 2002	A quality of care improvement demonstration project was concluded in Mexico. Baseline data on quality of care collected in 5 countries in Central America and 3 in the Caribbean. Uncertain if the objective will be reached by 2007.	Quality of care improvement projects in preparation in various countries.

Priority Area 2. Prevention and Control of Noncommunicable Diseases (*cont.*)

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
In 50% of the countries, reduce mortality due to motor vehicle accidents by 20%.	mortality rate per 100,000	15 per 100,000 (all LAC)	20% below 2002	Data for all countries not yet available.	Based on some initial data, technical unit recommends revising the objective. **REVISE OBJECTIVE:** *In 30% of LAC countries reduce mortality due to motor vehicle accidents by 15%.*
Increase reporting of domestic violence by 200%.	% reporting	n/a	200% above 2002	Data unavailable for the original objective. Progress against proposed revised objective: -Integrated model of intervention developed and applied in communities of 11 countries. -Sexual violence introduced in the model since 2003. -Project on regional monitoring system (Observatory) of GBV policies and programs approved and financed by Spain and WHO. -Pilot Virtual Course on domestic/sexual violence delivered to service providers. -BRA,COR,DOR,HON are implementing model of legislation on GBV.	Objective is unrealistic - data is not available. **REVISE OBJECTIVE:** *Intersectoral models to address gender-based-violence (GBV) consolidated and expanded in terms of formulation and monitoring of policies and legislation, development of norms and protocols of care, capacity building, and research development.*

Priority Area 3. Promotion of Healthy Lifestyles and Social Environments

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
Increase by 30% the number of countries that have undertaken at least 2 of the following: creating smoke-free spaces, eliminating advertising of tobacco, and increasing taxes on tobacco.	% countries	6 countries Note: In the 2001 school survey, 12 countries reported having a policy for smoke-free spaces in schools (PAHO 2004).	30% above 2002	8	In 2002 there were 6 countries (Brazil, Canada, Costa Rica, Peru, Uruguay, and the United States) with reasonable local or national smoke-free policies, comprehensive ban on promotion of tobacco products, or taxes equivalent to 66% of retail price. By the end of 2004, there were two additional countries that have made progress and met the indicator (Cuba and Ecuador). In addition, 7 countries (Argentina, Bahamas, Belize, Honduras, Panama, Suriname, and Trinidad and Tobago) have made progress in one of the three components of the indicator.
Increase by 30% the number of countries with policies and incentives for the reduction in consumption of alcohol and in substance use.	% countries	3 countries	30% above 2002	PAHO is providing information and tools for policy development and legislation changes in countries. - Brazil and Mexico are in the process of changing legislation regarding alcohol sales. - There was training on Brief Interventions (BI) for alcohol problems in Cuba. - Assistance was provided to Mexico and Brazil on alcohol and drug abuse policies. - Research to inform policy on alcohol and gender was and continues to be conducted in 10 countries. - A brochure on alcohol policy and awareness was created and distributed in four languages. - A manual for surveillance on alcohol consumption was published in Spanish.	Progress is on-going. The objective refers to "policies and incentives" which can be hard to define and measure. For this reason the progress noted focuses on PAHO's interventions in this area.
In 80% of the countries, increase the availability of life skills education programs to at least 50% of secondary schools.	% schools with programs available	Two countries (2001 LA survey) Note: In the 2001 school survey, 12 LA countries reported implementing life skills education in schools (PAHO 2004). In the Caribbean school network meeting in 2001, 14 Caribbean countries reported this as well (PAHO 2002).	50% of schools in 80% of countries	PAHO is mobilizing resources to carry out training within the context of the Health-Promoting Schools (HPS) Regional Initiative. As of now progress towards the objective is uncertain.	Training in Life Skills Education is a need and priority of the countries. Funding is needed to carry out this training.

Priority Area 3. Promotion of Healthy Lifestyles and Social Environments					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
Mental health systems reformed in 12 more countries to protect the human rights of the mentally ill and to increase provision of community-based, primary mental health care.	# countries	In 2002 there were 8 countries where mental health reform had resulted in significant changes in the mental health system: Argentina, Barbados, Belize, Brazil, Chile, Cuba, Guatemala, Jamaica.	Significant advances in 12 more countries.	Good progress was made in the development of capacities of countries. Significant advances were made in Mexico, Nicaragua, Paraguay, Peru, Saint Lucia.	Subregional meetings on policy development took place in the Southern Cone, Andean Subregion, Central America, and the Caribbean. Two TCC's were developed in this area. Training workshops were organized on mental health and human rights in several countries. Technical support is being provided to 17 countries.
Increase by 25% the number of schools at the primary and secondary levels in which physical education is mandatory throughout the school life.	# schools where mandatory	15 LA countries have physical education activities, although it is not known if it is mandatory (2001 LA survey).	25% above 2002	The Regional Health-Promoting Schools (HPS) Initiative includes this activity, as well as the promotion of healthy spaces to carry out physical activity in the school setting. As of 2004 progress was unknown, but should be available by 2007.	The 2006 planned regional survey will compile this information.
Increase the number of countries in which all commercial flour is fortified with bioavailable iron.	# countries	8 Latin American countries and 7 Caribbean countries under CARICOM agreement using iron of poor bioavailability.	any increase	4 countries have switched to using iron compounds of higher bioavailability or have legislation in place (BOL, COL, DOR, ECU)	It is extremely likely that the target will be reached by 2007. Extrabudgetary funding from the GAIN (Global Alliance for Improved Nutrition) has been obtained to assist BOL and DOR in implementing new fortification legislation.
In the 11 high-risk countries, increase the coverage of at least 3 doses of vitamin A supplementation to at least 50% of children less than 3 years.	% of children covered	10 countries with sub-clinical vitamin A deficiency as a public health problem and implementing vitamin A supplementation.	50% coverage in 11 countries	4 countries reported >50% coverage of children 6-59 months for the first dose, 2 countries reported >30% for the first dose, and 1 country has been relying only on its sugar fortification with vitamin A since 2002.	Vitamin A supplementation is tracked as the number of children 6-59 months receiving up to 2 doses of vitamin A per year; therefore, the objective of 3 doses cannot be tracked. Only 6 countries continually report on vitamin A supplementation coverage with vaccination coverage data to the Immunization Unit. It is likely that the target of more than 50% of children receiving at least 1 dose can be reached by 2007 in 6 countries that are providing vitamin A supplements and tracking and reporting this information to PAHO.
Increase by 30% the number of countries undertaking surveillance to identify trends in behavior and social conditions that influence lifestyles.	# countries	Partial surveillance in 2 countries: Brazil and Mexico Note: In the 2001 school survey, 14 countries in LA reported having carried out at least one survey of risk behaviors in school children and youth.	30% above 2002	National surveillance in 2 countries: Chile and Mexico. Partial surveillance in 3 countries: Argentina, Brazil, and Colombia.	Objective needs to be reexamined for next Strategic Plan.

Priority Area 4. Healthy Growth and Development

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
Reduce the maternal mortality to no more than 100 per 100,000 live births or 20% of the 2000 level.	maternal mortality ratio	190 per 100,000 live births (2000 level)	100 per 100,000	Information not available for 2004. Most of the maternal mortality data available now is for 1999, 2000, 2001, or 2002. Thus progress for the period 2002-2004 is uncertain.	MM surveillance systems have been strengthened in the Region, however, they are not strong enough to provide timely data. Also, when the surveillance systems improve, the mortality registries increase. Vital registration systems in the region continue to be weak. Note: A USAID-backed project in underway in 14 countries in the region to improve reporting on this indicator, MDG indicator #16.
Increase the percentage of pregnant women seeking care in the first trimester by 30% and the deliveries by skilled attendants to 90%.	a) Proportion of pregnant women attended by trained personnel during pregnancy. b) % of deliveries attended by skilled personnel.	a) 70.2% (LAC) b) 88.1% (LAC)	a) 30% above 2002 b) Increase in 2% points	a) 71.6% (LAC) b) 88.9% (LAC)	There are many challenges with these two indicators: 1) There are vast disparities within and among countries regarding skilled attendance and prenatal visits, particularly between the rich and the poor. 2) Many countries report on institutional births and do not use the definition of skilled attendant. 3) Countries do not measure those "seeking care." The objective may remain the same, but the indicators should be as at left.
Reduce perinatal mortality by 10% of the 2002 level.	perinatal mortality rate. Proposed proxy: Neonatal mortality rate.	Unavailable - neonatal mortality rate in 2002 was approximately 24 per 1,000 births.	10% below 2002 = 21.6 per 1,000 births	Approximately 24 per 1,000 births (data quality varies). Neonatal mortality should be available in PAHO's core database as of 2005.	Currently, due to the lack of data, PAHO is unable to reliably estimate perinatal mortality for the Region, inasmuch as late fetal deaths are not even registered in many countries. Neonatal mortality has been proposed (and is expected to be approved) for measurement beginning in 2005. Note: perinatal = during pregnancy through first 7 days of life; neonatal = first 28 days of life (accounts for 60% of infant deaths, an MDG indicator).

Priority Area 4. Healthy Growth and Development (*cont.*)					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
Increase the number of countries carrying out developmental screening in preschool-aged children by 25%.	# countries	Data unavailable	25% above 2002	Data to measure progress against this specific indicator/objective is not available.	For the current planning period 2003-2007, progress will not be verifiable. Suggest developing alternative indicator for next Strategic Plan. **Drop objective.**
Reduce the adolescent fertility rate (15-19 years of age) to 20% of the 2002 level.	a) Fertility rate	a) 80 per 1,000 (source: U.N. Department of Economic and Social Affairs)	a) 20% reduction	a) 78 per 1,000 = 2.5% reduction (source: U.N. Department of Economic and Social Affairs - obtained by linear interpolation from the corresponding United Nations fertility medium – variant quinquennial population projections).	Fertility rates among adolescents were incorporated in the PAHO Integrated Management of Adolescent Needs (IMAN) project in 2004. It is uncertain if the objective will be reached by 2007.

		Priority Area 5. Promotion of Safe Physical Environments			
Objective	***Indicator(s)***	***Baseline*** ***(end 2002)***	***Target*** ***(end 2007)***	***Progress to date*** ***(end 2004)***	***Comments/Explanation of Progress***
Towards the United Nations Millennium Development Goals and Vision 21 of Water for People, reduce by 25% the gaps in universal coverage and quality of potable water and in sanitation services identified in the "PAHO/WHO/UNICEF Regional Evaluation 2000."	% of gaps in coverage/ quality of potable water and sanitation services.	E-2000 (1998 data) % Gaps in water coverage Total: 15.4 Urban: 7.0 Rural: 38.8 % Gaps in water service quality Disinfection: 41 Continuity: 60 Water losses: 45 % Gaps in sanitation coverage Total: 20.8 Urban: 10.2 Rural: 50.4 % Gaps in wastewater treatment Total: 86	JMP 2007 (2005 data) % Gaps in water coverage Total: 11.6 Urban: 5.3 Rural: 29.1 % Gaps in sanitation coverage Total: 15.6 Urban: 7.7 Rural: 37.8	JMP 2004 (2002 data) % Gaps in water coverage Total: 11.0 Urban: 5.0 Rural: 31.0 % Gaps in sanitation coverage Total: 25.0 Urban: 16.0 Rural: 56.0	Based on JMP definitions of improved water and sanitation, on average LAC countries are on track to achieve gap reduction in water access but are not fulfilling their objective to reduce the gap in access to sanitation. The Region needs to continue reducing these gaps, while improving equity and quality of the services in benefit of their impact and sustainability on public health and development. NB: The 2002 figures are based on different survey techniques than the 2000 figures. CSD 13 of April 2005 identified monitoring limitations of MDG 7, Target 10. JMP (WHO, UNICEF, and partners) are working to improve their monitoring tools for overcoming part of these limitations, including aspects of equity and quality of the services. PAHO (SDE and AIS) will contribute to improve data analysis and information use associated with water, sanitation, and health in the context of LAC.

Priority Area 5. Promotion of Safe Physical Environments (*cont*.)					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
All countries will have established national policies and local plans for the capitals and medium-sized cities for the effective management of solid waste.	# countries	n/a	100%	Focus has been at the national level and in capital cities, not medium-sized cities: - 10 countries established national policies for solid waste management - 25 countries established national and local plans for capitals National policies: BAR, BRA (some states), CHI, COL, ECU, ELS, PAN, PAR, PER, TRT National plans: BAR, BLZ, BVI, Cayman Islands, CUB, GRA, JAM, PAN, PER, ELS, TRT, VEN In process: BAH, BOL, DOM, ECU, ELS, GUT, HAI, PAR, SKN Local plans: COL, CUB, MEX, URU	The 2007 target should be reconsidered to 50% instead of 100%. The objective of establishing plans for management of waste for all medium-sized cities should be reconsidered (there are more than 830 medium-sized cities in LAC). It is proposed to set the goal to an increase of 25% above 2002. **Revise objective:** *50% of countries will have established national policies and local plans for the capitals for the effective management of solid waste. 25% of countries will have plans for at least 50% of their medium-sized cities.*
All countries-at-risk will have established programs for improving outdoor air quality in urban areas prone to air pollution, and/or indoor air quality in poor housing affected by the improper home use of fuel for cooking, heating, and cottage industries.	# countries (among those at-risk)	n/a	100%	Four countries Outdoor air pollution: PER is executing a national plan. ECU and URU are initiating negotiations with stakeholders for implementation of national plans. Indoor air pollution: GUT and PER are conducting intervention projects at local level. By the end of 2004, Argentina, Belize, Brazil, Costa Rica, Chile, Honduras, Nicaragua, El Salvador, Guatemala, and Panama made progress in the operational regulations for the use of pesticides.	The objective is unlikely to be reached by 2007. **Revise objective:** *Eight countries will have established programs for improving outdoor air quality in urban areas prone to air pollution, and/or indoor air quality in poor housing affected by the improper home use of fuel for cooking, heating, and cottage industries.*

Priority Area 5. Promotion of Safe Physical Environments (*cont*.)

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
At least 15 countries will have effective implementation of sanitary surveillance of pesticides and have made improvements in the operational regulations for the importation and use of pesticides.	# countries	n/a	15	10	By the end of 2004, Argentina, Belize, Brazil, Costa Rica, Chile, Honduras, Nicaragua, El Salvador, Guatemala, and Panama made progress in the operational regulations for the use of pesticides and seven of them have made progress in the operational regulations for the use of these substances.
In all countries, integrated food safety programs ensure as a minimum that all major commercial establishments practice hazard analysis critical control point (HACCP) or other modern food safety approaches to handling of food.	# countries	n/a	100%	5 countries (14%) with integrated food safety programs and 15 (43%) with HACCP system.	Due to the low priority and political willingness by the countries to establish integrated food safety programs, it will not be possible to reach 100% in this area of the objective. However, it is envisaged that 85% of the countries will have a HACCP system implemented. NB: The Regional Food Safety Action Plan for 2006-2007 has been prepared jointly with INPPAZ, and is congruent with the WHO Global Food Safety Strategy. **Revise objective:** ***85% of LAC countries will have a hazard analysis critical control point (HACCP) system implemented.***
Increase by 50% the number of countries undertaking risk assessment of environmental conditions of workers on a routine basis, and in each country, increase by 30% the number of registered workplaces with programs for the promotion and protection of workers' health.	a) # countries b) # registered workplaces	a) estimated 0 b) estimated 15 workplaces	a) 50% above 2002 b) 30% above 2002	a) Surveillance systems in place for three events—occupational accidents, pesticide poisoning, muscular-skeletal disorders—in 8 countries (Argentina, Bolivia, Brazil, Chile, Colombia, Jamaica, Mexico, Panama, Uruguay). b) PAHO's operational objective was to multiply the baseline by at least 4 times (15 X 4 = 60 workplaces). This objective was met many times over, with 700 workplaces (companies) in the 8 countries implementing programs to promote and protect workers' health.	PAHO's Healthy Work Environment Initiative, that had SIDA-Sweden's financial support, has had a strong catalytic effect. In this regard, the work with CERSSO, ILO, the U.S. Department of Labor, and the National Safety Council should be acknowledged, as it improved the use of PAHO's workplace tool kit. On the basis of this program's success, SICA asked permission to use the methodology of PAHO's initiative to implement a Central American Health and Safety Project in 5 more economic sectors.

Priority Area 6. Disaster Preparedness, Management and Response

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
Increase the national and intersectoral capacity for preparedness for and response to natural and manmade disasters.	a) Availability of training workshops on all aspects of disaster reduction. b) Guidelines, manuals, and other publications and multimedia materials developed or updated and distributed.	n/a	any significant increase	- Courses and workshops on contingency planning, mass casualty management, and first responder training have been held in the Caribbean and at subregional level in South America and Central America and have involved all national agencies responding to disasters. - LIDERES courses (high-level disaster management courses) were carried out to improve the quality of the Region's preparedness and response capacity; an added benefit is the health sector risk management network that has emerged. PAHO/WHO is now assisting other WHO Regions to develop similar initiatives.- In the past two years, four simulation exercises were conducted annually to evaluate country response capacity, and plans were adjusted.- PAHO continued to assign high priority to the production of training materials and technical guidelines and manuals that support disaster preparedness and mitigation.	PAHO continues to support a wide variety of events throughout the Americas. The number and variety of training events have increased, thanks to stronger involvement of the network of disaster focal points in the PAHO Country Offices, which are taking over the more "traditional" disaster preparedness training of specific national interest.
Building codes and other mitigation features for construction of new health and utilities infrastructure operational in all at-risk countries.	# countries (among those at-risk)	n/a	100%	Progress has been good but irregular. A Disaster Mitigation Advisory Group has been established to advocate for and assist countries in building new safe hospitals. The devastation caused by the 2004 hurricane season prompted Member States at the 45th Directing Council to unanimously approve a resolution "to urge Member States to adopt "Hospitals Safe from Disasters" as a national risk-reduction policy, to set the goal that all new hospitals are built with a level of protection that better guarantees their remaining functional in disaster situations, and implement appropriate mitigation measures to reinforce existing health facilities, particularly those providing primary care.	The World Conference on Natural Disaster Reduction in Kobe, Japan, provided a major boost in terms of visibility for this topic, and Member States are expected to step up efforts in this area in the coming years. The effectiveness of advocacy for disaster mitigation and the actual implementation of measures can only be tested/evaluated in the aftermath of a disaster. Political commitment at the highest level is necessary. Availability of data is also an issue.

Priority Area 6. Disaster Preparedness, Management, and Response (*cont.*)					
Objective	**Indicator(s)**	**Baseline (end 2002)**	**Target (end 2007)**	**Progress to date (end 2004)**	**Comments/Explanation of Progress**
In all countries, plans and programs to address biological, chemical, and radiological (BCR) terrorism incorporated into national disaster plans.	# countries	No country had a comprehensive plan.	12 at-risk countries with a disaster plan that includes BCR preparedness.	Country progress has been poor, since this has not been a high priority for many countries, excluding Canada and the United States. PAHO-specific activities have included: - Seminars and training activities, including simulation exercises, which took place in Argentina, Barbados, Mexico, and Panama. - A Web site and specialized short technical guides and training materials that were developed and compiled. - Information sent to all ministries of health, and guidelines translated.	Due to the slow pace of activity in this area by Member States (Canada and the United States excepted), it is unlikely this objective will be reached. Donors have committed little funding for this area outside of their own countries. Thus, while the Secretariat will certainly report on progress in this area, the objective should be significantly revised. **Revise objective:** *In countries that have made the issue a priority, plans and programs to address biological, chemical, and radiological (BCR) terrorism incorporated into national disaster plans.*
In all disaster situations, human, technological, and financial resources mobilized and coordinated at the national and regional levels within 24 hours.	Ad hoc, as the situation warrants.	n/a	80%	- In all disaster situations over the last 2½ years that warrant external assistance, PAHO has been able to coordinate the mobilization and deployment of human resources within 24 hours to assist Member States in assessment of damage and needs in the health sector. The mobilization of financial resources to meet health needs has always been sufficient (and in some cases has exceeded the Organization's capacity to absorb them in the short period of time granted to emergency projects). However, the mobilization of financial resources has not always been accomplished within the 24-hour time frame (see comments on progress). - In the period 2003-2004, support was coordinated and mobilized for nine countries. The bulk of resources were mobilized for Haiti, which faced three emergency situations in 2004 alone.	There is increasing competition globally when it comes to mobilizing financial resources. Donor agencies are scrutinizing proposals much more closely and in some cases expressing interest in contributing to the design of emergency projects, thereby increasing the amount of time it takes to actually have PD funds in hand.

Priority Area 7. Ensuring Universal Access to Integrated, Equitable, and Sustainable Health Systems					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
In all countries, the reform of the health sector is reoriented to strengthen the steering role of health authorities, and the essential public health functions.	# countries	n/a	100%	41 countries in the Region have completed the Essential Public Health Functions exercise. 2 countries have completed the Steering Role Function assessment.	By 2007, 100% of countries will have completed an assessment of the Steering Role Function and formulated strengthening plans for the Steering Role and the Essential Public Health Functions.
New manpower management approaches contribute to increased coverage and/or effectiveness and /or efficiency of the health services at national and institutional levels.	New career path regulations. * Observatories of human resources. * Databases about equity in the deployment of human resources. *Studies about Nursing Migration. *Database on Unions and Professional Associations in Health Services. *Online Training in HR management for decentralized Units. *HR components in priority/MDG-related programs.	n/a	National plans integrating 5 major challenges in 6 countries. *Career paths:12 Observatories: 25 countries and 2 subregional Database about equity as a regular data collection in 10 countries Migration monitoring systems in Andean and Caribbean subregions. Database on unions extended to all countries. *Online training course integrated to permanently make offerings in the Virtual Campus *HR plans in HIV and other MDG-related programs tested in 6 countries.	Career path regulations : 8 countries (+67%) * Observatories of Human resources: 21 countries (+78 %) * Databases on equity in the deployment of human resources: 6 countries (+60 %) * Studies about nursing migration: 12 countries (N/A) * Database on Unions and Professional Associations in Health Services: 15 countries (+50 %) * Online Training in HR management for decentralized Units: 11 countries (+70 %) * HR components in priority programs: framework and assessment tools developed (+30 %)	The Directing Council in 2004 urged the Member States to participate and strengthen the HR policies at the national level. WHO decided to dedicate the World Health Day 2006 to Human Resources in Health, launching new initiatives in the Region.
In all countries, social protection in health extended to the informal labor sector.	# countries	n/a	100%	8 countries have done studies to measure exclusion of social protection in health.	As of mid-2005, it is not feasible to have 100% of countries with social protection in health extended to the informal labor sector by the end-2007. Suggested re-focus on strategies. **Revise objective:** *Fifteen countries with strategies and/or schemes to extend social protection in health to the informal labor sector under implementation.*

Priority Area 7. Ensuring Universal Access To Integrated, Equitable and Sustainable Health Systems (*cont.*)

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
More effective technology management and evaluation in one-third of the countries; and increased access of the poor to selected services through the use of telemedicine programs in at least half of these.	a) # countries conducting health technology workshops (see comments) b) # countries with telemedicine access	a) 10 workshops in LAC with approximately 400 individuals trained (3 in the U.S.) b) n/a* * This is a field with little systematic data, and the objective/indicator is not specific enough to measure meaningfully.	a) 1/3 b) any increase	a) Since 2002 12 technology management and clinical engineering workshops have been held in 10 countries, with approximately 800 individuals trained. Approximately 3 workshops are done per year. b) Several LAC countries are starting to implement telemedicine solutions at some level. The main developments are university-centered projects linking universities to local health posts in rural areas.	The main PAHO vehicle for addressing the objective/indicator (a) has been a series of workshops sponsored by the American College of Clinical Engineering, PAHO, and partner organizations. The workshops educate national authorities on health care technology management and assessment, medical devices regulation, organization of technology support services, and contract management. Both (a) and (b) are ill defined and should be revised for the next Strategic Plan.
Increase connectivity among information systems that support health management and planning at local, national, and subregional levels.	connectivity	n/a	any increase	PAHO has acted as a catalyst and facilitator in connectivity projects such as: e-records for hospitals and health networks, satellite links for telemedicine, and ministry of health information systems.	Again, this objective and indicator are not well defined and are difficult to measure. An alternative should be examined for the next Strategic Plan.

Priority Area 8. Promotion of Effective Health Input Into Social, Economic, Environment, and Development Policies					
Objective	*Indicator(s)*	*Baseline (end 2002)*	*Target (end 2007)*	*Progress to date (end 2004)*	*Comments/Explanation of Progress*
Increase the number of countries able to demonstrate inclusion of health priorities in sustainable human development plans and/or in the negotiation and implementation of trade and integration agreements at regional, subregional, and national levels.	# countries	Limited reference to health in development plans, as well as trade and integration negotiations.	Health prioritized in development plans of 15 countries. Health prioritized by trade and integration agreements at subregional and regional levels.	The health sector is seen as a key development partner in several countries. Access to medicine, migration (including personal health), International Health Regulations, food safety, and other health issues are part of subregional and regional integration negotiations and agendas. Objective should be reached by 2007.	- MDGs and Summit of the Americas favor prioritization of health . - Inter-country negotiations on integration processes (including trade) at global, regional and subregional levels are more open to the consideration of health concerns.
Increase availability of information on the impact of policies adopted by the health and other development sectors on health inequities related to poverty, gender, and ethnicity.	availability on: a) poverty b) gender c) ethnicity	a-c) Data available just from occasional studies.	a) Data about the health impact of poverty reduction available in at least 15 countries. b-c) Any increased availability.	a) Data available from PRSP and a few countries. b-c) Data unavailable. Progress against proposed revised objective: One country currently has information available (target for 2007 is three countries).	a) PRSP and other initiatives promote the availability of such information. b-c) Data is not available, either for establishing a baseline or monitoring progress. **Revise objective:** *a) Increase availability of information on the impact of policies adopted by the health and other development sectors on health inequities related to poverty.* *b) Increase the number of countries with available information on gender inequities in health polices.*
Double the number of countries with legislation for effective control of selected health risks and equitable safeguard of health as a human right.	# countries	4 countries	Double 2002 (8 countries)	Model legislation prepared on the following topics: 1. Health financing and insurance (extension of social protection in health). 2. Health Codes/General Health Acts (covering all the areas related to health). 3. Specific regulations for the enactment of sections of Health Codes/General Health Acts.	Process includes: 1. A consensus building phase with ministries of health and parliaments. 2. The drafting of the model legislation (general or specific) with the participation of relevant actors (parliaments, civil society, private sector, professional and patients associations, among others). 3. The enactment of drafted legislation by national parliament. Even though the later requires an intense follow up process, final approval relies on parliaments. The number of countries with legislation is expected to double; the effectiveness of that legislation will remain to be seen.

Priority Area 8. Promotion of Effective Health Input into Social, Economic, Environment, and Development Policies (*cont.*)

Objective	Indicator(s)	Baseline (end 2002)	Target (end 2007)	Progress to date (end 2004)	Comments/Explanation of Progress
At least half of the countries report routinely on surveillance of inequities in health, as well as on access to and financing of health care initiatives related to poverty, gender, and ethnicity at national and subnational levels.	# countries reporting on: a) poverty b) gender c) ethnicity	a-c) Very few countries with systematic surveillance of poverty-, gender-, and ethnicity-related health inequities.	a) 50%+ b) 50%+ c) 50%+	a) HIPC/PRSP and a few countries are monitoring poverty-related health inequities. b-c) Data not available. **Y**	a) Global and regional initiatives are facilitating the achievement of this objective. b-c) Most countries are not tracking this indicator at this time; PAHO is supporting the collection and availability of gender-disaggregated health data, but this will not address the specific indicator, which will likely not be measurable. **Revise objective:** *At least half of the countries report routinely on surveillance of inequities in health, as well as on access to and financing of health care initiatives related to poverty at national and subnational levels.*
All countries of the Region utilize analysis of national health expenditures and other key financial measures in the formulation, monitoring, and evaluation of health policies and plans.	# countries	n/a	100% (48 countries)	67% (32 countries) **G**	Of a total of 48 countries, there are already 32 countries who have made progress and utilize analysis of national health expenditures and other key financial measures in policy planning; however, further work is needed for a systematic use of these indicators in the formulation, monitoring, and evaluation of health plans and policies.

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