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DRAFT STRATEGIC PLAN FOR THE PAN AMERICAN SANITARY BUREAU, 2008-2012

This Strategic Plan for the Pan American Sanitary Bureau, 2008-2012 (SP 08-12) is presented to the Subcommittee on Program, Budget and Administration (SPBA) for its consideration as a draft working document. The Bureau welcomes input from Member States on how to improve this Plan.

This document is being developed with full participation staff at all levels of the PASB. It is incomplete, and much work remains to be done before the full draft is submitted to the 140th session of the Executive Committee. Among the changes and revisions to be made are the following:

(a) Changes made to the WHO Medium-term Strategic Plan as a result of Member States' input at the January 2007 WHO Executive Board will be incorporated–most notably the merger of Strategic Objectives 10, 11, 13 and 14 (lamentably there was insufficient time for the Bureau to incorporate these changes prior to the SPBA).

(b) The analytical sections of each strategic objective will be refined.

(c) The Region-wide expected results (RERs) and indicators will be reviewed and completed.

(d) The indicators for the regional and subregional levels will be further developed (the subregional level is new for this Strategic Plan; the Region of the Americas is the only WHO Region currently working at this level).

(e) The resource envelopes assigned to strategic objectives will be reviewed and, as necessary, revised.

Finally, the Bureau notes that it intends to circulate this document among its partners and international organizations, including those agencies in the United Nations and the Inter-American system.

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To be completed by 1 May 2007 (for submission to the Executive Committee)

Executive Summary

To be completed by 1 May 2007 (for submission to the Executive Committee)

Introduction

1. This Strategic Plan for the Pan American Sanitary Bureau, 2008-2012 (SP 08-12, or the "Plan"), is the Bureau's highest-level planning instrument. Strategic plans are approved every five years by the Pan American Sanitary Conference. This Plan sets out the Bureau's strategic objectives and expected results for the planning period. It is a product of the efforts of country offices, centers and technical areas throughout the Organization. Staff at all levels have had the opportunity to participate in the Plan's development and to comment on its contents.

2. This Strategic Plan is intended as a transparent planning instrument that allows Member States to understand what programmatic objectives will be achieved using resources that they and others may provide to the Bureau for the planning period. The Plan is also the basis for all subsequent planning and programming in the Organization from 2008 to 2012. The document will not only guide the Pan American Sanitary Bureau's work, but is a comprehensive sum of the work to be carried out by the Bureau during this period.

3. From 1986 to 2002, the Organization adopted four-year framework documents containing policy orientations to guide technical cooperation with Member States; in 2002 the name of this instrument was changed to "Strategic Plan" and the period covered was expanded to five years: 2003-2007. The 2008-2012 Plan builds on this rich experience, and implements several key innovations designed to:

(a) Increase the PASB's accountability to its Member States, as well as the transparency of its operations;

(b) Further the implementation of results-based management in the PASB by applying results-based planning in a comprehensive and integrated fashion;

(c) Maximize participation by Member States, partner organizations and PASB staff in the development of planning instruments;

(d) Further align the operations of the PASB with those of WHO;

(e) Emphasize the country focus strategy of the Organization;

(f) Integrate and simplify the planning process in order to reduce the planning, monitoring and reporting burden on the PASB's country offices and technical areas, and to enable results reporting.

A New Planning Process

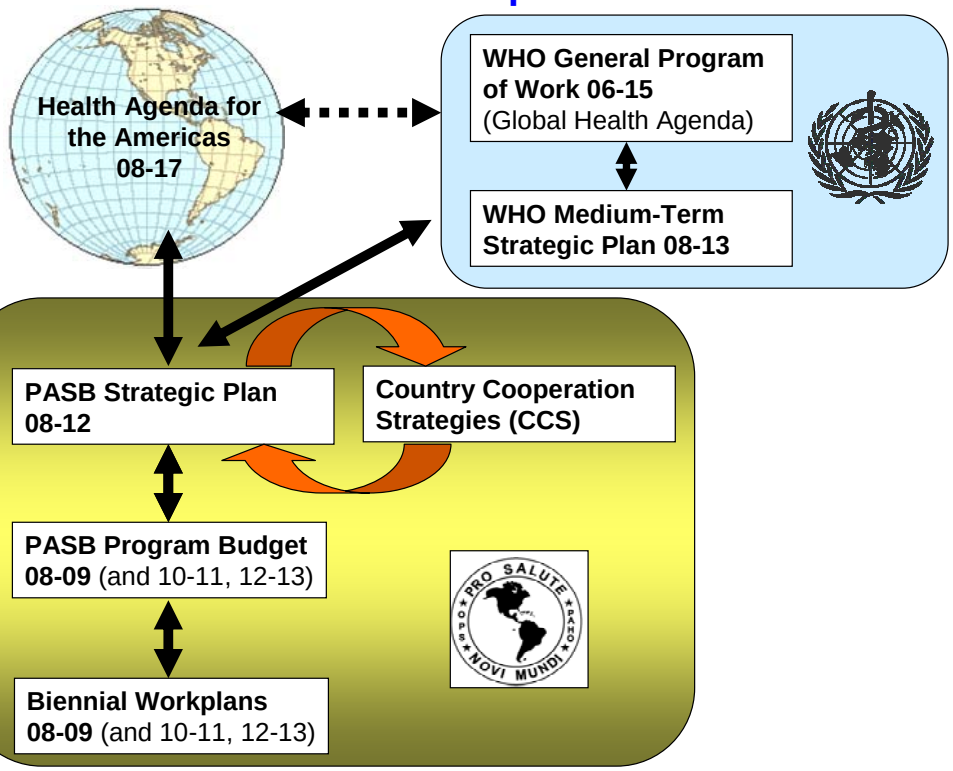
4. For the first time, the PASB Strategic Plan contains strategic objectives that are identical to those of WHO. The Strategic Plan will cover three biennia and, in another first, defines the Bureau's Region-wide Expected Results (RERs) and indicators. The Program Budgets for the period (2008-2009, 2010-2011 and 2012-2013) will define where resources will be expended in order to achieve the results defined in the Strategic Plan. These Program Budgets will be shortened and simplified, with RERs identical to those in this Plan**.** Thus the need for extensive program planning every two years is greatly reduced. At the same time, end-of-biennium assessments of the Program Budgets will serve as progress reports on the implementation of the SP 08-12, since the RERs and its indicators included in both documents will be identical. This concept is further elaborated in the section on Monitoring, Assessment and Evaluation, below.

5. While the PASB's Governing Bodies do not review the biennial Workplans of individual organizational entities, Member States may wish to note that operational planning at this level has also been reformulated to allow for full integration with the Strategic Plan and Program Budget. The biennial Workplans feed the Program Budget; this process represents the "bottom-up" aspect of the planning process. Workplans are being developed in concert with the Program Budget 2008-2009, so that the latter can accurately reflect the programs to be implemented at country level.

6. The full integration of all levels of the planning process is a crucial step in the implementation of results-based management, where expected results from all entities– country offices, centers, and technical areas in regional headquarters–aggregate to Region-wide Expected Results, then in turn to WHO's global Organization-wide Expected Results.

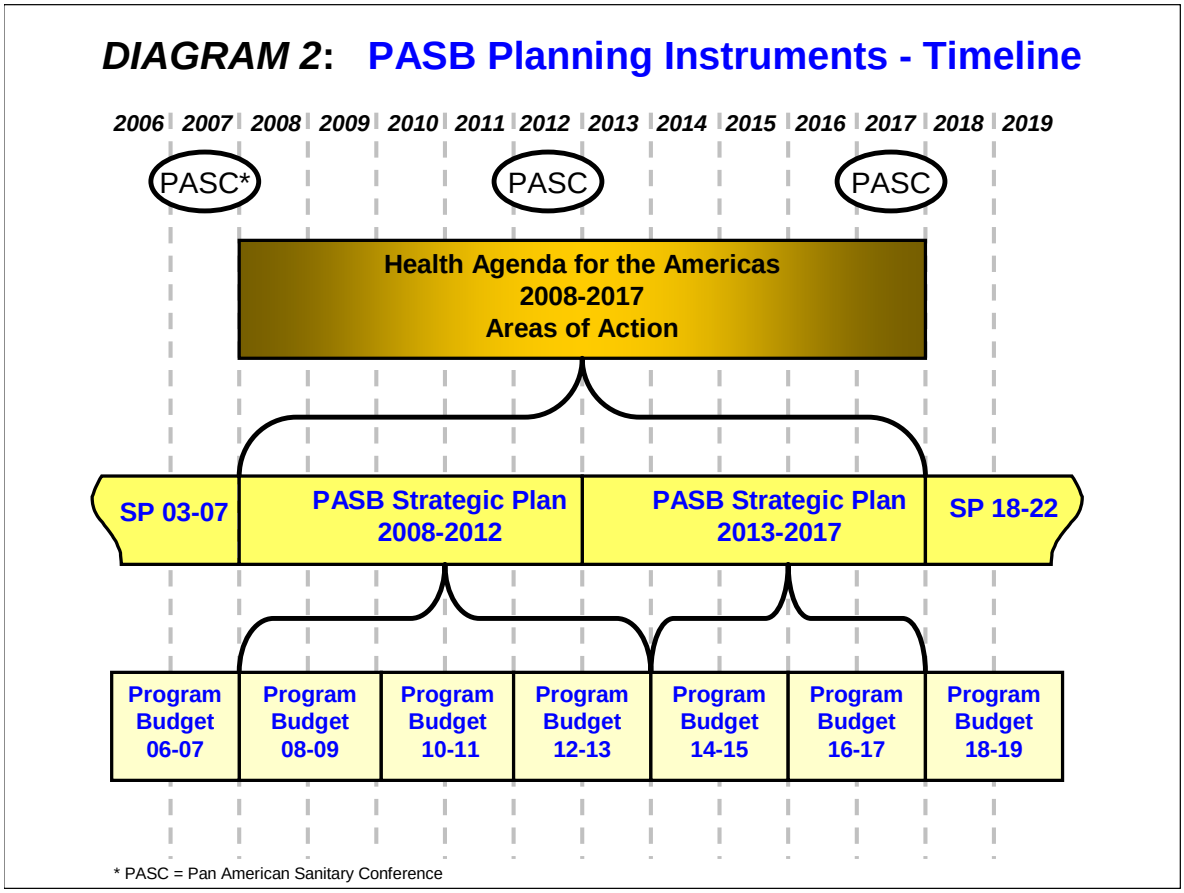
7. The following diagram graphically depicts the key elements in the PASB's planning process for 2008 onward and its relationships and alignment with the Health Agenda for the Americas 2008-2017 and WHO's high-level planning instruments.

***DIAGRAM 1*: PASB Planning Instruments for 2008 Onward and relationships**



Five Years, Three Biennia

8. Given the fact that the PASB works on a biennial budgeting basis, and that the Pan American Sanitary Conference (PAHO's highest Governing Body, which approves strategic plans) meets every five years, there is an inherent timing conflict in the planning and budgeting instruments. The solution, as proposed in document CD47/9, Methodology for the Formulation of the Strategic Plan for the Pan American Sanitary Bureau, 2008-2012, reviewed by the 47th Directing Council, is that this five-year SP 08-12 will programmatically cover three biennia (a six-year period) as depicted in the following diagram.



9. Thus, the programmatic expected results contained in each program budget are clearly linked to only one strategic plan, which is essential for coherent monitoring and reporting. The consequence of this proposal is that from a programmatic perspective, the strategic plans will de facto cover alternating six- and four-year periods. This system will also allow for programmatic alignment with WHO. The reporting of aggregated results will be done through the Program Budget assessments, to be completed every two years. This is depicted in Diagram 3 in the section regarding alignment with WHO, below.

Situation Analysis in the Region

Economic and Social Trends

10. Over the past decade, the Region of the Americas has witnessed a series of economic, social, and demographic changes with a potential impact on health.

11. After years of stagnation, economic growth resumed; today, nearly one-third of the countries exceed a growth rate of 6%. Per capita gross national income (GNI) [1] in the Region in 2004 put it among the regions with the highest income in the world. While the average income in Latin America and the Caribbean (LAC) is US$7,811, in some of its subregions—notably the Latin Caribbean, Andean Area, and Central America—the values are 20, 40, and 65% lower, respectively. The GNI of the richest countries is up to 23 times that of the poorest countries. The economic crises had a serious impact in 2002, especially in Argentina, Uruguay, and Venezuela, a situation that turned around in the majority of the countries by 2005. Notwithstanding the economic growth, the inequality in income distribution has increased. Income distribution in the Region (measured by the Gini coefficient) is one of the most unequal in the world and did not improve between 1990 (Gini of 0.383) and 2002 (Gini of 0.403). Inequalities result in poverty and their intensity is manifested in different segments of the population, such as households headed by women, certain ethnic groups, or rural populations. An estimated 41% of the population in LAC is poor and 17% is indigent.

12. Economic improvement brought with it improvements in labor market conditions, helping to mitigate the difficult social situation in Latin America and the Caribbean (LAC). Even so, urban unemployment held at nearly 10% between 2001 and 2004.[2] However, in 2004 it ranged among countries from a low of 2.0% to a high of 18.4%. Although more women are employed, their conditions of employment and opportunities for growth are inferior to those of men. Despite the existence of regulations, child labor is a concern, particularly given the unsafe, risky conditions in which it occurs.

13. Natural and man-made disasters have had a devastating impact on countries' economies. In 2005 alone, hurricanes were responsible for more than US$ 205 billion in losses, with 7 million people affected.[3] Damages in the small countries and economies of Central America and the Caribbean were estimated at more than US$ 2.22 billion, revealing their vulnerability and the need for prevention and mitigation plans and measures.

14. Population growth has slowed, although it ranges from 0.4% in the English speaking Caribbean to 2.1% in Central America. Unequal socioeconomic development drives people to move to urban areas in search of jobs and a better life. Thus, the urban proportion of the population in LAC grew from 65 to 78% between 1980 and 2005, with a lesser rate in Central America (53.2%) and the Spanish speaking Caribbean and Haiti

[1] Pan American Health Organization (PAHO). Health Situation in the Americas: Basic Indicators 2006. Washington, D.C,: PAHO, 2006

[2] Economic Commission for Latin America and the Caribbean (ECLAC). Social Panorama of Latin America 2005. Statistical Annex. ECLAC: Santiago, 2006.

[3] Economic Commission for Latin America and the Caribbean (ECLAC). Preliminary overview of the Economies of Latin America and the Caribbean. ECLAC: Santiago de Chile, 2005.

(59.7%). Urbanization poses challenges for health in terms of the availability of resources and basic services, waste and refuse management, transportation, and violence prevention. Rural areas suffer from the ongoing problems of poverty, limited resources, and lack of access to health services. Factors such as the chaotic growth of cities, indiscriminate industrial development, and migration from rural to urban areas adversely impact the environment, health, and quality of life of the population, contributing to marginalization—characterized by makeshift housing, poverty, environmental pollution, and higher levels of disease and violence. Makeshift housing in urban areas increased by 14% between 1990 and 2001, affecting 127 million people. In response to this trend, efforts have been made to address health determinants factors by creating healthy and sustainable public policies, healthy spaces, and public-private partnerships; strengthening support networks; mobilizing the media; and encouraging action by local governments in health promotion and development.

Trends in Health Problems and Risk Factors

15. Thanks to improvements in living conditions, including access to water and sanitation and to primary maternal and child health care, average life expectancy in the countries of the Region increased to 74.6 years in 2005. Consequently, the population is aging, demanding new services while manifesting greater economic dependency. Other important changes are related to environmental degradation and pollution, new lifestyles and behaviors, information dissemination, and the erosion of social and support structures in the population, which contribute to risk factors such as obesity, hypertension, an increase in accidents and violence, problems related to smoking, alcoholism, drug abuse, and exposure to chemical substances.

16. The Region's morbidity and mortality profile is changing, with communicable diseases replaced by chronic diseases as the leading causes, a phenomenon attributable to advances in technology and the aging of the population. Communicable diseases are still a major cause of mortality, with 58 deaths per 100,000 populations in 2000–2004,[4] and they are a heavy burden in poorer countries: for example, in Haiti the incidence of tuberculosis (TB) is seven times that of the Region. Added to this are challenges such as TB/HIV co-infection and multi - and extreme resistance to TB drugs. In 2006, 50% of dengue cases occurred in Brazil,[5] while malaria is endemic in 21 countries. Neglected[6] diseases cause anemia, malnutrition, memory loss and lower IQ, stigma and discrimination, permanent disability, and premature death. Several of these diseases often go hand in hand, multiplying their impact on health and the social and economic

[4] Health Situation in the Americas. Basic Indicators. Pan American Health Organization/World Health Organization. 2006
[5] 2006: Number of Reported Cases of Dengue and Dengue Hemorrhagic Fever (DHF), Region of the Americas (by country and subregion)
[6] PAHO Regional Program on Parasitic and Neglected Diseases

conditions of individuals and populations. The threat posed by potentially epidemic and pandemic diseases such as pandemic influenza is a challenge, since maintaining governments' commitment to address a problem that has not yet materialized is a complex undertaking.

17. Sixty percent of diseases affecting humans over the last ten years were caused by pathogens that originated in animals or their products, so prevention and control is needed. Human rabies transmitted by dogs decreased by 95% in the last 25 years of active control programs; however, for other zoonoses few actions have been implemented. Eradication of foot-and-mouth disease is important for food security and socioeconomic development; the Region is moving toward this goal. Travel and trade allow dissemination of infectious agents from their natural foci. Food safety is another public health and economic issue. Modernization of inspection services, strengthening of reference services, harmonization of legislation and *Codex Alimentarius* support, are in place to address food safety.

18. Chronic diseases (CD) are major causes of death and disability in the Region, responsible for over 60% of all deaths and most health care costs. Their causes are hypertension, obesity, hyperglycaemia and hyperlipidemia, caused by lifestyle and behavioral actors. Trends forecast a two-fold or more increase of ischemic heart disease, stroke and diabetes in LAC; mortality from lung, breast and prostate cancers is also increasing. Communicable diseases affect men and women differently; racial/ethnic groups and the poor are more likely to be involved. Annual costs of CD are enormous; for diabetes, the estimated was US$65 billion for LAC in 2000.

19. In 2006, over 50 million people in LAC were 60 years or older, a group growing 2.5 times faster than the overall population. Studies show that more than 50% of this elderly group report poor health, 20% report limitations on daily living activities, and 60% have a serious CD. Their access to health services is also limited and more than 30% report that their health needs are unmet. In contrast, few LAC countries have health promotion goals for the elders. Shifts in funding can provide large impacts, since cost-effective solutions exist, from promotion to prevention and disease management, but stakeholders from different sectors need to be sensitized.

20. Smoking prevalence in the Americas varies, but exposure to second-hand smoke is both universal and high in most countries. The response has been the Framework Convention on Tobacco Control (FCTC), ratified by 60% of the countries. There has been progress in recent years, notably the major advances in Brazil and Uruguay and parts of the United States, Canada, and Argentina. The future poses challenges to implementing the measures contained in the FCTC: strong health warnings on the packaging of tobacco products; the creation of smoke-free environments; and a wide ban

on the advertising, endorsement, and sponsorship of tobacco products. It should be noted that the tobacco industry successfully lobbies for weak legislation.

21. In LAC, comprehensive and integrated actions are needed to achieve the health-related Millennium Development Goals (MDG) by 2015, particularly among vulnerable groups. Where governments and social systems fail to reach, families and communities often perform strategic health functions and, are a source of support and protection to the health and well-being of citizens; such local mechanisms need to be empowered, supported and strengthened. MDGs 1, 4, 5 and 6 call for reducing the prevalence of underweight children, the under-5 mortality rate and maternal mortality (MM) ratio; and halting and reversing the spread of HIV/AIDS.

22. In LAC, poor nutrition, the underlying cause in 42% to 57% of child deaths, exacerbates the impact of illnesses. Stunting and anemia are the most prevalent problems affecting growth and nutrition with 25% and 70% of infants and young children affected, respectively. At the same time, overweight and obesity affect 25% of children in some countries.

23. In 2005, the under-5 child mortality rate in LAC meant that 450,000 children died. One third of countries had rates of 30 or more deaths per 1,000 live births; these countries accounted for 60% of deaths, with perinatal and infectious diseases accounting for more than 60% and 25% of them, respectively. Half of the mortality reduction between 1990 and 2000 is attributed to childhood immunization; thus, use of new vaccines may expand gains, but vaccination coverage needs to be maintained. The lifetime maternal mortality risk of 1 in 160 translates into 22,000 annual deaths, 10 to 50% of them occurring among young women. Most of maternal mortality results from preventable causes, but in some countries essential obstetric and neonatal services are of poor quality or not in place, or are under-used because of access barriers or a lack of skilled personnel. Notable urban-rural disparities exist: fewer rural women attend 4 or more antenatal consultations and large proportions do not have access to skilled birth care. Adult HIV prevalences show that the epidemic is concentrated in North America (0.8 %) and Latin America (0.5%) and generalized in the Caribbean (1.2%), where it is the leading cause of death among young adults. In 2006 in LAC, 167,000 new HIV infections occurred and 84,000 people died of AIDS, with more women affected. Affected people continue to live in environments of stigma and discrimination.

24. Mental illness imposes a high health burden in the Americas. In 2002 it accounted for an estimated 25% of the total disability-adjusted life years lost to all diseases, with unipolar depression a significant component. Only a minority of people suffering from mental illness receive treatment, despite the impact of the problem. In 80% of the countries, the majority of beds are located in psychiatric—rather than general—hospitals, and 25% of the countries have yet to provide community care. Nevertheless, mental

health is on the countries' agendas; there are successful local and national experiences, user and family associations are emerging, and advocacy is growing. Cost-efficient interventions are possible, which can make the limited response satisfactory over time.

25. Traffic accidents are responsible for over 130,000 deaths and 1,200,000 injuries each year in the Americas. The leading causes are driving under the influence of alcohol, speeding, poor road and vehicle maintenance, and failure to use seat belts and helmets. Society is demanding that governments make this a priority issue, and countries such as Chile, Costa Rica, Colombia, and Cuba have managed to reduce the mortality from this cause. Networks of individuals and organizations have sprung up to promote plans and programs, improve information systems, expand knowledge about the causes, and evaluate interventions.

26. Violence remains a critical problem for populations in some countries of the Region, notwithstanding the interest of governments and society to deal with it; laws are on the books, but their enforcement varies so widely that it is impossible to say that they have had a positive impact. Measuring and assessing the impact of legislation is a challenge, but mechanisms such as the observatories of violence and hospital emergencies will lead to better information. Homicides increased in some countries, with men under 35 the most affected group; in Colombia, however, they decreased by 50% between 2001 and 2005. Surveys put the prevalence of family violence at 10 to 60%. Juvenile gang violence spread in the Region, especially in El Salvador, Mexico, the United States, Honduras, Guatemala, Jamaica, Brazil, and Colombia. Efforts are needed to improve the sector's treatment of victims, including financing for plans and programs.

27. Toxic chemical exposure is a serious public health problem in the Region. The use of chemicals in different phases of industrial and agricultural production processes puts the entire population at permanent risk, especially vulnerable groups such as children, pregnant women, workers, older adults, and the population with limited education and access to information about the toxicity of certain products. The volume of these substances has increased, and per capita exposure to some of them, such as pesticides, is three times higher than the global average per WHO. Although it is improving, the reporting of morbidity and mortality from acute and chronic poisoning does not reflect the magnitude of the problem. Efforts should be centered on: toxicosurveillance; strengthening of legislation, rigor in the registration of chemicals, the prevention of illegal trafficking in toxic and hazardous substances; civil society participation in chemical surveillance and control mechanisms; the adoption of chemical safety as part of sustainable development policies; and expanding alternatives to pesticides, such as integrated pest management and organic agriculture.

28. In 2004, the economically active population was estimated at 414 million workers, or 46% of the Region's population--a 13% increase over the year 2000.

According to WHO (2005), 60% of workers are exposed to hazardous and unhealthy working conditions that entail a variety of risks that impact health. It is estimated that accidents in the workplace, 8% of global accidents, result in 312,000 deaths and 10 million disability-adjusted years of life lost. Activities such as agriculture, construction, and mining are the most dangerous. Informal employment is associated with greater occupational risk and unstable working conditions with no legal protection, compensation, or health benefits; women, children, and older adults are the least protected groups working in this sector.

Trends in the Health System Response

29. The health subsystems of LAC specialized in different population strata, producing segregation. The architecture of the health systems, with its unintegrated arrangement of subsystems serving different population strata, led to segmentation and fragmentation. The health service delivery networks that were created followed the pattern of the subsystems, with limited integration and communication among health units and within and between subsystems and different levels. Service delivery was concentrated in the more affluent urban areas and the salaried population, resulting in inefficient resource utilization and leaving the economically and socially marginalized unprotected. Many countries reformed their health systems to increase cost-effectiveness, financing sustainability, and decentralization, giving the private sector an important role. The reforms did not consider the countries' geographic, social, demographic, and political structure or the degree of institutional development in the sector. Instead, models suggested by multilateral financing agencies were adopted, centered on financial and management changes, deregulation of the labor market, and decentralization.

30. The creation of unregulated insurance and health service delivery markets and the proliferation of intermediaries in health service delivery accentuated the fragmentation of these systems. Thus, multiple uncoordinated and competing agents operate, creating overlapping and the duplication of service delivery networks without the complementarity of services and continuity of care. This situation hinders comprehensive care and the development of quality standards. Although the goal was to achieve greater pluralism, efficiency, and quality in health service delivery, in practice the State lost its steering capacity, health system operations were undermined, and public health issues took a back seat. The segmentation of financing accentuated segregation, with the emergence of benefits plans that differed in quality and quantity for the population, depending on financial circumstances. This resulted in major differences in the guarantee of assured rights, per capita spending levels, and access to services, along with repressiveness and inadequacy in public expenditure, with out-of-pocket expenditures predominating and catastrophic risks for the financial security of families. An estimated 20 to 25% of the population in LAC (200 million people) do not have regular, timely access to the health system. From the standpoint of performance, the

segmented and fragmented systems combine the worst of two worlds: inequity and inefficiency.

31. Public health expenditure is a basic public policy instrument for improving health status, reducing inequalities in the population's access to health services, and protecting people from the adverse effects of disease or early mortality on living conditions. Public health expenditure as a percentage of GDP in LAC rose from 2.6% in the 1980s to 3.6% in 2005-2006, below the figure of 7.3 to 8.6% in developed countries; it ranges from 1.3% in poor countries to 4.5% in those with high levels of public health service coverage, and to 7.5% to 10% in countries with health systems that provide universal coverage. Part of the growth of public expenditure in health has been for insurance systems, but with modest gains in coverage. In 2006, 23% of the Region's population (140 million people) was covered by public health insurance systems. Critical measures for improving health status and reducing inequalities in access to health services include: greater public expenditure on health, public health, and health care; improvements in the distributive impact of that expenditure; and an expansion of the coverage of public health insurance and social protection programs.

32. Health systems are based on the availability and competency of personnel who offer accessible, quality services. Numerous studies and the World Health Report 2006 of WHO indicate the need for an optimal number and quality of health workers to meet public health targets. To ensure that available competencies meet health needs a medium-term effort must be planned to address the following challenges: long-term policies and plans to adapt the workforce to anticipated changes in health systems and to develop the institutional capacity to review them periodically; the right people in the right places, with the equitable distribution of health professionals in regions, based on the population's health needs; regulation of health worker migration to guarantee care for the population; working conditions that foster a commitment to the institutional mission of guaranteeing health services for the population; and mechanisms for interaction between training institutions and health services to adapt health workers' training to a model of universal, equitable, and quality care that serves the population.

33. There are inequalities in access to essential health technologies and services in the Region; an estimated 125 million people living in LAC lack access to them. Many countries have inadequate and/or deteriorating physical infrastructures, lack of adequate specifications for purchasing new technologies, inappropriate organization of health services and insufficient qualified health personnel. As result, nonfunctioning technologies, under-used services, minimally trained staff, insufficient prevention policies, ineffective diagnostic and therapeutic protocols, and unsafe conditions for patients occur. For many technologies, it is critical to ensure that incorporation and use be done under legislation and supervision by regulatory authorities. National policies are needed to cover all aspects of health technologies and services, but will be successful

only if supported by regulatory mechanisms. While the advantages of health technologies and services are many, they can represent an unnecessary cost if the quality provided and its management are unacceptable. For health care to have greatest impact, particularly where resources are limited, priority should be given to the selection, establishment and procurement of essential health technologies and services. Control of health problems and achievement of health-related MDGs will rely on their correct use.

Other Challenges for the Future

34. Addressing and monitoring health problems calls for timely, reliable, quality data and information. Health information in the Americas is far from optimal in terms of its coverage and quality.[7] The countries' vital statistics and health information systems have limitations when it comes to providing the evidence needed for decision-making. Current problems require decisions in health to be based on: reliable health information systems that generate timely quality information, disaggregated in various ways; data from the health sector as well as other sectors, including health determinants; and the use of analytical methodologies and efficient tools for information and knowledge generation. For this purpose, a strategy has been developed for monitoring the performance of health information systems, based on the guidelines of WHO/PAHO and the Health Metrics Network.

35. A fundamental strategic tool for monitoring inequalities, global changes such as the aging of the population, urbanization, and changes in the mortality structure, as well as agreements and commitments such as the MDGs, is a set of basic indicators for the regional, national, and subnational level. Greater emphasis on data analysis and health information, the development of national and local capacities for application of the different methodological approaches, and adequate communication of health knowledge will result in higher quality data and greater use of health information, impacting the health systems and, thus, the health of populations.

Lessons Learned from Previous Strategic Plans

36. Based on the Organization's experience with previous strategic plans, Program Budgets and other high-level planning instruments and processes, a number of thematic lessons learned have been applied to the development of the SP 08-12.

[7] Commission on Social Determinants of Health. Action on the social health determinants: learning from previous experiences. Geneva: WHO, 2005

Integration among all levels of planning, from strategic to operational.

37. In an era when results-based management is mainstreamed and accountability for achievements is the norm rather than the exception, all planning efforts in the Organization must speak to each other. The Mid-term Assessment of the 2003-2007 Strategic Plan highlighted this issue for the Bureau, in that the planned results of the biennial Workplans did not aggregate to the respective Program Budgets, which in turn did not aggregate to the objectives set out in the 03-07 Strategic Plan. The new 08-12 Plan rectifies this, enabling true results-based planning for the Organization from the strategic to the operational plans. This will enable not only ease of monitoring and reporting, but also increased accountability and transparency of the PASB's activities to PAHO Member States.

A complete and comprehensive plan

38. Over the past decade, there have been many plans, programs and projects from various sources (internal and external) for the Bureau to implement. Not all of these initiatives have been completely harmonious. This Strategic Plan, therefore, is considered to be both comprehensive and complete: there will be no operational work undertaken by the Bureau that does not contribute to the objectives contained in this Plan. The Bureau believes that sufficient flexibility is built into the expected results set out for the PASB that it will be able to change and respond to new challenges in the health arena as they arise.

Country Cooperation Strategy

39. The PASB has worked in a decentralized way at country level, with biennial Workplans (formerly called "biennial program and budgets" or BPBs) in every country offices, for decades. In recent years the Country Cooperation Strategy was introduced. The Country Cooperation Strategy (CCS) is the PASB's strategic planning mechanism at country level; it has proven to be a key component of the country focus policy. The CCS methodology, proposed by WHO and adapted to the region, reflects a medium-term vision for WHO/PAHO cooperation with a given country or group of countries, and defines a strategic framework for working with them.

40. The CCS represents a balance between country priorities and regional (as well as global) strategic orientations and priorities in line with national health development objectives. It constitutes a framework for WHO/PAHO cooperation in and with the country/group of countries concerned, highlighting what the organization will do, how will do it and with whom. All levels of the Organization (global, regional, subregional and country) must be present in the biennial Workplans of PAHO/WHO Representatives

(PWRs) in order to fully exploit our potential. The biennial Workplan is thus a true "One Country Plan" where the efforts of all levels of the Organization convene.

41. As of mid-2007, 11 CCSs were completed, 7 were in the final stages, and 9 were planned for completion in 2007 or early 2008. In addition, an analysis of country CCSs by subregion is being carried out; and will feed into the Subregional Cooperation Strategies (SCSs) and the respective biennial Workplans. An SCS is underway for Central America and another is under consideration for the Caribbean

42. The CCS has proved to be a strategic tool allowing open dialogue with national stakeholders and technical cooperation partners. In 2006, the Bureau undertook an assessment of the CCS documents already prepared. This preliminary assessment analyzed the strategic agendas and variables to draw lessons learned and make recommendations to improve the CCS process in the region. The results of the assessment have been shared with PASB managers, as a valuable input for the planning and programming process. Apart from this, guidelines and instruments to carry out a CCS were also reviewed in order to further improve the CCS process; capturing lessons learned and disseminating best practices.

43. The Bureau's country presence, as set out in the CCS and led by the PWR, is valued by the Member States and is what makes our Organization unique; this Strategic Plan recognizes and builds on these strengths.

Strategic Alliances and Partnerships.

44. The PASB's experience over the past decade has shown that improving the health situation in the Americas requires not only strong political commitment, but also integrated health and development policies, and broad participation of civil society as a whole. This participation has to occur at all levels, from the individual and local community up to the national, subregional, regional and global level. The large number of new national and international actors working to improve health necessitates a collaborative approach. The Pan American Sanitary Bureau is uniquely suited to lead and coordinate these collective efforts, and catalyze change to increase institutional capacity. This includes joint and coordinated efforts between the public sector, the private sector, and civil society.

45. Another important aspect is intersectoral work. Experience shows that progress on the determinants of the health requires cooperative action with other sectors including education, agriculture, environment, finance, and international relations to ensure holistic plans and actions.

46. Interagency work has also been fundamental. The Bureau will continue to strengthen its work with other agencies of the United Nations system and of the Inter-American System for the purpose of avoiding duplication and increasing synergies. Moreover, the Bureau will work to strengthen joint efforts with existing partners and improve links with nontraditional partners. Health networks will continue to be developed.

47. It is important to note coordination of the PASB's work with the UN system. Work on the Common Country Assessment-CCA and the UN Development Assistance Framework (UNDAF) has been intensive. This work has related closely to the Country Cooperation Strategy (CCS). The PASB will continue to participate in the UN reform process, strengthening partnerships with those who work for health and development at the country level. The harmonization of programs and strengthening of the UN teams in countries are primary objectives.

Key Countries and vulnerable groups

48. The 2003-2007 Strategic Plan introduced the concept of Key Countries as a strategic priority for the PASB. The translation from concept to operational reality was worked out over time, notably through prioritization for assignment of resources, personnel, and resource mobilization. This included the development of the Regional Program Budget Policy (CD45/7) that increased the overall allocation of resources to the country level.

49. The Key Countries were defined in the 2003-2007 Strategic Plan based on the following:

(a) The Highly Indebted Poor Countries (HIPC): Bolivia, Guyana, Honduras, and Nicaragua;

(b) Haiti, while not an HIPC, has maternal and infant mortality rates, two of the most sensitive health development indicators that are the highest in the Region and among the highest in the world.

50. At the same time, the Bureau became conscious that the needs of vulnerable populations in other countries, notably the poor, may not have been receiving requisite attention. Based on this experience, while there will be a continued emphasis on providing support to the Key countries, especially Haiti, the new Strategic Plan seeks to simultaneously address the needs of vulnerable populations in all countries of the region.

Resource estimation

51. Previous strategic plans did not attempt to assign resource estimates or "envelopes" to strategic priorities, at times giving the impression that all strategies had equal priority, and avoiding the very real issue of what activities should receive more or less resources. In order to ensure that the 08-12 Plan sets out realistic and achievable strategic priorities and supports them with resources, it includes an analysis of funding sources and levels needed to meet expected results. The resource levels included allow Member States to quickly see the relative priority given to different programmatic areas, and will also directly inform the Program Budgets for the period.

Framework for Technical Cooperation

52. This Framework classifies expected results into three categories: 1) addressing the unfinished agenda, 2) facing new challenges and 3) protecting achievements. This categorization proved useful in determining priorities in the 2004-2005 and 2006-2007 Program Budgets, and has been similarly applied in developing the priorities for this Strategic Plan.

Strategic Direction

53. The Strategic Plan for the Pan American Sanitary Bureau 2008-2017 is aligned with the WHO's General Programme of Work (GPW) and its Medium-term Strategic Plan (MTSP). The process of programmatic alignment with WHO has been carried out gradually over past planning cycles, recognizing the PASB's role as the WHO Regional Office for the Americas. With this SP 08-12, this process of programmatic integration is complete.

54. At the same time, the Bureau is also the health agency of the Inter-American System. In this capacity, the Bureau responds to the specific health needs of the countries of the Americas, which are summarized in the Health Agenda for the Americas 2008-2017.

55. Therefore, this Strategic Plan addresses both of these roles at the same time, responding to the GPW (via the MTSP), and the Health Agenda for the Americas in this Region. Both of these documents determine the strategic direction of the Pan American Sanitary Bureau. Maintaining the balance between the regional specificity that enhances the PASB's added value to its Member States and the PASB's role as Regional Office for the Americas of the World Health Organization is the challenge addressed in this Strategic Plan.

56. The PASB also responds through this Strategic Plan to the mandates of its Governing Bodies and other important fora. In September 2000, the United Nations Millennium Declaration committed countries to a global partnership to reduce poverty and improve health and education, along with promoting peace, human rights, gender equality and environment sustainability. The specific actions of this Plan to achieve the Millennium Development Goals are described in the Strategic Objectives section.

The Health Agenda for the Americas 2008-2017 [8]

57. The countries of the Americas have developed and launched a Health Agenda for the Americas 2008-2017 (Health Agenda or HAA). The stated intent of the HAA is "to guide the collective action of national and international stakeholders who seek to improve the health of the peoples of this Region". The HAA defines eight Areas of Action:

(a) Strengthening the National Health Authority;

(b) Tackling Health Determinants;

(c) Harnessing Knowledge, Science, and Technology;

(d) Strengthening Solidarity and Health Security;

(e) Diminishing Health Inequities among and within Countries;

(f) Reducing the Risk and Burden of Disease;

(g) Increasing Social Protection and Access to Quality Health Services;

(h) Strengthening the Management and Development of People Working for Health.

58. This Strategic Plan defines the Bureau's contribution to the countries' call for action in the Health Agenda. The following table shows which Strategic Objectives in this Strategic Plan contribute to which Health Agenda Areas of Action. Please note that "contribution" is defined as the SO containing one or more RER that explicitly addresses the Area of Action.

[8] **Note: this section may need to be revised pending the finalization of the Health Agenda in mid-2007**

	Health Agenda´s Areas of Action							
PASB´s Strategic Objectives	a) Strengthening the National Health Authority	b) Tackling Health Determinants	c) Harnessing Knowledge, Science, and Technology	d) Strengthening Solidarity and Health Security	e) Diminishing Health Inequities among and within Countries	f) Reducing the Risk and Burden of Disease	g) Increasing Social Protection and Access to Quality Health Services	h) Strengthening the Management and Development of People Working for Health
1. To reduce the health, social and economic burden of communicable diseases	X					X		
2. To combat HIV/AIDS, tuberculosis and malaria	X		X	X	X	X		
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	X	X		X		X	X	
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	X		X	X	X		X	X
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact				X				
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex		X		X		X		
7. To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches		X			X			
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	X	X		X				
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	X			X		X		
10. To improve the organization, management and delivery of health services	X			X	X		X	
11. To strengthen leadership, governance and the evidence base of health systems	X		X	X				

12.To ensure improved access, quality and use of medical products and technologies	**X**		**X**	**X**				
13.To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	**X**			**X**				**X**
14.To extend social protection through fair, adequate and sustainable financing	**X**			**X**	**X**		**X**	
15.To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfill the mandate of WHO/PAHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	**Contributes to all**							
16.To develop and sustain WHO/PAHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	**Supports all**							

59. Thus, the Strategic Plan's Strategic Objectives and their respective Region-wide Expected Results demonstrate the contribution of the PASB to the Health Agenda for the Americas.

WHO General Program of Work 2006-2015

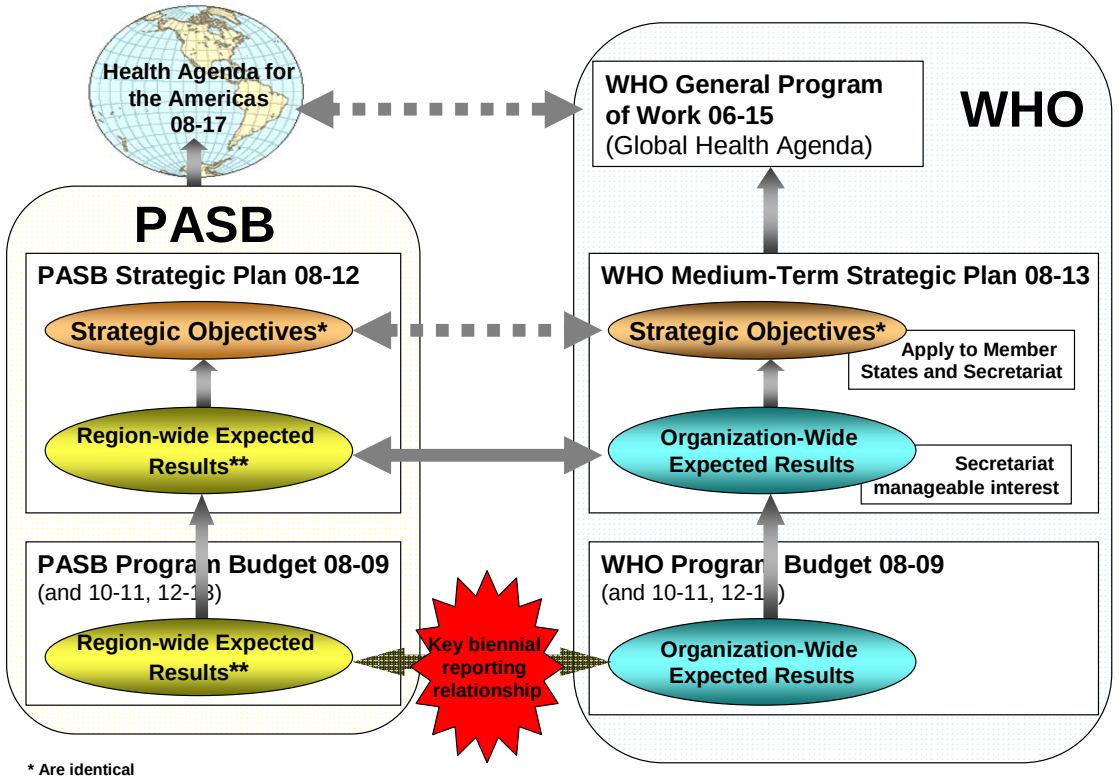
60. As noted, the Bureau seeks to harmonize the programs and objectives of the PASB and the WHO Bureau, while at the same time maintaining the regional specificity that addresses PAHO Member States' concerns and priorities, summarized in the Health Agenda for the Americas.

61. In keeping with the policy of greater programmatic alignment with WHO, this Strategic Plan directly adopts the 16 Strategic Objectives from WHO's MTSP. Furthermore, the PASB's contribution to WHO's organization-wide expected results (OWERs) is explicitly quantified in the Region-wide expected results (RERs). This is the first time that RERs have been developed with indicators that aggregate directly to the global level.

62. With respect to WHO's highest level planning instrument, the General Program of Work (GPW), the Bureau sees its contribution both in terms of the Strategic Plan's relationship to the Health Agenda for the Americas (developed in alignment with the Global Health Agenda contained in the 11th GPW) and the MTSP (developed by WHO to respond to the GPW), as well as in the core functions, a concept originating in the GPW.

63. The relationship between the Bureau planning mechanisms of the PASB and WHO is graphically represented in diagram No. 3.

***DIAGRAM 3*: Relationship between PASB and WHO Secretariat Strategic Planning**



Strategic Framework for Cooperation

64. The Strategic Framework for Cooperation is a mechanism for the Bureau to address regional and global health mandates, like those included in the 2000 United Nations Millennium Declaration (Millennium Development Goals). The Framework is comprised of three components: completing the unfinished agenda, protecting the achievements already attained, and tackling new challenges.

65. While each country operates in a particular way throughout this continuum, it is joint action—synergistic and synchronized, orchestrated and enhanced by the PASB—that can guarantee that we meet our common goals.

66. To **complete the unfinished agenda**, the PASB will focus on:

(a) Reducing high and unjustifiable maternal, infant, and child mortality rates;

(b) Reducing the unacceptable health indicators of the poorest sectors of society, and among these, indigenous peoples and Afro-descendants;

(c) Tackling the persistence of preventable or curable diseases that we refer to as "neglected," among them filariasis, trachoma, parasite infections, plague, Chagas' disease, brucellosis, and yellow fever;

(d) Reducing malnutrition and food insecurity in the Hemisphere's poorest communities;

(e) Extending coverage in water and sanitation.

67. To **protect the achievements** in health in the region, the Organization will emphasize:

(a) Expansion of vaccination coverage;

(b) Improved local health development and governance;

(c) Improved border health and subregional integration on health concerns;

(d) Enhanced primary health care;

(e) Sound public policies designed to improve people's quality of life.

68. In concert with our national counterparts and local and international partners, the PASB will **tackle the new challenges** of:

(a) The spread of HIV/AIDS;

(b) Increasing violence;

(c) SARS;

(d) The avian flu virus;

(e) The smoking epidemic (notably among women and youth);

(f) Disasters as they occur.

69. Each of the priorities listed above is integrated into the Region-wide Expected Results of the PASB, and has received high priority in the allocation of resources.

Core Functions

70. The PASB has adopted WHO's core functions as its own, with minimal modification of the term "technical support" to "technical cooperation" as used in the Region. The core functions were included in the 11th General Program of Work, with their origin in WHO's Constitution. They clarify the Organization's role in responding to

the global health agenda laid out in the 11th GPW, building on WHO's original mandate and an analysis of its comparative advantage.

71. The main reasons to include the core functions in the PASB Strategic Plan, and monitor their implementation, are as follows:

(a) To assess whether the PASB is expending its resources to perform the functions its Member States deem to be priorities. This can include a discussion of the allocation of resources for "normative work" versus "technical cooperation" keeping in mind that the two are complementary.

(b) To analyze and strengthen the functional role the PASB takes in its engagement with Member States and with other partners, including the UN agencies. This analysis can be performed to determine differences among the three levels of the PASB (regional, subregional and country) and among countries.

(c) To contribute to the global effort to group activities by core function and enable WHO-wide analysis of expenditures.

72. Therefore, beginning in 2008 the PASB will classify its expenditures by core function. The core functions are as follows (similar to WHO's in order to allow for world-wide aggregation of data):

(a) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;

(b) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;

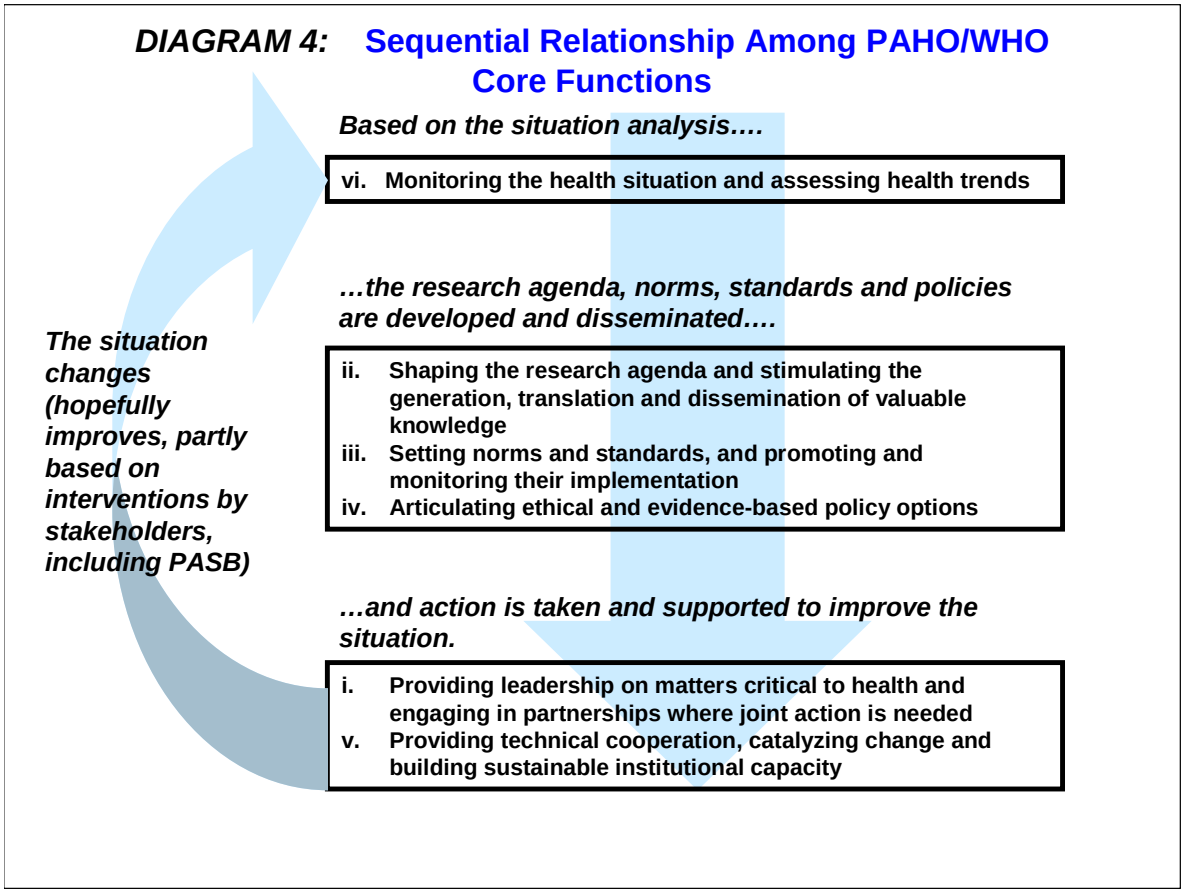
(c) Setting norms and standards, and promoting and monitoring their implementation;

(d) Articulating ethical and evidence-based policy options;

(e) Providing technical cooperation, catalyzing change and building sustainable institutional capacity;

(f) Monitoring the health situation and assessing health trends.

73. The following diagram No. 4 depicts the logical and sequential flow among the core functions of PAHO/WHO.



Strategic Objectives and Region-wide Expected Results

74. This section sets out the PASB's Strategic Objectives, which have been adopted directly from the WHO Medium-term Strategic Plan 2008-2013. Member States will note that the Strategic Objectives (or SOs) as approved by the World Health Assembly apply to all of WHO – both the WHO Bureau (which includes the PASB) and WHO Member States (and thus PAHO Member States). Therefore, while the WHO Bureau is responsible for monitoring progress toward the SOs, both Member States and the WHO Bureau are accountable for their achievement, since this is outside the Bureau's manageable interest.

75. The WHO Bureau is accountable for achievement of the Organization-Wide Expected Results (OWERs, also set out in the WHO MTSP). Similarly, the PASB is accountable for achievement of the Region-wide Expected Results (RERs). RERs contribute directly to all OWERs that apply to this Region; indeed RER indicators have

been developed to aggregate directly to applicable OWER indicators. Some RERs are specific to the region, and relate only to the broader SO, not a specific OWER.

76. The RERs (and their indicators) form a contract between the Bureau and PAHO Member States. If the PASB receives the levels of funding requested in its respective Program Budgets for the three biennia covered under this Strategic Plan, then Member States should expect the RERs to be achieved. Similarly, any proposed changes to the RERs will be presented to Governing Bodies for approval at the earliest opportunity.

A note regarding baselines and targets

77. During the development of the RERs and indicators for the Strategic Plan, the question arose as to what should be the universe of countries in which the PASB works. This is not a simple question to answer, but is highly relevant to indicators measured by the "number of countries" where a milestone is to be reached. For the purpose of aggregating achievements across geographic and political entities as diverse as Brazil, the British Virgin Islands, and the US-Mexico border, the following was agreed:

(a) For the purposes of the PASB's Strategic Plan's RERs and indicators, in order to facilitate operational planning and programming, the Bureau shall be considered to work in 40 countries and territories.

(b) These 40 countries and territories include:
- Thirty-five Member States: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, and Venezuela;
- Three Participating States (meaning their territories in the Americas): France, the Kingdom of the Netherlands, and the United Kingdom of Great Britain and Northern Ireland;
- One Associate Member: Puerto Rico;
- The United States-Mexico Border Field Office in El Paso, Texas.

(c) For reporting against the PASB Strategic Plan and respective Program Budgets, the Bureau will report achievements in these 40 countries and territories. However, when reporting against WHO OWERs, the Bureau will aggregate results only from the 35 Member States.

78. In all indicators measuring the "number of countries…" the universe of countries (denominator) is 40 unless an alternative denominator is specified. In the latter case, the baseline and targets are presented as a fraction, e.g. "15/21".

NOTE TO SPBA VERSION: The indicators are not numbered logically; they are organized to enable linking to WHO's MTSP indicators. The indicators will be re-ordered and re-numbered for the version of the PASB Strategic Plan for the Executive Committee.

Strategic Objective # 1
To reduce the health, social and economic burden of communicable diseases

Scope

79. The work under this strategic objective focuses on prevention, early detection, diagnosis, treatment, control, elimination, and eradication measures to combat communicable diseases that disproportionately affect poor and marginalized populations in the Region of the Americas. The diseases to be addressed include, but are not limited to: vaccine-preventable, tropical, zoonotic and epidemic-prone diseases, excluding HIV/AIDS, tuberculosis and malaria.

80. **Indicators and Targets**

- Coverage of interventions targeted at the control, elimination or eradication of tropical diseases. Target: 80% in the 29 countries (25 Latin America plus 4 in the Caribbean) with emphasis on the five key countries by 2013.

- Coverage of interventions targeted at epidemic prone diseases. Target: 80% in the 40 countries by 2013.

- The mortality rate due to vaccine-preventable diseases. Target: one third reduction by 2015.

- The proportion of countries achieving and maintaining certification of poliomyelitis eradication and destruction or appropriate containment of all polioviruses. Target: 100% by 2010.

Issues and Challenges

81. The work undertaken under this strategic objective aims at a sustainable reduction in the health, social and economic burden of communicable diseases, guided by the principles of access and equity, disease control, and development of public health infrastructure. This is in line with the global health agenda articulated in WHO's Eleventh General Programme of Work, 2006-2015 and includes investing in health to reduce poverty, building individual and global health security, harnessing knowledge, science and technology, strengthening health systems and improving universal access. The Health Agenda for the Americas (CE 139/5) provides a strong foundation for the proposed public health interventions under this strategic objective.

82. In Latin America and the Caribbean more than 210 million people live below the poverty line, and they bear the burden of communicable diseases. They account for 13.46% of deaths in all age groups, and 74 % of deaths in children in the Region. The

burden of communicable diseases is significant; WHO estimates that this group of diseases accounted for 25,000 DALYs in 2005. Indigenous population are especially vulnerable to this group of diseases, which deserves culturally appropriate interventions.

83. National **immunization** programs have reached approximately 90% vaccination coverage for all of the childhood vaccines, and they strive to achieve greater than or equal to 95% coverage in all municipalities. This is one of the best ways to ensure equitable access to existing vaccines and ultimately provide new life-saving vaccines that address important public health priorities to the people who need them most. . Despite the success of polio eradication and measles elimination, pockets of unvaccinated susceptible persons still persist, leading to outbreaks of diseases like diphtheria and pertussis, which carry high case-fatality rates.

84. PAHO promotes the strengthening of national capacity to introduce new vaccines based on the best available information. PAHO will continue to advocate that PAHO's framework and technical guides for vaccine introduction be strictly adhered to, as endorsed by PAHO's 47th Directing Council in September 2006 in Resolution CD47.R10. Fundamental to this process is that the vaccines be prequalified by WHO so that quality and safety is assured, supported by competent national regulatory authorities.

85. High quality surveillance will allow adequate preparedness to be in place for pandemics and vaccine-preventable actions related to threats of national and international concern. Surveillance systems for vaccine-preventable diseases need urgent upgrading, with emphasis on capacity development. Other challenges relate to assuring the quality of vaccines, which need to be guaranteed by competent national regulatory authorities.

86. **Emerging and Re-emerging Infectious Diseases**: The international spread of infectious diseases continues to pose a problem for global health security due to factors associated with today's interconnected and interdependent world, namely, population movements, through tourism, migration or as a result of disasters; growth in international trade in food and biological products; social and environmental changes linked with urbanization, deforestation and alterations in climate; and changes in methods of food processing, distribution and consumer habits. These factors have reaffirmed that infectious disease events in one country or region are potentially a concern for the entire world. Countries need to develop core capacities to respond to these challenges. Detection and response to Epidemic prone diseases, including pandemic influenza, SARS and neuro-invasive syndromes caused by arboviruses such as West Nile, need to be addressed within the framework of the International Health Regulations (IHR).

87. **Neglected diseases (NDs)**, directly or indirectly, affect the capacity of many countries in the Region to meet the MDGs. NDs have adverse effects not only on health and well-being but also contribute to low levels of school attendance, to poverty, and

stem from environmental problems. Lack of routine epidemiological surveillance and data-recording for the NDs in the Region make it difficult to accurately estimate disease burden. However, national surveys and special studies shed light on the burden in some populations. PAHO/WHO estimates that 20-30% of Latin Americans are infected with one of several intestinal helminths and/or schistosomiasis, two very important NDs. Lymphatic filariasis affects approximately 750,000 people while onchocerciasis puts 500,000 people at risk in the Region; both diseases are targeted for elimination. A study of cystic echinococcosis noted an estimated total of 52,693 DALYS lost in the Region, while economic losses total more that $120 million per year. Today there is better knowledge of the extrinsic determinants of neglected diseases, while new safe and inexpensive methods to monitor these diseases in populations and treat infected persons make their prevention, control and even elimination more feasible than ever before.

88. The global registered prevalence of **leprosy** in the Region of the Americas at the beginning of 2006 was 32,904 cases (0.39 per 10,000). The number of cases reported during 2005 was 41,780 (4.98 per 10,000). The global new case detection shows a decline as the number reported has fallen by over 10,000 compared to the new cases reported in 2004. Brazil, which traditionally accounted for the highest burden of leprosy regionally, has improved toward the goal of elimination. Countries that have achieved this goal are making efforts to further reduce the leprosy burden with *WHO Global Leprosy Strategy*, with emphasis on early detection and integrated approach in primary health services.

89. The number of **chagas** infected persons is estimated at 16 to 18 million. The estimated incidence of vector-borne transmission is 41,800 new cases per year, and the number of new cases of congenital chagas is 13,550. General seroprevalence in regional blood banks average 1.28%. It is estimated that different chagasic cardiopathies occur in 4,600.000 patients, and 45,000 people die per year as a consequence of this disease.

90. Major progress achieved in the Region:

- Transmission by T.infestans interrupted in over 80% of endemic Southern Cone countries.
- Reduction of domiciliary T.infestans infestation and in paediatric seroprevalence of T.cruzi infection in Bolivia, the major endemic country in the Region.
- Mexico has declared Chagas disease as a public health priority and is now implementing prevention and control activities.
- Serological screening coverage of Chagas control and blood banks programs in over 98% of endemic countries.

91. Between 2001 and 2005, more than 30 countries of the Americas reported a total of 2,879,926 cases of **dengue** and dengue hemorrhagic fever, reaching alarming figures

in 2002, in which year 1,015,420 cases were reported. During the same 2001-2005 period, 65,235 cases of dengue hemorrhagic fever were also reported. The Regional Dengue Program seeks to promote public health policies through a multi-sectoral, integrated management and interdisciplinary approach (EGI-dengue), making it possible to prepare, implement, and consolidate a strategy at the sub regional and national levels. This strategy comprises six key components: mass communication, entomology, epidemiology, laboratory, patient care and environment.

92. There has been a reduction of 90% in the number of cases of **rabies** transmitted by dogs as a result of 20 years of effective control efforts. During 2005, only 11 cases were reported.

93. PAHO/WHO has a primary role in preparedness, detection, risk assessment, communications and response to public health emergencies such as epidemics and pandemics. These can place sudden and intense demands on health systems. They expose existing weaknesses and, in addition to their impact on morbidity and mortality, can disrupt economic activity and development. Seventy-five percent of new diseases affecting human beings during the last ten years have been caused by pathogens originating in animals or animal products. There is an important link between human and animal health that needs to be addressed to prevent and control zoonotic diseases. The need for rapid response is a drain on available resources, staff, and supplies away from well defined public health priorities and routine disease control activities. PAHO has verified over 200 epidemics of international concern over the last five years.

94. Under the revised International Health Regulations (2005), which will come into effect in June 2007, PAHO/WHO will have a binding legal obligation to strengthen its internal epidemic alert and response capacity. In addition, PAHO is to support its Member States in the development and maintenance of minimum core capacities for the detection, and response to, public health risks and emergencies of which the majority are attributable to communicable diseases, thereby strengthening its early warning system. This entails technical assistance in conducting national assessments and corrective plans of action so as to strengthen national capacities.

Lessons learned:

- Prevention, control and surveillance of communicable diseases are essential components of human well being, including access to health, economic development, fair trade and security.
- Prevention of communicable diseases, including vaccine-preventable, epidemic-prone and neglected diseases, is one of the most cost-effective public health interventions. It has proven to be remarkably successful in yielding positive

economic returns, and narrowing gaps in equity by covering hard to reach marginalized, and economically disadvantaged population groups.

- PAHO's framework and technical guides for vaccine introduction should be strictly adhered to, as endorsed by its *47th Directing Council, September 2006, Resolution CD47.R10.*
- The PASB should assume a leadership role in setting a regional research agenda that will have an innovative and sustainable impact on disease control through the improvement, development and evaluation of new tools, interventions and strategies for public health priority needs.

Strategic Approaches

95. To achieve this objective, Member States will have to invest in human, political and financial resources to ensure and expand equitable access to high quality and safe interventions for the prevention, early detection, diagnosis, treatment and control of communicable diseases. Key components for this are:

- The establishment and maintenance among Member States of effective coordination with other partners and across all relevant sectors at the country level.
- Research promotion through adequate investment, capacity strengthening and effective partnership between the academic and public sector (programs). Mechanisms should be explored to encourage transfer of technology and new modalities of technical cooperation (i.e. south-to-south).
- Compliance of Member States with WHA 2005 established target dates for the implementation of the International Health Regulations.

96. In supporting Member States' efforts, the PASB will focus on:

- Strengthening collaboration with regional health stakeholders, partnerships and the civil society.
- Securing community access to existing and new tools and strategies, including vaccines and medicines, that meet acceptable standards of quality, safety, efficacy and cost-effectiveness, while reducing disparities.
- Strengthening its capacity to provide technical cooperation, and build capacity of Member States to better respond to commitments as per Health Assembly resolutions related to communicable diseases and the International Health Regulations. This includes facilitating national and international resource mobilization and advocacy efforts.
- Moving from vertical to horizontal approaches and, on the basis of a thorough assessment of past successes and failures in the creation of strategies for integrated health systems development, build on past strengths and address

weaknesses, capitalizing, among others, on subregional spheres, including economic fora (i.e. CARICOM, RESSCAD, etc.).

- Expanding institutional networks to improve public health.
- Maintaining and strengthening an effective international system for alert and response to epidemics and other public health emergencies, and facilitating public health preparedness in collaboration with other stake holders, including private and civil society organizations as appropriate.
- Providing Member States with tools, strategies and technical assistance to evaluate and strengthen monitoring and surveillance systems.
- Coordinating integrated surveillance systems at global and regional levels to inform policy decisions and public health responses.
- Shaping the research agenda for use in the formulation of ethical and evidence-based policy options and for direct application to public health interventions.

Assumptions and Risks

97. This strategic objective would be achieved under the following assumptions:

- That the entry into force of the International Health Regulations in 2007 will translate into a renewed commitment by all Member States to strengthen their national surveillance and response systems, and a sustained interest in and support for PAHO/WHO's activities on the part of donors and technical partners, including networks and partnerships.
- That in developing and strengthening national health systems, the aim will continue to be universal and equitable access to essential health interventions.
- That there will be a receptive and positive attitude towards coordination and harmonization of actions among the increasing number of actors in global public health.
- That effective communications mechanisms will be in place to maintain a strong and interactive coordination of efforts at the global, regional and subregional level.
- That political commitment and resources will be in place to secure effective surveillance and adequate preparedness for pandemics and vaccine-preventable actions related to threats of national and international concern.

98. The following risks may adversely affect achievement of the strategic objective:

- Diversion of resources either away from the Region of the Americas (i.e. pandemic influenza), or away from communicable diseases and towards other aspects of health and development, and the fact that prevention and control of communicable diseases are not recognized and visibly maintained as a health priority, particularly in the least developed countries.

- Emergence of parallel health agendas due to lack of communication and coordination among partners.
- Low investment and/or political commitment concerning the International Health Regulations and the fragmented approach of governments towards their implementation.
- Low or insufficient investment in research activities that might impact adversely on health interventions.
- An influenza or other pandemic-prone disease that could cause unprecedented morbidity and mortality, as well as grave economic harm. Advanced planning for appropriate detection and rapid response strategies will be required.

RER # 1.1	**Policy and technical support provided to Member States to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child health interventions with immunization.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.1.1.1	Number of countries achieving >95% DPT3 coverage nationally.	16	20	25
1.1.1.2	Percentage of municipalities with coverage level for DPT3 <95% in Latin America and the Caribbean.	38%	35% (5,277)	30% (4,523)
1.1.2	Number of countries supported to make evidence-based decisions on information available in the context of the introduction of new vaccines.	5	10	20
1.1.3	Number of essential child and family health interventions integrated with immunization for which guidelines on common program management are available.	4	6	8
1.1.4	Number of countries that have established a specified national budget line for vaccines, or vaccine legislation.	30	32	35
RER # 1.2	**Effective coordination and provision of support to Member States to maintain, by means of surveillance systems and appropriate immunization strategies, the polio free status and to ensure containment, leading to a simultaneous cessation of oral polio vaccination globally.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.2.1	Number of countries using oral polio vaccination (OPV) in accordance with internationally agreed upon time-line and process for cessation of routine OPV.	35	35	35
1.2.2	Percentage of final reports or updates on polio containment submitted by Regional Commission.	100%	100%	100%
1.2.3	Number of facilities storing poliovirus in the Americas.	1	1	1
1.2.5	Number of countries with sustained surveillance of acute flaccid paralysis.	40	40	40

RER # 1.3	**Effective coordination and support provided to Member States to provide access for all populations to interventions for the prevention, control, and/or elimination of neglected diseases, including zoonotic diseases**.			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.3.1	Number of countries achieving dracunculiasis eradication certification.	39	40	40
1.3.2	Number of countries that are implementing WHO Global Strategy for further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities.	1/1	1/1	1/1
1.3.3	Population at risk of lymphatic filariasis in four endemic countries receiving mass drug administration (MDA) or preventive chemotherapy.	2.4 million	4.7 million	6 million
1.3.4	Coverage of at-risk school-age children in endemic countries with regular treatment against schistosomiasis and soil transmitted helminthiasis (STH).	38%	50%	75% coverage
1.3.5	Number of countries that have incorporated a multidisease, interprogrammatic, intersectoral approach to the prevention, control or elimination of neglected diseases.	1/35	4/35	10/35
1.3.6	Number of countries that have incorporated an intersectoral, interprogrammatic approach to the prevention, control or elimination of zoonosis of public health importance.	1	4	10
1.3.7	Number of countries in Latin America that eliminated human rabies transmitted by dogs.	11/21	12/21	16/21
1.3.8	Number of countries of the Southern Cone supported in the maintenance of control programs in echinococcosis.	4	4	4
1.3.9	Number of countries in Latin America and the Caribbean assisted to maintain surveillance and preparedness for emerging or re-emerging zoonotic diseases (e.g. avian flu and bovine spongiform encephalopathy).	7/33	13/33	22/33
1.3.10	Number of countries with total interruption of Chagas Disease vector transmission (T infestans for South Cone, and Rhodnius prolixus in Central America).	3/21	11/21	15/21
1.3.11	Number of countries with total Chagas screening of blood banks for transfussional transmission.	14/21	20/21	20/21
1.3.12	Number of endemic countries with onchocerciasis elimination certification.	0	1	3
1.3.13	Number of endemic countries benefiting from new arrangements for production of Chagas disease treatment drugs.	2/21	21/21	21/21
1.3.14	Number of countries implementing new and improved interventions and implementation strategies for neglected diseases whose effectiveness has been determined and the evidence made available to appropriate institutions for policy decisions. COMBI = communication for behavioral impact.	COMBI for NDs = 2.	COMBI for NDs: 4.	COMBI for NDs: 6.
1.3.15	Number of countries that are implementing WHO Global Strategy for further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities.	0/24	8/24	15/24

RER # 1.4	**Provision of policy and technical support to Member States to enhance their capacity to carry out communicable disease surveillance and response as component of comprehensive surveillance and health information systems.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.4.1	Number of countries with enhanced surveillance of all communicable diseases of public health importance.	12/39	15/39	18/39
1.4.2	Number of countries receiving technical assistance from PASB to adapt generic surveillance and communicable disease monitoring tools or protocols to specific country situations.	0	20	30
1.4.3	Number of countries reporting using the joint reporting form on immunization surveillance and monitoring are received annually by 15 May.	13	18	20
1.4.5	Number of new and improved anti-microbial resistance (AMR) tools, interventions and implementation strategies whose effectiveness has been determined to appropriate institutions for policy decisions.	5	7	10
RER # 1.5	**New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed, validated, available, and accessible.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.5.1	Number of consensus reports published on subregional, regional or global research needs and priorities for a disease or type of intervention.	None	3 reports	6 reports
1.5.3	Number of new and improved interventions and implementation strategies whose effectiveness has been evaluated and validated.	none	2	6
1.5.4	Proportion of peer-reviewed publications based on PAHO/WHO-supported research where the main author's institution is in a developing country.	0%	30%	60%
1.5.5	Number of countries which have implemented Tropical Disease Research (TDR) new ten year vision, under the coordination of PAHO/WHO.	0	9	12
1.5.6	Number of new and improved drugs or vaccines for neglected disease being tested/evaluated or introduced into health services in the Region with PASB assistance, which have received internationally recognized approval for use.	0	1 new drug or vaccine	2 new drugs or vaccines
1.5.7	Number of Member States which have developed their research capacity through the technical cooperation of PAHO/WHO in partnership with other leading institutions in the region and outside the region.	3/33	5/33	7/33

RER # 1.6	Member States assisted to achieve the core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.6.1	Number of countries that have completed the assessment of core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005).	4	32	40
1.6.2	Number of countries supported by PASB to develop plans of action to meet minimum core capacity requirements for early warning and response in line with their obligations under the International Health Regulations.	0	32	40
1.6.3	Number of countries whose national laboratory system is engaged in at least one internal or external quality-control program for communicable diseases.	19/36	24/36	30/36
1.6.4	Number of Member States participating in training programs focusing on the strengthening of early warning systems, public health laboratories or outbreak response capacities.	38/38	38/38	38/38
RER # 1.7	**Member States and the international community equipped to detect, contain and effectively respond to major epidemic and pandemic-prone diseases (e.g. dengue, influenza, meningitis, yellow fever, hemorrhagic fevers, plague and smallpox).**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.7.1	Number of countries having national preparedness plans and standard operating procedures in place for major epidemic prone diseases (e.g. pandemic influenza).	0	10	40
1.7.2	Number of international support mechanisms for diagnosis and mass intervention (e.g. international laboratory surveillance networks and vaccine-stockpiling mechanisms for meningitis, hemorrhagic fevers, plague, yellow fever, influenza, smallpox).	5	6	7
1.7.3	Number of countries with basic capacity in place for safe laboratory handling of dangerous pathogens and safe isolation of patients who are contagious.	20	25	40
1.7.4	Number of countries implementing interventions and strategies for dengue control (EGI - Dengue).	12	15	17
1.7.5	Number of countries implementing interventions and strategies for dengue control (COMBI Plans for Dengue).	COMBI Plan for Dengue: 8 country plans.	COMBI Plans for Dengue: 10	COMBI Plans for Dengue: 14

RER # 1.8	**Coordinated regional and global capacity for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern rapidly available to Member States**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
1.8.1	Number of sites with the global event management system to support coordination of risk assessment, communications and field operations for headquarters, regional and country offices.	1	10	28
1.8.2	Number of countries with partner institutions participating in the global outbreak alert and response network and other relevant regional sub-networks.	29	35	40
1.8.4	Median time to verification of outbreaks of international importance, including laboratory confirmation of etiology.	7 days	5 days	3 days

Strategic Objective #2
To combat HIV/AIDS, tuberculosis and malaria

Scope

99. This strategic objective focuses on efforts to strengthen health systems and services response to combat HIV/AIDS, TB and Malaria in the Region. Universal access to comprehensive care for HIV/STI, TB and Malaria that includes the continuum of care from prevention to treatment constitute the long term goal under this strategic objective. To attain this long term goal program policies will be promoted that are evidence based and embrace the values of equity (including gender equity), excellence, solidarity, respect, integrity, efficiency, participation and autonomy. Strategic lines of actions are outlined regarding the strengthening of health sector leadership and the engagement of civil society; designing and implementing effective, sustainable HIV/AIDS/STI, TB and Malaria Programs and building human resource capacity; Strengthening, expanding and reorienting health services for prevention, diagnosis, treatment and care of HIV, TB, and Malaria; improving access to medicines, diagnostics, and other commodities; and improving information and knowledge management, including epidemiological surveillance. Specific interventions taking into account the burden of these diseases but also the needs of specific population and/or vulnerable groups as applicable (women, infants, children, young people, men having sex with men, commercial sex workers, injecting drug users, migrant population, mobile workers and indigenous peoples). Particular attention is given to strengthen health sector readiness and response to address emerging issues such as outbreaks, epidemics, emergencies, and drug resistance. Interventions to identify gaps between policy and practice, and bottlenecks that impede over-all availability of and access to quality services will be developed to assure attainment of targets and sustainability of desired results.

100. The scope of work in this strategic objective is comprehensively discussed in the Regional HIV/STI Plan for the Health Sector, 2006-2015; the Regional Plan for Tuberculosis Control, 2006-2015; and the Regional Plan for Malaria in the Americas, 2006-2010.

101. **Indicators and Targets**

- Reduction in the number of new HIV infections in all countries. Target: By 2010, 50% reduction followed by a further 50% reduction in new infections by the end of 2015 (baseline: 2006).
- Universal Access to comprehensive care including prevention, care, and antiretroviral treatment. Target: By 2010.

- Reduction in the incidence of mother-to-child transmission of HIV Target: By 2015, incidence will be less than 5%. (baseline: 2006).
- Elimination of congenital syphilis: Target: By 2015 incidence of congenital syphilis will be less than 0.5 cases per 1000 live births.
- Reduction of tuberculosis incidence in all countries. Target: by 2013, have halted and begun to reverse the incidence of tuberculosis (baseline: 39 cases per 100 000 inhabitants, 2005).
- Reduction in tuberculosis mortality of the disease at regional level. Target: 2013, reduction from 6 per 100,000 inhabitants in 2005 to 5 in 2013 (in accordance with MDGs).
- Reduction in tuberculosis prevalence of the disease at regional level. Target: 2013, reduction from 50 per 100,000 inhabitants in 2005 to 48 in 2013 (in accordance with MDGs).
- Reduce the burden of malaria in the Americas by 2010 and further by 2013. Target: 50% reduction in morbidity and mortality by 2010; >50% reduction by 2013 (baseline: 2000 morbidity and mortality figures[9]).
- Prevent the reintroduction of transmission in previously declared transmission-free countries. Target: All transmission-free countries retain their transmission-free status.
- Elimination of malaria from countries where such objective is deemed feasible. By 2013, at least 1 additional country in the region certified or enrolled in a WHO certification process for malaria elimination (baseline: 0 countries in 2007).

Issues and Challenges

HIV/AIDS/STI

102. At the end of 2005, approximately 3,230,000 million people were living with HIV in the Americas.[10] Of these, approximately 1,940,000 million were living in Latin America and the Caribbean (LAC). The epidemic is currently increasing (Graph 1); at least an estimated 220,000 people were newly infected with the virus during 2005. To December 2005, 1,540,414 AIDS cases were reported to PAHO/WHO, of which 30,690 (2%) were pediatric cases (<15 years old). It is estimated that these numbers are far from reality due to under registration and delays in reporting. Within LAC, the subregion most affected is the Caribbean, which ranks second amongst the world's ten regions for HIV prevalence with adults rates of 2-3%. The epidemic in LAC is diverse and all modes of transmission co-exist. The epidemic is generalized in the Caribbean while in most parts of Latin America and North America it is concentrated. The three groups that most

[9] PAHO, Regional Strategic Plan for Malaria in the Americas 2006 -2010
[10] WHO/UNAIDS, 2006

commonly have prevalence rates of more than 5% in those places are men who have sex with men (MSM), male commercial sex workers and infection drug users. The four groups that most commonly have HIV prevalence rates of 5% or more are not self-contained. They overlap and interact with other groups that, in turn, overlap and interact still with others, so that HIV infection can spread outward into the general population. The groups they are most likely to overlap and interact with includes prisoners, migrant workers, member of the uniformed services, truckers and other transport workers, and workers in mines and other isolated settings, so these are also groups where an epidemic is likely to concentrate before and if not tackled becomes more generalized (PAHO/WHO/UNAIDS, unpublished report, 2005). Even though an important proportion of countries still exhibit concentrated epidemics, trends are to a shift to generalized epidemics. In 2005, 30% of adults living with HIV/AIDS in the Americas were women, ranging from 25% in North America to 31% and 51% in Latin America and the Caribbean respectively (UNAIDS, 2006 report). The male to female sex ratio in reported AIDS cases is declining rapidly in the Region. Region-wide the proportion of all reported adult cases (for which sex is reported) occurring in women has increased over time, from 6.1% before 1994 to 15.8% in 1999; in 2002, the proportion was 16.5%. More and more young people are being affected by the epidemic. In LAC the UNAIDS estimated number of children <15 increased from 130,000 in 2003 to 140,000 in 2005. Limited recent data exist regarding HIV infection in indigenous people; however, Canada reports that they are disproportionately affected by the HIV virus (PAHO/WHO Regional HIV/STI Plan, 2006-2015). Higher rates of HIV infection than the general population have been found in indigenous communities and some ethnic communities.

103. To date, most infections are due to unprotected sexual intercourse, however, in several Southern Cone countries, injecting drug use is the major driving factor behind transmission.

104. Despite the introduction of Antiretrovirals (ARV), AIDS deaths continue to increase in the Region. The estimated number of deaths in adults and children due to AIDS increased from 97,000 in 2003 to 104,000 in 2005. However, a decline in reported mortality was observed in some countries with early introduction of ARV (Bahamas, Brazil, Canada, and USA).

105. While responding to the threat posed by the HIV/AIDS epidemic, the Region continues to be challenged by the spread of sexually transmitted infections (STI). It is estimated that on annual basis 50 million new cases of STI occur in the Americas. Surveys conducted in some Caribbean countries found that STI patients are seriously affected by the HIV epidemic. In several instances, HIV prevalence rates are 2 to 6 times higher in STI patients than in the general population. The magnitude of STI in the Region is difficult to measure due to limited data, underreporting and weaknesses of the surveillance systems. Examples of data from different countries and different

methodologies can illustrate the problem. In a sentinel site in Chile, of 10,525 STI consultations between 1999 and 2003, 22% of patients were diagnosed with condyloma, 10.4% with latent syphilis and 10.1% with gonorrhea. The same pattern regarding cases of gonorrhea and syphilis was observed among STI patients in Nicaragua during the period 2000 to 2002. A population-based survey (4) conducted in 2004 among adults in Barbados found that 14.3% of that population was infected by gonorrhea or chlamydia. In the United States, cases of primary and secondary syphilis declined between 1990 and 2000 %). However, cases of syphilis increased during the period 2000-2002 and continued to increase from 2002 (6,862 cases) until the end of 2003 (7,177 cases). Surveys conducted to determine the prevalence of syphilis among different most at risk populations have demonstrated that vulnerable groups in Latin America are heavily affected by STI. For example in 2003, Syphilis prevalence in Paraguay was 4.33% among blood donors and 6% among pregnant women in comparison with a high 37.4% prevalence rate among female sex workers. In 2004, a survey conducted by the Ministry of Health-Guyana found that 27% of female sex workers were infected with Syphilis. In Latin America and the Caribbean, 330,000 pregnant women are diagnosed with syphilis every year but are not treated adequately. This results in 110,000 infants being born with congenital syphilis yearly. Among these, only of 15,570 cases of congenital syphilis were reported from 11 Latin American and Caribbean countries in 2003. In countries where cases of congenital syphilis are reported annually, an increasing trend is being observed. In Venezuela cases increased from 50 in 2000 to 135 in 2002, and in Brazil, the rate of congenital syphilis per 1000 live births increased from 1 in 2001 to 1.5 in 2003.

106. The challenges ahead for the health sector remain in strengthening its capacity for the implementation of public health interventions which combines prevention, care and treatment to achieve greater impact in significantly reducing the number of new HIV infections and providing care and support to those living with HIV. The quest for universal access to prevention, care and treatment shall be the focus of the health sector interventions in the next decade.

Malaria

107. Malaria is a preventable and treatable vector-borne disease that afflicts approximately a million people in the Americas each year. One out of three inhabitants of the Region are considered at risk of getting infected and 21 countries in the Region have areas where malaria is considered endemic while other nations report imported cases which can potentially cause re-introduction of local transmission if not managed appropriately.

108. Pregnant women and children are considered vulnerable worldwide; and in the Americas, the vulnerable population includes persons living with HIV/AIDS, travelers, miners, loggers, banana and sugarcane plantation workers, indigenous groups,

populations in areas of armed and / or social conflict, and people along areas of common epidemiologic interest / border areas.

109. Malaria-related illness and deaths cost great burden to the economy of the Americas as 55% to 64% of cases are among people in their most-economically productive years of life.

Tuberculosis

- TB is a preventable and curable disease that is far from being eliminated as a public health problem in the Region. Despite progress in the Americas in the last decade, estimates indicate more than 447,000 cases and approximately 50,000 deaths every year. It affects predominantly the adult population, in reproductive age: 61% of the 2005 reported infectious cases were between 15 to 44 years old.
- Even though TB can affect everyone, there are specific vulnerable groups with the highest burden of the disease: the poor, migrants, marginalized populations, prisoners, people living with HIV/AIDS and the indigenous population.
- There are marked differences in the burden of disease between countries in the Region. In those countries with established market economies the estimated incidence is 5 cases per 100,000 inhabitants, however, in those countries with limited resources the estimated incidence rate is over 100 cases per 100,000 inhabitants. Twelve countries notified 80% of the total burden of TB in the Americas.
- The implementation of the DOTS strategy has contributed to advance in the control of this disease. A total of 33 countries had applied this strategy in 2005 with 88% coverage. However, the lack of total expansion of the services and the quality of services being provided impeded the Region to fully achieve the WHO targets for 2005 (at least 70% of people with infectious tuberculosis will be diagnosed, under the DOTS strategy, and at least 85% cured). The Region detected 65% of infectious cases (2005) and cured 80% of the infectious cases (2004) under DOTS.
- The main challenges identified for TB control in the Region are the HIV/AIDS epidemic, the TB multi-drug resistance (MDR-TB) and the TB extremely drug resistant (XDR-TB) along with the weaknesses of the health systems and the human resource crisis. In TB new cases, HIV prevalence ranges from 8 to 10% and the primary TB-MDR is 1.2%, with important variations among countries. These challenges are negatively impacting national programs for TB control since the burden of the disease may increase, including its mortality.
- The inadequate use of second line drugs is generating resistance to these drugs. With the increase of TB extremely resistant (XDR-TB), the lethality rate could increase as well as the cost for the health system.

Lessons learnt

- Previous and ongoing initiatives on HIV/AIDS, tuberculosis and malaria (e.g. “3 by 5”, Stop TB strategy and Global Plan to Stop TB 2006-2015, Roll Back Malaria, and the Global Fund to Fight AIDS, Tuberculosis and Malaria) have been good catalysts at global, regional and national levels in a longer-term global effort to realize the Millennium Development Goals. The challenge is to move towards universal access to prevention, treatment and care interventions in order to combat the three diseases.
- Interventions against these diseases can be expanded even in the most resource-challenged settings, but sound planning, sustainable financing and well-supported infrastructures are essential.
- Strengthening of health systems, adequate financial support, clear milestones, robust monitoring and evaluation, and enhanced partnership structures with improved coordination are essential ingredients in scaling up interventions against the three diseases so as to reach the goal of universal access.
- Various entry points and opportunities exist for scaling up prevention, treatment and care interventions against HIV/AIDS, tuberculosis and malaria in resource-limited settings, including integrated service delivery.
- Engagement of communities, affected persons, civil-society organizations, the private sector and other relevant stakeholders is essential to ensure local ownership and sustainability.
- Major difficulties remain for scaling up interventions at country level; ensuring sustainable financing and its effective use; steering financial and human resources towards clear public health results; ensuring linkages with relevant programs and initiatives; building synergies between interventions and service-delivery modes; minimizing competition between the various disease programs; and development and evaluation of more effective intervention tools.
- Program alignment and harmonization in the various levels of work (global, regional, subregional, country, and grassroots) needs further strengthening.
- Clarity and a common understanding of program objectives and concepts must be reinforced.
- Programmatic focus / constancy and consistency of efforts need to be sustained despite the complex nature and factors of these disease(s).
- Resources are limited and efforts and results must be optimized.
- Accountability within the organization and its sphere of influence needs to be reinforced.
- Proactive approach and better foresight must be maintained.
- Identify, enable, and sustain champions / human resource must be strengthened.
- Gaps between policy and practice must be minimized.

- The participation of all health care providers (public, private and traditional) provides opportunities to increase access to services for the prevention, control and treatment of TB, HIV and Malaria, particularly to vulnerable groups (i.e. indigenous population, prisoners, sex workers, migrants etc.).

Strategic Approaches

110. For the implementation of this strategic objective, PASB will utilize the following strategic approaches:

- Country driven technical cooperation, prioritization of countries according to magnitude of the problem and the nature of the health sector response and intensifying direct support to countries. Country offices will strengthen their responses to address comprehensively these diseases, identifying mechanisms to create synergies and harmonization of resources in the provision of technical cooperation and the execution of their biennial Workplan.
- Subregional action to respond to the diversity of the Region. Collaborative work with subregional entities and coordinating mechanisms (i.e. SISCA, RESSCAD, COCISS, ORAS, REMSAA, CARICOM, PANCAP, etc.).
- Interprogrammatic action. Joint planning, implementation, monitoring and evaluation around common topics will be foster between the three units responsible for the prevention and control of these diseases. Human Resources and Drug resistance are two priority issues that will require a joint effort.
- Facilitating Technical cooperation between countries.
- Advocacy for equitable universal access to prevention, care and treatment for HIV/STI, TB, and Malaria and for the elimination of stigma and discrimination against people with HIV and TB, and vulnerable groups.
- Strengthening alliances and partnerships at regional, subregional and country levels.
- Mainstreaming HIV/AIDS, TB and Malaria in PASB by developing mechanisms for interprogrammatic and interdisciplinary action to tackle these diseases, identifying synergy and pooling of resources and expertise as required.
- Technical support for the implementation of the Regional Plans for HIV/STI, Tuberculosis and Malaria. This will include:

    - Strengthening public health functions of the Health Systems to effectively combat HIV/STI, TB and Malaria through the development of relevant supportive National and Local Policies, Leadership and Management;
    - Strengthen and Support Human Resources and Provider Networks, including public, private and traditional providers;
    - Secure and Sustain Financing;

- Development of gender sensitive and intercultural approaches for the prevention and control of the three diseases;
- Deliver a Package of Interventions for Prevention, Diagnosis, Treatment, Care and Support for HIV, TB and Malaria, including clinical management of drug resistance (ARV drug resistance, TB MDR and TBXDR);
- Strengthen Monitoring, Evaluation, and Surveillance Systems for Decision Making and Accountability Towards HIV, TB and Malaria Targets;
- Ensure Availability and Proper Use of High Quality Medicines, Diagnostics, and Health Commodities. Continued support to the Strategic Fund for Public Health Supplies;
- Expand Quality-Assured Laboratory Networks;
- Deliver Services to Hard-to-Reach Populations and Vulnerable Groups (including indigenous populations);
- Empowering Affected Persons and Communities;
- Enable and Promote Research to Advance Prevention, Treatment, and Care;
- Implement control infection measures in the health facilities and in congregate populations, in order to protect patients, health staff and community.

Assumptions and Risks

111. The following assumptions and prerequisite conditions are essential in achieving this Strategic Objective:

- HIV/AIDS, TB and Malaria will continue to be recognized as a priority in all levels of the national and international health agenda; and receive adequate resource allocations;
- National health systems will correspondingly be strengthened towards realizing universal access to essential health services and care;
- Stakeholders will work in synergy towards the attainment of common goals and targets.

112. The following risks have been identified that may hinder achievement of the strategic objective:

- That raising and sustaining of the necessary resources may be difficult, both for the Bureau and Member States, as more competing priorities emerge and the cost of services increase due to the life-time chronic condition of HIV and the treatment of emerging resistance (AVR-DR, TB-MDR and TB-XDR); particularly, attracting resources to the Region will become increasingly difficult.

- That health gains in combating HIV/AIDS, tuberculosis and malaria may not be sustained in the least developed countries, without increased political and financial commitment.
- That PAHO/WHO's leadership among the growing number of partners, and the interaction among them, may be difficult to sustain, especially in the face of increasing competition for resources and special problems raised by coordination and harmonization.

Region-wide Expected Results

RER # 2.1	**Enhanced capacity of endemic countries for increased coverage of HIV, malaria and TB prevention, treatment and care among the poor, hard to reach, and vulnerable populations.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.1.1	Number of supported countries that have achieved the national intervention targets for HIV/AIDS consistent with the goal of universal access to HIV/AIDS prevention, treatment and care.	9	12	15
2.1.2	Of 21 malaria endemic countries, number implementing all components of the Global MALARIA control strategy within the context of the Roll Back MALARIA initiative and PAHO's Regional Plan for MALARIA in the Americas, 2006-2010 and national intervention targets.	20/21	21/21	21/21
2.1.3.1	Number of countries detecting 70% of estimated cases of pulmonary TUBERCULOSIS with a positive smear test.	13	21	25
2.1.3.2	Number of countries with a treatment success rate of 85% of TUBERCULOSIS cohort patients.	10/25	21/25	25/25
2.1.4	Number of countries that have achieved targets for prevention and control of sexually transmitted infections (70% of persons with sexually transmitted infections at primary point-of-care sites appropriately diagnosed, treated and counseled).	TBD in 2007	25	40
2.1.5	Number of countries working with the Ministries of Justice or Internal Affairs to control TB/HIV in prisoners.	10	18	25
2.1.6	Number of countries with work plans and functioning programs for TUBERCULOSIS control in indigenous populations (16 countries with indigenous population).	8/16	12/16	15/16
2.1.7	Number of countries applying TUBERCULOSIS control strategies in big cities (12 countries with cities with over 2 million inhabitants).	3	5	12

RER # 2.2	**Policy and technical support provided to countries towards expanded <u>gender sensitive</u> delivery of prevention, treatment and care interventions for HIV/AIDS, malaria and TB; including integrated training and service delivery; wider service provider networks; strengthened laboratory capacities and better linkages with other health services, such as reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.2.1.1	Number of targeted countries with integrated/ coordinated gender-sensitive policies on HIV/AIDS.	TBD	20	25
2.2.1.2	Number of targeted countries that have developed integrated/ coordinated gender sensitive policies on TUBERCULOSIS.	0/25	15/25	25/25
2.2.1.3	Number of targeted countries with integrated or coordinated gender-sensitive policies on MALARIA, particularly in pregnant women.	0/21	8/21	12/21
2.2.2.1	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by HIV/AIDS.	2	20	40
2.2.2.2	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by TUBERCULOSIS.	0/25	10/25	25/25
2.2.2.3	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by MALARIA.	0/21	10/21	21/21
2.2.3.1	Number of countries monitoring access to gender-sensitive, good-quality health services for HIV/AIDS.	2	20	40
2.2.3.2	Number of countries monitoring access to gender-sensitive, good-quality health services for TUBERCULOSIS.	0/25	10/25	25/25
2.2.3.3	Number of countries monitoring access to gender-sensitive, good-quality health services for MALARIA.	8/21	18/21	21/21
2.2.4	Number of countries involving other health providers (public, profit private and non profit private - Public and private mix) in TUBERCULOSIS control activities.	6/25	9/25	15/25
2.2.5	Number of countries that include Multi-Drug Resistant (MDR) TUBERCULOSIS management into the Direct Observed Treatment Short (DOTS) strategy and could prevent and treat Extensive Drug Resistant (XDR) TB.	13/25	20/25	25/25

2.2.6	Number of countries implementing the syndromic management of respiratory diseases in primary health care (Practical Approach to Long Health - PAL initiative).	5/25	11/25	21/25
2.2.7	Number of countries with laboratory networks of TUBERCULOSIS that fulfill international standards.	5/25	10/25	25/25
RER # 2.3	**Regional guidance and technical support provided on policies and programs to promote equitable access to essential medicines of assured quality for the prevention and treatment of HIV, tuberculosis and malaria, and their rational use, including appropriate vector control strategies, by prescribers and consumers; and uninterrupted supply diagnostics, safe blood and other essential commodities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.3.1.1	Number of global standards related to HIV/AIDS reviewed, adapted to regional needs and/or adopted.	4	7	10
2.3.1.2.	Number of countries implementing new or updated regional norms; and quality standards for diagnostic tools for TUBERCULOSIS.	2/25	5/25	8/25
2.3.1.3	Number of countries implementing revised / updated diagnostic and treatment guidelines on MALARIA.	16/21	21/21	21/21
2.3.1.4	Number of countries implementing revised/updated norms and quality standards for medicines and diagnostic tools for HIV/AIDS.	TBD	11	40
2.3.2.1	Number of countries with high incidence of P. falciparum MALARIA deploying artemisinin-based combination therapy obtaining them from a pre-qualified manufacturer.	6/13	10/13	13/13
2.3.2.2	Number of countries with endemic MALARIA conducting regular surveys of anti-malarial drug quality.	8/21	20/21	20/21
2.3.3.1	Number of countries receiving support to increase access to affordable essential medicines for TUBERCULOSIS whose supply is integrated into national pharmaceutical systems.	33/33	33/33	33/33
2.3.3.2	Number of malaria-endemic countries receiving support to increase access to affordable medicines for MALARIA whose supply is integrated into National pharmaceutical systems.	21/21	21/21	21/21
2.3.3.3	Number of countries receiving support to increase access to affordable essential medicines for HIV/AIDS whose supply is integrated into national pharmaceutical systems with prices negotiated through the strategic fund.	17	18	21
2.3.3.4	Number of countries purchasing 1st line TUBERCULOSIS drugs through the PAHO Strategic Fund.	1	5	10
2.3.4	Cumulative number of patients treated with support from the Global TUBERCULOSIS Drug Facility.	40,000	60,000	100,000
2.3.5.1	Number of countries implementing quality-assured HIV/AIDS screening of all donated blood.	32	35	40

2.3.5.2	Number of countries administering all medical injections with safe equipment as part of strategy to prevent transmission of HIV associated with health care.	TBD	20	40
RER # 2.4	**Global, regional and national surveillance, evaluation and monitoring systems strengthened and expanded to monitor progress towards targets and resource allocations for HIV, malaria and tuberculosis control along with monitoring the impact of control efforts and the evolution of drug resistance.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.4.1.1	Number of targeted countries that regularly collect, analyze and report surveillance coverage, outcome and impact data on TUBERCULOSIS using WHO's standardized methodologies, including appropriate age and sex dis-aggregation.	26	30	35
2.4.1.2	Number of endemic countries using epidemiologic indicators for monitoring and evaluating the disease burden of MALARIA.	21/21	21/21	21/21
2.4.1.3	Number of countries that regularly collect, analyze and report data on HIV/AIDS surveillance coverage, outcome and impact using WHO's standardized methodologies, including appropriate age- and sex-disaggregation.	TBD	20	40
2.4.2.1	Number of targeted countries collaborating with WHO on annual surveillance, monitoring and financial allocation data for inclusion in the annual global reports on TUBERCULOSIS control and the achievement of targets.	27	30	40
2.4.2.2	Number of countries providing WHO annual data on surveillance, monitoring and financial allocation for inclusion in the annual global reports on control of malaria and the achievement of targets.	21/21	21/21	21/21
2.4.2.3	Number of countries providing WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of HIV/AIDS and the achievement of targets.	TBD	40	40
2.4.3.1	Number of countries reporting on sex and age disaggregated surveillance and monitoring of TUBERCULOSIS drug resistance.	0/25	10/25	25/25
2.4.3.2	Number of endemic countries reporting age- and sex-disaggregated data from surveillance and monitoring of malaria drug resistance.	8/21	20/21	20/21
2.4.3.3	Number of countries reporting age- and sex-disaggregated data from surveillance and monitoring of HIV/AIDS drug resistance.	TBD	30	40
2.4.4	Number of countries reporting on surveillance and monitoring of co-infection TB/HIV.	15	20	40

RER # 2.5	Political commitment and mobilization of resources secured through advocacy and nurturing of HIV, malaria and tuberculosis partnerships at country, regional and global levels.			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.5.1.1	Number of targeted countries with functional partnerships for TUBERCULOSIS control.	4/25	8/25	25/25
2.5.1.2	Number of malaria endemic countries actively involved in networks / collaborations to combat MALARIA in the region.	21/21	21/21	21/21
2.5.1.3	Number of countries with functional partnerships for HIV/AIDS control.	TBD	20	40
2.5.2.1	Number of targeted countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for TUBERCULOSIS.	13/25	15/25	25/25
2.5.2.2	Number of countries that receive PASB support in accessing international financial resources to combat malaria.	12/21	14/21	14/21
2.5.2.3	Number of countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for HIV/ AIDS.	TBD	15	20
2.5.3.1	Number of countries that have involved communities, persons affected by the diseases, civil society organizations, private sector in planning, design, implementation and evaluation of TUBERCULOSIS programs.	3/25	10/25	25/25
2.5.3.2	Number of endemic countries involved in active MALARIA networks / collaborations in the region that include academia and other under-represented sectors, including communities, civil society organizations, private sector.	12/21	21/21	21/21
2.5.3.3	Number of countries involving communities, persons affected by the diseases, civil-society organizations and the private sector in planning, design, implementation and evaluation of HIV/AIDS.	TBD	20	40
RER # 2.6	**New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of HIV, tuberculosis and malaria developed, validated, available, and accessible.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.6.1.2	Number of endemic countries with a clear and implemented research agenda that gives adequate focus on MALARIA diagnosis and treatment.	8/21	21/21	21/21
2.6.1.3	Number of countries that do research on Integrated Vector Management (IVM) in MALARIA.	14/21	21/21	21/21

2.6.2.1	Number of new and improved interventions and implementation strategies for TUBERCULOSIS, whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	3	5	6
2.6.2.2	Number of endemic countries implementing revised / updated diagnostic and treatment guidelines on MALARIA and vector control prevention (e.g. insecticide treated nets).	15/21	21/21	21/21
2.6.2.3	Number of new and improved interventions and implementation strategies for HIV/AIDS, whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	TBD	2	4
2.6.3.1	Number of peer-reviewed publications arising from PAHO/WHO-supported research on HIV/AIDS, and for which the main author's institution is based in a developing country.	Baseline information is not available, it will be established in 2007	3	7
2.6.3.2	Number of countries implementing operational research in the National TUBERCULOSIS Program (NTP) plans and publishing their studies.	0/25	5/25	15/25
RER # 2.7	**Support provided to countries to strengthen resource mobilization strategies and implement mechanisms to increase absorption capacity**.			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.7.1	Average projected budget per person at risk of MALARIA allocated to support malaria programs and interventions in the 21 endemic countries.	$0.65 per capita at risk	TBD according to projected prevention and control needs	TBD according to projected prevention and control needs
RER # 2.8	**The capacity of developing countries increased to take the lead in HIV, tuberculosis and malaria research.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
2.8.1.1	Number of countries with a clear and well-implemented MALARIA research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	8/21	13/21	15/21
2.8.1.2	Number of countries with a clear and well-implemented TUBERCULOSIS research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	0/25	5/25	15/25
2.8.1.3	Number of countries with a clear and well-implemented research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	4	21	21

Strategic Objective #3

To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries

Scope

113. This Strategic Objective (SO) encompasses policy development, program implementation, monitoring and evaluation, strengthening of health and rehabilitation systems and services, implementation of prevention programs and capacity building, in the area of: chronic noncommunicable conditions (including cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, hearing and visual impairment and genetic disorders); mental, behavioral, neurological and psychoactive substance use disorders; injuries due to road traffic crashes, drowning, burns, poisoning or falls and violence in the family, the community or between organized groups; disabilities from all causes. Some notable characteristics of this SO:

- Comprehensive, requiring a combination of interventions for the population and individuals.
- Integrated, with prevention and control strategies focusing on major Chronic diseases (heart disease, stroke, cancer, diabetes, hypertension, mental disorder or injury/disability); cross cutting risk factors (e.g., diet, physical activity, tobacco, alcohol, drug abuse, road use behavior); and social determinants.
- Intersectoral, because major determinants of the chronic disease burden lie outside the health sector (e.g. poverty, laws, regulations, taxes, pricing, policies in agriculture, school nutrition, mass transport).
- Takes a life-course approach, because chronic diseases share multiple causes and pathways, a long development period, often start before birth, cause more than one comorbidity, and occur throughout life, often leading to functional impairment and/or disability, depression and premature mortality, tend to progress with ageing, and are also affected by the effects of physical and social settings/support, pathogenic microorganisms, occupational and domestic hazards, health care quality and accessibility.

114. **Indicators and Targets**

- A 2% annual reduction in chronic disease death rates from the major chronic diseases over and above current trends.

- To halt and begin to reverse current increasing trends of mental, behavioral, neurological and psychoactive substance use disorders (specific target TBD).
- To halt and begin to reverse current increasing trend in mortality from injuries (2% reduction in mortality rate from injuries per year).

Issues and Challenges

- Chronic diseases, mental disorders, violence and injuries are the major causes of death and disability in almost all countries, responsible for 75% of all deaths and most of the health costs, are rapidly increasing, and some affect men and women differently, as well as affect disproportionately some racial/ethnic groups.
- Major part of this increasing burden will be borne by low- and middle-income countries, but management is fragmented and tertiary care still consumes most of the resources.
- A wide range of cost effective, proven solutions exist from promotion, through prevention and disease management.
- Most major chronic disease determinants lie outside the health sector (diet, physical activity, alcohol, tobacco).
- Insufficient sensitization among audiences that matter about the human and economic impact and the availability of cost-effective interventions; Insufficient awareness about the link between chronic diseases and poverty; not on the MDGs explicitly.
- Resources available in the Organization not proportional with magnitude of problem, and are fragmented.
- Data and information for setting baselines and monitoring progress, especially risk factors, not well developed and capacities of countries vary widely to collect, analyze, report and use NCD data in program and policy.
- The challenges in this context are to increase awareness of the magnitude of the problem and the potential for health promotion and disease prevention; to increase the political will and international partnerships to address the problem; to initiate/deepen appropriate multi-sectoral collaboration; to synergize such resources as are available in the Organization, and to generate the necessary additional resources in an environment of competing interests; to develop the data and information systems for improved policy making, planning and MandE, especially those pertaining to modifiable risk factors, such as behaviors and the related cost data; and to re-orient the health services towards prevention and care providers' attitudes on stigmatization of mental health problems, cultural competency, etc.

Strategic Approaches

- Advocacy and policy work with governments, including an advocacy campaign to at least half the Cabinets over the life of the Plan stressing intersectoral action and healthy public policies, and public-private partnerships.
- Leveraging the subregional integration movements, e.g., Caribbean, Central America, Andean, and Southern Cone.
- Strengthening the surveillance, research and information base for policy, planning and evaluation, especially those pertaining to risk factors, using the WHO Stepwise approach to Surveillance (STEPS) methodology, and establishing this on a sustainable basis in at least half the countries.
- Shifting the balance to more Health Promotion and Disease Prevention, including a range of healthy public policies in nutrition and physical activity, tobacco control, alcohol control, and injury prevention and mental health where people live and work.
- Reorienting the health services and the integrated management of disease and risk factors-to stress prevention and the use of the primary health care approach, screening, etc., and leveraging the Strategic Fund to rationalize and help countries reduce the costs of drugs needed in chronic disease management.
- Inter programmatic work within the organization, connecting national, subregional, regional and global levels, and strengthened partnerships with key actors in countries and internationally.
- Priority will be given to those options which address problems where proven, rapidly effective interventions available ("Low hanging fruit" approach), and based on Political Feasibility in a given country or subregion.

Assumptions and Risks

- Data and information availability for effective policy, planning, monitoring and evaluation.
- Ability to secure high-level multisectoral collaboration in countries, individually and collectively.
- Partners in and out of the Organization respond and embrace approach.
- The MDGs will be adapted to reflect the importance of addressing chronic diseases in combating poverty and under-development.
- Options analysis will be used in planning and prioritization processes to take into account evidence-based interventions that have been proven successful or promising.
- Options analysis also has to monitor development and use, and costs of appropriate biotechnology (e.g. vaccine for HPV), genetic involvement in the etiology of some chronic diseases, leveraging use of other developments, e.g.,

using cell phone networks for collecting risk factor data, disseminating health messages, and improving compliance with necessary medications.

Region-wide Expected Results				
RER # 3.1	**Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable conditions, mental and behavioral disorders, violence, injuries and disabilities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.1.1	Number of countries that have a focal point or unit for injuries and violence prevention with own budget in the health ministry.	9	14	24
3.1.3	Number of countries that have a unit or focal point in the ministry of health (or equivalent) on mental health and substance abuse.	23	28	30
3.1.4	Number of countries that have a unit or department for chronic noncommunicable conditions with its own budget in the health ministry.	21	36	38
3.1.5	Number of countries where an integrated chronic disease and health promotion advocacy campaign has been taken to Cabinet-level to stimulate healthy public policy implementation.	3	10	20
3.1.6	Number of countries that have a Unit or focal point in the ministry of health (or equivalent) on disabilities prevention and rehabilitation.	10	19	27
RER # 3.2	**Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable conditions, mental and behavioral disorders, violence, injuries and disabilities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.2.1	Number of countries that have and are implementing national plans to prevent unintentional injuries and violence.	13	17	23
3.2.2	Number of countries that are implementing national plans for disability, including prevention, management and rehabilitation according to PAHO/WHO guidelines and Directing Council resolutions.	5	15	24
3.2.3	Number of countries that are implementing a national mental health plan according to PAHO/WHO guidelines and Directing Council resolutions.	27	29	30

3.2.4	Number of countries that have and are implementing a nationally approved policy document for the prevention and control of chronic, noncommunicable conditions.	13	32	36
RER # 3.3	**Improved capacity in countries to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities, as well as their risk factors and determinants**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.3.1	Number of countries that have published a national compilation of data on the magnitude, causes and consequences of injuries and violence.	11	16	22
3.3.2	Number of countries that have published a national compilation of data on the prevalence and incidence of disabilities.	8	15	19
3.3.3	Number of countries with national information systems and annual report that includes mental, neurological and substance abuse disorders.	21	24	28
3.3.4	Number of countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions.	14	28	32
3.3.5	Number of countries documenting the burden of hearing and visual impairment including blindness.	7	14	21
RER # 3.4	**Improved evidence compiled by the Bureau on the cost-effectiveness of interventions to address chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.4.1	Number of interventions for which evidence is available on the cost-effectiveness of widely available interventions for the management of selected mental and neurological disorders (depression, psychosis, and epilepsy) prepared and made available.	1	3	6
3.4.2	Availability of summarized evidence on the cost-effectiveness of a core package of interventions for chronic noncommunicable conditions together with an estimate of the regional cost of implementation in the Americas.	0	Package available and disseminated to countries and subregions	Package in use by countries and subregions

3.4.3	Number of countries with cost analysis studies on violence and/or injuries conducted and disseminated.	7	12	17
RER # 3.5	**Support provided to countries for the preparation and implementation of multi-sectoral, population-wide programs to prevent chronic non-communicable illnesses, disabilities, mental and behavioral disorders, injuries and violence.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.5.3	Number of countries implementing strategies recommended by PAHO/WHO for population wide prevention of disabilities, including hearing and visual impairment and blindness.	5	15	24
3.5.4	Number of countries for which guidance and support has been provided for the preparation and implementation of multi-sectoral population-wide programs to prevent hearing and visual impairment, including blindness.	TBD	TBD	TBD
3.5.5	Number of countries for which guidance and support has been provided for the preparation and implementation of multi-sectoral population-wide programs to prevent violence and injuries.	10	15	21
3.5.6	Number of countries having program of mental health promotion, and mental, behavioral and substance abuse prevention integrated into the National Mental Health Plan.	0	9	17
3.5.7	Number of countries implementing the Regional Strategy on an Integrated approach to prevention and control of Chronic Diseases, including Diet and Physical Activity.	3	10	30
RER # 3.6	**Support provided to countries to strengthen their health and social systems for integrated prevention and management of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.6.1	Number of countries that apply guidelines for violence and /or injuries in their health care services.	9	15	22
3.6.2	Number of countries that strengthened their rehabilitation services using the recommendations in The World Report on Disability and Rehabilitation and related PAHO/WHO guidelines and resolutions.	5	15	24

3.6.3	Number of countries with a systematic assessment of their mental health systems using the WHO-AIMS assessment instrument for mental health systems and utilizing the information to strengthen national mental health services.	9	15	25
3.6.4	Number of targeted countries implementing integrated primary health care strategies recommended by WHO in the management of chronic, noncommunicable conditions.	10	20	36
RER # 3.7	**Strengthened interprogrammatic approach for improved synergy and impact in the prevention and control of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.7.1	Number of countries that have applied an Interprogrammatic approach to address violence and/or injuries.	22	28	35
RER # 3.8	**Countries supported to develop monitoring and evaluation instruments to measure advances in the prevention and control of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
3.8.1	Number of countries that have significantly increased their capacity to deal with violence and/or injuries.	10	15	20
3.8.2	Integrated regional information system for countries and the Bureau developed for monitoring and evaluation including mortality, morbidity and risk factors, costs, programmatic coverage and input/policy indicators, for chronic diseases and risk factors (diet, physical activity, tobacco, alcohol), health promotion, mental health and injuries and violence.	System under development	System approved by Governing Bodies	System in use

Strategic Objective #4

To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals

Scope

115. The work under this strategic objective focus on reducing mortality and morbidity to improve health during key stages in life and ensuring universal access to coverage with effective interventions for maternal, newborn, child, adolescent, and sexual reproductive health, using a life-course approach and addressing equity gaps. Work will be undertaken to support actions to strengthen health systems, formulate and implement policies and programs that promote healthy and active ageing for all individuals.

116. **Indicators and Targets**

- Proportion of births attended by skilled health personnel. Target: at least 92% in the Americas.
- Maternal mortality ratio. Target: less than 5 countries with maternal mortality ratio above 100 per 100 000 live births.
- Under-5 mortality rate. Target: 28 countries having met or on track to meet Millennium Development Goal Target 5 (reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate).
- Access to reproductive health services, as measured by unmet need for family planning or contraceptive prevalence rate; the fertility of women aged 15-19 years as a proportion of total fertility among women of all ages; and syphilis screening for pregnant women. Target: 25 countries having met or on track to meet their national targets for all three indicators.
- Adolescent health, as measured by fertility proportions, HIV prevalence in young people aged 15–24 years, obesity and overweight, tobacco use and injury rate. Target: 25 countries having met or on track to meet their national targets for two of the five indicators and showing no deterioration in the three other indicators.

117. All indicators will be disaggregated by age and, where relevant, sex.

Issues and Challenges

118. This strategic objective is aimed at strengthening the core service components of primary health care and addressing an enormous burden of disease, while intensifying action towards reaching key health-related Millennium Development Goals (especially 4 and 5) and improving access to reproductive health care. In the Region of the Americas, the situation is worsening for some conditions (e.g., the incidence of sexually transmitted infections, fertility among adolescents), and is stagnating for others (e.g., maternal and neonatal mortality). At this time, most countries are not on track to meet the internationally agreed goals and targets.

119. Political will to make a difference in these areas is flagging and resources are insufficient. Those most affected (e.g., poor women and children in developing countries), have limited influence on decision-makers and are often excluded from care. Some issues are politically and culturally sensitive and do not draw the attention that they should, given the burden placed on public health. These issues will require advocacy and establishing relevant partnerships with the United Nations and other agencies in the countries. Efforts to improve the quality of necessary health care and to increase coverage are insufficient. Competing health priorities, vertical program approaches and lack of coordination between governments and development partners result in program fragmentation, missed opportunities and an inefficient use of the limited resources that are currently available. Lack of attention to gender inequality and gaps in health equity undermine ongoing efforts to decrease mortality and morbidity. This pattern can be changed through the concerted action of all involved.

120. In the Region, technical knowledge and program experience indicate that effective interventions exist for most of the problems covered by this strategic objective and that basic interventions are feasible and affordable even in resource-constrained settings. There is general agreement that what is required is action towards reaching universal access to, and coverage using key interventions. To this end, adopting a life-course approach that recognizes the influence of early life events and of inter-generational factors on future health outcomes will serve to bridge gaps and build synergies between program areas while also providing effective support to ensure active and healthy aging.

121. Additionally, interventions must be implemented within a primary health care setting and it must be ensured that they are in a culturally sensitive context. Expanding social protection in health is of interest to Member States in the older adult population and it should include the expansion of coverage and participation in the primary health care context.

122. Maternal and child health services, as well as some other reproductive health services, have long served as the backbone of primary health care and as a platform for

other health programs, especially for poor and marginalized populations; but they are now overburdened and overstretched. Scaling-up implies the development of a functioning health system that maintains a suitable infrastructure, a reliable supply of essential drugs and commodities, functional referral systems, competent and well-motivated health workers, and links with community leaders.

123. Lessons learned show that:

- The interventions that need to be scaled up are cost-effective and can be applied to scale even in resource-constrained settings, if sufficient attention is placed on developing an enabling policy environment and addressing key gaps in health systems;

- The programs concerned contribute to narrowing gaps in equity as they reach out to the most vulnerable and marginalized populations, including children, adolescents and women, indigenous populations, and serve as critical entry point and platform for other key public health programs.

Strategic Approaches

124. Achieving the strategic objective will require Member States and the PAHO Bureau to work closely together. Maximizing the participation with WHO/PAHO Collaborating Centers and PAHO Centers is needed. Accomplishing the strategic objective also means ensuring PAHO/WHO Country Representatives and Member States prioritize this work and allocate country funds appropriately. This strategic objective will require a country-led planning and implementation process for scaling up towards universal access to and coverage by maternal, newborn, child adolescent, sexual and reproductive health care, while addressing gender inequality and growing health inequities that fuel the high levels of mortality and morbidity.

125. In collaborating with Member States to advance the regional health agenda, PAHO will contribute to national strategies and priorities, and bring country realities and perspectives into global and regional policies and priorities. PAHO will also provide leadership and advocacy for investing in children and adolescents with a human rights approach. A continuum of care must be ensured that runs through the life course and spans the home, the community and different levels of the health system. This needs to occur within the broader framework of strengthening health systems to ensure adequate and equitable financing and delivery of quality health support services, with marginalized and underserved groups receiving priority attention.

126. This approach will also require the promotion of community-based interventions and participation of community leaders to increase the demand for services and to

support appropriate care in the home across the life course. The Region has conducted extensive work at the family and community level within the context of primary health care and has documented best practices and lessons learned. The sexual and reproductive health of women and men outside the reproductive process beyond reproductive age will also receive attention. In addition, it will be necessary to develop, implement and evaluate policies and programs that promote healthy and active aging and the highest attainable standard of health and well-being for their older citizens.

127. Achieving the strategic objective also involves strengthening the promotion of active and health aging to prevent early deterioration (both physical and mental) and expanding human resources in education in gerontology and geriatrics for family and community caregivers.

128. Emphasizing good monitoring, evaluation, and documentation of evidence and best practices, and formulating strategies, including case management and interventions for prevention and health promotion in an ecological model, will all ensure that the strategic objective is achieved.

Assumptions and Risks

129. The following assumptions underlie achievement of the strategic objective:

- Overall strengthening of health systems will occur, including the development and maintenance of a suitable infrastructure, a reliable supply of essential drugs and commodities, functional referral systems and a competent and well-motivated workforce.
- National actions will be undertaken for dealing with the crisis affecting human resources for health.
- Key processes will be pursued such as the improved harmonization of the work performed by UN agencies at the country level and the integration of health issues in national planning and implementation instruments.
- Potential for raising new resources for PAHO's work in these areas will be materialized, as there is considerable political interest in making progress towards the Millennium Development Goals; this will be likely increase with the support of global partnerships and initiatives, including the Partnership on Maternal, Newborn and Child Health.
- Latin America and the Caribbean have an aging process that will increase in the coming years. Despite the rapid aging of the Region, a significant window of opportunity for appropriate interventions to ensure that the aging of the population does not become a factor that can contribute to the collapse of health and social security systems in Latin America and the Caribbean.

130. The following risks have been identified that may adversely affect the achievement of this strategic objective:

- Threats posed by the continued possibility of a pandemic of Asian Flu in the Region, AIDS pandemic and setbacks in malaria and dengue control.
- In some countries, increasing poverty, natural crises, political instability and food insecurity may lead to the reversal of direction in some indicators.
- Lack of funds and political will are other factors that may negatively affect the accomplishment of the objective.
- Finally, a debilitated healthcare force including strikes and brain-drain may be a deterrence to the completion of the objective.

Region-wide Expected Results

RER # 4.1	**Support provided to Member States to develop comprehensive policies, plans and strategies promoting universal access to effective interventions in collaboration with other programs and sectors, paying attention to gender inequality and gaps in health equity, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.1.1	Number of countries that have policies, plans and programs promoting universal access to effective interventions in maternal, adolescent, and child health.	7	12	32
4.1.2	Number of countries that create a policy of universal access in sexual and reproductive health.	5	11	16
4.1.3.1	Number of countries that have laws, policies, and programs of geriatric health that include components of comprehensive health care.	11	15	18
4.1.3.2	Number of countries in which more than 50% of the population over 60 years old receive health and social service protection (in CAN and USA, over 65 years).	11	13	15
RER # 4.2	**National research capacity strengthened to produce evidence, technologies, and interventions with equity to improve health in mothers, newborns, children, adolescents and youth, to promote active and healthy ageing, and to improve sexual and reproductive health.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.2.1.1	Number of new research centers in neonatal, child, and adolescent health that are strengthened.	0	2	4
4.2.1.2	Number of new institutions that incorporate in the CLAP/MRH (Maternal and Reproductive Health) Network through the implementation of the Perinatal Information System (SIP).	50	75	150

4.2.2.1	Number of studies regarding health investment in social protection and geriatric health addressing the needs of those over 60.	9	11	15
4.2.2.2	Number of operational research studies in priority issues utilizing the data bases of Perinatal Information System (SIP).	13	50	100
4.2.2.3	Number of operational research studies in priority issues in child and adolescent health.	10	20	25
4.2.3.1	Number of new or updated systematic reviews on best practices, policies and standards of care for neonatal, child and adolescent health and food and nutrition interventions.	0	5	10
4.2.3.2	Number of evidence-based documents of effectiveness to improve key practices on sexual and reproductive health throughout the life course.	0	5	10
RER # 4.3	**Guidelines, approaches and tools for improving maternal care in use at the country level, with technical support provided to Member States to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.3.1.1	Number of countries that have implemented national strategies to ensure skilled care at delivery.	7	12	22
4.3.1.2	Number of countries that have implemented evidence based normative guides in sexual and reproductive health.	8	11	26
4.3.1.3	Number of countries that have adopted perinatal technologies to improve the quality of attention for mother and newborns.	8	12	27
4.3.2	Number of countries adapting and utilizing IMPAC (integrated management of pregnancy and childbirth) policy, technical and managerial norms and guidelines.	4	8	15
RER # 4.4	**Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.4.1.1	Number of countries with at least 50% of target districts implementing strategies for neonatal survival and health including neonatal Integrated Management of Childhood Illnesses (IMCI).	4	8	18
4.4.1.2	Number of countries that have implemented national strategies to ensure skilled care to newborns.	7	12	22
4.4.2.1	Number of countries that have adopted and implemented evidence-based guidelines and norms in maternal care and IMCI including newborns.	10	15	20

RER # 4.5	**Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.5.1	Number of countries implementing rights-based interventions in child health and development.	6	11	21
4.5.2.1	Number of countries that have adapted IMCI guidelines and where 75% or more of targeted districts are implementing them.	4	10	20
4.5.2.2	Number of countries that have implemented community-based policies using an IMCI methodology based on social actors to strengthen primary health care with respect to community and family health.	10	15	20
RER # 4.6	**Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.6.1.1	Number of countries with national programs in adolescent health and development.	6	11	16
4.6.1.2	Number of countries in the region implementing integrated strategies in adolescent health and youth development (Integrated Management of Adolescent and their Needs-IMAN).	3	10	15
RER # 4.7	**Guidelines, approaches and tools available, with technical support provided to Member States for accelerated action towards implementing the Global Reproductive Health Strategy, with particular emphasis on ensuring equitable access to good quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.7.1.1	Number of countries that have adopted the WHO Global Strategy of Reproductive Health.	5	8	15
4.7.2	Number of countries that have reviewed national laws, regulations and policies related to sexual and reproductive health according to WHO's recommendations.	1	3	5

RER # 4.8	**Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for ageing and health as a public health issue; for the development and implementation of policies and programs to maintain maximum functional capacity throughout the life course; and to train health care providers in approaches that ensure healthy ageing.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
4.8.1	Number of targeted countries that have implemented community-based policies with a focus on strengthening primary health-care capacity to address healthy ageing.	4	7	12
4.8.2	Number of countries that have multi-sectoral programs for strengthening primary heath care capacity to address healthy ageing.	8	10	14

Strategic Objective #5

To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact

Scope

131. The focus is on an integrated, comprehensive, multisectoral and multidisciplinary approach to reduce the impact of natural, technological or manmade hazards on public health in the Western Hemisphere. This is achieved primarily by strengthening the institutional capacity of the health sector, and in particular the Ministry of Health, in preparedness, risk reduction and in assuming its operational and regulatory responsibilities promptly and appropriately in response to any type of disaster. Main activities encompasses: advocacy, technical assistance, knowledge management and training.

132. **Indicators and Targets**

- Access to functioning health services. Target: 90% of affected populations with levels of access similar to, or better than, pre-emergency conditions within one year.
- Formal Health Disaster Program. Target: 15 Member States with a health disaster program with full time staff and specific budget.
- Resource mobilization. Target: In all major disaster situations, human, technological, and financial resources mobilized and coordinated at the national and regional levels within 24 hours.

Issues and Challenges

- This strategic objective is designed to contribute to human wellbeing, minimizing the negative effect of disasters and other humanitarian crises by responding to the health needs of vulnerable populations affected by such events.
- Disaster response will depend on the national capacity to manage disasters. International assistance only complements the national response. All efforts of the Organization must be directed to building national capacity and ensuring that international humanitarian health assistance supports the national structure. Disaster plans still focus on single hazards. They must be multi-hazard and multi-institutional.
- Natural hazards remain the most common threat to Latin American and Caribbean countries. Regardless of the frequency and severity of natural hazards, it is generally admitted that the countries' vulnerability is on the rise as a result of unsafe development practices and the deterioration of existing infrastructure. Safe hospitals will be the ideal target to contribute to risk reduction in the Americas.

- Technological disasters are perhaps the most overlooked risk factors for countries that have reached a certain level of industrial development. Little has been done in terms of regulation and prevention, and the health sector is poorly prepared to face a large-scale chemical, radiological and other technological disaster. This risk can only increase with economic development in the countries and the globalization of trade.
- Internal conflicts have a direct impact on the health of the population. Despite the relatively stable situation of the Region there have been a number of individual internal conflicts. A certain number of crises are to be anticipated over the next five-year period.
- The emerging threat of pandemic influenza in 2005 revealed that epidemics do not constitute a sufficiently important part of national disaster plans. Despite recent planning, health institutions are still inadequately prepared to face these kinds of threats.

Strategic Approaches

- As part of the United Nations humanitarian reform process, WHO has been asked to ensure the coordination, effectiveness and efficiency of activities concerning preparedness, response and recovery in relation to health action in crises. WHO leads the United Nations Inter-Agency Standing Committee Health Cluster. PAHO/WHO is the Health Cluster leader for the Western Hemisphere.
- Preparedness is a prerequisite for effective emergency response. Building national capacity to manage risk and reduce vulnerability calls for the following: advocacy, updated policies and legislation, training, appropriate structures, scientific information, plans and procedures, resources and partnerships.
- National emergency response needs to be improved in a wide range of areas, including mass-casualty management; water, sanitation and hygiene; nutrition; response to chemical and radiological accidents; communicable and non-communicable diseases; maternal and newborn health; mental health; pharmaceuticals; health technologies; logistics; health information services; and restoration of the health infrastructure. Strong technical guidance and leadership and better coordination will be needed to ensure that there are no shortcomings in those areas in future emergencies.
- The right people with the right skills need to be identified immediately after a disaster; the faster the response, the better the outcome. It is important to build national capacity and compile a roster of appropriately trained experts on call. Criteria and procedures should be agreed for collaboration involving all sectors.
- Developing the necessary knowledge bases and competencies in order to prepare for and respond to emergencies.
- Developing partnerships and coordination mechanisms with governments and civil society as well as with networks of collaborating and other centres of

excellence and UN Agencies, in order to ensure timely and effective interventions when needed.

- Developing technical and operational capacities across PAHO/WHO in support of countries in crises, particularly for conducting health assessments, mobilizing resources, coordinating health action, tackling shortcomings, providing guidance and monitoring the performance of humanitarian action in relation to the health and nutrition of affected populations.
- Harnessing the wide array of skills available across the Organization in response to emergencies, including in the areas of mental health, nutrition, water and sanitation, food safety, medicines, violence and injury prevention, mass-casualty management, communicable diseases, and maternal and child health.

Assumptions and Risks

133. Assumptions:

- Disaster preparedness and risk reduction receive strong political support at all levels. All member states remain relatively stable.

134. Risks:

- Humanitarian response is very demanding in terms of expert time and administrative support. The procedures of UN organizations are not particularly suited for field operational response activities. The risk of distracting staff from development priorities is real. This can be addressed by delegating implementation as much as possible to PWRs and technical programs and by refraining from submitting proposals that may be difficult to implement.
- Large multicountry disasters, such as occurred during the strong hurricane seasons of 2004 and 2005, seriously affect the implementation of the Program's work plan. However, they also offer great opportunities for new ideas, political support and creative initiatives.
- Work in the area of emergency preparedness and response may be incorrectly perceived as an additional responsibility that is secondary to the Organization's regular normative and developmental work.

Region-wide Expected Results

RER # 5.1	**Standards developed, capacity built and technical support provided to all member states and all partners for the development and strengthening emergency preparedness plans and programs at all levels**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
5.1.1	Number of countries in which disaster preparedness plan for the health sector are developed and evaluated.	24	30	35

5.1.2	Number of countries where comprehensive mass-casualty management plans are in place.	12	16	22
5.1.4	Number of countries developing and implementing programs for reducing the vulnerability of health, water and sanitation infrastructures.	7	20	30
5.1.5	Number of countries with a health disaster program with full time staff and specific budget.	8	11	15
RER # 5.2	**Timely and appropriate support provided to all member state in providing immediate assistance to population affected by crisis.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
5.2.1	Proportion of emergencies for which health and nutrition assessments are being implemented.	40%	65%	85%
5.2.2	Number of Regional training programs on emergency response operations.	4 training programs	6 training programs	7 training programs
5.2.3	Proportion of emergencies for which interventions for maternal, newborn and child health are in place.	50%	75%	85%
RER # 5.3	**Standards developed, capacity built and technical support provided to member states for reducing health sector risk to disaster and ensure the quickest recovery of affected population.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
5.3.1	Proportion of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component.	100%	100%	100%
5.3.2	Proportion of humanitarian action plans for complex emergencies and formulation processes for consolidated appeals with strategic and operational components for health included.	100%	100%	100%
5.3.3	Proportion of countries in transition or recovery situations benefiting from needs assessments and technical support in the areas of maternal and newborn health, mental health and nutrition.	100%	100%	100%
RER # 5.4	**Coordinated technical support on all technical areas such as communicable disease, mental health , health services, food safety , radionuclear, in response to most likely public health treats provided to all member states in preparedness, recovery and risk reduction.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
5.4.1	Proportion of emergency-affected countries where a comprehensive communicable disease-risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies.	90%	100%	100%
5.4.2	Proportion of situations involving acute natural disasters or conflicts for which a disease-surveillance and early-warning system has been activated and where communicable disease-control interventions have been implemented.	90%	100%	100%

RER # 5.5	**Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
5.5.1	Number of countries where expert networks are in place for responding to food-safety and environmental public health emergencies.	7	10	15
5.5.2	Number of countries with national plans for preparedness, and alert and response activities in respect of chemical, radiological and environmental health emergencies.	20	24	28
5.5.3	Number of countries with focal points for the International Food Safety Authorities Network and for environmental health emergencies.	27	29	32
5.5.4	Proportion of food-safety and environmental health emergencies benefiting from intersectoral collaboration and assistance.	25%	65%	100%
5.5.5	Number of countries achieving a state of preparedness and completing stockpiling of necessary items in order to ensure a prompt response to chemical and radiological emergencies.	7	10	15
RER # 5.6	**Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
5.6.1	Proportion of affected countries in which the United Nations Health Cluster is operational.	100%	100%	100%
5.6.2	Number of emergency-related Regional interagency mechanisms and working groups where PAHO/WHO is actively involved.	4	8	10
5.6.3	Proportion of disasters in which reports are widely disseminated with value added health information.	100%	100%	100%

Strategic Objective #6

To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

Scope

135. The work under this strategic objective focuses on integrated, comprehensive, multi-sectoral and multidisciplinary health promotion processes and approaches across all relevant PAHO/WHO and country programs, and the prevention and reduction of six major risk factors: use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diet and physical inactivity, and unsafe sex.

136. The main activities involve:

- Capacity building for health promotion and major risk factors prevention and reduction across all relevant programs and initiatives.
- Surveillance of risk factors and monitoring of policy and program interventions.
- Development of ethical and evidence-based policies, strategies, interventions, recommendations, standards and guidelines for prevention and reduction of the major risk factors.
- Development of mechanisms to ensure the necessary collaboration among all parties.

137. **Indicators and Targets**

- A 10% reduction in the total tobacco prevalence rate in half of the member states by 2013.
- A 10% increase in the number of Member States that have stabilized or reduced the level of harmful use of alcohol by 2013.
- 10% of Member States with high burden of adult obesity to stop the rise in prevalence by 2013.
- 75% of Member States collecting population based information on major risk factors: low fruit and vegetable intake, physical inactivity, tobacco use, and alcohol abuse; and anthropometry by 2013.
- 30% increase of youths aged 15-24 who can by 2013 correctly describe at least three ways of preventing non-desirable outcomes

of unprotected sex, such as STI, HIV infection and/or unplanned pregnancies.

Issues and Challenges

138. The 2002 World Health Report "Reducing Risks, Promoting Healthy Life"[11] reports that in 26 countries of the Americas the attributable mortality (in parenthesis number of deaths per 1000) by risk factor and sex rank is the following:

(a) Males

- Alcohol (207);
- High Blood Pressure (170);
- Tobacco (163);
- Overweight (117);
- Cholesterol (88);
- Low fruit and vegetable intake (81).

(b) Females

- High Blood Pressure (162);
- Overweight (144);
- Cholesterol (79);
- Low fruit and vegetable intake (58);
- Tobacco (58);
- Physical inactivity (55).

139. In the poorest countries of the Region, those in group D of World bank categories, the attributable mortality by risk factors for men have a very similar ranking: alcohol (22), high blood pressure (20) and unsafe sex (17); and for women high blood pressure (20), overweight (18) and unsafe sex (11). In these countries underweight contributes to 14,000 deaths among males and 11,000 deaths among females.

140. The six major risk factors addressed in this strategic objective are responsible for more than 60% of the mortality and at least 50% of the morbidity burden worldwide. They affect predominantly poor populations in low- and middle-income countries. While emphasis has been placed on the treatment of the adverse effects of these risk factors, much less attention has been devoted to prevention and how to effectively modify the determinants.

[11] WHO 2002 World Health Report assigned countries to the following categories, according to their mortality : A-very low child, very low adult; B-low child, low adult; C-low child, high adult; D- high child, high adult; E- high child; very high adult. In the Americas only Canada, Cuba and the United states are in category A, 26 countries are in category B; Bolivia, Ecuador, Guatemala, Haiti, Nicaragua, and Peru are in category D. There are no countries in categories C or E.

141. Tobacco use is the leading cause of preventable deaths worldwide, with at least 50% of tobacco-attributable deaths occurring in developing countries. It causes one million deaths in a region every year, with the Southern Cone having a highest mortality rate from smoking related causes. Tobacco use and poverty are closely linked and prevalence rates are higher among the poor. Fortunately, effective and cost-effective measures are available to reduce tobacco use. The WHO Framework Convention on Tobacco Control is an evidence-based treaty designed to help reduce the burden of disease and death caused by tobacco use.

142. Alcohol consumption is responsible for 4.8% of all the deaths and 9.7% of all Disability Adjusted Life Years in the year 2000 in the Region, with most of the burden in Central and South America. It is estimated that it led to at least 279,000 deaths in that year. Intentional and unintentional injuries accounted for about 60% of all alcohol-related deaths and almost 40% of alcohol-related disease burden. Most of the disease burden affects men (83.3%), while 77.4% of the burden comes from the population aged 15-44, thus affecting mostly young people and young adults in their most productive years of life. In some countries of the Region, injection drug use is a significant force behind the rapid spread of HIV infection. Alcohol and other psychoactive substance use are related to unsafe sexual behavior as well. Despite the evidence that alcohol is the leading risk factor for the burden on health and society, there are limited resources at PAHO and in countries to prevent and treat the harms caused by alcohol. Even though the treatment of other drug use disorders is cost- effective, treatment responses are weak and not integrated into health systems.

143. Regionally, a worrisome decrease in physical activity levels is widespread in LAC. Between 30-60% of the Regions' population does not achieve the minimum recommended levels of physical activity. This has been driven by increased urbanization, motorized transportation, urban zoning polices that promote car depending suburbs, lack of attention to pedestrians and cyclists.

144. The "nutrition transition" in the Region is characterized by low consumption of fruits and vegetables, whole grains, cereals and legumes. This is coupled with high consumption of food rich in saturated fat, sugars and salt, among them milk, meat, refined cereals and processed foods. This dietary pattern is a key factor leading to rise in prevalence of overweight and obesity. Population based studies in the Region show that in 2002 50% to 60% of adults and 7% to 12% of children less then 5 years of age were overweight and obese.

145. Unsafe sexual behavior significantly increases the burden of disease through unintended pregnancy, sexually transmitted diseases, including HIV/AIDS, and other social, emotional and physical consequences that are currently severely underestimated in present disease estimates. WHO estimates that unsafe sex is the second highest-ranking

global risk factor to health in high mortality countries. Each year 80 million women globally have an unwanted pregnancy, 46 million opt for termination, and 340 million new cases of sexually transmitted infections and five million new HIV infections are reported. Risky behavior does not often occur in isolation, for example, hazardous use of alcohol and other drugs and unsafe sex frequently go together. Many of these behaviors are not the result of individual decision-making but reflect existing policies, social and cultural norms, inequities and low education levels. Thus, PAHO-WHO recognizes the need for a comprehensive integrated health promotion approach and effective preventive strategies.

146. Despite the substantial global burden of poor health associated with the major risk factors, the effort continues to be focused on control of transmission of infectious diseases. The countries of the Americas should emphasize action against related Risk factors to non-communicable diseases, which have become the principal cause of morbidity and premature mortality in the Region.

147. The Member States should be very active in promoting awareness and political commitment to act decisively to promote health and healthy lifestyles, and prevent and reduce risk factor occurrence.

148. Significant additional investment in financial and human resources is urgently needed at all levels within WHO, Region of the Americas and, Member States to strengthen capacities and national and global responses to the prevention and early detection of these Risk factors and burden of death, disease and disability caused by these factors.

Strategic Approaches

149. An integrated approach to health promotion and the prevention and reduction of major risk factors will enhance synergies, improve the overall efficiency of interventions and dismantle the current vertical approaches to risk-factor prevention.

150. In countries, the strengthening of institutions and national capacities for surveillance, prevention and reduction of the common risk factors and related health conditions are essential actions. Furthermore, strong leadership and stewardship by health ministries is necessary to ensure the effective participation of all sectors of society. Action at the multi-sectoral level is vital because the main determinants of the major risk factors lie outside the health sector.

151. Leadership and capacity in health promotion need to be significantly scaled up in line with increased needs and activities across in country all relevant health programs. There is a need to implement resolutions at global (WHO 2005), regional (PAHO 2001

and PAHO 2006) and subregional levels (REMSAA and RESSCAD 2002) as countries commitments, which incorporate both the Mexico Declaration and the Bangkok Charter, respectively (the health promotion document DC 47.16, 2006).

152. Comprehensive approaches that use a combination of strategies to address policy issues, surveillance, health promotion and prevention and integrated management of risk factors is recognized and endorsed by Member States through the Regional Strategy and Plan of Action for Integrated Prevention and Control of Chronic noncommunicable Diseases , where changes at individual, household and community levels are needed, and their sustainability can be assured only if they are accompanied by environmental, institutional and policy changes. Implementation of DPAS is an example for this.

153. In supporting Member States' efforts, the Bureau will significantly enhance its presence in countries and focus on:

- Providing global and regional leadership, coordination, communication, collaboration and advocacy for health promotion to improve health, reduce health inequalities, control major risk factors and contribute to national development objectives.
- Providing evidence-based ethical policies, strategies and technical guidance and support to countries for the development and maintenance of national systems for surveillance, monitoring and evaluation, giving priority to countries with the highest or increasing burdens.
- Encouraging increased investment at all levels and building internal PAHO/WHO capacity, especially in subregional and country offices, in order to respond effectively to organizational and Member States' needs in health promotion and risk-factor prevention and reduction.
- Supporting countries to build multisectoral national capacities in order to mainstream gender and equity perspectives and strengthen institutional knowledge and competence in relation to the major risk factors.
- Supporting the establishment of multi-sectoral partnerships and alliances throughout Member States and building international collaboration for the generation and dissemination of research findings.
- Leading effective action to address policy and structural barriers, strengthen household and community capacity and ensure access to education and information in order to promote safe sexual behaviors and manage the consequences of unsafe sexual behaviors and practices.
- Leading effective actions to control alcohol consumption and related harms and providing direct technical assistance in the development, review and evaluation of alcohol policies which can have the most impact at the population level.

- Providing direct technical assistance in the implementation of the WHO Framework Convention on Tobacco Control, in collaboration with the permanent secretariat of the Convention, as well as to non-Parties to enable them to strengthen their tobacco control policies and become Parties to the Convention.
- Promote and urge investment in urban planning within an urban sustainable development framework. More specifically, priority should be given to areas that: promote clean air, promote walking and biking, create incentives for Public Massive Transportation systems, defense of public spaces, develop more recreational areas and promote road safety and crime-free streets.
- Facilitate a common understanding of evidence-based practice, and the need to strengthen the evaluation of health promotion effectiveness.
- Providing direct technical assistance in the implementation of the WHO Global Strategy on Diet, Physical Activity and Health (DPAS) on a regional, sub regional and national level in collaboration with multiple actors e.g. governments, sports and food industry, media etc.
- Provide direct technical assistance in the implementation of Regional Strategy and Action plan for integrated prevention and control of chronic noncommunicable diseases (CNCDs).

Assumptions and Risks

154. This strategic objective would be achieved under the following assumptions:

- That there is additional investment in financial and human resources to build capacity for health promotion and risk factor prevention;
- That effective partnerships and multisectoral and multidisciplinary collaborations in relation to policies, mechanisms, networks and actions are established involving all stakeholders at national, regional and international levels;
- That there is a commitment to comprehensive and integrated policies, plans and programs addressing common risk factors, and recognition that integrated approaches to major risk-factor prevention result in benefits across a range of health outcomes;
- That investment in research, especially to find effective population-based prevention strategies, is increased.

155. The following risks may adversely affect achievement of the strategic objective:

- Working or interacting with the private sector presents risks associated with the competing interests of industries, including the tobacco, alcohol, sugar and processed food and non-alcoholic drinks industries, and requires that the rules of engagement are followed in all cases. Improvements in public health are of paramount importance.

- That health promotion and risk-factor prevention may be adversely affected by the low priority afforded to this area and hence the scarcity of resources allocated by WHO, Region and countries. Continued advocacy for increased investment is essential in order to minimize this risk.
- That integrated approaches to prevention and reduction may also compromise organizational and country capacity to provide specific disease and risk-factor expertise unless the critical mass of expertise is protected and the required level of resources obtained. Adequate resources for integrated approaches, as well as critical mass of expertise in major areas, must be maintained.

Region-wide Expected Results

RER # 6.1	**Technical assistance and support provided to the countries to strengthen their capacity for health promotion in all relevant programs and forge decentralized, interdisciplinary intersectoral and interagency partnerships to promote healthy public policies and prevent and reduce the presence of the principal risk factors.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
6.1.1	Number of countries that have adopted the health promotion framework.	18	20	26
6.1.2	Number of countries with multi-sectoral mechanisms or networks strengthened for health promotion and major risk factor prevention.	14	16	22
6.1.3	Number of countries, among the 28 with a baseline health promotion capacity study conducted, which improved health promotion capacity.	0/28	20/28	26/28
6.1.4	Number of countries with functioning Healthy Schools Networks (or equivalent).	7	12	17
6.1.6	Number of countries that enact the Urban Health Conceptual framework.	0	2	5
RER # 6.2	**Technical cooperation provided to strengthen national systems with an integrated approach for surveillance of the principal risk factors, developing, validating, promoting, and strengthening frameworks, instruments, and operating procedures for the countries**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
6.2.1	Number of countries supported that have developed a functioning national surveillance mechanisms for, or regular reports on, major health risk factors in adults.	6	10	20
6.2.2	Number of countries supported that have developed a functioning national surveillance mechanisms for, or regular reports on, major health risk factors in youth.	11	20	34

RER # 6.3	**Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the public health problems concerned**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
6.3.1.1	Number of countries that have adopted legislation or its equivalent in relation to the following settings and articles: (a) smoking bans in health-care and educational facilities consistent with the Framework Convention on Tobacco Control.	4	14	28
6.3.1.2	Number of countries that have adopted legislation or its equivalent in relation to the following settings and articles: (b) bans on direct and indirect advertising of tobacco products in national media consistent with the Framework Convention on Tobacco Control.	0	5	10
6.3.1.3	Number of countries that have adopted legislation or its equivalent in relation to the following settings and articles: (c) health warnings on tobacco products consistent with the Framework Convention on Tobacco Control.	6	21	28
6.3.2.1	Number of countries with comparable national tobacco use prevalence data disaggregated by age and sex. (a) Young population (13 to 15 years of age).	33/36	35/36	35/36
6.3.2.2	Number of countries with comparable national tobacco use prevalence data disaggregated by age and sex. (b) Adult population.	0	25	28
6.3.3	Number of countries that have established or reinforced a national coordinating mechanism or focal point for tobacco control.	15	20	28
RER # 6.4	**Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
6.4.1	Number of countries supported that have developed policies, plans, advocacy and programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use.	9	13	20
6.4.2	Number of policies, strategies, recommendations, standards and guidelines developed according to WHO procedures to assist Member States in preventing and reducing public health problems caused by alcohol, drugs and other psychoactive substance use.	3	6	9

RER # 6.5	**Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
6.5.1	Number of countries that have develop national guidelines to promote physical activity.	7	10	20
6.5.2.1	Number of countries (with cities above 500,000 inhabitants) that have initiated / established programs on: a) mass rapid transportation systems.	7	12	25
6.5.2.2	Number of countries (with cities above 500,000 inhabitants) that have initiated / established programs on: b) clean fuels in transport.	3	7	20
6.5.2.3	Number of countries (with cities above 500,000 inhabitants) that have initiated / established programs on: c) road safety initiatives.	5	10	20
6.5.2.4	Number of countries (with cities above 500,000 inhabitants) that have initiated / established programs on: d) pedestrian-friendly environments, ciclovias cities, crime control.	14	30	40
6.5.3.1	Number of countries that have initiated policies to a) phase-out trans-fats, reached agreements with food industry to reduce sugar, salt and fat in processed foods.	4	15	30
6.5.3.2	Number of countries that have initiated policies to b) eliminate direct marketing/publicity to children under 12 years.	2	7	12
6.5.3.3	Number of countries that have initiated policies to c) initiate programs to increase consumption of low fat dairy, fish and fruits and vegetables.	10	20	30
RER # 6.6	**Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
6.6.1	Number of countries with evidence on the determinants and consequences of unsafe sex to identify effective interventions and to develop guidelines accordingly.	Not available	Research implemented on determinants and consequences of unsafe sex in order to develop three evidence based guidelines for promoting safe sexual behaviors.	3 new or adapted guidelines validated and implemented in 10 countries with WHO-PAHO technical support.
6.6.2	Number of countries supported that have initiated or implemented new or improved interventions at individual, family and community levels to promote safe sexual behaviors.	4	10	10

Strategic Objective #7

To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches

Scope

156. The work under this strategic objective focuses on leadership in intersectoral action on the broad social and economic determinants of health; improvement of population health and health equity by better meeting the health needs of poor, vulnerable and excluded social groups; connections between health and various social and economic factors (labor, housing and educational circumstances; trade and macroeconomic factors; and the social status of various groups such as women, children, elderly people, and ethnic minorities); formulation of policies and programs that are ethically sound, responsive to gender inequalities, effective in meeting the needs of poor people and other vulnerable groups, and consistent with human-rights norms.

157. **Indicators and Targets**

- Proportion of national health indicators disaggregated by sex and age and at least two other determinants (ethnicity, place of residence, and/or socioeconomic status) and available for explanatory research.
- Number of social and economic indicators on conditions favorable to health disaggregated by sex, race-ethnicity and place of residence (e.g. education levels, agricultural production, infrastructure, housing and employment conditions, criminal or violent events, community development, and household income).
- Number of policies and work plans of priority non-health sectors (e.g. agriculture, energy, education, finance, transport) which have incorporated health targets.
- Number of health-related policies plans, programs, legislation, and national mechanisms of protection and legislation (e.g. national constitutions and health sector strategies) that explicitly address and incorporate gender equality, human rights and equity in their design and implementation consistent with international and regional human rights conventions and standards.
- Extent to which national development and poverty reduction plans set out how the right to the enjoyment of the highest attainable standard of health and other related human rights and freedoms without discrimination will be progressively realized (explicit

responsibilities of stakeholders, targets, time frame and budget allocation).

- Percentage of reduction in specific health outcomes associated with gender inequalities.

Issues and Challenges

158. Health equity is an overarching goal endorsed by PAHO/WHO Member States. In recent decades, health equity gaps among countries and among social groups within countries have widened, despite medical and technological progress. PAHO/WHO and other health and development actors have defined tackling health inequities as a major priority and have pledged to support countries through more effective actions to meet the health needs of vulnerable groups (WHR 2003, WHR 2004, WDR 2006). Meeting this goal will require attending to the social and economic factors that determine people's opportunities for health. An intersectoral approach, although often politically difficult, is indispensable for substantial progress in health equity. The Millennium Development Goals underscore the deeply interwoven nature of health and economic development processes, the need for coordination among multiple sectors to reach health goals, and the importance of addressing poverty gender and ethnic/racial inequality. (UN Millennium Project Final Report).

159. This situation raises challenges for ministries of H=health, which must work in innovative ways to foster intersectoral collaboration. This includes working on the social and economic determinants of health and their relationship with the MDGs and aligning key health sector-specific programs to better respond to the needs of vulnerable populations. Effective means to promote health gains for vulnerable groups include the integration into health sector policies and programs of equity-enhancing, pro-poor, gender-responsive, multiethnic/racial ethically sound approaches. Human rights law as enshrined in international and regional human rights convention and standards offer a unifying conceptual and legal framework for these strategies and standards by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders involved.

160. The crucial challenges for achieving the above include; 1) developing sufficient expertise regarding the social and economic determinants of health and their relationship with the MDGs as well as regarding ethics and human rights at the global, regional and country levels to be able to support Member States in collecting and acting on relevant data and acting on an intersectoral basis; 2) ensuring that all the technical areas at PASB HQs reflect the perspectives of social and economic determinants (including gender and poverty), ethics, and human rights in their programs and normative work.; and third, to adopt the correct approach for measuring effects. This final challenge is especially great because results in terms of increased health equity and equality with regard to the most vulnerable groups will seldom be rapidly apparent or easily attributed to particular interventions. Distinctive modes of evaluation are required for assessing processes—how

policies and interventions are designed, vetted and implemented. One must assess whether the steps taken are known to be effective in bringing about change, rather than measuring health outcomes themselves. The relationship of the health sector as a whole with other parts of government and society is also an important indicator.

Strategic Approaches

161. The structural determinants of health encompass the political, economic and technological context; patterns of social stratification by differentiating factors such as employment status, income, education, age, gender and ethnicity; the legal system; and public policies in areas other than health. Fostering collaboration across sectors is therefore essential.

162. Achieving this strategic objective will require policy coherence among all ministries based on a whole-government approach that positions health as a common goal across sectors and social constituencies in light of a shared responsibility to ensure the right of everyone to enjoy the highest attainable standard of health consistent with international and regional obligations of PAHO Member States under international human rights law.

163. National strategies and plans should take into account all forms of social disadvantage and vulnerability that have an impact on health and should involve civil society and relevant stakeholders through, for example, community-based initiatives. Principles, norms, and standards of human rights and ethics should guide the policy-making process to ensure the fairness, responsiveness, accountability and coherence of health-related policies and programs while overcoming social exclusion.

164. Redressing the root causes of health inequities, discrimination and inequality with regard to the most vulnerable groups will need coordinated integration by both the PAHO/WHO secretariat and Member States to ensure that gender equality, multiethnic/racial, poverty, ethics and human rights-based perspectives are incorporated into health guideline preparation, policy-making and program-implementation.

Assumptions and Risks

165. The principal **assumptions** underlying this strategic objective are that:

- In many settings, Ministries of Health, provided with adequate information and political and technical backing, will be willing and able to take leadership on addressing the broader determinants of health, moving towards a "whole government" approach to health.
- Within PAHO/WHO and country offices-it will be possible to build sustained support for the incorporation of social determinants of health (in relation to the MDGs, gender equality, multi-ethnic concerns and human rights) into the Organization’s technical cooperation and policy dialogue with Member States in a

manner that is consistent with international human rights instruments and standards.

- In many countries, health program designers and implementers will be willing and able to incorporate equity-enhancing, pro-poor, gender-responsive, multi-ethnic and human rights-based strategies into their programs despite technical and political complications.

166. The key risks for progress on this strategic objective are identified as follows:

- Lack of effective consensus among partners in countries, including agencies within UN System, other international partners and non-governmental organizations on policies and framework for action;
- There may be insufficient investment by national governments to ensure that treaties, declarations, guidelines, and standards of human rights are effectively implemented;
- Economic, gender, multhiethnic and poverty analysis may not be widely available.

Region-wide Expected Results

RER # 7.1	**Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
7.1.1	Number of countries that have being supported in developing national strategies to address the social determinants of health and that have implemented key policy recommendations of the Commission on the Social Determinants of Health in the fight against inequity.	2/11	7/11	11/11
7.1.2	Number of countries whose PAHO/WHO Country Cooperation Strategy documents (CCS) include explicit strategies at the national and local level that address the social and economic determinants of health.	0/11	5/11	11/11
7.1.3	PASB has a regional plan for action on the social and economic determinants of health.	0	1	1
7.1.4	Number of countries with at least one local government that has a strategy for action on the social and economic determinants of health in relationship with the MDGs.	0/11	5/11	11/11
7.1.5	Number of countries participating in PAHO/WHO regional course on health determinants and public policies to advance the MDGs.	0	11	40
7.1.6	Number of Representative Offices whose Work Plan contains items for improving the health of ethnic/racial groups and allocates financial and human resources for this purpose.	5/36	8/36	15/36

7.1.7	Number of CCS that include the health perspective of ethnic/racial groups.	5	8	15
7.1.8	Number of units in the regional office that have incorporated the ethnic/racial perspective into their biennial Work Plan.	7	10	19
7.1.9	Percentage of technical documents on the MDGs produced for the Governing Bodies that include the ethnic/racial perspective.	2	5	10
RER # 7.2	**Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
7.2.1.1	Number of countries which public policies target the social and economic determinants of health on an intersectoral basis.	0/11	7/11	11/11
7.2.1.2	Number of countries with at least one strategic alliance for the advancement of the MDGs, social policies and health determinants.	1/11	5/11	11/11
7.2.2	Number of subregional and regional fora organized (alone or with other international organizations) for policymakers, program implementers and civil society on intersectoral actions to address the social and economic determinants of health and achieve the Millennium Development Goals.	0	1	3
7.2.3	Number of tools developed and disseminated for assessing the impact of non-health sectors on health and health equity for the MDGs advancement.	0	1	3
7.2.4	Number of countries that have implemented Faces and Places in at least one of their poorest municipalities. Faces and Places addresses MDGs and social determinants.	0/38	12/38	30/38
7.2.5	Number of partnerships and alliances with NGOs, civil society networks, Collaborating Centers, and National Institutions of Excellence to advance the MDGs and the social determinants of health and other equity agendas.	1	4	8
7.2.6	Number of countries with specific national plans to improve the health of ethnic/racial groups.	10/21	13/21	19/21
7.2.7	Number of subregions working through health plans and programs to improve the health of ethnic/racial groups.	0/3	1/3	2/3

RER # 7.3	Social and economic data relevant to health collected, collated and analyzed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
7.3.1.1	Number of countries receiving support from PASB to develop ethnicity and gender sensitive data of sufficient quality to assess and track health inequity among key population groups.	8	15	36
7.3.1.2	Number of countries with national health information systems that routinely publish information disaggregated by sex.	TBD	TBD	TBD
7.3.1.3	Number of institutional mechanisms for developing and/or supporting the conceptualization and monitoring of gender equity in health installed in the countries with PAHO support.	8	10	13
7.3.2	Number of countries receiving support from PASB that have at least one national policy addressing the social determinants of health and the MDGs, that incorporates an analysis of disaggregated data at the sub-national level.	0/11	7/11	11/11
7.3.3	Number of countries receiving support from PASB that have at least one national, provincial and municipal program on health equity that uses disaggregated data.	0	3	6
7.3.4	Number of countries that have being supported by PAHO/WHO to develop inequity maps at the sub-national level to identify the most vulnerable municipalities with in the frame of the MDGs and health determinants.	0	3	6
7.3.5	Number of countries with national health information systems that include the variable of ethnic/racial origin and analyze it.	0/36	5/36	10/36
RER # 7.4	**Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
7.4.1	Number of countries that have developed tools and guidance documents for Member States and other stake-holders on how to use human rights to advance health and to reduce health gaps in health equity and discrimination.	5	10	18
7.4.2	Number of countries with national laws, policies, plans and programs developed for Member States and other stakeholders consistent with regional and internal human rights conventions, standards, and ethical guidance.	5	10	18
7.4.3	Number of countries that human rights protection laws in the context of health determinants.	2	4	8

RER # 7.5	Gender analysis and responsive actions incorporated into WHO's normative work and support provided to Member States for formulation of gender-sensitive policies and programs.			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
7.5.1	Number of critical interventions that contribute to building evidence on the impact on gender and ethnic/racial equity on health and on effective strategies to address them.	0	6	12
7.5.2	Number of tools and guidance documents developed for member states on how to use gender approaches in health analysis.	0	1	2
7.5.3	Number of publications that contribute to building evidence on the impact of gender on health.	1	3	6
7.5.4	Number of PAHO programs and countries with strategies for action to address gender and ethnicity as determinants of health and their relationship with the advancement of all MDGs.	0	6	12
7.5.5	Number of PWRs whose BPB and CCS include specific objectives, indicators, and budgetary resources for implementation of the Gender Equality Policy.	3	4	6
7.5.6	Number of initiatives included in the subregional BPB within the framework of application of the Gender Equality Policy.	0	1	2
7.5.7	Number of conceptual and methodological tools developed, validated, and disseminated for implementation of the Gender Equality Policy.	10	13	16
7.5.8	Number of publications and successful experiences in mainstreaming the gender equality perspective in health initiatives published and disseminated.	8	12	16
7.5.9	At the regional level, number of technical or administrative units whose BPB includes objectives, indicators, and budgetary resources for implementation of the Gender Equality Policy.	1	4	7

Strategic Objective #8

To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health

Scope

167. The work under this strategic objective focuses on achieving safe, sustainable, and health-enhancing human environments, protected from social, biological, chemical, and physical hazards, and promoting human security and environmental justice from the effects of global and local threats.

168. **Indicators and Targets**

Proportion of urban and rural populations with access to improved water sources and improved sanitation. Target: according to the Millennium Development Goals; by 2013, 96.2% of urban populations and 76.9% of rural populations, will have to access of improved drinking water sources (baselines 2002 estimates 95% and 69% respectively); by 2013, 90.1% of urban populations and 48% of rural populations will have access to improved sanitation facilities (baselines 2002, estimates 84% and 44% respectively).

- Burden of disease measured by years of life expectancy lost for poisoning due to environmental risks. Target: by 2013 adults 46% and children 60% (baselines 2002 estimates 68% and 85% respectively).

- Burden of disease from selected occupational risks measure by percentage attributable fraction of hepatitis B infections in health workers due to inappropriate handling of syringes. Target: by 2013 estimates 20% (baseline 2002, 40%).

- Proportion of population with access to toxicological information services. Target: by 2013 60% of countries (baseline estimates 2006, 35%).

- Burden of disease among children by road accidents and diarrheal diseases with environmental causes. Target: by 2013 estimates 26% for road accidents and 84% for diarrheal diseases (baselines estimates 2002, 42% for road accidents and 94% for diarrheal diseases).

Issues and Challenges

169. Environmental and occupational risks contribute to a large portion of morbidity and morality in the Region, but few countries have comprehensive policies to perform analysis and establish public policies to manage them. Modern production processes

introduce new or magnify old chemical, physical and biological health risks in the Region. The countries do not have policies on urban development that promote health, social equity, and environmental justice. These risks affect not only the present generation, but also future generations due to their long-term health effects.

170. Rapid changes in lifestyles, increasing urbanization, production and energy consumption, climatic changes and pressures on ecosystems could, in both the short and long term, have even greater consequences for public health and health costs than is already the case, if the health sector fails to act on currently emerging environmental hazards to health. For effective health sector action, risks have to be reduced in the sectors and the settings where they occur–homes, schools, workplaces and cities, and in sectors such as energy, transport, industry and agriculture.

171. Health systems urgently need new information about the epidemiological impacts of key environmental hazards and their prevention, as well as to be equipped with tools for primary intervention. Increasingly, health policy-makers are called on to participate in economic development and policy forums whose decisions have profound long-term impacts on pollution, biodiversity, and ecosystems, and thus on environmental health. Health professionals, often trained in treatment of the individual, thus need to be better equipped with skills and methods for monitoring and synthesizing health and environmental data; proactively guiding strategies for public awareness, protection and prevention; and responding to emergencies.

172. Although the health sector cannot implement development policies on its own, it can provide the epidemiological evidence and the tools, methods or guidance necessary for assessing the health impacts of development and designing healthier policies or strategies. Concurrently, non-health sectors must be made aware of hazards to health and thus informed and empowered to act. For this to happen, integrated assessment and cross-sectoral policy development should be encouraged, bringing parties from the health and other sectors together.

173. More than 5 million children die each year from environment-related diseases and conditions, such as diarrhea, respiratory illnesses, malaria, and unintentional injuries. Millions more children are debilitated by these diseases or live with chronic conditions linked to their environment, ranging from allergies to mental and physical disability. This suffering is not inevitable. Most of the environment-related diseases and deaths can be prevented using effective, low-cost, and sustainable tools and strategies.

174. Latin America is one of the areas of the world with the greatest consumption of pesticides. Central America, for example, imports 1.5kg of pesticides per habitant, which is 2.5 times higher than the world average. Banned pesticides are still imported in many

countries of Latin America. More stringent national and international legislation and comprehensive interventions are needed.

175. The deleterious health effects from persistent organic pollutants (POPs) and heavy metals, such as lead, mercury, and others, are increasingly recognized. However, there are no information systems in place so that risks can be analyzed and knowledge disseminated about the identification, control, and/or elimination of these risks.
Climate change and other global risks add to the current health burden. Some impacts include an increase in current health hazards, from changed nutrition profiles, water scarcity, to patterns in vector-borne diseases. Accidental releases or the deliberate use of biological and chemical agents, or radioactive material require effective prevention, surveillance, and response systems to contain or mitigate harmful health outcomes.

176. The consumption of products has changed in the Region and in many cases poses new risks to health. A revision of sanitary surveillance and regulation processes in the Region has been the main tool to respond to human consumers' health.

177. It has been estimated that every year 5 million occupational accidents occur in Latin America, of which 90,000 are fatal, equivalent to 300 deaths daily.

178. Local governments are challenged to find suitable, sanitary, sound solutions for 360,000 tons of garbage produced daily in Latin America. Although water coverage has reached 90.3% and 84.6% of the population had access to drinking water in Latin America, those without access are the most vulnerable populations of the Region living in rural areas and urban slums.

179. Political, legislative, and institutional barriers to improving environmental conditions are numerous and the human resources with adequate specialization on risk assessment and management are still lacking in many countries. National and local health authorities are thus often unable to collaborate with other socioeconomic sectors where the health-protective measures have to be taken. Agenda 21, adopted at the United Nations Conference on Environment and Development (Rio de Janeiro, 1992), the World summit on Sustainable Development Plan of Implementation (Johannesburg 2002), together with the Millennium Development Goals (MDGs), provide the necessary international policy framework for action.

180. Through a strategic alliance with the areas of education and labor, a Joint Action plan on Health and Environment was agreed upon by the Ministers of Health and Environment at a June 2005 meeting in Mar del Plata. The Action Plan will develop strategic programs in response to the Millennium Development Goals with three main priorities: Integrated water resource and waste management, sound management of chemicals and children's environmental health. All ministers expressed the urgent need

for PAHO, the Organization of American States and the United Nations Environmental Program to work together on these issues. PAHO will take the lead on Children's Environmental Health as an integrated strategy to achieve the MDGs.

Strategic Approaches

- Improving the development, training, and availability of technical human resources.
- Developing and improving methodologies to evaluate and manage risks and preventive services.
- Updating the normative and regulatory processes.
- Establishing information systems to identify, analyze, monitor, and control environmental and occupational risks.
- Promoting the adequate use of technology to improve the sensitivity and specificity of environmental surveillance.
- Developing and strengthening intersectoral and interagency networks for the strategic alliance between heath, environment, education and labor.
- Creating a network on children environmental health as a strategy to support countries in the achievement of the MDGs.
- Improving data recording and indicators formulation systems.
- Promoting research projects.
- Implementing technical cooperation with the participation of centers of excellence and networks from several sectors to promote interprogrammatic and inter-institutional integration.

Assumptions and Risks

181. The following assumptions underline the achievement of this strategic objective:

- That health sector personnel become increasingly cognizant of the mounting burden of disease from environmental health risks in light of new evidence.
- That decision-makers (such as policymakers, banks and civil society) in sectors of the economy with the greatest impact on public health will increasingly prioritize health and put the health costs and benefits of their actions at the center of their decision-making processes.
- That development partners (collaborating centers, cooperation agencies, foundations, recipient countries and banks) will increasingly recognize that reducing environmental hazards to health makes a major contribution to the achievement of the relevant Millennium Development Goals.
- That the climate remains favorable, in the context of United Nations system reform, for WHO/PAHO to show more global leadership in public health and the environment, setting health more explicitly in humanitarian response and goals of environmental sustainability and economic development.

182. Because hazards to environmental health come primarily from actions in non-health sectors, risk reduction depends on intervention beyond the direct control of the health sector. The health sector, therefore, must influence those other sectors to pay more attention to environmental health and exert enough leverage to effect the desired changes. In that context, the risks that may prevent achievement of this strategic objective include the following:

- That expectations from other sectors for quick results and reductions of environmental health risks may exceed the capacity of the health sector to provide support for their actions. This pitfall can be avoided by selecting realistic, achievable aims.
- That information about the best options for sectoral interventions to improve occupational and environmental health is inaccessible. This danger can be overcome through investment by health agencies in analysis and documentation of the most effective and cost-beneficial interventions.
- That global leaders and partners in the arenas of development and/o the environment show weak or transient commitment to improving environmental health. Investments in partnerships, outreach and more strategic global communications on environmental health issues (such as flagship reports on global environmental health and prospects) can overcome this problem.

183. That health systems continue to respond weakly in reducing the range of occupational and environmental health risks and rooting out their causes. This weakness can be overcome by establishing global and regional forums and focused initiatives in order to give health and the environment a high priority and to push for action through partnerships; by outreach and communications targeted to health-sector interests and needs; and by strengthening the capability of health systems to integrate health and environmental issues into traditional health sector agendas.

Region-wide Expected Results

RER # 8.1	**Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, electro-magnetic fields (EMF), radon, drinking water, waste water re-use) developed and updated; technical support to international environmental agreements and for monitoring the Millennium Development Goals (MDGs).**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
8.1.1	Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year.	2	4	8
8.1.3	2 Millennium Development Goals Indicators (target 10).	2	2	2

8.1.4	Number of international environmental agreements whose implementation is supported by PASB.	3	4	6
8.1.5.1	Number of countries implementing PAHO/WHO guidelines on chemical substances.	11	15	20
8.1.5.2	Number of countries implementing PAHO/WHO guidelines on air quality.	6	8	12
8.1.5.3	Number of countries implementing PAHO/WHO guidelines on water.	10	16	20
RER # 8.2	**Technical support and guidance provided to countries for the implementation of primary prevention interventions that reduce environmental health risks; enhance safety; and promote public health, including in specific settings and among vulnerable population groups (e.g. children, elderly).**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
8.2.1.1	Establishment of global or regional strategies for primary prevention of environmental health hazards in specific settings (workplaces, homes, schools, human settlements and health-care settings).	2	4	6
8.2.1.2	Number of countries where global or regional strategies for primary prevention of environmental health hazards are implemented in specific settings (workplaces, homes, schools, human settlements and health-care settings).	TBD	TBD	TBD
8.2.2	Number of new or maintained global or regional initiatives to prevent occupational and environmentally-related diseases (e.g. cancers from ultraviolet irradiation or exposure to asbestos, and poisoning by pesticides or fluoride) that are being implemented with PASB technical and logistics support.	1 regional initiative on occupational health	2 global interventions (on asbestosis and hepatitis B) and 1 PASB/AMRO regional initiative on occupational health and silicosis	2 global and 1 PASB/AMRO regional intervention started and maintained on health safety and working conditions in the health sector
8.2.3	Number of studies evaluating the costs and benefits of primary prevention interventions in specific settings that have been conducted and whose results have been disseminated.	1	2	4
8.2.4	Number of countries following WHO's guidance to prevent and mitigate emerging occupational and environmental health risks, promote equity in those areas of health and protect vulnerable populations.	0	1	2

RER # 8.3	**Technical assistance and support to countries for strengthening occupational and environmental health policy- making, planning of preventive interventions, service delivery and surveillance.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
8.3.1	Number of countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance.	9	15	20
8.3.2	Number of national organizations or universities implementing PAHO/WHO-led initiatives to reduce occupational risks (e.g. among workers in the informal economy, to implement the WHO global strategy for occupational health for all, or to eliminate silicosis).	2	4	6
RER # 8.4	**Guidance, tools, and initiatives supporting the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture); assessing health impacts; costs and benefits of policy alternatives in those sectors; and harnessing non-health sector investments to improve health, environment and safety.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
8.4.1	Initiatives implemented in countries to develop and implement health-sector policies at the regional and national levels.	0	2	4
8.4.2	Production and promotion in target countries of sector-specific guidance and tools for assessment of health impacts and economic costs and benefits and promotion of health and safety.	Use of tools and guidance produced	Use of tools and guidance produced in 2 sectors	Use of tools and guidance produced for 4 sectors
8.4.3	Establishment of networks and partnerships to drive change in specific sectors or settings, including an outreach and communications strategy.	Use of networks established by WHO / PAHO	Use of networks established by WHO / PAHO in 2 countries	Use of networks established for 4 sectors, with communications strategy implemented
8.4.4	Number of regional or national events conducted with PASB's technical cooperation with the aim of building capacity and strengthening institutions in health and other sectors for improving policies relating to occupational and environmental health in at least 3 economic sectors.	One regional event conducted	2 national events conducted with PASB's technical support	4 regional or national events conducted with PASB's technical support

RER # 8.5	**Enhance health sector leadership to support a healthier environment and influence public policies in all sectors so as to address the root causes of environmental threats to health. Including by responding to emerging and re-emerging environmental health concerns from development, evolving technologies, global environmental change as well as consumption and production patterns.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
8.5.2	Number of citations by mass media, of outreach and communications strategy on occupational and environmental issues implemented regionally and in partnership.	TBD	5% increase in citations	10% increase over baseline in citations
8.5.4	Organization of a regular high-level forum on health and environment for global and regional policy-makers and stakeholders.	0	1 Regional Forum of the Americas held	2 fora in the Americas
8.5.5	Availability of quinqennial report on trends, scenarios, and key development issues and their health impacts.	1 report "Health in the Americas"	1 report (same) "Health in the Americas"	2 reports

Strategic Objective #9

To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development

Scope

184. The work under this strategic objective focuses on improving the nutritional status throughout the life course, especially among the poor and other vulnerable groups, and through strategic collaborative efforts among Member States and other partners towards the achievement of the Millennium Development Goals, in order to contribute to the promotion of equity in health, to prevent and combat disease and to improve the quality of and lengthen lives of the peoples of the Americas. The achievement of the Millennium Development Goals, especially the reduction of poverty and hunger, diminishing the impact of infant morbidity and mortality, and achieving sustainable development, will be promoted through an intersectoral approach in food safety control programs that will improve health, tourism, and trade in food products.

185. **Indicators and Targets**
(WHO's, to be reviewed for Region)

- Proportion of underweight children under-5 years of age;;
- Proportion of overweight and obese children and adolescents under 20 years of age;
- Under-5 mortality caused by diarrhea.

Issues and Challenges

186. The basic malnutrition problems in the Region are infant underweight and stunting, micronutrient deficiencies, and overweight/obesity in the general population, affecting approximately 140 million people. Most countries face a double burden of disease with the coexistence of obesity and under nutrition jeopardizing efforts to achieve development goals. This double burden of disease places enormous demands both on governments, on account of the high cost of treatment, and on individuals and families, resulting in higher costs to society in terms of disability days and loss of quality of life. The poor are more affected than the wealthy both in relative and in absolute terms. In addition, suboptimal nutrition in all its forms, including micronutrient deficiencies, seriously compromises the efficacy of other social and economic interventions owing to its direct impact on the immune system, and increases the risk of disease, disability and death. Underweight and stunting are major determinants of infant and child mortality.

187. Limited access to enough food in order to meet energy requirements affects about 53 million people. Poor dietary quality, alone and in association with infectious diseases, is a determinant of growth failure, cognitive and intellectual impairment and other

deficiencies. Maternal nutrition during the reproductive period is essential to infant and young child nutrition. Breastfeeding merits special recognition because of its short- and long-term effects on maternal and infant health and nutritional status. Its benefits during infancy and early childhood in all socioeconomic groups are indisputable in the Region. Critical to children's health and physical growth are inadequate complementary feeding practices, particularly between the ages of 6 and 24 months, when children start eating family foods to complement breast milk. Reduced access and consumption of micronutrient-rich foods are responsible for the high prevalence of anemia in women and children in the Region.

188. In rural and poor urban areas, overweight and obese parents, often suffering from specific deficiencies such as Vitamin A, iron, calcium, folate, and zinc, are frequently found to have stunted and anemic children. The rise in obesity and noncommunicable diseases in the Americas is linked to poverty, inadequate diets, and sedentary lifestyles. The failure to achieve even the minimum recommended levels of physical activity is also a matter for concern. A dominant dietary pattern of over-consumption of high-energy foods is commonly associated with low micronutrient intake and a downward trend in the consumption of fruit, vegetables and whole grains. Increased consumption of foods that are rich in saturated fats, sugar and salt is linked to lower prices of processed foods, new marketing strategies and to changes in diet from traditional to processed foods. Home food production practices have also been reduced. The enrichment of processed foods also needs to be reviewed in relation to obesity. Obesity is both a disease in its own right, and an important risk factor for many non-communicable chronic diseases (NCD) such as type 2 Diabetes Mellitus, hypertension, ischemic heart diseases, stroke, specific types of cancer (breast, endometrial, and colon), other diseases such as gallbladder disease and osteoarthritis, among others. The factors mentioned above, when associated with a sedentary lifestyle, play a large part in onset of the noncommunicable disease (NCD) epidemic in adulthood.

189. In the United States, there are estimates of burden associated to the occurrence of food-borne diseases (FBDs) and contaminated foods with seven pathogens transmitted by foods of between US $ 5.6 to 9.4 billions annually. In Latin America and the Caribbean, acute bacterial and virus diarrheal diseases due to contaminated food and water remains as one of the primary causes of morbidity and mortality in all age groups, but particularly in children less than 5 years old, with a greater impact in the vulnerable and poorest population. A recent study on the vision, performance and strategies (DVS) was conducted in an Andean country by PAHO/WHO and IICA. The study reviewed the official health indicators of 2004 and revealed that only the economic medical burden associated with the occurrence of 6,829 cases of Salmonella thypi accounted to 1.9 millions of US dollars. The same year, health authorities recorded 8,402 cases of Salmonelosis, 7.095 cases of food borne intoxication, and five cases of cholera. This situation obviously depicted only the tip of the iceberg.

190. In addition to improving public health, effective food safety systems are also vital to maintain consumer confidence in the food system and to provide a sound regulatory foundation for domestic and international trade in food, which supports economic development. Food Safety is considered among one of the priority criteria to assess in ranking the tourism destination worldwide. Food-borne diseases outbreaks due to lack of good food safety and potable water have been major causes of disruption of many countries, in which tourism is the primary source of revenue and employment.

Strategic Approaches

191. The principles guiding the design of this Strategic Objective are that of the life course approach, enabling policy environments at all levels, health promotion, primary health care, and social protection. Furthermore, this Strategic Objective encompasses five nutrition-related interdependent strategic areas:

- Development and Dissemination of Macro policies Targeting the Most Critical Nutrition-related Issues: nutrition-relevant public policies will be assessed with a view to identify and improve their contribution to optimal nutrition, healthy eating, physical activity, and overall health outcomes. Activities will be geared to encouraging enabling institutional environments conducive to optimum nutrition, food security and dietary and lifestyle behavior change. This will entail action at various levels, to include the international, regional, subregional, national and subnational, in a synergistic way, to move the nutrition agenda forward within the health sector and across sectors. The challenge is to increase the adoption of new legislative, organizational frameworks to improve nutrition, to strengthen the regulatory and promotional role of Member States as supported by verifiable evidence and expert consensus taking into account economies of scale and governmental financial capabilities.

- Strengthening Resource Capacity through the Health and Non health Sectors Based on Standards: technical cooperation activities will encourage scaling-up of services for the provision of quality comprehensive preventive health and nutrition care, with emphasis on maternal and child care, nutrition in adolescents, in the elderly, in patients with HIV/AIDS, innovative supplementation and fortification initiatives to address micronutrient deficiencies, and the prevention of obesity in vulnerable groups. Most importantly, it will tackle missed opportunities by addressing risk factors for optimal growth and development, adequate micronutrient status, and adequate diets and lifestyle behaviors within existing health care initiatives.

- Information, Knowledge Management and Evaluation Systems: technical cooperation will support surveillance and evaluation of changes in dietary habits, food purchasing behaviors, macronutrient contents of diets, patterns of physical activity, and protective and risk factors of suboptimal nutrition and obesity and nutrition-related chronic diseases through the life course in relation to trends in nutritional status, and will strengthen efforts at monitoring the obesity epidemic by developing adequate measures, especially among adults, in order to increase awareness at government levels. Activities will also support the identification and intervention of groups at high risk and vulnerable to under and over nutrition, food insecurity and unsafe foods.

- Development and Dissemination of Guidelines, Tools, and Effective Models: technical cooperation activities will encourage the dissemination of guidelines, norms and state-of-the-art papers on the improvement of service delivery, successful interventions and research findings through health and nonhealth audiences such as community leaders, governmental authorities, mass media and technical personnel. The strategic area will encourage a balanced coverage of health and nutrition from both a biomedical and a lifestyle perspective.

- Mobilizing Partnerships, Networks, and a Regional Forum in Food and Nutrition: activities in this Strategic Objective will foster horizontal technical cooperation among countries and sharing regional expertise, dissemination of lessons learned, and regional working groups and networks to move forward the nutrition in health and development agenda. Furthermore, PAHO will seek its relative niche and comparative advantage complementing nutrition-related efforts of the broader development community and multiple highly qualified and competent health and nutrition actors to improve nutrition in Member States. Consensus with external experts and stakeholders will be promoted with a multidisciplinary approach.

192. Food safety must play a central role in national development policies. Nevertheless, in the Americas guaranteeing food safety involves activities conducted by several agencies and institutions whose mandates are often not clearly defined. This has resulted in fragmentation of the food control system and inefficient use of resources. Cooperation and coordination at national, subregional, regional and international levels is required to improve effectiveness and thus protection of the health of the consumer and enhance opportunities for trade and tourism. Furthermore the PASB should act as linking and consultation center based on promotion of updated and relevant information and cost/effective capacity building, for the resolution of priority epidemiologically food

safety problems. Also, the PASB should facilitate bilateral and multilateral cooperation to make feasible/viable agreements, joint projects, and missions, through out the mobilization of trained national human resources, technical cooperation among countries by subregions, and, food safety experts in specific areas, where the national capacity does not exist.

193. In supporting Member States efforts in the field of food safety, PASB will focus on the following strategic approaches:

- To work with national governments to strengthening foodborne disease surveillance systems and developing burden of disease studies. This is needed to facilitate allocation of resources towards appropriate foodborne disease control efforts.
- To enhance institutional capacity and human capacity in conducting systematic epidemiological approaches to make decisions based on scientific evidence such as systematic reviews, meta-analysis and risk assessments.
- To enhance institutional capacity and human capacity to developing leadership in public health for designing integrated food safety systems based on the risk analyses approach, including: risk assessment, risk management, and risk communication and education.
- To build partnerships, alliances and effective interactions with agencies of UN System and OAS System, as well with National Public Health Agencies, including the ministries of health, agriculture, education, bureau of standards, and tourism among others, as well as NGO's to achieve sustainable and effective food safety policy implementation and increase technical support and external resources.
- To strengthen linkages between the health, agricultural, and private sectors to ensure that food safety interventions are planned and executed in an integrated manner from farm to fork through out political advocacy, resource mobilization and regional technical fora such as COPAIA and RIMSA.
- To enhance risk communication and education in food safety and the application of basic WHO guidelines for implementation of the five keys to safer food and the healthy food market within the strategy of healthy settings.

Assumptions and Risks

194. This strategic objective would be achieved under the following assumptions:

- That access to adequate nutrition, food security and food safety are increasingly acknowledged to be human rights and necessary prerequisites for health and development;

- That individual behavior will be backed up by efficient promotional and preventive systems and a supporting environment to allow the public to make informed choices to prevent malnutrition in all its forms, and diseases arising from unsafe food;
- That Member States are committed to comprehensive and integrated policies and plans, and to the development and strengthening of their national food security, nutrition and food safety programs on the basis of reliable and updated evidence;
- That effective networks and partnerships with other technical cooperation agencies are established and fostered involving all stakeholders at international, regional, subregional and national levels;
- That there will be interprogrammatic coordination of PAHO/WHO resources, and increased in-house support to mobilizing resources through the preparation of sound and feasible projects and tapping voluntary contributions from developed countries to WHO;
- That effective decision-making and communication mechanisms will be in place to maintain strong and interactive coordination of efforts at the global, regional and sub regional levels guided by PAHO's Regional Strategy on Nutrition in Health and Development, the Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet, Physical Activity, and Health, and WHO's Global Food Safety Strategy;
- There will be a scaling up of the cost-effective food safety interventions for the management of food hazards/risks.

195. The following risks may adversely affect achievement of the strategic objective:

- Emergence of parallel health, nutrition, and food security and safety agendas due to lack of communication and coordination among partners;
- Low investment and/or political commitment of governments concerning nutrition, food security and food safety poses threats to the sustainability of long-term interventions.

Region-wide Expected Results

RER # 9.1	**Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food safety and food security, and support a research agenda.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
9.1.1	Number of countries assisted by PASB with institutionalized (legislation) and functional coordination mechanisms (national development policies and plans, and poverty reduction strategies) to promote intersectoral approaches and actions in the areas of food safety, food security and nutrition.	17	25	35

9.1.2	Number of countries with financial resources allocated to nutrition priorities in the context of multi-sectoral national policies and plans to attain the MDGs, and other regional, subregional, national and local mandates and commitments.	12	20	32
9.1.3	Number of countries with social marketing campaigns recognizing and disseminating best practices in health, nutrition and food safety (general population, public, private, and civil society organizations, and professionals, among other groups).	13	18	30
9.1.4	Number of countries that have included nutrition, food safety and food security activities in their sector-wide approaches (health, education, and agriculture), including a funding mechanism to support nutrition, food security and food safety activities in health and non-health sectoral programs.	10	18	27
9.1.5	Number of countries where local governments participate in healthy settings initiatives that address nutrition, food safety, and food security issues of vulnerable groups, in the context of efforts to attain comprehensive local development.	17	24	35
9.1.6	Number of countries where local governments apply strategies aimed at increasing food security and safe livestock trade products i.e. foot and mouth disease.	4	10	12
RER # 9.2	**Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
9.2.1	Number countries where new nutrition, food security and food safety prevention and management norms, standards, guidelines and training manuals that are designed, and/or adapted are disseminated, to national counterparts and other agencies that provide technical cooperation to Latin America and the Caribbean.	14	23	34
9.2.2	Number of countries implementing standards and recommendations included in global and regional strategies, according to national needs and priorities.	11	18	32
9.2.3	Number of countries to incorporate improved food and nutrition, and food safety standards, norms, and guidelines in Primary Health Care in health service delivery systems.	16	24	35
9.2.4	Number of countries that implement a research agenda producing sound evidence-based information for public policy analysis and implementation, and program design, monitoring and evaluation.	10	21	29

RER # 9.3	**Monitoring and surveillance of needs and assessment and evaluation of responses in the area of food security, nutrition and diet-related chronic diseases strengthened and ability to identify best policy options improved.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
9.3.1	Number of countries that produce and publish reliable information on: • Nutritional deficiencies and risk factors in different population groups; • Social, economic and health determinants of food and nutrition insecurity; • Overweight and obesity in children and adolescents.	11	20	32
9.3.2	Number of countries that have nationally representative and periodically-collected surveillance data on major forms of malnutrition.	12	18	26
9.3.3	Number of countries that produce sound scientific evidence on the basis of systematic monitoring and evaluation of program effectiveness in the areas of nutrition and food security.	5	13	32
9.3.4	Number of countries that have established reliable surveillance systems at the national and local levels that feed available information systems for planning and implementation purposes both in stable and in humanitarian crisis situations.	12	20	27
9.3.5	Number of countries that have strengthened national institutional capacity in situation analysis of food and nutrition and its determinants, for public policy analysis and decision making, through the establishment of national and subregional Observatories.	3	11	22
RER # 9.4	**Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programs aimed at improving nutrition throughout the life-course, in stable and emergency situations.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
9.4.1.1	Number of countries with PASB support that have developed national programs that implement at least three high-priority actions recommended by the Global Strategy for Infant and Young Child Feeding.	5	10	20
9.4.1.2	Number of countries with PASB support that have developed national programs that implement actions in at least 2 of the following programmatic areas: • Prevention and control strategies to reduce micronutrient malnutrition; • Promotion of healthy dietary practices to prevent diet-related chronic diseases; • Inclusion of nutrition in comprehensive responses to HIV/AIDS and other epidemics; • National preparedness and response to food and nutrition emergencies.	8	15	25

RER # 9.5	**Zoonotic and non-zoonotic foodborne diseases surveillance, prevention and control systems strengthened and food hazard monitoring and evaluation established (integrated into existing national surveillance systems with results being disseminated to all key players)+F302.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
9.5.1	Number of countries that have established or strengthened intersectorial actions for surveillance, prevention, and control of FBD, including participation in existing regional food safety intersectorial networks such as : INFAL, Pulse Net; and global networks such as: WHO-GSS.	18	25	35
9.5.2	Number of countries that have initiated integrated foodborne disease surveillance for selected foodborne pathogens, and to assessing antimicrobial resistance of relevant foodborne pathogens.	2	9	20
9.5.3	Number of countries conducting periodically foodborne diseases burden of illness studies, including the establishment of groups working with translation of evidence based methods (systematic reviews, meta-analysis and risk assessments).	3	9	20
RER # 9.6	**Capacity built and support provided to countries, including their participation in international standard-setting to increase their ability to assess risk in the areas of zoonotic and non-zoonotic foodborne diseases and food safety, and to develop and implement national food control systems, with links to international emergency systems.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
9.6.1	Number of Latin America and Caribbean countries receiving support from the FAO/WHO Codex Trust Fund to participate in relevant Codex Meetings.	33	33	33
9.6.2	Number of countries that received PASB support to build national integrated food safety systems with a component of foodborne diseases surveillance and food contamination monitoring links to the WHO networks: International Food Safety Authorities Network (INFOSAN) and Global Outbreak Alert and Response Network (GOARN).	18	30	35
9.6.3	Number of countries participating in the Master Degree Program on Food Safety Management by PAHO/WHO.	11	23	34
9.6.4	Number of countries participating in the PAHO/WHO-IICA Food Safety Executive Leadership Series (EFLS).	15	23	34

RER # 9.7	Capacity of Member States strengthened through the improvement of knowledge, competencies and skills in topics related to national multi-sectoral policy-making, planning, and program management, monitoring and evaluation in food security, nutrition and food safety.			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
9.7.1	Number of countries with better and more competent human resources, in health and non-health sectors, in the design and management of integrated social, economic, food and nutrition public policies and plans at national and local levels, in stable as well as humanitarian crisis situations.	10	15	25
9.7.2	Number of countries with improved undergraduate and graduate academic programs that develop a more competent workforce, in health and non-health sectors, for program design, implementation, monitoring and evaluation in nutrition, food security and food safety, in stable as well as humanitarian crisis situations.	17	25	35
9.7.3	Number of countries in PASB supported active networks of national academic institutions, and food safety and Nutrition international research and training centers for workforce development that are strengthened and expanded.	12	18	27

Strategic Objective #10
To improve the organization, management and delivery of health services

Scope

196. The work under this strategic objective focuses on working with countries to strengthen health services in order to provide equitable and quality health care for all people in the Americas, with focus on the neediest populations and most dire health situations. The work is accomplished by equipping countries with proven best practice tools, knowledge solutions, and expertise, and by activating networks and partnerships that catalyze and sustain positive change. The Regional Declaration on the New Orientations for Primary Health care and PAHO's position paper on Renewing Primary Health Care in the Americas (CD46/13, 2005) is the framework to strengthen the health care system of the countries in the Americas.

197. **Indicators and Targets**

Improved health, as reflected in the achievement of other strategic objectives, is the best indicator of the successful functioning of a health service. Overall progress towards this particular strategic objective will be assessed by the number of countries that can demonstrate progress in terms of the following composite indicators:

- Coverage for a range of priority health interventions (for communicable and noncommunicable diseases). Target: significant improvement in at least 50% of countries.
- Technical and organizational quality, including compliance with minimum standards of care and patient safety and improved responsiveness. Target: significant improvement in at least 50% of countries.
- Efficiency as measured by a score for outputs of health services related to a given set of financial and human resources inputs. Target: significant improvement compared in at least 50% of countries.
- Countries reporting progresses on their implementation of PHC based health systems according to the Regional Declaration. Target: at least 40% of countries.

Issues and Challenges

- The Region of the Americas is one of the most unequal regions of the world, not only in terms of income distribution, but also in terms of access to social services. There are profound inequities in access to health services among the different countries of the Region as well as within individual countries. It is estimated that

125 million people living in Latin America and the Caribbean do not have access to basic health services (about 27% of the population). While in countries such as Canada 100% of children are delivered by trained health personnel, this figure is only 24.2% in Haiti, 31,4% in Guatemala and 60.8% in Bolivia. Within countries, inequities affect primarily low-income, rural and indigenous populations. Although averages of utilization of health services have improved in recent years, inequities still persist or have even worsen.

- Several types of barriers explain inequities in access to health services. The most common ones are cultural (language, lifestyles, health beliefs), social (level of education), economic (ability to pay, having health insurance), organizational (hours of work, availability of personnel and medicines, availability of personnel trained to meet the health needs of population groups such as older adults, etc.) and geographical (distance) barriers. These barriers account for a large proportion of people that do not utilize health services and instead self-medicate, consult to the pharmacy, go to a traditional healer or do nothing about their health problems.
- Until now, most efforts of governments, NGOs, donors, bilateral and multilateral agencies have been trying to tackle inequities in access to health services by expanding coverage of basic services in undeserved areas. Although positive, this approach has been supply-driven paying little attention to local cultural preferences and social realities. Users and consumers have been left aside from important decision-making regarding their health services. Moreover, some of these efforts have been hindered by organizational problems such as lack of personnel, shortages of medicines and/or inadequate hours of operation.
- Another important challenge in the Region of the Americas is poor quality of health care. The lack of quality leads to ineffective, inefficient and costly health services, as well as to low satisfaction with services. The problems of quality can be found at all levels of the system, from the individual provider level all the way up to the facility and system levels.
- A very frequent problem in most countries of the Region is the poor resolution capacity of primary care services. In addition to their poor effectiveness and efficiency, most primary care services are reactive, fragmented, disease-oriented and predominantly curative. Primary care services have little or no individual and community participation, poor intersectoral collaboration and no accountability for results.
- Another important problem is the poor performance of hospitals in terms of clinical outcomes and patient safety. Hospitals are not doing enough in terms of providing the best care possible to their patients. Patients are constantly submitted to ineffective, unnecessary and/or even harmful diagnostic/therapeutic procedures. This situation leads to inefficient use of resources as well as to high fatality, hospital infection and early readmission rates. A measure of ineffective or unnecessary procedures is the level of variation observed in the use of procedures among hospitals of similar characteristics.

- The lack of coordination of care among the different levels of care and points of service is another frequent problem of health services. This leads to fragmented and inopportune care, to duplication of services and unnecessary increase in health costs.
- A particular problem of organizing and managing services relates to emergency care systems. In many cities of the Region, emergency services have not been systematically organized and are not properly managed. A recent survey done by PAHO in 12 countries of the Region, found eight of those countries have pre-hospital care administered mainly by voluntary organizations. Even though the development of emergency service systems is not a priority for most countries (only five of the countries surveyed provide state funding for emergency services), the increased incidence of motor vehicle and other severe injuries together with acute medical conditions are placing more demands for having an effective emergency care system.
- The main foundation to promote effective health services with good management practices is the availability of reliable, timely and accurate information for decision making and the translation of information into knowledge and action. Information and knowledge are the cornerstone to expose underlying factors related to the services being delivered and the basis for modifying the status quo and improving the health of populations. Health services which utilize information resources to promote better organization and management of their resources, improve access, eliminate inequity, and promote effectiveness are better equipped to achieve the MDGs.
- There is a plethora of information available that consolidate knowledge and evidence on provision of health services. However, these resources are not always available to those who need them or organized to guide decisions regarding the management and provision of health services for the population. On the other hand, needs-based knowledge on countries' health services status is scarce. The inequity that exists in access to health services information and knowledge must be addressed so that knowledge is accessible, disseminated and shared among countries. Understanding of the countries' health services status is essential for the delivery of sound technical cooperation projects.

Strategic Approaches

- The most important approaches are derived from the principles and operational elements of Primary Health Care (PHC) based health systems. These principles include among others universal accessibility and coverage on the basis of health needs, community and individual participation and self-reliance, intersectoral action in health and appropriate technology and cost-effectiveness in relation to available resources. The PHC approach will permeate and cut across all of the technical cooperation strategies.

- PAHO/WHO's Working Document CD46/13 and the Regional Declaration of the New Orientations for Primary Health Care will become the basis of the technical cooperation strategy. Universal access to information and knowledge will help to overcome inequities in access to these resources and to share vital information among countries of the Region.
- Other significant approach for the technical cooperation will be to build from lessons learned and developments that already exits in the countries, the exchange of experiences and best practices among the different countries of the Region. Through this approach, it will articulate and advocate for key regional initiatives in the area of health services delivery.
- Development of new tools and instruments will require appropriate testing and validation of these instruments in specific country locations, particularly at the regional and local levels. This approach will encompass the definition of geographical boundaries for a defined population through community-based demonstration projects.
- The establishment of meaningful partnerships, alliances and networks within the Organization, as well as outside of the Organization is required: government, universities, research centers, collaborating centers, professional associations and others.

Assumptions and Risks

198. Service delivery cannot be improved without the basic conditions of economic, social and political stability. Yet, for many low-income countries these conditions do not prevail. There is thus a need for a close synergy with work on Strategic Objective 5.

199. Much of the increase in health funding from external sources is focused on the achievement of disease-specific outcomes (particularly in relation to AIDS). There is thus a risk that program implementation reinforces separate vertical programs. Although some functions need to be carried out separately, most service delivery needs to be carried out by a single network of facilities. The objective of reducing exclusion is likely to be compromised if governments focus only on the public sector network. Similarly, there is a risk that they will concentrate exclusively on primary or first contact care at the expense of dealing with inequities and inefficiencies in the hospital sector.

Region-wide Expected Results

RER # 10.1	**Countries supported to provide equitable access to quality health care services, with special emphasis on vulnerable population groups, and with health services that reflect recognized standards, best practices and available evidence.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
10.1.2	Number of Member States that have received support and have increased access to basic health care services as a result of PASB's initiatives on Extending Social Protection in health and the PHC renewal.	13	18	21
10.1.3	Number of Member States supported that have strengthened national programs for quality improvement of service delivery.	9	19	24
RER # 10.2	**Organizational and managerial capacities, including information systems, of service delivery institutions and networks in Member States are strengthened with a view of improving service delivery performance.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
10.2.1	Number of Member States supported that have incorporated health services productive management methodologies.	5	14	23
RER # 10.3	**Mechanisms and regulatory systems are in place in Member States to ensure collaboration and synergies between public and non-public service delivery systems that lead to better overall performance in service delivery.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
10.3.1	Number of assisted Member States that have adopted PASB's policy options and mechanisms for integrating the health care delivery network, including public and non-public providers.	3	20	24
RER # 10.4	**Service delivery policies and their implementation in Member States increasingly reflect the PHC approach, particularly in relation to social participation, intersectoral action, emphasis in promotion and prevention, integrated care, family and community orientation, and respect of cultural diversity.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
10.4.3	Number of Member States in which managers and providers have been trained with PAHO's Primary Health Care competencies for health care personnel.	0	14	24
10.4.4	Number of member States that report progress in implementing PHC-based Health Systems according to PAHO's Position Paper and Regional Declaration on PHC.	1	15	23

Strategic Objective #11
To strengthen leadership, governance and the evidence base of health systems

Scope

200. PAHO/WHO technical cooperation will be geared to boosting the political and technical capacity of the Member States through their government agencies to guarantee a single orientation consistent with the social values and objectives that guide the health systems in order to guarantee the governance of their systems and the necessary capacities to enable the national health authority to exercise its role as the steering agency in a competent manner. This is essential, as the main characteristic of the majority of systems in the Region of the Americas is institutional and organizational fragmentation and segmentation, which result in exclusion and inequity. It also addresses the need for generating scientific knowledge and information to aid in decision-making, the strengthening of strategic functions such as sector planning and regulation, and the opening and preservation of democratic forums for social and political dialogue so indispensable for governance and adherence to the values and objectives of the national health systems.

201. The responsibilities and functions of the sectoral steering role, the basis for the governance of the systems, are related to the management, definition, and implementation of regulatory frameworks and instruments, the guarantee of insurance and financing for the system to report the serious problem of shortages, poor management, high out-of-pocket expenditures, and the regressiveness of public spending, inter alia, that affect most health systems. The steering role also includes the harmonization of health service delivery and ensuring the performance of the essential public health functions. Overcoming the fragmentation and segmentation of the health systems is one of the greatest challenges for the period 2008-2012.

202. One condition that should be reversed through cooperation is the fragmentation and lack of synergy in international health cooperation, especially in countries heavily dependent on it. Strengthening the steering role and its functions and defining national strategic plans are a *sine qua non* for moving forward with the harmonization, alignment, and coordination of external health assistance.

203. The sustainable national capacity to generate health intelligence, strengthening the capacity for health system and health policy research

and the development of information systems, is key to improving the quality of public policies and their continuity and effectiveness and to channeling the interests and contributions of the various stakeholders in national health development.

204. **Indicators and Targets**

- Reduction of social exclusion in health and inequities in access to health systems.
- Greater continuity and sustainability of public policies, as well as government health teams.
- Existence of regulatory and oversight mechanisms in the health systems
- Availability of instruments for sector planning and the definition of national health objectives.
- Competent national teams for sector planning and the definition of national health objectives.
- Methodological instrument for evaluating performance at the different levels of the health systems and performance evaluation exercises conducted in the systems.
- Infrastructure, institutionality, and national and subnational teams strengthened for performance of the essential public health functions.
- Progress in bridging the knowledge gap and increasing the use of scientific knowledge in public health policy-making from its currently low levels.
- Development of research policies and plans that address health systems' need to better exercise their steering role.
- Improvement of scientific output on health policies and systems and the performance of EPHF 10.
- More publications based on public health and health systems research in the Region listed in the systems that index scientific literature.
- Greater availability of quality information to guide policy-making and health system management.
- Two-thirds of the countries of the Region meet the standards set by information systems at the national, subregional, and regional levels.
- Competent national teams for developing and maintaining health information systems.

Issues and Challenges

- The lessons learned reveal that managing health systems in the best interest of citizens requires vision, leadership, and policies that strike a balance among the

many demands on the systems; but what is needed above all is a complex series of institutional measures that at present are only partially available.

- The majority of the countries of the Region are encountering technical and political problems in the definition, governance, sustainability, and evaluation of public health policies and in clearly defining health objectives, creating sector development plans, and intervening in the regulation of sector markets in defense of their citizens. In many countries, the ministry of health has little capacity to manage the growing number of actors and agents, the financing and execution networks with which it must deal, relations with public agencies (ministries of finance and planning, national legislative bodies, etc.), international agencies, multilateral, bilateral and nongovernmental organizations, and the different types of private companies and civil society organizations.
- Resolution CD40.R12 requested technical cooperation to develop the competencies necessary for executing the steering role as one of the linchpins of the institutional development of health systems. During the five year period 2001-2005 PAHO/WHO addressed the development of theory and practice in regard to the steering role in health as an intrinsic priority area of State modernization. The Organization has promoted a profound regional and subregional debate and exchange of views on the conceptualization, sphere of activity, and mechanisms for strengthening the steering capacity in health, using as a basic input the wealth of experience amassed by the countries of the Region of the Americas, particularly during the boom of the reform processes in the 1990s.
- Strengthening of the steering role in the health sector should, in the final analysis, be guided by the goal of reducing inequities in health conditions within the framework of integral sustainable development, and of eliminating unjust inequalities in terms of access to personal and nonpersonal health services and the financial burden that access to them implies.
- The main challenge facing the health systems is contributing to the reduction of inequalities and social exclusion in health through greater coverage, access, quality, and financial sustainability. According to the 2003 calculation of the HP/HSS Unit, 230 million people in LAC have no health insurance and 125 million lack permanent access to basic health services.
- Thus, the resolutions of the Directing Council of PAHO and WHO to support the countries in expanding social protection in health and achieving universal access to basic health services are especially important.
- There is also the 2005 mandate from the Directing Council of PAHO to help build health systems based on PHC and reduce health system segmentation and fragmentation, which leads to inequity and social exclusion in health.
- Part of the problem is the limited availability and use of quality scientific knowledge and information for decision-making. Many countries lack the mechanisms and information necessary for responsible, transparent management. There is limited capacity to conduct health research of national interest, including

health systems research, or to set up and maintain a reliable health information system and translate research findings into policy and practice; the countries have difficulty striking a balance between responding to the international demand for health information and attention to their own knowledge and information needs.

- There are difficulties reconciling the competing demands for the limited resources available in the services and programs and making decisions on how to organize them to maximize resource utilization and make it possible to perform the essential public health functions.
- It is necessary to increase the health authority's capacity to effectively interact with other sectors that influence social, economic, and environmental health determinants.

Strategic Approaches

205. Achieving this SO will require support for the Member States in developing sustainable structures and processes that, with the participation of the different relevant actors, have the necessary competencies to create the health systems that the countries need and determine most effective and efficient way to administer the health sector. Similarly, efforts should be made to ensure that the National Health Authority has the competencies it needs to examine and develop compulsory rules and regulations, guidelines, and incentives that will foster equal conditions for all actors in the health system, and above all, the protection of citizens' right to have access to health. To the extent that governments decentralize to more closely address community concerns, it will be possible to establish and promote mechanisms for assigning effective responsibilities, resources, and management guidelines to protect the national health priorities agreed upon.

206. Strengthening responsible management will require building a culture of investment and action with respect to scientific information and data, as well as the establishment of timely, functional, reliable, and relevant health information systems.

207. Building and sustaining the necessary capacity for conducting research on public health and on health policies and health systems of national interest, including health systems research, in order to set up and maintain reliable health information systems and translate research findings into policy and practice will be one of the main conditions. It is necessary to improve mechanisms to ensure that the right knowledge reaches the right people (policymakers, administrators, experts, development partners, and the general public) to develop an effective decision-making process and monitor performance throughout the health system.

208. To support the activities of the Member States, PAHO/WHO will focus on:

- Maintaining technical assistance approach for the countries appropriate to the political, cultural and social context in order to strengthen governance/steering role;
- Helping strengthen the steering capacity of the National Health Authority in order to develop public health policies consistent with national policies and to allocate resources according to public policy objectives;
- Guaranteeing TC for the creation of national information systems that will make it possible to generate, analyze, and utilize reliable information from population-based sources (surveys, civil registry), as well as clinical and administrative data sources, through collaboration with partners (e.g., the United Nations, other agencies, and the Health Metrics Network);
- Helping build national capacity to conduct research for policy-making, to evaluate health system performance, and to summarize the national experience to provide orientation grounded in scientific data;
- Formulating a PAHO in health research policy and strategies to improve research and strengthen health systems and policies, as well as public health, with the participation of the Member States;
- Facilitating the sharing and dissemination of information technologies, knowledge, and experiences among and within the countries; improving access to information and knowledge; and bridging the current gap between knowledge and practice in health on a regional scale, summarizing experiences and disseminating information on best practice, promoting an enabling environment for creating, exchanging information exchange/translating, and effectively applying the knowledge in order to improve health; and helping eliminate the imbalance between rich and poor countries in terms of access to information technology, knowledge, and information;
- Supporting policies to develop highly trained, motivated, and committed human resources to assume responsibility for individual and institutional development plans and performance evaluation.

Assumptions and Risks

209. This SO will be considered achieved if the following premises apply:

- There is political commitment and a basic consensus that the State is responsible for the health of the entire population;
- There is a change in the way external partners operate in terms of financing and execution, in particular by putting the principles of the Paris Declaration on Aid Effectiveness into practice, so that they strengthen, rather than undermine, national activities aimed at improving governance/the steering role;
- Effective partnerships are created and effective participation of stakeholders at the national, subregional, and regional level is maintained; especially important in

this regard are the international and regional organizations that invest in information, as well as a number of bilateral donors;

- Progress is made in governance, the State steering capacity, and the strategic management of development in general, not simply in the health sector;
- The countries and development partners make increasing use of objective data for resource allocation.

210. It has been determined that the following risks could adversely affect attainment of the strategic objective:

- Lack of international and national investment in this area, especially in the middle-income countries, where the majority of the Region's poor reside;
- Unsustainable public policies and lack of intersectoral coordination;
- Poor coordination and harmonization among the major international partners;
- A preference for investing in short-term unsustainable solutions.

Region-wide Expected Results				
RER # 11.1	**Strengthen the national health authority's capacity to execute its steering role, improving policy-making, regulation, strategic planning, the orientation and execution of the reforms, and intersectoral and interinstitutional coordination in the health sector at the national and local level**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
11.1.1	Number of countries in which execution of the steering role has been evaluated: policy-making, strategic planning, execution of reforms, and interinstitutional coordination in the health sector at the national and local level.	3	4	6
11.1.2.1	Number of countries that have institutionalized agencies that regulate sector operations (such as the Health Authorities) and generated regulatory frameworks.	TBD	TBD (10% increase)	TBD (25% increase)
11.1.2.2	Number of countries that have created medium- and long-term sector plans or identified national health objectives.	4	5	7
RER # 11.2	**Improve regional coordination of international cooperation in health and strengthen the countries' subregional and national coordinating capacity to meet national health development targets**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
11.2.1	Number of countries in which the action of the principal health sector donors is harmonized and consistent with government plans and priorities.	3	4	7

11.2.2	Number of countries whose health priorities are not effectively financed.	2	3	4
11.2.3	Number of countries in which the Ministry of Health entities for coordinating international cooperation have been strengthened.	5	6	8
RER # 11.3	**Contribute to an improvement in health information systems at the regional, subregional, and national level for the analysis, management, monitoring, and evaluation of public policies and health systems to achieve the health objectives at all levels**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
11.3.1	Number of countries that have set up the process for monitoring and evaluating the performance of health information systems, based on the standards of WHO/PAHO and HMN supported by the secretariat.	3	7	15
11.3.2	Number of countries with permanent active plans for strengthening vital and health statistics, including the production of information and use of the international classifications (ICD), that conform to the international standards set by PAHO/WHO and the Health Metrics Network.	3	8	40
11.3.3	Number of countries that have implemented the Regional Core Health Data Initiative and that steadily produce and publish basic health indicators at the subnational level (first or second administrative level).	9	13	21
RER # 11.4	**Contribute to the accessibility, equitable dissemination, and use of scientific knowledge and evidence in decision-making.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
11.4.1	Number of countries that use basic health indicators and other available statistical information for evidence-based analysis of priority health problems.	40	40	40
11.4.2	Number of countries whose analytical capacity for generating information and knowledge in health has improved as a result of PAHO technical cooperation.	4	7	10
11.4.3	Establishment and maintenance in regional and subregional plans for effective research on coordination mechanisms and leadership in health.	0	2	4
11.4.4	Number of countries addressing priority health problems through the systematic use and generation of research evidence.	TBD	7	15
11.4.5	% of published PASB guidelines that fulfill and reflect evidence-based processes in their development.	<5%	>10%	>20%

11.4.6	Functional Regional Advisory Committee on Health Research.	The Regional ACHR is being revitalized	Functional Regional ACHR meeting regularly	Alignment and coordination between the Regional and Global ACHR
RER # 11.5	**Facilitate knowledge generation in priority areas, including research on health systems, with the participation of different social actors, ensuring that they meet high methodological and ethical standards**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
11.5.1	Number of countries whose national health research systems meet the basic international standards (to be defined by WHO).	TBD during 2007	TBD during 2007	TBD during 2007
11.5.2	Number of countries that meet the commitment made at the Mexico Summit to devote at least 2% of the health budget to research.	TBD during 2007	TBD (10% increase)	TBD (25% increase)
11.5.3	Number of LAC countries with national ethics/bioethics commissions for monitoring adherence to ethical standards in scientific research.	14/36	20/36	30/36
11.5.4	Number of countries with established functional processes allowing a systematic approach to the use of research evidence in policy-making.	TBD in 2007	6	15
11.5.5	Number of countries registering research protocols following agreed WHO criteria (and with minimum dataset).	TBC	5	8
RER # 11.6	**Contribute to the opening and strengthening of mechanisms for dialogue and social and political consensus building at the different levels, with participation by the relevant actors to improve policies and health systems**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
11.6.1	Number of countries (health ministries and schools of public health) adopting knowledge-management strategies to bridge the gap between knowledge and its application.	10	15	25
11.6.2	Number of countries with access to essential scientific information and knowledge.	TBD	10	20
11.6.3	Number of countries that have cyberhealth frameworks and services based on scientific data.	TBD	12	30
11.6.4	Number of countries that have developed and maintain entities and/or processes for democratic deliberation and social participation on matters of collective interest, social control, and the generation of policy proposals.	5	8	12

Strategic Objective #12
To ensure improved access, quality and use of medical products and technologies

Scope (this is WHO's, to be reviewed for the region)

211. Medical products include chemical and biological medicines; vaccines; blood and blood products; cells and tissues mostly of human origin; biotechnology products; traditional medicines and medical devices. Technologies include, among others, those for diagnostic testing, imaging, and laboratory testing. The work undertaken under this strategic objective will focus on making access more equitable (as measured by availability, price and affordability) to essential medical products and technologies of assured quality, safety, efficacy and cost-effectiveness, and on their sound and cost-effective use. For the sound use of products and technologies, work will focus on building appropriate regulatory systems; evidence-based selection; information for prescribers and patients; appropriate diagnostic, clinical and surgical procedures; vaccination policies; supply systems, dispensing and injection safety; and blood transfusion. Information includes clinical guidelines, independent product information and ethical promotion..

212. **Indicators and Targets**

- Ensured improvement in access to essential medical products and technologies with rational use of them within LAC and support through recognition in countries' constitution or national legislations. Target: more than 60% of countries.
- Quality of medical products and technologies being monitored and ensured in LAC. Target: more than 75% of countries monitoring.
- Supply systems strengthened in LAC as to planning and procurement of quality medical products and technologies. Target: at least 70% of countries.
- Developmental stage of national regulatory capacity. Target: national regulatory authority assessed, 47% of countries with basic-level, 28% with intermediary level and 25% with high-level regulatory functions in place.

Issues and Challenges

213. From the simplest of health care systems to the most advanced, in rich and poor countries alike, health technologies form the backbone of health services. Yet access to health technologies is at the same time one of the most distinct differences between rich and poor countries. Strong health systems invariably rely heavily on access to and use of health technologies. Together, they form a dense mesh throughout the health services into which they are interwoven. A strong mesh of health technologies is one of the most fundamental prerequisites for the sustainability and self-reliance of health systems.

Health technologies evolve or are invented as solutions to perceived health problems and are initially evaluated and applied for that purpose. As experience in their use accumulates, health technologies may come to be used, either directly or after slight modifications, to address many other problems than those for which they were initially developed. Some technologies are inherently safe, but the vast majorities are not and require systematically established quality assurance and quality control measures if undesired effects are to be avoided in their application. Indeed, for many technologies, it is desirable to ensure that any adaptation coordinate under national legislation and their application under supervision by regulatory authorities. Even though most developing countries cannot afford the vast variety of health technologies, if the elements that make up this mesh are carefully chosen, a country may still be able to offer its citizens a safe and reliable health service to its citizens, even where resources are limited.

214. The economic impact of medical products and technologies is substantial, especially in developing countries. While spending on pharmaceuticals represents less than one-fifth of total public and private health spending in most developed countries, it represents 15 to 30% of health spending in transitional economies and 25 to 66% in developing countries. In most low income countries pharmaceuticals are the largest public expenditure on health after personnel costs and the largest household health expenditure. And the expense of serious family illness, including drugs, is a major cause of household impoverishment. Despite the potential health impact of essential drugs and despite substantial spending on drugs, lack of access to essential drugs, irrational use of drugs, and poor drug quality remain serious global public health problems. The concept of essential drugs incorporates the need to regularly update drug selections to reflect new therapeutic options and changing therapeutic needs; the need to ensure drug quality; and the need for continued development of better drugs, drugs for emerging diseases, and drugs to meet changing resistance patterns.

215. An additional concern to Member States are the free-trade agreements that are being negotiated or implemented in different subregions, and their impact on access of populations to new products launched in the market. PAHO has been following very closely this situation and has been advising countries in relation to access to anti-retroviral therapy and has helped with the subregional and national negotiations.

216. Most national immunization programs in the region utilize vaccines that have been procured through PAHO’s revolving fund. These vaccines have their quality assured by the WHO prequalification system that includes not only the assessment of the manufacturer and the vaccines but also the assessment of the National Regulatory Authority (NRA) of the country as the responsibility for the oversight is delegated to the NRA. Assessment of NRAs has become an important tool to identify their strengths and weaknesses in the compliance with the 6 regulatory functions: a) registration, b) surveillance of vaccine use, c) lot release system, d) access to a quality control

laboratory, e) inspection of manufacturers, and f) evaluation of clinical results. The strengthening of NRAs will also help towards the creation of a network of regulatory authorities that can serve as a basis for product quality in the region. So far two NRAs have been declared fully compliant (Brazil and Cuba) and five have undergone preliminary assessments. Several causes have been identified as problems for non-compliance: the lack of organizational and independent structures, lack of qualified human resources, lack of coordination of activities and poor infrastructure.

217. Few countries have invested in improving their vaccine production facilities: Brazil, Cuba, Mexico and Venezuela. Two manufacturers are already pre-qualified to supply vaccines to UN agencies: Biomanguinhos in Brazil for yellow fever and CIGB in Cuba for hepatitis B. A second Brazilian manufacturer has requested prequalification of two of its products: DTP and DTP+hepB. PAHO is identifying how to collaborate with these manufacturers to address the issue of regional vaccine self-sufficiency and production of certain vaccines of regional or local public health relevance such as pandemic flu vaccine or Argentinean hemorrhagic fever vaccine.

218. The World Health Organization (WHO) and the International Federation of Red Cross and Red Crescent Societies (IFRCRCS) have estimated that, for a community to have enough blood to cover its needs, a number of blood units that is equivalent to 5% of the population, or 50 per 1 000 inhabitants, must be collected each year. The aggregated donation rate for the Region of the Americas is 24.5 per 1 000, with 20 million units of blood collected for a population of 815 million. Of 42 countries and territories of the Region of the Americas, only one country, Cuba, achieves the WHO/IFRCRCS standard. The inequity in the availability of blood among countries of the Region of the Americas is also manifested within the countries, with some major urban areas having access to the majority of blood available.

219. Not only does promotion of voluntary blood donation assure sufficiency and, therefore, availability of blood but also contributes to its safety. Voluntary blood donors are less likely to be infected with transfusion-transmitted infections (TTIs), especially if they donate repeatedly. In Latin America and the Caribbean, only Aruba, Cuba, Curacao, and Suriname collect 100% of their blood units from voluntary, altruistic, non-remunerated donors; Bermuda and British Virgin Islands do so from over 98% of them. Bolivia, Dominican Republic, Honduras, Panama and Peru report paid donation of blood. The units of blood must be screened for the presence of markers of TTI before being transfused. The high prevalence rates of TTI markers among blood donors and the number of unscreened blood units result in the transmission of infections to patients.

220. There is a strong correlation of blood safety and availability and efficiency of the national blood system. Data from 42 countries of the Region, including Canada and the United States, indicate that those countries with higher donation rates per 1,000

inhabitants have blood services that process higher number of blood units per year, are more likely to have high proportions of voluntary blood donors, and to have universal testing.

221. Access to image diagnosis services in most countries in our Region is far from the situation that developed countries implement, where the annual frequency is above 1,000 studies/ 1,000 inhabitants. In countries in our Region that are considered of health care level II (22 countries in the Region), the value is around 150/ 1,000 and in Level III countries, comprising five countries, this value is near 20/ 1,000. Access is also misbalanced due to the costs of theses services, poor insurance coverage and concentration in large urban areas. As quality is essential to achieve the expected results of diagnosis, quality evaluation has been carried out in several countries (Argentina, Bolivia, Colombia, Cuba), demonstrating the need to implement quality assurance programs. A lack of professionals has also been detected, including radiology, technology and medical physics.

222. Access to radiotherapy services is even more critic. Developed countries have 4 to 5 high-energy radiotherapy units per million inhabitants and most countries in our region have less than one and some countries much lower numbers (Nicaragua, El Salvador, Honduras, Guyana, Peru, Haiti), also with few professionals. Costs associated with these services, both as a capital investment as well as the projection for working and maintenance need a well structured planning and management, not present in most countries. Frequently the costs are higher than those in developed countries, as well as we find an unequal geographic distribution and timing of use. More complex equipments, such as computerized tomography, Nuclear Magnetic Resonance, linear accelerators and high dose brachitherapy, involve even more critical issues.

223. The area of physical infrastructure and technology incorporated within the health services has not experiences major changes during the last biennium. There is a continuous deterioration and outdating of infrastructure and equipment and governments do not have a clear idea of the status in the private sector. Several donors and banks are working simultaneously, and sometimes duplicating efforts in this area, while most governments lack of specific programs to regulate the importation, distribution, use and disposal of equipments. Nevertheless, several issues must be highlighted.

224. As communicable diseases are an important burden of morbidity and mortality, jointly with low levels of development and scarce local resources, our Unit has been involved in supporting and reorienting national laboratory networks towards a more intensive role in health surveillance. The public health role of the laboratory today is a clear concept, including sustainable implementation of a system for quality assurance within the laboratory networks, a strong interaction with epidemiologic surveillance in disease control, an integrated response over outbreaks and follow-up of the epidemiologic

investigation process, besides registration and authorization for clinical laboratories, the development of external evaluation programs and voluntary access to accreditation.

Strategic Approaches

- Advocacy and support to Member States in the development, implementation and monitoring of national medicine policies that facilitate accessibility and affordability of medicines.
- Advocacy for implementing tools for improving cost efficient medicine supply systems with emphasis in the public health services and targeted population groups.
- Strategic Fund for procurement of public health supplies through PAHO, facilitated to assure continuous availability of low-cost quality products for priority public health programs.
- Support Member States in discussion the implementation of a public health approach, the WTO TRIPS flexibilities and the Doha Ministerial Declaration within their legal framework and during the negotiation of bilateral and regional free-trade agreements.
- Support Member States and subregional integration initiatives in their effort to advance in drug regulatory harmonization by strengthening the Pan American Network for Drug Regulatory Harmonization (PANDRH) initiative.
- Advocacy for the awareness and guidance to Member States to the rational use of medicines.
- Ensure adequate access to quality vaccines and biologicals within the Health Systems.
- Coordinate a Regional Program in Transfusion Blood Safety to assure availability of quality blood, which includes promotion of voluntary blood donation, development of effective and efficient national blood systems and accurate screening of 100% of the blood.
- Support provided to strengthen diagnostic imaging and radiation therapy services, enforce regulations to protect against ionizing and non-ionizing radiation, and boost the capacity to respond to radiological or nuclear emergencies.
- Strengthen the capacity to operate and maintain the physical plant and equipment of the health services network in the countries of the Region;
- Support ministries of health in the regulation and operation of medical devices and medical equipment in general.
- Support the institutional development of Public Health Laboratories and strengthen quality of clinical laboratory operations.

Assumptions and Risks

225. Addressing the unfinished agenda in the Region of the Americas has to take into account the need to address specific activities related to the different modalities of health systems and services, jointly in inter-departmental actions. Additionally, we need to address specific actions to vulnerable populations.

226. Joint efforts have been addressed, with PAHO working together with other UN Organizations, optimizing the efforts of governments, donors, NGOs, bilateral and multilateral agencies and enhancing PPP, in order to tackle inequities in access to health services and essential supplies.

227. From the analysis it is clear that essential quality medical products and technologies, being them medicines, vaccines, safe blood or other technologies, they all have similar problems: access, quality, policies and regulations, and information. In order to better coordinate the activities that are being carried out in the Region, and to provide a better coherence they have been grouped into a new approach which takes into consideration the potential assumptions and risks, but strategically will have a comprehensive and integrated approach to support national, subregional and regional activities:

- Access to quality products;
- Policy and Regulation;
- Essential Health Technology.

Region-wide Expected Results

RER # 12.1	**Development and monitoring of comprehensive national policies on access, quality and rational use of essential public health supplies (including medicines, vaccines, herbal medicines, blood products, diagnosis services, medical devices and health technologies) advocated and supported.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
12.1.1	Number of countries supported to develop and implement Policies and Regulations for essential medical products and technologies.	14/36	23/36	27/36
12.1.2	Number of countries receiving support to design or strengthen comprehensive national procurement and supply systems.	19/36	21/36	21/36

RER # 12.2	**International norms, standards and guidelines for the quality, safety, efficacy and cost-effectiveness of essential public health supplies developed and their national/ regional implementation advocated and supported.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
12.2.4	Number of countries assessed and supported in strengthening their capacity for regulation of essential medical products and technologies.	2/36	5/36	7/36
RER # 12.3	**Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported in regional and national programs.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
12.3.1.2	Number of countries provided with support to promote sound and cost effective use of medical products and technologies.	10/36	16/36	20/36
12.3.2	Number of countries with a national list of essential medical products and technologies updated within the last five years and used for public procurement and/or re-imbursement.	29	30	34
RER # 12.4	**Support development of policies and legal frameworks, and enhance human resource capacity to reduce barriers to access to essential public health supplies.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
12.4.1	Number of countries supported with the necessary tools to develop policies and legal frameworks and enhance human resource capacity to reduce barriers to access to essential public health supplies.	11	20	24

Strategic Objective #13

To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes

Scope

- The work under this strategic objective is guided by the Objectives and Challenges of the Toronto Call to Action (2005), built in part on the Health Agenda for the Americas and the frame of reference for developing national and subregional plans and a regional strategy for the Decade of Human Resources in Health (2006 - 2015).
- This strategic objective also addresses the different components of the field of human resource development, management operations, and regulation of the field by health authorities, and the different stages of workforce development—entry, working life and exit—focusing on developing national workforce plans and strategies.
- Strategic planning and effective regulation of the education system and job market are promoted to achieve equitable distribution of health workers; achieve an appropriate mix of health workers responsive to population needs; improve management of the health workforce and its environment, for example by offering financial and non-financial incentives, especially for underserved populations.

228. **Indicators and Targets**

- Density of the health workforce (disaggregated by country, gender, and occupational classification, where possible);
- Urban-rural distribution of health workers (disaggregated by country, sex, and occupational classification, where possible).

Issues and Challenges

229. Data from the Region of the Americas show:

- 7.5 million men and women work in health services;
- 70% of the health-care workforce are women;
- There are 4.58 million doctors, nurses, and dentists in the Region;
- 60 to 70% of national health budgets covers salaries.

230. A clear correlation exists between the density of health workers and attainment of high levels of coverage with essential health interventions, such as immunization and skilled care in delivery. The more health workers there are per inhabitant, the higher the likelihood of infant, child, and maternal survival. Many countries have not met the

expected targets of intervention coverage established in the Millennium Declaration. The *World Health Report 2006*, for example, has identified many countries in which the density of health workers falls below the minimum level established. In the Americas the scarcity is not as acute or as huge as in Africa, but serious problems exist in some professional categories and in distribution.

231. The nursing shortage is particularly acute. As an illustration this shortage has promoted migration from developing to developed countries, the effect of which is especially felt in the Caribbean:

- Caribbean countries have a 35% nursing vacancy rate;
- In Jamaica and Trinidad and Tobago the rates are even higher, above 50%;
- Canada will have some 60,000 unfilled positions in the next six or seven years;
- The nursing shortage in the United States currently tops 168,000, and this figure will increase in the near future.

232. Although countries in general have an apparently sufficient number of doctors and nurses, a disproportionate number of these professionals settle in urban areas, creating critical shortages in rural areas:

- Ecuador: the capital city, Quito, has 12 nurses per 10,000 inhabitants, while the average for the whole country is 5.3 per 10,000;
- Nicaragua: 50% of the health workforce works in the capital city of Managua, serving only 20% of the population;
- Paraguay: there is 1 nurse per 2,000 inhabitants in the capital, and 1 nurse per 9,000 inhabitants in the rest of the country;
- Uruguay: 80% of the doctors live in the capital, serving only 45% of the population;

233. There are many reasons for these acute shortages. In many developing countries, production capacity is limited due to years of underinvestment in health education institutions. There are also push and pull factors that cause many health professionals to leave their health posts, resulting in geographical imbalances between rural and urban areas within a country and between countries and regions, with significant migration from developing countries toward more developed ones. The migration of health workers leads to serious consequences for health systems in developing countries, already suffering the effects of years of poorly managed health care reforms and economic stagnation.

234. Even when the necessary number of professionals exists, health team composition is often off balance:

- Brazil: Doctors comprise 66% of total health professionals;
- El Salvador: there in only one nurse for every two doctors;
- Dominican Republic: there is only one nurse for every eight doctors;
- Uruguay: 66% of all doctors are specialists;
- Nineteen LAC countries have more doctors than nurses.

235. **The Americas have identified the challenge.** Twenty-nine countries of the Region and a significant number of international agencies met in Toronto, Ontario, Canada to discuss the challenges facing the health workforce in the Region. Participants at the meeting agreed on a call to action that calls on all countries to mobilize political will, resources, and institutional actors to contribute to developing human resources in health, as a way of achieving the Millennium Development Goals and universal access to quality health services for all populations in the Americas by 2015.

236. Improving human capacity is no easy task. All the countries are making a sustained effort as part of the Decade of Human Resources in Health (2006-2015), whose goals are to:

- strengthen leadership in public health;
- increase investment in human resources;
- coordinate and integrate actions in all areas;
- ensure the continuity of supportive policies and interventions;
- improve information gathering for decision-making.

237. **Main Objectives for the Decade 2006-2015:**

- Define policies and long-term plans to adapt the health workforce to the health needs of the population and develop the institutional capacity to implement these policies and review them periodically.
- Put the right people in the right places, obtaining an equitable distribution of health workers in the different regions based on the different health needs of the population.
- Regulate the movements of health professionals to guarantee access to health care for the entire population.
- Establish ties between health workers and health organizations that encourage commitment to the institutional mission to guarantee quality health services for the entire population.
- Develop mechanisms for collaboration and cooperation between the academic/training sector (universities, schools) and the health services in order to adapt the education of health professionals to a model of universal care that

provides equitable, quality services that meet the health needs of the entire population.

Strategic Approaches

- Fulfilling this strategic objective implies ensuring effective TC to advance the development of an available workforce, in the right places, in adequate numbers, and with the skills necessary to meet the health needs of the population, within the context of each country's health system.
- Thus, it will be necessary to intensify efforts to foster improvement in the health workforce in national, subregional, and regional plans, strengthening national capacities for comprehensive human resource management, developing strategic plans and creating and promoting partnerships at all levels. It is essential to maintain information systems on health personnel for evidence-based formulation of integrated policies and national strategic plans on human resources in health, which are systematically implemented, supervised, and evaluated. Information on best practices should be compiled and disseminated, based on scientific criteria, for development, training, and management of health personnel. Similarly, sufficient funds are needed to finance the health workforce, which will call for consultations and negotiations with the ministries of finance, labor, and education as well as international development agencies.
- It will also be necessary to expand capacities and improve the quality of educational and training institutions; and ensure an appropriate skill mix and equitable geographical distribution of the health workforce through effective deployment and retention measures, through context-specific incentives.
- In supporting Member States' efforts, PAHO will gather and share the knowledge (data, information, and evidence) needed to change current practices, so that health workforce challenges are addressed and guarantee continuous improvement of health workers' general performance. Specifically, the Bureau will:
  - Support the strengthening of national health workforce leadership, both centrally and peripherally, to mobilize resources for the health workforce, and design, implement, monitor, and evaluate health workforce policies and plans in the context of the Decade of Human Resources in Health (2006-2015) and ensure that they are responsive to health needs;
  - Support the establishment of HRH monitoring in the countries, ensuring its sustainability;
  - Respond to countries in HRH crisis;
  - Facilitate agreements with other agencies, to have more effective financial mechanisms for health resources development and the management of domestic and international migration;
  - Strengthen national educational systems, especially schools and universities, to support training for all types of health workers, developing appropriate skills and competencies;

- Strengthen the knowledge base, supporting national capacity to develop health workforce information systems and promote human resources research;
- Support mechanisms for creating subregional networks of institutions of excellence, for example, to develop health workforce observatories, to generate information for evidence-based policy-making, monitoring, and evaluation;
- Collaborate on setting norms and standards for the health workforce, including development of internationally agreed-upon definitions, classification systems, and indicators.

- Support efforts for horizontal integration and cooperation among countries to implement joint strategies and address health workforce migration issues

Assumptions and Risks

238. Achieving this strategic objective requires the following:

- Sustain recent regional, subregional, and national efforts to promote the health workforce development included in the Toronto Call to Action.
- Cross-sector and interagency partnerships (UNESCO, ILO, ECLAC) in support of health workforce development will continue to promote the active participation of all direct stakeholders, including civil society, professional associations, and the private sector.
- The following risks may adversely affect achievement of the strategic objective if:

  - The financing of health workforce development remains at low levels;
  - The issue of human resource development continues to be neglected;
  - The affected countries remain unable to take the reins and manage the Response to the crisis by themselves;
  - The developed countries continue active recruiting, thus provoking uncontrolled migration;
  - Market forces continue to exert excessive pressure in favor of out-migration and the exodus of professionals (brain drain).

Region-wide Expected Results				
RER # 13.1	**Human resource plans and policies implemented at the national, subregional, and regional levels to improve performance of primary care-based systems and achieve health objectives and the Millennium Development Goals**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
13.1.1	Number of countries with 10-year plans of action for strengthening health workforce, with active participation of stakeholders and governments.	12	16	28
13.1.2	Number of countries that have a government unit responsible for planning and preparing policies for HRH development.	4	12	20
13.1.3	Number of countries with programs to boost the development of HRH, especially primary care.	7	11	12
13.1.4.1	Number of countries with regulatory mechanisms (quality control) in education and health practices.	12	16	20
13.1.4.2	Number of subregions with regulatory mechanisms (quality control) in education and health practices.	1	2	3
RER # 13.2	**Set of baseline human resources information and data systems implemented at the national, subregional, and regional levels**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
13.2.1	Number of countries with databases for health workforce development and trends that are updated at least every two years.	10	22	29
13.2.2	Number of countries that will participate in a Regional Indicator System for Human Resources in Health, allowing the comparison and measurement of progress toward meeting identified challenges (including indicators on geographical distribution, migration, labor relations, and health professional training trends).	0	22	29
13.2.3	Number of countries with official unit integrated into regional observatories of human resources in health.	19	29	40
13.2.4	Number of countries with strategies to promote research on human resources in health.	5	8	14
RER # 13.3	**Strategies and incentives developed to attract and retain health workers (with the right skills) based on individual and group health needs [neglected populations]**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
13.3.1	Number of countries with policies to recruit and retain health workers to strengthen primary care.	6	15	20

13.3.2	Number of countries that have set up incentive and strategy systems to achieve geographical redistribution of their health workers to neglected areas.	4	10	20
RER # 13.4	**Strengthened management capacity in countries to improve health workers' performance and motivation, including development of healthy and productive working conditions and environments**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
13.4.1	Number of countries participating in strategic partnerships to implement national and subregional human resource plans in the framework of the Toronto Call to Action.	2	4	6
13.4.2	Number of countries with at least one national institution, including support centers, participating actively in a regional network for human resource development for health workers.	6	10	20
13.4.4	Number of countries that collect data on hiring conditions, the labor climate, and strategies in health services	4	8	11
13.4.5.1	Number of countries with training programs to increase skills in the area of human resources policies for health workers.	1	8	15
13.4.5.2	Number of subregions with training programs to increase skills in the area of human resources policies for health workers.	2	4	4
RER # 13.5	**Education strategies and systems strengthened at the national level, for developing and maintaining health workers' skills, appropriate to the context of health practice and the health status of the population, focused on PHC**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
13.5.1	Number of countries where planning mechanisms exist along with training institutions and health services for continuous updating of work skills.	19	25	35
13.5.2	Number of countries with policies and strategies for improving undergraduate and post-graduate education in health priorities and primary health care.	4	10	15
13.5.3.1	Number of countries actively participating in strategies for virtual education networks and leadership in global health within the framework of regional health priorities and policies in the Americas.	7	20	30

RER # 13.6	Help to increase knowledge about, address, and solve problems facing national health systems as a result of the international migration of health workers in the medium and long term			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
13.6.1	Number of subregions that participate in a network for monitoring health worker migration.	2	3	4
13.6.2	Number of subregions that have agreed on mechanisms for recognition of education abroad (titles and diplomas) for professional practice.	1	2	3

Strategic Objective #14
To extend social protection through fair, adequate and sustainable financing

Scope

- WHO Resolution WHA58.33 in 2005: Sustainable Health Financing, Universal Coverage, and Social Health Insurance.
- PAHO Resolution CSP26.R19 in 2002: Extension of Social Protection in Health: joint PAHO-ILO initiative.
- Sustainable collective financing of the health system and social protection.
- Protection of households against catastrophic health expenditures.
- Elimination or reduction in economic, geographical, cultural, ethnic, and gender barriers to access arising from the organization of the system.
- Elimination of the differences in guaranteed rights to access products, services, and opportunities in health as well as all discrimination based on ethnicity, gender, age, religion, or sexual preference.
- Elimination or reduction of institutional segmentation in systems and operational fragmentation of the service network.
- Adequate and timely access to quality health services with equity.
- Advocacy to put health on government agendas.

239. **Indicators and Targets**

- Increased public expenditure for health, with emphasis on primary care expenditure.
- Smaller proportion of households that fall below the poverty line owing to health expenditure.
- Fewer countries with a high proportion of out-of-pocket expenditure in health.
- Greater proportion of the population with explicit ensured rights of access to products, services, and opportunities in health.
- Smaller proportion of the population without regular and timely access to health services.
- More Member States with research capacity to assess social exclusion and inequities in health and system financing and expenditure as a strategic measure to increase efficient and equitable public expenditure and establish collective, universal social protection policies.
- More Member States able to coordinate, harmonize, and align international cooperation in health.

Issues and Challenges

- The way a health system is financed and organized is a key determinant of the population's health and well-being.
- Expenditure levels, especially public expenditure, are still insufficient for an adequate supply of health services, which means that families are forced to make out-of-pocket payments that affect household finances and the increase risk of poverty.
- Major segments of the population do not have regular and timely access to health services and continue to experience disparities in access due to economic, geographical, cultural, and ethnic factors, as well as gender, age, religion and sexual preference.
- Health system segmentation and fragmentation lead to greater inequity and inefficiency in the use of sector resources, as well as further reductions in the access of poorer and more vulnerable populations.

Strategic Approaches

- Engage in advocacy, emphasizing the need for greater funding in regional and national plans that is predictable, sustainable, and collective in nature, as well as participation in partnerships that further this aim.
- Offer technical cooperation to countries and ministries of health to ensure that health has an important place on the domestic development agenda, and support countries in developing and sustaining high levels of efficient, responsible, and transparent management.
- Develop reliable data and knowledge to inform policy options on equitable collective funding mechanisms to reduce dependency on direct payments from households.
- Collaborate with the countries so that they can research, monitor, evaluate, design, and implement strategies, policies, and programs to address the causes of social exclusion in health.
- Strengthen national capacity to evaluate policy options to reduce inequalities in income as an underlying cause of health disparities and establish national strategies to increase social and financial protection in health.
- Strengthen national capacity to generate strategic health intelligence through applied research, innovative comparative studies, use of analytical methodologies, and knowledge management.
- Strengthen national capacities, especially in the ministries of health and social security agencies, to promote social dialogue to reach a consensus with civil society and relevant stakeholders on national health objectives and social protection strategies.

- Develop and support partnerships, associations, and formal/informal networks for the development of institutional, organizational, and human capacities, through the sharing of knowledge, best practices, and lessons learned, ongoing human resource training, and the production, organization and dissemination of conceptual and analytical frameworks, methodologies, and instruments.

Assumptions and Risks

- Achieving this strategic objective requires establishing regional, subregional, and national partnerships, particularly with international financial institutions, ECLAC, ILO, ISSA, CISS, CIESS, subregional integration agencies such as SICA, CAN, MERCOSUR, CARICOM, ALBA; and bilateral development partners and ministries of labor/social security, finance/treasury, planning, central banks, and national statistics institutes, as well as universities and research centers.
- Countries undertaking health system reforms are interested in the search for universal, equitable access to health services for their people and that resources for this purpose are allocated and available to the health sector.
- Countries' experiences vary, and the lessons learned in national processes can serve as valuable input for technical cooperation among countries.

240. Potential risks are:

- Recent increases in the countries' funding for health could be tied to attention to a few specific health problems and not to a vision that integrates financing with universal care.
- Greater funding from external sources could increase system segmentation and weaken sector institutions, undermining the steering role due to parallel and segmented financing, insurance, and service delivery mechanisms.

Region-wide Expected Results

RER # 14.1	**Support given to Member States to develop institutional, organizational, and human capacities for policy-making based on ethical principles, international commitments, and utilization of state-of-the art scientific knowledge and information on economic, financial, political, social, and health issues; also technical cooperation to improve performance of the health system financing plan and social protection plan, to eliminate/reduce economic barriers to access, and increase financial protection, equity, and solidarity in the financing of health services and activities, and efficiency in resource utilization.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
14.1.1	Number of countries with institutional development plans in the area of policies and regulations to improve the performance of health systems financing plans and social protection plans.	7	10	15

14.1.3	Number of countries with functioning research units to evaluate economic, financial, and health expenditure, and that use such data to develop relevant policies on eliminating/reducing economic barriers to access and increasing financial protection, equity and solidarity in financing services and efficient resource utilization.	10	13	18
14.1.4	Number of Member States that have conducted studies detailing social exclusion from health care at the national or subnational levels.	11	15	20
14.1.5	Number of Member States with health policies to extend social protection aimed at universal coverage.	8	10	12
RER # 14.2	**Promotion, information, and technical cooperation measures implemented at the regional, subregional, and national levels to mobilize additional stable financing for health.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
14.2.2	Number of Member States that have developed/improved planning processes and/or monitoring of international cooperation with respect to PRSPs, SWAPS, MTEFs and other long-term financing mechanisms.	7	9	12
14.2.3	Organize and disseminate data, knowledge, and lessons learned on the harmonization and alignment of international cooperation, and ongoing processes to share experiences among participating countries.	3	7	10
14.2.4	Number of Member States that have institutionalized the periodic production of health statistics/national health statistics in accordance with the U.N.'s statistical system.	14	18	25
RER # 14.6	**Compilation and periodic dissemination of information on health financing and expenditure, with knowledge-based strategy incorporated into regional plan and domestic agendas on researching health systems and policies focused on increasing social protection in health**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
14.6.1	Number of Member States with up-to-date data on health financing and expenditure published periodically by the PAHO Core Data Initiative and the WHR/WHO statistical annex.	32	35	40
14.6.2	Number of Member States with domestic agendas for research on health systems and policies, with emphasis on increasing social protection in health and utilizing health financing and expenditure data.	6	10	15

14.6.3	Regional plan for research on health systems and health policies, especially extending social protection and utilizing data on health financing and expenditure.	0	Regional plan for research on health systems and policies designed and approved by the Member States	Regional plan for research on health systems and policies currently in execution
RER # 14.7	**Technical cooperation provided on insurance systems and mechanisms and/or the extension of coverage, and promotion of the sharing of experiences and lessons learned among Member States.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
14.7.1	Number of countries that received technical cooperation in insurance systems and mechanisms and/or coverage extension.	18	22	30
14.7.2	Number of Member States participating in the sharing experiences and lessons learned on insurance and/or coverage extension.	37	41	41

Strategic Objective #15

To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfill the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

Scope [pending review]

241. This strategic objective facilitates the work of the PASB to achieve all other strategic objectives. It recognizes that the context for international health has changed significantly. The scope of this objective covers three broad, complementary areas: 1)leadership and governance of the Organization; 2)the PASB's support for, presence in, and engagement with individual Member States; and 3)the Organization's role in bringing the collective energy and experience of Member States and other actors to bear on health issues of global and regional importance.

242. The main innovation implicit in this objective is that it seeks to harness the depth and breadth of the PASB's country experience in order to influence global and regional debates, thereby to influence positively the environment in which national policy-makers work, and contribute to the attainment of the health-related Millennium Development goals and other internationally agreed health-related goals.

243. **Indicators and Targets**

- Number of countries implementing health-related resolutions and agreements adopted by the Health Assembly and PAHO Directing Council. Target: more than half the Member States by 2013.
- Number of countries that have a Country Cooperation Strategy (CCS) agreed by the government, with a qualitative assessment of the degree to which PAHO/WHO resources are harmonized with partners and aligned with national health and development strategies. Target: 30 by 2013 (baseline: 3 in 2006-2007).
- Degree of attainment by Official Development Assistance for Health of Paris Declaration benchmarks on harmonization and alignment. Target: 100% of benchmarks met by 2013.

Issues and Challenges

244. The leadership and governance of the Pan American Health Organization is assured by governing bodies–the Directing Council, the Executive Committee and its subcommittee–and through the senior officers of the Bureau at regional and national levels: the Director, Deputy Director, Assistant Director and PAHO/WHO Country Representative.

245. The Governing Bodies need to be serviced effectively, and their decisions implemented in a responsive and transparent way. Clear lines of authority, responsibility and accountability are needed within the Bureau, especially in a context where resources, and decisions on their use, are increasingly decentralized to locations where programs are implemented.

246. At all levels, the Organization's capabilities need to be strengthened to cope with the ever-growing demand for information on health. The Organization should be equipped to communicate internally and externally in a timely and consistent way at global, region and country levels–both proactively and in times of crises–in order to demonstrate its leadership in health, provide essential health information, and ensure visibility.

247. There is a need for strong political will, good governance and leadership at country level. Indeed, the State plays a key role in shaping, regulating and managing health systems and designating the respective health responsibilities of government, society and the individual. This means dealing not only with health-sector issues but with broader ones, for instance reform of the civil service or macroeconomic policy, which can have a major impact on the delivery of health services. The Bureau, for its part, needs to ensure that it focuses its support around clearly articulated country strategies, that these are reflected and consistent with PAHO/WHO's medium-term plans and program budgets, and that the Organization's presence is matched to the needs and level of development of the country concerned in order to provide optimal support.

248. At the Regional level, certain mechanisms could be strengthened to allow stakeholders to tackle health issues in a transparent and effective way. PAHO/WHO should help to ensure that national health policymakers and advisers are fully involved in all international forums that discuss health-related issues. This is particularly important in a time of social and economic interdependence, where decisions on issues such as trade, conflict and human rights can have major consequences for health. The numerous actors in public health, outside government and intergovernmental bodies, whether activists, academics or private-sector lobbyists, need to have forums so that they can contribute in a transparent way to global and national debates on health-related policies; they also play a part in ensuring good governance and accountability.

Lessons learned

- With an increasing number of sectors, actors and partners involved in health, PAHO's role and strengths need to be well understood and recognized. PAHO will need to maintain its position in order to achieve its objectives and contribute to reaching the health-related Millennium Development Goals.

- The growing number of others involved in health work has also led to gaps in accountability and an absence of synergy in coordination of action. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society groups, in tackling health problems.
- Expectations of the United Nations system are increasing, as is the need to be more clear on how it adds value. Of particular importance are relations at country level, where many changes are taking place as international organizations align their work with national health policies and programs, and harmonize their efforts so as to reduce the overall management burden. In this context, PAHO/WHO needs to continue to play a proactive role, and to devise innovative mechanisms for managing or participating in global partnerships in order to make the international health architecture more efficient and responsive to the needs of Member States.

Strategic Approaches

249. Achieving the strategic objective will require Member States and the Bureau to work closely together. More specifically, key actions should include leading, directing and coordinating the work of PAHO; strengthening the governance of the Organization through stronger engagement of Member States and effective Bureau support; and effectively communicating the work and knowledge of PAHO/WHO to Member States, other partners, stakeholders and the general public.

250. In collaborating with countries to advance the global and regional health agenda, PAHO/WHO will contribute to national strategies and priorities, and bring country realities and perspectives into global policies and priorities. The different levels of the Organization would be coordinated on the basis of an effective country presence that reflects national needs and priorities. At the national level, the Organization will promote multi-sectoral approaches for advancing the global and regional health agenda; build institutional capacities for leadership and governance and for health development planning; it will also facilitate technical cooperation among developing and developed countries.

251. Other actions include promoting development of functional partnerships and a global health architecture that ensures equitable health outcomes at all levels; encouraging harmonized approaches to health development and health security with organizations of the United Nations system, other international bodies, and other stakeholders in health; actively participating in the debate on reform of the United Nations system; and acting as a convener on health issues of global and regional importance.

Assumptions and Risks

252. The following assumptions underlie achievement of the strategic objective:

- That commitment from all stakeholders to good governance and strong leadership is maintained; and Member States and the Bureau comply with the resolutions and decisions of the governing bodies.
- That the current relationship of trust between Member States and the Bureau is maintained.
- That accountability for actual implementation of action decided on will be strengthened in the context of the results-based management framework.
- That possible changes in the external and internal environment over the period of the Medium-term Strategic Plan will not fundamentally alter the role and functions of WHO; however, WHO must be able to respond and adapt itself to, for instance, changes stemming from reform of the United Nations system.

253. Among the risks that might affect achievement of the strategic objective consideration could be given to possible consequences of the reform of the United Nations system; opportunities would be increased if PAHO/WHO takes initiatives and plays a proactive role in this process. Also, the increasing number of partnerships might give rise to duplication of efforts between initiatives, high transaction costs to government and donors, unclear accountability, and lack of alignment with country priorities and systems; remedial action would be needed if this development occurs.

Region-wide Expected Results

RER # 15.1	**Effective leadership and direction of the Organization through the enhancement of governance, coherence, accountability and synergy of the work of PAHO/WHO to fulfill its mandate in advancing the global and regional health agendas.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
15.1.1	Proportion of PAHO Governing Bodies resolutions adopted that focus on policy and strategies to be implemented at regional, subregional and national levels.	40%	45%	55%
15.1.2	Proportion of documents submitted to governing bodies within constitutional deadlines, in all official languages.	95%	100%	100%
15.1.3	Proportion of Summits Declarations reflecting commitment in advancing the Health Agenda for the Americas.	60%	65%	75%
15.1.4	Percentage of oversight projects completed under the biennial work plan which seek to evaluate and improve processes for risk management, control and governance.	90%	98%	100%

15.1.5	Effective regional forum capacity established for a) closing the unfinished cycle of unmet needs of science-based public health policies and interventions and, b) linking non-traditional PAHO´s partners and stakeholders with PAHO´s governance and policy-making bodies and activities.	None	1. Strategic alliances with non-traditional PAHO partners established 2. Regional Forum Platform established and functioning	Regional forum capacity fully achieved by PAHO
15.1.6	Number of Regional Forum conducted that develop position papers and policy recommendations for the improvement of Public Health in the Americas.	0	2	5
15.1.7	Number of Subregional Fora conducted that develop position papers and policy recommendations for the improvement of public health in the respective subregion.	0	3	5
RER # 15.2	**Effective PAHO/WHO country presence established to implement technical cooperation programs that are aligned with 1) Member States' national health and development agendas, 2) guided by the CCS, and 3) coordinated with the UN country team and other partners.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
15.2.1	Number of countries using Country Cooperation Strategies (CCS) as a basis for planning the PASB's country work and for harmonizing cooperation with the United Nations CCA/UNDAF.	20	30	35
15.2.2	Number of countries where PAHO/WHO's presence reflects the respective Country Cooperation Strategy.	20	30	35
15.2.3	Number of countries in which a joint assessment mechanism is implemented biennially to define the contribution of the Bureau to national health outcomes.	10	30	40
15.2.4	Number of subregions that have a Subregional Cooperation Strategy (SCS).	0	1	4
15.2.5	Number of Technical Cooperation among Countries (TCC) projects.	TBD	TBD	TBD
RER # 15.3	**Regional strategies and mechanisms strengthened to effectively provide more sustained and predictable technical and financial resources for health, that responds to the Health Agenda for the Americas.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
15.3.2	Number of partnerships with Memoranda of Understanding in support to the Health Agenda for the Americas.	TBD	TBD	TBD
15.3.3	Proportion of trade agreements in the Americas that appropriately reflect public health interests.	less than 5%	10%	20%

15.3.4	Number of agreements with bilateral and multilateral organizations, including UN agencies, supporting the Health Agenda for the Americas.	TBD during 2007	10	25
RER # 15.4	**Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
15.4.1	Number of countries that have access to relevant health information and advocacy material for the effective delivery of health programs as reflected in the country cooperation strategies.	TBD	TBD	TBD
15.4.2	Web utilization statistics available for web pages, blogs, list servers, virtual health library, and WHO's HINARI and GIFT projects.	TBD	TBD	TBD
15.4.3	Number of multilingual (non-English) pages available on the PAHO web site.	TBD	TBD	TBD
15.4.4	Number of PAHO publications sold per biennium.	TBD	TBD	TBD

Strategic Objective #16

To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively

Scope

254. The scope of this objective covers the functions that support the work of the Bureau in countries, centers, subregions and technical areas at headquarters. It includes strategic and operational planning and budgeting, performance monitoring and evaluation; and management of financial resources through monitoring, mobilization and coordination. The entities implementing this SO ensure an efficient flow of available resources throughout the Organization; management of human resources, including human resource planning, recruitment, staff development and learning, performance management, and conditions of service and entitlements; provision of operational support, ranging from the management of infrastructure and logistics, language services, staff and premises security, and staff medical services to the management of information technology; and appropriate accountability mechanisms across all areas.

255. The strategic objective also covers broad institutional reform that will ensure that the above functions are continuously strengthened and provide better, more efficient and cost-effective support to the Organization.

256. **Indicators and Targets**

- Cost-effectiveness of the enabling functions of the Organization, i.e. the share of overall budget spent on this strategic objective relative to the total PASB budget. Target: [to be confirmed].
- Achievement of RERs under SOs 1-14. The main function of SO 16 is to enable the programmatic work covered under SOs 1-14 to occur efficiently and effectively.

Issues and Challenges

257. As noted, the functions performed under SO16 exist principally to enable the efficient and effective operation of the programmatic functions culminating in SOs 1-14. Therefore, the issues and challenges that affect the entire Organization also apply to this SO. That being said, there are some specific challenges faced by the “support functions”:

- Partners and contributors are expecting increasing transparency and accountability in terms of both measurable results and use of financial resources.

- PAHO's implementation of result-based management remains incomplete; while results-based planning and budgeting are in place, the extent to which managers are incorporating performance data and analysis into their day-to-day decision-making processes must be enhanced.
- The increasing percentage of the Organization's budget that comes from voluntary contributions (as opposed to regular budget) presents challenges, especially given the high ratio of staff costs to non-staff costs.
- Human resource management is an issue when the average age of professional staff is 50 years old or older, and a high percentage (approximately 31%) will be retiring over the next five to seven years.
- Delegation and accountability models that ensure efficiency while maintaining controls are being developed, and will be implemented during the period.

Strategic Approaches

258. In order to achieve the strategic objective and respond to the above challenges, broad complementary approaches are required. Significant efforts have been made in institutional strengthening to enhance the Bureau's administrative and managerial capabilities, efforts that are showing results. These approaches will be intensified during the coming years, and include the move from an organization managed mainly through tight, overly bureaucratic controls to post facto monitoring in support of greater delegation and accountability; the shift of responsibility for, and decision-making on, the use of resources closer to where programs are implemented; improvement of managerial transparency and integrity; reinforcement of corporate governance and common Organization-wide systems; and strengthening of managerial and administrative capacities and competencies in all locations, in particular country offices.

Assumptions and Risks

259. It is assumed that the changes in the external and internal environment that are likely to occur over the six-year period of the plan will not fundamentally alter the role and functions of PAHO. Nonetheless, managerial reforms should help shape PAHO into a more flexible organization that is able to adapt to change.

260. The Bureau will continue its efforts to "do more with less" without compromising the quality of its services. This strategy is not without risk and must not be carried out to the detriment of institutional knowledge, quality, appropriate controls and accountability. This objective is inherently linked to the work of the rest of the Organization: increasing workload in other strategic objectives will require increased resources to support that work, even if the relationship is not necessarily linear.

Region-wide Expected Results

RER # 16.1	**PAHO/WHO is a results-based Organization whose work is guided by strategic and operational plans that build on lessons learnt; reflect country needs; are developed jointly across the Organization; and are effectively used to monitor and evaluate performance.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
16.1.1	Number of PASB entities whose biennial Workplans are results-based and explicitly address the country focus strategy as defined in the CCS (where applicable) as determined through a consultative process involving governments (where applicable), and incorporating lessons learned from the previous biennium.	TBD	40%	All
16.1.2	Proportion of reports on expected results contained in the Strategic Plan and Program Budget submitted in a timely manner to the satisfaction of Governing Bodies (as indicated in respective resolutions).	50%	80%	100%
16.1.4	Proportion of managers and project officers trained and certified on result-based management, planning, project management, and operational planning and monitoring and accountability mechanisms.	0%	50%	100%
16.1.5	The Strategic Plan (SP) and respective Program Budgets (PBs) are results-based, take into account the country-focus strategy and lessons learnt, and document an inclusive development process involving all levels of the Organization, per judgment of Governing Bodies.	In progress	PB 10-11 developed with these characteristics	SP 13-17 and PB 12-13 developed with these characteristics
16.1.6	Results Based Management strategy approved by Governing Bodies and applied throughout the Organization.	In progress	Approved by Governing Bodies	Full implementation
16.1.7	Percentage of PASB entities where the Strategic Alignment and Resource Allocation (SARA) exercise has been completed and follow-up mechanism implemented.	In progress	100%	100%
16.1.8	Percentage of Regional Program Budget Policy targets fully implemented.	66%	100%	N/A
16.1.9	Accountability Framework to support Delegation of Authority to country level approved and implemented.	In progress	Approved by Governing Bodies	Full implementation

RER # 16.2	**Monitoring and mobilization of financial resources strengthened to ensure implementation of the Program Budget, including enhancement of sound financial practices and efficient management of financial resources.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
16.2.1	Degree of PASB compliance with International Public Sector Accounting Standards.	International Public Sector Accounting Standards not implemented	International Public Sector Accounting Standards approved by Member States, analysis completed, and financial systems ready for implementation in 2010.	International Public Sector Accounting Standards fully implemented
16.2.2	Proportion of strategic objectives with expenditure levels meeting or exceeding program budget targets.	TBD (areas of work)	50%	100%
16.2.3	Proportion of voluntary contributions that are un-earmarked.	TBD	15%	20%
16.2.4	Resource mobilization gap.	TBD	Baseline <20%	Baseline <60%
16.2.5	Voluntary contributions funds returned to partners.	TBD	Baseline <10%	Baseline <20%
RER # 16.3	**Human Resource policies and practices promote a) attracting and retaining qualified people with competencies required by the organization's plans, b) effective and equitable performance and human resource management, c) staff development and d) ethical behavior.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
16.3.1	Proportion of offices with approved human resources plans for a biennium.	15%	75%	100%
16.3.3	Proportion of staff in compliance with the cycle of the Performance Planning and Evaluation System (PPES) i.e. objectives and development needs have been discussed between staff and supervisor.	85%	100%	100%
16.3.4	Human resources performance evaluation system linked to Workplans.	No	Yes	Yes
16.3.5	Proportion new staff who are retained after their probationary period.	TBD	TBD	TBD
16.3.6	Proportion of new staff that remain at least five years with the Organization.	TBD	TBD	TBD
16.3.7	Number of complaints made via the conflict management system.	TBD	TBD	TBD

RER # 16.4	**Information systems management strategies, policies and practices ensuring reliable, secure and cost-effective solutions, while meeting the changing organizational and technology needs of the Organization.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
16.4.1	Proportion of significant IT-related proposals, projects, and applications tracked for progress and status via portfolio management processes.	0%	40%	80%
16.4.2	Level of compliance with service level targets agreed for managed IT-related services.	0%	50%	75%
16.4.3	Number of country offices using consistent, integrated, near real-time management information	36	36	36
RER # 16.5	**Managerial and administrative support services enable the effective and efficient functioning of the Organization.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
16.5.1	Level of user satisfaction with select managerial and administrative services (including security, travel, transport, mail services, cleaning and food services).	low (satisfaction rated less than 50%)	medium (satisfaction rated 50%-75%)	high (satisfaction rated over 75%)
16.5.2	Proportion of standard operating procedures utilized by PASB staff during regional emergencies.	0%	50%	100%
16.5.3	Proportion of Internal benchmarks met or exceeded for specialized services such as procurement and translation.	TBD	10% over baseline	20% over baseline
RER # 16.6	**A physical working environment that is conducive to the well- being and safety of staff in all entities.**			
RER Indicator #	**RER Indicator text**	**RER Indicator Baseline (end-2007)**	**RER Indicator Target 2009**	**RER Indicator Target 2013**
16.6.1	Proportion of contracts under the PASB infrastructure capital plan for approved project(s) that are awarded and all construction work substantially completed on a timely basis.	100%	100%	100%
16.6.2	Proportion of PASB entities that have implemented policies and plans to improve staff health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) compliance.	65%	75%	100%
16.6.3	Proportion of entities (HQs, PWRs, and Centers) that improve and maintain their physical infrastructure, transport, office equipment, furnishings and information technology equipment as per their biennial Workplans.	75%	90%	100%

Ensuring Efficient and Effective Implementation

261. During the past five years, the PASB has implemented several institutional change initiatives that comprise a fundamental shift in the way the Organization carries out its duties. The five organizational change objectives established by the Director - 1) Enhance Country Focus; 2) Foster Innovative Modalities of Technical Cooperation; 3) Establish a Regional Forum; 4) Become a Learning Knowledge-Based Organization; and 5) Enhance Management Practices – led to the establishment of cross-functional teams mandated to determine how best to meet these objectives. These teams were called "Roadmap teams" and their work has largely been completed.

Organizational Change Objectives and the Roadmap teams

262. This Strategic Plan incorporates RERs and indicators to measure the achievement of these organizational change objectives:

(a) Enhance Country Focus;
(b) Become a Learning Knowledge-Based Organization (which includes the Regional Forum);
(c) Enhance Management Practices – notably through results-based management.

263. The objective regarding Modalities of Technical Cooperation is manifested throughout the Strategic Plan, and indeed in the day-to-day work of PAHO's country offices and regional technical units.

264. The Roadmap teams have concluded their work and made recommendations to Executive Management. The resultant changes to working modalities and management approaches will have been mainstreamed by the end of 2007, paving the way for improved implementation of the Strategic Plan.

265. In keeping with the comprehensive nature of this Plan, and monitoring and reporting on its implementation (see below), the PASB will no longer provide updates to Governing Bodies regarding institutional strengthening activities and organizational change objectives, as these are concluded or incorporated into the corporate planning and management of the Organization, in this Strategic Plan and in other instruments.

Country Cooperation Strategies

266. As discussed above under Lessons Learned, the CCS is the PASB's strategic planning at the country level; by 2012 all of the countries in Latin America and the Caribbean will have completed a CCS. It is an exercise conducted by the central,

regional and country level of the Bureau, together with the national authorities and the important health actors in a country to define the PASB's technical cooperation, with a view to responding better to country needs. The relation between the PASB Strategic Plan and the Country Cooperation Strategies is reciprocal. CCSs have been analyzed for input to this Strategic Plan and the reverse will be true once the Plan is approved: the Strategic Plan will guide future CCSs in the Region (see Diagram 1, above). The biennial Workplans of the PAHO/WHO Representations and PAHO Technical Centers respond fully to their respective CCS, where completed.

Results-based Management

267. The ongoing implementation of results-based management as a management tool in the PASB has two main goals, 1) to ensure the Organization focuses on results in the planning, implementation and assessment of its programs and 2) to improve accountability and transparency to Member States.

268. For nearly two decades the PASB has planned and budgeted for results–the American Region Planning and Evaluation System (AMPES) itself is based on the Logical Framework (LOGFRAME) approach used in result-based management. The culture of working for results is not new to the PASB; what is new for the 2008-2012 planning period in terms of result-based management is the following (some of these elements are noted in more detail elsewhere in this document):

(a) The expected results of the Organization are consistent from the highest (global) level to the lowest (Workplan, country) level and vice-versa. The chain of results can be seen in diagram No. 5 below. Aggregation of results indicators is possible through the different levels for the first time, enabling improved performance monitoring and reporting (see below on Monitoring, Assessment and Evaluation).

(b) Each entity's Office Specific Expected Results (OSERs) contribute to the achievement of the Region-wide Expected Result (RER) through aggregation. Thus each RER represents the results of the collective work of the Pan American Sanitary Bureau, for which it is accountable. This is a new concept in the Organization (see Diagram 6, below).

(c) Specific result-based management indicators that will measure result-based management achievements are included in SO 16.

(d) The Accountability Framework will be developed and implemented in congruence with the revised WHO Accountability Framework.

(e) Accompanying the Accountability Framework, a new Delegation of Authority will be issued, aligning levels of authority with accountability for results.

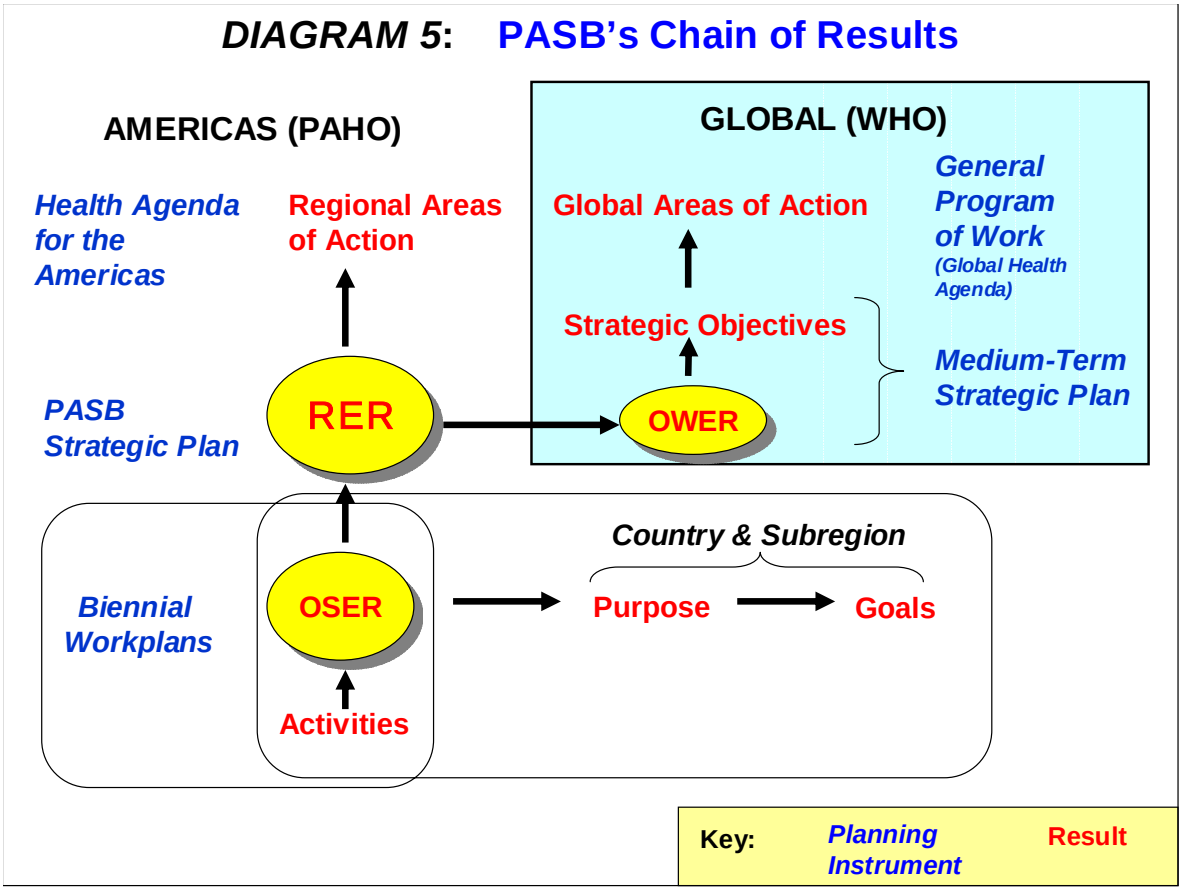
(f) The Managerial Framework will be finalized in order to provide guidance to managers at all levels to perform their jobs in the most effective and efficient manner.

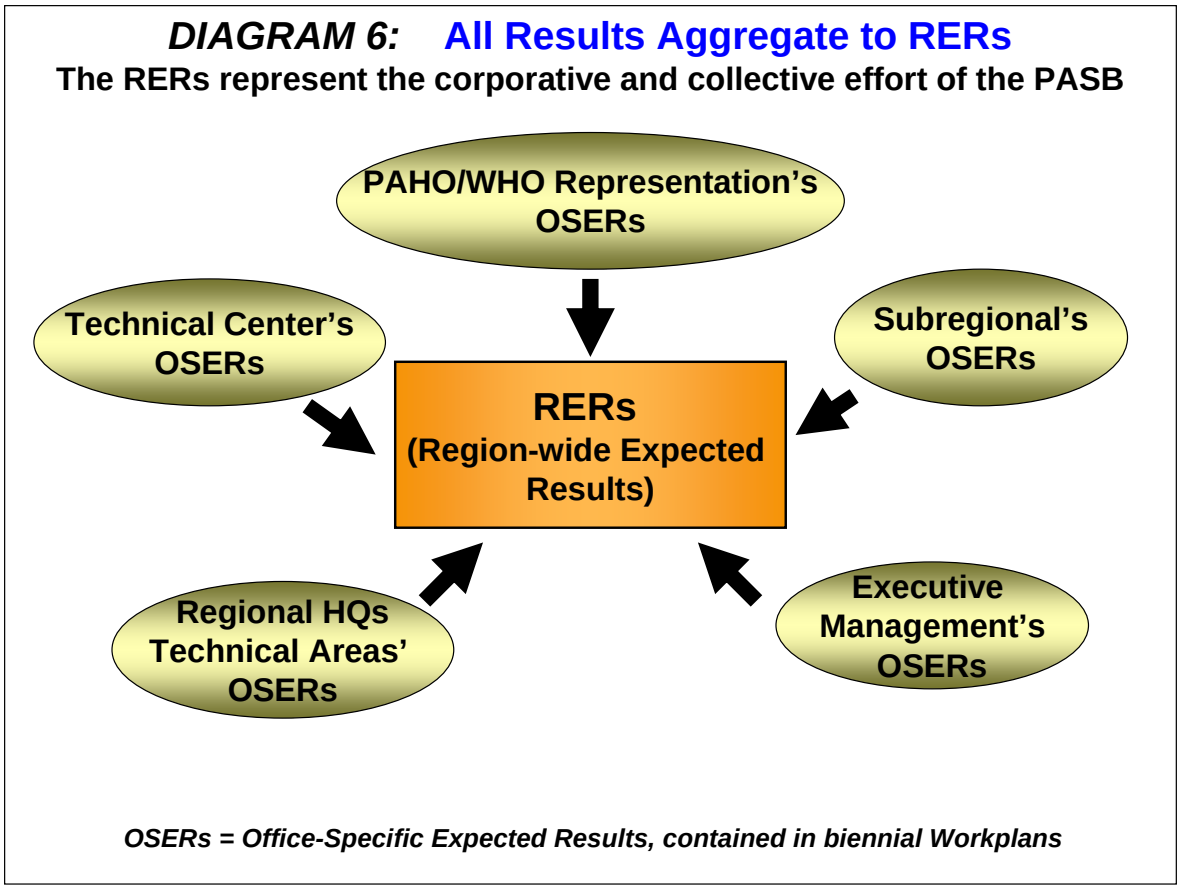
(g) The Strategic Assessment and Resources Alignment (SARA) exercise will ensure that resources (including staff) are being deployed optimally to achieve the Organization's objectives and expected results.

(h) The creation of the evaluation function assigned to a specific entity in the PASB will allow for more objective evaluation of programmatic achievements post-implementation.

269. With these measures, the PASB will continue to be at the forefront of result-based management implementation and mainstreaming in the UN system. The following diagrams depict the relationship among results at various levels of the Organization, with the RER as the main focus for the PASB.

***DIAGRAM 5*: PASB's Chain of Results**





Strategic Assessment and Resource Alignment (SARA)

270. Since the end of 2006, the PASB has undertaken a Strategic Assessment and Resource Alignment, or SARA, exercise. It involves the systematic review of all entities in the PASB to ensure that:

(a) Functions carried out by each entity contribute to the achievement of PAHO's strategic priorities as defined by Governing Bodies (including this Strategic Plan) and other applicable mandates;
(b) Available resources (human, financial and material) are assigned so as to achieve maximum efficiency and effectiveness in performing these functions.

271. The SARA exercise is based on a self-assessment and is highly participative. It may result in revisions to the Organizations structure, and/or the shifting of resources among functional areas. It is estimated that the exercise will be completed for all entities in PAHO near the end of 2007.

A Stronger PASB for 2008 and Beyond

272. The PASB, and more specifically its managers, remain committed to ensuring that the findings of PAHO in the 21st Century, the recommendations of the 2004 External Auditor's Special Report, and the Report on the Activities of the Internal Oversight Services continue to be implemented during the 2008-2012 planning period.

273. With the conclusion of the Roadmap teams' work and the incorporation of the organizational change objectives into this Strategic Plan, as well as the inclusion of key indicators of achievement for the SARA exercise, this Strategic Plan becomes what its predecessors often were not: a truly comprehensive summation of all significant results to be achieved by the Organization during the period 2008-2012, both programmatic and institutional.

274. When the main SARA exercise is completed near the end of 2007, the Organization will have been through a period of significant change and restructuring during the five years leading up to 2008. While ongoing improvements will no doubt be made, these changes will have enabled the PASB to efficiently and effectively achieve its mission.

Funding the Strategic Plan

275. PAHO is engaged with WHO in a results-based budgeting approach to determining the resource requirements to carry out its work. The cost of achieving specific expected results over a given period of time is expressed through an integrated budget comprising all sources of funding.

276. PAHO receives its funding from three main sources:

(a) PAHO Regular Budget: comprises assessed contributions (quotas) from PAHO Member States plus miscellaneous income;

(b) Region of the Americas' share from the WHO regular budget: referred to as the AMRO share;

(c) Voluntary Contributions: the majority of voluntary contributions received by PAHO are a result of direct negotiations with its donor partners; a lesser amount is channeled by donors to the region through WHO.

277. While funding sources from (a) and (b) above are considered unearmarked, voluntary contributions from (c) can be categorized as either earmarked or unearmarked. Effective financing of the PASB Strategic Plan and associated program budgets will

require careful management of the different sources and types of income to ensure complete funding of planned activities. Unearmarked funding, such as assessed contributions, provides a predictable and flexible resource base that facilitates financing of the Organization's core activities. Earmarked funding—which accounts for the majority of voluntary contributions currently negotiated—is less flexible and less predictable, and, thus, is more likely to contribute to funding gaps in relation to program budget requirements.

278. Earmarked funding received from donor partners continues to pose a challenge for ensuring alignment between the Organization's planned activities and actual resources mobilized. To the extent that donor partners can be persuaded to provide increased levels of unearmarked voluntary contributions—also referred to as "negotiated core voluntary contributions" by WHO—the Organization will become more successful in fully financing its Strategic Plan and Program Budgets, consequently increasing the probability of achieving its expected results. To this end, the Bureau fully supports WHO's efforts in actively seeking to increase the proportion of negotiated core voluntary contributions and will continue its own efforts in this area. PAHO will finance the Strategic Plan through all resources available to it, with the expectation of receiving an increasing share of negotiated core voluntary contributions.

279. Table 1 below summarizes the estimated resource envelope for the PAHO Strategic Plan.

Table 1

		Strategic Plan		
	PB 2006-2007	**PB 2008-2009**	**PB 2010-2011**	**PB 2012-2013**
PAHO	333,094,000	344,566,000	684,000,000	746,000,000
WHO	198,018,000	282,000,000		
	531,112,000	626,566,000	684,000,000	746,000,000

280. The PASB Strategic Plan has an estimated resource envelope of just over $2 billion for the three-biennium period ending in 2013. This projection begins with a proposed budget of $627 million (which includes all sources of funding) for 2008-2009 and contemplates biennial increases of roughly 9%, commensurate with the proposed costing of $14 billion for the WHO MTSP and expectations for inflationary costs in the Region.

281. The significant increase in the cost of international transactions to U.S. dollar-based budgets is being felt worldwide, and the PASB is no exception. A thorough analysis of current costs and trends points to an expected cost increase of between 13% and 15% for the 2008-2009 biennium. For the PAHO regular budget, this translates to

roughly $37 million for cost increases alone, of which approximately $24 million are related to the cost of fixed-term staff.

282. An alternative, more optimistic scenario, including stabilizing forces that curb the U.S. dollar devaluation over the short term, yields a projected cost increase of about 10% for the next biennium. This translates to roughly $26 million for the regular budget, of which approximately $17 million are related to the cost of fixed-term staff. Furthermore, the Bureau has reduced an additional 12 fixed-term positions so far in the biennium (in addition to the 41 positions abolished during 2004-2005) thus containing the estimated cost increase to about $14 million for fixed-term staff for 2008-2009, an increase of 8.3% compared with the budget component for fixed-term staff for 2006-2007, and an increase of 5.3% compared with the total budget for 2006-2007.

283. In consideration of the expressed position of many Member States regarding their ability to accept budget increases, the Bureau is prepared to take the "optimistic" scenario forward in constructing the proposed 2008-2009 program budget with the understanding that the economic reality may be different and may require significant adjustments to planned programmatic targets contained in the Region-wide Expected Results.

284. Table 2 below compares the proposed budget 2008-2009 with the approved budget for 2006-2007.

Table 2. Financing of the Program Budget 2008-2009

Source	2006-2007	2008-2009	% change
Assessed contributions from Member States	173,300,000	180,066,000	3.9%
+ Miscellaneous income	14,500,000	14,500,000	0.0%
= Total PAHO share (Regular Budget)	187,800,000	194,566,000	3.6%
+ WHO share (Regular Budget)	77,768,000	85,000,000	9.3%
= Total Regular Budget	265,568,000	279,566,000	5.3%
+ Estimated Voluntary Contributions *	265,544,000	347,000,000	30.7%
= Total Resource Requirements	531,112,000	626,566,000	18.0%

* Represents the combined total estimated resources from PAHO donor partners as well as from WHO

285. The proposed budget for 2008-2009 of $627 million represents an increase of 18% compared to the $531 million budget approved for 2006-2007. The largest source of the budget increase comes from the estimated voluntary contributions of $347 million, representing a 30.7% increase, of which $197 million is budgeted to come from WHO. This budget was developed jointly with WHO/HQ and the other WHO Regions by teams of staff working together globally, grouped by Strategic Objective.

286. The regular budget share of the budget of $280 million represents an increase of $14 million, or 5.3%, compared to the biennium 2006-2007, and is all attributable to the projected increase in the cost of fixed-term staff. This increase is proposed to be funded by an increase to the portion from PAHO assessed contributions of 3.9%, and the remainder from the 9.3% budget increase in the AMRO share of the budget ($85 million for AMRO included in the WHO budget presented to the WHO Executive Board in January 2007).

287. It should be noted that there are several significant non-staff costs expected to be incurred over the next few years which are not being included in the proposed regular budget increase; these include UN mandatory implementation of International Public Sector Accounting Standards (IPSAS), PAHO's expected involvement with the Global Management System (GSM) project being implemented by WHO, and expenditure related to the Master Capital Investment Plan.

288. The Bureau realizes that, in consideration of the budget reality also being faced by many Member States, budget increases must be maintained at an absolute minimum. Correspondingly, it is also important for Member States to keep in mind that additional funding for required expenditure such as IPSAS, GSM and the Master Capital Investment Plan will need to be prioritized from within the budget designated for regional program activities which is already being reduced in nominal terms and further taxed by inflation.

289. The purchasing power of the Organization's operating budget for program activities has been eroded over the last several biennia given that budget approvals by Member States have only considered increases to net staffing costs. The erosion is particularly acute for the regional level (such as regional centers and entities based in Washington) where the ratio of fixed-term staff costs to activity costs is typically higher than in countries because of the nature of the work. As the cost of fixed-term positions continues to rise, it becomes increasingly difficult for the Bureau to strive for further efficiencies by continuing to streamline operations and realign program areas, despite efforts made to reduce fixed-term positions.

290. The situation explained above is compounded by the fact that the Regional Program Budget Policy will progressively allocate a larger share of the budget to the

countries over the next two biennia, as was the case for 2006-2007. The further reduction of the regular budget for regional activities creates a challenge for the Organization in carrying out its normative work and for the ability of regional entities to respond to backstopping needs of countries.

291. Given that voluntary contributions provided by donor partners are generally earmarked for specific objectives and are less predictable, the Bureau will continue to make every effort to manage these contributions in light of the overall expected results contained in the Strategic Plan. Thus, regular budget funds become essential for securing many of the Organization's basic core functions. It should be noted that the $14 million increase to the regular budget only addresses the part of the Organization's core functions related to staff costs.

292. Table 3 provides a Region-wide view of the budget by the 16 Strategic Objectives and compares the proposed program budget 2008-2009 with the approved budget for 2006-2007. It should be noted that, for comparative purposes, a crosswalk methodology (developed by WHO) has been applied to convert the 2006-2007 budget from 38 Areas of Work to 16 Strategic Objectives.

Table 3. Proposed Program Budget 2008-2009 by Strategic Objective

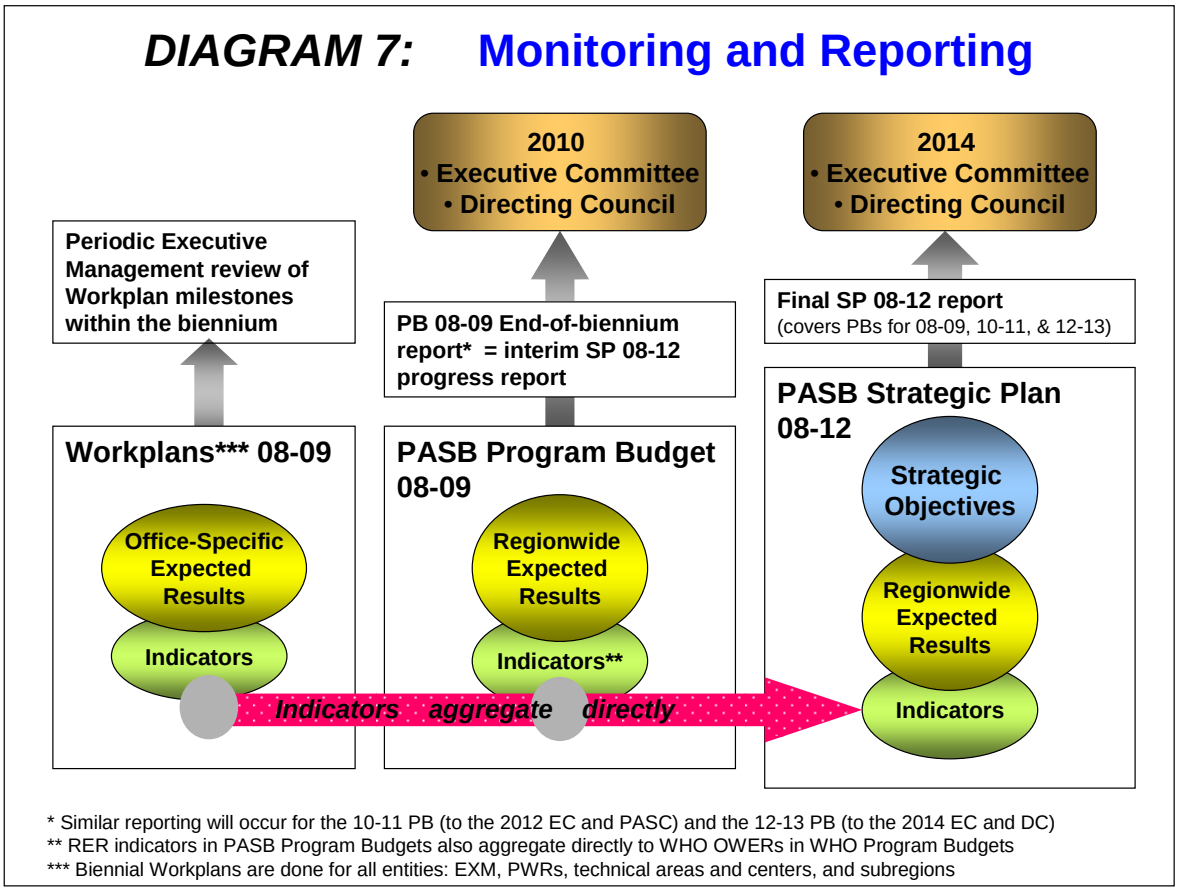
SO Description		2006-2007 Baseline	2008-2009 Proposed Budget	% Change
		PAHO/WHO	PAHO/WHO	
SO1	To reduce the health, social and economic burden of communicable diseases.	65,509,000	77,828,000	19%
SO2	To combat HIV/AIDS, tuberculosis and malaria	64,504,000	76,331,000	18%
SO3	To prevent and reduce disease, disability and premature death form chronic noncommunicable conditions, mental disorders, violence and injuries	18,297,000	23,331,000	28%
SO4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	21,535,000	36,523,000	70%
SO5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	34,381,000	38,990,000	13%
SO6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	15,207,000	24,896,000	64%
SO7	To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	8,619,000	13,070,000	52%
SO8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	23,992,000	27,223,000	13%
SO9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	18,407,000	27,495,000	49%
S10	To improve the organization, management and delivery of health services.	31,286,000	32,367,000	3%
S11	To strengthen leadership, governance and the evidence base of health systems	33,904,000	34,104,000	1%
S12	To ensure improved access, quality and use of medical products and technologies	16,825,000	19,824,000	18%
S13	To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	17,078,000	20,500,000	20%
S14	To extend social protection through fair, adequate and sustainable financing	14,216,000	17,092,000	20%
S15	To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfill the mandate of WHO/PAHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	52,799,000	55,779,000	6%
S16	To develop and sustain WHO/PAHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	94,553,000	101,213,000	7%
TOTAL		**531,112,000**	**626,566,000**	**18%**

Monitoring, Assessment and Evaluation

293. In the past, reporting against progress in implementing strategic plans has been hampered by the lack of integration among the different levels of planning in the Organization. As an example, the set of objectives, expected results and indicators used in the 2006-2007 country-level Workplans differed from those in the 2006-2007 Program Budget, which in turn differed from those in the 2003-2007 Strategic Plan, as well the OWERs and indicators in the global WHO Program Budget for 2006-2007.

294. As discussed above, this issue has been thoroughly addressed for the planning period beginning in 2008, where there is vertical integration of expected results and indicators among all levels of planning–from the global WHO Medium-term Strategic Plan to this PASB Strategic Plan to the respective Program Budgets and in turn to the Workplans (in the AMPES system). While this new system may have some negative aspects, notably a reduction in programming flexibility at country level, these are outweighed by the benefits: true corporate results-based planning, as well as the possibility of monitoring and reporting through direct aggregation of results.

295. This last point is the principal innovation for the 08-12 Strategic Planning period: that the achievement of expected results (as measured by SMART–specific, measurable, achievable, realistic and time bound–indicators) can be aggregated directly, and in most cases automatically in the AMPES system, from the country level to the regional and global levels on a biennial basis. And since the Region-wide Expected Results in the Program Budgets will be exactly the same as those in this Strategic Plan, the end-of-biennium Program Budget reports will serve as interim progress reports for the Strategic Plan. The sum of the three biennia covered under this Plan will form the basis for the final report on this Strategic Plan, to be presented to the Governing Bodies in 2014. The monitoring and reporting relationship among planning instruments is presented here graphically, with key submissions to Governing Bodies highlighted.



296. As shown, programmatic monitoring and assessment will focus on entities' Workplans and, via aggregation, Program Budgets (2008-2009, 2010-2011 and 2012-2013). Significant time and effort has been dedicated to improving the AMPES system to incorporate the required changes, allowing for quality-control through monitoring of SMART indicators. The regular monitoring and reporting of results in a systematic fashion will allow managers to evaluate and adjust their implementation strategies and Workplans as needed–a key element of the full implementation of results-based management in the Organization.

297. PASB also will report to WHO on the achievements of Member States with respect to the Strategic Objectives. WHO will then prepare a global report regarding the achievement of the Strategic Objectives at the global level.

298. The experience gained during the six-year biennium (as reported in Program Budget assessments) may require adjustments in the RERs (and even SOs). External

changes in the environment may also require changes in the PASB's strategies and expected results. Whenever such changes are needed at the level of RER or above, they will be provided to the Governing Bodies for review and approval.

Evaluation

299. In the PASB, the evaluation function is separated organizationally from the planning, monitoring and assessment functions, in order to foster impartiality in the conduct of evaluations. The evaluation function (and respective staffing) has been put in place only in 2007, therefore the working modalities with respect to periodicity and scope are still under development.

Action by the SPBA

300. The Subcommittee on Program, Budget and Administration is asked to review this document and provide comments to the Bureau in order that this Strategic Plan may be revised and improved for submission to the Executive Committee in June of 2007.

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