Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

158th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 20-24 June 2016

Provisional Agenda Item 4.1

CE158/11, Rev. 1
2 June 2016
Original: English

PRELIMINARY REPORT OF THE END-OF-BIENNIUM ASSESSMENT OF THE PROGRAM AND BUDGET 2014-2015/FIRST INTERIM REPORT ON THE PAHO STRATEGIC PLAN 2014-2019

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

1. The purpose of this report is to present to the Pan American Health Organization (PAHO) Governing Bodies the findings of the final assessment of the implementation of the PAHO Program and Budget 2014-2015. While the report focuses on the first biennium, it also includes progress toward the achievement of the six-year targets in the PAHO Strategic Plan 2014-2019.

2. The reported results are the product of a first-ever joint Pan American Sanitary Bureau (PASB) and Member State monitoring and assessment of outputs and outcomes. The report builds upon and deepens the Organization's commitment to results-based management and enhanced accountability and transparency.

3. Significantly, all of PAHO's 51 countries and territories[1] participated fully in the joint assessment. The Region of the Americas is the first to have conducted a joint performance assessment with national counterparts, and lessons learned in the process will be disseminated and documented as best practices. The joint assessment process began with country-level assessments; these were followed by validation by PAHO technical experts and consolidation of Organization-wide results for presentation to the PAHO Governing Bodies. The results in this report also contributed to the World Health Organization Programmatic and Financial Report for 2014-2015 including audited financial statements for 2015 presented to the World Health Assembly in May 2016.

4. During 2014-2015, PAHO exercised its leadership, convening, and catalytic role to improve the health of the peoples of the Americas in collaboration with Member States and partners. The Organization engaged in direct technical cooperation, mobilized resources, strengthened partnerships and networks, built capacity, generated and provided evidence, and advocated for actions to achieve the results in the Program and Budget 2014-2015 and advance the priorities of the PAHO Strategic Plan 2014-2019. This was done in the context of closing gaps in performance on key Millennium Development Goals (MDGs) while transitioning to the implementation of the new Sustainable Development Goals (SDGs) set forth in the 2030 Agenda for Sustainable Development.

5. The assessment of the Program and Budget 2014-2015 shows steady progress toward achieving the Strategic Plan targets for 2019, with 90% of the outcome indicators on track. At the output level, which represents the specific results for the biennium, the assessment shows that all 114 outputs assessed were achieved or partially achieved.

6. Notable progress has been made in improving health and well-being across the Region. Landmark achievements at impact level include validation of the elimination of mother-to-child transmission of HIV and congenital syphilis in Cuba; declaration of the elimination of endemic transmission of rubella and congenital rubella syndrome in the Region of the Americas; verification of the elimination of onchocerciasis in Ecuador and

[1] For the purposes of this report, 51 countries and territories are considered. French St. Martin was not assessed. The full list can be found in Annex F.

Mexico; reduction of mortality and morbidity related to malaria and dengue; and further reduction of under-5 child mortality, which led to the achievement of MDG4 in the Region.

7. At the outcome level, substantial gains were made in the expansion of coverage and access to health services in line with the universal health strategy and in strengthening the preparedness and response capacity for outbreaks and emergencies. Also observed were increased treatment of communicable diseases, increased access to mental health services, reduction of tobacco use, improvements in reproductive health, and increased capacity to address the determinants of health.

8. Important achievements were also recorded at the output level in the development of policies, strategies, plans, programs, laws, norms, and guidelines, in addition to operational efficiencies and process improvements within the PASB. These achievements will enable the PASB and Member States to continue improving health outcomes and impacts in the remaining four years of the Strategic Plan.

9. However, key challenges and gaps remain in certain areas, such as noncommunicable diseases and risk factors, maternal health, financing for health, maintaining and strengthening core capacities for emergency and crisis response, and increasing the resilience of health systems. The Organization, both Member States and the PASB, in collaboration with partners across the Region and beyond, will need to find strategies to address such challenges. They will also need to continue advocating and investing the necessary resources to keep public health issues at the top of the political and development agendas. The SDGs provide an excellent opportunity to bring prominence to the Organization's work.

10. The Program and Budget 2014-2015 was 97.6% financed in total, representing an improvement from the preceding biennium. However, uneven funding across program areas remains a challenge, with some priority programs receiving less than 75% of their approved budget. These gaps impeded effective program delivery. Key actions to address funding gaps in future biennia include targeting resource mobilization toward programmatic priorities identified by Member States, as well as strategic allocation of the Organization's flexible funding. This requires active advocacy and ongoing strategic communication to further engage partners and donors in efforts to achieve the results of the PAHO Strategic Plan and its Program and Budgets.

11. Building on the achievements and reflecting on the lessons learned will serve to deepen and extend the reach of the Organization's technical cooperation, effectiveness, and accountability for results in order to fulfill the strategic vision of the PAHO Strategic Plan 2014-2019: *"Championing Health: Sustainable Development and Equity."*

II. INTRODUCTION

12. Pursuant to Resolution CD52.R8 (2013), the Pan American Sanitary Bureau (PASB) is pleased to present reports of biennial performance assessments on the implementation of the Pan American Health Organization (PAHO) Strategic Plan 2014-2019 and its Program and Budgets. This report presents results of the Program and Budget 2014-2015, the first Program and Budget of the PAHO Strategic Plan 2014-2019, and serves as the first interim report on progress toward achieving the results of the Strategic Plan.

13. This report relies on information from the joint assessment conducted by the PASB in collaboration with Member States and the internal PASB performance monitoring and assessment (PMA) process. The assessment produced an analysis of the Region's public health situation, focusing on progress made toward achieving the outcomes of the PAHO Strategic Plan 2014-2019; it also outlined challenges that emerged during implementation of the Program and Budget 2014-2015 and actions required to address these challenges in the upcoming biennia. The assessment also presents a comprehensive budget analysis of available resources and their allocation and expenditure by functional level and programmatic category.

14. The 2014-2015 end-of-biennium assessment is the first formal joint assessment exercise to be carried out by the PASB and Member States. All 51 countries and territories of the Region participated in the assessment, which was conducted within the accountability and reporting framework of the PAHO Strategic Plan 2014-2019. It builds upon PAHO's tradition of and commitment to results-based management (RBM). It also provides an opportunity to reflect on the public health gains, gaps, challenges, opportunities, and lessons learned in the Region in order to guide interventions in the 2016-2017 biennium and beyond.

15. The report incorporates recommendations made by Member States during the 10th Session of the Subcommittee on Program, Budget, and Administration (SPBA) in March 2016 and the 3rd Meeting of the Strategic Plan Advisory Group (SPAG)[2] of Member States in April 2016. The final draft report presented at the 55th Directing Council in September 2016 will include any further recommendations from the 158th Session of the PAHO Executive Committee in June 2016. The findings in this report served as the main input from the Region of the Americas to the World Health Organization (WHO) Program Budget 2014-2015 assessment that was presented to the World Health Assembly in May 2016.

[2] At the request of Member States, the SPAG was established in October 2014 to provide advice and input to the implementation of the joint monitoring and assessment process and to the refinement of the programmatic stratification framework in the PAHO Strategic Plan 2014-2019 (Resolution CD53.R3). It includes 12 members designated by the ministries of health of the Bahamas, Brazil, Canada, Chile, Costa Rica, Ecuador, El Salvador, Jamaica, Mexico, Paraguay, Peru, and the United States of America. The group is chaired by Mexico and co-chaired by Ecuador.

16. The report consists of eight sections.

I. Section I is the executive summary, which provides an overview of the report and a summary of the main findings of the end-of-biennium assessment.

II. Section II introduces the report.

III. Section III explains the end-of-biennium assessment process, including the methodology for the programmatic and budget implementation assessments, followed by highlights and lessons learned.

IV. Section IV is the regional overview, an analysis of the Region's public health status and progress made in advancing priorities identified in the Strategic Plan, as well as gaps, challenges, and risks faced in the countries and Region-wide.

V. Section V is a corporate analysis of programmatic implementation and achievements at the category, outcome, and output levels.

VI. Section VI is an analysis of the budget implementation of the Program and Budget, including the mobilization and allocation of resources by programmatic and functional level.

VII. Section VII presents conclusions, recommendations, and lessons learned.

VIII. Section VIII consists of six annexes, A-F. Annex A contains detailed reports by category, program area, outcome, and output, and supplements the information in Sections IV, V, and VI. The methodology for the category reports is detailed in Section III. Other annexes provide examples of the technical definitions of the outcome and output indicators, a list of outcome and output indicators with low or no progress, indicators with proposed changes for 2016-2017, abbreviations used in this report, and the list of countries and territories in the Region.

III. END-OF-BIENNIUM ASSESSMENT PROCESS

17. This section describes the components of the end-of-biennium assessment process: the joint assessment with Member States and the PASB's internal performance monitoring and assessment (PMA) processes, including budget implementation and resource analysis. It also contains the main lessons learned and recommendations from these processes. These lessons will serve to inform and improve future assessments.

18. The overall end-of-biennium assessment process utilizes qualitative and quantitative approaches to assess programmatic and budget implementation. The process for the 2014-2015 assessment, the first under the PAHO Strategic Plan 2014-2019, was carried out over a five-month period. It began with the countries' self-assessments in November 2015, followed by validation by the PASB Category and Program Area Network (CPAN).[3] In addition to the joint assessment of outcome and output indicators with Member States, the PASB completed its internal PMA of Biennial Work Plans in all 83 offices across the country, subregional, and regional functional levels, including a review of programmatic (completion of products and services) and budget implementation.

19. Preliminary results of the end-of-biennium 2014-2015 assessment were presented along with an outline of this report to the 10th Session of the Subcommittee on Program, Budget, and Administration. This draft end-of-biennium report is being presented for the Executive Committee's review and input in June 2016. The final draft, based on guidance received from the Executive Committee, will be completed in July 2016 and then presented to the Directing Council in September 2016 for approval. The findings in this report served as the main input from the Region of the Americas to the WHO Program Budget 2014-2015 assessment that was presented to the World Health Assembly in May 2016.

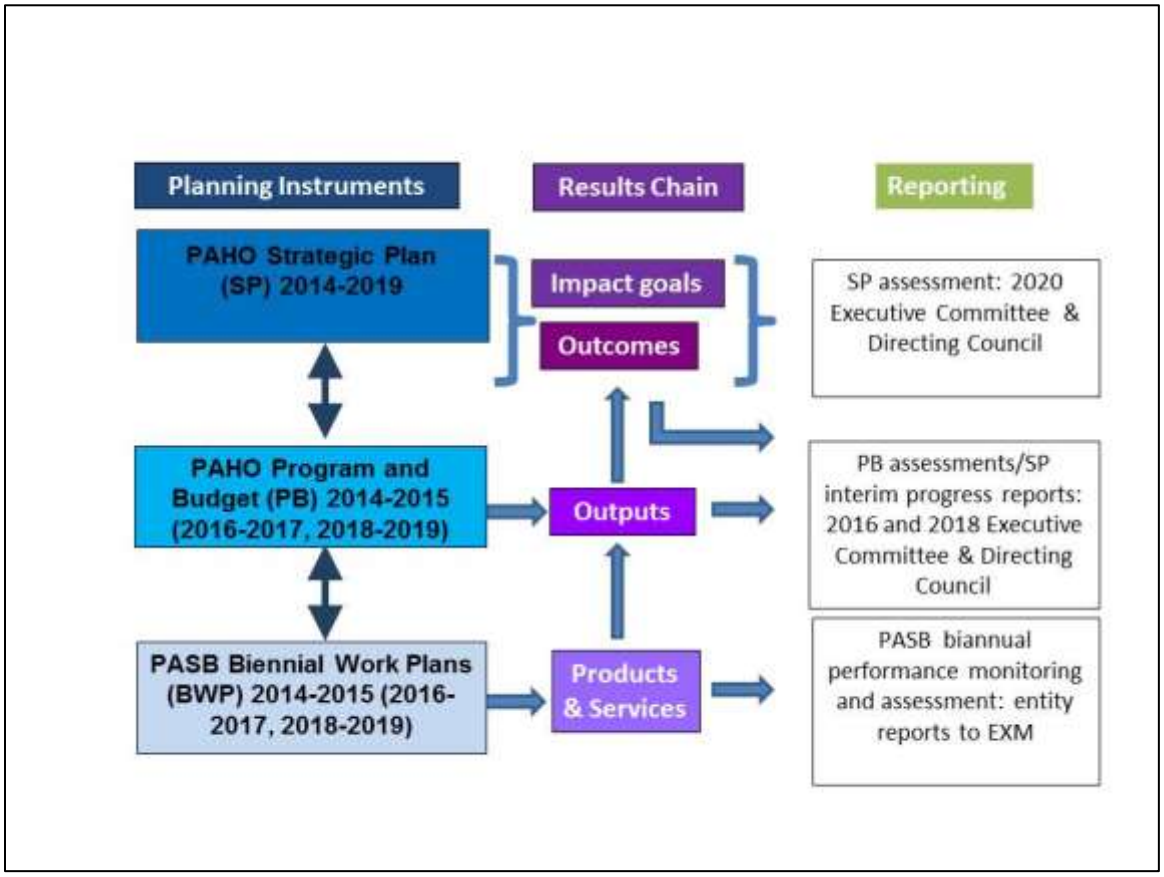
20. The assessment process described below follows the requirements approved by Member States (Resolutions CD52.R8 and CD53.R3) and guidelines developed with the SPAG. Furthermore, this assessment report carries out the commitment of Member States and the PASB for joint accountability and transparency, as agreed during the development of the PAHO Strategic Plan and the first Program and Budget 2014-2015.

21. Figure 1 shows the order, sequence, and frequency of monitoring, assessment, and reporting to the PAHO Governing Bodies. PASB develops Biennial Work Plans containing products and services (bottom of the figure), which represent the direct contribution and responsibility of the PASB to achieve the outputs defined in the Program and Budget. There is an internal corporate review of the status of delivery of the products and services in the work plans every six months, involving all PASB entities. This exercise is led by the Director and PASB Executive Management (EXM).

[3] The CPAN is a network of PASB management and technical teams. Category facilitators lead a team of outcome/program area and output failitators, who assess the outcomes and outputs under their responsibility. The category and program facilitators include PASB Department Directors and Unit Chiefs, respectively.

22. Moving up the results chain, at the close of each Program and Budget period, the Organization completes an end-of-biennium assessment, in which both the PASB and the Member States measure achievement of the outputs in the Program and Budget and the extent of progress toward reaching the outcomes in the Strategic Plan. After six years, spanning three Program and Budgets, the Organization will assess whether the outcome and impact goals in the Strategic Plan have been achieved.

Figure 1: PAHO/WHO Planning Instruments and Reporting, 2014-2019



Joint Assessment

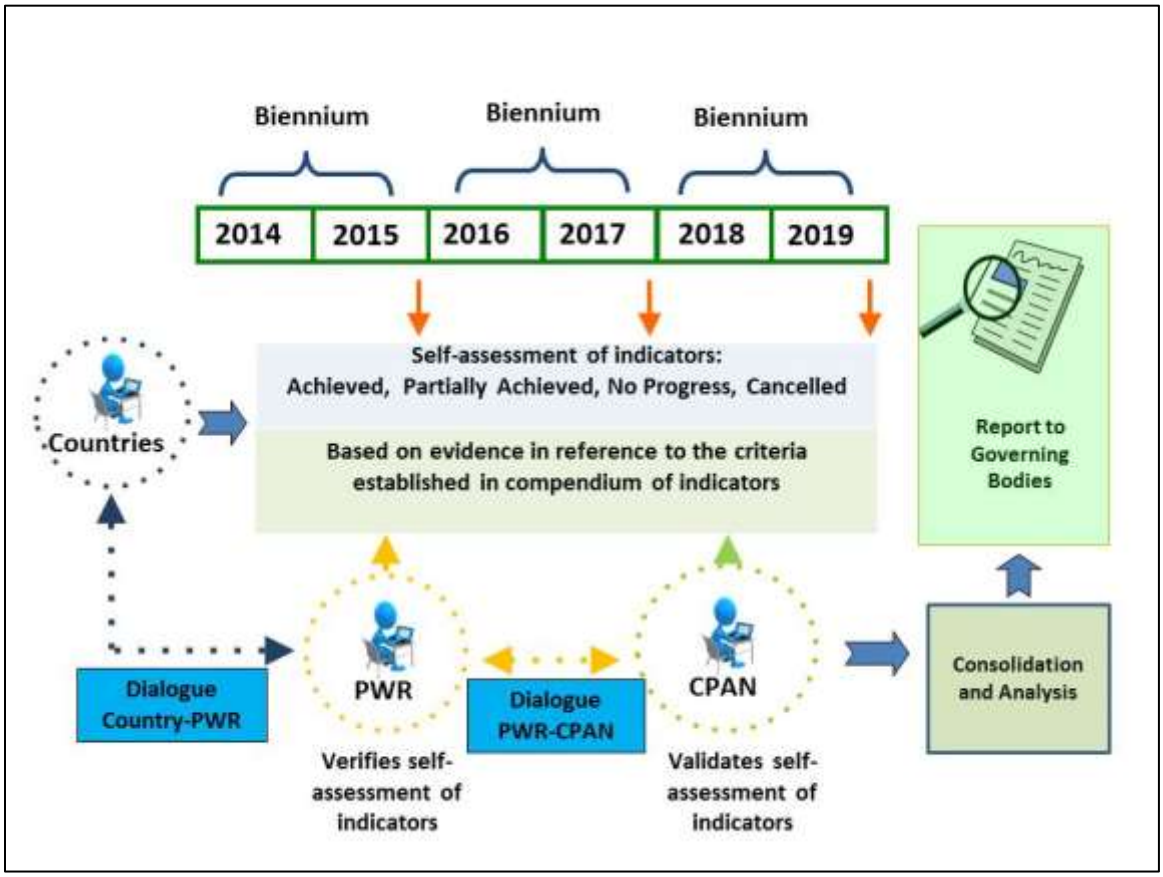
23. Figure 2 presents an overview of the joint assessment process flow. In order to fulfill the joint monitoring and assessment mandate, the PASB, in collaboration with the SPAG, developed the PAHO Strategic Plan Monitoring System (SPMS) in 2015 to facilitate the joint assessment of outcome and output indicators by national health authorities and the PASB. It contains the programmatic information required to monitor and assess implementation of the PAHO Strategic Plan 2014-2019 and the Program and

Budget 2014-2015, including the compendium of indicators with technical definitions and criteria to assess the achievement of each outcome and output indicator. Each country and territory in the Region had access to the SPMS, and designated focal points were trained in the use of the system.

24. Following completion of the country-level self-assessments facilitated by the PAHO/WHO Representative (PWR) Offices, the PASB CPAN reviewed and validated them to ensure that the measurement criteria established in the compendium of indicators had been consistently and correctly applied.

25. The results from all countries and territories, along with additional information available at the regional level, were then consolidated to determine whether the indicator targets for the biennium had been reached. Purely regional indicators that were not designed to be assessed at country level were also assessed by the CPAN. Altogether, this information is the basis for assessing the status of outputs and outcomes of the PAHO Program and Budget 2014-2015 and Strategic Plan 2014-2019. Annex A details the CPAN's assessment, and particulars on the corporate assessment methodology follow.

Figure 2: PAHO's Strategic Plan and Program and Budget Assessment Process, 2014-2019



Corporate Assessment of Outputs, Outcomes, and Categories

26. The CPAN conducts the overall category performance assessments. Each category assessment follows a bottom-up, integrated approach involving the complete results chain, using quantitative and qualitative information, to determine achievement in the PAHO results chain.

27. Output facilitators assess outputs by measuring achievement of their indicator targets. Input from the countries and territories through SPMS is the primary information used in the output assessment, complemented by additional sources of information available to PASB. Output achievement is rated as follows:

a) ***Achieved:*** The indicator target set in the Program and Budget (PB) 2014-2015 (number of countries/territories, number or % for regional indicators) has been reached. Those cases in which the indicator target has been exceeded are highlighted.
b) ***Partially achieved:*** Progress was made over the baseline value set in the PB (number of countries/territories, number or % for regional indicators), but the target for 2015 was not achieved. The reasons why the indicator was not achieved are explained.
c) ***No progress:*** There was no increase over the baseline value set in the PB (number countries/territories, number or % for regional indicators). The factors hindering progress and those cases in which there has been a decrease below the baseline (i.e. countries fell from baseline status) are highlighted.

28. Pursuant to Resolution CD53.R3 (2014), which authorizes the Director of PASB to "incorporate any necessary changes to the Program and Budget 2014-2015 in response to the amended version of the PAHO Strategic Plan 2014-2019," changes to the output indicators for the Program and Budget 2014-2015 are marked in the output assessment table based on the midterm review and validation exercise conducted by PASB.

29. Outcome facilitators assess outcomes by measuring progress toward achieving their indicator targets using information collected through the SPMS and a qualitative analysis of the factors that contribute toward progress or hindrance of achieving the outcome. Outcome achievement is assessed as follows:

a) ***Achieved:*** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached. Those cases in which the indicator target has been exceeded are highlighted.

b) ***In progress:*** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way to reach the target set in the Strategic Plan by 2019.

c) ***No progress:*** There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and

progress toward achieving the indicator target by 2019 could be in jeopardy. Those cases in which there has been a decrease below the baseline are highlighted (i.e. countries fell from baseline status).

30. Category facilitators assess categories based on the aggregated analysis of the assessment of outputs and outcomes, and a qualitative analysis of factors contributing to the progress or hindrance of achievement in the category. The overall category and program area/outcome assessment rating is determined by the category and program area facilitators, respectively, taking into consideration the programmatic and budget implementation, resources analysis (human and financial), and operational and programmatic risks. Ratings are defined as follows:

a) ***Met expectations (green):*** achieved 90% to 100% of the results for the period being assessed. Progress is on track, as planned; no impediments or risks that affect the achievement of results are foreseen.

b) ***Partially met expectations (yellow):*** achieved 75% to 89.9% of the results for the period being assessed. Progress may be at risk, and action is required to overcome delays, impediments, and risks.

c) ***Insufficient progress (red):*** achieved <75% of the results for the period being assessed. Progress is in jeopardy due to impediments or risks that could preclude the achievement of results. Immediate corrections are required.

Budget Implementation

31. The budget implementation and resource analysis considers the funds available to implement the Program and Budget 2014-2015, the level of implementation of such funds, any funding gaps, and efforts to mobilize resources to fill the gaps.

32. *Budget implementation:* This factor is assessed for the Organization as a whole, by functional level (country, intercountry, subregional, and regional entities), and by category and program area. Implementation by budget segment (Base Programs, Outbreak and Crisis Response, and National Voluntary Contributions) and by funding source (Regular Budget and Other Sources) is also analyzed. The budget implementation rate is calculated by dividing the funds implemented by the amount of funds available for implementation of the program.

33. *Resource analysis:* The Program and Budget establishes the estimated level of resources (planned cost) required by the PASB as a whole to implement the program of work approved by the Governing Bodies for a given biennium. The Program and Budget also establishes the estimated resource requirement for each category and program area. During the biennium, resources are mobilized to fill the Organization's funding gap in relation to the approved Program and Budget. The corporate funding gap is progressively reduced during the biennium as resources are mobilized and awarded to functional levels, categories, and program areas. The allocation of resources by category, program area, and programmatic priority is analyzed to determine whether the Organization was able to

follow the guidance from the Governing Bodies to provide appropriate allocations to priority areas, as defined in the Strategic Plan 2014-2019. This analysis is done by comparing the allocations with the approved Program and Budget for a category and program area in the biennium.

Highlights of the 2014-2015 End-of-Biennium Joint Assessment

34. As noted above, this was the first-ever joint assessment, going beyond the previous internal self-assessment by the PASB, and is the result of requests by Member States for increased accountability. The joint assessment is unique to the WHO Region of the Americas, and Member States have recommended that this experience be shared as a best practice with WHO Headquarters and other WHO Regions. It also represents an enhancement and broadening of RBM as well as an opportunity to reflect in more depth on the PASB's technical cooperation.

35. The joint assessment process with Member States was launched in mid-November 2015[4] with designation of national health authority focal points, who coordinated the self-assessment of output and outcome indicators by countries and territories in collaboration with the PWRs. Through orientation, training, and active follow-up, involving technical and decision-making health officials, a 100% participation rate was attained, with all 51 countries and territories. Active participation in the joint assessment fostered an increased sense of ownership of PAHO's program implementation and assessment on the part of many countries and territories. This resulted in a thorough and rigorous process that gave greater validity to the assessment results.

36. Considering all of the individual country/territory linkages, a total of 2,301 individual output assessments and 891 outcome assessments were possible. Of these, 2,287 assessments were entered at the output level and 884 at the outcome level, resulting in a response rate over 99% for both outcomes and outputs.

37. The majority of the country assessments were validated by the CPAN. In cases where the CPAN did not immediately agree with an assessment, additional information to substantiate the assessment was often sought. In several instances the CPAN proposed a change to the assessment, and many revisions were in an upward direction: that is, based on available evidence of country-level action, the CPAN judged that the country had under-assessed its performance. Consensus on the assessments was reached through coordination and dialogue between the CPAN, the PWRs, and national health authorities.

38. Overall, the results show that the SPMS was an effective tool for conducting the joint assessment. This would not have been possible without collaboration between the Department of Planning and Budget and the Department of Communicable Diseases and Health Analysis, which together developed and administered the system, and the advice

[4] Prior to launch, pilot tests were conducted with national health authority focal points in several countries in order to fine-tune the system and ensure its readiness to be used as the tool for the joint assessment.

and guidance from the SPAG on its deployment. Member States appreciated the innovation and recommended that it be shared as a best practice throughout WHO.

Lessons Learned from the Joint Assessment Process

39. The joint assessment methodology represented a major change that served to enhance accountability and transparency on the part of both Member States and the PASB. As this was the first time the process was applied, it required a flexible approach, adequate training and orientation, and ongoing dialogue among all stakeholders. The enthusiasm and commitment of all countries and territories and the leadership and support from the PASB's management and technical teams, including the CPAN, led to a successful exercise, with full participation despite the challenges of time, coordination, capacity, and country context.

40. The amended Strategic Plan, approved in September 2014, included refined impact and outcome indicators and a detailed compendium of indicators endorsed by the SPAG and approved by PAHO Governing Bodies. This established a sound framework for the joint monitoring and assessment agreed with Member States. In order to align the Program and Budget 2014-2015 outputs with the Strategic Plan outcomes, Member States authorized the PASB to make corresponding adjustments to the Program and Budget, which required a revision of the baselines and targets for the output indicators. Therefore, the end-of-biennium 2014-2015 assessment was done using the revised baselines and targets in the Amended Strategic Plan and the PASB's adjustments to the Program and Budget.

41. Because the Program and Budget 2014-2015 was halfway through implementation when the amended Strategic Plan was approved, the baselines and targets for the 2014-2015 output indicators were not fully validated with the countries and territories, which affected the overall assessment of outputs. This can be remedied by using the 2014-2015 end-of-biennium assessment to validate baselines and targets for Program and Budget 2016-2017 outputs to ensure a more accurate assessment at the end of the present biennium. In addition, the newly approved Sustainable Development Goals (SDGs) will also be considered as a reference in all relevant indicators.

42. The stringent approach followed by most countries and territories was one of the strengths of the process; however, rigorous application of the methodology also led to under-assessments in some cases. This, compounded with the aspirational nature of some indicators and targets, resulted in an underrating of some indicators, particularly at the output level.

43. The joint assessment process not only allowed measurement of progress during the biennium, but also represented an opportunity for Member States and the PASB to jointly reflect on the results and to strengthen their technical cooperation.

44. A common concern that arose during the assessment was that official acknowledgment of achievement of an indicator might be interpreted to mean that

technical cooperation in that area could be curtailed (the "graduation effect"). This concern is unfounded, as countries often require ongoing collaboration in order to maintain their achievements and make additional progress beyond the outputs and outcomes. This raises the broader question of the implications of the assessment and how the results will be used to inform future programs of work.

45. This interim assessment of the PAHO Strategic Plan 2014-2019 and Program and Budget 2014-2015 focused on the achievement of outcomes and outputs, respectively; however, it also provided a window on impact-level results and challenges. The monitoring and assessment of progress at the impact level will require specific attention in the remaining two biennia of the Strategic Plan.

46. Limited time to undertake the necessary consultations with technical teams in the national health authorities, as well as for the CPAN to provide necessary feedback, was an often-expressed concern. In addition, indicators beyond the responsibility of the national health authority, requiring input from and collaboration with other sectors such as agriculture, education, environment, public security, and social security, presented a measurement and coordination challenge for the authorities leading the assessment. Given the prevalence and importance of multidimensional health and development indicators, intersectoral collaboration is essential to obtain complete data for the assessment. Advance planning and clarification of roles and responsibilities among all involved is needed to meet this challenge. Keen attention will be paid to these issues, in addition to improving timing, duration, and coordination aspects, in future exercises.

47. The assessment validation process, in which the CPAN sometimes requested more information from the authorities or proposed changes to the assessments, represented an opportunity for the different levels to engage in dialogue and attain common understanding of the criteria for assessment and the countries' achievements. Resolving discrepancies required an intensive process, one that did not always lead to consensus, given differing interpretations of the indicator definitions and metrics as well as shortcomings in data availability and reliability. As established in the guidelines for assessment, any discrepancies that remained unresolved are not published in this report for Governing Bodies.

48. To address the above issues, the Organization will need to reinforce active collaboration and dialogue, not only during the assessment phase but also during the planning phase and during implementation of the program of work.

IV. REGIONAL OVERVIEW

49. This section summarizes the progress made in advancing the public health priorities of the Region during implementation of the PAHO Strategic Plan 2014-2019 and the PAHO Program and Budget 2014-2015. It highlights some of the most significant achievements, challenges, and lessons learned during the biennium. Detailed information on each of the categories is provided in the reports in Annex A.

Reducing the Burden of Communicable Diseases

50. The Region continued to see a reduction in the burden of communicable diseases. Key achievements and important progress included: *(a)* increasing access to interventions for prevention and treatment of HIV and sexually transmitted infections (STI); *(b)* increasing the number of tuberculosis (TB) patients successfully diagnosed and treated; *(c)* building country capacity in surveillance, prevention, control, and/or elimination of malaria and other vector-borne diseases, and neglected, tropical, and zoonotic diseases; and *(d)* increasing vaccination coverage of hard-to-reach populations and communities while maintaining the achievements to date in the control, eradication, and elimination of vaccine-preventable diseases.

Key Achievements

51. Landmark achievements in 2014-2015 include certification of the elimination of mother-to-child transmission (EMTCT) of HIV and congenital syphilis in Cuba, as well as verification of the elimination of onchocerciasis in Ecuador and Mexico. A historic global and regional public health milestone was the declaration of the elimination of endemic transmission of rubella and congenital rubella syndrome in the Americas in April 2015.

52. The Americas continued to be the region with the highest antiretroviral therapy coverage worldwide (46% of all persons estimated living with HIV). Eleven countries and territories have reported over 95% coverage of HIV prophylaxis treatment for prevention of mother-to-child transmission of HIV, and 14 countries and territories have reported at least 95% coverage of syphilis treatment in pregnant women.

53. Based on the latest available information, the cumulative number of TB bacteriologically confirmed patients that have been successfully treated increased by 403,000 to 1.85 million by 2013, representing important progress toward achieving the 2019 target of 2.5 million.

54. The dengue fatality rate was reduced from 0.07% to 0.05% between 2010 and 2014, according to the latest available data, a 28% decrease.

55. The Region continued to see a reduction of confirmed malaria cases, with 389,390 in 2014, a 67% reduction compared to 2000. There were 87 deaths, a reduction of 79% in the same period. This reaffirms the Region’s progress in combating malaria. In

addition, 100% of confirmed malaria cases in the public sector are receiving first-line antimalarial treatment.

56. Sixteen of the 23 endemic countries reached the goal of eliminating leprosy as a public health problem, based on information at the end of 2014. Countries continued to increase access to diagnosis and treatment of leishmaniasis and to enhance integrated surveillance and control actions.

57. During 2014-2015, the Region continued to maintain a low number of deaths due to canine rabies, with a total of 20 fatal confirmed cases compared to 22 in 2012-2013.

58. The Region continued to maintain achievements in vaccination coverage, with above 90% regional average coverage of three doses of the diphtheria, tetanus, and pertussis (DTP)-containing vaccine.

Challenges

59. Gaps remain in access to prevention, diagnosis, and treatment of several communicable diseases such as HIV, STIs, viral hepatitis, TB, and malaria, among others.

60. Insufficient human and financial resources and limited coordination among all partners and stakeholders are obstacles to the surveillance, prevention, screening, monitoring, and interventions needed to curb several communicable diseases.

61. Preventing the further spread of arbovirus circulation, and more recently of the chikungunya and Zika viruses, requires an integrated approach that presents significant financial, technical, and management challenges.

Lessons Learned

62. The process for validation of EMTCT in Cuba, including the assessment mission and meetings of the Regional Validation Committee, provided valuable experience that can be used to update documents and inform the process for the next countries that have already requested PAHO to provide validation of elimination.

63. Given that the TB in large cities initiative was developed with a solid epidemiological framework, taking into account social determinants of health, and has had successful results, lessons learned from this process will be used to support the initiative's expansion to HIV, diabetes, and mental health, among others.

64. Intersectoral and inter-programmatic work leads to improved synergies and achievement of joint successes, as seen with the integrated deworming/vaccination campaigns, the work on TB in large cities, and others. However, continued efforts, particularly in intersectoral work, are needed to maintain these achievements, as many countries face changes in political counterparts and strategic partners.

65. The development and approval of the Plan of Action for Prevention and Control of Viral Hepatitis has refocused necessary attention on silent epidemics in the Region.

Tackling Noncommunicable Diseases, Risk Factors, and Mental Health

66. During the 2014-2015 biennium, promoting and strengthening multisectoral coordination was key to addressing noncommunicable diseases (NCDs) and their risk factors. Additionally, policies, plans, and guidelines were developed or updated to implement evidence-based interventions (best buys). Political awareness was raised regarding the importance of NCDs and the need to promote investment to scale up multisectoral action. The PAHO Directing Council approved regional action plans to tackle mental health, violence against women, road safety, and disability and rehabilitation, and to prevent childhood and adolescent obesity.

Key Achievements

67. Evidence from the Region suggests a decline in tobacco use among adults from 19% in 2010 to 16.4% in 2015, signaling the likelihood that the outcome target (17%) will remain achievable in 2019.

68. By the end of 2015, 16 countries in the Region had national NCD plans of action, and 14 countries had set national NCD targets and indicators in line with the commitments established at the 2014 United Nations (UN) High-Level Meeting on Noncommunicable Diseases. In addition, guidelines on NCDs and the chronic care model for integrated NCD management were developed, contributing to the strengthening of health systems and services for NCDs.

69. Twenty-one countries and territories initiated or consolidated the integration of mental health at the primary care level.

70. The Brasilia Declaration on Road Safety and the Mesoamerican road safety plan represent important achievements, as they provide concrete guidelines for actions at national and local levels to achieve the targets of the Decade of Action for Road Safety 2011-2020 and related SDG targets.

71. The Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women was approved by PAHO's 54th Directing Council in 2015, making the Region of the Americas the first in WHO to endorse a framework for action on violence against women. This document has also served as an important contribution to the development of the Global Plan of Action on Violence, to be reviewed by the Sixty-ninth World Health Assembly (2016).

72. The implementation of the Plan of Action on Disabilities and Rehabilitation has contributed to the progress observed in access to habilitation and rehabilitation services and social services for persons with disabilities.

73. The implementation of the Plan of Action for the Prevention of Obesity in Children and Adolescents has been instrumental in supporting countries to develop policies and legislation with respect to marketing of foods to children, improving the school nutrition environment, and front-of-package labeling to better inform consumers about foods high in salt, fats, and sugars. Concrete actions in the countries included taxes on sugar-sweetened beverages implemented in Barbados, Dominica, and Mexico, and legislation on front-of-label packaging introduced in Bolivia, Chile, and Ecuador. The nutrient profile model developed by PAHO is helping to underpin such important changes.

Challenges

74. Tackling NCDs and regulating risk factors will require not only a recognition of their importance but also a scaling up of intersectoral collaboration, as well as the ability to successfully implement and enforce sound policies and effective legislation. Success on this front is constrained by the powerful interests of the tobacco, alcohol, and food industries, as well as by a lack of financial and human resources to address these issues.

75. Reduction of the harmful use of alcohol remains a major challenge, with no evidence of progress toward achieving this outcome reported during the recent biennium. Current trends project an increase in per capita alcohol consumption, greater use among women, and higher rates of binge drinking. In the absence of successful policy implementation, the outcome targets will not be achieved. Therefore, higher priority must be given immediately to tackling alcohol as a major health concern. Though several countries have developed national alcohol policies or plans, most of these were ultimately not approved by national authorities, bringing into question the will to address this risk factor.

76. With many countries relying on five-year surveys of NCDs and risk factors, gaps in surveillance are preventing measurement of the prevalence of risk factors and NCDs, as well as nutritional and mental health indicators, which are not included in current survey protocols.

77. Although there is wide recognition in the Region of the burden of violence, injuries, and disabilities on health and development, the response is not commensurate with the magnitude of the problem due to inadequate funding, insufficient availability of information, and limited capacity in countries.

78. Although some countries in the Region meet the WHO criteria for best practices on road safety legislation, there are weaknesses in the enforcement of these laws.

Lessons Learned

79. Experience in the past biennium has shown that in order to address the challenges noted above, capacity needs to be strengthened at the regional level, and more human and financial resources are needed at the country and subregional levels. This should be

coupled with a strengthening of national institutional capacity to develop, implement, and enforce policies, plans, programs, and legislation.

Promoting Good Health throughout the Life Course and Addressing the Determinants of Health

80. During the biennium, progress was made in addressing key issues related to women, maternal, newborn, child, adolescent, and adult health, following a life-course approach and taking into consideration the social and environmental determinants of health and the cross-cutting themes (CCTs) of gender, equity, human rights, and ethnicity. In light of the obstacles to achieving MDG5, related to maternal health, increased attention was placed on the implementation of plans to reduce maternal and perinatal mortality and to promote sexual and reproductive health.

Key Achievements

81. The Region continued to see a downward trend in the under-5 mortality rate, achieving the MDG4 target with an overall reduction of 69% between 1990 and 2015.

82. A reduction of the maternal mortality ratio by 21% during 2013-2014 was observed in countries with more than 7,000 deliveries per year.

83. As a result of collective efforts with countries and partners, the adolescent fertility rate continued on a downward trend, from 65.6 per 1,000 in 2013 to 64.4 in 2014 among women 15 to 19 years of age. Six countries updated or developed national adolescent health strategies and policies.

84. Eighteen countries were implementing integrated plans for maternal and perinatal mortality reduction, in line with regional plans of action on maternal mortality and neonatal health.

85. The Age-friendly Cities and Communities initiative was expanded to more than 65 cities in the Region, and the evidence-based self-care programs for older persons with multiple chronic conditions have been implemented in two Latin American countries and in 10 Eastern Caribbean countries.

86. The Strategy and Plan of Action on Dementias in Older Persons was approved by the 54th Directing Council. The Organization of American States, with PAHO's support, approved the Inter-American Convention on Protecting the Human Rights of Older Persons.

87. Ten countries have introduced human rights norms and standards in subregional declarations and national policies, laws, and/or ministerial decrees. Two countries reformed civil codes based on the UN Convention on the Rights of Persons with Disabilities and approved or updated protocols on mental health by ministerial decree in a manner consistent with universal and regional human rights conventions. Eight countries

have reformed national laws based on human rights norms and standards in areas such as HIV, adolescent health, disability, and tobacco control.

88. Institutional capacity to quantify and analyze social inequalities in health was strengthened in 19 countries. This included the production of health equity profiles addressing the social, economic, and environmental dimensions of sustainable development.

89. The regional Plan of Action on Health in All Policies (HiAP) was approved by the 53rd Directing Council, and a road map has been developed to implement the plan, including in the context of the post-2015 development agenda. In addition, a systematic review of SDG3 and its 30 targets was completed to guide the implementation of the post-2015 agenda.

90. Country capacities were strengthened in water quality surveillance, home interior air quality, occupational health, and climate change adaptation. There was significant progress in measuring and reducing inequities by strengthening capacity in Water Safety Plans.

Challenges

91. Despite the reduction in maternal mortality mentioned above, no country in the Region achieved the MDG5 target of a 75% reduction in the maternal mortality rate from 1990 to 2015. At least 11 countries significantly reduced maternal mortality (by 40% or more) during that period.

92. There is still an urgent need to reduce preventable causes of death and severe morbidity in newborns and mothers, particularly by increasing access to high-quality services and closing information gaps.

93. There has been limited collaboration with nontraditional stakeholders that are making important decisions affecting the right to health and related human rights (parliaments, ministries of foreign affairs and other ministries, and national human rights commissions, among others).

94. Stakeholders have different levels of knowledge and understanding of the cross-cutting themes and their meaningful integration and implementation across health programs.

95. There is limited capacity to respond to the countries' growing demands for support in translating the social determinants of health into concrete action.

96. Great challenges remain with respect to achieving the MDG targets on sanitation, closing the urban/rural gap in water and sanitation, and decreasing the use of solid fuels as the main source of household energy in the Region, as countries transition to the SDGs. Multisectoral efforts and coordination to address environmental and occupational health issues affecting the Region will be critical to this end.

Lessons Learned

97. The integrated vision and holistic approach applied in the project Zero Maternal Deaths from Hemorrhage, which incorporated programmatic and health services aspects, allowed for a streamlined response to the obstetric hemorrhage emergency with a more efficient use of resources. This model has been expanded in the ministries of health, with positive results.

98. A broader, multisectoral approach that includes other stakeholders within and outside the health sector is necessary to accomplish the policies on aging in the Region.

99. Technical activities and discussions related to the links between Zika, women's rights, and gender inequalities, as well as the particular vulnerabilities of people living in situations of poverty, show that stronger collaboration is required to ensure that PAHO's work during all public health emergencies adequately considers the CCTs, structural inequalities, and international and regional human rights norms and standards applicable to women's health.

100. As part of implementing the Regional Plan of Action on Health in All Policies, there is a need to document and share best ways of applying the concepts of social determinants of health, HiAP, and the SDGs. Also, the implementation of the SDGs and associated indicators presents an opportunity to capitalize on their synergies with the HiAP agenda.

101. The Region needs to improve and consolidate water governance, with a paradigm shift toward the sustainable integration of water resources management from catchment to consumer, along with efforts to reduce inequalities. Steps should be taken to include water safety plans as part of national water strategies.

Strengthening Health Systems toward the Progressive Realization of Universal Health

102. Significant progress continued to be made in the implementation of the Strategy for Universal Access to Health and Universal Health Coverage. This included the development of national road maps that expand access to services through primary care within integrated health service delivery networks; the development of comprehensive financing strategies in countries; the realignment of policies on human resources for health that meet the existing needs of health systems and services; and improved access to safe, efficacious, and quality medicines and health technologies, according to the health needs of the population. Progress was also seen in the development of integrated health information systems, with concrete actions in the countries to improve their health information systems and monitoring of basic indicators, training, and preparation of documents to facilitate health analysis and support decision-making as they move toward universal health.

Key Achievements

103. Consistent with the Strategy for Universal Access to Health and Universal Health Coverage and the Strategy on Health-related Law, technical cooperation was increased to support the development and/or implementation of plans of action and/or road maps toward universal health in 10 countries. Eleven countries have developed regulatory frameworks for universal health, and work is under way in 15 countries to implement financial frameworks for universal health.

104. With a view to improving people-centered, integrated, and quality health services, 23 countries had implemented the integrated health service delivery network strategy by the end of 2015, and 12 countries had implemented national strategies and/or plans for improving quality of care and patient safety.

105. As a result of the ongoing work to strengthen medicines regulatory systems, 10 countries developed institutional development plans, and the regulatory profiles of 17 countries were published. Furthermore, in collaboration with the Council for Human and Social Development (COHSOD), policies on pharmaceuticals in the Caribbean were strengthened. PAHO's collaboration with MERCOSUR, the Southern Common Market, in price negotiations for high-cost medicines resulted in significant reductions in the price of medicines for HIV/AIDS and hepatitis C.

106. Countries are making progress in developing and implementing their human resources for health (HRH) policies and plans with a view to achieving universal health and addressing current and future health needs of their populations. At least 17 countries have action plans aligned with the policies and needs of their health care delivery system.

107. The Region has made notable progress in strengthening routine health information systems, adopting new technologies and strategies for research and evidence, and incorporating ethics in health research. This helps countries improve health analysis to support decision-making as they move toward universal health. In this regard, PAHO has provided technical cooperation to strengthen health information systems across the Americas in alignment with strategies presented in the PAHO Regional Plan of Action for Strengthening Vital and Health Statistics. A web-based platform for health information (PLISA, by its Spanish acronym) was developed and represents an additional valuable resource that the Region and countries can use to monitor mortality, vector-borne diseases, core health indicators, and progress of the impact indicators in the PAHO Strategic Plan 2014-2019.

Challenges

108. Further action is needed to define policies to reform countries' health financing strategies so that they contribute to progress toward universal health. Even though several countries in the Region developed strategies to increase public health expenditure, few reported progress towards the target of the share of public health expenditure of at least 6% of gross domestic product (GDP). Increasing public health expenditure will require a strong political commitment on the part of countries in the Region to create the fiscal

space needed to achieve universal access to health and universal coverage for their populations.

109. Increasing countries' capacity to monitor and evaluate progress toward universal health will need stronger information systems that can produce quality timely data to measure progress in population access and coverage to health services, governance and leadership, equity and efficiency of health financing, and action on social determinants of health in the Region.

110. Stronger commitment is needed to the implementation of policies and reforms to strengthen health services delivery and tackle fragmentation, poor technical quality, late referrals, lack of access to preventive services, and overemphasis on acute disease-centered care and hospital-based treatment.

111. Information is insufficient to accurately determine the reduction in the percentage of hospitalizations for ambulatory care sensitive conditions in 2015. Further efforts are needed to strengthen information systems in the Region in this regard.

112. Countries and territories in the Region have been challenged by the ever-increasing cost of medicines and other health technologies, requiring the adoption of overarching strategies in this area. Strengthening of regulatory systems also needs to be prioritized in Member States that have limited capacity in this area.

113. With respect to human resources, important challenges include alignment of HRH policies, plans, and regulations with health systems and integrated service delivery needs; limited data on HRH; and limited integration between the health and education sectors.

Lessons Learned

114. Building on the high-level dialogue with international financial agencies and countries in 2015, PAHO should continue engaging with the World Bank, the Inter-American Development Bank (IDB), and the United States Agency for International Development (USAID), among others, to reach a consensus on health financing in the Americas, in particular on recommendations for the preparation of grants and projects concerning co-payments and other out-of-pocket expenditures.

115. Recent experience with the preparation of health systems to cope with outbreaks of Ebola, chikungunya, and Zika virus diseases has provided an opportunity to improve the health system response in this regard. Whereas some time ago the global agendas in universal health and health security appeared to be competing, there now seems to be a growing global consensus that health security can only be achieved by strengthening health systems toward universal health while also working to increase their resilience.

116. Subregional approaches, once political commitment has been ensured, have proven to be viable alternatives for ensuring efficiency and sharing resources among Member States with limited capacity.

117. Improving access to high-cost medicines and other health technologies may require exploring and developing new strategies for collaboration among countries.

118. Mobilizing resources for health research requires concerted work with other sectors (e.g., science and technology, education, industries, and other economic stakeholders). Industrial and economic partners are particularly important, given their capacities to scale up developments.

Building Resilience and Reducing Mortality, Morbidity, and Social Disruption from Epidemics, Emergencies, and Disasters

119. Efforts during the biennium focused on strengthening countries' capacities in prevention, risk reduction, preparedness, surveillance, response, and early recovery in relation to emergencies, disasters, and outbreaks. Countries' capacity to respond more efficiently and effectively to emergencies and disasters from all types of hazards was increased, with intensified efforts to respond to Zika and Ebola virus disease (EVD) outbreaks, as well as to a number of severe floods and droughts that impacted the Region. Particular emphasis was placed on building core capacities under the International Health Regulations (IHR) of 2005, strengthening resilience of health facilities to disasters, enhancing capacity of countries and territories to coordinate health humanitarian assistance, and maintaining the Region free of foot-and-mouth disease (FMD) outbreaks.

Key Achievements

120. A total of 22 countries in the Region requested and were granted the 2014-2016 extension on National IHR Plans, showing their commitment to establish national public health capacities. As part of the development of IHR capacities, technical support was provided to update these plans within the context of the Framework for Strengthening National Preparedness and Response for Ebola Virus Disease in the Americas. The EVD preparedness framework was developed and implemented with direct technical cooperation provided to more than 26 Member States as part of ongoing preparedness and response efforts for emerging infectious disease outbreaks.

121. The 24/7 epidemiologic monitoring and response system was maintained to rapidly inform Member States about threats or public health risks. During the biennium, 38 alerts and epidemiological updates were disseminated, and 31 event updates (10 related to Zika virus) were posted on the IHR Event Information Site for National IHR Focal Points.

122. Countries enhanced their capacity to respond to the chikungunya and Zika virus outbreaks through development of clinical management tools and strengthening of laboratory capacity.

123. The cholera fatality rate in Haiti was maintained below 1% (0.89% for 2015), as PAHO continued to provide leadership and technical support to address the protracted cholera emergency.

124. PAHO actively mobilized national and international resources for response operations in all Grade 1 and Grade 2 emergencies that affected the Region. The Organization increased its institutional capacity for all-hazards disaster preparedness, surveillance, and response in accordance with its Institutional Response to Emergency and Disasters policy.

125. Leadership and technical support was provided to Member States in the implementation of the Plan of Action on Safe Hospitals. The number of countries and territories applying the Hospital Safety Index to assess hospital safety from disasters increased to 36, with most of them also implementing corrective measures in priority health facilities.

126. The innovative effort to integrate climate change and disaster risk reduction considerations in the health sector (the SMART hospitals initiative) has been scaled up to seven countries in the Caribbean, namely Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, and Saint Vincent and the Grenadines.

127. The Region of the Americas remains without FMD notifications since January 2012. No new outbreaks of foot-and-mouth disease have been reported in countries or zones recognized as FMD-free since April 2013, which represents a historical milestone. Leadership and technical cooperation was provided for implementation of the Plan of Action 2011-2020 of the Hemispheric Program for the Eradication of Foot-and-Mouth Disease.

128. The Plan of Action for the Coordination of Humanitarian Assistance 2015-2019 and the Plan of Action on Antimicrobial Resistance were approved by PAHO/WHO's 53rd and 54th Directing Councils, respectively.

129. Seven Member States have strengthened their food inspection capacities, with a focus on risk-based food inspection.

Challenges

130. It is important to ensure countries' commitment to continue their efforts to build sustainable core capacities for the IHR, taking into account the lessons learned from EVD preparedness and response and other public health emergencies.

131. Limited financial and human resources (qualified and immediately available) for disaster risk reduction remains an ongoing challenge.

132. There is a need for strong national commitment, multisectoral coordination, and inter-programmatic approaches to strengthen food safety capacities and the integration of food safety into broader strategies and plans on nutrition and noncommunicable diseases in the Region.

133. With respect to foot-and-mouth disease, PAHO faces increased expectations and demands from countries for continued technical cooperation to maintain the gains to date

in the Americas. Steps must be taken to address the remaining challenges in countries without FMD-free status and to further advance national programs to achieve "FMD-free without vaccination" status.

134. There is a need to intensify regional activities and national commitment to implement national antimicrobial resistance plans.

Lessons Learned

135. Mechanisms to facilitate the exchange of good practices and information sharing between countries should be applied to strengthen preparedness and response to emerging pathogens in the 2016-2017 biennium.

136. In the context of the EVD framework, technical missions in the countries have made it possible to identify discrepancies between expert findings and the countries' self-assessments of IHR core capacity scores. This shows the need to refine the monitoring approach of the implementation of IHR to place more emphasis on the function of public health systems.

137. The use of regional estimates of the foodborne disease burden as an advocacy tool led to increased awareness among national authorities and the prioritization of these diseases by Member States. This has contributed to the development of mandatory national estimates.

138. Strengthening multisectoral participation of stakeholders, both within and outside the health sector, is critical for achieving success in the implementation of the Plan of Action on Safe Hospitals.

Fostering Efficient and Effective Functioning of the Organization

139. In addition to the technical achievements outlined above, PAHO made steady progress in strengthening and improving its enabling functions and corporate services to deliver its technical cooperation programs. In this regard, the Organization continued to strengthen its country focus, with a new framework for cooperation among countries in health development and a strategy for the eight key countries. Concrete measures were taken to reinforce subregional technical cooperation. Building partnerships for leadership in health also continued with the UN Country Teams. Results-based management continued to be the cornerstone of the planning, budgeting, program management, monitoring, and assessment processes across the Organization, with increased participation of Member States through comprehensive bottom-up and prioritization approaches.

Key Achievements

140. PAHO continued to strengthen and expand its engagement with Member States, the United Nations and inter-American systems, subregional integration mechanisms, and partners for the implementation of the PAHO Strategic Plan, employing government-wide approaches. In addition, country collaboration was strengthened through increased

promotion of the country focus policy, and the PAHO key countries strategy was updated to support targeted technical cooperation.

141. The joint assessment process for the PAHO Strategic Plan and Program and Budget was implemented for the first time, with the participation of all countries and territories. To facilitate this process, a new joint monitoring and assessment system, the SPMS, was developed and made available to all Member States. This initiative is unique in all regions of WHO and will enhance transparency and accountability in program and budget formulation and implementation.

142. The Program and Budget 2014-2015 was 97% financed, and an integrated budget with an 8.8% increase was approved by Member States for 2016-2017.

143. PAHO has pioneered a robust and scientific programmatic prioritization methodology as an integral part of strategic planning and program and budget development. This innovative approach is the result of intense and productive collaboration with key public health experts from the national health authorities in the Region.

144. In 2015 PAHO adopted, configured, and installed the new PASB Management Information System (PMIS), using Enterprise Resource Planning software, within budget and on time.

145. Progress was made in the implementation of the Enterprise Risk Management policy with the identification of corporate risk and mitigation plans that will be implemented in 2016-2017.

146. To realize cost savings and efficiencies, Service Level Agreements with Key Performance Indicators were implemented to improve administrative and support services. Preliminary results are encouraging, with a reduction of operating costs by 2%-3%.

147. The PASB also continued to employ innovative technologies and communication platforms to facilitate its technical cooperation in an effective and efficient manner. Consolidated efforts in both media outreach and webpage view development have contributed to increased positioning and ranking of the Organization within the international community.

Challenges

148. Applicability and use of the multi-partner country coordinating mechanism varies depending on the national context and presence of development and aid agencies in countries and territories.

149. Efforts toward resource mobilization with non-state actors in the Americas is currently restricted by ongoing efforts within the context of WHO governance reform to finalize the WHO framework of engagement with non-state actors.

150. More progress is pending in the area of evaluation, where an integrated approach is expected to consolidate lessons learned from evaluation reports and other means.

151. There were continuing difficulties in attracting sufficiently flexible funds that could be strategically allocated to program areas of greatest need or highest priority, as well as in obtaining full financing for the AMRO portion of the WHO Program Budget.

152. A major challenge was the need to dedicate significant staff time to the development and testing of the PMIS even as staff also worked to fulfill ongoing programmatic and administrative responsibilities.

153. Uneven capacity in the areas of strategic communication and knowledge management limits the opportunity to effectively promote and position the work of the Organization.

Lessons Learned

154. Expanding strategic alliances beyond traditional health stakeholders has contributed to strengthening PAHO's visibility and its role as a "broker".

155. The process of developing Country Cooperation Strategies provides an opportunity to strengthen PAHO's leadership and advocacy in matters relating to health at the national level; and provides the main reference framework to guide the technical cooperation program with and for countries.

156. Ongoing support and engagement from top-level management has been instrumental for advancing accountability mechanisms across the Organization.

157. The bottom-up planning and prioritization processes used for development of the PAHO Strategic Plan and the Program and Budgets contributed substantially to more realistic plans and budgets, with an increased focus on priorities defined jointly with Member States. The unprecedented participation of Member States and staff from across the PASB in the planning and budgeting processes of the Organization should result in increased ownership of and commitment to the implementation, monitoring, and assessment of the approved Strategic Plan 2014-2019 and the three corresponding Program and Budgets.

158. The new joint monitoring and assessment process and system implemented for PAHO's Strategic Plan and Program and Budget, involving Member States and the PASB, enhanced accountability and transparency in the Organization and further embedded results-based management across PAHO.

159. The compendium of indicators led to the development of sound technical criteria for the measurement of indicators and facilitated dialogue and the resolution of discrepancies in the joint assessment with Member States. It has also revealed the need to replicate this good practice across all plans of action developed by the Organization in order to ensure systematic and objective assessment of results.

160. The end-of-biennium assessment has led to the reconsideration of previously unvalidated output baselines and targets. The results of the 2014-2015 end-of-biennium assessment will serve as an input for the validation and possible revision of the baselines and targets for outputs in the Program and Budget 2016-2017. In addition, the health-related targets in the Sustainable Development Goals will be factored into the 2016-2017 output validation to ensure that the outputs contribute to meeting those commitments.

161. The changing environment and demands for health and development require that the Organization continue to incorporate innovation, technology, and the right mix of skills to remain at the forefront in responding to the current and emerging public health challenges of the Region.

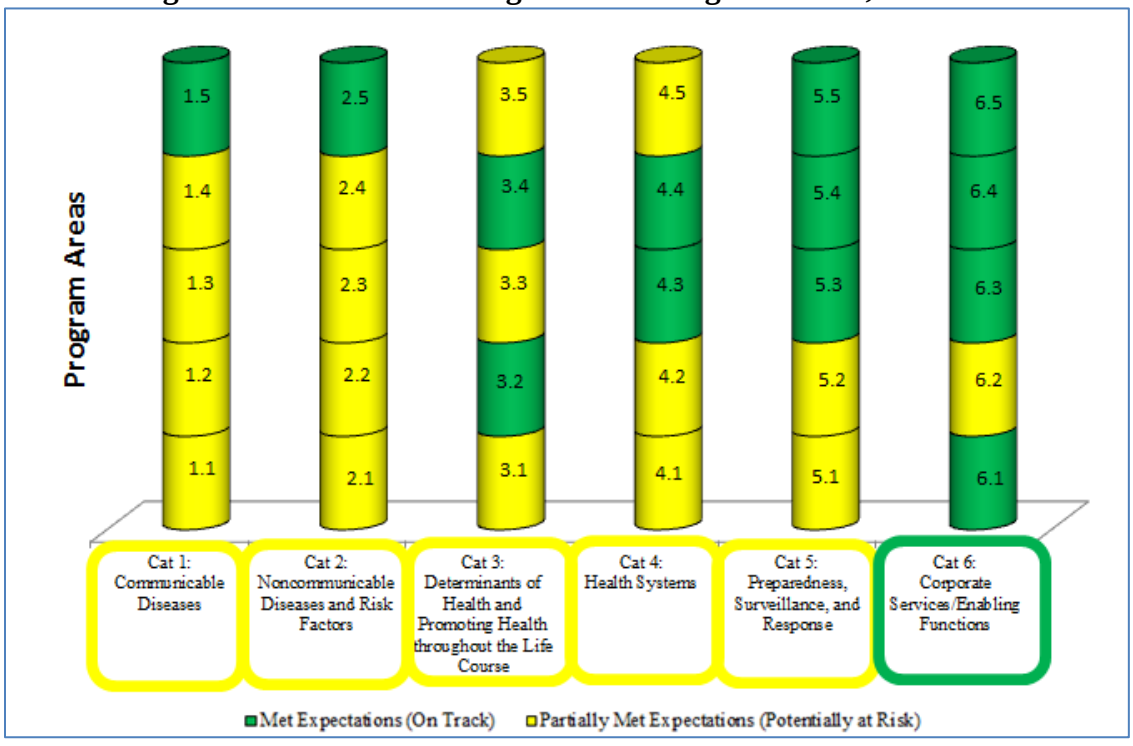
V. PROGRAMMATIC IMPLEMENTATION OVERVIEW

162. This section presents a summary of assessment results, including the implementation of the Program and Budget 2014-2015 and interim progress toward achieving the results of the PAHO Strategic Plan 2014-2019. It outlines the status of the categories and program areas, including progress in achieving the 83 outcome indicators and 115 output indicators through joint efforts by the Member States and the PASB. A summary of the assessment of products and services delivered by the PASB for the 2014-2015 biennium is also presented. A detailed progress report by category and program area, including assessment of outcome and output indicators, is provided in Annex A.

Overview of Category Assessment

163. As seen in Figure 3, five of the six categories partially met expectations, while one (Category 6) fully met expectations during the biennium. In regard to program areas, 13 out of 30 met expectations; these program areas are on track to achieve the results of the Strategic Plan by 2019. The remaining 17 program areas partially met expectations, although important progress was made in each of them. Decisive actions will need to be taken in order to ensure that the delays, impediments, or challenges that hinder progress are addressed in the next biennium to get these program areas back on track, while efforts must be maintained in those program areas that met expectations. It is notable that no category or program area was rated as being in trouble during this first assessment.

Figure 3: Overview of Categories and Program Areas, 2014-2019

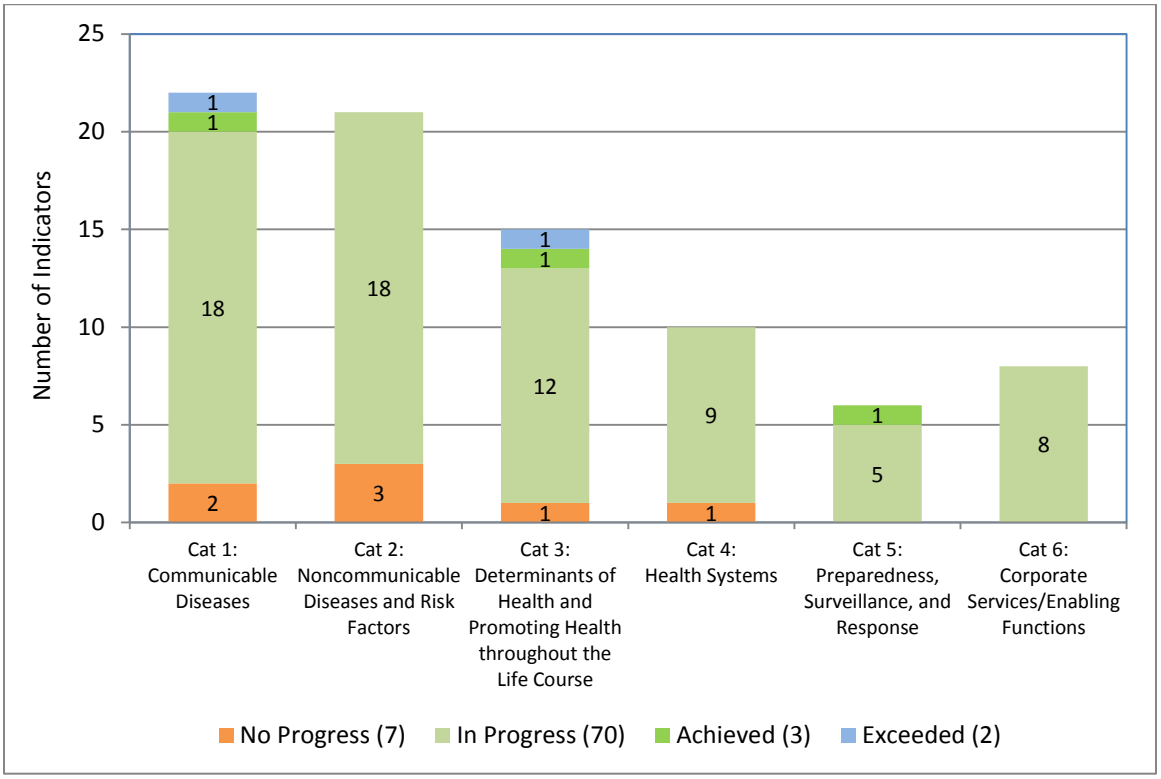


Assessment of Outcome Indicators

164. As shown in Figure 4, during the first biennium of the Strategic Plan 2014-2019, the Region made substantial progress toward achieving the outcome indicator targets, which measure progress in improving health or reducing risk factors. For instance, 5 (6%) of the 83 outcome indicators have already achieved or exceeded their targets set for 2019. They include 1.3.1 (malaria), 1.5.4 (polio), 3.1.1 (methods of family planning), 3.1.5 (pneumonia), and 5.5.1 (response to an emergency). Also, 70 (84%) of the 83 indicators are in progress, and of those, 8 saw attainment of over 80% of their targets, which indicates that the Region is well on track toward achieving the outcome targets by 2019.

165. In spite of the overall steady progress toward the achievement of targets set for the six-year period of the Plan, there remain challenges to achieving the indicators set for 2019. This is especially true for outcome indicators in Category 2 (Noncommunicable Diseases and Risk Factors) and Category 4 (Health Systems), where progress will depend on new commitments that require additional efforts and resources from within and beyond the health sector. Outcome indicators that are not advancing as expected will require close monitoring and accelerated action to address the underlying challenges that are hindering progress. In particular, four out of the seven outcome indicators rated with no progress in this biennium will need immediate remedial actions: 2.1.1a, 2.1.1b, and 2.1.1c, all related to alcohol use and its consequences, and 4.1.2, which established a target for public expenditure in health of at least 6% of gross domestic product (GDP). These indicators, especially the one related to universal health (4.1.2), require strong political commitment and advocacy from both Member States and the PASB, as well as intersectoral collaboration.

Figure 4: Overview of Outcome Indicators Assessment, 2014-2019



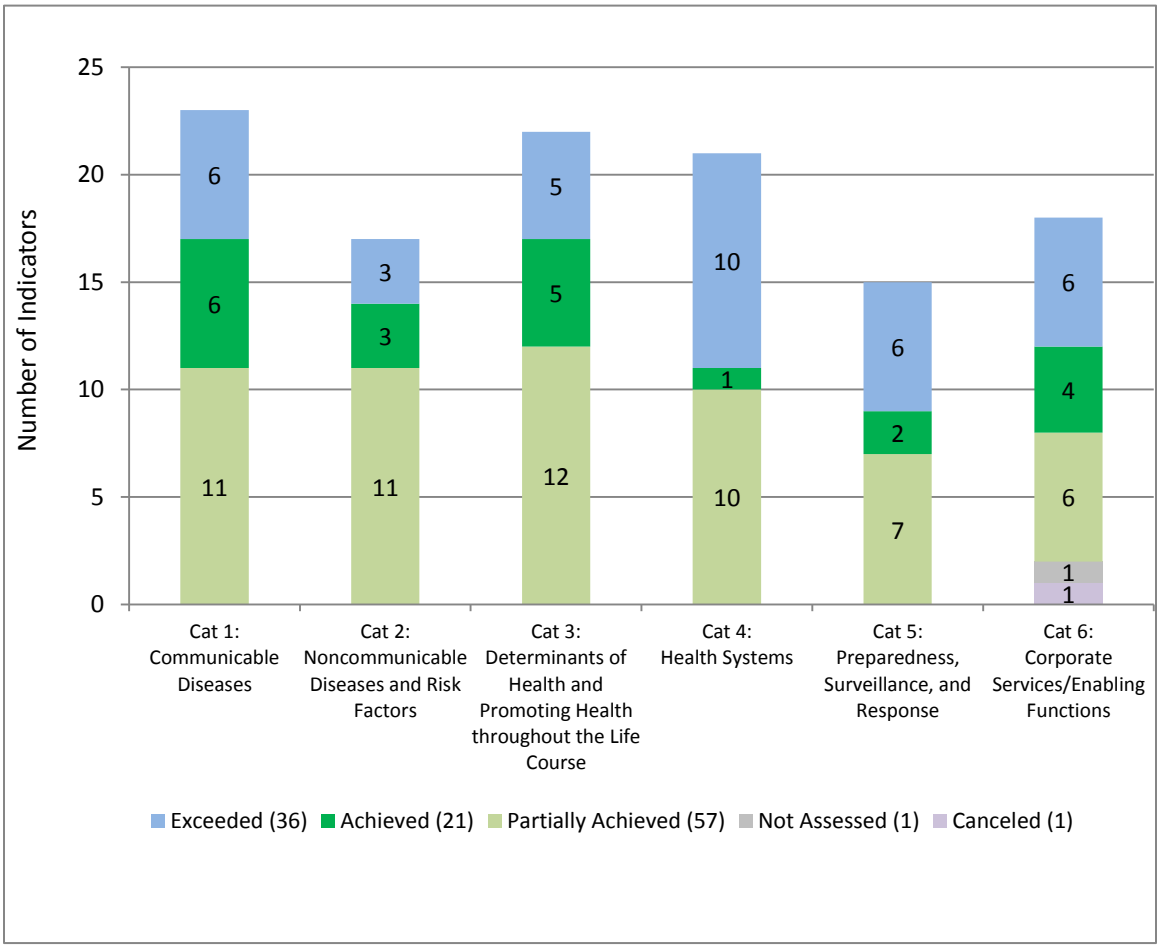
Assessment of Output Indicators

166. The output indicators measure changes in policies, strategies, plans, programs, and norms to improve systems and services. As shown in Figure 5, at the end of 2015, 57 of the 116 output indicators were achieved or exceeded, while another 57 were partially achieved.[5] From the 57 indicators that were achieved, 36 exceeded the 2015 targets. Furthermore, considerable progress was made in the 57 indicators that were partially achieved, with work continuing into 2016-2017. The details on each output indicator are provided in the category reports in Annex A, including the list of countries and territories that achieved and partially achieved each indicator.

167. The main issues that affected the non-achievement of both outcome and output indicators included: *(a)* lack of reliable information with which to appropriately measure and monitor the progress by countries and territories; *(b)* insufficient political support, limited institutional capacity, and weak intersectoral actions, as well as competing priorities on the regional and national agendas; and *(c)* aspirational targets in some indicators; for instance, 49 output indicators had targets twice their baseline value.

[5] In addition to the 114 output indicators assessed, one indicator, OPT 6.1.5, was cancelled based on the revision of the PAHO Strategic Plan 2014-2019 indicators with the Countries Working Group and another (6.2.3) was not assessed due to lack of data for this biennium.

Figure 5: Overview of Output Indicators Assessment, 2014-2019



Overview of Products and Services Achievement, 2014-2015

168. As outlined in Section III, in addition to the joint assessment of outcome and output indicators with Member States, the PASB completed its internal performance monitoring and assessment of the 2014-2015 Biennial Work Plans in all 83 entities across the country, subregional, and regional functional levels. A summary of the products and services assessment is presented below. These products and services represent the contribution of the PASB to achieving the outputs in the Program and Budget in line with the Organization's core functions:

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, dissemination, and application of valuable knowledge.

c) Setting norms and standards, and promoting and monitoring their implementation.

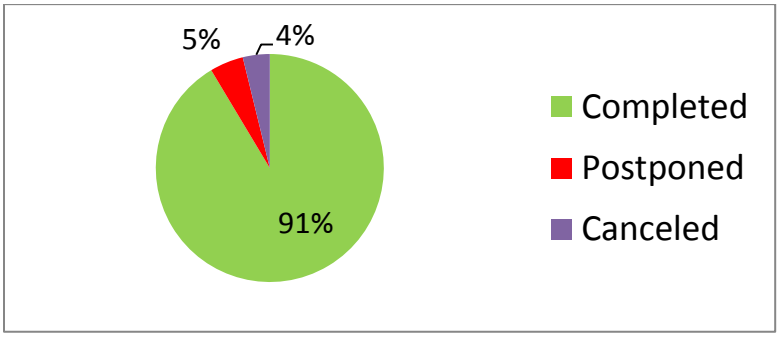
d) Articulating ethical and evidence-based policy options.

e) Establishing technical cooperation, catalyzing change, and building sustainable institutional capacity.

f) Monitoring the health situation and assessing health trends.

169. As seen in Figure 6, 91% of the products and services defined for the 2014-2015 biennium were completed as expected, while 5% were postponed and 4% were cancelled. The ongoing monitoring of work plan implementation allowed the PASB to identify the key issues and remedial actions that led to the high rate of completion of planned products and services. The main reasons for postponement or cancellation were the emergence of competing priorities and demands for expanded technical cooperation in other areas.

Figure 6: Overview of Products and Services, 2014-2015



170. With respect to the completion of products and services by functional level, a consistently high achievement was attained across the three levels, as shown in Table 1. Additional presence at country and subregional levels is expected to enhance the implementation of work plans in 2016-2017.

Table 1: Assessment of Products and Services by Functional Level, 2014-2015

Functional Level	Completed Products and Services
Regional	876/930 (94%)
Subregional	137/154 (89%)
Country	2,627/2,925 (90%)
Total	3,640/4,006 (91%)

VI. BUDGET IMPLEMENTATION

171. This section provides an analysis of the funds available to implement the PAHO Program and Budget 2014-2015, including the allocation of resources and level of implementation by functional level, programmatic category, and funding source. This section also reviews the resource mobilization efforts of the PASB during the biennium, including gaps and trends.

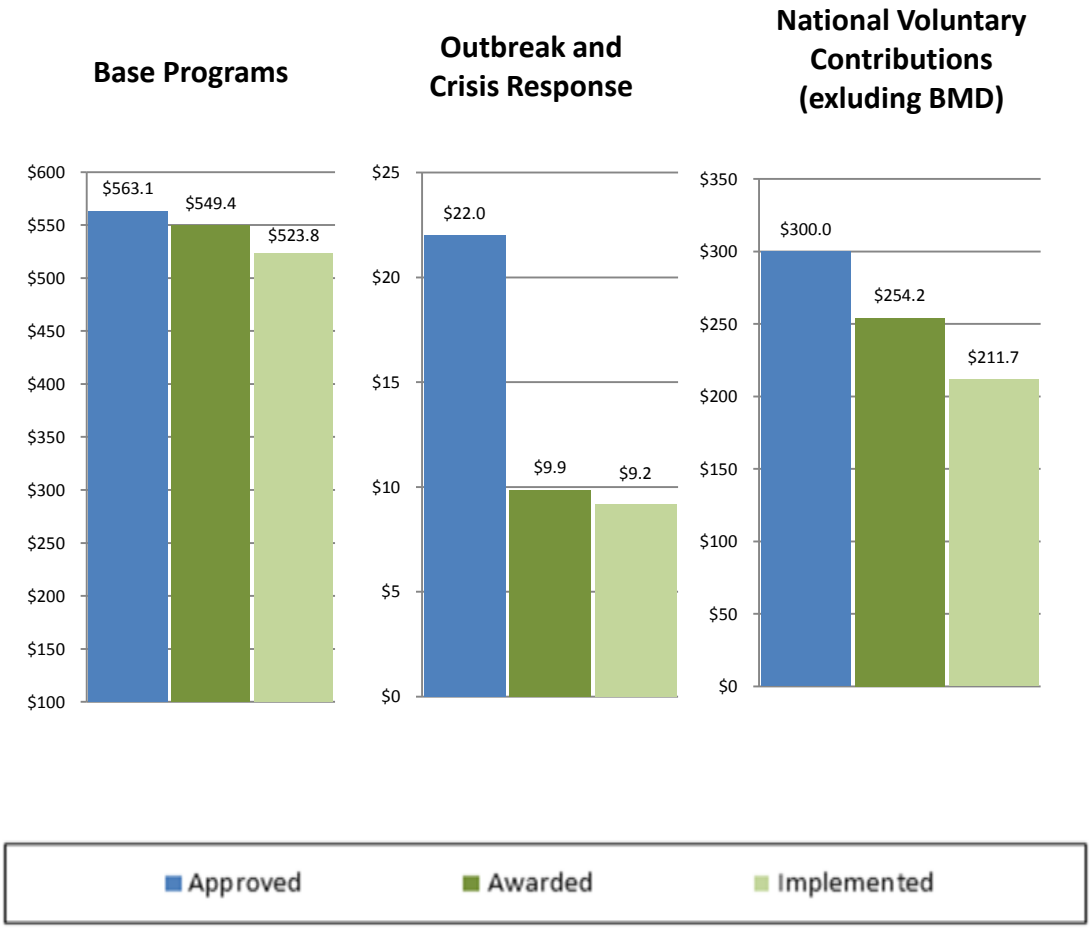
Budget Overview: 2014-2015

172. The approved Program and Budget for the 2014-2015 biennium was US$ 563.1 million for Base Programs, consisting of $279.1 million (49.5%) from the Regular Budget (RB) and $284.0 million from Voluntary Contributions.[6] The approved Program and Budget also included $22 million for Outbreak and Crisis Response (OCR) and $300 million for National Voluntary Contributions (NVCs). The total approved resource requirements for the Program and Budget 2014-2015 from all budget segments came to $885.1 million.

173. Funds available for the biennium were $825.8 million, or 93.3% from all segments. This excludes an additional $1.15 billion in NVC funding for the Brazil *Mais Médicos* (BMD) program that had not been budgeted in the Program and Budget 2014-2015. As shown in Figure 7, the awarded Program and Budget for Base Programs accounted for $549.4 million, National Voluntary Contributions accounted for $254.2 million (excluding BMD), and OCR accounted for $9.9 million.

[6] Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

Figure 7: Total Program and Budget Funding by Segment, 2014-2015 (US$ millions)



174. Overall budget implementation of the funds available across all segments was 95.3% ($1.8 billion of $1.9 billion, including BMD. The implementation disaggregated by segments was as follows:

a) Base Programs: 95.3% ($523.8 of $549.4 million)

b) OCR: 93.8% ($9.2 million of $9.9 million)

c) NVCs: 83.3% ($211.7 million of $254.2 million), excluding the *Mais Médicos* project

d) The implementation rate of the *Mais Médicos* project was 99% (i.e. $1.15 billion of $1.16 billion).

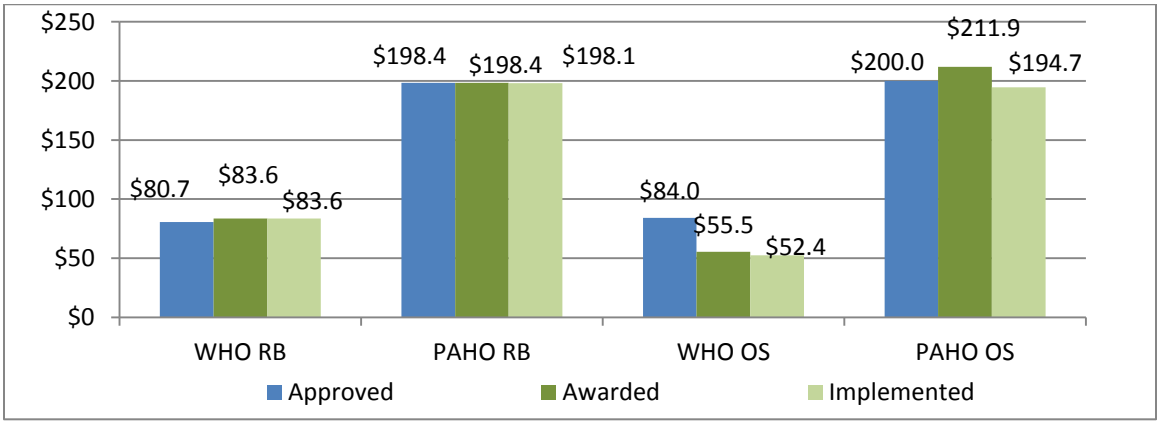
175. Compared to the preceding biennium, more funds were available for Base Programs in 2014-2015 in both absolute terms ($549.4 million vs. $525 million) and relative terms (97.6% vs. 86.0%).

176. The analysis of each budget segment is presented in the following sections.

A) Base Programs Segment

177. The approved budget for the Base Programs segment was $563.1 million, a decline of nearly $50 million from the 2012-2013 level of $613.0 million. The reduction was the result of a downward trend in direct donor contributions to PAHO and voluntary contributions for the Americas Region (AMRO) from WHO. This resulted from the lingering effects of the financial crisis and shrinking public budgets for health and development aid, as well as the growing number of middle-income countries in the Region that are less often targeted for assistance. The AMRO share of the overall PAHO budget account is 30%, as detailed in Figure 8, which also shows funding and implementation compared with budget by source.

Figure 8: Budget Overview by Source, 2014-2015
(US$ millions)



178. The total budget implementation of Base Programs was 95.3% of the approved Program and Budget ($523.8 million against $549.4 million). Regular Budget funds from both PAHO and WHO were fully implemented, while implementation of Other Sources (including voluntary contributions and carryover from 2012-2013) was 92%. Most unimplemented funds from voluntary contributions carry over into the 2016-2017 biennium.

179. Regular Budget funds are allocated to the functional levels in accordance with the PAHO Budget Policy (Document CSP28/7 [2012]), which has an Interim Assessment that is being presented to the 158th Executive Committee (Document CE158/12 [2016]). The PAHO Budget Policy prescribes the following distribution:

a) Country (40% minimum): represents funds awarded directly to PWRs for country-level technical cooperation.

b) Intercountry (18%): represents funds to support decentralized technical cooperation and multicountry programs.

c) Subregional (7%): funds allocated to the Caribbean, Central America, and South America subregional entities for technical cooperation in health with countries within each subregion. The technical cooperation programs at subregional level support individual or groups of countries towards the achievement of health development goals within the framework of the Organization's mandates and commitments.

d) Regional (35%): funds to lead, coordinate, and support technical cooperation across the Region, including enabling and corporate functions.

180. The country, intercountry, and subregional allocations account for 65% of the total Regular Budget and represent direct support for technical cooperation provided to countries.

181. Table 2 shows the breakdown of Regular Budget allocation and implementation across functional levels in relation to the Budget Policy. The country level received slightly more than the Budget Policy prescribes, while the regional level received slightly less.

Table 2: Regular Budget Overview by Functional Level, 2014-2015
(US$ millions)

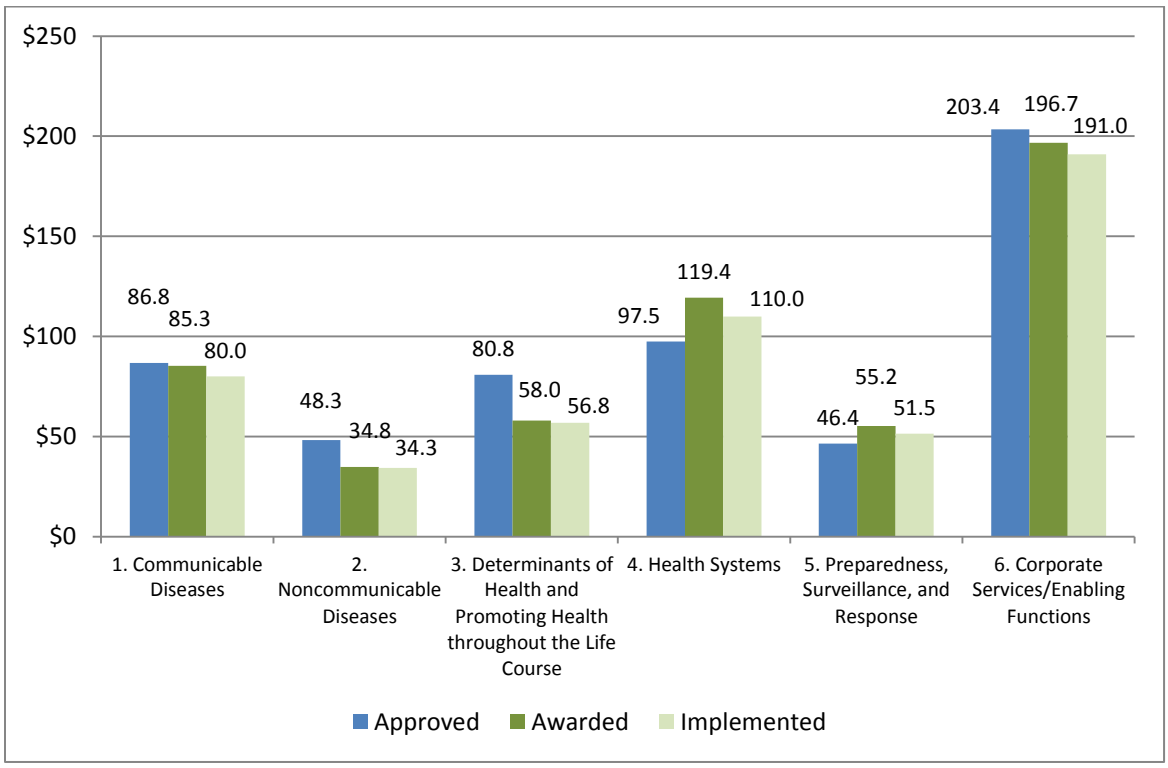
Functional Level	Budget Policy Allocation	Budget Policy (%)	Actual Allocation	Actual Allocation (%)	Net Increase (Decrease)
Country	109.6	40	113.0	41	3.4
Intercountry	49.3	18	50.0	18	0.7
Subregional	19.2	7	20.0	7	0.8
Regional	95.9	35	94.0	34	(1.9)
Subtotal	**274.1**	100	277.0	100	2.9
Retirees' health insurance	5.0		5.0		0
Grand Total	**279.1**		**282.0**		**2.9**

182. As mentioned above, the PAHO Program and Budget was 97.6% funded, with $549.4 million. The distribution of available funds and implementation by category is shown in Figure 9 below. All categories were funded at levels of 70% or higher against the approved budget, and Categories 4 and 5 were awarded more funds than their approved budget levels ($119.4 and $55.2 million against approved budgets of $97.5 and $46.4 million, respectively). This is due in large part to the receipt of earmarked funds for programs in these categories and additional funds for emergency and disaster preparedness in response to the Ebola outbreak.

183. Category 1 was nearly fully funded. However, Categories 2 and 3 were severely underfunded, receiving just 72% of their approved budgets ($34.8/$48.3 million and $58.0/$80.8 million, respectively). According to the programmatic prioritization in the

PAHO Strategic Plan 2014-2019, these two categories contain Tier 1 high-priority program areas—for example, Program Areas 3.1 (women, maternal, newborn, child, adolescent, and adult health) and 2.1 (noncommunicable diseases and risk factors). In these areas, achievement of expected results was hampered by resource constraints, as discussed elsewhere in the report. Category 6, which includes the cost of PAHO's core presence and leadership in countries, was 97% funded ($196.7/$203.4 million).

Figure 9: Budget Overview by Category 2014-2015 (US$ millions)



184. Implementation of funds awarded exceeded 90% in all six categories, being highest in Category 2 (99%), Category 3 (98%), and Category 6 (97%). However, implementation against the approved Program and Budget was highest in Category 4 (113%) and Category 5 (111%). The category reports in Annex A provide detailed budget information.

185. Twenty-three program areas (19 technical and 4 enabling) out of 29 (the total excluding Program Area 5.5) had 75% or more of their approved Program and Budgets funded, which satisfies the indicator for Output 6.3.2 concerning the alignment of resources with the Organization's priorities. However, there was wide variability in funding compared with budget by program area, as shown in Table 3. Although some of the underfunded program areas are emerging priorities (e.g., NCDs), they are not yet established targets for investment by donors, a deficiency that will be addressed in

PAHO's resource mobilization strategy. In other cases, program areas were over-budgeted – for example, Program Area 6.3, which has been corrected in the PAHO Program and Budget 2016-2017.

Table 3: Budget Overview by Category and Program Area 2014-2015 (US$ millions)

Category	Approved PB	Awarded	Budget Implementation	Awarded as % of Approved PB	Implemented as % of Awarded	Implemented as % of Approved PB
1. Communicable Diseases	**86.8**	**85.3**	**80.0**	**98**	**94**	**92**
1.1 HIV/AIDS and STIs	15.7	12.7	11.9	80	94	75
1.2 Tuberculosis	3.9	6.7	6.5	174	97	169
1.3 Malaria and other vector-borne diseases (including dengue and Chagas)	7.5	11.4	11.0	151	97	146
1.4 Neglected, tropical, and zoonotic diseases	11.5	14.5	12.9	126	89	112
1.5 Vaccine-preventable diseases (including maintenance of polio eradication)	48.2	40.1	37.7	83	94	78
2. Noncommunicable Diseases and Risk Factors	**48.3**	**34.8**	**34.3**	**72**	**99**	**71**
2.1 Noncommunicable diseases and risk factors	20.9	17.9	17.7	86	99	84
2.2 Mental health and psychoactive substance use disorders	3.3	3.0	3.0	93	100	93
2.3 Violence and injuries	7.6	4.2	4.1	55	99	54
2.4 Disabilities and rehabilitation	2.2	2.0	2.0	94	97	91
2.5 Nutrition	14.3	7.7	7.5	54	98	53

Category	Approved PB	Awarded	Budget Implementation	Awarded as % of Approved PB	Implemented as % of Awarded	Implemented as % of Approved PB
3. Determinants of Health and Promoting Health throughout the Life Course	**80.8**	**58.0**	**56.8**	**72**	**98**	**70**
3.1 Women, maternal, newborn, child, and adolescent, and adult health, and sexual and reproductive health	42.7	27.0	26.2	63	97	61
3.2 Aging and health	1.7	1.6	1.6	96	100	96
3.3 Gender, equity, human rights, and ethnicity	8.6	5.8	5.8	68	99	67
3.4 Social determinants of health	11.6	11.8	11.7	102	99	101
3.5 Health and the environment	16.2	11. 7	11.6	72	99	71
4. Health Systems	**97.5**	**119.4**	**110.0**	**123**	**92**	**113**
4.1 Health governance and financing; national health policies, strategies, and plans	11.9	12.8	12.4	107	97	104
4.2 People-centered, integrated, quality health services	13.6	17.4	17.2	128	99	127
4.3 Access to medical products and strengthening of regulatory capacity	22.9	25.7	22.8	112	89	100
4.4 Health systems information and evidence	32.9	30.5	28.6	93	94	87
4.5 Human resources for health	16.2	16.9	13.4	104	79	83
PALTEX	--	16.1	15.5	--	96	--

Category	Approved PB	Awarded	Budget Implementation	Awarded as % of Approved PB	Implemented as % of Awarded	Implemented as % of Approved PB
5. Preparedness, Surveillance, and Response	**46.4**	**55.2**	**51.5**	**119**	**93**	**111**
5.1 Alert and response capacities	9.9	10.5	9.8	107	93	99
5.2 Epidemic- and pandemic-prone diseases	8.0	9.7	9.1	121	94	113
5.3 Emergency risk and crisis management	19.0	21.0	19.7	111	94	104
5.4 Food safety	9.5	14.0	12.9	147	93	136
Subtotal Categories 1-5	**359.7**	**352.7**	**332.8**	**98**	**94**	**93**
6. Corporate Services/Enabling Functions	**203.4**	**196.7**	**191.0**	**97**	**97**	**94**
6.1 Leadership and governance	58.5	61.8	60.4	106	98	103
6.2 Transparency, accountability, and risk management	4.9	4.7	4.6	96	99	96
6.3 Strategic planning, resource coordination, and reporting	49.5	25.9	25.4	52	98	51
6.4 Management and administration	77.4	92.9	89.2	120	96	115
6.5 Strategic communications	13.1	11.4	11.4	87	100	88
Grand Total	**563.10**	**549.40**	**523.78**	**97.6**	**95.3**	**93**

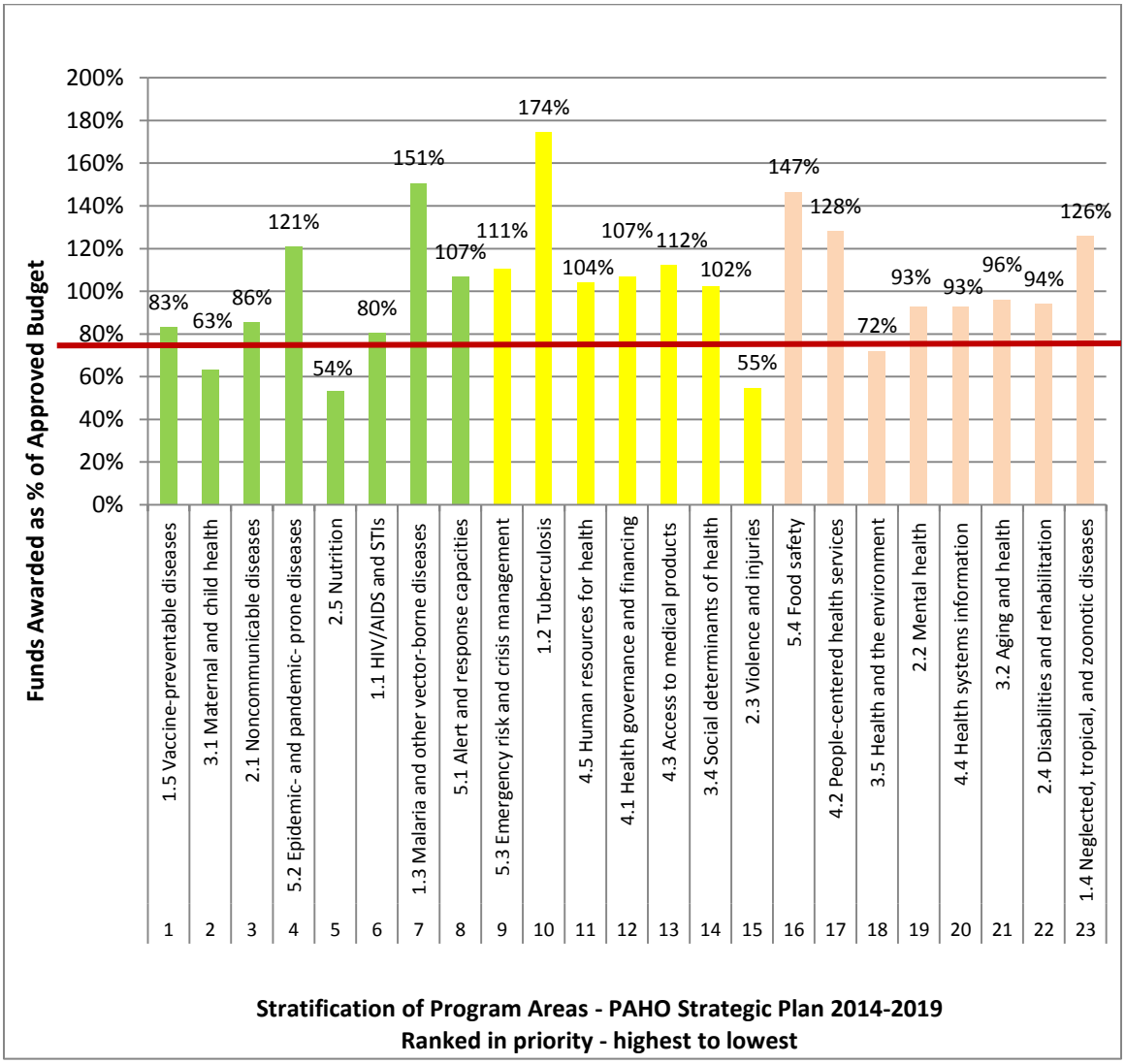
Analysis of Resource Allocation versus Prioritization of Program Areas

186. The PAHO Strategic Plan 2014-2019 ranked the program areas by programmatic priority (excluding program areas related to the cross-cutting themes and enabling functions) in order to guide resource mobilization and allocation during implementation.

187. Figure 10 shows 23 program areas ranked in three priority tiers, as approved in the Strategic Plan: *(a)* Tier 1 or high (left, in green), *(b)* Tier 2 or medium (center, in yellow) and *(c)* Tier 3 or low (right, in pink). It also shows the level of funding of each program area as a percentage of the approved budget in the Program and Budget

2014-2015. The red bar set at 75% represents the minimum target level of funding for each program area.

Figure 10: Programmatic Priority Ranking vs. Resource Allocation, 2014-2015



188. In line with the programmatic priorities stratification methodology, one would expect all Tier 1 program areas (highlighted in green) to have received at least 75% of their approved budgets. However, only six of eight did so, and only three of eight received full funding or more. This may be due to over-budgeting or the inability of priority programs (especially NCDs) to attract donor funding. Other causes of under-financing or misaligned financing in relation to priorities are *(a)* the limited amount of flexible, non-earmarked funds that can be used to fill gaps, and *(b)* the reality that 75% of Regular Budget funds are linked to fixed-term posts, which are not easily transferred or redirected to different categories or program areas, given the program-specific technical

nature of these positions. Another point to consider is that program areas are not mutually exclusive: for example, cross-cutting program areas, such as health systems, contribute to the work under other technical program areas.

189. While the level of funding is important to enable the PASB to better respond to the demands of technical cooperation in all program areas, the level of programmatic implementation does not rely solely on availability of financial resources within the PASB. The priorities of Member States and partners, reflected in their investment of resources and in their political, strategic, and technical collaboration, make a major difference in achieving the results under each of the program areas and categories.

190. PAHO's adoption of an integrated budget starting in 2016-2017, which no longer prescribes in advance as part of the resolution how and where to allocate the Regular Budget, will facilitate the strategic allocation of the most flexible funds to priorities with funding gaps.

Resource Mobilization and Funding Gap Analysis

191. The approved Program and Budget 2014-2015 was 97.6% funded ($549.4 million) at the close of the biennium. As seen in Table 4, there was a funding gap of $171.4 million at the beginning of the biennium, but this was largely filled by the biennium end, mainly through the mobilization of more than $120 million in new PAHO/WHO voluntary contributions.

Table 4: Status of the Funding Gap by Biennium, 2014-2015
(US$ millions)

Funding Type	PB 2014-2015	
	Beginning of Biennium	End of Biennium
Approved Program and Budget	563.1	563.1
Regular Budget	279.1	282.0
Other Sources – (including voluntary contributions and carryover)	112.6	267.7
Funding gap	171.4	13.7

192. Table 5 shows the top 10 donors to PAHO in 2014-2015, and the categories they support. Together, the top 10 donors provided half of PAHO's total voluntary contributions for 2014-2015 and 11% of the approved budget for Base Programs. Of these 10, six (CDC, USAID, EC, Global Affairs Canada, UNDP, and Spain) each contributed more than $5 million of the PAHO Program and Budget for Base Programs during the biennium.

Table 5: Top 10 Donors to PAHO in 2014-2015, by Category

Donor	Funds Awarded (US$ millions)	Category Funded					
		1: Communicable Diseases	2: Noncommunicable Diseases	3: Determinants of Health and Promoting Health throughout the Life Course	4: Health Systems	5: Preparedness, Surveillance, and Response	6: Corporate Services/Enabling Functions
U.S. Centers for Disease Control and Prevention (CDC)	13.8	✓	✓	✓	✓	✓	✓
U.S. Agency for International Development (USAID)	12.3	✓		✓	✓	✓	
European Commission (EC)	6.9	✓	✓	✓		✓	
Global Affairs Canada	6.3	✓	✓	✓	✓	✓	✓
United Nations Development Programme (UNDP)	6.1	✓	✓	✓	✓	✓	✓
Government of Spain	5.7		✓	✓	✓	✓	✓
Global Alliance for Vaccines and Immunization (GAVI)	3.7	✓			✓		
Government of the United Kingdom (Department for International Development, DFID)	2.3					✓	
Government of Norway (Norwegian Agency for Development Cooperation, Norad)	1.7	✓		✓	✓		

Donor	Funds Awarded (US$ millions)	Category Funded					
		1: Communicable Diseases	2: Noncommunicable Diseases	3: Determinants of Health and Promoting Health throughout the Life Course	4: Health Systems	5: Preparedness, Surveillance, and Response	6: Corporate Services/Enabling Functions
Bill and Melinda Gates Foundation	1.5	✓			✓		

193. Of the top 10 donors, two provided funding in all six categories of the Program and Budget. By category, eight of 10 donors provided funding to Categories 1 and 4. The remaining donors on average funded between two and five categories each. While PAHO welcomes the contribution of partners, any funding it accepts must be aligned with the Program and Budget priorities approved by Member States.

194. Additional details of challenges in resource mobilization by category and program area are provided in the category reports in Annex A.

B) Outbreak and Crisis Response Segment

195. During the biennium, a total of $9.9 million was made available for this segment, against an estimated $22 million presented in the Program and Budget 2014-2015. Though the Program and Budget segment for Outbreak and Crisis Response was approved at $22 million, the amount actually required depends on the scale and severity of emergencies and outbreaks that occur, and therefore it cannot be forecast with much precision. While the allocation was 45% of the approved resource requirement, it represented the entire need for the Region of the Americas in 2014-2015, and 93% of the OCR funds were implemented.

C) National Voluntary Contributions Segment

196. Over the 2014-2015 period, a total of $254.2 million in National Voluntary Contributions was made available to implement national technical cooperation programs. This exceeds the amount of Member State assessed contributions to PAHO’s regional programs ($192 million). The main contributors to NVCs over this period are shown in Table 6.

Table 6: Funding of National Voluntary Contributions by Country, 2014-2015

Donor	Funds Awarded (US$ millions)	% of NVCs
Government of Brazil	217.50	85.57
Government of Colombia Financial District Health Fund	19.04 0.33	7.62
Government of Argentina	5.52	2.17
Government of Mexico	2.35	0.93
Government of Panama	0.71	0.28
Government of Peru	0.68	0.27
Government of Costa Rica	0.66	0.26
Government of Ecuador	0.56	0.22
Government of Honduras	0.52	0.20
Government of Bahamas	0.41	0.16
Government of Guatemala	0.18	0.07
Government of Uruguay	0.18	0.07
Government of Belize	0.17	0.07
Government of Venezuela	0.12	0.05
Government of El Salvador	0.03	0.01
Other contributors	5.21	2.05
Grand Total	254.16	100
Mais Médicos (Brazil)	1,163.00	
Total NVCs 2014-2015	1,417.16	

197. The amount of NVCs increased by 150% compared to the preceding biennium (from $329.6 million in 2010-2011 to $565.5 million in 2012-2013 to $1,417.2 million in 2014-2015). The Government of Brazil continued to be the largest contributor to this funding modality for in-country technical cooperation, providing 85.5% of National Voluntary Contributions (excluding *Mais Médicos*). The governments of Colombia and Argentina were the next largest sources of NVCs.

198. The *Mais Médicos* project alone was 357% the level of National Voluntary Contributions (from all other sources) received in the 2014-2015 biennium. Additionally, other National Voluntary Contributions from Brazil accounted for 85.5% of total NVCs received (excluding *Mais Médicos*) in the 2014-2015 biennium.

VII. CONCLUSIONS AND RECOMMENDATIONS

199. The assessment of the Program and Budget 2014-2015 shows that the Organization made steady progress toward achieving the Strategic Plan targets for 2019, with 90% of the outcome indicators on track and over 97% of the Program and Budget funded and implemented. The progress thus far is a result of the close collaboration among countries and territories with the suppo**rt** of the PASB and partners at the country, subregional, and regional levels.

200. As documented in the assessment of categories and program areas, significant progress has been made in improving health and well-being across the Region. Landmark achievements at impact level include validation of the elimination of mother-to-child transmission of HIV and congenital syphilis in Cuba; declaration of the elimination of endemic transmission of rubella and congenital rubella syndrome in the Region of the Americas; verification of the elimination of onchocerciasis in Ecuador and Mexico; reduction of malaria and dengue cases and fatalities; decline of tobacco consumption; achievement of the MDG4 target, with an overall reduction of the under-5 mortality rate by 69% between 1990 and 2015; reductions in maternal mortality and adolescent fertility; improved health outcomes through expansion of coverage and access to health services; and strengthening of national and regional preparedness and capacity to respond to ongoing and emerging issues.

201. However, key challenges and gaps remain in certain program areas, such as NCDs and risk factors, maternal health, financing for health, maintaining and strengthening core capacities for emergency and crisis response, and increasing health systems resilience. The Organization, both Member States and the PASB, in collaboration with partners across the Region and beyond, will need to find strategies to address major challenges that are hindering progress. They will also need to continue advocating and investing the necessary resources to keep public health issues at the top of the political and development agendas. The SDGs provide an excellent opportunity to bring prominence to the Organization's work.

202. The lessons learned from each category assessment in this report provide a valuable opportunity to reflect upon successes and failures, to replicate successful interventions, and to avoid repeating mistakes.

203. The Organization needs to continue improving and promoting successful models for an integrated approach to technical cooperation in order to optimize resources and maximize impacts in addressing the public health priorities and needs of the countries. Fostering successful experiences through inter-programmatic, intersectoral, and intercountry collaboration and exploring new modalities of technical cooperation will be critical to extend the reach and effectiveness of PAHO technical cooperation. The Organization also needs to ensure that its programs are tailored and responsive to Member States' situations and needs, while ensuring that it adds value in line with the Organization's core functions and the principles of equity and Pan Americanism.

204. Although the Program and Budget 2014-2015 was more than 97% financed, certain priority program areas did not meet the minimum targeted financing level (75% of the approved budget). The PASB should take advantage of an integrated budget and programmatic approach to resource mobilization to strategically allocate flexible resources to underfunded programs and priorities, such as those in Category 2 (Noncommunicable Diseases and Risk Factors) and Category 3 (Determinants of Health and Promoting Health throughout the Life Course). The Organization should continue to broaden and deepen its external sources of support for PAHO's Program and Budgets and Strategic Plan, especially for programs that have been less attractive to donors.

205. With the introduction of the joint assessment methodology, the Organization has made significant strides toward further consolidating RBM in close collaboration with Member States. This progress was made possible by the commitment and involvement of all countries and territories in the Region, the PASB Executive Management, and staff across all PASB levels. Equally important was the development of processes and tools to facilitate implementation of the methodology, including the SPMS.

206. Continuous improvement is needed to strengthen the quality and precision of the indicators. Nevertheless, it is evident that the joint assessment methodology is robust for effectively demonstrating progress toward achieving the output and outcome indicators. A key challenge is to ensure the consistent application of the methodology in future assessments.

207. A factor that contributed to non-achievement of some outcomes and outputs was unrealistic targets for the planning period, established without due consideration to particular challenges in some countries or the need for multisectoral action. Looking toward 2016-2017 and beyond, the Organization needs to use a balanced approach to goal setting to ensure that targets are reasonably attainable, and yet high enough to motivate actions toward the necessary changes at the outcome and impact levels during the planning period.

208. While notable progress has been made in the quality of both information and reporting, there are key areas (such as maternal health, chronic diseases and risk factors, mental health, violence and injuries, disabilities and rehabilitation, and access to health services) in which limited up-to-date and reliable data are available to measure progress toward achieving the impact indicators. Data limitations presented a challenge in defining the baselines for the indicators and thus affected the monitoring and assessment process.

209. Building on the positive experience from the internal performance monitoring and assessment that has strengthened work plan implementation, continuous tracking of progress toward the outputs and outcomes should be considered in order to identify challenges and implement timely adjustments during implementation. In this regard, the use of milestones could be considered as an effective and practical approach to monitor interim progress during the biennium.

210. PAHO successfully pioneered the joint assessment with Member States and delivered valid results, despite challenges with logistics, timing, and data. Given this experience and the joint responsibility and commitment of Member States and the PASB for the attainment of results, the joint monitoring and assessment of indicators will be embedded in future performance assessments. Going forward, the programmatic lessons learned derived from the joint assessment will inform the design and implementation of technical cooperation activities.

211. In the spirit of a learning Organization and the promotion of best practices, the joint assessment process and its results will be documented and disseminated at country, subregional, regional, and global levels to further enhance accountability, results-based management, and collaboration with Member States.

Action by the Executive Committee

212. The Executive Committee is invited to take note and provide comments on the Preliminary Report of the End-of-Biennium Assessment of the Program and Budget 2014-2015/First Interim Report on the PAHO Strategic Plan 2014-2019.

Annexes

Annex A: Category Reports

2014-2015 End-of-Biennium Assessment
Category 1 Report

CATEGORY 1: COMMUNICABLE DISEASES	OVERALL CATEGORY ASSESSMENT RATING[1] Partially met expectations

CATEGORY PROGRAMMATIC AND BUDGET OVERVIEW

Table 1. Category 1 Programmatic and Budget Summary

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget implementation against PB (%)	Budget implementation against Awarded (%)	Output Indicator Rating	Outcome Indicator Status
1.1 HIV/AIDS and STIs	15.73	12.65	80.4	75.3	93.7	2/4 achieved, 2/4 partially achieved	3/3 in progress
1.2 Tuberculosis	3.86	6.74	174.4	169.1	96.9	1/3 achieved, 2/3 partially achieved	2/3 in progress, 1/3 no progress
1.3 Malaria and other Vector-borne Diseases (including Dengue and Chagas)	7.54	11.37	150.7	146.1	96.9	3/5 achieved, 2/5 partially achieved	1/4 achieved, 3/4 in progress
1.4 Neglected, Tropical, and Zoonotic Diseases	11.48	14.46	126.0	112.2	89.1	2/5 achieved, 3/5 partially achieved	8/8 in progress
1.5 Vaccine-Preventable Diseases (including Maintenance of Polio Eradication)	48.19	40.09	83.2	78.3	94.1	4/6 achieved, 2/6 partially achieved	1/4 achieved, 2/4 in progress, 1/4 no progress
TOTAL	**86.81**	**85.32**	**98.3**	**92.2**	**93.8**	**12/23 achieved, 11/23 partially achieved**	**2/22 achieved, 18/22 in progress, 2/22 no progress**

[1] Assessment ratings for the overall category and for program areas/outcomes are determined by the PAHO category and program area facilitators, respectively, taking into consideration the programmatic and budget implementation, analysis of resources (human and financial), and operational and programmatic risks. Ratings are defined as follows:

- **Met expectations** (Green): achieved 90% to 100% of the results for the period being assessed. Progress is on track, as expected; no impediments or risks that affect the achievement of results are foreseen.
- **Partially met expectations** (Yellow): achieved 75% to 89.9% of the results for the period being assessed. Progress may be at risk, and action is required to overcome delays, impediments, and risks.
- **Insufficient progress** (Red): achieved <75% of the results for the period being assessed. Progress is in jeopardy due to impediments or risks that could preclude the achievement of results. Immediate corrections are required.

Table 2. Category 1 Budget Overview by Functional Level

Functional Level	Funds Awarded (US$ millions)	Awarded by Level (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
Country	28.50	33.40	27.30	95.8
Intercountry	20.10	23.56	18.07	89.9
Subregional	4.17	4.88	3.96	95.0
Regional	32.55	38.15	30.68	94.2
Total	**85.32**	**100.00**	**80.01**	**93.8**

CATEGORY PROGRAMMATIC ANALYSIS

Overall Category Assessment Summary

During the 2014-2015 biennium, the Pan American Sanitary Bureau (PASB) worked toward the overarching goal of reducing the burden of communicable diseases in the Region, in collaboration with Member States and strategic partners. As detailed below, key achievements were attained and important progress was made to increase access to essential interventions for prevention and treatment of HIV and sexually transmitted infections (STI); to improve diagnosis and treatment of tuberculosis (TB); to increase country capacity in surveillance, prevention, control, and/or elimination of malaria and other vector-borne diseases, as well as of neglected, tropical, and zoonotic diseases, through the implementation of comprehensive plans and strategies; and to increase vaccination coverage for hard-to-reach populations and communities while maintaining the achievements to date in the control, eradication, and elimination of vaccine-preventable diseases (VPD).

Based on an analysis of the programmatic and budgetary components of Category 1 and its respective program areas, and taking into consideration the mitigation of identified operational and programmatic risks, Category 1 is assessed as having partially met expectations during the 2014-2015 biennium.

Overall, the technical program area network assessed 2/22 outcome indicators as achieved (9%), 18/22 outcome indicators as in progress (82%) and 2/22 outcome indicators as no progress (9%); and 12/23 output indicators as achieved (52%), and 11/23 output indicators as partially achieved (48%). At the program area level, 1/5 was achieved, and 4/5 were rated as having partially met expectations. The assessment noted tremendous progress toward achieving indictors but also underscored important challenges that will need to be addressed in the next biennium.

Based on the corporate financial information provided above, Category 1 mobilized more than US$ 85 million during 2014-2015 through joint efforts across all functional levels of the Organization. Overall, a total of 94% of awarded funds were executed by the end of 2015, and 92% of funding was implemented when compared to the approved budget. Broken down by functional level, the percentages of Category 1 awarded funding allocated to the country, intercountry, subregional, and regional levels were 33%, 24%, 5%, and 38%, respectively. Implementation of awarded funding was very high at the country (96%), intercountry (90%), subregional (95%), and regional (94%) levels at the end of 2015.

Important funding gaps exist in Program Areas 1.1 and 1.5. Moreover, although the funding awarded to Program Areas 1.2, 1.3, and 1.4 exceeded the approved budget, this should not mask the fact that several programs (e.g.,

dengue, Chagas, rabies/zoonosis) require additional resources to achieve the intended results. Additionally, some important lessons regarding initial planned cost estimates, alignment with the prioritization of program areas, and resource mobilization capacity can be drawn when further analysis is conducted on implementation against the Program and Budget 2014-2015 (PB 14-15) and awarded funding.

Programmatic Summary by Program Area

1.1 HIV/AIDS and STIs

Overview

The Americas continued to be the region with the highest antiretroviral therapy (ART) coverage worldwide (46% of all persons estimated to be living with HIV). In 2013 the World Health Organization (WHO) issued updated guidelines with a higher CD4 threshold for initiation of ART, followed by the 2015 recommendation to "treat all" regardless of CD4 count. Argentina, Brazil, Canada, Mexico, and the United States have already introduced the treat-all approach, and more countries are expected to update their national guidelines in the next biennium. Based on estimates of the Joint United Nations Programme on HIV/AIDS (UNAIDS), at the end of 2014, countries with the highest ART coverage of adults (age 15+ years) with HIV were Cuba (70%), Chile (64%), Belize (55%), Costa Rica (54%), and Panama (53%). Achieving 80% ART coverage in 22 countries by 2019 will be a challenge. However, access to antiretroviral (ARV) drugs at lower prices has been expanding thanks to joint procurement through the PAHO Strategic Fund and procurement mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), as a key component of PAHO's technical cooperation with countries. In addition, according to the 2015 update on elimination of mother-to-child transmission (EMTCT) of HIV and congenital syphilis in the Americas, using data reported by countries to the UNAIDS-WHO Global AIDS Response Progress Reporting (GARPR), 11 countries and territories have reported over 95% coverage of HIV prophylaxis treatment for prevention of mother-to-child transmission (MTCT) of HIV, and 14 countries and territories have reported at least 95% coverage of syphilis treatment in pregnant women. This demonstrates progress toward the targets of 24 and 22 countries in outcome indicators 1.1.2 (HIV prophylaxis treatment for MTCT) and 1.1.3 (syphilis treatment in pregnant women), respectively.

With respect to 2014-2015 output indicators, countries have made important progress in adopting national strategies and guidelines adapted to global and regional recommendations. This includes adoption of the four flagships of the Regional Strategic Plan for HIV/AIDS/STI, 2006-2015 within their national strategies, as well as alignment of national guidelines with the WHO 2013 guidelines on the use of ART for treatment and prevention of HIV infection. In addition, regional consensus on the global 90-90-90 HIV treatment and prevention targets was achieved through two regional forums, resulting in updates to national targets.

Achievements

- A key achievement during the biennium was the validation of EMTCT of HIV and congenital syphilis in Cuba. Following a validation mission in March 2015 and a process supported by PAHO/WHO, the Cuban Ministry of Health, and other regional partners, confirmed the certification on 24 June 2015. A progress report on EMTCT of HIV and congenital syphilis in the Americas, published in December 2015, revealed 16 countries and territories of the Americas reporting data compatible with achievement of dual elimination targets (Anguilla, Antigua and Barbuda, Barbados, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cuba, Dominica, Montserrat, Puerto Rico, Saba, St. Kitts and Nevis, Turks and Caicos, United States). Validations in the Bahamas, Barbados, the Organisation of Eastern Caribbean States (OECS) countries, and the United Kingdom territories in the Caribbean have been included in the EMTCT plan for 2016.
- Additional achievements include the approval of new 90-90-90 regional targets for HIV treatment and

prevention and ending stigma/discrimination, achieved this biennium through two regional-level conferences in Mexico City (May 2014) and Rio de Janeiro, Brazil (August 2015). Seventy-five percent of countries have incorporated, or are in the process of incorporating, the 90-90-90 HIV treatment and prevention targets into their national strategic plans.

- The first regional Plan of Action for the Prevention and Control of Viral Hepatitis was approved by the Governing Bodies during PAHO's 54th Directing Council, showing the support of Member States for efforts to intensify the public health response to viral hepatitis in the Region. Recommendations for country surveillance and monitoring of response to viral hepatitis B and C have been developed, and six countries successfully engaged in data mining exercises (Argentina, Brazil, Chile, Colombia, El Salvador, Panama).

Challenges

- Gaps persist in HIV prevention and care services for key population groups, including men who have sex with men, sex workers, and transgender women. This requires a comprehensive health system approach along with targeted actions to address the specific needs of these populations.
- There are continuing challenges related to the availability of timely and complete information from countries needed to adequately assess progress on updated STI strategies (output 1.1.3) and outcomes in countries, as well as the regional situation. This is compounded by difficulties in maintaining political commitment and securing national resources to address STIs. An additional challenge faced by many countries is a lack of quality disaggregated strategic information due to weak health information systems focused on HIV and STI and linked to maternal and child health data.
- Systematic mechanisms for routine country reporting on hepatitis remain limited. Efforts to support country data and reporting have begun, but they face several interrelated weaknesses in countries, including lack of a coordinated and organized response to viral hepatitis, insufficient data, and difficulties organizing the data into a structured information system.
- Ensuring access to prevention, diagnosis, and treatment of viral hepatitis represents a significant challenge for the Region. There is a need to maintain and expand hepatitis B immunization programs in order to increase coverage for all children and for members of key populations and vulnerable groups, aligned with the Plan of Action for the Prevention and Control of Viral Hepatitis (2015).

Lessons Learned

- The process for validation of EMTCT in Cuba, including the assessment mission and meetings of the Regional Validation Committee, provided valuable experience that can be used to update documents and inform the process for the next countries that have already requested PAHO to provide validation of elimination.
- The development and approval of the Plan of Action for the Prevention and Control of Viral Hepatitis has helped focus necessary attention on the silent epidemics in the Region.

1.2 Tuberculosis

Overview

PAHO has provided consistent technical cooperation to Member States to promote the adoption of rapid diagnostic technology, as well as to update and implement country plans to reflect WHO guidelines for early diagnosis and treatment of multidrug-resistant tuberculosis (MDR-TB) and TB-HIV. At the end of 2015, the cumulative number of TB bacteriologically confirmed patients that have been successfully treated was 1.85 million, an increase of 403,000 since 2012; this represents important progress toward achieving the 2019 target of 2.5 million. A total of 3,568 MDR-TB patients were placed on treatment in the Region in 2014. However, despite the progress in countries, the case detection rate for the Region dropped from 79% to 77%. One explanation for this is that the rate could be

affected by the updated WHO estimates of the TB burden in the Region.

Achievements

- A key achievement is approval of the Plan of Action for the Prevention and Control of Tuberculosis by the Governing Bodies during PAHO's 54th Directing Council, aligned with the WHO post-2015 Global End TB Strategy.
- Successful implementation and expansion of the initiative for TB control in large cities has allowed an increased focus on populations in situations of vulnerability during 2014-2015. The initiative plans to further expand in the next biennium for the inclusion of additional programs, such as HIV, diabetes, and mental health, among others.

Challenges

- The level of political commitment and coordination with ministries of health often affected the implementation of planned activities during the biennium. For example, in 2015 three MDR-TB monitoring and evaluation missions by the Regional Green Light Committee (rGLC) were cancelled.
- Implementation of rapid diagnostic technologies for tuberculosis, such as GeneXpert, has been slower than expected due to both technical and financial challenges, including the introduction of a new technology, adaptation of relevant guidelines, and resource constraints. A regional concept note for strengthening the TB laboratory network has recently been presented to the Global Fund to address these gaps. Implementation of this plan is expected to begin in 2017, following revision and finalization in 2016.

Lessons Learned

- Given that the TB in large cities initiative was developed with a solid epidemiological framework, taking into account social determinants of health, and has had successful results, lessons learned from this process will be used to support the initiative's expansion to HIV, diabetes, and mental health, among others.
- The work on TB in large cities has demonstrated that both intersectoral and inter-programmatic work leads to improved synergies and to joint successes. However, continued efforts are needed to maintain these achievements (particularly in intersectoral work), as many cities face political changes.

1.3 Malaria and Other Vector-borne Diseases (including Dengue and Chagas)

Overview

The regional malaria, dengue, and integrated vector management programs continue to foster alliances with strategic partners to provide quality technical cooperation to countries to strengthen national programs and ensure installed capacity in the prevention, surveillance, control, and/or elimination of malaria and other vector-borne diseases. Countries continue to reinforce their efforts to eliminate malaria by upgrading routine malaria information systems, focusing on populations in situations of vulnerability, strengthening malaria case management, increasing access to first-line antimalarial treatment, and enhancing capacity through trainings that can be replicated in other countries. In reference to dengue, countries have implemented the new PAHO/WHO dengue classification to improve diagnosis and treatment, resulting in improved case management at the primary health care level. These efforts have been implemented within the framework of the Integrated Management Strategy for Dengue Prevention and Control (IMS-Dengue), and they are aligned with the WHO Global Strategy for Dengue Prevention and Control 2012-2020. With respect to Chagas, there has been a gradual increase in the coverage and quality of care for patients infected by *T. cruzi*. Additional progress achieved in endemic countries includes universal screening of blood donors for Chagas, notification of cases, documentation of congenital Chagas, outbreak detection and

management, and procurement and use of medicines.

Achievements

- The Region continued to see a reduction of confirmed malaria cases with 389,390 by the end of 2014, a 67% reduction compared to 2000; and 87 deaths, a reduction of 79% in the same period. This reaffirms the Region's progress in combating malaria. In addition, 100% of confirmed malaria cases in the public sector are receiving first-line antimalarial treatment.
- The continuing decline in malaria cases and deaths in 19 of the 21 endemic countries affirms the Region's progress in combating malaria.
- Epidemiological surveillance systems for dengue have been strengthened, and there was an observed reduction in the dengue fatality rate from 0.07% to 0.05% between 2010 and 2014.
- Of the 21 Chagas-endemic countries, 17 continued to maintain interruption of vector-borne domiciliary transmission by the main vector, as reflected by a household infestation index of less than or equal to 1% in the country or in its endemic areas.
- Two Technical Advisory Groups (TAG) were established for vector control/elimination programs during the biennium. The TAG for malaria held its first meeting in October 2015 and will serve as the principal advisory group to PAHO on matters related to malaria in the Region. The TAG for entomology was established to strengthen coordination of sustainable and integrated vector control activities, to reinforce national capacity to improve the efficacy of vector control programs, and to ensure the rational use of insecticides.

Challenges

- Despite noted progress in the decline of malaria cases in endemic countries, further reduction in the malaria burden and the subsequent achievement of malaria elimination targets could be accelerated if the following challenges were addressed: *(a)* limited coordination among all partners and stakeholders in intensifying efforts to foster timely and universal access to quality and evidence-based interventions; *(b)* outdated malaria policies and strategic frameworks that do not reflect accelerated efforts toward malaria elimination; *(c)* weak surveillance at all levels of the health system, making it difficult to rapidly detect malaria threats and trigger appropriate responses, as well as identify resistance to antimalarial medicines and insecticides; *(d)* limited commitment of stakeholders, which translates into insufficient resources for malaria efforts; and *(e)* the need to address contextual specificities and prepare for the "end game" and beyond.
- It is imperative to prevent the further spread of arbovirus circulation, and more recently the chikungunya and Zika viruses, and to diminish the presence of the *Aedes aegypti* mosquito throughout the countries as it continues to adapt to urban areas. This will require an integrated approach that presents significant financial, technical, and management challenges.

Lessons Learned

- Best practices and examples of effective efforts to address malaria in the Region include the Amazon Network for the Surveillance of Antimalarial Drug Resistance / Amazon Malaria Initiative (RAVREDA/AMI) and the Malaria Champions of the Americas. The sustainability of these initiatives and the successful achievement of established targets underscore the strong sense of community and country ownership, effective capacity-building activities, as well as the engagement of local champions who are able to effectively advocate for continued technical and programmatic support.
- IMS-Dengue has provided a platform for many countries to incorporate elements of prevention and control of the chikungunya and Zika viruses and other arboviruses.

1.4 Neglected, Tropical, and Zoonotic Diseases

Overview

The Region continues to make significant advances toward the elimination of neglected infectious diseases (NID). During 2014-2015, WHO verified the elimination of onchocerciasis in Ecuador and Mexico. Guatemala requested verification by PAHO and WHO, which will be carried out during 2016. Brazil and Venezuela have also made significant progress in the formulation of an operational plan of action 2015-2016 for the elimination of onchocerciasis in the Yanomami border area. The regional NID program applied an inter-programmatic approach to overcome logistical challenges and introduce innovation into technical work. The first example was the use of a warehouse in Panama to store and distribute NID medicines in response to urgent requests from Member States, which promoted Pan Americanism and provided timely support to countries facing medicine shortages. Also, inter-programmatic work resulted in the development and implementation of tools shared between regional programs (e.g., a toolbox for monitoring of deworming and vaccination coverage, and integration of deworming in Vaccination Week in the Americas) and promoted the use of common platforms to expand coverage of health services for those most in need.

In regard to rabies, all recommendations of the 14th Meeting of Directors of National Programs for Rabies Control in Latin America (REDIPRA 14) were implemented during the biennium. These included *(a)* execution of the first regional proficiency exercise for national rabies laboratories, with the participation of 23 laboratories; *(b)* development of a new model to guide surveillance for canine rabies control and elimination; and *(c)* tailored technical cooperation with six priority countries (Bolivia, Brazil, Guatemala, Haiti, Nicaragua, Peru) to strengthen dog immunization campaigns, increase access to post-exposure prophylaxis (PEP), and develop national rabies action plans. REDIPRA 15 was held in September 2015 and provided new resolutions to guide technical cooperation by PAHO and the Pan American Foot-and-Mouth Disease Center (PANAFTOSA) for the control and elimination of rabies transmitted by dogs for the next biennium, an important step toward achieving the regional goal.

Achievements

- A total of 12 countries had NID plans, programs, or strategies in place. Six of these countries successfully launched NID integrated plans of action and have already carried out some activities. Additionally, endemic countries for specific NIDs, such as lymphatic filariasis, trachoma, and schistosomiasis, have attained or are progressing toward the target coverage goals for treatment of populations at risk.
- According to the latest available data (2014), 16 of 23 leprosy-endemic countries have reached the goal of eliminating the disease as a public health problem.
- Countries continue to strengthen access to diagnosis and treatment of leishmaniasis, as well as to enhance integrated surveillance and control actions.
- During the biennium, the Region continued to maintain a low number of deaths due to canine rabies, with a total of 20 confirmed cases compared to 22 and 30 confirmed cases in 2012-2013 and 2010-2011, respectively.

Challenges

- The Region and its NID-endemic countries continue to face several obstacles to elimination. These include *(a)* lack of timely and affordable access to essential medicines, vaccines, and equipment; *(b)* lack of adequate human and financial resources for surveillance, screening, monitoring, and entomological interventions to combat various NIDs; *(c)* weak monitoring and evaluation systems; *(d)* insufficient political will at the higher governance levels, delaying achievement of national and subnational elimination goals; *(e)*

gaps in health education, social participation, good hygienic practices, and access to adequate sanitation and safe water; *(f)* insufficient services for NID treatment and prevention at the primary and secondary health care levels; *(g)* failure to capitalize on inter-programmatic and intersectoral opportunities for disease elimination and control, and on donations of NID medicines by WHO; and *(h)* lack of proven strategies and interventions to tackle post-elimination public health issues remaining among people living in the Region's indigenous, Afro-descendant, rural, and periurban poor communities.

- The technical tools for the elimination of dog-mediated human rabies are readily available to countries as needed. However, the regional goal of elimination was not achieved by 2015. This was mainly due to the insufficient commitment by national authorities and lack of resources to support sustained rabies control efforts, including the provision of PEP, dog vaccination and surveillance, human rabies surveillance, and education and communication activities.
- The results from a survey to identify country priorities regarding zoonosis in the Region, combined with growing demands from countries for support in confronting these risks, confirm the increased need for technical cooperation on zoonotic diseases (e.g., brucellosis, West Nile virus, and equine encephalitis) and additional resources to address country needs.

Lessons Learned

- Effective coordination between the PAHO regional NID program, WHO headquarters (Department of Control of Neglected Tropical Diseases), and key partners and stakeholders, working together to encourage and support governments to address NIDs in their national and subnational health plans, allowed the Region to move forward with actions to control and eliminate these diseases. Additionally, the use of an inter-programmatic approach helped strengthen country capacity through the provision of more effective, integrated technical cooperation, such as the deworming with vaccination campaigns and the use of the warehouse in Panama to overcome stock-outs in the countries.

1.5 Vaccine-Preventable Diseases

Overview

During 2014-2015, the Region of the Americas reaffirmed its status as a global leader in the elimination of VPDs and the strengthening of national immunization programs. As part of continued efforts to ensure high vaccination coverage by reaching populations in hard-to-reach communities, the 13th annual Vaccination Week in the Americas was implemented across the Region, reaching over 60 million people with quality and effective vaccines. Countries also successfully submitted and implemented plans of action that include specific interventions to improve vaccination coverage among unvaccinated and undervaccinated populations. The Integrated Surveillance Information System for Vaccine-Preventable Diseases was expanded. The measles outbreak in the northeast of Brazil, which presented the largest obstacle to attaining the verification of measles elimination in the Region, was declared interrupted by the International Expert Committee for Measles and Rubella Elimination in the Americas. Additionally, countries have begun the introduction of inactivated polio vaccine (IPV) as part of the regular polio immunization scheme, and they are preparing to switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) as part of the Polio Eradication and Endgame Strategic Plan 2013-2018. Finally, the adoption of the Regional Immunization Action Plan 2016-2020 by PAHO's 54th Directing Council will provide a road map for maintaining the achievements made to date while taking the necessary steps to strengthen the various components of national immunization programs. However, despite these noted advances, the Region has witnessed reduced vaccination coverage rates. PAHO encourages countries to step up their efforts in the next biennium to ensure universal and equitable access to vaccination, as well as the use of quality vaccination data.

Achievements

- The declaration of the elimination of endemic transmission of rubella and congenital rubella syndrome in the Americas in April 2015 represents a historic global and regional milestone in public health.
- The Region continued to maintain achievements in vaccination coverage with a regional average above 90%.
- As part of the ongoing effort to support countries in improving vaccination coverage of unvaccinated and undervaccinated populations, the development of tools for the identification of low-coverage municipalities and for subsequent interventions was successfully completed. The possible impact on coverage will be assessed with the publication of 2015 data.
- A total of 41 countries purchased vaccines and biological products through the PAHO Revolving Fund for Vaccine Procurement, totaling more than $1 billion over the biennium.

Challenges

- Insufficient investments in national immunization programs continue to present a challenge to program sustainability, with potential negative impacts on vaccination coverage goals and effective operations.
- The concept of Universal Health Coverage needs to be clearly conveyed to countries to ensure visibility, strengthen priority programs, and attain regional objectives.

Lessons Learned

- The inter-programmatic approach to expansion of coverage monitoring has proven to be one of the most effective and efficient methods of increasing access to immunization services for vulnerable and/or isolated populations, as demonstrated through the successful collaborative work between the immunization and NID programs (e.g., deworming).

Risks

The most relevant risks identified for Category 1 in the PAHO Strategic Plan 2014-2019 are listed below, with information regarding their status and any mitigation actions taken to address them. New risks identified during the biennium are also highlighted.

- A shift in health priorities at the global, regional, or national level results in diminished financial support for communicable disease and immunization programs.
    - There was a lack of fiscal security in several communicable disease programs during the biennium, such as for EMTCT, viral hepatitis, and NIDs, which impeded completion of some programmed activities. Successful resource mobilization through the creation of new partnerships and negotiation of extensions to existing agreements led to the diversification of funding sources to support key programs, in addition to making more efficient use of existing resources.
    - The Organization, alongside countries and partners, successfully fostered an interest in malaria through strategic advocacy and communication efforts, resulting in an increase in malaria funding and a strong commitment of countries to malaria elimination. This commitment is sustained through PAHO's intensified efforts to consolidate, update, and implement the countries' national malaria plans. These plans address key challenges related to the context of the countries, including vulnerable groups, outbreak preparedness and response, supply chain, etc.
- Mobility across borders contributes to the complexity of disease prevention, control, and elimination.
    - With respect to rabies and other zoonotic diseases, the mobility of people, animals, and goods

across borders contributes to the complexity of prevention, control, and elimination efforts in certain countries (e.g., between Brazil and Bolivia). The promotion of South-South cooperation between neighboring countries has proven effective in improving coordination of actions across borders and among vulnerable populations.

- Emergencies, disasters, and pandemics divert resources allocated to key communicable disease programs and make it difficult or impossible to collect and collate strategic information.
    - The main challenge impeding the collection of quality strategic information has been weak health information systems in countries that make limited investments to improve them. This issue was prioritized during the biennium, and tailored technical cooperation was provided to countries to enhance national capacity. Additionally, there is a continued need for modeling and forecasting to identify health trends and develop interventions to adequately address them. Human resources will be allocated in the next biennium to ensure that this area of expertise is met at the regional and country levels.
- Stigma and discrimination increase toward persons with HIV.
    - Stigmatization of and discrimination toward key populations affected by the HIV epidemic is an ongoing challenge. An increased focus on combination HIV prevention, and the approval of the stigma and discrimination targets in the Region, provided opportunities to address these issues.
- NIDs continue to be given very low priority in the government agendas of certain countries and partners.
    - As mentioned in the lessons learned above, effective coordination between PAHO, WHO, and key strategic partners enabled support to governments addressing NIDs through the development and implementation of national and subnational health plans. This fostered country ownership and allowed the Region to move forward with actions to control and eliminate NIDs. As a new plan of action on NIDs is presented to PAHO Governing Bodies in 2016 and rolled out in the Region, best practices for elevating the topic of NIDs in government agendas should be shared and applied, particularly in light of regional elimination goals.
- There is a shortage of drugs and biologicals used to treat NIDs and zoonotic diseases in the Region, resulting from insufficiency of available raw materials.
    - In some countries, shortages of biologicals used to treat rabies (e.g., dog/human vaccines, PEP treatments) have sometimes occurred as a result of inadequate vaccine production technology. Mitigation actions include the procurement of modern rabies vaccines through the PAHO Revolving Fund, as well as advocacy and technical cooperation actions to promote the production of modern rabies vaccines (e.g., cell culture).
- Investment in immunization activities is low or insufficient, putting the goal of universal coverage in jeopardy.
    - Although this remains a challenge, there is a commitment from countries to provide high-quality vaccines to those most in need, as demonstrated by the participation of 41 countries in the Revolving Fund for Vaccine Procurement. Purchases of vaccines and biological products represent an investment of more than $1 billion.

New risks introduced during the biennium:

- The unpredictable occurrence of health emergencies or disasters has the ability to derail ongoing planning and implementation efforts.
    - This risk presented in the context of emerging infectious disease outbreaks, especially of Ebola and Zika. An inter-programmatic response by the Organization addressed the increasing demands of the countries for support in their preparedness and response efforts and helped prevent the burden of the response from falling on one department only. It is important that lessons learned from the Organization's response to these outbreaks be documented in order to improve actions to mitigate

such situations in the future.

- The elimination of dog-mediated human rabies will not be achieved by 2015.
  - As previously mentioned, the elimination goal was not achieved by 2015 due to various factors, including insufficient commitment by some national authorities to sustain rabies control efforts. However, technical cooperation with key countries (e.g., Bolivia, Haiti) was strengthened to enhance national capacity. The main strategies to achieve elimination by 2019 are the implementation of the Action Plan for the Elimination of Human Rabies Transmitted by Dogs, approved by REDIPRA 14 and reaffirmed by REDIPRA 15, as well as efforts to enhance high-level advocacy in priority countries to increase their commitment to elimination.

Budget Implementation Analysis

Based on the financial information provided in Table 1 above, Category 1 mobilized over $85 million during 2014-2015 through joint efforts across all functional levels of the Organization. Overall, a total of 94% of awarded funding was executed by the end of 2015, and 92% of funding was implemented when compared to the PB 14-15 approved budget, thus meeting the budgetary implementation target for the biennium.

Further budgetary analysis by program area demonstrates that the amount of awarded funding for three program areas, namely, 1.2 (tuberculosis), 1.3 (malaria and other vector-borne diseases), and 1.4 (neglected, tropical, and zoonotic diseases), greatly exceeded the approved budget estimates, with high levels of execution against awarded funding and the approved PB 14-15. While only $3.9 million was approved in the PB 14-15 for Program Area 1.2, a total of $6.7 was awarded, with 97% of that amount implemented during the biennium. Based on this scenario, retrospective budgetary analysis for this area, and ongoing collaboration with key donor partners, it is clear that the awarded funding levels in 2014-2015 correspond to the true budget for tuberculosis. In regard to Program Area 1.3, the budget for the Strategy and Plan of Action for Malaria 2011-2015, which guided PAHO malaria efforts in the Region, included an important component to support strong malaria advocacy and resource mobilization efforts; these have been pursued successfully, as evidenced by a significant increase in external malaria funds channeled through PAHO. As far as Program Area 1.4, resource mobilization and high execution of funding were facilitated by frequent analysis of funding gaps and of financial implementation, combined with a high level of commitment among donors and partners, including WHO headquarters, to the control and elimination of NIDs in the Region.

Table 1 also highlights important funding gaps in Program Areas 1.1 and 1.5. One reason for this is the potential overestimation of initial PB 14-15 funding levels, which included human resources that were not pursued, given limited funding. Additionally, challenges were encountered in mobilizing resources for certain technical programs within these program areas, such as STIs, HIV/STI strategic information, the ProVac Initiative, and the monitoring of vaccine coverage.

Table 3. Category 1 Budget Overview by Program Area and Functional Level

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
1. Communicable Diseases	**85.32**	**100.00**	**80.01**	**93.8**
1.1 HIV/AIDS and STIs	**12.65**	**14.83**	**11.85**	**93.7**
Country	4.01	4.70	4.00	99.7
Intercountry	2.60	3.05	2.39	91.7
Subregional	0.69	0.81	0.63	91.8
Regional	5.34	6.26	4.83	90.4

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
1.2 Tuberculosis	**6.74**	**7.90**	**6.53**	**96.9**
Country	1.82	2.14	1.77	97.0
Intercountry	1.38	1.62	1.34	97.0
Subregional	0.30	0.41	0.34	96.9
Regional	3.18	3.73	3.08	96.9
1.3 Malaria and Other Vector-borne Diseases (including Dengue and Chagas)	**11.37**	**13.33**	**11.02**	**96.9**
Country	5.30	6.22	5.20	98.0
Intercountry	1.67	1.95	1.60	96.0
Subregional	0.44	0.52	0.43	96.1
Regional	3.96	4.64	3.80	96.0
1.4 Neglected, Tropical, and Zoonotic Diseases	**14.46**	**16.95**	**12.89**	**89.1**
Country	3.32	3.90	3.27	98.2
Intercountry	7.41	8.68	6.09	82.2
Subregional	0.40	0.47	0.38	95.1
Regional	3.33	3.91	3.15	94.6
1.5 Vaccine-Preventable Diseases (including Maintenance of Polio Eradication)	**40.09**	**46.99**	**37.71**	**94.1**
Country	14.03	16.45	13.07	93.1
Intercountry	7.05	8.26	6.66	94.5
Subregional	2.28	2.67	2.18	95.5
Regional	16.73	19.61	15.81	94.5

Across the functional levels of the Organization (Table 2), the percentages of Category 1 awarded funding allocated to the country, intercountry, subregional, and regional levels were 33%, 24%, 5%, and 38%, respectively. Implementation of awarded funding at the country (96%), intercountry (90%), subregional (95%), and regional (94%) levels was very high at the end of 2015. As highlighted in Table 3, similar allocation and implementation trends across functional levels also occur at the program area level. Additional analysis has been conducted to further understand these trends in allocation. In general, main contributors to the higher allocation at the intercountry and regional levels include the significant number of regional, PAHO Center (PANAFTOSA), decentralized, and country staff currently under the regional/intercountry budget ceiling, as well as a substantial level of regionally allocated resources that directly benefit countries through the provision of capacity-building activities, monitoring and evaluation exercises, and technical cooperation missions, among others. It is important to consider the intricacies of the funding mechanisms used to mobilize resources, which require that funding be channeled primarily through the regional level, e.g., the funding through United States Agency for International Development (USAID).

Resource Mobilization

Category 1 successfully mobilized $85 million to advance toward the goal of reducing the burden of communicable diseases in the Region. Funding was successfully mobilized through strong alliances with the Bill & Melinda Gates Foundation (immunization, malaria); US Centers for Disease Control and Prevention (HIV, immunization); Global Fund to Fight AIDS, Tuberculosis and Malaria (HIV, TB, malaria); Government of Brazil (hepatitis, leptospirosis, NIDs, rabies, zoonosis); Mexican Agency for International Development Cooperation, AMEXCID (malaria); PAHO Foundation (dengue); UNAIDS Unified Budget, Results and Accountability Framework, UBRAF (HIV, MDR-TB, TB);

UNICEF (EMTCT); USAID (immunization, TB, malaria, NIDs); and WHO (Chagas, leishmaniasis, leprosy, malaria, NIDs, polio, TB).

Although the funding awarded to Program Areas 1.2 (TB), 1.3 (malaria and other vector-borne diseases), and 1.4 (NIDs) exceeded the approved budget, this should not mask the fact that several programs (e.g., dengue, Chagas, NIDs, rabies/zoonosis) require additional resources to obtain satisfactory results. For those areas already underfunded, such as Program Area 1.1, drastic cuts in funding that traditionally supported core activities have already been communicated to PAHO (e.g., a 50% cut in UNAIDS/UBRAF funding for HIV/STI). This results in a significant funding gap for the program area.

The prioritization ranking carried out by countries may have played a role to some degree in resource mobilization efforts across program areas. The low amount budgeted for Program Area 1.2 during the biennium can potentially be explained by its medium-level priority ranking (Tier 2). However, given the program's ability to mobilize resources and the number of countries requesting technical cooperation, a larger estimated budget was requested for 2016-2017, consistent with historical numbers for mobilization and implementation. In regard to Program Area 1.3, the budget for the Strategy and Plan of Action for Malaria 2011-2015 was conceptualized and proposed in such a way as to make the programs scalable (i.e., targets could be achieved more quickly and effectively given additional resources). In addition to the high level of priority (Tier 1) given by countries, an important contributor to successful malaria resource mobilization efforts was the Malaria Champions of the Americas, which documented best practices among countries and demonstrated that targets can be achieved when technical and financial investments from both internal (country) and external contributors are sufficient to bridge the gaps. Although Program Area 1.4 (NIDs) was ranked as low priority (Tier 3) by the countries, there is a strong global alliance working to reach established elimination goals. Effective coordination between PAHO/WHO and key partners and stakeholders, aimed at encouraging and supporting governments to address NIDs, allowed the Region to move forward with actions to control and eliminate these debilitating diseases.

Recommendations

- Consider the development of a robust public health-based elimination agenda, including elimination of viral hepatitis B and C as a public health threat by 2030, as indicated in WHO's Global Health Sector Strategy on Viral Hepatitis, 2016-2021, and in the PAHO Plan of Action for Prevention and Control of Viral Hepatitis (2015). Sustained interdepartmental collaboration and significant investment will be needed to pursue that goal. A PAHO elimination agenda should address selected infectious diseases (HIV, tuberculosis, hepatitis C virus, neglected tropical diseases) and build upon the well-established EMTCT platform to add other infections that are vertically transmitted, such as the hepatitis B virus and Chagas in endemic areas (Phase-2 EMTCT or EMTCT+).
- Address the shortage of benzathine penicillin G (BPG) by advocating among vaccine manufacturers and other parties in global forums and high-level meetings to scale up production. Through functional inter-programmatic collaboration, and in partnership with WHO, a regional assessment of the status of the BPG shortage, including stock-outs and projected demands for 2016, was finalized. The PAHO Strategic Fund (SF) is currently supporting one country with an emergency procurement of BPG, and in response to the findings of the survey, is proactively contacting the other four that reported stock-outs to explore their interest in using the SF mechanism for future purchases. Furthermore, the SF is mapping regional capacity for the production of BPG and exploring eligible manufacturers in the Region that could scale up production to help supply BPG to countries to mitigate future shortages.
- Further expand the initiative for TB control in large cities, which has been successfully implemented and

expanded during this biennium. The initiative can be widened to include additional programs such as HIV, diabetes, and mental health, among others.

- Reinforce human resources in the Caribbean and at the regional level (PAHO headquarters) to address the sudden decrease of resources from UBRAF, which has generated a significant financial gap in HIV/STI planning.
- Support approval and implementation of the Plan of Action for Malaria Elimination 2016-2020, which is currently under development and is scheduled for presentation to the 158th session of the Executive Committee in June 2016. The current draft is the result of a process initiated at the PAHO/AMRO Regional Consultations on the Global Technical Strategy for Malaria 2016-2030 and the Action and Investment to Defeat Malaria 2016–2030 (AIM) in April 2014. This was followed by consultations with partners and stakeholders during multiple country visits and technical meetings, and by the October 2015 Regional Consultation on the Development of the Plan of Action for Malaria Elimination 2016-2020.
- Advocate with ministries of health and agriculture to commit the necessary resources for the elimination of dog-mediated human rabies in high-risk countries (Bolivia, Haiti, Nicaragua, and Peru) that continue to present challenges.
- Support the streamlining and strengthening of coordination between Universal Health Coverage and priority programs by carrying out and communicating a common and consistent message to the Member States for operational strengthening of health services (including community-based services).
- Continue supporting high-level dialogue and negotiations with manufacturers to maintain or obtain best prices for vaccines (especially new vaccines), with the participation of key stakeholders.

Assessment by Program Area

Program Area 1.1: HIV/AIDS and Sexually Transmitted Infections **OUTCOME: Increased access to key interventions for HIV and STI prevention and treatment** OCM Indicator Assessment: 3/3 In Progress OPT Indicator Assessment: 2/4 Achieved, 2/4 Partially Achieved	**Rating: Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[2, 3]
1.1.1	Number of countries and territories that have 80% coverage of antiretroviral therapies (ART) in eligible populations	6	22	In progress (7 achieved + 14 in progress)

Seven countries and territories achieved the indicator: BMU, BRB, CUB, CUW, SAB, STA, SXM.

Additionally, 14 countries and territories are in progress to achieve this indicator: ABW, ARG, BHS, BON, CHL, CRI, DOM, ECU, GUY, JAM, PAN, PER, PRY, TTO.

In 2013, WHO modified the guidelines for antiretroviral treatment initiation by recommending ART for all adults with HIV and a CD4 count at or below 500 cells/mm3. In 2015, WHO recommended a treat-all approach regardless of CD4 count. These new guidelines increased the denominator of eligible patients and therefore decreased national coverage of ART in many countries. Nevertheless, Latin America and the Caribbean continues to be the world region with the highest ART coverage (46% of all persons estimated to be living with HIV). Currently no Member State or associate country in the Region has reached the target of 80% coverage (two territories have done so, Saba and Bermuda). However, most countries have updated their guidelines based on the 2013 WHO guidelines, and a few are adopting a treat-all approach (Argentina, Brazil, Mexico). Achieving 80% ART coverage in 22 countries by 2019 will be a challenge, but access to ARV drugs at lower prices has been expanding as a result of joint procurement through the PAHO Strategic Fund and Global Fund procurement mechanisms. Technical cooperation with countries is under way to improve efficiency and effectiveness of service provision and possibly achieve the target set in the Strategic Plan.

[2] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached.
- **In progress:** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way/on track to achieve the target set in the Strategic Plan by 2019.
- **No progress**: There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and progress toward achieving the indicator target by 2019 could be in jeopardy.

[3] The regional indicators are assessed by the responsible regional entity/Category and Program Area Network (CPAN) based on the latest available information, according to criteria defined in the compendium of indicators.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress*
1.1.2	Number of countries and territories with at least 95% coverage of HIV prophylaxis treatment for prevention of mother-to-child transmission of HIV	0	24	In progress (14 achieved + 9 in progress)

Fourteen countries and territories achieved the indicator: ABW, AIA, BMU, BON, BRB, CHL, CUB, CUW, DMA, GRD, SAB, SLV, STA, VCT. Confirmation from one country was pending at the time of this report.

An additional nine countries and territories are in progress: BLZ, CAN, COL, GUY, HND, MEX, PER, USA, VEN.

The number and percentage of pregnant women with HIV who receive antiretrovirals has increased every year. In 2014, 81% [69%-95%] of HIV-positive pregnant women in low- and middle-income countries in the Region received antiretroviral therapy for the prevention of mother-to-child transmission of HIV. This is 43% more than five years ago, with coverage that increased from 56% [48%-66%] in 2010 to 81% in 2014. Coverage in 2014 was 78% [64%-94%] in Latin America, and 89% [78%-95%] in the Caribbean. According to the 2015 report on EMTCT using country-reported data, at of the end of 2014, 11 countries reported ART coverage greater than 95%, showing progress toward the target of 24 in 2019.

1.1.3	Number of countries and territories with at least 95% coverage of syphilis treatment in pregnant women	0	22	In progress (10 achieved + 9 in progress)

Ten countries and territories achieved the indicator: AIA, BMU, BON, BRB, CUB, CUW, DMA, GRD, HND, SAB.

An additional nine countries and territories are in progress: BLZ, CHL, COL, GUY, MEX, PER, SLV, VCT, VEN.

Confirmation of the final assessment from two countries was pending at the time of this report.

According to the 2015 report on EMTCT, more than half of the countries in the Region (56% or 29/52) reported on the treatment of syphilis-positive pregnant women in 2014, six more than in 2010. The figures range from 50% to 100%, with an estimated regional value of 85% coverage of syphilis treatment in pregnant women.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating[4, 5]
1.1.1	Implementation and monitoring of the regional HIV/STI plan through technical cooperation at the regional and national levels	Number of countries and territories implementing the national HIV/STI strategies in accordance with the WHO Global health sector strategy on HIV/AIDS 2011-2015 and the regional HIV/STI plan for the health sector 2006-2015	8	27	Partially achieved (21 achieved + 6 partially achieved)
Twenty-one countries and territories achieved the indicator: AIA, ABW, BMU, BOL, COL, CUW, DMA, DOM, HND, HTI, JAM, KNA, MEX, PRY, PER, SAB, SLV, STA, SUR, TTO, VGB. Confirmation from one country was pending at the time of this report. Another six countries partially achieved the indicator: BHS, BON, ECU, GTM, GUY, VEN. The countries worked in collaboration with PAHO to adapt and translate global and regional strategies into national strategies that reflect country specificities. Countries have disseminated updated national strategies to relevant health institutions and have provided training to the public and private sectors. Country progress is documented by regional reporting and by the midterm review of the current HIV/STI Plan of Action. These demonstrate that countries have adopted the four flagships of the current HIV/STI plan within their national strategies, suggesting close alignment with the Regional Plan. In addition, through two regional forums, 26 countries endorsed the global 90-90-90 treatment targets (Mexico, 2014), and 23 countries endorsed the updated HIV prevention targets (Brazil, 2015). This resulted in updates to their national strategic plans, aligning them with the post-2015 response and the UN Sustainable Development Goals.				
1.1.2	Adaptation and implementation of the most up-to-date norms and standards in preventing and treating pediatric and adult HIV infection, integrating HIV and other health programs, and reducing inequities	Number of countries and territories that have adopted/adapted the WHO 2013 guidelines on the use of antiretroviral therapies (ART) for the treatment and prevention of HIV infection	10	31	Exceeded (33 achieved + 5 partially achieved)
Thirty-three countries and territories achieved the indicator: ABW, ARG, ATG, BLZ, BMU, BOL, BON, BRA, BRB, COL,					

[4] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set in the Program and Budget (PB) 2014-2015 (number of countries/territories, number or % for regional indicators) has been reached. Indicator targets that have been exceeded are noted as such.
- **Partially achieved**: Progress was made over the baseline value set in the PB (number of countries/territories, number or % for regional indicators), but the target for 2015 was not achieved.
- **No progress:** There was no increase over the baseline value set in the PB (number countries/territories, number or % for regional indicators).

[5] The regional indicators are assessed by the responsible regional entity/CPAN based on the latest available information, according to criteria defined in the compendium of indicators.

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating[4, 5]
CRI, CUB, CUW, DMA, DOM, ECU, GRD, GTM, GUY, HND, HTI, JAM, KNA, LCA, MEX, PAN, PER, PRY, SLV, STA, URY, VCT, VEN. Confirmation from ten countries was pending at the time of this report. Five countries and territories partially achieved the indicator: BHS, SAB, SXM, TCA, TTO. Another three target countries are in the process of adapting their national guidelines based on the WHO 2013 recommendations (ART initiation criteria of CD4 ≤500): Bahamas, Dominican Republic, and Trinidad and Tobago.					
1.1.3	Facilitation of development, implementation, and monitoring of national strategies for the prevention and control of sexually transmitted infections	Number of countries and territories that have updated their STI strategy based on global or regional recommendations	26	34	Partially achieved (16 achieved + 12 partially achieved)
Sixteen countries and territories achieved the indicator: ARG, BMU, BRA, CAN, COL, CUB, CUW, DMA, HND, JAM, MEX, NIC, PAN, PER, URY, VEN. Confirmation from one country was pending at the time of this report. An additional 12 countries and territories partially achieved the indicator: BHS, BLZ, BOL, CHL, DOM, GTM, GUY, HTI, SAB, SLV, STA, TTO. The development of STI strategies in the Region has been guided by the Global Strategy for the Prevention and Control of STIs. Technical assistance on STIs has been provided through opportunities linked with HIV, as few specific investments in STIs exist in the Region, with the exception of the Gonococcal Antimicrobial Surveillance Programme (GASP).					
1.1.4	Updating and implementation of national plans of action for the elimination of mother-to-child transmission of HIV and congenital syphilis	Number of countries and territories implementing a national plan of action for the elimination of mother-to-child transmission of HIV and congenital syphilis	35	39	Achieved (39 achieved + 2 partially achieved)
Thirty-nine countries and territories achieved the indicator: ABW, AIA, ARG, ATG, BHS, BLZ, BMU, BON, BRA, BRB, BOL, CHL, COL, CRI, CUB, CYM, DMA, DOM, ECU, GRD, GTM, GUY, HND, HTI, JAM, KNA, LCA, MEX, MSR, NIC, PAN, PRY, SLV, SUR, TTO, URY, VCT, VEN, VGB. Confirmation from three countries was pending at the time of this report. Additionally, two countries partially achieved the indicator: PER, TCA. In 2014, a total of 34 countries and territories had national plans to eliminate MTCT of HIV, in some cases combined with plans for the elimination of congenital syphilis.					

Program Area 1.2: Tuberculosis **OUTCOME: Increased number of tuberculosis patients successfully diagnosed and treated** OCM Indicator Assessment: 2/3 In Progress, 1/3 No Progress OPT Indicator Assessment: 1/3 Achieved, 2/3 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
1.2.1	Cumulative number of TB bacteriologically confirmed patients successfully treated in programs that have adopted the WHO-recommended strategy since 1995	1.45 million patients	2.50 million patients	In progress (1.85/2.50 million)
The number of successfully treated new TB cases in 2013 was 201,000. When these are combined with 202,000 in 2012, 403,000 additional cases have been successfully treated since the baseline calculation in 2012. This shows progress in the Region toward achieving the outcome indicator. The data are available two years following the treatment status, presenting a limitation in measuring the indicator for treatment success in 2015.				
1.2.2	Annual number of tuberculosis patients with confirmed or presumptive MDR-TB, based on WHO definitions (2013), including rifampicin-resistant cases, placed on MDR-TB treatment in the Americas	2,960 patients	5,490 patients	In progress (3,568 patients)
A total of 3,568 MDR-TB patients were placed on treatment in the Region in 2014. Analysis of 2015 data is currently being finalized.				
1.2.3	Percentage of new TB patients diagnosed in relation to the total number of TB incident cases	79%	90%	No progress (77%)
In 2014, the case detection rate for the Region was 77%. Despite noted progress in countries, this represents a slight decline. One possible explanation is related to how WHO updates estimates of the TB burden in the Region. In the first semester of 2016, the Regional TB program has planned a meeting to review these estimates.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
1.2.1	Countries enabled to implement new diagnostic approaches and tools to strengthen TB diagnosis	Number of countries and territories implementing WHO-recommended rapid diagnostic for TB	11	27	Achieved (26 achieved + 2 partially achieved)
Twenty-six countries and territories achieved the indicator: ARG, BRA, BON, CAN, CHL, COL, CRI, CUW, DMA, DOM, ECU, GTM, GUY, HND, HTI, MEX, NIC, PAN, PER, PRY, PRI, SLV, SUR, URY, USA, VEN. Confirmation from six countries was pending at the time of this report. Additionally, two countries partially achieved the indicator: BLZ and JAM. According to the WHO Global Tuberculosis Report 2015, as well as mission reports and information communicated by countries, 25 countries are implementing rapid diagnostic technologies for TB. The Region has made significant					

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
progress in procurement and implementation of GeneXpert, as well as other rapid diagnostic methods, although full rollout has been slower than anticipated in several countries.					
1.2.2	Policy guidance and technical guidelines updated to strengthen country capacity for early diagnosis and treatment of MDR-TB patients	Number of countries and territories implementing WHO guidelines for early diagnosis and treatment of MDR-TB	16	28	Partially achieved (24 achieved + 8 partially achieved)
Twenty-four countries and territories achieved the indicator: BHS, BMU, BON, BRB, CAN, CHL, COL, CRI, CUB, CUW, DMA, DOM, ECU, GRD, HND, HTI, MEX, NIC, PER, PRI, PRY, SLV, URY, VEN. Confirmation from four countries was pending at the time of this report. Another eight countries partially achieved the indicator: ARG, BOL, GTM, GUY, JAM, PAN, SUR, TTO. According to the Global Tuberculosis Report 2015, as well as mission reports and information communicated by Member States, a total of 23 countries and territories have updated their MDR-TB guidelines according to latest WHO recommendations. Six Caribbean countries (Bahamas, Barbados, Bermuda, Dominica, Grenada, Jamaica) updated their guidelines for early diagnosis and treatment of MDR-TB following Caribbean Public Health Agency (CARPHA) guidelines, which mirror WHO guidelines. Technical support has been provided by PAHO/WHO at regional, subregional, and country levels, as well as through monitoring and evaluation visits by the Regional Green Light Committee (rGLC).					
1.2.3	Policy guidance and technical guidelines updated to strengthen country capacity for early diagnosis and treatment of TB-HIV patients	Number of countries and territories implementing WHO guidelines for early diagnosis and treatment of TB-HIV	20	33	Partially achieved (23 achieved + 5 partially achieved)
Twenty-three countries and territories achieved the indicator: ABW, ARG, BMU, BOL, BON, BRA, BRB, CHL, COL, CUW, DMA, DOM, GRD, GUY, HND, JAM, MEX, NIC, PER, PRY, SLV, TTO, VEN. Confirmation from one country was pending at the time of this report. An additional five countries partially achieved the indicator: ECU, GTM, LCA, PAN, VCT. Countries are updating and implementing their TB-HIV guidelines according to the latest WHO recommendations. At regional level, the clinical TB-HIV guidelines are being updated and will further support this process into the 2016-2017 biennium. Strong collaboration between TB and HIV programs at all levels is still needed.					

Program Area 1.3: Malaria and Other Vector-borne Diseases (including Dengue and Chagas) **OUTCOME: Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of malaria and other vector-borne diseases** OCM Indicator Assessment: 1/4 Achieved, 3/4 In Progress OPT Indicator Assessment: 3/5 Achieved, 2/5 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
1.3.1	Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy (based on PAHO/WHO recommendations)	85%	95%	Exceeded (100%)
Based on the information managed in the regional malaria database, 100% of confirmed malaria cases in the public sector are receiving first-line antimalarial treatment. Current information is based on figures reported directly by countries to PAHO, with the assumption that stock-outs and supply chain management issues are addressed accordingly. Coordination is ongoing with the WHO Global Malaria Programme to identify an alternative method that could be used to track this indicator, given the possible challenges in the system.				
1.3.2	Number of countries and territories with installed capacity to eliminate malaria	10	21	In progress (16 achieved + 4 in progress)
Sixteen countries and territories achieved the indicator: ABW, ARG, BLZ, BMU, BOL, COL, CRI, CUW, GTM, HND, JAM, MEX, PAN, PRY, SLV, SUR. Confirmation from three countries was pending at the time of this report. Another four countries are in progress to achieve this indicator: DOM, ECU, HTI, NIC. Countries have made some important progress in strengthening national malaria programs, including the implementation of key diagnosis, treatment, and surveillance interventions, in both public and private sectors. Progress has also been made in harnessing the necessary political commitment and engagement of stakeholders, per WHO guidelines (2012).				
1.3.3	Number of countries and territories with installed capacity for the management of all dengue cases	14	30	In progress (18 achieved + 12 in progress)
Eighteen countries and territories achieved the indicator: BHS, BMU, BON, BRA, COL, CRI, CUW, DMA, GUY, HND, JAM, MEX, PAN, SAB, SLV, SXM, TTO, VEN. Additionally, 12 countries and territories are in progress to achieve this indicator: ABW, ARG, BOL, DOM, ECU, GTM, KNA, NIC, PER, PRI, PRY, STA. The second edition of the dengue clinical guidelines has been a key tool for training health workers in countries on the proper management of dengue cases throughout the Region. Following the dissemination of the 2009 WHO dengue classification and implementation of several clinical trainings, carried out in collaboration with the International Dengue Task Force (GT-Dengue), a decrease of 28% (from 0.07% to 0.05%) in the dengue case fatality				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
rate was observed in the Americas. However, one of the challenges highlighted by countries, which will be particularly relevant in the next biennium, is how to modify services to include the management of chikungunya and Zika virus cases.				
1.3.4	Number of countries and territories where the entire endemic territory or territorial unit has a domestic infestation index (by the main triatomine vector species or by the substitute vector, as the case may be) of less than or equal to 1%	17	21	In progress (15 achieved + 5 in progress)
Fifteen countries and territories achieved the indicator: BRA, CHL, COL, CRI, GTM, GUF, GUY, HND, MEX, NIC, PAN, PER, PRY, SLV, URY. Confirmation from six countries was pending at the time of this report. Another five countries are in progress to achieve this indicator: ARG, BLZ, BOL, ECU, SUR. Confirmation from one country was pending at the time of this report. Countries and territories that achieved this indicator made efforts to interrupt vector-borne home transmission (domestic infestation index less than or equal to 1%) in all of their endemic territories and maintain this achievement. The countries in progress interrupted vector-borne home transmission in some of their territories. In order to advance in this indicator, enabling policies and additional resources will be needed.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
1.3.1	Countries enabled to implement malaria strategic plans, with focus on improved diagnostic testing and treatment, therapeutic efficacy, and monitoring and surveillance	Number of malaria-endemic countries and territories in which an assessment of malaria trends is being undertaken using routine surveillance systems	22	25	Achieved (25 achieved)
Twenty-five countries and territories achieved the indicator: ABW, ARG, BLZ, BOL, BRA, COL, CRI, CUW, DOM, ECU, GLP, GTM, GUF, GUY, HND, HTI, MEX, MTQ, NIC, PAN, PER, PRY, SLV, SUR, VEN. Confirmation from five countries was pending at the time of this report. A total of 25 endemic and nonendemic countries for malaria achieved the indicator and continue to reinforce their routine malaria information systems as part of their official commitment/aspiration to achieve malaria elimination. Additionally, official malaria reports are shared with PAHO annually, including reports of imported malaria cases.					
1.3.2	Updated policy recommendations and strategic and technical guidelines on vector control diagnostic testing, antimalarial treatment, integrated management of	Number of malaria-endemic countries and territories that are applying malaria strategies to move toward elimination based on WHO criteria	9	18	Achieved (18 achieved)

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
	febrile illness, surveillance, epidemic detection, and response				
Eighteen countries and territories achieved the indicator: ARG, BLZ, COL, CRI, DOM, ECU, GTM, GUY, HND, HTI, MEX, NIC, PAN, PER, PRY, SLV, SUR, VEN. Confirmation from five countries was pending at the time of this report. These countries and territories continue to intensify and reinforce their efforts to attain malaria elimination by focusing on vulnerable populations, strengthening malaria case management, and providing training that can be replicated in other countries.					
1.3.3	Implementation of the new PAHO/WHO dengue classification to improve diagnosis and treatment within the framework of IMS-Dengue and the WHO Global Strategy for 2012-2020	Number of countries and territories implementing PAHO/WHO-recommended strategies to improve comprehensive dengue epidemiological surveillance and patient management	12	29	Exceeded (32 achieved + 2 partially achieved)
Thirty-two countries and territories achieved the indicator: ABW, AIA, ARG, ATG, BOL, BON, BRA, BRB, COL, CRI, CUW, DMA, DOM, ECU, GTM, GUY, HND, JAM, KNA, LCA, MEX, NIC, PAN, PER, PRY, SAB, SLV, STA, SXM, VCT, VEN, VGB. Confirmation from six countries was pending at the time of this report. An additional two additional countries and territories partially achieved the indicator: GRD, MSR. The implementation of the new PAHO/WHO dengue classification to improve diagnosis and treatment, within the framework of IMS-Dengue and the WHO Global Strategy for 2012-2020, is under way throughout the Region, utilizing a subregional training modality. Countries are strengthening their epidemiological surveillance systems with the support of GT-Dengue and the Dengue Collaborating Centers. This has contributed to a reduction in the case fatality rate from 0.07% to 0.05% between 2010 and 2014.					
1.3.4	Implementation of the Strategy and Plan of Action for Chagas Disease Prevention, Control and Care	Numbers of countries and territories that have established integrated control programs for Chagas in the endemic territorial units where the transmission is domiciliary	17	21	Partially achieved (17 achieved + 1 partially achieved)
Seventeen countries and territories achieved the indicator: ARG, BOL, BRA, CHL, COL, CRI, GTM, GUF, GUY, HND, MEX, NIC, PAN, PER, PRY, SLV, URY. Confirmation from one country was pending at the time of this report. Additionally, one country partially achieved the indicator: SUR. Confirmation of the final assessment from three countries was pending at the time of this report. Countries in the Region have established integrated national control programs for Chagas that are integrated with promotion, prevention, control, and primary health care, including subregional initiatives. Also, four subregional initiatives are fully operational.					

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
1.3.5	Endemic countries enabled to strengthen their coverage and quality of care for patients infected with *Trypanosoma cruzi*	Number of endemic countries and territories implementing national plans of action to expand coverage and quality of care for patients infected with *Trypanosoma cruzi*	18	21	Partially achieved (10 achieved + 9 partially achieved)

Ten countries and territories achieved the indicator: ARG, CHL, CRI, GTM, GUF, HND, MEX, NIC, PAN, URY. Confirmation from one country was pending at the time of this report.

An additional nine countries partially achieved the indicator: BLZ, BOL, BRA, COL, ECU, PER, PRY, SLV, SUR. Confirmation from two countries was pending at the time of this report.

Confirmation of the final assessment from two countries was pending at the time of this report.

There has been a gradual increase in the coverage and quality of care for patients infected by *T. cruzi.* Progress achieved in endemic countries includes notification of cases, documentation of congenital Chagas, outbreak detection and management, and the procurement and use of medicines.

Program Area 1.4: Neglected, Tropical, and Zoonotic Diseases **OUTCOME: Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of neglected, tropical, and zoonotic diseases** OCM Indicator Assessment: 8/8 In Progress OPT Indicator Assessment: 2/5 Achieved, 3/5 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
1.4.1	Number of countries with annual increase in the proportion of diagnosed and treated cases of leishmaniasis, per the recommended treatment in the PAHO/WHO guidelines	0	12	In progress (2 achieved + 10 in progress)

Two countries achieved the indicator: BRA, MEX.

An additional 10 countries are in progress to achieve the indicator: ARG, BOL, COL, GTM, HND, NIC, PAN, PER, PRY, SLV.
Both Brazil and Mexico achieved this indicator and will continue to work to strengthen access to diagnosis and treatment of leishmaniasis. The countries assessed as in progress are implementing activities to improve the diagnosis and treatment of the disease according to PAHO/WHO guidelines and are reporting available data to the Regional Information System of Leishmaniasis (SisLeish). Some challenges confronted by the countries include limited active surveillance in health services and shortages of medicines for treating the different clinical manifestations of the disease.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
1.4.2	Number of endemic countries and territories with high burden of leprosy that have reduced, by 35%, the rate of new cases with grade-2 disabilities per 100,000 population, as compared to their own baseline 2012 data	0/10	10/10	In progress (10 in progress)
Ten countries are in progress to achieve this indicator: ARG, BOL, BRA, COL, CUB, DOM, ECU, MEX, PRY, VEN. Confirmation from two countries was pending at the time of this report. Argentina, Brazil, Mexico, and Paraguay have made good progress toward achieving the target. Colombia, Cuba, the Dominican Republic, and Venezuela need to strengthen surveillance and intensify their efforts for early case detection. Bolivia and Ecuador need to strengthen their programs, including case detection and management. All countries need to improve the quality and coverage of disability assessment at diagnosis and their disability prevention programs. Technical cooperation will be provided in the next biennium to strengthen leprosy surveillance and information systems in the countries.				
1.4.3	Number of endemic countries having achieved the recommended treatment target coverage (65% or more) of population at risk of lymphatic filariasis	1/4	4/4	In progress (2 achieved + 2 in progress)
Two countries achieved the indicator: BRA, HTI. An additional two countries are in progress to achieve this indicator: DMA, GUY. Brazil is on track to achieve the elimination of lymphatic filariasis in its only active transmission focus, in the state of Pernambuco, within the next five years. Haiti's elimination program has made great progress under often difficult and challenging circumstances. Additional efforts are needed in the Dominican Republic and Guyana to sustain the coverage of treatment for the disease in endemic areas, including the implementation of mass drug administration rounds.				
1.4.4	Number of endemic countries having achieved the recommended treatment target coverage (85% or more for each round of treatment) of population at risk of onchocerciasis	1/2	2/2	In progress (1 achieved + 1 in progress)
One country achieved the indicator: BRA. An additional country is in progress to achieve the indicator: VEN. Confirmation of the final assessment from one country was pending at the time of this report. Brazil and Venezuela have reached the treatment coverage target in known endemic communities. However, Venezuela should reinforce actions to reach isolated, recently discovered communities, establish their onchocerciasis endemicity status, and plan the necessary interventions.				
1.4.5	Number of endemic countries having achieved the recommended treatment target coverage (80% or more) of population at risk of trachoma that could lead to blindness	0/3	3/3	In progress (1 achieved + 2 in progress)
One country achieved the indicator: COL. An additional two countries are in progress to achieve this indicator: BRA, GTM.				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
Confirmation of the final assessment from one country was pending at the time of this report. Brazil, Colombia, and Guatemala have reached the target treatment coverage in their known foci. However, it is recommended that Brazil reevaluate the epidemiological situation in several municipalities to redefine the number of people in need of treatment. Guatemala should evaluate the impact of the round of treatment completed in 2014 to determine whether additional treatment is needed. It is recommended that Colombia establish an operational plan to treat people in three new foci recently discovered.				
1.4.6	Number of endemic countries having achieved the recommended treatment target coverage (75% or more) of population at risk of schistosomiasis	0/2	2/2	In progress (2 in progress)
Two countries in progress for this indicator: BRA, VEN. Additionally, one country was pending confirmation at the time of this report. Brazil is achieving treatment coverage, but the criteria for treating people differ from WHO recommendations; an evaluation of the impact of those criteria should be done to ensure that the elimination goal will be reached. Venezuela has not reached the target coverage and therefore must continue efforts to achieve the minimum required coverage, as recommended by WHO, to tackle this disease and reach the elimination goal.				
1.4.7	Number of endemic countries having achieved the recommended treatment target coverage (75% or more) of population at risk of soil-transmitted helminthiasis	5/24	16/24	In progress (4 achieved + 8 in progress)
Four countries achieved the indicator: DOM, MEX, NIC, TTO. An additional eight countries are in progress to achieve this indicator: BOL, BRA, COL, ECU, GUY, HTI, PRY, SLV. Confirmation of the final assessment from three countries was pending at the time of this report. According to data on deworming received from 11 countries, 19.2 million school-age children at risk of infection were treated in 2014, equivalent to a regional coverage of 56.7% (46.7% in 2013). Additionally, more than 5 million preschool-age children at risk of infection were treated, reaching a regional coverage of 38.7%. Countries will continue working to increase the treatment target coverage of populations at risk of soil-transmitted helminthiasis.				
1.4.8	Number of countries and territories with established capacity and effective processes to eliminate human rabies transmitted by dogs	28	35	In progress (16 achieved + 12 in progress)
Sixteen countries and territories achieved the indicator: ARG, BLZ, BRB, CAN, CHL, CRI, CUB, HND, JAM, MEX, PAN, PRY, SLV, TTO, USA, URY. Additionally, 12 countries and territories are in progress to achieve the indicator: BHS, BOL, BRA, DOM, ECU, GRD, GTM, GUY, HTI, NIC, PER, VEN. Countries/territories have made significant progress in the establishment of capacities for the elimination of dog-mediated human rabies, including implementation of national vaccination campaigns, strengthening of surveillance in priority areas, and development of strategies on risk analysis. The Action Plan adopted during REDIPRA 14 and updated during REDIPRA 15 provides essential guidance for this process. However, countries continue to				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
experience some challenges in updating policies to facilitate this work and in operationalizing protocols related to surveillance.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
1.4.1	Implementation and monitoring of the WHO Roadmap for neglected infectious diseases (NIDs) through the Regional NID Plan	Number of endemic countries and territories implementing a national or subnational plan, program, or strategy to reduce the burden of priority NIDs according to their epidemiological status	6	11	Exceeded (12 achieved + 1 partially achieved)
Twelve countries achieved the indicator: BRA, COL, GTM, GUY, HND, HTI, MEX, NIC, PER, PRY, SLV, SUR. Confirmation from three countries was pending at the time of this report. One country partially achieved the indicator: VEN. Confirmation of the final assessment from five countries was pending at the time of this report. A total of 12 countries have NID plans, programs, or strategies in place. Additionally, six of these countries have launched NID integrated plans of action (Brazil, Colombia, El Salvador, Guatemala, Honduras, Nicaragua) and have already carried out some activities as part of their national efforts to tackle NIDs. Brazil and Venezuela have made significant progress in the formulation of an operational plan of action 2015-2016 for the elimination of onchocerciasis in the Yanomami area.					
1.4.2	Endemic countries enabled to establish integrated surveillance of leishmaniasis in human population	Number of endemic countries and territories that have integrated surveillance of human leishmaniasis	4	10	Partially achieved (8 achieved + 2 partially achieved)
Eight countries achieved the indicator: BRA, COL, MEX, NIC, PAN, PRY, SLV, VEN. Another two countries partially achieved the indicator: BOL, PER. Confirmation of the final assessment from four countries was pending at the time of this report. The eight countries that achieved this indicator in 2015 did so by providing updated information about surveillance of human leishmaniasis through the SisLeish information system. Although significant progress has been made, these countries should continue to enhance integrated surveillance and control actions.					
1.4.3	Implementation of the PAHO/WHO Plan of Action for the Elimination of Leprosy	Number of endemic countries and territories applying PAHO/WHO-recommended strategies for elimination of leprosy as a public health problem	18	23	Achieved (22 achieved + 2 partially achieved)

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
		at the first subnational administrative level			
Twenty-two countries and territories achieved the indicator: ABW, BOL, COL, CRI, CUB, CUW, DOM, ECU, GTM, GUY, HND, HTI, JAM, MEX, NIC, PAN, PER, SLV, SUR, TTO, URY, VEN. Confirmation from five countries was pending at the time of this report. Another two countries partially achieved the indicator: ARG, PRY. A total of 23 countries and territories report that they are applying and implementing PAHO/WHO recommended strategies for elimination of leprosy as a public health problem at the first subnational administrative level (departments, states, provinces, etc.). According to the latest available data (2014), 16 countries have reached the goal of eliminating leprosy as a public health problem (prevalence below 1 per 10,000 population) at the first subnational administrative level.					
1.4.4	Countries enabled to implement plans of action for the prevention, surveillance, control, and elimination of rabies	Number of countries and territories implementing the plans of action to strengthen rabies prevention, prophylaxis, surveillance, control, and elimination	30	37	Partially achieved (25 achieved + 6 partially achieved)
Twenty-five countries and territories achieved the indicator: ABW, ARG, BLZ, BMU, BOL, BRA, BRB, CAN, CHL, COL, CRI, CUB, CUW, GRD, GUY, HND, HTI, JAM, MEX, NIC, PRY, SLV, URY, USA, VEN. Additionally, six countries partially achieved the indicator: DOM, ECU, GTM, PAN, PER, TTO. There have been significant achievements in the implementation of rabies recommendations included in the action plan agreed during REDIPRA 14. Key countries (Bolivia, Haiti, Nicaragua, Peru) were prioritized when implementing actions to develop national plans against rabies, strengthen the immunization of dogs, train for post-exposure prophylaxis treatment, secure vaccines and reagents, develop materials for vaccination campaigns, create and disseminate educational materials, and so on. The first regional proficiency exercise for national rabies laboratories was executed, and innovative tools for canine rabies elimination (epidemiological model, smartphone application, virtual course, epidemiological alerts) were developed. REDIPRA 15 was organized, resulting in new recommendations that will guide PAHO/PANAFTOSA's work plan on the control and elimination of dog-transmitted human rabies for the next biennium. The regional rabies surveillance system, SIRVERA, was upgraded; the final version will be available to countries in early 2016. In addition, through the CaribVET Veterinary Public Health Working Group, a subregional regional survey on rabies was conducted in the Caribbean.					
1.4.5	Countries enabled to implement plans of action for strengthening zoonotic disease prevention, surveillance, and control programs	Number of countries and territories implementing plans of action to strengthen zoonosis prevention, surveillance, and control programs according to international standards	2	19	Partially achieved (10 achieved + 5 partially achieved)
Ten countries and territories achieved the indicator: ABW, BMU, BRA, CAN, GUY, MEX, PAN, SLV, USA, VEN. An additional five countries and territories partially achieved the indicator: BON, COL, PRY, PER, TTO.					

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
Confirmation of the final assessment from three countries was pending at the time of this report. A total of 10 countries and territories have completed a prioritized action plan for zoonotic diseases and developed a comprehensive surveillance system for priority zoonotic diseases. An additional four countries are in the process of drafting action plans to facilitate the implementation of intersectorial zoonosis actions and strengthen detection of and responses to zoonotic diseases. Additionally, technical cooperation was provided to countries (Argentina, Bolivia, Brazil, Chile, Nicaragua, Paraguay, Peru, Uruguay) to implement disease prevention and control interventions and strengthen zoonosis surveillance. A zoonosis survey was completed to identify country priorities and guide further support to countries. The promotion of One Health at the highest level of agriculture and health in Caribbean countries continued at the CaribVET Steering Committee and the CaribVET Veterinary Public Health Working Group meetings, as well as implementation of the second and third modules of the One Health Leadership Series. Support continued to the hydatidosis network through the implementation of its 2015 annual meeting and the publication by PANAFTOSA of the first epidemiological report on the situation of cystic echinococcosis in South America.					

Program Area 1.5: Vaccine-Preventable Diseases (including Maintenance of Polio Eradication) **OUTCOME: Increased vaccination coverage for hard-to-reach populations and communities and maintenance of control, eradication, and elimination of vaccine-preventable diseases** OCM Indicator Assessment: 1/4 Achieved, 2/4 In Progress, 1/4 No Progress OPT Indicator Assessment: 4/6 Achieved, 2/6 Partially Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
1.5.1	Regional average coverage with three doses of the diphtheria, tetanus, and pertussis (DPT)-containing vaccine	92%	94%	No progress (90%)
During the biennium, the Region has maintained regional average coverage rates above 90% thanks to the political and technical commitment of Member States to immunization programs that offer safe, effective, and affordable vaccines. Immunization coverage has been maintained and advanced in the majority of Member States in the Region. At the same time, however, the Region has witnessed a reduction in coverage. Some Member States have not shown the expected progress or have reported decreases in coverage for various reasons, including operational and financial challenges, thereby significantly affecting the average coverage of the Region. This calls to attention the situation of one country that reported a decrease in their coverage of vaccination of more than 15% between 2014 and 2015 compared to 2013 due to a change in their immunization registry systems. While such changes were considered as a good practice by the Strategic Advisory Group of Experts in Immunization in the evaluation of the Global Vaccination Action Plan, it significantly impacted the regional immunization coverage average. PAHO encourages countries to step up their efforts to ensure universal and equitable access to vaccination, as well as the use of quality vaccination data.				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
1.5.2	Number of countries and territories with reestablishment of endemic transmission of measles and rubella virus	0	0	In progress
The elimination of endemic transmission of rubella and congenital rubella syndrome (CRS) in the Region was declared in April 2015. Progress is also being made toward the elimination of measles, with the last case detected in Brazil in July 2015 (following the temporary reestablishment of endemic measles transmission in 2014). The Measles Elimination Verification Regional Report has been prepared and will be presented to the International Expert Committee for Measles and Rubella Elimination in the Americas (IEC) and the PAHO Directing Council in October 2016.				
1.5.3	Number of countries and territories that have introduced one or more new vaccines	34	51	In progress (37 achieved + 13 in progress)
Thirty-seven countries and territories achieved the indicator: ABW, ARG, ATG, BHS, BMU, BON, BRB, CAN, CHL, COL, CRI, CUB, CUW, CYM, DMA, ECU, GLP, GUF, GUY, HND, HTI, MEX, MTQ, NIC, PAN, PER, PRY, SAB, SLV, STA, SUR, TTO, URY, USA, VCT, VEN, VGB. An additional 13 countries and territories are in progress: AIA, BLZ, BOL, BRA, DOM, GTM, JAM, KNA, LCA, MSR, PRI, SXM, TCA. Confirmation from two countries was pending at the time of this report. Confirmation of the final assessment from one other country was pending at the time of this report. Countries worked in collaboration with PAHO to introduce new vaccines into national immunization schedules based on the latest evidence available, including data generated by 18 sentinel hospitals in eight countries as well as cost-benefit analysis. The primary new vaccines introduced include human papillomavirus vaccine (HPV), pneumococcal conjugate vaccine (PCV), rotavirus vaccine, and inactivated polio vaccine (IPV). Additionally, the Revolving Fund led successful negotiations with manufacturers to ensure that HPV vaccines were available to countries at reduced prices.			
1.5.4	Number of countries and territories reporting cases of paralysis due to wild or circulating vaccine-derived poliovirus (cVDPV) in the preceding 12 months	0	0	Achieved
All countries maintain surveillance of acute flaccid paralysis cases, and PAHO monitors quality surveillance indicators to generate recommendations for the countries. Additionally, PAHO has provided continuous support to adequately prepare countries for IPV introduction and for the switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV); this includes face-to-face and virtual meetings, the development of technical documents, and communication and training materials. At the beginning of 2015, 32 countries had an OPV-only schedule; by the end of 2015, 22 of them had introduced IPV. Overall, a total of 36 countries will participate in the switch, 31 of which have successfully submitted their plans to PAHO.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
1.5.1	Implementation of the Global Vaccine Action Plan as part of the Decade of Vaccines Collaboration to reach unvaccinated and undervaccinated populations	Number of countries and territories with immunization coverage <95% that are implementing strategies within their national immunization plans to reach unvaccinated and undervaccinated populations	15	23	Partially achieved (19 achieved + 9 partially achieved)
Nineteen countries and territories achieved the indicator: ABW, ARG, BHS, BRB, CHL, CUW, DMA, DOM, GUY, JAM, KNA, LCA, PER, SAB, STA, SUR, SXM, TTO, VEN. Confirmation from three countries was pending at the time of this report. Another nine countries and territories partially achieved the indicator: BMU, BOL, COL, CRI, GTM, PAN, PRY, SLV, TCA. Additionally, a number of countries/territories (Anguilla, Antigua and Barbuda, Belize, Bonaire, British Virgin Islands, Cayman Islands, Cuba, Curação, French Guiana, Grenada, Guatemala, Honduras, Haiti, Martinique, Montserrat, Nicaragua, St. Eustatius, St. Vincent and the Grenadines) have submitted plans of action that include specific interventions to improve vaccination coverage of unvaccinated and undervaccinated populations. The development of tools for the identification of low-coverage municipalities and subsequent interventions was successfully completed to support countries in improving vaccination coverage in unvaccinated and undervaccinated populations. The draft of the document on lessons learned in reaching low-coverage municipalities in selected countries was completed. This document will guide technical cooperation to countries in the next biennium to replicate successful experiences and share best practices. Work to advance integrated coverage monitoring, utilizing an inter-programmatic approach, has been ongoing. A joint regional workshop was held to discuss integrated monitoring and the methodologies and tools presented in the modules.					
1.5.2	Implementation of the Plan of Action to Maintain the Americas Free of Measles, Rubella, and Congenital Rubella Syndrome	Number of countries and territories implementing the Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Region of the Americas	7	42	Achieved (42 achieved)
Forty-two countries and territories achieved the indicator: ABW, ARG, ATG, BHS, BLZ, BMU, BOL, BRA, BRB, CAN, CHL, COL, CRI, CUB, CUW, DMA, DOM, ECU, GRD, GTM, GUY, HND, HTI, JAM, KNA, LCA, MEX, NIC, PAN, PER, PRY, SAB, SLV, STA, SUR, SXM, TTO, URY, USA, VCT, VEN, VGB. Confirmation from four countries was pending at the time of this report. Countries that achieved the indicator are implementing interventions aligned with the Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome (CRS) Elimination in the Americas, 2012-2014. An important public health milestone was achieved during the biennium with the declaration of the elimination of endemic transmission of rubella and CRS in the Region in April 2015. The outbreak of measles in the northeast of					

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
Brazil was declared as interrupted by the International Expert Committee, and the Region continues to advance toward the verification of measles elimination.					
1.5.3	Countries enabled to generate evidence on the introduction of new vaccines	Number of countries and territories generating evidence to support decisions on the introduction of new vaccines	12	19	Exceeded (21 achieved + 1 partially achieved)
Twenty-one countries and territories achieved the indicator: ABW, ARG, BMU, BOL, BRA, CHL, COL, DMA, DOM, ECU, GTM, GUY, HND, JAM, NIC, PER, PRY, SAB, SLV, STA, VEN. Confirmation from eight countries was pending at the time of this report. In addition, one country partially achieved the indicator: KNA. Pneumococcal conjugate vaccine impact studies were completed in Chile, Colombia, and Peru, and PCV10 and PCV13 effectiveness study protocols were initiated in Brazil and the Dominican Republic, respectively. Additionally, substantial progress was made regarding new vaccine introduction sentinel surveillance and data quality: 18 sentinel hospitals in eight countries (Bolivia, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, Peru, Venezuela) are advancing toward inclusion in the Global New Vaccines Surveillance Network.					
1.5.4	Maintenance of regional surveillance systems for the monitoring of acute flaccid paralysis (AFP)	Number of countries and territories with a surveillance system upgraded to the Integrated Surveillance Information System for Vaccine-Preventable Diseases (ISIS) or creating bridges to the centralized immunization database and the WHO database	15	21	Exceeded (26 achieved + 2 partially achieved)
Twenty-six countries and territories achieved the indicator: ABW, ARG, BHS, BON, BRA, CHL, COL, CRI, DMA, DOM, ECU, GTM, GUY, HND, HTI, JAM, KNA, MEX, NIC, PAN, PER, PRY, SLV, SUR, URY, VEN. Confirmation from three countries was pending at the time of this report. Another two territories partially achieved the indicator: CUW, STA. Confirmation of the final assessment from two countries was pending at the time of this report. The use of the Integrated Surveillance Information System for Vaccine-preventable Diseases (ISIS), or a system creating a bridge to the centralized immunization database and the WHO database, was expanded during the biennium, with significant achievements in the Dominican Republic, Ecuador, Guyana, and Panama. Currently, Bolivia is still using the Polio Elimination Surveillance System, with plans to upgrade the system in 2016.					

OPT #	Output Title	OPT Indicator	Baseline 2012	Target 2015	Assessment Rating
1.5.5	Countries enabled to implement new algorithms for the isolation and intratypic differentiation of poliovirus with improved performance indicators	Number of countries and territories implementing the new diagnostic algorithms at the national or subnational level	6	35	Exceeded (35 achieved + 3 partially achieved)
Thirty-five countries and territories achieved the indicator: ABW, ARG, ATG, BHS, BLZ, BOL, BON, BRA, BRB, CAN, COL, CRI, CUB, DMA, DOM, ECU, GRD, GTM, HND, HTI, JAM, KNA, LCA, MEX, NIC, PAN, PER, PRY, SLV, STA, SUR, TTO, URY, VCT, VEN. Confirmation from 25 countries was pending at the time of this report. Another three countries partially achieved the indicator CHL, GUY, SAB. Confirmation of the final assessment from one country was pending at the time of this report. The regional polio laboratory network is composed of 11 laboratories that implement new algorithms and provide service to all countries/territories at the national or subregional level. Polio surveillance has been maintained through this mechanism since the last case of wild poliovirus in 1991. Surveillance is technically very demanding, hence the sharing/pooling of services among countries.					
1.5.6	Processes established for long-term poliovirus risk management, including containment of all residual poliovirus and the certification of polio eradication in the Region	Number of countries and territories implementing Phase II of the Polio Containment Action Plan	0	46	Partially achieved (35 achieved + 10 partially achieved)
Thirty-five countries and territories achieved the indicator: ABW, ARG, BLZ, BMU, BOL, BRA, BRB, CAN, CUB, CUW, CYM, DMA, DOM, ECU, GRD, GTM, GUF, HND, HTI, JAM, KNA, LCA, MSR, NIC, PAN, PRY, SAB, STA, SUR, SXM, TTO, URY, USA, VEN, VGB. Confirmation from three countries was pending at the time of this report. Additionally, 10 countries partially achieved the indicator: AIA, ATG, CHL, COL, CRI, GUY, MEX, PER, SLV, VCT. Confirmation of the final assessment from two countries was pending at the time of this report. In 2014 WHO published a Global Action Plan (also known as GAPIII or the Containment Plan) to minimize poliovirus facility-associated risk after type-specific eradication of wild poliovirus and sequential cessation of routine OPV use. A small working group meeting to define the implementation of this global plan in the Region was held in 2015, and the format of the survey was finalized in June 2015. Following these initial steps, consistent communication with the countries was maintained to initiate the implementation process and advance toward reaching GAPIII objectives. All countries/territories have been implementing the regional GAPIII through capacity-building activities, based on recommendations from the PASB.					

2014-2015 End-of-Biennium Assessment
Category 2 Report

CATEGORY 2: NONCOMMUNICABLE DISEASES AND RISK FACTORS	**OVERALL CATEGORY ASSESSMENT RATING[6]** **Partially met expectations**

CATEGORY PROGRAMMATIC AND BUDGET OVERVIEW

Table 1. Category 2 Programmatic and Budget Summary

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget Implementation against PB (%)	Budget Implementation against Awarded (%)	Output Indicator Rating	Outcome Indicator Status
2.1 Noncommunicable Diseases and Risk Factors	20.96	17.93	85.5	84.4	98.7	2/7 achieved, 5/7 partially achieved	10/14 in progress, 3/14 no progress, 1/14 not assessed
2.2 Mental Health and Psychoactive Substance Use Disorders	3.26	3.02	92.7	92.9	100.2	1/3 achieved, 2/3 partially achieved	1/1 in progress
2.3 Violence and Injuries	7.59	4.16	54.9	54.3	98.9	3/3 partially achieved	2/2 in progress
2.4 Disabilities and Rehabilitation	2.16	2.04	94.1	91.1	96.8	1/2 achieved, 1/2 partially achieved	2/2 in progress
2.5 Nutrition	14.32	7.67	53.6	52.7	98.3	2/2 achieved	3/3 in progress

[6] Assessment ratings for the overall category and for program areas/outcomes are determined by the PAHO category and program area facilitators, respectively, taking into consideration the programmatic and budget implementation, analysis of resources (human and financial), and operational and programmatic risks. Ratings are defined as follows:

- **Met expectations** (Green): achieved 90% to 100% of the results for the period being assessed. Progress is on track, as expected; no impediments or risks that affect the achievement of results are foreseen.
- **Partially met expectations** (Yellow): achieved 75% to 89.9% of the results for the period being assessed. Progress may be at risk, and action is required to overcome delays, impediments, and risks.
- **Insufficient progress** (Red): achieved <75% of the results for the period being assessed. Progress is in jeopardy due to impediments or risks that could preclude the achievement of results. Immediate corrections are required.

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget Implementation against PB (%)	Budget Implementation against Awarded (%)	Output Indicator Rating	Outcome Indicator Status
TOTAL	**48.29**	**34.82**	**72.1**	**71.1**	**98.7**	**6/17 achieved, 11/17 partially achieved**	**18/22 in progress, 3/22 no progress, 1/22 not assessed**

Table 2. Category 2 Budget Overview by Functional Level

Functional Level	Funds Awarded (US$ millions)	Awarded by Level (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
Country	13.10	37.62	12.94	98.8
Intercountry	5.95	17.08	5.86	98.6
Subregional	1.66	4.76	1.64	98.6
Regional	14.12	40.55	13.91	98.6
Total	**34.82**	**100.00**	**34.35**	**98.7**

CATEGORY PROGRAMMATIC ANALYSIS

Overall Category Assessment Summary

Category 2 aims to reduce the burden of noncommunicable diseases (NCDs) through health promotion and risk reduction, prevention, treatment, and monitoring of NCDs and their risk factors. The category includes five program areas designed to meet this challenge: NCDs and risk factors (2.1), mental health (2.2), violence and injuries (2.3), disability (2.4), and nutrition (2.5).

Each year, three of every four deaths in the Region of the Americas are attributable to NCDs, and 34% of these deaths occur prematurely in people 30 to 69 years of age. This makes NCDs, and their related risk factors, the leading cause of disease, disability, and premature death in the Americas, representing both a complex public health challenge and a threat to social and economic development.

As a result, there is increased global recognition of the importance of NCDs and their risk factors, as well as of mental health, substance use, violence, human security and road safety, disabilities and rehabilitation, and nutrition, not only as major health concerns, but also as factors highly relevant to human development. Consequently, NCDs have been prioritized in the PAHO Strategic Plan 2014-2019, in the Plan of Action for the Prevention and Control of Noncommunicable Diseases in the Americas 2013-2019, in the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020, and in the United Nations (UN) Sustainable Development Goals (SDGs) under the theme of good health and well-being.

During the 2014-2015 biennium, PAHO promoted multisectoral coordination, developed guidelines, and supported

countries in the development of NCD policies and plans and in the implementation of evidence-based interventions ("best buys"). Regional and subregional meetings were organized to raise political awareness of the importance of NCDs and promote investment to scale up multisectoral action. Additionally, the Directing Council approved regional action plans to tackle mental health, violence against women, road safety, disability, and rehabilitation and to prevent childhood and adolescent obesity. As a result, 16 countries have developed national action plans, while 14 countries have set national NCD targets.

However, important challenges persist. Tackling NCDs and regulating risk factors will require not only recognition of their importance, but also a scaling up of intersectoral collaboration as well as the ability to successfully implement and enforce sound policies and effective legislation. Success on this front is constrained by the powerful interests of the tobacco, alcohol, and food industries, as well as by a lack of financial and human resources to address these issues.

Similarly, PAHO has experienced an increase in the demand for technical cooperation on NCDs, risk factors, and mental health. In order to meet this increased demand, the past biennium has taught us that in addition to strengthening capacity at the regional level, there must be a focus on strengthening human and financial resources at the country and subregional levels of the Organization.

As shown in Table 1, Category 2 is rated as having partially met expectations, with 18 of the 22 outcome indicators in progress, 3 without progress (requiring accelerated actions in the new biennium), and 1 that could not be assessed due to measurement challenges. Among the 17 output indicators, 6 were achieved and 11 were partially achieved. In regard to the approved budget, the category received US$ 35 million out of $48 million (72%), of which 99% was implemented. Details on programmatic and budget implementation follow.

Programmatic Summary by Program Area

2.1 Noncommunicable Diseases and Risk Factors

This program area addresses policies, programs, and services on NCDs and their risk factors, and aims to improve country surveillance capacity with the goal of monitoring progress toward global and regional commitments in this area.

Achievements

- Current outcome indicators suggest a decline in tobacco use among adults, from 19.0% in 2010 to 16.4% in 2015, signaling the likelihood that the outcome target will be achieved in 2019. Among all strategies to combat NCD risk factors, tobacco control is recognized as having potentially the most significant impact on reducing the burden of ill health and premature death.
- Sixteen countries in the Region have developed national NCD plans of action, and 14 countries have set national NCD targets and indicators, fulfilling commitments established at the 2014 UN High Level Meeting on NCDs.
- The focus during this biennium has been on development of NCD policies, country plans, risk factor reduction policies, and management and surveillance strategies. To monitor advances in these areas, the Organization coordinated a national NCD capacity survey, which Member States completed in 2015.
- At least 12 countries have conducted risk factor prevalence surveys, and estimates have been provided to the Organization and disseminated through the NCD data portal.
- Guidelines and guidance were developed on salt reduction and hypertension; diabetes; cervical, breast, and childhood cancers; chronic kidney disease; and the chronic care model for integrated NCD management. These have contributed to the strengthening of health systems and services for NCDs.
- In the Caribbean subregion, a Forum of Key Stakeholders on NCDs was held to reignite the political commitment to this issue. As follow-up, a series of key informant interviews were conducted to define strategies to achieve

this. Subsequent work has continued to strengthen the political engagement with NCDs in this subregion.

- Regionally, an Inter-American Task Force on NCDs has been established to harness and leverage resources and technical expertise for a multisectoral response. This task force, led by PAHO, includes key agencies of the inter-American system, namely the Organization of American States, Inter-American Institute for Cooperation on Agriculture (IICA), Economic Commission for Latin America and the Caribbean (ECLAC), and Inter-American Development Bank, as well as the World Bank.

Challenges

- Attention to and resources for risk factor reduction policies, health system strengthening for NCDs, and ongoing monitoring and surveillance are insufficient, especially in the face of competing public health priorities and interference from the private sector, notably the tobacco, food, and beverage manufacturing industries.
- Obesity continues to be a serious problem, with 29% of adults having a body mass index (BMI) greater than 30 kg/m^2 in the Americas, as compared to 11% worldwide. Tobacco use continues to be high, with 19% of adults smoking in the Region, and 22% of adults report heavy episodic drinking.
- Diabetes is linked to obesity, and few countries have frequent surveys that allow the estimation of diabetes prevalence over time. However, estimates suggest that the number of people living with diabetes in the region will increase from 62 million presently to 109 million by 2030.
- Limited up-to-date data currently exist on hypertension control, a key intervention in reducing the burden of cardiovascular disease and related complications and premature mortality.
- Salt consumption is another factor related to elevated blood pressure, and there is an urgent need to increase the capacity of countries to measure salt consumption at the population level rather than continuing to rely on information from research studies.
- Much work remains to achieve the targets for cervical cancer screening and chronic kidney disease/end-stage renal disease (CKD/ESRD) treatment.
- With many countries relying on five-year surveys of NCDs and risk factors, gaps in surveillance are preventing measurement of the prevalence of risk factors and NCDs, as well as nutritional and mental health indicators, which are not included in current survey protocols.

Lessons Learned

- Experiences over the past two years point to the fact that capacity building, better infrastructure, and more funding are needed to meet the NCD targets and goals by 2019.
- There is an urgent need to build intersectoral networks to tackle NCDs and risk factors, as many of the underlying drivers of the epidemic exist outside the health sector.
- While risk factor prevention remains a key pillar of the effort to tackle NCDs and risk factors, it is also clear that there must be more emphasis on chronic disease management, given that countries that have reported the greatest declines in premature mortality (principally cardiovascular disease reduction) have done so through improved delivery of acute care.
- It will be important to develop effective surveillance systems to monitor the increase and decrease in prevalence of NCDs and risk factors in order to respond with effective prevention and control programs, as well as adequate public policies.
- Strong political engagement and leadership is key to advancing the agenda to reduce the NCDs and risk factors. Legislative frameworks exist in some cases, notably the Framework Convention on Tobacco Control (FCTC), but political will is required for full implementation and ongoing monitoring and enforcement.

2.2 Mental Health and Psychoactive Substance Use Disorders

This program area aims to strengthen national capacity in mental health and substance use with a focus on improving treatment and care through a community-based and human rights approach.

Achievements

- A total of 31 countries and territories have national mental health policies or plans. Half of them are being updated as required by the regional Strategy and Plan of Action on Mental Health.
- Twenty-one countries and territories have initiated, or consolidated in some cases, their efforts to integrate mental health at the primary care level by training their professionals in the Mental Health Gap Action Programme (mhGAP), a tool developed by WHO for this purpose.
- Commitment to address mental health was reaffirmed by representatives of 29 countries and territories at a regional conference on mental health.

Challenges

- Program Area 2.2 faces both sociopolitical and acute financial constraints that are more pronounced than those faced by other programs. For example, individuals suffering from mental health issues, disabilities, and substance use in our Region still confront a considerable level of stigma; as a consequence, countries have not invested financial resources at the level that is required to address these public health concerns.
- Although almost all countries and territories in the Region are working on some of the mental health priorities identified in the PAHO Strategic Plan, interest is not always correlated with actual funding support.
- Mental health services remain insufficiently integrated into primary health care, resulting in limited access to appropriate treatment for those suffering from mental disorders in the Region.
- Poorly developed or absent information systems in the area of mental health lead to a lack of national evidence on the prevalence, burden of disease, and mortality.
- Reduction of the harmful use of alcohol remains a major challenge, with no evidence of progress toward achieving this outcome reported during the biennium. Current trends project an increase in per capita alcohol consumption, greater use among women, and higher rates of binge drinking. In the absence of successful policy implementation, the outcome targets will not be achieved. Therefore, higher priority must be given immediately to tackling alcohol as a major health concern. Though several countries have developed national alcohol policies or plans, most of these were ultimately not approved by national authorities, demonstrating that the will to address this risk continues to be offset by barriers to successful implementation.

Lessons Learned

- The strategy of integrating mental health and substance use services at the primary care level has proven to be key to achieving the priorities identified in the Organization's Strategic Plan 2014-2019. The adoption of the Strategy and Plan of Action on Mental Health has been instrumental in advancing some of the items on the agenda, such as the integration of mental health in primary care and a clearer approach to the development of community-based services as an alternative to care in traditional mental institutions. Through this integration effort, a closer collaboration with other technical programs is gradually being established and strengthened. The integration of mental health and substance use into the health context, particularly at the primary care level, increases the likelihood that people with these conditions will have access health services as needed.
- In the case of alcohol, approaching this risk factor in a systematic and integrated way, in conjunction with the other NCD risk factors such as tobacco use, unhealthy diet, and physical inactivity, has helped to highlight the limited progress made on alcohol regulation as compared to other risks, as well as the need to strengthen the institutional capacity of the health authorities to make necessary changes.

2.3 Violence and Injuries

This program area focuses on implementing policies and programs that address prevention of violence and injuries, particularly in the areas of road safety and violence against women, children, and youth.

Achievements

- A number of countries currently meet the WHO criteria for best practices on legislation related to drunk driving (6 countries), speed limits (5), helmet use (7), seatbelt use (19), and use of child restraints (13).
- The Brasilia Declaration on Road Safety, approved in November 2015, provides concrete guidelines to help governments achieve the targets of the Decade of Action for Road Safety 2011-2020, as well as incorporate the SDG targets related to road safety (targets 3.6 and 11.2).
- Development of the Master Plan for the Strengthening of Road Safety in Mesoamerican Cities focused on road safety measures in urban areas of Central America and the Dominican Republic. These included strengthening road safety leadership, promoting legislation and enforcement, improving sustainable mobility, developing information systems (including data quality), as well as enhancing post-crash care. Fourteen city plans were also developed, following the objectives of the Master Plan.
- In the area of violence against women, this biennium saw an important milestone with the approval by PAHO's 54th Directing Council of the Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (CD54/9 Rev. 2). In approving this document, the Region of the Americas became the first WHO region to have its highest authorities endorse a framework for action on violence against women. This document has also served as important input to the drafting of the Global Plan of Action on Violence, to be reviewed by the 2016 World Health Assembly. This will undoubtedly facilitate the achievement of the outcome indicator by the target date, 2019.
- In the area of violence against children, the Organization has established important collaborations (e.g., with UNICEF, Johns Hopkins University, London School of Hygiene and Tropical Medicine) to advance the evidence base on the prevalence of and health system response to violence against children in the Americas. The Organization is also supporting efforts to develop policy and clinical guidelines on this issue, as well as a prevention package, which is an effort to align various agencies (WHO, UNICEF, US Agency for International Development, Centers for Disease Control and Prevention) around the same recommendations for prevention of violence against children.
- The first WHO Global Status Report on Violence Prevention was published in December 2014 with the participation of 21 countries of the Americas. To strengthen this effort, additional data were collected, using the same protocol, from nine more countries in the English-speaking Caribbean in 2015. In addition, a grant was obtained from the UN Trust Fund for Human Security to mainstream the human security approach in national youth violence prevention plans in Central American countries and the Dominican Republic.

Challenges

- Availability of data remains a major concern; some countries report being unable to provide data on the agreed road safety indicators. Other challenges include limited intersectoral work, competing national priorities, insufficient investment in road safety policies, and low enforcement capacity. Specifically, though a number of countries meet the WHO criteria for best practices on legislation regarding drunk driving, speed limits, and use of helmets, seatbelts, and child restraints, law enforcement in these five areas remains weak across the Region.
- The SDGs call for a 50% reduction in mortality related to road crashes by 2020, in contrast to the PAHO Strategic Plan 2014-2019, which calls for no increase in mortality by 2019 (mortality is currently 150,000 deaths annually). Achieving the more stringent goal in the SDGs calls for a major change to "business as usual," and must be

considered to be of the highest priority to the Organization and Region. This will require not only the commitment of more resources, but significant political commitment to reducing the number of injuries and deaths to the levels agreed in the SDGs.

- Although Member States and territories are increasingly recognizing violence against women and children as a threat to both health and development, inadequate funding and limited capacity result in responses that do not correspond to the magnitude of the problem.
- Within the framework of Health in All Policies and the human security approach, one of the main challenges in violence prevention is to strengthen collaboration between the health sector and the law enforcement/justice sector to help implement the 2030 Agenda for Sustainable Development. In particular, this collaboration should include improving surveillance systems, evaluating violence prevention interventions, and strengthening the relationship between primary health care services and community police units.

Lessons Learned

- The Brasilia Declaration on Road Safety, the PAHO and WHO resolution on strengthening health systems to address violence, and the participation of Member States in the WHO Global Status Report on Violence Prevention point to the fact that political will to tackle violence and injuries exists in the Region, but that more human, technical, and financial resources and the development of strong intersectoral partnerships are needed to achieve the SDGs.
- Legislation is a key strategy to improve road user behavior and decrease road traffic causalities. Most countries in the Region can improve their laws on the risk and protective factors to be in line with international best practices.

2.4 Disabilities and Rehabilitation

This program area provides technical cooperation to expand access to key services for people with disabilities and also includes eye, ear, and oral health services as part of a wider strengthening of health systems.

Achievements

- There has been progress in improving access to habilitation and rehabilitation services and social services for persons with disabilities, while access to cataract surgery has also increased. Certainly the approval of the regional Plan of Action on Disabilities and Rehabilitation has helped advance the disability and rehabilitation agenda.

Challenges

- Though most countries in the Region have signed on to the United Nations Convention on the Rights of Persons with Disabilities, they have not yet updated their existing legislation and policies to be in line with the Convention and with PAHO/WHO recommendations.
- What is needed is a review, in each country, of mainstream and disability-specific policies, systems, and services to identify gaps and barriers, followed by efforts to address them. However, disabilities are not always ranked as a priority, which makes achieving this goal difficult.
- In addition to mainstream services, people with disabilities may require access to specific measures, such as rehabilitation, and support services, including assistive technology. However, investment in specific programs and services for people with disabilities is most often not available.
- It is vital to improve public understanding of disability, confront negative perceptions, and represent disability fairly. However, decision makers in the Region have not prioritized educating the public on this issue.

- Many countries have few staff working in rehabilitation fields. Developing standards in training for different types and levels of rehabilitation personnel can assist in addressing resource gaps.
- National data collection systems on disabilities do not exist, and disability-disaggregated data often are not available.

Lessons Learned

- To achieve universal health access and coverage, it is necessary to strengthen public services that include services for people with disabilities, as well as to refine evaluation tools to measure improvement in access to services.
- The generation and publication of evidence regarding best practices has served as a strong advocacy and planning tool.

2.5 Nutrition

This program area aims to strengthen the evidence base for effective nutrition interventions and develop and evaluate policies, regulations, and programs, promoting multisectoral approaches involving key sectors such as education, agriculture, and the environment.

Achievements

- The focus in this biennium has been on the development of nutrition policies related to prevention of childhood and adolescent obesity, micronutrient deficiencies, and stunting, and the promotion of breastfeeding. The adoption of the Plan of Action for the Prevention of Obesity in Children and Adolescents by Member States in 2014 has been instrumental in supporting countries to develop legislation and policies with respect to marketing of foods to children, improving school nutrition (lunch and snacks provided by schools and foods sold inside schools), and front-of-package labeling to better inform consumers about foods high in salt, fats, and sugars. To assist with these efforts, PAHO has developed a nutrient profile model that can be used to underpin these reforms.
- Legislation in line with the International Code of Marketing of Breast-milk Substitutes was strengthened in Bolivia, Brazil, El Salvador, and Honduras, while Mexico banned the donation of infant formula in hospitals and health care services.
- Taxes on sugar-sweetened beverages were implemented in Barbados, Dominica, and Mexico, and legislation on front-of-label packaging, consistent with WHO recommendations, was introduced in Bolivia, Chile, and Ecuador.
- Restrictions on the marketing of foods and beverages to children were also put into place in Brazil, Bolivia, Chile, and Mexico. Policies to improve the school food environment were adopted in many countries.
- Regionally, steps have been taken to revitalize the Baby-Friendly Hospital Initiative (BFHI), set country targets, and monitor progress. Most notably, Uruguay and the United States have had great success implementing the BFHI and systematically monitoring progress. Mexico has also made good progress on this front.
- Regional and subregional meetings were held on the prevention of obesity in children and adolescents, and the development of national implementation plans was supported in Honduras and Puerto Rico, among others.

Challenges

- To prevent overweight, the focus must be on changing the food environment, and this includes the implementation of fiscal and regulatory policies that directly affect the food and beverage industries. As a result, industry has taken aggressive action to halt and/or weaken legislation. The same is true for efforts to improve legislation and monitoring of formula consumption in line with the International Code of Marketing of Breast-

milk Substitutes.
- School nutrition is a strategic area for action and one where PAHO has yet to become active.
- Although many countries have legislation, policies, and norms for improving nutrition, many of these are not implemented or are poorly implemented.
- Surveillance systems are lacking to measure key nutrition indicators and the coverage of effective nutrition interventions.

Lessons Learned

- Although political will exists in the Region to prevent obesity and promote breastfeeding, powerful economic interests are working against implementing the legislation, and regulations need to encourage consumers to make healthy choices, particularly when it comes to processed food products and beverages. There is a need to improve the countries' institutional capacity to develop legislation, strong monitoring and evaluation frameworks, and well-established mechanisms to impose sanctions when indicated.

Risks

The most relevant risks identified for Category 2 in the PAHO Strategic Plan 2014-2019 are listed below, with information regarding their status and any mitigation actions taken to address them.

- Competing global and national priorities reduce the attention given to NCDs and their risk factors, including interventions for mental health and disabilities at the primary health care level.
- Low institutional capacity to regulate at the national level allows the tobacco, alcohol, processed food, and sugary beverage industries to interfere and hinder progress in countries.
- There is limited enforcement of legislation dealing with NCD risk factors (including road safety and violence) at country level.
    - Although decision makers at both national and regional levels acknowledge the need to address NCDs and risk factors, lack of vigorous political engagement has resulted in inadequate progress in key areas, such as the full implementation of the FCTC, limitations on the harmful use of alcohol, and reduction in the production and consumption of unhealthy food products. This situation has also been complicated by competing priorities, including concerns about Ebola preparedness and the chikungunya epidemic, among others. This underscores the importance of political commitment, intersectoral work, and true recognition of the importance of NCDs and risk factors to health systems, societies, and development, with appropriate investment, as prerequisites for progress.
    - In addition to the development of effective national programs to address NCDs and risk factors, the promotion of intersectoral work needs to be prioritized, given that addressing Category 2 topics requires approaches that go well beyond the health sector. Much work remains to be done on both these fronts to counteract the effects of low political prioritization of NCDs and risk factors, a lack of regulatory capacity, and limited enforcement of existing legislation.
- The aggregation of data and the limited availability of information on NCDs and risk factors hide important equity aspects of these diseases and conditions, weakening evidence-based interventions.
- The complexity of monitoring and reporting systems, including the variety of methodologies used, reduces the capacity of countries and territories to report their progress in addressing NCDs and risk factors.
- Low priority is given to violence prevention efforts, both because the consequences of violence are often invisible in current health statistics and because evaluating progress is equally challenging.
    - Although steps have been taken to address this situation, there is much that needs to be done to improve data quality, surveillance systems, and the standardization of reporting mechanisms. Furthermore,

persistent financial and technical barriers limit the ability of Member States to assess results of the implementation of public policies and report on progress toward targets.

- Investment in prevention and control of NCDs is insufficient at national and international levels, jeopardizing the implementation of the global NCD strategy and the proposed regional NCD plan of action for 2013-2019.
    - Compounding the challenges described above is the fact that unlike infectious diseases, Category 2 topics have not attracted the interest of external donors, who have not stepped up to meet the growing financial needs related to NCDs, risk factors, and mental health. The reality is that these health issues demonstrate slow change over time and do not manifest the quantifiable progress that spurs donor interest and investment in other public health concerns, such as communicable diseases and maternal and child health.

Budget Implementation Analysis

The overall funding level compared to the Program and Budget 2014-2015 (PB 14-15) for Category 2 was 72% ($35 million), which is below the minimum 75% funding target for categories. There is clearly a misalignment with the priority level of Category 2 topics, which are recognized as among the highest public health priorities for the Region. This is mainly due to challenges in mobilizing resources for these issues, as noted above. Nevertheless, the work conducted in Category 2 has successfully brought attention to these relevant issues and advanced agendas related to NCDs and risk factors, mental health and substance use, violence and disabilities, and nutrition, while operating within the constraints of a severely underfunded program.

Program Area 2.1 (NCDs and risk factors) was awarded 85.5% of the requested funding and will need additional funds to deliver optimally on the targets in 2016-2017. It is important to highlight that during the 2014-2015 biennium, Program Area 2.1 was ranked as the number one priority among all program areas of the Organization by countries and territories, which further emphasizes the incongruity of the budget gap for Program Area 2.1.

Program Areas 2.4 (disabilities and rehabilitation) and 2.2 (mental health) were awarded 94.1% and 92.7% of the approved program budgets, respectively; it should be noted that these program areas were the most conservatively budgeted. Given the high implementation rate of both program areas, it may be assumed that the capacity to implement the program of work was not matched by the planned program budget. Program Area 2.2 ranked squarely in the middle in terms of prioritization. Program Areas 2.3 (violence and injuries) and 2.5 (nutrition) were both allocated considerably less funding than requested, receiving only 54.9% and 53.6%, respectively, of their planned budget amounts. Again, the high budget implementation for both program areas, 98.9% and 98.3% respectively, suggests that additional funds could have been used to further advance the technical goals of both program areas. This particularly the case of Program Area 2.5, which operated with a planned budget deficit of $6.65 million, and like Program Area 2.2, also ranks in the middle in terms of prioritization.

Table 3. Category 2 Budget Overview by Program Area and Functional Level

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
2. Noncommunicable Diseases and Risk Factors	**34.82**	**100.00**	**34.35**	**98.7**
2.1 Noncommunicable Diseases and Risk Factors	**17.93**	**51.49**	**17.69**	**98.7**
Country	7.60	21.83	7.58	99.7
Intercountry	2.83	8.14	2.78	97.9
Subregional	0.76	2.19	0.75	98.0
Regional	6.73	19.33	6.59	97.9
2.2 Mental Health and Psychoactive Substance Use Disorders	**3.02**	**8.68**	**3.03**	**100.2**
Country	0.82	2.36	0.82	99.9
Intercountry	0.59	1.71	0.60	100.3
Subregional	0.20	0.56	0.20	100.2
Regional	1.41	4.05	1.41	100.3
2.3 Violence and Injuries	**4.16**	**11.96**	**4.12**	**98.9**
Country	2.49	7.15	2.49	100.0
Intercountry	0.45	1.30	0.44	97.3
Subregional	0.14	0.41	0.14	97.7
Regional	1.08	3.10	1.05	97.3
2.4 Disabilities and Rehabilitation	**2.04**	**5.85**	**1.97**	**96.8**
Country	0.41	1.17	0.36	89.5
Intercountry	0.45	1.29	0.44	98.7
Subregional	0.12	0.34	0.12	98.7
Regional	1.06	3.05	1.05	98.7
2.5 Nutrition	**7.67**	**22.03**	**7.54**	**98.3**
Country	1.78	5.11	1.69	95.0
Intercountry	1.62	4.64	1.60	99.3
Subregional	0.44	1.26	0.44	99.4
Regional	3.83	11.01	3.81	99.3

As depicted in Tables 2 and 3, the allocation of funds by functional level was in line with the overall intent of the PAHO budget policy. It is important to note that the $13.10 million allocated to countries was likely insufficient to address what is clearly an increasing regional epidemic. To address this matter, the Organization did its best to mobilize funds for countries throughout the biennium, and the $5.95 million in intercountry allocation complemented resources for direct technical cooperation to countries Across the Region, a limitation in human resources needed to address Category 2 themes posed an additional obstacle to addressing the challenges. Recommendations in this regard are included below.

The high level of implementation at each functional level also suggests that, had additional funds been mobilized, the programmatic implementation could have been higher. While moderate levels of resources were mobilized at the regional level in 2014-2015, this was not achieved at the subregional level. In sum, 2014-2015 was a period in which

Category 2 topics gained attention, but this was not matched by corresponding levels of funding to expand technical cooperation work.

Resource Mobilization

During the 2014-2015 biennium, the regional level successfully cultivated relationships with ongoing and new donors, such as the Centers for Disease Control and Prevention (CDC), CDC Foundation, Government of Brazil, American Heart Association, Russian Federation, International Development Research Centre of Canada, Bloomberg Philanthropies, Government of the United Kingdom, Government of Norway, World Diabetes Foundation, Spanish Agency for International Development Cooperation (AECID), and the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), among others. Efforts are under way to secure funds from the OPEC Fund for International Development, and new opportunities are being sought to meet the unfunded financial needs of Category 2.
Given that the category was spearheaded by a department that was restructured at the beginning of the biennium, Category 2 successfully mobilized resources, although it ultimately was not able to bridge the considerable budget deficit. It is important to note that a significant influx of regular budget funds was received throughout the biennium.

Recommendations

- Review the resources allocated to Category 2 to ensure that adequate financing and adequate human resources are available at all functional levels so that the program of work can be fully implemented.
- Raise the level of political awareness of the timelines for the achievement of the 2019 targets in the PAHO Strategic Plan in order to highlight the urgency of the program of work.
- Coordinate with subregional integration mechanisms, including the Union of South American Nations (UNASUR), the Southern Common Market (MERCOSUR), and the Central American Integration System (SICA), at a high political level in order to raise awareness among political leaders, much as was done in the Caribbean NCD stakeholders meeting.
- Ensure that all PAHO/WHO Representative Offices are aware of the priority of the NCDs, risk factors, and mental health topics, and are positioned to advance the work of the countries in addressing NCDs.
- Develop an institutional response to surveillance for NCDs, risk factors, and mental health such that countries are empowered to use scarce resources to report on their progress in a sustainable manner.

Assessment by Program Area

Program Area 2.1: Noncommunicable Diseases and Risk Factors **OUTCOME: Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors** OCM Indicator Assessment: 10/14 In Progress, 3/14 No Progress, 1/14 Not Assessed OPT Indicator Assessment: 2/7 Achieved, 5/7 Partially Achieved	**Rating: Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(rate as achieved, in progress, no progress)*[7,8]
2.1.1a	Total (recorded and unrecorded) alcohol per capita (APC) consumption among persons 15+ years of age within a calendar year in liters of pure alcohol, as appropriate, within the national context	8.4 liters/person/year (2010)	5% reduction	No progress (ND[9])
APC in 2014, as estimated by WHO, and based on data from 2008-2010, was 8.4 liters/person/year. No other estimation has been carried out by WHO to assess progress or project 2019 figures. This target is unlikely to be achieved, given that estimated trends point to a likely increase in APC if no policy changes are implemented.				
2.1.1b	Prevalence of alcohol-use disorders among adolescents and adults, as appropriate within the national context	6.0% for ICD 10 codes (2.6% for harmful use and 3.4% for alcohol dependence) in 2010	5% reduction	No progress (ND)
This indicator was originally assessed with data from 2010, and the baseline data provided are the estimates from WHO published in 2014. No other estimation has been carried out by WHO to assess progress or project 2019 figures. This target is unlikely to be achieved, given estimated trends showing an increase in consumption and heavy consumption among women and the limited reach of health services.				
2.1.1c	Age-standardized prevalence of heavy episodic drinking (HED)	13.7%	5% reduction	No progress (ND)
This indicator was first assessed with data from 2010, and the baseline data provided are the estimates from WHO as				

[7] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached.
- **In progress:** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way/on track to achieve the target set in the Strategic Plan by 2019.
- **No progress**: There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and progress toward achieving the indicator target by 2019 could be in jeopardy.

[8] The regional indicators are assessed by the responsible regional entity/Category and Program Area Network (CPAN) based on the latest available information, according to criteria defined in the compendium of indicators.

[9] Regional indicators without updated information; they normally rely on surveys and other sources of information that are not updated on a biennial basis.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(rate as achieved, in progress, no progress)*[7,8]
published in 2014. No other estimation has been carried out by WHO to assess progress or project 2019 figures. Given estimated trends showing an increase in heavy episodic drinking in adolescents and adults, this target is unlikely to be achieved if no policy changes are implemented.				
2.1.2a	Prevalence of current tobacco use among adolescents 13-15 years of age	TBD	TBD	Not Assessed (ND)
PAHO is working with WHO to produce estimates for this age group so as to ensure consistency with WHO indicators. WHO has not established a separate target for adolescent tobacco prevalence.				
2.1.2b	Age-standardized prevalence of current tobacco use (18+ years of age)	21%	17%	In progress (for age 15+, from 19.0% in 2010 to 16.4% in 2015)
Although PAHO does not have in-house data to produce estimates for this age range (18+ years of age), the indicator for those aged 15+ years shows that prevalence decreased from 19.0% in 2010 to 16.4% in 2015. This suggests that the target could be achieved by 2019.				
2.1.3a	Prevalence of insufficient physical activity in adolescents 13-17 years of age	Last country reported prevalence of insufficient physical activity between 2009 and 2012	5% reduction with respect to the country baseline prevalence value by 2016-2019	In progress (ND)
Data on physical activity are collected in the Global School-based Student Health Survey. However, countries are only just beginning to implement policies and programs in schools to encourage physical activity, and it is premature to assess impact at this point. These policies are likely to accelerate as a result of PAHO's Plan of Action for the Prevention of Obesity in Children and Adolescents.				
2.1.3b	Age-standardized prevalence of insufficient physical activity in adults	Last country reported prevalence of insufficient physical activity between 2009 and 2012	5% reduction with respect to the country baseline prevalence value by 2016-2019	In progress (ND)
Most countries are implementing bike lanes and recreational activities to encourage physical activity. However, instruments to record use of such physical activity interventions, to provide a basis for estimating their impact, need to be improved.				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(rate as achieved, in progress, no progress)*[7,8]
2.1.4	Percentage of controlled hypertension at population level (<140/90mmHg) among persons 18+ years of age	15%	35%	In progress (ND)
This objective is expected to be achieved by 2019. The information is collected every four to five years at the country level, and the available information is still insufficient to permit an analysis of regional scope and validity. However, based on reports from large epidemiological studies and information provided by some countries, the gap to achieve the target of 35% control is still very wide. In fact, only three countries have national reporting that reflects 35% hypertension control: Canada, Cuba, and the United States. Since it is most cost-effective to control hypertension in order to reduce cardiovascular mortality, priority has focused on supporting countries to implement innovative methods to achieve this goal. Currently Barbados, Chile, Colombia, and Cuba are moving toward the implementation of this type of initiative.				
2.1.5	Age-standardized prevalence of raised blood glucose/diabetes among persons 18+ years of age	18.8%	18.8%	In progress (ND)
Only one country has repeated a risk factor survey that includes diabetes (Argentina); it reported no increase in prevalence. Many countries have conducted a one-time survey and perhaps some will repeat these before 2019, so that comparable prevalence data will be available.				
2.1.6a	Prevalence of overweight and obesity in adolescents aged 13-17 years of age	TBD	TBD	In progress (ND)
Data on self-reported overweight and obesity are collected in the Global School-based Student Health Survey. However, countries are only just beginning to implement policies and programs in schools to improve the school nutrition environment, and it is premature to assess progress. As with obesity in children, the goal should be to halt the increase in prevalence. These policies are likely to accelerate as a result of PAHO's Plan of Action for the Prevention of Obesity in Children and Adolescents.				
2.1.6b	Prevalence of overweight and obesity in adults (men and women 18+ years of age)	TBD	TBD	In progress (ND)
Although many countries are implementing policies and programs to address adult obesity, nationally representative surveys are conducted at around five-year intervals in some countries, and they only collect data on women of reproductive age. Since 2013, few countries have done new surveys, and thus actual regional progress cannot be assessed. Reducing the prevalence of obesity among adults is very difficult: there are few examples of successful programs, and none to date at the national level.				
2.1.7	Age-standardized mean population intake of salt (sodium chloride) per day, in grams, in persons aged 18+ years of age	11.5 grams	7 grams	In progress (ND)
By 2019 the regional average intake will be available to calculate, as more countries are assessing their salt intake. Notably, the data on salt consumption derive from research studies and not from population-based studies, so sample size and methodologies differ. Only Argentina, Barbados, and Brazil have used studies based on a subsample of their populations to assess sodium intake in the overall population.				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(rate as achieved, in progress, no progress)*[7,8]
2.1.8	Number of countries and territories that have a cervical cancer screening program which achieves 70% coverage, as measured by the proportion of women 30-49 years of age who have been screened for cervical cancer at least once, or more often and for younger or older age groups according to national programs or policies, by 2019	5	15	In progress (4 achieved + 10 in progress)
Four countries achieved the indicator: ARG, CAN, COL, USA. Ten countries made progress on the indicator: BOL, BRA, CHL, CRI, GTM, HND, JAM, MEX, PRY, TTO. The baseline countries of BRA, CHL, and JAM need to strengthen their national cervical cancer program to get to 70% screening coverage and maintain the indicator. The target countries of BOL, CRI, GTM, HND, MEX, PRY, and TTO need to strengthen their country programs to achieve this indicator.				
2.1.9	Number of countries and territories with a prevalence rate of treated end-stage renal disease of at least 700 patients per million population (pmp)	8	17	In progress (5 achieved + 9 in progress)
Five countries achieved the indicator: ARG, CAN, CHL, PRI, USA. These countries have already surpassed the goal of 700 pmp. The following nine countries report partial progress: COL, CRI, CUB, DOM, ECU, PAN, PER, SLV, VEN. Ecuador and Colombia are close to reaching the goal. In general, there is progress, but it will require significant efforts to meet the target.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating[10, 11]
2.1.1	Countries enabled to develop national multisectoral policies and plans to prevent and control NCDs and risk factors, pursuant to the regional plan of action on NCDs	Number of countries and territories implementing national multisectoral action plans for the prevention and control of noncommunicable diseases and risk factors	14	20	Partially achieved (16 achieved + 12 partially achieved)
Sixteen countries and territories maintained or achieved the indicator: ARG, BMU, BRA, CAN, COL, CRI, DMA, GUY, HND, JAM, KNA, MEX, PRY, TCA, USA, VGB. Another 12 countries and territories partially achieved the indicator: ABW, BRB, CHL, CUB, CUW, ECU, GTM, PER, SAB, SLV, SUR, TTO. Most of these fell short because of challenges with implementation of the national NCD action plan once it had been developed. Multisectoral actions to address the root causes of NCDs through a Health in All Policies approach continues to be a challenge in all countries.					
2.1.2	Countries enabled to strengthen evidence-based interventions, regulations, and guidelines for the prevention and control of NCDs and risk factors	Number of countries and territories implementing at least one of the most cost-effective interventions (as defined by WHO) to tackle each of the four major NCDs and four risk factors (total of eight interventions)	35	35	Partially achieved (15 achieved + 12 partially achieved)
Fifteen countries and territories achieved the indicator: BMU, BRA, CAN, CHL, COL, CRI, CUB, DMA, DOM, JAM, MEX, SXM, USA, VEN, VGB. A total of 12 countries and territories only partially implemented at least one of the cost-effective interventions for NCDs and their risk factors: ARG, BHS, BON, BRB, ECU, GTM, GUY, KNA, MSR, PER, SAB, TTO. Confirmation of the final assessment for one country was pending at the time of this report. Progress is especially slow in risk factor reduction policies, and countries are urged to implement the regulations and policies to reduce tobacco and alcohol use, as well as to promote healthy foods and physical activity.					

[10] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set in the Program and Budget (PB) 2014-2015 (number of countries/territories, number or % for regional indicators) has been reached. Indicator targets that have been exceeded are noted as such.
- **Partially achieved:** Progress was made over the baseline value set in the PB (number of countries/territories, number or % for regional indicators), but the target for 2015 was not achieved.
- **No progress:** There was no increase over the baseline value set in the PB (number countries/territories, number or % for regional indicators).

[11] The regional indicators are assessed by the responsible regional entity/CPAN based on the latest available information, according to criteria defined in the compendium of indicators.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating[10, 11]
2.1.3	Countries enabled to strengthen their NCD and risk factor surveillance systems	Number of countries and territories reporting regularly on NCDs and risk factors, including chronic kidney disease (CKD) risk markers	9	11	Achieved (11 achieved + 6 partially achieved)
Eleven countries and territories achieved the indicator: ARG, BMU, BRA, BRB, CAN, CHL, COL, JAM, MEX, URY, USA. Additionally, six countries and territories partially achieved the indicator: BHS, BON, PAN, SLV, TTO, VEN. Confirmation of the final assessment for three countries was pending at the time of this report. Barbados and Uruguay have implemented a National Risk Factors survey that will allow them to monitor the global and regional NCD targets and indicators. They also have made progress in strengthening other key NCDs sources of information.					
2.1.4	Countries enabled to increase the percentage of persons with hypertension taking blood pressure-lowering medication	Number of countries and territories in which at least 50% of persons with hypertension are taking blood pressure-lowering medication	5	10	Partially Achieved (5 achieved + 2 partially achieved)
Five countries achieved the indicator: BRA, CAN, CHL, CUB, USA. Another two countries and territories partially achieved the indicator: ARG and BON. Confirmation of the final assessment for 10 countries were pending confirmation at the time of this report. Overall, this is usually a fairly stable report, based on population surveys undertaken every four to five years. However, as reported by the literature based on large epidemiological studies, achieving the goal of 50% treatment is quite uncommon in middle- and low-income countries. It is therefore very important to insist on the need to adhere to what is defined in the indicator and to report the source of data and the accuracy of the information provided in order to accurately assess progress.					
2.1.5	Countries enabled to increase the percentage of persons with diabetes taking blood glucose-lowering medications	Number of countries and territories in which at least 50% of persons with diabetes are taking blood glucose-lowering medication	6	10	Exceeded (11 achieved + 4 partially achieved)
Eleven countries and territories achieved the indicator: ARG, BMU, BRA, CAN, CHL, CRI, CUB, SAB, STA, USA, VEN. In addition, four countries and territories partially achieved the indictor: BON, COL, CUW, MEX. Confirmation of the final assessment for one country was pending at the time of this report. It is important to work with countries to ensure that they create indicators and evaluation methods that can accurately measure progress.					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating[10, 11]
2.1.6	Implementation of the WHO Framework Convention on Tobacco Control (FCTC)	Number of countries implementing policies, strategies, or laws in line with the FCTC	5	8	Partially achieved (4 achieved + 7 partially achieved)

Four countries achieved the indicator: BRA, CHL, PAN, URY.

Another seven countries partially achieved the indicator: BRB, COL, HND, JAM, MEX, PER, VEN.

Confirmation of the final assessment for eleven countries was pending at the time of this report.

Jamaica and Peru are still trying to present tobacco control bills to their parliaments that would allow them to reach the target for the next biennium. In order to improve the definition and measurement of this output and its indicator, the PASB/CPAN proposes the changes below for 2016-2017 (OPT 2.1.2e). The proposed changes would be included in the PAHO Strategic Plan monitoring system (SPMS) for countries to assess at the end of 2017.

> *Output: Countries enabled to implement very cost-effective interventions ("best buys") to reduce the four modifiable risk factors for noncommunicable diseases (tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol).*
> *Name of the indicator: Number of countries implementing policies, strategies, or laws in line with the WHO Framework Convention on Tobacco Control (FCTC).*
> *Definition of the indicator: Number of countries which have implemented at least three out of the four core measures in tobacco control included as "best buys" for NCD prevention and control at its highest level of achievement at the national level.*
> *Baseline and target: 4 and 7, respectively.*

2.1.7	Countries enabled to improve their CKD surveillance	Number of countries and territories with high-quality dialysis and a transplantation registry for CKD cases	12	21	Partially achieved (10 achieved + 12 partially achieved)

Ten countries and territories achieved the indicator: ARG, BON, CAN, CHL, COL, CUB, PRI, URY, USA, VEN.

Additionally, 12 countries partially achieved the indicator: BOL, BRA, CRI, DOM, ECU, GTM, HND, KNA, NIC, PAN, PER, SLV.

Confirmation of the final assessment from seven countries was pending at the time of this report.

Technical cooperation has focused on the countries of Central America and the Andean area, and progress is expected given that these countries were able to strengthen their national registries. It is important to emphasize the quality and accuracy of information and adherence to the technical indicator in order to ensure that measurements are reliable. Still, the Americas, and particularly Latin America, is the only region to have a regional registry of acceptable quality.

In order to improve the definition and measurement of this output and its indicator, the PASB/CPAN proposes the changes below for 2016-2017 (OPT 2.1.5). The proposed changes would be included in the PAHO Strategic Plan monitoring system (SPMS) for countries to assess at the end of 2017.

> *Name of the indicator: Number of countries and territories with a registry for high-quality dialysis and transplantation for CKD cases.*

Program Area 2.2: Mental Health and Psychoactive Substance Use Disorders **OUTCOME: Increased service coverage for mental health and psychoactive substance use disorders** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 1/3 Achieved, 2/3 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
2.2.1	Number of countries and territories that have increased the rate of consultations through mental health outpatient treatment facilities over the regional average of 975 per 100,000 population	19	30	In progress (9 achieved + 17 in progress)

Nine countries achieved the indicator: ARG, BLZ, BRA, CRI, CUB, DMA, PER, TTO, USA.

In addition, 17 countries and territories partially achieved this indicator: ATG, BHS, CHL, DOM, ECU, GRD, GUY, JAM, KNA, LCA, MEX, NIC, PAN, PRY, SUR, VCT, VGB.

The commitment shown by countries on the two outputs related to mental health (under Program Areas 2.1 and 2.2) indicates clear progress toward the achievement of this outcome.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
2.2.1	Countries enabled to develop and implement national policies and plans in line with the Regional Strategy on Mental Health and the Global Mental Health Action Plan 2013-2020	Number of countries and territories that have a national policy or plan for mental health in line with the Regional Strategy on Mental Health and the Global Mental Health Action Plan 2013-2020	20	30	Partially Achieved (21 achieved + 12 partially achieved)

Twenty-one countries and territories achieved the indicator: ARG, ATG, BON, BRA, CHL, COL, CRI, CUB, CUW, DOM, ECU, JAM, MEX, MSR, NIC, PAN, PRY, SLV, SUR, SXM, VEN.

Another 12 countries and territories partially achieved this indicator: ABW, BMU, BRB, DMA, GTM, GUY, KNA, LCA, PER, STA, TTO, VCT. The PASB/CPAN considers that partially achieved means that a plan/policy was developed but not approved.

Confirmation of the final assessment from three countries was pending at the time of this report.

There is an important element to consider: this indicator is a moving target. The indicator was created several biennia ago, and the technical note in the output indicator definition mentions the need to have policies/plans

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
approved or updated after 2001, with baseline countries identified accordingly. The indicator was then updated to align with a more recent milestone, the Global Mental Health Action Plan 2013-2020, which implies that all countries should have updated their policy/plan after 2013. For this exercise, we left those baseline countries identified by the end of the last biennium, which does not necessarily mean they have updated their policy and plans since 2013.					
2.2.2	Countries enabled to integrate a mental health component into primary health care using the Mental Health Global Action Plan Intervention Guide	Number of countries and territories that have established a program to integrate mental health into primary health care using the Mental Health Global Action Plan Intervention Guide	8	21	Exceeded (23 achieved)
Twenty-three countries and territories achieved the indicator: ARG, BHS, BLZ, BRA, BRB, CHL, COL, CRI, CUB, DOM, ECU, GTM, GUY, HND, JAM, KNA, MEX, PAN, PER, PRY, SAB, SLV, TTO. Two countries were pending confirmation at the time of this report. All countries that reported having begun or "established" the process of integrating mental health into primary health care were considered as achieved in line with the compendium of indicators.					
2.2.3	Countries enabled to expand and strengthen strategies, systems, and interventions for disorders due to alcohol and substance abuse	Number of countries and territories with a national alcohol policy or plan for the prevention and treatment of alcohol use disorders in line with the Regional Plan of Action/Global Strategy to Reduce the Harmful Use of Alcohol	10	17	Partially Achieved (6 achieved + 12 partially achieved)
Six countries achieved the indicator: BRA, CHL, COL, CUB, PRY, USA. Another twelve countries partially achieved the indicator: ARG, BLZ, CRI, DOM, ECU, GRD, HND, PER, SLV, SUR, TTO, URY. Confirmation from three countries was pending at the time of this report. Seven countries were pending confirmation at the time of this report. Countries are currently developing policies/plans, or they have developed but not approved them. Given the challenges to implementation of public health-based alcohol policies in our Region, including social acceptance of alcohol consumption, lack of awareness of its negative impact, and low political commitment to reducing the harmful use of alcohol, it is unlikely that the Region will meet the target of the corresponding outcome by 2019. It is noted that this indicator is measuring only progress related to alcohol program interventions.					

Program Area 2.3: Violence and Injuries **OUTCOME: Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women, and youth** OCM Indicator Assessment: 2/2 In progress OPT Indicator Assessment: 3/3 Partially Achieved	**Rating: Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
2.3.1	Number of countries and territories with at least 70% use of seatbelts by all passengers	4	7	In progress (3 achieved + 2 in progress)
Three countries achieved the indicator: CAN, COL, USA. Confirmation from one country was pending at the time of this report. Additionally, two countries are in progress to achieve this indicator: ARG, KNA. The self-ratings of two other countries still require clarification, but if the discrepancies are resolved by the end of 2019, the indicator can be reached. Countries should improve data collection on seatbelt use and strongly enforce their seatbelt laws to achieve this indicator by 2019. The health sector should work intersectorally, especially with transportation and police sectors, to fulfill the indicator.				
2.3.2	Number of countries and territories that use a public health perspective in an integrated approach to violence prevention	3	7	In progress (5 achieved + 6 in progress)
Based on country responses, three countries achieved the indicator: CAN, MEX, USA. In addition, based on the criteria in the compendium of indicators, five countries achieved it (BRA, CAN, JAM, MEX, USA) and six countries and territories made progress towards the goal (ABW, BON, SAB, STA, TTO, VEN). Countries have taken steps to apply a public health perspective in an integrated approach to violence prevention. For example, El Salvador has developed El Salvador Seguro, which reflects a public health perspective. Ecuador is implementing a new violence prevention plan, using an integrated public health approach, as a component of its Plan Nacional para el Buen Vivir. Trinidad and Tobago is working toward that goal, and baseline countries such as the United States and Canada have been using it for a number of years. Moreover, the 2013 WHO guidelines for provision of health services to victims of sexual and intimate partner violence and the 2014 WHO Global Status Report on Violence Prevention have been triggers for moving the issue forward in the countries. It is expected that the adoption of the PAHO regional action plan on strengthening the health system to address violence against women, and the adoption of the WHO global plan to strengthen the role of the health system in addressing interpersonal violence, in particular against women, girls, and children, will help achieve the outcome indicator by the target date.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
2.3.1	Countries enabled to develop and implement multisectoral plans and programs to prevent injuries, with focus on achieving the targets set under the Decade of Action for Road Safety 2011-2020	Number of countries and territories implementing comprehensive laws on reducing risk factors for road traffic injuries (speed and drunk driving) and increasing protective factors (helmets, seatbelts, and child restraints)	2	9	Partially achieved (3 achieved + 4 partially achieved)
Three countries achieved the indicator: CAN, CUB, URY. Another four countries partially achieved the indicator: ARG, CHL, KNA, SLV. Confirmation of the final assessment from 11 countries was pending at the time of this report. Legislative analysis indicates that the countries that achieved this indicator have comprehensive legislation on all risks (speed and drunk driving) and protective factors (helmet, seatbelt, and child restraint use). PAHO's analysis shows that most of these countries have comprehensive legislation in four out of five road safety factors (Argentina, Brazil, Ecuador, Chile, and Colombia). Member States are strengthening road safety legislation, and target countries are progressing toward the achievement of this indicator. However, the level of law enforcement is low across the Region. Countries need to strengthen the enforcement of legislation as well as improve regulation by taking into consideration PAHO/WHO recommendations.					
2.3.2	Countries and partners enabled to assess and improve national policies and programs on integrated violence prevention, including violence against women, children, and youth	Number of countries and territories implementing national policies, plans, or programs on violence prevention that include evidence-based public health interventions	4	7	Partially Achieved (6 achieved + 6 partially achieved
Six countries achieved the indicator: BRA, CAN, JAM, MEX, SLV, USA. Another six countries and territories partially achieved the indicator: ABW, BON, SAB, STA, TTO, VEN. Countries have continued to include evidence-based public health interventions for violence against women, children, and youth in their violence prevention programs. El Salvador has developed the national violence prevention plan El Salvador Seguro, which includes evidence-based public health interventions such as Familias Fuertes (Strengthening Families) for better parenting. Jamaica has a National Crime Observatory, an intersectoral collaboration to inform public health interventions, life skills training programs, and a safe school program. Trinidad and Tobago's plan is being finalized and will start implementation in 2016. PAHO is working to enhance the youth violence prevention component of the countries' policies, plans, and programs during 2016-17 by promoting incorporation of the human security approach.					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
2.3.3	Countries enabled to develop and implement a national protocol for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines	Number of countries and territories with a national protocol in place for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines	0	4	Partially Achieved (3 achieved + 12 partially achieved)

Three countries achieved the indicator: BOL, GRD, SLV.

Twelve countries and territories partially achieved the indicator: ABW, ARG, BMU, BON, COL, CRI, GUY, KNA, PER, STA, TTO, VEN.

Confirmation of the final assessment from two countries was pending at the time of this report.

During this assessment, it became clear that some countries were linking to the wrong indicator (2.3.2). To address this confusion and improve the definition and measurement of this output and its indicator, the PASB/CPAN proposes the changes below for 2016-2017 (OPT 2.3.3). The proposed changes would be included in the PAHO Strategic Plan monitoring system (SPMS) for countries to assess at the end of 2017.

> *Output: Development and implementation of policies and programs to address violence against women and children facilitated (this is aligned with the WHO output).*
>
> *Name of the indicator: Number of countries and territories that create or adjust national standard operating procedures/protocols/guidelines for the health system response to intimate partner and sexual violence, consistent with WHO's guidelines.*

Program Area 2.4: Disabilities and Rehabilitation **OUTCOME: Increased access to social and health services for people with disabilities, including prevention** OCM Indicator Assessment: 2/2 In progress OPT Indicator Assessment: 1/2 Achieved, 1/2 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
2.4.1	Number of countries that have attained at least 12% access to habilitation and rehabilitation services and social services for persons with disabilities	0	16	In progress (1 achieved + 6 in progress)

One country achieved the indicator: MEX.

Based on PASB/CPAN analysis, another six countries are in progress to achieve the indicator: ARG, BRA, CHL, CUB, ECU, VEN.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
During 2014-2015, these countries defined a methodology to evaluate access to rehabilitation services for people with disabilities. Progress is expected to take place in Bolivia, Colombia, Costa Rica, and Guyana, although great effort will have to be invested for these countries to achieve the indicator by 2019. Other countries that have the potential to achieve this indicator by 2019 are: Dominican Republic, El Salvador, Guatemala, Panama, and Trinidad and Tobago.				
2.4.2	Number of countries and territories reaching cataract surgical rate of 2,000/million population/year	19	25	In progress (12 achieved + 6 in progress)
Twelve countries and territories achieved the indicator: ABW, ARG, BRA, CRI, CUB, CUW, DMA, PRI, SUR, URY, USA, VEN. Another six countries are in progress to achieve the indicator: COL, DOM, NIC, PAN, PER, TTO. Confirmation of the final assessment from four countries was pending at the time of this report. Most countries report the cataract surgical rate annually, and the national trend in most countries shows a yearly increase. Countries not in the baseline aimed to achieve the target of 2,000/million population/year for 2019 because most of them were far below the target and will require several years of continuous increases to reach it. The method used to assess the indicator up through 2013 was through the national societies of ophthalmology. Given that now the national health authorities, instead of the national societies of ophthalmology, are reporting on this indicator, this indicator may require modification. Most Member States are counting only the public sector. Since the main responsibility of the public sector is with the poorest people who tend to have a higher prevalence of cataract blindness, PASB/CPAN proposes to measure the public sector cataract surgical rate in the coming years. That said, during 2016 a dialogue with Member States may result in increasing cooperation with private and nonprofit sectors to get the right numbers.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
2.4.1	Implementation of the recommendations of the World Report on Disability and the United Nations General Assembly High-Level Meeting on Disability and Development	Number of countries and territories implementing comprehensive programs on health and rehabilitation pursuant to the World Report on Disability and the United Nations High-Level Meeting on Disability and Development	5	9	Exceeded (10 achieved + 7 partially achieved)
Ten countries and territories achieved the indicator: ARG, BMU, BRA, CHL, COL, CUB, ECU, GUY, HND, VEN. Confirmation from one country was pending at the time of this report. Additionally, seven countries and territories partially achieved the indicator: ABW, BON, CUW, PER, SAB, SLV, TCA. Significant progress has been made in the development and implementation of comprehensive care programs for					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
people with disabilities across the social and health sectors. It is important to highlight the success rates of Member States with a federal system of government, including Argentina, Brazil, Canada, Mexico, and the United States. Countries with a decentralized system of government have also experienced success, as in the case of Colombia (achieved) and Peru (partially achieved). Guyana has implemented a new strategic plan in accordance with the recommendations of this indicator. Other countries that have made progress toward this indicator are Bolivia, Dominican Republic, Guatemala, and Trinidad and Tobago.					
2.4.2	Countries enabled to implement more effective policies and provide integrated services to reduce disability due to visual impairment and hearing loss	Number of countries and territories implementing eye and ear health policies and services in line with PAHO/WHO recommendations	26	29	Partially Achieved (14 achieved + 13 partially achieved)
Fourteen countries and territories achieved the indicator: ARG, BRA, COL, CUB, DMA, GUY, MEX, NIC, PAN, PER, PRY, SAB, USA, VEN. Additionally, 13 countries and territories partially achieved the indicator: ABW, BOL, BON, BRB, CHL, ECU, GTM, JAM, KNA, SLV, STA, SUR, TTO. Confirmation of the final assessment from four countries was pending at the time of this report. It is important to note that measuring vision and hearing loss in a single indicator will inevitably lead to progress being partial more often than not. The baseline and target was originally calculated based on “either eye OR ear policies and services.” Some countries are interpreting that to mean “eye AND ear policies and services.” Ear programs are just starting, so many qualify the indicator as partially achieved. During 2016 a dialogue with Member States may result in a change in interpretation that may lead to the indicator being reached in the future. This should not detract from the fact that countries have made gains, even if they are progressing at different rates for eye and ear health policies.					

Program Area 2.5: Nutrition **OUTCOME: Nutritional risk factors reduced** OCM Indicator Assessment: 3/3 In progress OPT Indicator Assessment: 2/2 Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
2.5.1	Percentage of children less than 5 years of age who are stunted	13.5%	7.5%	In progress (ND)
Although many countries are implementing policies and programs to address stunting, few countries have conducted new surveys during the biennium to monitor trends in stunting. For this reason, progress cannot be assessed at this time. However, the few countries with updated data, such as Bolivia, El Salvador, and Peru, show important declines.				
2.5.2	Percentage of women of reproductive age (15-49 years) with anemia	22.5%	18%	In progress (ND)
Although many countries are implementing policies and programs to prevent anemia in women of reproductive age, analyzing progress on this indicator suffers from the same problem of limited current data outlined in 2.5.1.				
2.5.3	Percentage of children less than 5 years of age who are overweight	7%	7%	In progress (ND)
As a result of the approval by the 53rd Directing Council of the Plan of Action for the Prevention of Obesity in Children and Adolescents, most countries are developing and implementing policies and programs to halt the rising prevalence of obesity by the end of the 2014-2019 Strategic Plan period. Measuring impact will only be possible for those countries that invest in nutrition monitoring systems or implement national nutrition surveys.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
2.5.1	Countries enabled to develop, implement, and monitor their action plans based on the global Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition	Number of countries and territories implementing national action plans based on the Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition	6	12	Achieved (11 achieved + 2 partially achieved)
Eleven countries and territories achieved the indicator: ARG, BMU, BOL, CAN, CHL, COL, GTM, GUY, JAM, PER, SLV. Confirmation from one country was pending at the time of this report. Another two territories partially achieved the indicator: SAB, SXM. Confirmation of the final assessment from eight countries was pending at the time of this report.					

<table>
<tr><th>OPT #</th><th>Output Title</th><th>OPT Indicator</th><th>Baseline 2013</th><th>Target 2015</th><th>Assessment Rating</th></tr>
<tr><td colspan="6">It is important to note that Uruguay stands out in the Region as having certified or recertified 84% of its facilities that attend deliveries as baby-friendly. Bolivia, Brazil, El Salvador, and Honduras passed new legislation and/or strengthened existing legislation on the marketing of breast-milk substitutes. Mexico took action to prohibit the donation of infant formula to health care facilities, and Chile extended maternity protection to six months to facilitate exclusive breastfeeding.</td></tr>
<tr><td>2.5.2</td><td>Updated norms and standards on maternal, infant, and young child nutrition, population dietary goals, and breastfeeding; policy options provided for effective nutrition actions for stunting, wasting, and anemia</td><td>Number of countries and territories implementing effective nutrition actions for stunting, wasting, and anemia, and overweight according to the national context</td><td>5</td><td>11</td><td>Achieved (11 achieved + 6 partially achieved)</td></tr>
<tr><td colspan="6">Eleven countries achieved the indicator: BOL, BRA, CHL, COL, GTM, GUY, HND, JAM, MEX, NIC, SLV.

Another six countries partially achieved the indicator: ARG, CUW, ECU, KNA, PER, VEN.

Confirmation of the final assessment from five countries was pending at the time of this report.

Most countries are strengthening their plans to improve norms and standards on maternal, infant, and young child nutrition. Most countries have norms in place for micronutrient supplementation of pregnant women and children, prevention of stunting, and promotion of breastfeeding. Nevertheless, these norms often are not well implemented.

With the exception of Ecuador and Peru, all Latin American countries have food-based dietary guidelines. Countries are increasingly developing norms for preventing overweight, including improving the school food environment. Chile, Costa Rica, Mexico, and the United States have been particularly active in this area. Draft policies on school nutrition have been developed in many Caribbean countries.</td></tr>
</table>

2014-2015 End-of-Biennium Assessment
Category 3 Report

CATEGORY 3: DETERMINANTS OF HEALTH AND PROMOTING HEALTH THROUGHOUT THE LIFE COURSE

OVERALL CATEGORY ASSESSMENT RATING[12]
Partially met expectations

CATEGORY PROGRAMMATIC AND BUDGET OVERVIEW

Table 1. Category 3 Programmatic and Budget Summary

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget Implementation against PB (%)	Budget Implementation against awarded (%)	Output Indicator Rating	Outcome Indicator Status
3.1 Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health	42.74	27.03	63.2	61.2	96.8	2/5 achieved, 3/5 partially achieved	2/7 achieved, 5/7 in progress
3.2 Aging and Health	1.68	1.62	96.2	95.9	99.7	2/3 achieved, 1/3 partially achieved	1/1 in progress
3.3 Gender, Equity, Human Rights, and Ethnicity	8.61	5.84	67.8	67.3	99.3	2/5 achieved, 3/5 partially achieved	1/1 in progress
3.4 Social Determinants of Health	11.56	11.82	102.3	101.2	98.9	3/4 achieved, 1/4 partially achieved	1/1 in progress
3.5 Health and the Environment	16.20	11.67	72.1	71.3	99.0	1/5 achieved, 4/5 partially achieved	4/5 in progress, 1/5 no progress

[12] Assessment ratings for the overall category and for program areas/outcomes are determined by the PAHO category and program area facilitators, respectively, taking into consideration the programmatic and budget implementation, analysis of resources (human and financial), and operational and programmatic risks. Ratings are defined as follows:

- **Met expectations** (Green): achieved 90% to 100% of the results for the period being assessed. Progress is on track, as expected; no impediments or risks that affect the achievement of results are foreseen.
- **Partially met expectations** (Yellow): achieved 75% to 89.9% of the results for the period being assessed. Progress may be at risk, and action is required to overcome delays, impediments, and risks.
- **Insufficient progress** (Red): achieved <75% of the results for the period being assessed. Progress is in jeopardy due to impediments or risks that could preclude the achievement of results. Immediate corrections are required.

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget Implementation against PB (%)	Budget Implementation against awarded (%)	Output Indicator Rating	Outcome Indicator Status
TOTAL	**80.78**	**57.98**	**71.8**	**70.3**	**98.0**	**11/22 achieved, 11/22 partially achieved**	**2 achieved, 12 in progress, 1 no progress**

Table 2. Category 3 Budget Overview by Functional Level

Functional Level	Funds Awarded (US$ millions)	Awarded by Level (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
Country	26.00	44.85	25.72	98.9
Intercountry	14.93	25.75	14.43	96.7
Subregional	2.53	4.36	2.49	98.5
Regional	14.52	25.04	14.18	97.7
Total	**57.98**	**100.00**	**56.82**	**98.0**

CATEGORY PROGRAMMATIC ANALYSIS

Overall Category Assessment Summary

During 2014-2015, the work under Category 3 addressed key issues related to health throughout the life course, including women, maternal, newborn, child, adolescent, and adult health, taking into consideration the social and environmental determinants of health and the cross-cutting themes (CCT): gender, equity, human rights, and ethnicity. The year 2015 marked an important juncture in transitioning from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs).

The assessment of Category 3 outcome and output indicators points to considerable progress in the efforts to improve health conditions throughout the life course and reduce inequalities in the Region. All 22 outputs have been either fully achieved (11) or partially achieved (11), and outcomes have been assessed as in progress (12) or achieved (2). One outcome was assessed as no progress. The high level of achievement of outputs augurs well for the achievement of outcomes by the end of the PAHO Strategic Plan 2014-2019. However, due to a sizable funding gap, ongoing human resources issues, and other strategic, technical, and managerial challenges identified in this report, Category 3 overall is assessed as having partially met expectations.

The numbers of countries implementing plans on maternal and perinatal mortality (18) and guidelines on family planning (24) have progressed well toward the targets defined for 2015. The Region implemented the interdepartmental project Zero Maternal Deaths from Hemorrhage. There has been an increase in technical cooperation on the prevention of adolescent pregnancy. The Organization of American States (OAS), with PAHO's technical support, approved the Inter-American Convention on Protecting the Human Rights of Older Persons, and PAHO issued a call to action for implementing the Convention. Human rights norms and standards have been

incorporated in subregional declarations and in national policies, laws, and/or ministerial decrees in several countries. The majority of countries have submitted assessments on their gender mainstreaming efforts. The regional Plan of Action on Health in All Policies (HiAP) was approved by the 53rd Directing Council of PAHO, and a road map has been developed for implementation of the plan. During the same session, a roundtable on the post-2015 development agenda was organized, and countries made recommendations and agreed on future activities. Subsequently, a regional network on the SDGs was launched.

Major challenges identified in Category 3 concerned coordination and inter-programmatic work across all levels of the Organization. The integration of the CCTs in work plans also needs further improvement.

From a budgetary standpoint, Category 3 received US$58 million of the $81 million approved for the 2014-2015 biennium (72%). Budget implementation reached an unprecedented 98% despite the challenges faced.

Programmatic Summary by Program Area

3.1 Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health

This program area responds to mandates on maternal, newborn, child, adolescent, and adult health through the generation of strategic information and the development and implementation of policies, strategies, and plans, with an emphasis on primary health care and obstetric care.

Achievements

- Information provided by countries with more than 7,000 deliveries per year shows a reduction of the maternal mortality ratio by approximately 21% in 2013-2014. By the end of 2016 there will be updated information from the final report on the regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity.
- From 1990 to 2015, the Region showed a 69% reduction in the under-5 mortality rate, achieving the target set by MDG4. Additionally, 18 countries have strategies on early childhood development.
- The adolescent fertility rate continues on a downward trend, from 65.6 per 1,000 in 2013 to 64.4 in 2014 for women 15 to 19 years of age. The reduction is slow and is unequal both between and within countries. This progress is the result of collective efforts by the countries, PAHO, and regional partners. Six countries also updated or developed national adolescent health strategies and policies.
- Eighteen countries are implementing integrated plans for maternal and perinatal mortality reduction, in line with regional plans of action on maternal and neonatal health.
- Evidence and data on the magnitude and consequences of violence against children in the Region were developed by PAHO and various partners. This is an important milestone in closing the information gap in this key area.
- Continued implementation of the regional Strategy and Plan of Action for Integrated Child Health and the Adolescent and Youth Health Regional Strategy and Plan of Action was facilitated by the development of technical materials, training tools, and joint activities with key partners.
- Evidence on reproductive, maternal, newborn, child, and adolescent health was improved through operational research and updated evidence-based materials.
- A PAHO/Norway strategic partnership, HIV Prevention in Young People Using a Human Rights Framework in Central America and the Caribbean, contributed greatly to the development of policies and plans that protect and promote the health of adolescents and youth in these subregions.

- A declaration on prevention of adolescent pregnancy was signed by the first ladies of eight countries of the Region, meeting in Honduras.
- Progress was made on increasing the availability of strategic adolescent health information. A multi-country analysis looked at adolescent health surveys conducted in six overseas Caribbean territories with PAHO support, with the goal of reducing the gap in adolescent health information. Support was provided to assist Haiti in implementing the Global School-based Student Health Survey.

Challenges

- Considerable challenges still affect efforts to reduce preventable causes of death and severe morbidity in newborns and mothers, particularly in relation to access to high-quality services.
- There is an ongoing need to effectively coordinate activities between departments and PAHO/WHO Representative (PWR) Offices for successful implementation of the interdepartmental project Zero Maternal Deaths from Hemorrhage.
- Implementation of the Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity requires continued monitoring.
- There is need for a final evaluation of the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care.
- To ensure continuity of the process started by the above-mentioned strategy and plan of action, regional goals and strategies need to be updated based on the global Every Newborn Action Plan, approved during the 67th World Health Assembly (2014).
- There are challenges to implementation of the Global Strategy for Women's, Children's and Adolescents' Health.

Lessons Learned

- The definition of priorities in technical cooperation has enabled the work to be more productive and to achieve sustainable and permanent results in countries.
- Establishing better internal coordination, within and between departments, has strengthened integration and has had a positive impact on the work with countries, creating an environment of teamwork at national and regional levels.
- Interdepartmental work on the project Zero Maternal Deaths from Hemorrhage allowed the Organization to approach the problem of maternal hemorrhage with an integrated vision and holistic response. The project incorporated programmatic and health services aspects, allowing for a streamlined response to the obstetric hemorrhage emergency and a more efficient use of resources. The ministries of health followed the same approach, which had a positive impact on the work in the various areas of intervention.

3.2 Aging and Health

This program area emphasizes the implementation of the regional Plan of Action on the Health of Older Persons, aimed at promoting the integration of older persons' health into health systems.

Achievements

- The OAS General Assembly approved the Inter-American Convention on Protecting the Human Rights of Older Persons, with support from PAHO, and PAHO launched a call to action for implementation of the Convention.
- The Age-Friendly Cities and Communities initiative, with a multisectoral approach, has been expanded to more than 65 cities in the Region.

- Evidence-based self-care programs for older persons with multiple chronic conditions have been implemented in two Latin American countries and 10 Eastern Caribbean countries.
- The World Report on Ageing and Health was launched in Washington, D.C., during the PAHO 54th Directing Council in 2015.
- The Strategy and Plan of Action on Dementias in Older Persons was approved by the 54th Directing Council.

Challenges

- There is limited institutional capacity in PAHO to respond to the impact of aging populations on the health systems in the Region.

Lessons Learned

- A broader, multisectoral approach that includes other stakeholders within and outside the health sector is necessary to carry out a better analysis of the policies on aging in the Region.
- Countries have started to include aging issues as a priority in their agendas due to the rapid demographic transitions they are facing.

3.3 Gender, Equity, Human Rights, and Ethnicity

This program area addresses the incorporation of the four CCTs set forth in the PAHO Strategic Plan (gender, equity, human rights, and ethnicity) across PAHO programs as strategic approaches to improve health outcomes through inter-programmatic plans, policies, and laws.

Achievements

- Nineteen countries strengthened their institutional capacities to quantify and analyze social inequalities in health, including the production of health equity profiles (mostly in maternal and child health) addressing at least the three dimensions of sustainable development (social, economic, environmental).
- Ten countries have introduced human rights norms and standards in subregional declarations and national policies, laws, and/or ministerial decrees. Two countries reformed civil codes based on the United Nations (UN) Convention on the Rights of Persons with Disabilities and approved or updated health protocols on mental health by ministerial decree in a manner consistent with universal and regional human rights conventions. Eight countries have reformed national laws based on human rights norms and standards in areas such as HIV, adolescent health, disability, or tobacco control.
- Thirty-two countries completed gender equality self-assessments, the results of which were analyzed and presented in the Report on the Evaluation of the Gender Equality Plan of Action 2009-2014. New strategic lines of action were approved by the 54th Directing Council in September 2015.
- Technical expertise and support on ethnicity and health have been significantly enhanced. PAHO has played a key interagency role as co-chair of the United Nations Development Group for Latin America and the Caribbean (UNDG LAC) Interagency Working Group on Indigenous Peoples. A priority focus within the group and in PAHO´s technical cooperation and capacity-strengthening efforts more broadly has been supporting countries in improving the availability and quality of their data on ethnicity and health.
- The CCT Secretariat was formally established in the Pan American Sanitary Bureau (PASB). The inter-programmatic work under this initiative is contributing to the implementation of an integrated conceptual framework to enhance PAHO's technical assistance on the four CCTs (gender, equity, human rights, and ethnicity). As part of its activities, the CCT Secretariat began work with University College London on a regional review of the four CCTs in relation to the social determinants of health.

Challenges

- There has been limited collaboration with nontraditional stakeholders that are making important decisions affecting the right to health and related human rights (parliaments, ministries of foreign affairs and other ministries, and national human rights commissions, among others).
- Stakeholders have different levels of knowledge and understanding of the CCT concepts, integration, and results. Wider and more active collaboration with other technical departments and with PWR Offices may facilitate more meaningful integration and implementation.

Lessons Learned

- Technical activities and discussions related to the links between Zika, women's rights, and gender inequalities, as well as the particular vulnerabilities of people living in situations of poverty, show that stronger collaboration is required to ensure that PAHO´s work during all such public health emergencies adequately considers the CCTs, structural inequalities, and international and regional human rights norms and standards applicable to women´s health.
- More efficient, timely, and inclusive information flows and other means of coordination are required to ensure alignment of PAHO tools, methods, approaches, and conceptual frameworks on gender, equity, human rights, and ethnicity across all areas of PAHO and with WHO.
- Although there is excellent inter-programmatic collaboration among relevant departments within the CCT Secretariat to support the integration of CCTs, additional resources are required to ensure continued coordination of this substantial area of strategic work across the Organization.

3.4 Social Determinants of Health

This program area focuses on implementing the Rio Political Declaration on Social Determinants of Health and entails strengthening partnerships between sectors to address the stark inequalities in the Region.

Achievements

- The Task Force and Working Group on Health in All Policies and the Sustainable Development Goals, composed of regional experts, were established in April 2015. Their role is to identify and address synergies between the SDGs framework and the regional Plan of Action on Health in All Policies, with the overall goal of advancing the cause of sustainable development and health equity in the Americas. Two core documents were developed and finalized by the Task Force and Working Group, namely a Reference Note on SDGs and HiAP and a Work Plan to guide implementation of the post-2015 development agenda.
- In response to Member States' requests for guidance on how to achieve the SDGs, PAHO published a concept paper, "Preparing the Region of the Americas to Achieve the Sustainable Development Goal on Health," and initiated a technical cooperation process with the countries, comparing the SDG targets with current country health policies and programs.
- In line with the regional Plan of Action on Health in All Policies, PAHO conducted three subregional trainings on HiAP, launched a regional HiAP network, produced subregional work plans on HiAP, and documented good practices on HiAP to demonstrate how the concept can be applied in a concrete manner. Additionally, a road map guiding implementation of HiAP, a white paper on HiAP, and a paper on HiAP and indicators were published in the latter part of the biennium.
- As a result of the Third Regional Forum on Urban Health held in Medellín, Colombia, in December 2015, the Medellin Call for Action on Healthy Cities, in which HiAP was central, was issued. This will inform future technical cooperation on urban health and healthy municipalities.

- A regional consultation on SDGs was held in Medellín in November 2015 to enhance the capacities of PWR Offices, health ministries, and other public institutions involved with the implementation of the 2030 Agenda for Sustainable Development in the Region of the Americas. A list of recommendations was identified, and a regional SDGs network was launched as a result of the meeting.
- A Regional Review on Health Inequalities and the four CCTs, to be conducted in 13 countries over a period of two years, was approved and funded.

Challenges

- There is limited capacity to respond to the countries' growing demands for support in translating the social determinants of health into concrete action.

Lessons Learned

- There is a need to capitalize on and further strengthen networks on the social determinants of health to ensure successful and timely technical cooperation.
- As part of implementing the regional Plan of Action on Health in All Policies, there is an urgent need to document and share best ways of applying the concepts of social determinants of health, HiAP, and the SDGs.
- The implementation of the SDGs and associated indicators presents an opportunity to capitalize on their synergies with the HiAP agenda.

3.5 Health and the Environment

This program area includes the response to regional and global commitments pertaining to environmental and occupational health. The goal is to increase institutional capacities to reduce health risks and impact and to generate evidence-based policies.

Achievements

- Household air quality has been incorporated in the health agenda of target countries, and there is an increased awareness of the risks of ambient air pollution and chemicals. Participation has increased in intersectoral mechanisms such as the Strategic Approach to International Chemicals Management (SAICM) and in activities related to the Minamata Convention on Mercury.
- Significant progress was made toward achieving the targets in the Strategy and Plan of Action on Climate Change, although some gaps remain.
- A highlight of the program area was the meeting with 35 PAHO/WHO Collaborating Centers, WHO, the United Nations Environment Programme (UNEP), other intergovernmental agencies, and nongovernmental organizations on the theme of "Climate-smart and sustainable societies: addressing public health vulnerabilities and promoting sustainable adaptation now." The meeting, held in Montreal in September 2015, reviewed current research and PAHO's strategy on sustainable development and health equity. The meeting's recommendations will guide implementation by the Collaborating Centers of the PAHO Strategic Plan 2014-2019. This is particularly important because of commitments made in the Paris Agreement, issued by the 2015 UN Climate Change Conference (COP21), and as a means to support implementation of the SDGs related to health and the environment.
- The approval of the Plan of Action on Workers' Health with full support from the Member States, the agreement with the Inter-American Conference of Ministers of Labor to work jointly to implement this plan, and the advances in updating regulations on occupational health and safety in many countries show great commitment to this program area.

- Through the implementation of water quality surveillance programs and water safety plans (WSP), country capacities were strengthened. For instance, there was systematization of water quality monitoring in the Dominican Republic. A final report assessing progress on the Millennium Development Goal on Water and Sanitation was published by the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation.
- There is also significant progress in measuring inequities and in strengthening capacity on water safety plans, especially related to emergency events. A free online course on WSPs was developed, in Spanish, by the Regional Technical Team on Water and Sanitation (ETRAS), aimed at personnel in the water sector with management, engineering, or operational responsibilities. In response to different outbreaks, regional and country capacities for the preparation of water safety plans with an emergency preparedness and response approach were strengthened in priority countries. This initiative also included the establishment of a network to exchange experiences and knowledge. These initiatives have allowed countries in the Region to improve access to safe water, thereby promoting human rights and the reduction of inequalities.

Challenges

- Great challenges remain with respect to achieving the MDGs on sanitation, closing the urban/rural gap in water and sanitation, and decreasing the use of solid fuels as the main source of household energy in the Region. The MDG targets related to environmental health were incorporated into the SDG agenda and remain a priority in the Region.
- Capacity and resources should be strengthened to respond to the significant need and demand by countries for technical cooperation to help them incorporate and strengthen environmental and occupational health in their national programs.
- Stronger multisectoral efforts and coordination are needed to address environmental and occupational health issues affecting the Region.

Lessons Learned

- There is a need to strengthen capacity for intersectoral work with nontraditional partners of the health sector.
- The Region needs to improve and consolidate water governance, with a paradigm shift toward the sustainable integration of water resources management from catchment to consumer, along with efforts to reduce inequalities. Steps should be taken to include the WSPs as part of national water strategies.

Risks

The most relevant risks identified for Category 3 in the PAHO Strategic Plan 2014-2019 are listed below, with relevant information regarding their status and mitigation actions taken to address them. New risks identified during the biennium are also highlighted.

- Competing priorities, disasters and epidemics, political turmoil, or civil unrest limit the resources for program areas in this category, compromising the achievement of results.
    - Funding gaps in priority program areas were identified, particularly in relation to Program Area 3.1. It is expected that in the 2016-2017 biennium, priority countries will have a focal point and that this program area will be fully funded to support the achievement of outcomes and outputs.
- Information systems produce limited disaggregated data and scarce data on the social determinants of health.
    - The CCT Secretariat and CCT Working Group developed a two-year proposal to gather and consolidate data and evidence from different sectors as part of a regional Review on Health

Inequalities.
    - The review will be launched in May 2016 and will facilitate the gathering of existing evidence on the social determinants of health.
- The health workforce is not prepared for the development of new active aging programs.
    - The Health Management for Older People, an online course offered by the Virtual Campus of Public Health, has involved 300 students and has been taught in three languages (Spanish, English, Portuguese).
    - The University Consortium on Public Health and Aging was developed and has involved 17 Latin American and 10 Caribbean countries.
- Although health priorities at the global, regional, and national levels prioritize the cross-cutting themes, they are easily overshadowed or sidestepped when challenged by national and international interest groups. There is limited knowledge and consensus among partners on definitions, frameworks, and strategies for the CCTs.
    - Both the CCT Secretariat and CCT Working Group were established within the PASB in December 2014, and they have steered efforts to mainstream the CCTs throughout PAHO's work. The CCT Working Group is tasked with providing support to the Secretariat in moving forward the collective CCT agenda by strengthening knowledge and consensus among partners on definitions, frameworks, and strategies for the CCTs.
    - The CCT Working Group is making active efforts to encourage PAHO's departments and units to work in an inter-programmatic manner. Progress has been most evident among the Working Group's member departments, which have increasingly developed a strong, cohesive, and transparent model of collaboration. Mainstreaming the CCTs and making their integration into all programs and country office activities "business as usual" will be a long-term effort and will require more focused advocacy to encourage high-level and technical buy-in and support.
- Outdated policies and laws, and limited enforcement of existing policies and laws, make it difficult to effectively address environmental and workers' health.
    - During 2014 and 2015 PAHO facilitated subregional consultations to discuss strategic lines of action for formulating and reviewing national health-related laws and regulations in a manner consistent with universal and regional human rights treaties and standards, upon request of PAHO Member States.
    - A working group on health-related law was established by the PAHO Executive Committee, and in 2015 the Directing Council approved the PAHO Strategy on Health-Related Law. This includes specific actions and objectives related to laws on the environment, worker's health, and other areas as established by the PAHO Strategic Plan 2014-2019.

New risks introduced during the biennium:

- The multisectoral approach is neither prominent nor pursued in programs and projects. The development of interdepartmental actions should be reinforced so that it becomes part of the organizational culture.
- There is possible duplication of work on health and human rights in countries by different UN agencies.

Budget Implementation Analysis

Table 3. Category 3 Budget Overview by Program Area and Functional Level

Category, Program Area, and Functional Level	Funds Awarded (US $millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation ($)
3. Determinants of Health and Promoting Health throughout the Life Course	**57.98**	**100.00**	**56.82**	**98.0**
3.1 Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health	**27.03**	**46.62**	**26.17**	**96.8**
Country	13.95	24.05	13.75	98.6
Intercountry	8.79	15.17	8.38	95.4
Subregional	0.87	1.51	0.85	97.1
Regional	3.42	5.89	3.19	93.3
3.2 Aging and Health	**1.62**	**2.79**	**1.61**	**99.7**
Country	0.50	0.87	0.50	100.0
Intercountry	0.31	0.53	0.31	99.6
Subregional	0.08	0.14	0.08	99.6
Regional	0.73	1.26	0.72	99.6
3.3 Gender, Equity, Human Rights, and Ethnicity	**5.84**	**10.07**	**5.79**	**99.3**
Country	1.12	1.94	1.12	99.7
Intercountry	1.26	2.17	1.25	99.2
Subregional	0.47	0.81	0.47	99.4
Regional	2.99	5.15	2.96	99.2
3.4 Social Determinants of Health	**11.82**	**20.39**	**11.69**	**98.9**
Country	5.34	9.20	5.28	98.9
Intercountry	1.78	3.08	1.76	98.8
Subregional	0.47	0.81	0.46	98.8
Regional	4.24	7.31	4.19	98.8
3.5 Health and the Environment	**11.67**	**20.13**	**11.55**	**99.0**
Country	5.09	8.79	5.06	99.4
Intercountry	2.79	4.81	2.73	98.0
Subregional	0.63	1.09	0.63	99.5
Regional	3.15	5.44	3.12	99.1

For the 2014-2015 biennium, Category 3 had an approved budget of $81 million, of which $58 million (72%) was funded. Budget implementation reached an unprecedented 98%. The funding gap between the approved budget and funds awarded remained wide, at $23 million or 28%.

As displayed in Table 1, Program Area 3.1 received just 63% of its approved budget, a level that is not commensurate with its priority position in the PAHO Strategic Plan (Tier 1 or high). Considering the funding gap and the actual needs

of this priority program area, increased attention will be paid to its funding. For instance, several country-level positions will be established during the 2016-2017 biennium to address the unfinished agenda in the reduction of maternal mortality in particular. Funds awarded to Program Area 3.2 nearly reached the approved budget, at 96%. The funding gap in Program Area 3.3, by contrast, remained high at 32%. It is worth noting that, due to the nature of the CCTs, their implementation may be spread across several program areas. Funding for Program Area 3.4 slightly exceeded the approved budget by 1%. Program Area 3.5 received 72% of the approved budget, with an implementation rate of 99%.

The country level received the greatest share of funds awarded (45%), followed by the intercountry (26%), regional (25%), and subregional (4%) levels. It is notable that 24% of the resources for the entire category went to the country level for Program Area 3.1, in line with the priorities and needs of the countries. This may reflect a final push by the countries to achieve the targets in Program Area 3.1 that are part of the unfinished agenda of the Region.

Resource Mobilization

Category 3 mobilized funding through alliances with the Colgate Palmolive Company; the European Commission; the governments of Brazil, Canada, Norway, Peru, Republic of Korea, and Spain; UN agencies, including the United Nations Development Programme, United Nations Population Fund, UNICEF, UNEP, and UN Trust Fund for Human Security; and the US Agency for International Development.

Recommendations

- Encourage and reinforce Category 3 to promote a multisectoral approach to reach SDG3 targets as follows:
  - Reduce maternal, newborn, and child mortality to specified levels;
  - Achieve universal access to sexual and reproductive health care services, including family planning;
  - Achieve universal health coverage and financial risk protection.
- Strengthen the health promotion and life course approach by working in a more integrated manner toward achieving other strategic goals.
- Ensure financial support for priority areas.
- Enhance support for the integration of the CCTs into the work of all categories and program areas.

Assessment by Program Area

Program Area 3.1: Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health **OUTCOME: Increased access to interventions to improve the health of women, newborns, children, adolescents, and adults** OCM Indicator Assessment: 2/7 Achieved, 5/7 In Progress OPT Indicator Assessment: 2/5 Achieved, 3/5 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[13,14]
3.1.1	Percentage of unmet need with respect to modern methods of family planning	15%	11%	Achieved (10.7%)
The UN median estimation of the unmet need for contraception in Latin America and the Caribbean as a whole is 10.7%, but there are very large gaps between countries, as well as gaps within countries between the richest and poorest populations. Unmet need for contraception is 16.3% in the Caribbean subregion, 11.2% in Central America, and 9.7% in South America. At the country level, Haiti has the highest unmet need at 32.9%, followed by Guyana at 26.5%, while the lowest is Puerto Rico at 6%, showing the wide variation between countries/territories. At the same time, intra-country variation is also high. In Bolivia, for example, the richest 20% have an unmet need for contraception of 11.9%, while the poorest 20% have 25.3%, meaning that their unmet need is twice as high. This pattern is repeated across all countries in the Region. Source: United Nations, Department of Economic and Social Affairs, Population Division, "Trends in Contraceptive Use Worldwide, 2015."			
3.1.2	Percentage of deliveries attended by trained personnel	95%	97%	In progress (95.6%)
According to the technical specifications of the indicator, information must come from the PAHO Basic Indicators. The PAHO Basic Indicators for 2015 show that the percentage of deliveries attended by trained personnel in the Region was 95.6%. Progress is slow, but it is ongoing.				

[13] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached.
- **In progress:** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way/on track to achieve the target set in the Strategic Plan by 2019.
- **No progress:** There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and progress toward achieving the indicator target by 2019 could be in jeopardy.

[14] The regional indicators are assessed by the responsible regional entity/Category and Program Area Network (CPAN) based on the latest available information, according to criteria defined in the compendium of indicators.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[13,14]
3.1.3	Percentage of mothers and newborns receiving postpartum care within seven days of childbirth	40%	60%	In progress (TBD)
Countries of the Region are not measuring this indicator in a regular way. Up to now, the only way to collect data on this indicator has been through the monitoring provided by the regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity. This indicator will be measured in 2017 for the final report of the plan, or when it is incorporated in the PAHO Basic Indicators.				
3.1.4	Percentage of infants under 6 months of age who are exclusively breastfed	38%	44%	In progress (<40%)
According to the WHO and UNICEF databases and *The Lancet*'s last publication on breastfeeding (2016), seven countries carried out national surveys between 2011 and 2012. The prevalence in six of them was less than 40% (range: 14.4%-39.7%); one country, Peru, had a prevalence of 67.6%. In 2013 only three countries conducted national surveys, reporting prevalence figures of 6.7%, 22.0%, and 72.3% (the higher figure again being Peru). Given the limited available data, it is difficult to determine whether we are approaching the target.				
3.1.5	Percentage of children aged 0-59 months with suspected pneumonia receiving antibiotics	29%	40%	Exceeded (46%)
According to WHO and UNICEF, seven countries conducted national surveys between 2011 and 2012. Four of these countries had a prevalence of 60%-70%, one had 50%-60%, and two had 40%-50%. Only two countries carried out national surveys in 2013, one with prevalence of 51.5% and the other with 46.6%. The 2012 baseline is 29%, which seems rather low according to the limited data available. The goal of 40% also seems set too low, since countries with surveys in 2012 already had higher percentages. The prevalence for the Americas published by WHO is 46%.				
3.1.6	Specific fertility rate in women 15-19 years of age	65.6 per 1,000	52 per 1,000	In progress (64.4 per 1,000)
Over the past five years the Region has seen a slow downward trend in adolescent fertility. According to UNdata, the estimated specific fertility rate was 65.6 in 2013 and 64.4 in 2014. It is important to recognize that the reductions have not been equal across or within countries. The 2013 baseline established for Outcome Indicator 3.1.6 was revised for this report from 60.0 to 65.6 per 1,000 based on the figures reported by UNdata for 2013. The corresponding changes will be incorporated in the technical definition of the indicator and will be used for future assessments.				
3.1.7	Number of countries and territories that adhere to PAHO's recommendation to conduct periodic medical occupational evaluations (PMOE) among the adult working population (18-65 years of age)	3	10	In progress (4 achieved + 4 in progress)
Four countries achieved the indicator: ARG, CHL, CUB, URY. Four countries are in progress: DOM, ECU, PER, VEN. Confirmation of the final assessment from two countries was pending at the time of this report. Results are very promising. Cuba and Uruguay were expected to achieve the indicator by 2019. Most countries have regulations in place, and in many, authority for these evaluations is vested in the Ministry of Labor or shared				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[13,14]
by several agencies (e.g., Colombia). Hence, intersectoral coordination and actions are required to advance the implementation.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating [15, 16]
3.1.1	Implementation of the regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity and the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care	Number of countries and territories implementing an integrated plan for maternal and perinatal mortality in line with regional plans of action on maternal mortality and neonatal health	4	19	Partially achieved (12 achieved + 4 partially achieved)
Twelve countries and territories achieved the indicator: COL, CUB, DMA, DOM, GTM, HND, MEX, NIC, PRY, SLV, STA, VEN. Four countries and territories partially achieved the indicator: ARG, BOL, CUW, JAM. Six countries were pending confirmation at the time of this report.					
3.1.2	Implementation of the regional Strategy and Plan of Action for Integrated Child Health, with emphasis on the most vulnerable	Number of countries and territories implementing a national integrated child health policy/strategy or plan consistent with legal frameworks and regulations	8	12	Exceeded (15 achieved + 4 partially achieved)
Fifteen countries and territories achieved the indicator: ABW, BRA, CHL, COL, CUB, CUW, GLP, GUY, HND, JAM, MEX, PAN, SLV, STA, VEN. Four countries and territories partially achieved the indicator: ARG, BON, SAB, TTO. Three countries (El Salvador, Honduras, Jamaica) have completed or updated their national plans/strategies, use a life course approach, and have a special focus on integrating nutrition, health, and development of children. Two					

[15] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set in the Program and Budget (PB) 2014-2015 (number of countries/territories, number or % for regional indicators) has been reached. Indicator targets that have been exceeded are noted as such.
- **Partially achieved:** Progress was made over the baseline value set in the PB (number of countries/territories, number or % for regional indicators), but the target for 2015 was not achieved.
- **No progress:** There was no increase over the baseline value set in the PB (number countries/territories, number or % for regional indicators).

[16] The regional indicators are assessed by the responsible regional entity/CPAN based on the latest available information, according to criteria defined in the compendium of indicators.

<table>
<tr><th>OPT #</th><th>Output Title</th><th>OPT Indicator</th><th>Baseline 2013</th><th>Target 2015</th><th>Assessment Rating [15, 16]</th></tr>
<tr><td colspan="6">other countries/territories (Bonaire and Trinidad and Tobago) are in the process of improving their response.</td></tr>
<tr><td>3.1.3</td><td>Implementation of the global Strategy for Sexual and Reproductive Health, focusing on addressing unmet needs</td><td>Number of countries and territories implementing WHO/PAHO guidelines on family planning</td><td>8</td><td>22</td><td>Partially Achieved (18 achieved + 5 partially achieved)</td></tr>
<tr><td colspan="6">Eighteen countries and territories achieved the indicator: ABW, BLZ, BRA, COL, CUB, DOM, GTM, JAM, MEX, NIC, PAN, PER, PRY, SLV, SUR, SXM, URY, VEN.

Five countries and territories partially achieved the indicator: CRI, KNA, SAB, STA, TTO. Three countries were pending confirmation at the time of this report.</td></tr>
<tr><td>3.1.4</td><td>Research undertaken and evidence generated and synthesized to design key interventions in reproductive, maternal, newborn, child, adolescent, and adult health, and other related conditions and issues</td><td>Number of studies conducted to inform the design of new or improved interventions for reproductive, maternal, newborn, child, adolescent, and adult health</td><td>4</td><td>10</td><td>Exceeded (3 systematic reviews and 10 research papers)</td></tr>
<tr><td colspan="6">3 systematic reviews and 10 research papers, over the baseline, were published.

<u>Systematic reviews:</u>
• Neonatal near miss: a systematic review. BMC Pregnancy Childbirth 2015;15(1):320.
• Costs of prematurity in biomedical literature in order to contrast with regional results: a systematic review. Submitted for publication.
• Revisión sistemática sobre la disponibilidad de programas y acciones orientadas a dar respuesta a la retinopatía del prematuro. Submitted for publication.
<u>Papers:</u>
• Neonatal near miss: the need for a standard definition and appropriate criteria and the rationale for a prospective surveillance system. Clinics (São Paulo) 2015;70(12):820-826.
• Progress in reducing inequalities in reproductive, maternal, newborn, and child health in Latin America and the Caribbean: an unfinished agenda. Rev Panam Salud Publica 2015;38(1):9-16.
• Gestational syphilis and stillbirth in the Americas: a systematic review and meta-analysis. Rev Panam Salud Publica 2015;37(6):422-429.
• Maternal and congenital syphilis in selected Latin America and Caribbean countries: a multi-country analysis using data from the Perinatal Information System. Sex Health 2015;12(2):164-169.
• Gestational syphilis and stillbirth in Latin America and the Caribbean. Int J Gynaecol Obstet 2015;128(3):241-245.
• Progresos y desafíos en salud neonatal en la Región de las Américas. Rev Panam Salud Pública (under review).
• An analysis of three levels of scaled-up coverage for 28 interventions to avert stillbirths and maternal, newborn and child mortality in 27 countries in Latin America and the Caribbean with the Lives Saved Tool (LiST). BMC Public Health (under review).
• Descripción de la situación de acompañamiento continuo en las mujeres en trabajo de parto y parto en países de América Latina y el Caribe. Prepared with the WHO Collaborating Center at the University of Chile and WHO/MCAH. Presented at 5th ICM Regional Conference of the Americas, Suriname, July 2015.</td></tr>
</table>

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating [15, 16]
• Taxonomía de países latinoamericanos respecto a algunas variables obstétricas y neonatales relativas a la modalidad de atención del parto. Prepared with the WHO Collaborating Center at the University of Chile. Presented at the 5th ICM Regional Conference of the Americas, Suriname, July 2015. • Maternal near miss and predictive ability of potentially life-threatening conditions at selected maternity hospitals in Latin America. Submitted for publication.					
3.1.5	Implementation of the regional Plan of Action on Adolescent and Youth Health	Number of countries and territories implementing national health-related policies or plans on comprehensive adolescent health	16	30	Partially Achieved (15 achieved + 13 partially achieved)
Fifteen countries achieved the indicator: BOL, BRA, CHL, COL, CRI, CUB, GTM, HND, HTI, MEX, NIC, SLV, SUR, URY, VEN. Thirteen countries and territories partially achieved the indicator: ABW, ARG, BON, CUW, DOM, ECU, GUY, KNA, PER, SAB, STA, TTO, VGB. Important progress was made in priority countries, including Bolivia, Guatemala, Suriname, and Haiti, in development or updating of their national adolescent health-related policies or plans.					

Program Area 3.2: Aging and Health **OUTCOME: Increased access to interventions for older adults to maintain an independent life** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 2/3 Achieved, 1/3 Partially Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
3.2.1	Number of countries and territories with at least one evidence-based self-care program for older adults (60 and over) living with multiple chronic conditions	n/a	15	In progress (1 achieved)
One country achieved the indictor: PER. Confirmation of the final assessment from one country was pending at the time of this report. The Region began to implement the program Tomando Control de su Salud that currently operates in Chile, Argentina, and the Eastern Caribbean. Master trainers received orientation, and the program is progressively spreading in all countries. Interdepartmental work is being developed with the Noncommunicable Diseases Department. Mexico and Peru are creating conditions for implementation of the program.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.2.1	Implementation of the regional Plan of Action on the Health of Older Persons, including strategies to promote active and healthy aging	Number of countries and territories that have incorporated strategies to promote active and healthy aging or access to an integrated continuum of care in their national plans	7	11	Achieved (11 achieved + 9 partially achieved)
Eleven countries and territories achieved the indicator: ARG, BRA, CAN, CHL, CRI, CUB, MEX, TTO, USA, VEN, VGB. Confirmation from three countries was pending at the time of this report. Nine countries and territories partially achieved the indicator: ABW, BON, BRB, CUW, DMA, JAM, KNA, SAB, SLV. It is important to highlight that all of them achieved changes. Confirmation of the final assessment from one country was pending at the time of this report. Mexico has a national plan to promote healthy aging, El Plan Nacional de Desarrollo 2007-2012. Argentina has provided important leadership in the process around the new Inter-American Convention on Protecting the Human Rights of Older Persons and in the global consultation on the Global Strategy and Action Plan on Ageing and Health.					
3.2.2	Countries enabled to assess and address the health needs of older persons for improved care	Number of countries and territories monitoring and quantifying the diverse health needs of older people, pursuant to WHO-recommended measures and models	5	10	Partially Achieved (9 achieved + 9 partially achieved)
Nine countries and territories achieved the indicator: ABW, ARG, CAN, CHL, CUB, JAM, MEX, SAB, USA. Nine countries and territories partially achieved the indicator: BON, BRA, COL, CRI, CUW, KNA, NIC, SLV, VEN. Brazil and Mexico have advanced in the national longitudinal research on aging. Colombia has already finished a national survey on health and well-being. Nicaragua has included older persons' issues as a priority in the Ministry of Health, and it also includes some data on older persons in the evaluation of health services. Although not all objectives have been achieved, countries show a commitment to continue working to improve the care of older persons based on their needs.					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.2.3	Countries enabled to implement policies and plans focusing on the health of women beyond reproductive age	Number of countries and territories implementing national health-related policies, legislation, or plans on the health of women beyond reproductive age	0	5	Exceeded (8 achieved)

Eight countries achieved the indicator: ARG, CAN, CHL, CRI, CUB, MEX, PER, USA. Confirmation from seven countries was pending at the time of this report.

These countries have put in place specific plans and programs focused on the health of women beyond reproductive age. In addition, a policy brief about the situation of older women's health in the Region is under discussion as a means to stimulate further efforts in this area.

Program Area 3.3: Gender, Equity, Human Rights, and Ethnicity **OUTCOME: Increased country capacity to integrate gender, equity, human rights, and ethnicity in health** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 2/5 Achieved, 3/5 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
3.3.1	Number of countries and territories that have an institutional response that addresses inequities in health, gender, equity, human rights, and ethnicity	32	39	In progress (13 achieved + 22 in progress)

Thirteen countries and territories achieved the indicator by meeting at least two of the conditions specified in the technical definition of the indicator: ARG, BON, BRA, CAN, CRI, GTM, HND, JAM, PAN, PRY, SLV, SXM, VEN.

Another 22 countries and territories were in progress: ABW, AIA, BOL, CHL, COL, CUB, CUW, DOM, ECU, GUY, HTI, KNA, LCA, MEX, MSR, NIC, PER, SAB, STA, TTO, URY, VGB.

Countries are making significant advances in each of the specific technical areas (gender, equity, human rights, and ethnicity) included under OCM 3.3.1; for example, the recent evaluation of the Gender Equality Plan of Action revealed that almost 80% of countries and territories report having gender plans and policies in place. However, challenges remain, as noted below each of the relevant output indicators. PAHO is renewing its commitment to support countries in furthering these advances and addressing challenges, not only through the continuing technical work in each area but also through the establishment and activities of the CCT Secretariat and CCT Working Group. As noted under OPT 3.3.1, the Secretariat and Working Group are striving to ensure that all of PAHO's technical support to countries integrates a focus on the CCTs in order to help all 39 countries and territories meet the target for 2019.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.3.1	Gender, equity, human rights, and ethnicity integrated into PAHO programs	Proportion of PASB entities integrating gender, equity, human rights, and ethnicity into operational planning	Data not currently measured	80%	Exceeded (81%)

81% of the PASB functional entities (a total of 49 PWR Offices, technical departments, and technical offices) integrated the CCTs into their 2014-2015 work plans. The CCT Working Group in PAHO is unique within the WHO system in its incorporation of gender, equity, human rights, and ethnicity into operational planning and reporting. Toward this end, the group has undertaken and provided feedback to reporting processes and has updated guidelines for Biennial Work Plan (BWP) planning processes for all PAHO's entities.

During the 2014-2015 biennium, 2,495 (62%) of the total 4,030 products and services across all entities were linked to the CCTs, with the highest level of linkage to equity (1,947, or 48%), followed by human rights (1,692, or 42%), and gender (1,553, or 39%). The lowest level of linkage was to ethnicity (1,122, or 28%). Leaving aside the enabling entities, 81% of the remaining 74 PASB entities (PWR Offices and technical entities) have integrated the CCTs into their work plans, as reviewed in the 2014-2015 and 2016-2017 BWPs.

In revisions of reports, the CCT Working Group identified challenges to the further integration and realistic implementation of the CCTs across the Organization. These challenges include differing levels of knowledge and understanding of CCT concepts (especially ethnicity), integration that is often aspirational (especially with respect to equity), scarce tangible results/outcomes, and lack of a systematic means of building on entry points (one CCT to another). Moreover, successful implementation of CCTs is not necessarily captured in performance monitoring and assessment processes. Although reporting of linkages is good, the relative lack of narrative reporting on this indicator provides further evidence that it remains difficult to adequately capture all advances.

The CCT Working Group is further developing its mechanisms, including training, for enhancing support to corporate processes so as to improve linkages to the CCTs during planning and reporting. It is also working to ensure that implementation of the CCTs across different programs of work becomes more integrated and results-oriented. The CCT Secretariat has developed a proposal for a regional review of the four CCTs in relation to the social determinants of health in collaboration with the Institute of Health Equity at University College London. This will help establish a firm evidence base for further work on the CCTs at country level and also generate debate on policy options to close equity and inequality gaps in health.

3.3.2	Countries enabled to implement and monitor health policies/plans that address gender equality	Number of countries and territories and territories implementing health policies or plans that address gender equality	16	22	Partially Achieved (11 achieved + 8 partially achieved)

Eleven countries achieved the indicator: ARG, CRI, DOM, GTM, HND, MEX, NIC, PAN, SLV, URY, VEN.

Eight countries partially achieved the indicator: BOL, COL, ECU, GUY, HTI, PER, PRY, TTO.

Confirmation of the final assessment from six countries was pending at the time of this report.

The large majority of countries in the Region are advancing gender equality in health. Countries report important progress with respect to policy documents developed and under implementation, inter-programmatic initiatives, and other advances.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.3.3	Countries enabled to implement health policies/plans and/or laws to address human rights	Number of countries and territories using human rights norms and standards to formulate policies, plans, or legislation	26	33	Partially Achieved (15 achieved + 8 partially achieved)
Fifteen countries and territories achieved the indicator: ARG, BON, CHL, CUW, DOM, GTM, HND, JAM, KNA, NIC, PAN, PRY, SLV, SXM, VGB. Confirmation from two countries was pending at the time of this report. Eight countries and territories partially achieved the indicator: AIA, COL, GUY, HTI, LCA, MSR, PER, TTO. Nine countries were pending confirmation at the time of this report. At the regional and subregional levels, PAHO has facilitated the formulation of human rights conventions and declarations based on human rights norms. Examples include, in the OAS, the Inter-American Convention on Protecting the Human Rights of Older Persons, and in the Central American Integration System (SICA), a plan for the prevention of pregnancy in adolescents. At country level, some important achievements on the reform of laws and policies based on human rights have happened in the areas of mental health, disability, and reproductive health, for example in Peru. A recommendation for the next biennium is to coordinate in advance with the PWR Offices, virtually and face-to-face as appropriate, specific steps toward the formulation of policies, plans, and/or laws addressing human rights. All PAHO Member States negotiated and approved in the 2015 Directing Council the Strategy on Health-Related Law, which provides specific recommendations and guidelines on how to formulate national laws based on human rights instruments.					
3.3.4	Countries enabled to implement health policies/plans to address equity in health	Number of countries and territories implementing health policies/plans or laws that address health equity	8	13	Exceeded (24 achieved + 1 partially achieved)
24 countries and territories achieved the indicator (ABW, ARG, BOL, BON, BRA, BRB, CAN, CHL, COL, CRI, CUB, CUW, DOM, JAM, MEX, PER, PRY, SAB, SLV, STA, SXM, TTO, USA, VEN). This means they implemented health policies/plans and/or laws that addressed health equity, including actions on the social determinants of health as well as the progressive realization of universality in health care. Confirmation of the final assessment from seven countries was pending at the time of this report. Additionally, one country partially achieved the indicator: BHS.					
3.3.5	Countries enabled to implement health policies/plans and/or laws to address ethnicity	Number of countries and territories implementing health policies/plans or laws for ethnic/racial populations	12	18	Partially achieved (10 achieved + 9 partially achieved)
Ten countries and territories achieved the indicator: ABW, BOL, BON, BRA, CAN, HND, PAN, SAB, SXM, VEN. Nine countries and territories partially achieved the indicator: COL, CUW, ECU, GTM, GUY, MEX, PER, PRY, SLV.					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
Advances on this output have been made during this biennium at regional, subregional, and country levels, and target countries have been involved. Two regional technical consultations with the ministries of health were conducted, with broad participation by countries of the Region. These initiatives have been key to giving ethnicity a more central place in national as well as regional health agendas. In the case of Honduras, a process has been initiated for the preparation of a health profile of indigenous and Afro-descendant populations. Peru and Mexico have made progress toward meeting the output, as reflected in their country evaluations. However, challenges still remain, given the complexities of the issues involved. In order to address these challenges more fully, as well as to make progress in other countries, the regional level emphasizes its readiness to offer technical support to countries in relation to this indicator and urges countries to reach out to coordinate such support.					

Program Area 3.4: Social Determinants of Health **OUTCOME: Increased leadership of the health sector in addressing the social determinants of health** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 3/4 Achieved, 1/4 Partially Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
3.4.1	Number of countries and territories implementing at least two of the five pillars of the Rio Political Declaration on Social Determinants of Health	13	27	In progress (2 achieved + 2 in progress)
Two countries achieved the indicator: CAN, MEX. Two countries made partial progress on the indicator: BHS, PER. Countries are making immense progress implementing the Rio Political Declaration on Social Determinants of Health, using HiAP as the operational tool. Peru, Suriname, and the Bahamas have demonstrated concrete results in the area of governance and intersectoral action. All of the target countries have been invited to participate in the Review on Health Inequalities coordinated by the CCT Secretariat and CCT Working Group, to be launched in May 2016.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.4.1	Implementation of the WHO Health in All Policies Framework for Country Action, including intersectoral action and social participation to	Number of countries and territories implementing the Health in All Policies Framework for Country Action	6	12	Achieved (12 achieved + 4 partially achieved)

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
	address the social determinants of health				

Six countries and territories reported that they achieved the indicator: ABW, ARG, CHL, CUB, SLV, VEN.

Ten countries and territories partially achieved the indicator: BHS, COL, CRI, ECU, MEX, PAN, SAB, TCA, TTO, VGB. In the estimation of PASB, six countries that are currently rated as partially achieved could actually be rated achieved.

All the target countries have actively engaged in implementation of the WHO Health in All Policies Framework for Country Action. From strategic discussions, the National Institute of Public Health (INSP, Mexico), Oswaldo Cruz Foundation (FIOCRUZ, Brazil), and Latin American School of Social Sciences (FLACSO, Chile) emerged as key institutions to carry forward this ambitious agenda in the Americas. Since their participation in WHO's first HiAP Training of Trainers, held in Geneva in March 2015, these institutions have actively contributed their capacity-building knowledge and experience to inform the Expert Consultation on HiAP held in Washington, D.C., as well as developing a road map for HiAP implementation in line with PAHO's Regional Plan of Action on HiAP. Each organization has conducted or will conduct a training workshop on HiAP, in partnership with PAHO, in its respective subregion. In this way, regional ownership of the initiative is developed, capacity is built, and networks of trained practitioners are developed. In the latter part of the biennium two trainings took place, one in Mexico and one in Brazil.

3.4.2	Countries enabled to generate equity profiles to address the social determinants of health	Number of countries and territories producing equity profiles that address at least two social determinants of health	0	9	Achieved (9 achieved + 8 partially achieved)

Nine countries and territories achieved the indicator: ARG, BRA, CAN, CUW, HND, NIC, PAN, SLV, VEN.

Eight countries and territories partially achieved the indicator: BLZ, BOL, BON, COL, CRI, ECU, PER, TTO.

Confirmation on the final assessment from four countries was pending at the time of this report.

Countries strengthened their institutional capacities to quantify and analyze social inequalities in health, including the production of health equity profiles (mostly in maternal and child health) addressing at least the three dimensions of sustainable development (social, economic, environmental).

3.4.3	Countries enabled to scale up local experiences using health promotion strategies to reduce health inequity and enhance community participation and empowerment	Number of countries and territories implementing health promotion strategies to reduce health inequities and increase community participation	10	20	Partially achieved (13 achieved + 7 partially achieved)

13 countries and territories achieved this indicator: ABW, BRA, CAN, CHL, COL, CUB, MEX, PAN, PRY, SAB, SLV, TTO, VEN.

7 countries and territories partially achieved the indicator: BLZ, CRI, CUW, ECU, PER, STA, SUR.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.4.4	Countries enabled to address health in the post-2015 development agenda, responding to the social determinants of health	Number of countries and territories integrating health in the post-2015 development agenda into their national planning processes	5	10	Achieved (10 achieved + 4 partially achieved)

Ten countries and territories achieved this indicator: ARG, BRA, CUW, ECU, GTM, HND, MEX, PAN, SLV, VEN.

Four countries and territories partially achieved the indicator: CHL, CRI, PER, SAB.

Confirmation of the final assessment from two countries was pending at the time of this report.

PAHO has been working closely with countries to prepare them to implement the 2030 Agenda for Sustainable Development, as well as with several institutions in the Region to strengthen the capacity of the countries to achieve the SDGs. A case in point is PAHO's collaboration with the Collaborating Center at FIOCRUZ (Brazil) and with the Sustainable Development Solutions Network on how best to strengthen capacity for implementation of the SDGs across the Region. Both analysis and capacity-building inform the national consultations that have been and continue to be conducted across the Region, focused on how countries will implement the SDGs. PAHO established a joint working group with the OAS to analyze the existing OAS mandates and programs that represent multisectoral opportunities to promote health equity, including the participation of champion countries such as Colombia and Mexico. During the latter part of the biennium PAHO published two core documents on SDGs, which have been disseminated and shared with the countries.

Program Area 3.5: Health and the Environment **OUTCOME: Reduced environmental and occupational threats to health** OCM Indicator Assessment: 4/5 In Progress, 1/5 No Progress OPT Indicator Assessment: 1/5 Achieved, 4/5 Partially Achieved	**Rating: Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
3.5.1	Number of countries and territories with a significant disparity (>5%) that have reduced the gap between urban and rural populations' access to improved water source	9	24	In progress (9 achieved + 12 in progress)

Nine countries and territories achieved the indicator: ARG, BHS, BLZ, CAN, CHL, CUB, GLP, URY, USA.

Twelve countries are in progress: BOL, COL, DOM, ECU, GTM, GUY, HND, JAM, NIC, PAN, PER, PRY.

Guyana and Honduras have completed institutional plans for strengthening their water quality monitoring programs in cooperation with their ministries of health. Bolivia and El Salvador have been supported in the development of WSPs. Peru has approved regulations to implement its WSP. Haiti is discussing WSP methodology and application and is reviewing a proposal for the development of a national program for water quality monitoring.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
3.5.2	Proportion of the population with access to improved sanitation	88%	92%	In progress
The Region did not achieve the MDG in 2015, although 36% of the population gained access to improved sanitation. Still, 106 million people in the Region have no access to improved sanitation. The following countries and territories met the MDG target: Anguilla, Argentina, Aruba, Bahamas, Barbados, Belize, Brazil, British Virgin Islands, Chile, Costa Rica, Cuba, Ecuador, El Salvador, Grenada, Honduras, Mexico, Paraguay, Peru, Puerto Rico, Uruguay, and Venezuela. The following made progress but did not meet the target: Bolivia, Cayman Islands, Colombia, Dominica, Guadeloupe, Guyana, Haiti, Jamaica, Nicaragua, Panama, Suriname, Trinidad and Tobago, and U.S. Virgin Islands.				
3.5.3	Number of countries and territories in which the proportion of population relying on solid fuels is reduced by 5%	14	20	No Progress (5 achieved + 8 in progress)
Five countries achieved the indicator: BRB, CAN, ECU, USA, VEN. Eight countries are in progress: ARG, GRD, HND, KNA, NIC, PER, PRY, TTO. Although some countries show decreasing trends in solid fuel use (SFU), including Honduras (−1%), Peru (−2%), and Paraguay (−7%), overall progress was insufficient to what was expected. Countries that increased their SFU are Guatemala (+7%), Mexico (+1%), and Haiti (+1%). All countries in progress are likely to achieve the 2019 target; however, Guatemala and Haiti face challenges and will require high commitment to scale up national programs to achieve the target. Among the baseline countries, all sustained decreasing trends in SFU. Additionally, Colombia had no change, at 14% SFU; Dominican Republic had an increase of +2%; and El Salvador decreased from 22% to 19% but remains at significant risk. There are challenges with data collection and measuring.				
3.5.4	Number of countries and territories with capacity to address workers' (occupational) health with emphasis on critical economic sectors and occupational diseases	11	24	In progress (4 achieved + 13 in progress)
Four countries and territories achieved the indicator: ARG, BRA, CAN, USA. Thirteen countries and territories are in progress: ABW, BHS, BON, COL, DMA, HND, JAM, PER, SAB, SLV, TCA, TTO, VEN. Confirmation from one country was pending at the time of this report. Confirmation of the final assessment for three countries was pending at the time of this assessment. Regulations on occupational health and safety seem to be advancing. However, technical cooperation should be strengthened to ensure optimal results.				
3.5.5	Number of countries and territories with the capacity to address environmental health	11	24	In progress (10 achieved + 19 in progress)
Ten countries achieved the indicator: BON, BRA, BRB, CAN, CUW, DMA, ECU, SAB, USA, VEN. Confirmation from three countries was pending at the time of this report. Nineteen countries are in progress: ABW, ARG, BHS, COL, GRD, GUY, HND, JAM, KNA, MEX, NIC, PER, PRY, SLV, STA, SXM, TCA, TTO, VEN. Confirmation from four countries was pending at the time of this report. Confirmation of the final assessment from one country was pending at the time of this report.				

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
To support capacity-building, a self-learning course on environmental epidemiology is being prepared.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.5.1	Countries enabled to strengthen their capacity to assess health risks and develop and implement policies, strategies, and regulations for the prevention, mitigation, and management of the health impact of environmental risks	Number of countries and territories with national monitoring systems to assess health risks and inequities resulting from inadequate water and sanitation	7	16	Achieved (15 achieved + 8 partially achieved)
Fifteen countries and territories achieved the indicator: BON, BRA, BRB, CHL, COL, CRI, CUW, DMA, DOM, JAM, MEX, TCA, TTO, USA, VGB. Eight countries and territories partially achieved the indicator: AIA, ARG, BOL, PER, SAB, SLV, STA, VEN. Brazil has strengthened its national health capacities with regard to its water safety plan and sanitation safety plan, including a water quality monitoring component. Colombia and Costa Rica have strengthened their capacities to prepare WSPs with an emergency approach. The Dominican Republic has developed instruments for use by emergency response teams through sectoral coordination in water and sanitation. Jamaica has a system for ongoing monitoring of risks through routine water quality assessments. El Salvador has supported the development of a WSP. Peru has approved a regulation to implement its WSP and has strengthened emergency response teams in water and sanitation.					
3.5.2	Countries enabled to develop and implement norms, standards, and guidelines for environmental health risks and benefits associated with air quality and chemical safety	Number of countries and territories with national air quality standards based on WHO guidelines and public health services on chemical safety	8	10	Partially achieved (8 achieved + 7 partially achieved)
Eight countries and territories achieved the indicator: BRA, CHL, JAM, MEX, PRI, STA, USA, VEN. Seven countries and territories partially achieved the indicator: ARG, BON, COL, CRI, CUW, PAN, PER. Confirmation of the final assessment from two countries was pending at the time of this report.					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
3.5.3	Countries enabled to develop and implement national policies, legislation, plans, and programs on workers' health	Number of countries and territories with an occupational carcinogen exposure (CAREX) matrix and national information systems on occupational injuries and diseases	6	11	Partially achieved (5 achieved + 5 partially achieved)
Five countries achieved the indicator: CAN, COL, GTM, PAN, SLV. Five countries partially achieved the indicator: ARG, CHL, CRI, NIC, PER. Confirmation of the final assessment from three countries was pending at the time of this report. This project demands substantial work at country level, with intensive interdisciplinary and intersectoral interactions. A regional training was held, and follow-up was provided by the CAREX regional steering committee, led by PAHO. The next countries to achieve the indicator will mostly likely be Chile and Peru; Argentina and Mexico are also committed to advancing in this area. These are very important advances toward building the Regional CAREX system for the Americas.					
3.5.4	Implementation of the PAHO/WHO Strategy and Plan of Action on Climate Change	Number of countries and territories implementing the PAHO/WHO Strategy and Plan of Action on Climate Change	2	16	Partially achieved (4 achieved + 9 partially achieved)
Four countries achieved the indicator: BRA, DMA, HND, NIC. Nine countries and territories partially achieved the indicator: ARG, BHS, BON, CHL, COL, CRI, CUW, MEX, PER. Confirmation of the final assessment from one country was pending at the time of this report. Countries demonstrate a high level of commitment to addressing climate change, as representatives at the COP21 were vigorously engaged in the discussions and fully supported the inclusion of health in the text of the convention. Venezuela was particularly concerned with the inequity aspects of climate change.					
3.5.5	Countries enabled to develop and implement national policies, plans, or programs to reduce the use of solid fuels for cooking	Number of countries implementing large-scale programs to replace inefficient cook stoves with cleaner models that comply with WHO indoor air quality guidelines	1	3	Partially achieved (1 achieved + 2 partially achieved)
One country achieved the indicator: HND. Two countries partially achieved the indicator: GTM, PER. Guatemala, Honduras, and Peru have national programs. Honduras has an ambitious national plan to replace traditional cookstoves with improved ones; Peru has a large-scale, two-pronged national program to replace traditional cookstoves with improved biomass cookstoves and liquefied petroleum gas (LPG) stoves. Guatemala has a national program to replace traditional cookstoves with less-polluting biomass stoves, and has a forum					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
called “mesa de leña” in which PAHO participates – there are some promising private initiatives to promote the use of LPG as well. All countries where 10% or more of the population uses solid fuels participated in a training workshop held in Honduras in June 2015, preparing them to implement the WHO guidelines on indoor air quality. Twelve countries that attended the workshop made progress in this area.					

2014-2015 End-of-Biennium Assessment
Category 4 Report

CATEGORY 4: Health Systems	**OVERALL CATEGORY ASSESSMENT RATING[17]** **Partially met expectations**

CATEGORY PROGRAMMATIC AND BUDGET OVERVIEW

Table 1. Category 4 Programmatic and Budget Summary

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget Implementation against PB (%)	Budget Implementation against Awarded (%)	Output Indicator Rating	Outcome Indicator Status
4.1 Health Governance and Financing; National Health Policies, Strategies, and Plans	11.95	12.79	107.0	104.1	97.2	3/4 achieved, 1/4 partially achieved	1/2 in progress, 1/2 no progress
4.2 People-Centered, Integrated, Quality Health Services	13.58	17.39	128.1	126.8	99.0	1/2 achieved, 1/2 partially achieved	1/1 in progress
4.3 Access to Medical Products and Strengthening of Regulatory Capacity	22.90	25.69	112.2	99.7	88.9	4/4 achieved	2/2 in progress
4.4 Health Systems Information and Evidence	32.86	30.54	92.9	87.1	93.7	3/7 achieved, 4/7 partially achieved	2/2 in progress
4.5 Human Resources for Health*	16.19	16.90	104.4	82.82	79.34	4/4 partially achieved	3/3 in progress
TOTAL	**97.48**	**103.31**	**106.0**	**97.0**	**91.5**	**11/21 achieved, 10/21 partially achieved**	**9/10 in progress, 1/10 no progress**

***** This program area was awarded additional resources for management of the PALTEX program in the amount of $16.11 million, of which $15.52 million (96.3%) was implemented. PALTEX is PAHO's special program that facilitates access to textbooks and training materials for health human resources in Member States.

[17] Assessment ratings for the overall category and for program areas/outcomes are determined by the PAHO category and program area facilitators, respectively, taking into consideration the programmatic and budget implementation, analysis of resources (human and financial), and operational and programmatic risks. Ratings are defined as follows:

- **Met expectations** (Green): achieved 90% to 100% of the results for the period being assessed. Progress is on track, as expected; no impediments or risks that affect the achievement of results are foreseen.
- **Partially met expectations** (Yellow): achieved 75% to 89.9% of the results for the period being assessed. Progress may be at risk, and action is required to overcome delays, impediments, and risks.
- **Insufficient progress** (Red): achieved <75% of the results for the period being assessed. Progress is in jeopardy due to impediments or risks that could preclude the achievement of results. Immediate corrections are required.

Table 2. Category 4 Budget Overview by Functional Level

Functional Level	Funds Awarded (US$ millions)	Awarded by Level (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
Country	48.12	46.57	41.37	86.0
Intercountry	18.51	17.91	22.25	95.8
Subregional	7.52	7.27	8.25	97.2
Regional	29.16	28.22	22.64	96.4
Total	**103.31**	**100.00**	**94.51**	**91.48**

CATEGORY PROGRAMMATIC ANALYSIS

Overall Category Assessment Summary

Work in Category 4 aims to strengthen health systems based on primary health care, with an emphasis on people-centered, quality, integrated service delivery. It also focuses on health governance and financing, leading toward the progressive realization of universal access to health and universal health coverage.

Member States have made significant progress in this category. Countries and territories have reported advances in accordance with the Strategy for Universal Access to Health and Universal Health Coverage , adopted by the 53rd PAHO Directing Council in 2014 (CD53.R14). There is broad recognition that the ongoing processes of health systems reform are of great importance. This includes the development of national road maps toward universal health that expand access to services through primary care within Integrated Health Service Delivery Networks; the development of comprehensive financing strategies in countries; the realignment of policies on human resources for health that meet the existing needs of health systems and services; and provision of access to safe, efficacious, and quality medicines and health technologies according to the health needs of the population. The development of integrated health information systems is progressing positively. Countries are taking steps to improve their health information systems and follow up on basic indicators, methodologies, training, and preparation of documents to facilitate health analysis and support decision-making as they move toward universal health. Strategic partnerships, such as those with the United States Food and Drug Administration (FDA), Bill and Melinda Gates Foundation, Health Canada, Government of Spain, PAHO Foundation, Mexican Agency for International Development Cooperation (AMEXCID), and Rockefeller Foundation, among others, continue to play a key role in the achievement of outcomes across the program areas.

Four of the five program areas successfully mobilized resources to ensure implementation of the program of work, contributing to achievements. Significant funds were mobilized at the country level, highlighting the high priority countries give to this category.

The Region has made significant progress in the five program areas under this category, with 9 of 10 outcome indicators in progress and 11 of 21 output indicators achieved. However, this first biennium has demonstrated that major challenges remain to be overcome in order to reach the outcome and impact targets set for 2019. The end-of-biennium assessment has offered an excellent opportunity for technical departments within the Pan American Sanitary Bureau (PASB) to assess feedback received from the countries and territories in order to better formulate interventions aimed at improving health systems in the Region and achieving universal health.

Programmatic Summary by Program Area

4.1 Health Governance and Financing; National Health Policies, Strategies, and Plans

Overview

This program area is one of the cornerstones of the Organization's technical cooperation with Member States. The work with countries continued to strengthen their health systems in alignment with the universal health strategy adopted by the 53rd Directing Council (CD53.R14) in 2014. Major efforts have been made to foster a corporate response to support the implementation of the universal health strategy in the Region. As a result, there has been good progress in this program area at both output and outcome levels. Progress at the output level successfully met the expectations set for the biennium, as the target countries set for 2015 have moved ahead with the definition of national health policies, strategies, and plans for health governance and financing. At the outcome level, countries have made gains, and the impact of the multiple interventions implemented by Member States, the Secretariat, and other stakeholders to increase government expenditure in health should be observed in the coming years. Nevertheless, closing the health financing gap in the Region in order to reach the goals set for this program area will depend not only on the social and economic preconditions but , most importantly, on the political commitment of countries in the Region to create fiscal space for universal health.

Achievements

- Member States and the Secretariat engaged in the development and negotiation of the landmark Strategy for Universal Access to Health and Universal Health Coverage in 2014, with the adoption of the corresponding regional strategy during the 53rd PAHO Directing Council (CD53.R14). Consistent with the universal health strategy, technical cooperation was increased for the development and implementation of plans of action, law reforms, and/or road maps toward universal health in countries such as the Bahamas, Chile, Colombia, Ecuador, El Salvador, Honduras, Jamaica, Panama, Paraguay, and Peru.
- To date, six countries and territories of the Region have committed at least 6% of their gross domestic product (GDP) to public expenditure in health, namely Aruba, Canada, Costa Rica, Cuba, Uruguay, and United States of America. A high-level dialogue with country delegates and international financial agencies was organized on Universal Health Coverage Day (12 December 2015) to increase awareness and discuss policy options/interventions to augment fiscal priority given to health and to improve the efficiency of health financing. Participating agencies included the Inter-American Development Bank, World Bank, International Monetary Fund (IMF), Economic Commission for Latin America and the Caribbean (ECLAC), Organisation for Economic Co-operation and Development, and World Health Organization (WHO). The dialogue and advocacy interventions are continuing into 2016, with expected country actions to increase fiscal space for health and financing for public health.
- Twenty countries and territories (Bahamas, Brazil, Canada, Chile, Colombia, Cuba, Dominican Republic, Ecuador, El Salvador, Guyana, Honduras, Jamaica, Mexico, Montserrat, Peru, Saba, Trinidad and Tobago, United States of America, Uruguay, and Venezuela) developed comprehensive national health policies, strategies, and/or plans whose goals include universal health, exceeding the 16 target countries set for 2015. To promote these results, a methodology to guide national dialogue and the development of plans of action toward universal health was developed and piloted in a number of those countries.
- Fifteen countries (Bahamas, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Mexico, Panama, Peru, United States of America, and Uruguay) have developed and implemented financial frameworks for universal health. To promote these results, studies were conducted on public expenditure and financial options for universal health.

- Fifteen countries were trained on the System of Health Accounts (2011) methodology and on use of the Health Accounts Production Tool. They are also developing work plans to institutionalize and systematize the production of health accounts. Studies focusing on the efficiency of health expenditures are under way in three countries.
- Eight countries (Brazil, Canada, Chile, Colombia, Mexico, Panama, Peru, and United States of America) reported that they are able to monitor and evaluate health systems and service indicators related to universal health. PAHO led the implementation of a monitoring and evaluation instrument for universal health in six of those countries.
- PAHO has supported the efforts of countries (for example, El Salvador, Panama, and Paraguay) to update health-related laws and regulations, including the health code, which will facilitate achievement of universal health. Other countries and territories (such as Bahamas, Dominican Republic, Ecuador, Honduras, and Sint Maarten) initiated the process of reviewing national health laws and regulations with the specific objective of attaining universal health, and PAHO plans to provide technical cooperation in the 2016-2017 biennium. As a result of efforts by these and other countries, 11 countries to date have developed regulatory frameworks for universal health (Bolivia, Brazil, Colombia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Peru, Suriname, and Uruguay).
- In 2015, PAHO Member States approved the Strategy on Health-related Law, which provides specific recommendations and guidelines applicable to output 4.1.3 on how to formulate and implement national laws and regulations to advance toward universal health. During the next biennium, PAHO will disseminate and promote this strategy in countries to facilitate the accomplishment of output 4.1.3 (universal health) and objectives in other important health areas, such as climate change adaptation, noncommunicable diseases and risk factors, and women's health.

Challenges

- Further efforts are needed to define policies to reform countries' health financing strategies with respect to *(a)* collection of funds, *(b)* pooling systems, and *(c)* design of payment systems and allocation of resources, so that they contribute to the advance toward universal health. Creating fiscal space for universal health by changing the taxation structure and reducing the size of the informal economy has been shown to have a major impact in countries.
- Increasing public expenditure in health in the target countries will require strong political commitment on the part of countries to create fiscal space for universal health. Some countries will be able to make progress if they create the necessary fiscal space as a short- and medium-term objective. In others, changes must be introduced to promote greater integration of total health expenditure, reduce segmentation, and improve the equity and efficiency of health systems. In addition, the current macroeconomic and political environment of the Region may slow down countries' efforts to increase fiscal space for universal health, which could ultimately have a negative impact on the number of target countries set for 2019 that will be able to increase public expenditure in health.
- Increasing countries' capacity to monitor and evaluate progress toward universal health will need stronger information systems that can produce quality data with which to measure progress in population access to and coverage of health services, governance and leadership, equity and efficiency of health financing, and action on social determinants of health. It will also require strengthening mechanisms for accountability and social participation.

Lessons Learned

- Despite the adoption of the resolution on universal health, it appears that a number of regionally based partners continue to support, in the preparation of grants and project documents, the concept of payments

at the point of service. This practice can significantly curtail access to services, in particular for people living in conditions of vulnerability. Countries should continue to work on protecting the gains made toward universal access to health and universal health coverage. A high-level dialogue should be organized between PAHO, the World Bank, the Inter-American Development Bank, and the United States Agency for International Development to reach a consensus on health financing in the Americas, in particular on recommendations in the preparation of grants and projects with regard to co-payments and out-of-pocket expenditures.

4.2 People-Centered, Integrated, Quality Health Services

Overview

Work in this program area aims to increase access to comprehensive, quality, people-centered services. It is key to the effective implementation of the regional Strategy for Universal Access to Health and Universal Health Coverage, and will ultimately help to improve service delivery organization and management. It focuses on strengthening the response capacity of the first level of care, articulated within Integrated Health Service Delivery Networks (IHSDNs), as well as overall quality of care and patient safety. Specifically, this program area supports the development of country capacity for the implementation of the IHSDNs framework, along with other instruments.

Achievements

- Six countries and territories (Argentina, Cuba, Mexico, Saba, United States of America, and Venezuela) reported a reduction in the percentage of hospitalizations for ambulatory care sensitive conditions in 2015.
- Twenty-three countries and territories have implemented IHSDN strategies (Argentina, Belize, Bolivia, Brazil, British Virgin Islands, Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Trinidad and Tobago, Turks and Caicos, United States of America, and Uruguay).
- A regional consultation with 16 countries of the Region on the progressive expansion of health services was organized in 2015, leading to the development of a publication on models of care and critical elements for the operationalization of IHSDNs within the context of the universal health strategy. The meeting led to a regional dialogue on barriers to health and on the need for new care and service network models that would better meet current needs.
- Twelve countries have implemented national strategies and/or plans for quality of care and patient safety (Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, El Salvador, Mexico, Panama, Paraguay, and Peru). A regional consultation on quality of care within health systems was organized in 2015 to update recommendations on this issue.

Challenges

- There remains an urgent need to strengthen the capacity of countries and territories in the Region to improve health service delivery. Stronger commitment is required to develop policies and reforms that tackle fragmentation, poor technical quality, late referrals, lack of access to preventive services, and overreliance on acute disease-centered care and hospital-based treatment. Despite ongoing efforts, more countries in the Region need to prioritize investment in the first level of care. This should be linked to efforts to increase fiscal space for health and public expenditure in health.
- Strengthening the first level of care in the context of IHSDNs requires redefining the role of hospitals. However, this is not an easy endeavor. Hospitals will need to reposition themselves to be more people- and community-centered and to work in closer contact with the first level of care within IHSDNs. The role of

hospitals should transition from an "emphasis on illness and the filling of hospital beds" toward a new role for hospitals as part of a collaborative network of service providers who provide continuous, quality health care to people throughout their lives. Along with efforts to strengthen the first level of care, steps should be taken to increase efficiency and reduce costs of hospital care, and to facilitate the changing role and capacities of hospitals in the context of universal health. In particular, it is critical to analyze new investments in hospitals to facilitate the changes required and to improve the efficiency both of individual hospitals and of networks.

- Information is insufficient to accurately determine the reduction in the percentage of hospitalizations for ambulatory care sensitive conditions in 2015. While some countries have reported progress, they did not provide data. Further efforts are needed to strengthen information systems in the Region in this regard.

Lessons Learned

- Recent experience with the preparation of health systems to cope with outbreaks of Ebola, chikungunya, and Zika virus diseases has provided an opportunity for PAHO to improve the health system response in this regard. Whereas some time ago the global agendas in universal health and health security appeared to be competing, there now seems to be a growing global consensus that health security can only be achieved by strengthening health systems toward universal health while also working to increase their resilience.

4.3 Access to Medical Products and Strengthening of Regulatory Capacity

Overview

This program area aims to promote access to and rational use of safe, effective, and quality medicines, medical products, and health technologies, as countries move toward universal access to health and universal health coverage. Member States have made tangible progress in the development, implementation, monitoring, and evaluation of national policies on access to, quality of, and use of medicines and other health technologies. National and subregional regulatory capacity has also been strengthened. Additional priorities within this program area include the implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and the strengthening of the PAHO Strategic Fund.

Achievements

- As a result of the ongoing work to strengthen medicines regulatory systems, 10 countries developed institutional development plans (Bahamas, Barbados, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Mexico, and Peru). Vaccine regulation was strengthened in 18 countries (Bolivia, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, United States of America, and Venezuela). A medical device regulation assessment tool was piloted in five countries (Colombia, Cuba, Ecuador, Mexico, and Panama).
- The Plan of Action for Universal Access to Safe Blood 2014-2019 was adopted by the 53rd Directing Council (CD53.R6). With the Technical Support of PAHO, in October 2015 the Ministers of Health of the Andean Region (REMSAA) adopted a Resolution on Blood Safety for the Andean Subregion that affirms the creation of the Subregional Technical Commission on Blood. Then, in November 2015, the REMSAA approved the Subregional Andean Plan on Universal Access to Safe Blood 2016-2020. Furthermore, in support of national blood programs, in Haiti the elaboration of national blood safety policy and law was supported, and the national policy was approved and launched. The first evaluation of the implementation of the national blood policy in El Salvador was supported, as well as the revision of the legislative framework on blood in Bolivia. In the Dominican Republic, the national blood policy was elaborated, and national guidelines for the

appropriate use of blood were developed. Panama was supported in the revision of the national legal frameworks for blood. In Peru, an evaluation and revision of the national program on voluntary blood donation took place, and recommendations were made. A national plan on hemovigilance was developed in Paraguay, and it is currently in the process of implementation.

- Important advances have been made in the governance and regulation of medicines and health technologies. One such point of progress is the initiation of the Caribbean Regulatory System. This project has received support from the National Regulatory Authorities (NRA) of Regional Reference (NRAr) to define procedures for the centralized registration of medicines. The mechanism to recognize NRAr has been applied by the U.S. FDA and Health Canada. The regulatory profiles of 17 countries of the Region were published through the PAHO Regional Platform on Access and Innovation for Health Technologies (PRAIS), generating information that can be used to set priorities for strengthening regulatory systems.
- In collaboration with the Council for Human and Social Development (COHSOD), policies for pharmaceuticals in the Caribbean were strengthened. A new project was launched, endorsed by COHSOD, to develop medicines regulatory capacity within the Caribbean (the Caribbean Regulatory System), with the support of the Bill and Melinda Gates Foundation and national regulatory authorities of regional reference, to improve the quality and safety of medicines in the Caribbean.
- PAHO provided political and technical support to the ministerial level of MERCOSUR, the Southern Common Market, which is leading price negotiations for high-cost medicines in 2015. The mechanism that links the negotiations with the procurement capacity of the PAHO Strategic Fund resulted in significant reductions in the price of medicines for HIV/AIDS and hepatitis C, increasing the awareness of Member States of the value of participating in the Strategic Fund.
- Countries have made progress in developing strategies for evaluation, integration, and management of drugs and other health technologies. Achievements include *(a)* strengthening of the Regional Network of Health Technology Assessment for the Americas (RedETSA); *(b)* mapping of processes for the evaluation and incorporation of technologies within health systems and services in 27 countries, and examining the decision-making process for the inclusion or non-inclusion of medicines and health technologies in services and benefits plans; *(c)* conducting case studies of evaluation and incorporation of technologies in Brazil, Canada, and Colombia; and *(d)* developing a set of indicators for assessing pharmacovigilance systems and drug information centers.
- Capacity-building continued throughout the biennium on key issues related to health technology assessment (HTA), rational use of health technologies, and diagnostic imaging:
    - HTA and promotion of rational use were carried out in 10 Caribbean countries. In addition, a working group was established to develop a proposal for subregional cooperation.
    - RedETSA held monthly webinars, and an exchange program among institutions was organized. The first program was hosted by Brazil with visits from Argentina, Colombia, Costa Rica, El Salvador, and Paraguay.
    - Webinars on diagnostic imaging (mammography, computed tomography, abdominal sonography, ultrasounds) and instructed courses on mammography were conducted in Belize. Training on obstetric sonography was conducted in Guyana, Jamaica, and Trinidad and Tobago, and on digital radiology in Nicaragua.

Challenges

- Countries and territories in the Region have been challenged by the ever-increasing cost of medicines and other health technologies. While several Member States have adopted comprehensive frameworks to progressively expand access to safe, efficacious, and quality health technologies, some have found it difficult to adopt the overarching strategies needed in this area. The rational use of medicines and the adoption of

other evidence-based approaches like HTA remain a challenge due to lack of capacities in some countries. Human resources development in these areas and in health technologies is critical.

- Strengthening of regulatory capacity needs to be prioritized in Member States with limited capacity in this area. In particular, the improvement of regulatory capacity in most countries of Central America remains a challenge, since it has not been adopted as a high priority on the agendas of the ministries of health.

Lessons Learned

- Subregional approaches, once political commitment has been ensured, have proven to be viable alternatives for ensuring efficiency and sharing resources among Member States with limited capacity.
- Improving access to high-cost medicines and other health technologies may require exploring and developing new strategies that emphasize collaboration among countries.

4.4 Health Systems Information and Evidence

Overview

The production and use of knowledge, scientific evidence, and health information are key inputs, supporting all aspects of health action, such as research, planning, operations, surveillance, monitoring and evaluation, as well as prioritization and decision-making. Health systems require quality health information complemented by robust research, knowledge management, knowledge translation, and information and communication technologies. Strong data and evidence lead to health sector-wide optimizations that impact all aspects of the program area. Ultimately, evidence-based policies and interventions tailored to local conditions contribute to changes in behaviors (individual, social, and political) that result in better living conditions for the peoples of the Americas and reduced inequities in health.

The Region has made notable progress in strengthening routine health information systems and adopting new technologies and strategies for research and evidence. Disparities, however, remain between countries regarding the coverage, reliability, timeliness, and quality of information collected and produced by health information systems. In the biennium, technical cooperation leveraged intersectoral networks and partnerships to enrich the policy process, decision-making, and development of technical standards, guidelines, and strategies. PAHO's support for the development of national eHealth strategies provided direct benefits to countries and promoted sector-wide planning and coordination of regional decentralized health systems and improved capacity for planning, budgeting, and service delivery. Similarly, PAHO's technical cooperation relevant to the Policy on Research for Health addressed each of the policy's objectives at different levels (regional, subregional, local) and provided structural and procedural strategic improvements to enhance the impact of research for health and its governance.

Achievements

- Sixteen countries have installed capacities to conduct periodic assessments of their health situations, which result in reports publically available and invaluable for decision-making and resource allocation. PAHO has provided technical cooperation to strengthen health information systems across the Americas. PAHO will utilize the upcoming Health in the Americas 2017 process as an opportunity to ensure that all countries and territories conduct a thorough analysis.
- Countries have continued to implement measures to improve their health information systems in order to better monitor their progress on the health situation. Efforts to strengthen PAHO's technical cooperation in this area include the conceptualization and development of innovative strategies and interventions, including the forthcoming Health Information and Analysis Toolkit on Data Management, which will encompass data

management, methodologies, trainings, and technical guidelines.

- A web-based platform for health information (PLISA, by its Spanish acronym) is operational and can be used as a resource for information on mortality, vector-borne diseases, and core health indicators, and to monitor progress of the Strategic Plan 2014-2019 impact indicators, among other purposes (available from http://www.paho.org/data/index.php/en/).
- An online training on the International Classification of Diseases (ICD-10) is available in English, French, and Spanish, free of charge. It has been completed by more than 600 public health professionals across the Region. This new achievement complements PAHO's ongoing flagship initiatives, including the annual work plan of the Latin American and Caribbean Network for the Strengthening of Health Information Systems (RELACSIS), as well as efforts under the Regional Core Health Data Initiative (data available at http://www.paho.org/hq/index.php?option=com_tabs&view=article&id=2151&Itemid=3632&lang=en).
- Twelve countries have made progress in developing and implementing national eHealth strategies: Brazil, Canada, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Guatemala, Jamaica, Panama, Peru, and United States of America.
- Countries are advancing aspects of the Policy on Research for Health through subregional efforts and networks that are expected to facilitate harmonization and coherence: examples include the Caribbean countries, the Council of Ministers of Health of Central America (COMISCA), RELACSIS, and the Ministerial Ibero-American Network of Learning and Health Research (RIMAIS). Research teams (over 300 experts and master of public health students) have been trained through strategic partnerships and "train the trainers" schemes on effective project planning and evaluation in biomedical research, grants writing, and peer review. Progress has been made on several important aspects of the Policy on Research for Health (e.g., clinical trial registration), and scholarships for graduate studies in health at the master's and doctoral levels have been offered to more than 180 professionals from 23 countries in partnership with the Organization of American States (OAS) and Member States.
- Knowledge translation and evidence mechanisms were strongly advanced as a result of the iPIER initiative (Improving Programme Implementation through Embedded Research) in nine countries (Argentina, Bolivia, Brazil, Chile, Colombia, El Salvador, Mexico, Panama, and Peru), with scaled-up efforts to strengthen health policy and systems research and the definition of national and regional evidence and research agendas.
- A significant effort was made to strengthen national guidelines programs by establishing standards, improving implementation strategies, and supporting development of guidelines using GRADE methods. Training was provided in 10 countries (Argentina, Brazil, Chile, Colombia, Costa Rica, Dominica, Guatemala, Honduras, Panama, and Peru).
- The Virtual Health Library is available to over 23 countries in the Region in Spanish and Portuguese. Member States have provided significant support to collect, index, process, and disseminate the technical and scientific literature in public health and medicine in LILACS, a regional scientific database managed by the Latin American and Caribbean Center on Health Sciences Information (BIREME).
- Nine countries (Argentina, Chile, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Jamaica, and Peru) have advanced ethical research through the use of ProEthos software to strengthen ethics review and the revision of national frameworks to ensure that human subject research is ethical. The incorporation of ethics into public health decision-making was advanced through the development of novel training materials and capacity-building at different levels.

Challenges

- High personnel turnover within countries and territories has led to significant disruptions in the collection and analysis of vital health statistics, affecting both timeliness and quality. Policies to address this issue are needed to ensure continuous collection of high-quality mortality data and birth registrations. Similarly,

countries need robust health information systems to improve data quality and management and to strengthen capacities for health information analysis.

- Limited coordination and convening by the WHO Advisory Committee on Health Research has affected the work of the PAHO Advisory Committee on Health Research (ACHR).
- Monitoring and evaluation and continuous updating of country profiles requires consistent and sustained training and a responsible assigned officer. Countries need to designate a responsible officer, within the health and science and technology offices, who can keep the indicators updated and generate reports with actionable data to guide decisions on research governance and stewardship.

Lessons Learned

- Donor-funded initiatives such as RELACSIS, a South-South network that has supported the delivery of technical cooperation and dissemination of best practices, are insufficient if countries do not ensure sustainability of gains in their health information systems, including vital statistics. National resources are necessary to ensure that these practices are adapted and integrated into existing national strategies and guidelines.
- Countries need to adopt strategies from the Policy on Research for Health in order to advance policies and agendas on health research and to develop relevant regulations and standards. PAHO should coordinate and align regional efforts to advance the Policy on Research for Health, factoring in recommendations from the ACHR as feasible.
- Setting priorities for future research requires use of existing and new tools, including assessment of inequities and dissemination of existing knowledge, among others.
- Mobilizing resources for health research requires concerted work with other sectors (e.g., science and technology, education, industries, and other economic stakeholders). Industrial and economic partners are particularly important, given their capacities to scale up developments.

4.5 Human Resources for Health

Overview

This program area focuses on the development and implementation of policies and plans on human resources for health (HRH) in order to advance toward universal access to health and universal health coverage. Work has been undertaken with countries to improve the organization of human resources within health systems, as well on the issues of competencies development, working conditions, and stability of the health workforce. Another priority has been to work with academic institutions to support the reorientation of education in the health sciences toward primary health care and align this education with the social mission of the universal health agenda. The work completed in this biennium will contribute to the development of a new regional strategy on human resources for health for consideration by PAHO Governing Bodies.

Achievements

- At least 17 countries have advanced toward the development and implementation of HRH action plans aligned with the policies and needs of their health care delivery systems. In the development of national road maps toward universal health, this area of action constitutes a priority for Member States as they progressively expand access to health services to meet the current and future needs of their populations. Countries have made progress in improving the number and distribution of health workers, which is directly related to the goal of achieving universal health.
- An analysis of the level of achievement of the Regional Goals for Human Resources for Health 2007-2015 has

been prepared by Member States and will guide the definition of future priorities in the regional agenda on human resources for health. In addition, there has been progress in the discussion of a new agenda for human resources post-2015, taking into account the progress reported, the challenges that countries faced in meeting the regional goals for 2007-2015, future needs and challenges related to the advancement toward universal health, the aging of the Region's population, and the increase of chronic diseases, among others. This new agenda is being developed in alignment with the development of the WHO Global Strategy on Human Resources for Health: Workforce 2030, which was presented at the World Health Assembly in May 2016.

- Use of the Virtual Campus for Public Health as a learning platform continues to grow, providing training to approximately 55,000 health professionals through its regional and country nodes. The Virtual Campus remains an important instrument for country capacity-building in health areas specific to regional mandates and priority public health issues. The Virtual Campus has achieved financial sustainability that has allowed it to provide ongoing technical support as a regional learning platform, in addition to supporting the growth and development of the country nodes.
- Other regional initiatives for developing human resources for health continue to be consolidated with the active support and participation of countries. Seventy-three professionals from the Americas were granted fellowships, and an additional 150 benefited from specific training initiatives (Special Programme for Research and Training in Tropical Diseases, Humphrey Fellowship Program, OAS/PAHO Scholarships Program) undertaken in collaboration with technical departments in PAHO and external partners. PAHO continued to support fellowship requests from other WHO Regions as well as to provide input and cooperation on global fellowship policy and other matters for WHO and the United Nations.
- A total of 74 professionals from 26 countries participated in the Edmundo Granda Ugalde Leaders in International Health Program in the biennium. Over 500 professionals from 40 countries have benefited from this program since its inception 30 years ago, and they continue to contribute as leaders and change agents working to advance the health of populations in their countries and around the world.
- The *Mais Médicos* program has incorporated 18,240 doctors in basic health care centers in 4,058 municipalities and 34 predominantly indigenous districts in Brazil, with support from PAHO. The program benefits approximately 63 million Brazilians. The monitoring and evaluation framework was approved by national authorities in Brazil and Cuba, as well as by PAHO, and was implemented in 2015, with analysis of preliminary results under way. The framework also includes the documentation of several case studies as well as good practices and lessons learned.
- A consortium of medical schools was established to strengthen the social mission of universities in the Region and specifically to train doctors from a public health and primary care perspective, with a view to helping underserved areas achieve health equity. This initiative is aligned with the strategy for universal health. Progress has also been made in training health personnel in intercultural competencies.
- The regional nursing program, in collaboration with the countries, defined and published research priorities in nursing. An analysis of the status and trends of nursing education (undergraduate and graduate levels), practice, and regulation in the Region has been undertaken. The role and scope of advanced practice nursing has been promoted and disseminated in Latin America.

Challenges

- One challenge is the limited production of HRH data on such topics as the distribution and competencies of health workers. Because of decentralization, national health ministries are not always responsible for producing HRH data. This, coupled with the fragmentation of health systems and the multiplicity of information systems (social security, armed forces, private sector), can make reporting difficult.
- The lack of integration between the health and education sectors, as well as university autonomy in some

countries, can present challenges in the reorientation of health sciences education to meet national HRH needs.
- The safety of health workers in the workplace continues to be an issue, especially in areas of armed conflict, violence, and epidemic management.
- Policy, planning, and regulation of HRH are not sufficiently aligned with the health systems and integrated service delivery.

Lessons Learned

- There is a need to recognize the different government structures within the Region that have some level of decision-making authority related to HRH and thus affect countries' abilities to implement and report on certain initiatives and programs. Integration between sectors is paramount in advancing toward universal health.
- Differentiated strategies are needed to address the various governance structures, the different contexts (sociocultural, political, economic), and underlying inequities in HRH coverage in countries.

Risks

The following presents an update on the risks identified under Category 4 in the Strategic Plan 2014-2019, including mitigation actions.

- Reduction of external funding from donors and limited national fiscal space to increase public health expenditure, amid a slowing of the growth of national economies, compromise the sustainability of equity-enhancing public policies.
    - Innovative papers and a proposal on the expansion of fiscal space and financing efficiencies are moving forward as a result of high-level dialogue on health financing and fiscal space with the OAS, IMF, and World Bank, among others.
- The persistence of segmentation hinders the efficiency of the health care delivery system and erodes its potential to reduce exclusion.
    - Even though a number of countries are taking important steps to reduce the level of segmentation within health systems, the impact of these actions will not be seen for a number of years, given the complexity of the processes involved.
- The persistence of fragmentation in health services limits the achievement of more equitable health results better aligned with people's needs and expectations.
    - Nonetheless, evidence from a PAHO/World Bank publication (2015) suggests that important advances have been made within the Region to ensure greater access to health services and health coverage, using targeted approaches to reach segments of the population that do not have access to the health system.
- Investments in technology and infrastructure are made without proper assessments and evaluation of needs.
    - This continues to be the case, despite efforts to strengthen governance and actions grounded in evidence-based decision-making. A number of new, high-cost strategic health products have been introduced into the Region; when incorporated within health systems, these are likely to significantly impact health care costs. Innovative strategies to ensure access and affordability will be discussed at the PAHO Governing Bodies meetings in 2016.
- Countries affected by a human resources crisis remain unable to take the lead and manage responses on their own.
    - Countries continue to be affected by shortages of human resources. However, they are taking steps

to strengthen planning and programming in human resources for health, ensuring more effective articulation of the planning process with other sectors such as labor and education. As costs within health care systems continue to increase, driven especially by second and tertiary care requirements, countries are beginning to shift their focus toward investment at the primary care level. Attaining a workforce with the right skill mix for primary care, including community health workers, will be critical to continue mitigation in this regard.

Budget Implementation Analysis

- The total approved 2014-2015 budget for Category 4, Health Systems, was US$97.48 million, which represented 17% of the total budget of the organization ($563 million).
- Category 4 was fully funded during 2014-2015, with 106% ($103.3 million) of the funds mobilized and awarded, of which 91.5% was implemented.
- Allocation of funds was 46.6% ($48.12 million) at country level, 17.9% ($18.51 million) at intercountry level, 7.3% ($7.52 million) at subregional level, and 28.2% ($29.16 million) at regional level. Budget implementation at the same functional levels was 86.0%, 95.8%, 97.2%, and 96.4% respectively (see table 2). Percentage of implementation shows an expected level of execution at the subregional and regional levels. The lower implementation by countries can be attributed to voluntary contributions allotted at country level that will expire after 2016.

Table 3. Category 4 Budget Overview by Program Area and Functional Level

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
4. Health Systems	**103.31**	**100.00**	**94.51**	**91.5**
4.1 Health governance and financing; national health policies, strategies, and plans	**12.79**	**12.40**	**12.43**	**97.2**
Country	6.53	5.47	6.31	96.7
Intercountry	1.72	1.44	1.68	97.8
Subregional	0.47	0.39	0.46	97.5
Regional	4.08	3.41	3.98	97.8
4.2 People-centered, integrated, quality health services	**17.39**	**16.80**	**17.22**	**99.0**
Country	10.80	9.04	10.71	99.1
Intercountry	1.54	1.29	1.52	98.5
Subregional	1.39	1.17	1.39	99.6
Regional	3.66	3.06	3.60	98.5
4.3 Access to medical products and strengthening of regulatory capacity	**25.69**	**24.90**	**22.84**	**88.9**
Country	12.79	10.71	11.05	86.4
Intercountry	3.28	2.75	3.00	91.3
Subregional	1.82	1.52	1.67	92.1
Regional	7.80	6.53	7.12	91.3

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
4.4 Health systems information and evidence	**30.54**	**29.60**	**28.61**	**93.7**
Country	8.21	6.88	6.85	83.5
Intercountry	10.43	8.73	10.00	95.9
Subregional	2.72	2.28	2.70	99.4
Regional	9.18	7.69	9.06	98.7
4.5 Human resources for health	**16.90**	**16.40**	**13.41**	**79.4**
Country	9.78	57.88	6.45	65.9
Intercountry	1.83	10.86	1.80	97.8
Subregional	0.92	5.46	0.91	98.7
Regional	4.36	25.79	4.26	97.8

- Budget implementation (expenditure/awarded) was above 90% in all program areas except two: 4.3 (access to medical products and strengthening of regulatory capacity) and 4.5 (human resources for health), which had implementation rates of 89% and 79%, respectively. The unobligated balance corresponds mainly to voluntary contributions allotted at country level that will expire within the next two biennia.
- Programs Areas 4.1 (health governance and financing; national health policies, strategies, and plans) and 4.2 (people-centered, integrated, quality health services) have exceeded the approved budget for 2014-2015. These two program areas have implementation rates above 97% (expenditure/awarded).
- During 2014-2015 the voluntary contributions mobilized were 42% of total budget awarded. Major efforts have been made to improve resource mobilization, mainly with donors such as Brazil, U.S. FDA, Spain, Global Alliance for Vaccines and Immunization (GAVI), Bill and Melinda Gates Foundation, Health Canada, Rockefeller Foundation, PAHO Foundation, AMEXCID, WHO, and WHO/EURO, among others. In addition, countries mobilized resources at national level to meet the budget requirement for the biennium.

Recommendations

- Support countries as they continue to move toward universal access to health and universal health coverage (UHC), both as an objective in itself and as a vehicle to achieve the Sustainable Development Goals (SDGs) and the development of resilient health systems. Important advances have been made within this category, especially in relation to health system reforms and the advance toward universal health. It is important that the global public health agenda continue to evolve. Disease outbreaks will continue to emerge globally and in the Region. Country support will be required to implement national strategies toward the achievement of the SDGs. The universal health strategy provides the reference framework for ensuring resilient health systems (linked with the effective implementation of the core competencies for the International Health Regulations), as well as achievement of SDG3.
- Engage in a high-level political effort to advocate for improved public financing in health. The issue of health financing is assuming prominence on the political agendas of the Region's countries, given the economic difficulties some are experiencing and the challenges they all face in expanding fiscal space for health. In measuring the outcomes within Category 4, it should be noted that very few countries have made advances in improving fiscal space for health (as determined by the outcome indicator). Even though this evaluation

relates to the first of three Program and Budget periods, it is unlikely that Category 4 outcomes will be achieved over the course of the Strategic Plan without such a high-level effort.

- Organize a high-level dialogue on health financing in Latin America and the Caribbean with the involvement of PAHO and other partner agencies. In the preparation of umbrella agreements or major projects with PAHO partners, it has been observed that some partners continue to insist on the inclusion of co-payments or fees at the point of health service delivery.
- Provide additional support from the perspective of health analysis and health systems and services. In the assessment of the category, it is evident that countries require additional support for the collection and analysis of health information, the assessment of the achievement of indicators, and the monitoring of advances toward the achievement of outcomes.
- Engage in further discussion and inter-programmatic work to improve program design, coordination, financing, implementation, and monitoring and review. Intensified action is required to ensure the assignment of additional resources, for example, for the implementation of the chronic kidney disease project in Central America and other regions.

Assessment by Program Area

Program Area 4.1: Health Governance and Financing; National Health Policies, Strategies, and Plans **OUTCOME: Increased national capacity for achieving universal health coverage** OCM Indicator Assessment: 1/2 In Progress, 1/2 No Progress OPT Indicator Assessment: 3/4 Achieved, 1/4 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[18, 19]
4.1.1	Number of countries and territories that have implemented actions toward the progressive realization of universal access to health and universal health coverage	n/a	12	In progress (3 achieved + 10 in progress)
Three countries achieved the indicator: ECU, MEX, PER. In addition, ten countries and territories made progress toward achievement of the indicator: BHS, GUY, HND, HTI, JAM, KNA, PER, PRY, SXM, TCA. Confirmation of the final assessment from five countries was pending at the time of this report. The baseline for the indicator is not available, as this indicator was not previously tracked. Since the indicator measures progress on actions that are also being assessed in the output indicators for this area, it is recommended that an alternative proxy outcome indicator be used to measure progress in the realization of universal health in a quantitative approach.				
4.1.2	Number of countries and territories with public expenditure in health of at least 6% of Gross Domestic Product (GDP)	6	20	No progress (5 achieved + 2 in progress)
Five countries achieved the indicator: CAN, CRI, CUB, URY, USA. Two countries made partial progress on the indicator: BRA, SLV. Confirmation of the final assessment from ten countries was pending confirmation at the time of this report.				

[18] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached.
- **In progress:** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way/on track to achieve the target set in the Strategic Plan by 2019.
- **No progress:** There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and progress toward achieving the indicator target by 2019 could be in jeopardy.

[19] The regional indicators are assessed by the responsible regional entity/Category and Program Area Network (CPAN) based on the latest available information, according to criteria defined in the compendium of indicators.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[18, 19]
Even though several countries in the Region developed strategies to increase public health expenditure, it is important to note that more time is necessary to see increases in such expenditure and that it is too early in the six-year period of the Strategic Plan to assess progress. Countries in the baseline should continue working to protect the gains made in advancing toward universal access to health and universal health coverage. This indicator would benefit from further and continuous work on the institutionalization of the production of health accounts to ensure proper resource and expenditure tracking.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating[20, 21]
4.1.1	Countries enabled to develop comprehensive national health policies, strategies, and/or plans, including UHC	Number of countries and territories that have a national health sector plan or strategy with defined goals/targets revised within the last five years	10	16	Exceeded (22 achieved + 6 partially achieved)
Twenty-two countries and territories achieved the indicator: BHS, BRA, CAN, CHL, COL, CUB, DMA, DOM, ECU, GUY, HND, JAM, MEX, MSR, PER, SAB, SLV, TTO, URY, USA, VEN, VGB. Six countries and territories partially achieved the indicator: ARG, BON, KNA, LCA, SXM, TCA. Confirmation of the final assessment from three countries was pending at the time of this report. This indicator exceeded the target for the biennium.					
4.1.2	Countries enabled to develop and implement financial frameworks for health	Number of countries and territories that have financial strategies for UHC	9	18	Partially Achieved (16 achieved + 5 partially achieved)
Sixteen countries and territories achieved the indicator: BHS, BRA, CAN, CHL, COL, CRI, CUB, DOM, ECU, MEX, PAN, PER, SLV, STA, URY, USA. Five countries have partially achieved the indicator: BOL, BON, KNA, SXM, TCA.					

[20] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached.
- **In progress:** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way/on track to achieve the target set in the Strategic Plan by 2019.
- **No progress:** There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and progress toward achieving the indicator target by 2019 could be in jeopardy.

[21] The regional indicators are assessed by the responsible regional entity/CPAN based on the latest available information, according to criteria defined in the compendium of indicators.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating[20, 21]
Confirmation of the final assessment from nine countries was pending at the time of the report. Further efforts are needed to define policies to reform countries' health financing strategies with respect to *(a)* collection of funds, *(b)* pooling systems, and *(c)* design of payment systems and allocation of resources, so that they contribute to the advance toward universal health.					
4.1.3	Countries enabled to develop and implement legislative and regulatory frameworks for UHC	Number of countries and territories that have legislative or regulatory frameworks to support UHC	6	12	Exceeded (17 achieved + 2 partially achieved)
Seventeen countries achieved the indicator: BOL, BRA, CAN, COL, CUB, ECU, GTM, HND, MEX, NIC, PAN, PER, SLV, SUR, SXM, URY, VEN. Two countries partially achieved the indicator: BHS, DOM. Confirmation of the final assessment from eight countries was pending at the time of this report. Countries have made major efforts to include national health-related law and regulatory frameworks in the context of access and universal health coverage. Other legal reforms have involved the formulation, review, and/or amendment of specific health-related laws in a manner consistent with universal and regional human rights treaties and standards (maternal health in Honduras; tobacco law in Jamaica, Mexico, and Colombia; nutrition law in Peru; mental health law in Guatemala; HIV law in Venezuela; criminal code in the Dominican Republic in the context of maternal health and reproductive rights). Also, the civil code in Argentina was reformed to review the legal capacity of persons with disability.					
4.1.4	Countries enabled to monitor and evaluate health systems and service indicators related to UHC and equity	Number of countries and territories that have conducted studies to monitor and evaluate their health systems and services indicators related to UHC and equity	0	8	Exceeded (9 achieved + 3 partially achieved)
Nine countries achieved the indicator: BRA, CAN, CHL, COL, GTM, MEX, PAN, PER, USA. In addition, three countries and territories partially achieved the indicator: BON, CRI, JAM. Confirmation of the final assessment from four countries was pending at the time of this report. Further improvements are needed with respect to the use of robust methods and the availability of surveys and quality data in the Region so that more countries are enabled to monitor and evaluate their health systems in terms of universal health and equity.					

Program Area 4.2: People-Centered, Integrated, Quality Health Services **OUTCOME: Increased access to people-centered, integrated, quality health services** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 1/2 Achieved, 1/2 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.2.1	Number of countries that have reduced by at least 10% hospitalizations for ambulatory care sensitive conditions	n/a	19	In progress (6 achieved + 6 in progress)

Six countries and territories achieved the indicator: ARG, CUB, MEX, SAB, USA, VEN.

In addition, six countries made progress toward achievement of the indicator: BRA, CHL, DOM, HND, LCA, SLV.

Confirmation of the final assessment from sixteen countries was pending confirmation at the time of this report.

The Region still needs to strengthen capacity at the first level of care. Also, efforts are needed to develop policies and reforms that tackle fragmentation, poor technical quality, late referrals, lack of access to preventive services, and overreliance on acute disease-centered care and hospital-based treatment.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
4.2.1	Policy options, tools, and technical guidance provided to countries to enhance equitable people-centered, integrated service delivery and strengthening of public health approaches	Number of countries and territories implementing integrated service delivery network strategies	10	15	Exceeded (23 achieved + 5 partially achieved)

Twenty three countries and territories achieved the indicator: ARG, BLZ, BOL, BRA, CAN, CHL, COL, CRI, CUB, ECU, GTM, HND, JAM, MEX, NIC, PER, PRY, SLV, TCA, TTO, URY, USA, VGB.
Another five countries partially achieved the indicator: CUW, DOM, GUY, PAN, SUR.

Confirmation of the final assessment from eleven countries was pending at the time of this report.

Progress toward this indicator will depend on the implementation of national strategies that are currently being planned.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
4.2.2	Countries enabled to improve quality of care and patient safety in accordance with PAHO/WHO guidelines	Number of countries and territories implementing national strategies and/or plans for quality of care and patient safety	8	12	Partially achieved (9 achieved + 11 partially achieved)

Nine countries achieved the indicator: ARG, BRA, BRB, CHL, COL, CUB, DOM, PAN, PER.

Additionally, 11 countries and territories partially achieved the indicator: BHS, BOL, CRI, GUY, JAM, KNA, PRY, SAB, SLV, TTO, VEN.

Confirmation of the final assessment from four countries was pending at the time of this report.

Program Area 4.3: Access to Medical Products and Strengthening of Regulatory Capacity **OUTCOME: Improved access to and rational use of safe, effective, and quality medicines, medical products, and health technologies** OCM Indicator Assessment: 2/2 In Progress OPT Indicator Assessment: 4/4 Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.3.1	Number of countries that ensure access to medicines included in the national essential medicines list without any payment at the point of care/service/dispensing of the medicine	4	31	In Progress (7 achieved + 8 in progress)

Seven countries achieved the indicator: BRB, CRI, ECU, MEX, SLV, TTO, VEN.

Another eight countries and territories made progress toward the indicator: BHS, COL, GTM, NIC, PAN, PER, TCA, URY.

Advocacy has focused on improving countries' legislation and norms to ensure access to essential medicines, as part of the progress toward universal health. For instance, El Salvador has significantly increased availability of medicines at different levels, and Barbados has made drugs in the public sector available free of charge at the point of delivery. Colombia has made progress in establishing the roles of pharmacotherapy committees. However, some important challenges remain, such as *(a)* increasing the population's access to the national essential medicines list without restrictions, free of charge at the point of care; *(b)* defining a legal framework for pharmacotherapy committees and for prescription, dispensing, and promotion of rational use of medicines; and *(c)* establishing mechanisms for sustainability.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.3.2	Number of countries and territories that have achieved or increased their regulatory capacity with a view to achieving the status of functional regulatory authority of medicines and other health technologies	7	33	In Progress (7 achieved + 24 partially achieved)

Seven countries achieved the indicator: BRA, CAN, CHL, CUB, SLV, URY, USA.

In addition, 24 countries and territories partially achieved the indicator: ARG, ATG, BHS, BRB, COL, CRI, DMA, DOM, ECU, GRD, GTM, GUY, HND, HTI, JAM, NIC, PAN, PER, PRY, SUR, TCA, TTO, VEN, VGB.

Confirmation of the final assessment from one country was pending confirmation at the time of this report.

Countries have taken steps to strengthen the safety, quality, and effectiveness of medicines and other health technologies. Chile, for example, has created a regulatory system, and its Public Health Institute (ISP) was recognized as a functional national regulatory authority. Other national regulatory authorities have made important progress as well (Ecuador and El Salvador). The Caribbean Regulatory System is a new subregional approach that will provide a centralized registration process for the Caribbean countries.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
4.3.1	Countries enabled to develop/update, implement, monitor, and evaluate national policies for better access to medicines and other health technologies	Number of countries and territories with national policies on access, quality, and use of medicines and other health technologies updated within the last five years	3	7	Exceeded (12 achieved + 13 partially achieved)

Twelve countries and territories achieved the indicator: BON, CRI, DMA, ECU, HTI, JAM, MEX, NIC, PAN, PRY, URY, VEN.

Another 13 countries and territories partially achieved the indicator: ARG, BHS, BRA, BRB, CHL, COL, DOM, HND, SAB, SLV, SUR, TTO, VGB.

The majority of countries have implemented national policies to ensure access to essential medicines and other priority health technologies based on public health needs. In addition, subregional mechanisms have made important progress toward ensuring access to high-cost medicines. MERCOSUR, for instance, conducted joint negotiations on antiretroviral and hepatitis C medicines.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
4.3.2	Implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property	Number of countries and territories reporting access and innovation indicators through the PAHO Regional Platform on Access and Innovation for Health Technologies (PRAIS) Observatory	5	7	Exceeded (8 achieved + 6 partially achieved)
Eight countries achieved the indicator: ARG, BOL, COL, DOM, PAN, PER, SLV, URY. In addition, six countries and territories partially achieved the indicator: BON, BRA, BRB, GTM, SUR, TTO. Confirmation of the final assessment from eight countries was pending at the time of this report. They have reported data to PRAIS through different mechanisms, such as Pharmaceutical Country Profiles and regulatory assessments.					
4.3.3	Countries enabled to assess their national regulatory capacity for medicines and other health technologies	Number of countries and territories having conducted an assessment of their regulatory functions for at least two of the following: medicines, medical devices, radiation safety, blood safety, and organ transplantations	7	11	Exceeded (13 achieved + 11 partially achieved)
Thirteen countries and territories achieved the indicator: ARG, BON, BRA, CAN, CRI, CUB, ECU, MEX, NIC, PER, SAB, STA, VEN. Another 11 countries and territories partially achieved the indicator: BRB, CHL, COL, DOM, GUY, HTI, JAM, PAN, SLV, TTO, VGB. A pilot assessment of the regulatory capacity of medical devices was performed in five countries: Colombia, Cuba, Ecuador, Mexico, and Panama. The results were presented at a regional meeting held in Colombia in October 2015.					
4.3.4	Countries enabled to implement processes and mechanisms for health technologies assessment, incorporation, and management, and for rational use of medicines and other health technologies	Number of countries and territories with mechanisms for health technologies assessment and evidence-based incorporation, selection, management, and rational use of medicines and other health technologies	3	8	Exceeded (12 achieved + 14 partially achieved)

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating

Twelve countries and territories achieved the indicator: BOL, BRA, CAN, CUB, MEX, NIC, PER, PRY, SAB, SLV, STA, URY.

Additionally, 14 countries and territories partially achieved the indicator: ARG, BHS, BON, BRB, CHL, COL, CRI, DOM, ECU, GTM, HTI, JAM, PAN, VEN.

Confirmation of the final assessment from four countries was pending at the time of this report.

Countries have made important advances in the implementation of integrated approaches for the assessment and rational use of health technologies. For example, El Salvador has created a new department within the Ministry of Health that integrates HTA and rational use of health technologies. Peru has created a new HTA entity that was recently incorporated into the regional RedETSA network. Argentina and Ecuador have made progress on donation and transplantation and on blood safety, among others. Argentina also has a coordinating unit on health technology assessment (UCEETS).

Program Area 4.4: Health Systems Information and Evidence **OUTCOME: All countries have functioning health information and health research systems** OCM Indicator Assessment: 2/2 In Progress OPT Indicator Assessment: 3/7 Achieved, 4/7 Partially Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.4.1	Number of countries and territories meeting the coverage and quality goals of the PAHO Regional Action Plan for Strengthening Vital and Health Statistics	14	35	In Progress (10 achieved + 22 in progress)

Ten countries and territories achieved the indicator: ARG, BRA, CAN, CHL, CRI, CUB, MEX, PRI, URY, USA.

Twenty-two countries and territories made partial progress on the indicator: AIA, ATG, BLZ, BOL, COL, DMA, DOM, ECU, GRD, GUY, HND, JAM, KNA, LCA, NIC, PER, SLV, SUR, TTO, VCT, VEN, VGB.

Confirmation from two countries was pending at the time of this report.

The Organization has advocated for the adoption of policies and interventions recommended under the Regional Plan of Action for Strengthening Vital and Health Statistics (PEVS). Approximately 30 countries have established inter-institutional committees to strengthen health information. Twenty-one countries achieved the PEVS targets for birth data, and 16 achieved targets for mortality data; 17 and 12 countries exceeded these targets, respectively. The South-South RELACSIS network has allowed for the exchange of best practices and experiences across the Region. Efforts are also under way to continue to improve coverage and quality of vital health statistics, focusing on mortality registers (mortality under-registry and ill-defined/unknown causes of death).

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.4.2	Number of countries and territories with functional mechanisms for governance of health research	5	26	In progress (9 achieved + 18 in progress)

Nine countries and territories achieved the indicator: BRA, CAN, CHL, CUW, DMA, MEX, PAN, PER, USA.

Eighteen countries and territories have made partial progress on the indicator: ARG, BHS, BOL, CRI, DOM, ECU, GTM, GUY, HND, JAM, PRY, SLV, STA, SUR, SXM, TCA, TTO, VEN.

Confirmation of the final assessment from three countries was pending at the time of this report.

The indicator includes four key components: defining national research priorities, ethical standards, proportion of prospectively registered clinical trials, and research translation mechanisms.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
4.4.1	Countries enabled to comply with comprehensive monitoring of the regional and country health situation, trends, and determinants	Number of countries and territories monitoring the health situation, trends, and determinants biennially	9	14	Exceeded (18 achieved + 7 partially achieved)

Eighteen countries and territories achieved the indicator: ARG, BLZ, BRA, CAN, COL, CRI, CUB, DMA, GLP, GTM, GUF, MTQ, NIC, PAN, PER, PRI, PRY, USA.

Seven countries and territories have partially achieved the indicator: BON, ECU, MEX, STA, SUR, TCA, TTO.

Confirmation of the final assessment from seven countries was pending at the time of this report.
It is expected that significant Region-wide improvements will result from the Health in the Americas 2017 process. Additional efforts are needed to build capacity in health information systems for data management and monitoring of health situation trends. Medium-term strategies to address deficiencies include allocating increased levels of funding and human resources for these essential public health functions and developing enabling policies and strategies to strengthen health information systems. Efforts are under way to develop a strategy for improving health data analysis throughout the Region using a process tailored to country needs.

4.4.2	Implementation of the regional Strategy and Plan of Action on eHealth	Number of countries and territories implementing an eHealth strategy	5	16	Partially Achieved (8 achieved + 11 partially achieved)

Eight countries and territories achieved the indicator: BON, BRA, CAN, CHL, COL, JAM, PRY, USA.

Another 11 countries and territories partially achieved the indicator: ARG, BLZ, CRI, CUW, DOM, MEX, PER, SLV, TTO, VEN, VGB.

Confirmation of the final assessment from four countries was pending at the time of this report.

The political commitment and the adoption of measures on eHealth have increased steadily. This has resulted in

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
stronger resource mobilization efforts for the adoption and development of digital services that will allow better access, expand coverage, and increase the financial efficiency of health care systems. PAHO expects that by the end of 2017, at least 12 more countries and territories will have national eHealth strategies (Argentina, Belize, British Virgin Islands, Costa Rica, Dominica, El Salvador, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, Venezuela).					
4.4.3	Implementation of the regional knowledge management strategy	Number of countries and territories implementing the regional knowledge management strategy	6	12	Partially achieved (7 achieved + 5 partially achieved)
Seven countries achieved the indicator: ARG, BRA, COL, DMA, GUY, MEX, PAN. Additionally, five countries and territories partially achieved the indicator: CRI, DOM, SAB, SLV, STA. PAHO provided tailored support to countries and territories for the achievement of this indicator, considering that the implementation of this strategy requires sustained prioritization of knowledge management and its related fields. As a result, significant progress was achieved during the biennium. For example, Argentina increased its contribution to the LILACS database; the country now has one national and five thematic Virtual Health Libraries (VHL). Also, three Argentine scientific journals have been indexed in the MEDLARS/NLM system by BIREME. In 2014, the Hospital Italiano de Buenos Aires was designated as a PAHO/WHO Collaborating Center in Knowledge Management. Brazil has one national and more than 25 thematic VHLs, becoming the country with most VHLs in the Region. In 2015, PAHO signed an agreement with Brazil's Ministry of Health to support the innovation and development of the Health Evidence-based Portal, an initiative from the country. In 2015, all LILACS collaborative centers processed a total of 23,039 documents (4.5% increase compared to 2014). Also worth noting is the development of the Caribbean Public Health Agency (CARPHA) EvIDeNCe Portal in Jamaica, which provides more than 16.5 million bibliographic records, 5 million of which have full text available. In order to achieve the milestones set for the regional knowledge management strategy, it is crucial to reinforce the importance of the WHO HINARI Programme, among others.					
4.4.4	Implementation of the regional Policy on Research for Health (CD49/10)	Number of countries and territories implementing the regional Policy on Research for Health	18	23	Partially Achieved (14 achieved + 15 partially achieved)
Fourteen countries and territories achieved the indicator: ARG, BRA, CAN, CHL, CUB, GLP, GUF, HND, MEX, MTQ, NIC, PER, PRY, USA. Another 15 countries partially achieved the indicator: ATG, COL, CRI, DOM, ECU, GUY, JAM, KNA, LCA, PAN, SLV, SUR, TCA, VCT, VEN. Confirmation of the final assessment from thirteen countries was pending at the time of this report. As of 2015, most countries have health research policies. Relevant country capacities have increased notably, albeit inconsistently. PAHO has partnered with schools of public health to advocate for implementation of the regional policy and has provided 180 scholarships for graduate studies at the master's and doctoral levels. The Organization has catalyzed the development of strategic tools to improve and provide access to evidence-based strategic resources for health research that enriches public health policy and decision-making.					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
4.4.5	Countries enabled to strengthen their capacity to generate and apply scientific evidence	Number of countries and territories integrating scientific evidence into practice, programs, or policies using standardized methodologies	8	12	Partially Achieved (9 achieved + 6 partially achieved)
Nine countries achieved the indicator: ARG, BRA, COL, CRI, CUB, MEX, NIC, PAN, PRY. Another six countries partially achieved the indicator: BOL, CHL, GTM, PER, SLV, TTO. Progress in fostering knowledge translation and evidence mechanisms includes improvements to 12 health programs through embedded research (the iPIER Initiative) in Argentina, Bolivia, Brazil, Chile, Colombia, Mexico, Panama, Peru, and Saint Lucia. National evidence programs have been strengthened through standards, strategies, training, and support for development of guidelines using the GRADE methods (PAHO virtual course held in over 10 countries). A regional platform for adapting guidelines and knowledge translation is available, and compliance within PAHO is increasing. National and subregional agendas, policies, norms, and regulations on research have been updated or developed. A subregional agenda on chronic kidney disease from non-traditional causes in Central America is available for national consultation.					
4.4.6	Countries enabled to address priority ethical issues related to public health and research for health	Number of countries and territories with accountability mechanisms to review research or incorporate ethics into public health	2	9	Exceeded (12 achieved + 2 partially achieved)
Twelve countries achieved the indicator: ARG, BRA, CHL, COL, GTM, HND, JAM, MEX, PAN, PER, SLV, VEN. In addition, two countries partially achieved the indicator: BHS, TTO. Steps have been taken to implement ProEthos to strengthen ethics reviews for human subject research (Argentina, Chile, Colombia, Costa Rica, El Salvador, Guadeloupe, Honduras, Peru). National frameworks have been revised to ensure ethical human subject research (Colombia, Costa Rica, Ecuador, Jamaica, and Peru), and training on research ethics has been provided at the subregional and national levels (Chile, Colombia, Costa Rica, Guatemala, Peru, and Trinidad and Tobago). Novel training materials and guidance and workshops were provided in Chile, Colombia, and Puerto Rico, and for PAHO staff to better incorporate ethics into public health decision-making.					
4.4.7	PAHO Core Health Data and Country Profile Initiative expanded to effectively monitor the SP 2014-2019	Proportion of impact indicators of the SP 2014-2019 being reported through the Core Health Data and Country Profile Initiative	n/a	100%	Achieved (100%)
This is a regional-level indicator that is designed to provide strategic data from countries and territories on progress toward attaining the impact indicators in the PAHO Strategic Plan 2014-2019. PAHO has built a regional and country database with baseline, progress, and target data.					

Program Area 4.5: Human Resources for Health **OUTCOME: Adequate availability of a competent, culturally appropriate, well regulated, well distributed, and fairly treated health workforce** OCM Indicator Assessment: 3/3 In Progress OPT Indicator Assessment: 4/4 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.5.1	Number of countries and territories with at least 25 health workers (doctors, nurses, and midwives) per 10,000 population	25	31	In progress (27 achieved)

Twenty-seven countries and territories achieved the indicator: AIA, ARG, BLZ, BRA, BRB, CAN, CHL, COL, CRI, CUB, CYM, DMA, GLP, GRD, LCA, MEX, MSR, MTQ, PAN, PER, PRY, SLV, SUR, TTO, URY, USA, VEN.

Confirmation of the final assessment from three countries was pending at the time of this report.

An additional seven countries and territories will face some challenges in order to reach this outcome by 2019 (Bolivia, Ecuador, Guadeloupe, Guyana, Haiti, Honduras, and Nicaragua). In 2015, these target countries reported the following data on number of health workers per 10,000 population: Haiti 3.6, Guyana 11.6, Guatemala 12.5, Honduras 13.6, Bolivia 14.1, Nicaragua 16.0, Ecuador 18.2. PAHO is working with these countries to strengthen planning capabilities in order to improve staffing and especially to address the problem of emigration by health workers.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.5.2	Number of countries and territories with national training programs on public health and intercultural competencies for primary health care workers	8	22	In progress (5 achieved + 16 in progress)

Five countries and territories achieved the indicator: BRA, CHL, CUB, CUW, PAN.

In addition, 16 countries and territories made progress toward the indicator: ARG, BON, COL, CRI, ECU, GRD, LCA, MEX, PER, PRY, SLV, STA, SXM, TCA, TTO, VEN.

Confirmation of the final assessment from one country was pending at the time of this report.

Progress on this indicator is noted in countries with ethnic and cultural diversity.

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
4.5.3	Number of countries and territories that have reduced by 50% the gap in the density of health workers (doctors, nurses, and midwives) between subnational jurisdictions (province, state, department, territory, district, etc.) that have a lower density of health workers than the national density	11	19	In progress (10 achieved + 2 in progress)
Ten countries and territories achieved the indicator: CUB, HND, JAM, NIC, PAN, PER, PRY, TCA, TTO, VEN. Two countries made partial progress on the indicator: BOL, KNA. Confirmation of the final assessment from thirteen countries was pending at the time of this report. The evaluation of this indicator requires each country to establish a baseline against which to measure progress. Compliance does not necessarily mean achieving the optimum distribution of health workers, but denotes progress in narrowing the gap between higher-density areas and underserved areas. It is important to note that the countries with the highest population concentrations have shown progress on this indicator.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
4.5.1	Countries enabled to develop and implement HRH policy and/or plans to achieve UHC and address current and future health needs of their population	Number of countries and territories with an HRH action plan aligned with the policies and needs of their health care delivery system	11	17	Partially achieved (7 achieved + 10 partially achieved)
Seven countries and territories achieved the indicator: AIA, CAN, CHL, CUB, SLV, URY, VEN. In addition, ten countries and territories partially achieved the indicator: BON, COL, CRI, DOM, ECU, KNA, MEX, PER, TTO, USA. Confirmation of the final assessment from six countries was pending at the time of this report. Substantial progress was made on this indictor, with important advances in most of the target countries.					
4.5.2	Countries enabled to improve the performance, working conditions, job satisfaction, and stability of their health workforce in agreement with the WHO Global Code of Practice on the International Recruitment of Health Personnel	Number of countries and territories with a comprehensive legal framework that ensures appropriate treatment of health workers	12	18	Partially achieved (9 achieved + 4 partially achieved)

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
Nine countries and territories achieved the indicator: BRA, CAN, CHL, COL, CRI, CUB, NIC, SAB, USA. Another four countries partially achieved the indicator: BHS, DOM, PER, SLV. Confirmation of the final assessment from seven countries was pending at the time of this report. There has been progress, but it is worth noting that establishment of a legal framework is a lengthy process in most countries. It is hoped that countries will build on this progress in the current biennium.					
4.5.3	Technical guidance being provided to academic health institutions and programs for health science education oriented toward primary health care	Number of academic curricula reoriented toward primary health care	7	12	Partially Achieved (6 achieved + 4 partially achieved)
Six countries and territories achieved this indicator: CUB, DOM, KNA, NIC, SAB, VEN. In addition, four countries and territories partially achieved the indicator: BON, COL, MEX, TTO. Confirmation of the final assessment from four countries was pending at the time of this report. An important challenge for countries remains insofar as universities have autonomy to define their own curricula.					
4.5.4	Countries and territories enabled to develop and implement innovative strategies to improve the public health, managerial, and clinical health workforce	Number of countries and territories that have established a node of the Virtual Campus for Public Health or equivalent e-learning network	7	14	Partially achieved (11 achieved + 8 partially achieved)
Eleven countries achieved the indicator: CHL, COL, CUB, DOM, ECU, HND, MEX, PER, PRY, SLV, URY. Additionally, eight countries and territories partially achieved the indicator: ABW, CRI, GUY, JAM, PRI, SAB, TTO, VEN. Confirmation of the final assessment from nine countries was pending at the time of assessment.					

2014-2015 End-of-Biennium Assessment
Category 5 Report

CATEGORY 5: PREPAREDNESS, SURVEILLANCE, AND RESPONSE	**OVERALL CATEGORY ASSESSMENT RATING[22]** **Partially met expectations**

CATEGORY PROGRAMMATIC AND BUDGET OVERVIEW

Table 1. Category 5 Programmatic and Budget Summary

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget Implementation against PB (%)	Budget Implementation against Awarded (%)	Output Indicator Rating	Outcome Indicator Status
5.1 Alert and Response Capacities (for IHR)	9.85	10.51	106.6	99.1	92.9	2/2 partially achieved	1/1 in Progress
5.2 Epidemic- and Pandemic-Prone Diseases	8.02	9.69	120.9	113.4	93.7	1/3 achieved, 2/3 partially achieved	1/1 in Progress
5.3 Emergency Risk and Crisis Management	18.98	21.03	110.8	104.1	94.0	5/5 achieved	2/2 in Progress
5.4 Food Safety	9.54	13.97	146.5	135.5	92.5	1/4 achieved, 3/4 partially achieved	1/1 in Progress
TOTAL	**46.39**	**55.20**	**119.0**	**111.1**	**93.4**	7/14 achieved, 7/14 partially achieved	5/5 in progress
5.5 Outbreak and Crisis Response	22.00	9.84	44.8	42.0	93.8	1/1 achieved	1/1 achieved

[22] Assessment ratings for the overall category and for program areas/outcomes are determined by the PAHO category and program area facilitators, respectively, taking into consideration the programmatic and budget implementation, analysis of resources (human and financial), and operational and programmatic risks. Ratings are defined as follows:

- **Met expectations** (Green): achieved 90% to 100% of the results for the period being assessed. Progress is on track, as expected; no impediments or risks that affect the achievement of results are foreseen.
- **Partially met expectations** (Yellow): achieved 75% to 89.9% of the results for the period being assessed. Progress may be at risk, and action is required to overcome delays, impediments, and risks.
- **Insufficient progress** (Red): achieved <75% of the results for the period being assessed. Progress is in jeopardy due to impediments or risks that could preclude the achievement of results. Immediate corrections are required.

Table 2a. Category 5 Budget Overview by Functional Level: Program Areas 5.1 to 5.4

Functional Level	Funds Awarded (US$ millions)	Awarded by Level (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
Country	13.71	24.85	13.53	98.7
Intercountry	19.90	36.04	18.32	92.1
Subregional	2.76	5.01	2.56	92.5
Regional	18.82	34.10	17.13	91.0
Total	**55.20**	**100.00**	**51.53**	**93.4**

Table 2b. Category 5 Budget Overview by Functional Level: Program Area 5.5 (Outbreak and Crisis Response)

Functional Level	Funds Awarded (US$ millions)	Awarded by Level (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
Country	8.75	88.86	8.22	94.0
Intercountry	0.30	3.06	0.28	92.2
Subregional	0.08	0.80	0.07	92.2
Regional	0.72	7.28	0.66	92.2
Total	**9.85**	**100.00**	**9.23**	**93.8**

CATEGORY PROGRAMMATIC ANALYSIS

Overall Category Assessment Summary

Category 5 focuses on strengthening country capacities for prevention, risk reduction, preparedness, surveillance, response, and early recovery in relation to all types of human health hazards that may result from emergencies or disasters. Particular attention is given to capacities that come under the requirements of the International Health Regulations (IHR) 2005. Work in this category aims to strengthen hazard-specific capacity-building in relation to a range of diseases with the potential to cause outbreaks, epidemics, or pandemics, and also in relation to food safety-related events, zoonoses, antimicrobial resistance, chemical and radiologic emergencies, natural hazards, and conflicts. It considers the human security approach to building coherent intersectoral policies to protect and empower people to increase community resilience against critical and pervasive threats. In addition, this category includes coordinated international health assistance to help Member States respond to emergencies when required.

With eight of 14 output indicators fully achieved and the remaining six partially achieved during the 2014-2015 biennium, Category 5 partially met expectations for the assessed period. All five program areas have demonstrated significant progress and achievements despite overall mixed results. Budget implementation was strong, with 94% of awarded funds being implemented.

A major effort in this category and for the Organization as a whole during the biennium was supporting the response to the outbreak of Ebola virus disease (EVD) in West Africa and providing technical cooperation to Member States to enhance their readiness for Ebola as part of a larger preparedness strategy for outbreaks and

other crises. While this Grade 3 emergency brought many challenges, including the disruption of many PAHO and Member State work plans, it also provided an opportunity to advance on many aspects of the program of work related to preparedness, surveillance, and response. The response to the Zika virus outbreak that began in 2015, with intensification of the outbreak and associated complications in the last quarter, will benefit from the enhancements instituted for Ebola.

The Ebola outbreak also triggered a Special Session of the 2015 World Health Organization (WHO) Executive Board on WHO's capacity to prepare for and respond to future large-scale and sustained outbreaks and emergencies. This led to the establishment of the high-level Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies with Health and Humanitarian Consequences. This advisory group has already provided recommendations on ways to strengthen WHO's capacity through internal changes, capacity-building support to Member States, and enhanced partnerships. The plan as agreed consists of six areas of work: infectious hazard management, Member State preparedness (IHR and all-hazards), risk assessment and health emergency information management, emergency operations (all-hazards/events), management and administration, and external relations. Implementation will focus on incident management, key issues for pilot testing, and transformative changes.

PAHO already has in place a number of elements called for in the proposed restructuring, including a strong regional response team, a cadre of trained health cluster and Foreign Medical Team coordinators, and a solid regional Global Outbreak Alert and Response Network. Additionally, PAHO/WHO's Institutional Response to Emergencies and Disasters (IRED) policy forms the basis of a training program that has been developed to enhance the capacity of PAHO/WHO managers and senior staff in operational readiness and emergency response. The training program has two main components:

- An e-learning course that will facilitate continuous learning. The English version was launched during semester 3 (January-June 2015), and the Spanish version was finalized in the last quarter of 2015 and will be launched in early 2016.
- Face-to-face training sessions in operational disaster readiness and response with PAHO/WHO Representatives (PWRs), administrators, and disaster focal points from the PWR Offices and PAHO departments and centers. This training expands on the content of the aforementioned e-course.

5.1 Alert and Response Capacities (for IHR)

Overview

This program area aims to ensure that all countries of the Region have the core capacities needed to fulfill their responsibilities under the IHR (2005) prior to the deadline in 2016. These cover national legislation, policy, and financing; coordination and national focal point communications; surveillance and risk communication; preparedness and response; infection prevention and control; human resources; and laboratory capacity-building and networking.

Achievements

- A total of 22 countries in the Region requested and were granted the 2014-2016 extension on national IHR plans, showing their commitment to establish national public health capacities. As part of the development of IHR capacities, technical support was provided to update these plans in the context of the Framework for Strengthening National Preparedness and Response for Ebola Virus Disease in the Americas (the Ebola preparedness framework).
- With respect to alert and response, 24/7 epidemiologic monitoring and response actions were maintained during the biennium to rapidly inform Member States about threats or public health risks, such as the Zika

virus. The majority of potential public health emergencies were risk-assessed and communicated from PAHO to the National IHR Focal Points (NFPs) within 48 hours. During 2014-2015, 38 alerts and epidemiological updates were disseminated to PAHO/WHO's Member States; 31 event updates (10 related to Zika virus) were posted on the WHO Event Information Site for NFPs; and 594 e-mail communications were sent to Member States about threats or public health risks. Additionally, intensified monitoring was provided during the Brazil 2014 World Cup, resulting in the communication of 177 public health events, of which 52% corresponded to infectious diseases.

Challenges

- PAHO/WHO capacity to provide actionable information and technical advice to national authorities about public health events that could pose a risk to international public health depends on timely notification and transparency by Member States in sharing information with PAHO, as well as on PAHO's capacity to maintain communication 24/7 with the IHR NFPs. Any delay in sharing information with the NFPs was due to deferred Member State response/review/comment on PAHO/WHO postings, and/or delay by WHO colleagues in posting this information on the secure WHO Event Information Site for NFPs.
- Countries need to ensure their commitment to continue efforts toward sustainable core capacities for IHR in light of the lessons learned from the EVD preparedness and response and other public health emergencies.

Lessons Learned

- Considering that public health preparedness is a continuous process, mechanisms to facilitate the exchange of good practices and information between countries should be applied to strengthen preparedness and response to EVD and other emerging pathogens in the 2016-2017 biennium.
- Despite the complexity of maintaining fluid and timely communication between the IHR NFPs, PAHO put in place several mechanisms during this biennium to achieve such communication. For instance, the Pan American Sanitary Bureau (PASB) increased the dissemination of information to Member States via e-mail, and in the case of Zika, the May 2015 Epidemiological Alert was written in a generic fashion to prevent delays in information-sharing.

5.2 Epidemic- and Pandemic-Prone Diseases

Overview

The work of this program area focuses on improving the sharing of knowledge and information available on emerging and reemerging infectious diseases; enhancing surveillance and response to epidemic diseases of potential international concern; supporting countries in improving their preparedness, response, and resilience to epidemics; providing guidance on evidence-based clinical management and infection control to reduce morbidity and mortality during outbreaks; and networking to contribute to global mechanisms and processes, in accordance with IHR provisions.

Achievements

- As a part of ongoing efforts in preparedness and response to emerging infectious disease outbreaks, the Ebola preparedness framework was developed and implemented, with direct technical cooperation provided to more than 26 Member States. It included three phases: *(a)* preparatory, which included consultations with Member States; *(b)* technical missions to 27 Member States, tailored to the needs of each country visited; and *(c)* follow-up to implement previous recommendations and assess future needs

related to policy, preparedness, surveillance, laboratory capacity, response, risk communication, and so on, in the context of IHR core capacities.

- Clinical management tools and laboratory capacity have been developed to strengthen countries' capacities for responding to chikungunya, and comprehensive technical cooperation has been mobilized and coordinated for countries affected by the Zika virus outbreak. These efforts have provided important lessons in regard to maintaining and achieving IHR core capacities to deal with emerging infectious diseases in the Region.
- The Region has been a pioneer in confronting antimicrobial resistance (AMR). The Plan of Action on Antimicrobial Resistance was successfully approved by the Organization's 54th Directing Council. The resulting resolution aligns with global-level strategies and will support advocacy related to this priority area in the Region. The Plan of Action was developed through consultative processes and strong collaboration involving the technical departments of the Organization as well as WHO, key partners, and Member States.

Challenges

- Despite representing an opportunity for further development of country preparedness, response, and resilience to epidemics, certain outbreaks (e.g., EVD) can lead to a narrow approach and planning process. This could result in missed opportunities to update operational plans for outbreak preparedness and response under a broader multi-hazard perspective.
- Recent circulation of arboviruses of public health importance in the Region has spurred intensified efforts that in turn have imposed an additional burden on the PASB, which must address the growing demands of the Member States in a timely manner. The heightened complexity of surveillance and control efforts in recent years has forced countries to restructure and adapt their public health plans in response to public health threats, in line with the IHR.
- Regional activities must be intensified to ensure an impact on the containment of AMR, including raising awareness and advancing education, reducing the misuse of antimicrobial drugs, expanding surveillance of drug resistance, improving infection prevention and control, and increasing investment in research and development around new antibiotic drugs and diagnostics.

Lessons Learned

- The EVD outbreak provided an opportunity to assess the operational implementation of IHR core capacities and health systems' preparedness to adequately respond to a potential EVD case or other emerging infectious disease. In the context of the EVD preparedness framework, technical missions in the countries have made it possible to identify discrepancies between expert findings and the countries' self-assessments of core capacity. This points to the need to refine the monitoring approach in the application of IHR to place more emphasis on the function of public health systems.
- It is important to note that a significant amount of time and effort was spent in preparedness and response activities against emerging infectious diseases, including EVD and Zika virus. These events presented both opportunities and challenges in regard to resource mobilization. While these diseases captured the attention of donors, at the same time they forced the Organization to redirect the work of technical staff from routine activities to response efforts.

5.3 Emergency Risk and Crisis Management

Overview

This program area reflects most of the Organization's preparedness and mitigation work, both to build its own institutional response capacity and to support Member States in their efforts to protect the physical, mental, and

social well-being of their populations and recover rapidly from emergencies and disasters. This has been done by strengthening national leadership roles of preparedness, monitoring, and response within the ministries of health; advocating the adoption of benchmarks for disaster preparedness; and reinforcing the Organization's own surge capacity, among other means.

Achievements

- PAHO's 53rd Directing Council approved Resolution CD53/12, Plan of Action for the Coordination of Humanitarian Assistance, 2015-2019. Tools and mechanisms have been developed and/or updated to support Member States in the implementation process, including an electronic platform for coordination of response in the health sector (HoPE) and an Advisory Group made up of experts in humanitarian response. The first meeting of the Advisory Group, convened in Peru in July 2015, provided recommendations for the operationalization of the Plan of Action.
- Three key PAHO initiatives (Safe Hospitals Initiative, SMART Hospitals Initiative, and Foreign Medical Teams) have been or are being scaled up to the global level and formed an important core of the health component of the Third United Nations World Conference on Disaster Risk Reduction. Additionally, thanks to PAHO's leadership and the active involvement of national health stakeholders, health was identified as a priority for disaster risk reduction in the Americas within the context of the post-2015 global framework on disaster risk reduction (DRR).
- PAHO continued to provide leadership and technical support to Haiti and Colombia to address their protracted emergencies related to cholera and to internal displacement due to armed conflict, respectively. In Haiti, support was provided to health authorities to implement the short-term phase of the National Plan for the Elimination of Cholera in Haiti, 2013-2022. PAHO's continuous support for strengthening the coordination, information management, epidemiological surveillance, and response capacities of the Haitian Ministry of Health, as well as logistical and technical support to cholera partners, contributed to controlling cholera-associated mortality and maintaining the overall cholera fatality rate in Haiti below 1% (0.89% for the year 2015). In Colombia, PAHO helped reenergize the health cluster mechanism, which it co-led with the Colombian Red Cross. In coordination with the Ministry of Health, the organizations also supported intersectoral work with other members of the Humanitarian Country Team and local humanitarian teams. PAHO's permanent and active presence in the field facilitated the opening of humanitarian space in areas controlled by armed groups and guerrillas and significantly contributed to the delivery of essential humanitarian health assistance by both governmental and non-state actors.
- Thirty-six countries and territories have applied the Hospital Safety Index (HSI) to assess hospital safety in disasters, with most of them also implementing corrective measures in priority health facilities. Member States, with leadership and technical support from PAHO, have made noticeable strides in implementation of Resolution CD50.R15, the Plan of Action on Safe Hospitals, 2010-2015. Numerous technical guides and electronic applications, such as an HSI application for mobile devices and an updated online hospital safety database, were developed to support the countries in this process.
- PAHO mobilized £8.72 million and garnered buy-in and commitment from national stakeholders in the Caribbean for implementation of the second phase of an initiative that integrates climate change and disaster risk reduction considerations in the health sector (SMART Hospitals Initiative). An offer has subsequently been received from the UK Government to scale up the £8.72 million Smart Hospitals Phase 2 Project by £30 million, with an expansion of the implementation period to five years and an increase in the number of countries to seven, with 50 health facilities being retrofitted. Phase 2 of this innovative initiative began in June 2015, and with the scale-up will run until December 2020.
- Advances have been made in integrating the cross-cutting themes into disaster risk management, particularly ethnicity:

- A document titled Recommendations for Engaging Indigenous Peoples in Disaster Risk Reduction was published in English and Spanish. The English version is already available on PAHO's website. This document, along with a module on Indigenous Peoples in Disaster Risk Reduction, is also being incorporated into the PAHO/WHO Knowledge Center on Public Health and Disasters.
- A practical guide for decision-making on disaster risk management in indigenous communities was drafted.
- A training program on indigenous populations and disaster was developed and implemented in Mexico for 28 communities in 10 municipalities.

- PAHO's readiness to mount an institutional response to emergencies has been enhanced:
  - Approximately 50 PAHO staff, including PWR administrators and disaster focal points, were trained in updated emergency response procedures during a regional health disaster training in Nicaragua in October 2015.
  - Revised action cards with all essential functions for institutional response were prepared in English and Spanish.
  - The Institutional Response to Emergencies and Disasters (IRED) policy is now available in all four official languages of the Organization.
- Important investments have been made in capacity-building for disaster risk management, including the development of technical materials and training. Twelve key examples of technical guides and guidelines, tools, and training materials were developed, and over 500 people throughout the Region were trained in critical aspects of disaster preparedness, risk reduction, and emergency coordination, including use of the incident command system in hospitals.

Challenges

- Ensuring multisectoral participation of stakeholders, both within and outside the health sector, is critical for achieving successful implementation of the Plan of Action on Safe Hospitals.
- Scarce resources for disaster risk reduction remain an ongoing challenge, especially since many donors are focusing more on readiness and response. PAHO has been successful in mobilizing resources for emergencies, but the downward trend in humanitarian financing for the health sector and the reduction in the Organization's staff cadre present challenges for the pace of advancement on some technical cooperation issues.
- There have been difficulties in recruiting qualified and immediately available project staff with adequate experience and knowledge in health and disaster management for some duty stations, particularly those requiring additional language competencies and/or specific security restrictions, such as Haiti.

Lessons Learned

- Documentation of the use of voluntary contributions (inventory of assets, materials purchased/distributed, and data on training participants disaggregated by age and sex) remains a weak area of project management and monitoring. Compliance with existing systems such as the Asset Management System, institution of appropriate information management systems, and ongoing promotion of good practices in project management are imperative to ensure systematic and complete information management.
- The training of administrative personnel has helped streamline administrative processes for more effective emergency response within the PASB. An inter-programmatic approach to training should be considered to further improve emergency operating procedures and ensure smooth operations in case of disaster.
- Clear, timely, accurate, and consistent communication with all partners must be ensured at all times for program/project development and implementation. Strong coordination among all relevant levels and departments of the Organization is essential in this regard.

- Donor partners are increasingly demanding that the Organization demonstrate value for money in the projects that it implements, and this is emerging as a critical issue for the mobilization of new resources as well as maintenance of existing resources. The Organization must therefore ensure that the relevant expertise, tools, and systems are in place and available to facilitate this consideration.

5.4 Food Safety

Overview

The work under this program area focuses on establishing efficient food safety systems to prevent and reduce foodborne diseases and promote consumer safety. It looks at strengthening risk-based, integrated national food safety systems, increasing the scientific advice and implementation of food safety standards and guidelines, and promoting cross-sectoral collaboration for reducing foodborne risks, including those arising from the human-animal interface.

Achievements

- The program continues with the implementation of the Food Safety Strategy presented at the 6th Meeting of the Pan American Commission on Food Safety (COPAIA 6), which provides a regional road map and guidance on strengthening food safety in the Region. Efforts have been made to strengthen multisectoral collaboration to better manage food safety throughout the food chain. In particular, there has been progress on strengthening the International Food Safety Authorities Network (INFOSAN), with the approval (Chile, 2014) and implementation (Mexico, 2015) of the Regional Strategy to Strengthen INFOSAN in the Americas.
- The 2015 World Health Day on food safety and the launch of the foodborne burden estimates raised awareness and had a big impact in countries, resulting in greater priority to food safety.
- Several Member States have strengthened the capacities of their inspection services, and food safety officers have undergone training on risk-based food inspection. Using the WHO Global Foodborne Infections Network platform for capacity-building, a risk analysis training has been conducted with the English-speaking Caribbean countries. In addition, a manual on strengthening surveillance and response for foodborne diseases has been developed with WHO Headquarters and will be implemented at country level to strengthen foodborne disease surveillance in the Region. A virtual course on management of food safety emergencies is available in the Virtual Campus.
- The Region of the Americas remains without foot-and-mouth disease (FMD) notifications since January 2012, and epidemiological surveys conducted by the countries report no evidence of FMD transmission among animals. In this context, the 42nd Meeting of the South American Commission for the Fight Against Foot-and-Mouth Disease (COSALFA), held by the Pan American Foot and Mouth Disease Center (PANAFTOSA) in Quito, Ecuador in April 2015 acknowledged that a new stage of the Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA) has begun: that is, the Region is beginning the FMD eradication process. A technical guide addressing the main challenges presented by this new stage of PHEFA was approved at the 5th Extraordinary Meeting of COSALFA held in Cuiaba, Brazil, in October 2015. Furthermore, COSALFA has requested the establishment of a regional FMD vaccine and antigen bank, to be set up and managed by PAHO/WHO.

Challenges

- Sustained national commitment, multisectoral coordination, and an inter-programmatic approach will be needed to strengthen food safety capacities and the integration of food safety into broader nutrition and noncommunicable disease strategies and plans in the Region.

- The high-level political mandate remains limited, and specific work plans are scarce. The Pan American Commission on Food Safety (COPAIA) should play an important role in this issue, promoting the development of adequate national food safety policies.
- Resources are insufficient to respond to increased expectations and demands from countries for continued technical cooperation in FMD to maintain the gains made in the Americas and advance national programs to achieve "FMD-free without vaccination" status.

Lessons Learned

- Food safety is an important component of IHR, and with emerging food safety threats, it is necessary to strengthen Member States' capacity to prevent, detect, assess, and respond to foodborne disease outbreaks. This capacity has improved during the last biennium due to good inter-programmatic work and enhanced communication between NFPs and INFOSAN focal points at country level.
- The use of regional estimates of foodborne disease burden as an advocacy tool led to increased awareness among national authorities and to the prioritization of the diseases by Member States. This has contributed to developing mandatory national estimates.

5.5 Outbreak and Crisis Response

Overview

This program area encompasses the Organization's support to help countries rapidly and adequately respond to disasters and emergencies that exceed national operational and/or coordination response capacity. In particular, this involves establishing efficient and effective response teams and adapted tools for coordination of international humanitarian assistance in the health sector. During the 2014-2015 biennium, PAHO continued supporting its Member States to respond more efficiently and effectively to disasters, in accordance with PAHO's IRED policy, which provides guidance for operationalizing the Performance Standards in the WHO Emergency Response Framework (ERF).

Achievements

- In 2014-2015 the Organization responded to 10 acute emergencies that met Grade 2 criteria, and in all these cases at least 70% of the 23 WHO Performance Standards in the ERF were met. The Organization's IRED policy was activated at Level/Grade 3 to support the United Nations (UN) response to Ebola in affected West African countries, as well as to facilitate technical cooperation for readiness to respond in Member States. ERF standards were applied to the Region's support for the Grade 3 emergency of the Nepal earthquake in 2015.
- PAHO actively mobilized national and international resources for operations in all the aforementioned emergencies. In the Grade 2 emergencies alone, for example, more than US$ 4.4 million was mobilized for response and some recovery actions.

Challenges

- Ability to attract funding depends in large part on demonstrated ability to deliver commitments within the agreed time frame, which in many cases of disaster response is six months to one year. However, administrative procedures at times conflict with and affect the capacity to implement funds and activities on time and efficiently.

Lessons Learned

- The global EVD emergency marked the first time since approval of IRED in 2012 that the policy was

activated at Level 3. Important lessons were identified during that process, and certain internal response mechanisms were reviewed and updated as a result. A more comprehensive, Organization-wide lessons-learned exercise needs to be instituted to back up subsequent policy, procedural, and institutional enhancements as necessary.

Risks

Although measures have been taken during 2014-2015 to address the risks identified for Category 5 in the PAHO Strategic Plan 2014-2019, the following risks continue to be relevant:

- Insufficient priority is given by countries or the Organization to this category of work, contributing to loss of funding. There is a failure to establish strong partnerships with other agencies involved in country-level emergency preparedness, alert, and response mechanisms.
- Weaknesses in verification mechanisms make it difficult to assess the achievement of the IHR core capacities, and States Parties have limited ability to maintain these capacities.
- It is difficult to recruit strong technical staff at national and subnational levels to implement plans and apply the required information-gathering tools.
- Lack of consensus impedes the completion of an emergency and disaster risk management framework for health.
- Political instability and deterioration in the security situation constrains operations within the health sector.
- There is limited contribution by other categories of work and technical departments to surge and readiness activities.

The following new risks also emerged during the biennium:

- Confusion between short-term emergency preparedness/readiness interventions and longer-term development of core response capacities may undermine the latter.
    - The EVD outbreak in West Africa has provided a magnifying glass to analyze the actual operational and functional status of core capacities and has generated momentum for mobilizing resources and addressing identified gaps. Nonetheless, there is a risk that the Region may not adequately capitalize upon actions taken to prepare for the arrival of EVD, and that these preparatory actions may be mistakenly regarded as something distinct from the core capacities. Achievements that have been made in the area of preparedness might be lost or reduced because of the fading interest in EVD. This will continue to constitute a risk for the Region in the foreseeable future.
- Competing messages between the political and technical levels in times of emergency can affect effective communication.
    - The adoption of unilateral travel and trade measures that affect countries experiencing intense EVD transmission is precautionary and not commensurate with the risk. The introduction of these measures raises concerns about the effectiveness of communication channels between the technical and political levels that should be addressed.
- Different grades of preparedness across the Region could jeopardize overall health security.
    - In the context of emerging infectious disease outbreaks (e.g., EVD, Zika), there is a risk that ongoing planning and implementation efforts may be derailed by the occurrence of health emergencies or disasters. Continued inter-programmatic work is important to document the lessons learned from the Organization in these responses, backed up by subsequent policy, procedural, and institutional enhancements as necessary.

- Excessive enthusiasm about FMD progress could result in reintroduction of the virus if the situation is not managed properly.
    - There are increased expectations and needs in the countries for the Organization to provide continued technical cooperation to preserve the favorable FMD situation achieved in the Americas. The gains made to date are motivating countries to advance their programs to achieve FMD-free without vaccination status. This trend calls for fundamental changes to the technical and financial aspects of the national FMD eradication programs, requiring stakeholders at national and regional levels to renegotiate their roles and responsibilities. The transition must be carefully managed to avoid increasing vulnerabilities, as an FMD virus reintroduction in one country, if not promptly and effectively managed, could have serious economic and social consequences for the entire Region.

Budget Implementation Analysis

Just over $55 million was awarded for Category 5 Base Programs during the biennium. This represents a 19% surplus against the $46.39 million approved in the Program and Budget. The overfunding is related primarily to funding directed to IHR and the Ebola and Zika emergencies (Program Areas 5.1 and 5.2) and additional funding from other sources received for FMD eradication (OPT 5.4.4). All Base Program areas were overfunded: Program Area 5.4 had the highest surplus (146.5%), followed by Program Areas 5.2 (120.9%), 5.3 (110.8%), and 5.1 (106.6%). For Outbreak and Crisis Response (OCR), $9.84 million was awarded out of an estimated $22 million (which primarily represents budget space, informed by historical practice).

The category's Base Programs have an overall award implementation rate of 93.4%, with greatest implementation at the country level (98.7%), followed by the subregional (92.5%), intercountry (92.1%), and regional levels (91.0%). Budget implementation is 92% or higher for all five program areas in the category. This was achieved despite the fact that funding from the Pandemic Influenza Preparedness (PIP) Framework arrived later than expected in the biennium, and despite the allocation, in some areas of the Organization, of at least 80% of technical staff to EVD activities, including country preparedness activities and missions to support the EVD response in West Africa. Program Area 5.3 achieved high implementation rates despite the constriction in staff cadre and the arrival of the majority of funds in the latter part of 2015.

In Program Area 5.3, there is an overall awarded budget implementation rate of 94%. The remaining 6% relates mainly to activities with implementation earmarked for the 2016-2017 biennium, per the approved timeline of the grants. Implementation rate is highest at country level (99.5%) and lowest at regional and intercountry levels (both 90.2%). However, as previously mentioned, most of the unused regional funds related to Other Sources (OS) being carried over to 2016-2017. Additionally, implementation at country level has been driven by project timelines, most of which ended during the biennium. Conversely, most OS funds awarded at regional level have timelines spanning the entire biennium or beyond. The overall budget implementation rate of 93.8% in Program Area 5.5 reflects the nature of OCR grants, which normally stipulate quick implementation timelines, usually six months to one year.

Table 3: Category 5 Budget Overview by Program Area and Functional Level
(Program Areas 5.1 to 5.4 represent Base Programs, and 5.5 represents non-base programs)

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
5. Preparedness, Surveillance, and Response	**55.20**	**100.00**	**51.53**	**93.4**
5.1 Alert and Response Capacities	**10.51**	**19.04**	**9.77**	**92.9**
Country	1.64	2.97	1.63	99.3
Intercountry	2.62	4.75	2.42	92.1
Subregional	1.12	2.02	1.05	93.9
Regional	5.13	9.29	4.67	91.1
5.2 Epidemic- and Pandemic-Prone Diseases	**9.69**	**17.56**	**9.09**	**93.7**
Country	2.90	5.26	2.78	95.8
Intercountry	1.88	3.41	1.75	92.9
Subregional	0.58	1.05	0.54	93.7
Regional	4.33	7.84	4.01	92.7
5.3 Emergency Risk and Crisis Management	**21.03**	**38.09**	**19.76**	**94.0**
Country	8.54	15.48	8.50	99.5
Intercountry	3.42	6.20	3.09	90.2
Subregional	0.93	1.68	0.84	90.5
Regional	8.13	14.73	7.33	90.2
5.4 Food Safety	**13.97**	**25.31**	**12.92**	**92.5**
Country	0.63	1.13	0.63	100.0
Intercountry	11.97	21.68	11.06	92.5
Subregional	0.14	0.25	0.13	89.8
Regional	1.24	2.24	1.11	89.5
5.5 Outbreak and Crisis Response	**9.85**	**100.00**	**9.23**	**93.8**
Country	8.75	88.86	8.22	94.0
Intercountry	0.30	3.06	0.28	92.2
Subregional	0.08	0.80	0.07	92.2
Regional	0.72	7.28	0.66	92.2

Resources for Category 5 were primarily awarded at intercountry level (36.04%), followed closely by regional (34.10%), country (24.85%), and subregional (5.01%) levels. The intercountry level of funding mainly reflects the support to PANAFTOSA as well as the costs of cross-country technical cooperation provided by decentralized human resources located in each of the three subregions. Additionally, a substantial fraction of regional funds was used to directly support country-level activities.

Resource Mobilization

The overfunding in Program Areas 5.1 and 5.2 was primarily linked to contributions received to support the Ebola and Zika outbreak responses. The main donors for Program Area 5.1 in 2014-2015 were the U.S. Centers for Disease Control and Prevention (CDC) and the Government of Brazil. Additionally, new contributions were received in Program Area 5.2 from the Government of Brazil, CDC, PAHO Foundation, and PIP Framework for the influenza, arbovirus, and laboratory programs.

The majority of funds awarded to Program Area 5.3 are from Other Sources, which accounts for the bulk of funds allotted at country level. Of the country-level OS funds, the majority are earmarked to support the protracted emergency programs in Haiti and Colombia (OPT 5.3.4), both of which depend almost entirely on voluntary contributions. The lion's share of these OPT 5.3.4 funds support actual activity costs. The PASB has consistently highlighted the challenge involved in mobilizing resources for DRR, a concern borne out by the distribution of funds awarded across Program Area 5.3 outputs at country level: four of the five OPTs in this program area together account for less than 20% of total funds, while response to protracted emergencies (OPT 5.3.4) receives more than 80%. More than 90% of funds awarded for OCR were voluntary contributions mobilized jointly by the regional and country levels to support response operations in nine countries (less than $2 million of this amount was carried over from the 2012-2013 biennium).

The overfunding for Program Area 5.4 is linked to a contribution received during the first semester of 2015 from the Ministry of Agriculture, Livestock and Food Supply of Brazil (MAPA) to support PANAFTOSA. These funds fully covered the maintenance costs of the Center. PANAFTOSA received additional funds under other agreements for direct technical cooperation, such as with Paraguay's National Service for Animal Quality and Health (SENACSA), Brazil's National Beef Cattle Council (CNPC), and Ecuador's Agency for Agricultural Quality Assurance (Agrocalidad), as well as income from the provision of reference laboratory reagents to the countries. For food safety, additional contributions were received from the CDC and WHO.

At least 55 new donor proposals and/or concept notes for disaster risk reduction (Program Area 5.3) and response (Program Area 5.5) and modifications to existing projects were prepared by the Organization in the biennium. Thirty-seven of these requests, prepared directly by the regional level or jointly with the country level, have been funded for over $30 million, including some multiyear grants; OCR accounts for almost $8 million, including response to cholera in Haiti. Two of the proposals developed during the biennium as well as one developed in the previous biennium remain under negotiation, including with Canada. Funds were also mobilized from the WHO Department of Emergency Risk Management and Humanitarian Response.

Although some technical areas in this category are receiving sufficient funding to ensure proper implementation of activities, others, such as alert and response, infection, prevention and control, antimicrobial resistance, and human-animal interface programs, face challenges in obtaining resources for technical cooperation. Identification of new donors and partners and the continued support of existing donors is needed to guarantee the provision of adequate technical cooperation to countries in these technical areas.

Recommendations

- Update relevant procedures outlined in the PAHO/WHO E-Manual to allow automatic activation of the Special Emergency Procedures for all disaster response projects, as is currently the case in WHO.
- Streamline the recruitment of human resources to ensure timely appointments and reduce the burden of the process on technical departments striving to provide effective technical cooperation. Toward this end, institutionalize processes such as internal detailing, promotion based on merit, and lateral transfers.
- Include disaster risk reduction in Organization-wide umbrella agreements as part of the development agenda rather than the humanitarian agenda.
- Continue to provide advocacy and support to ensure critical reflection and resolution of potential bottleneck processes, especially for emergency situations. An important consideration for the mobilization of resources is the ability to ensure prompt and successful execution. This is linked not only to the availability of adequate human resources, but also to the capacity to comply with regular organizational rules and procedures in a timely manner. The new PASB Management Information System (PMIS) may better facilitate these processes.
- Promote a "One Organization" approach, integrating all relevant technical disciplines to combat emerging infectious diseases and antimicrobial resistance.
- Establish a strategy for enhancing national capacity to respond to arboviruses in the Americas, including a control and elimination strategy for Aedes aegypti. Support and advocacy for the development of this strategy will be key.
- Support national action plans on AMR. In 2015, PAHO's 54th Directing Council approved a regional Plan of Action on Antimicrobial Resistance, and by 2017 all Member States are requested to have their own national action plans. Establishment of a comprehensive and interdepartmental technical cooperation strategy will be instrumental to ensure the successful elaboration and implementation of the action plans in all Member States.

Assessment by Program Area

Program Area 5.1: Alert and Response Capacities (for IHR) **OUTCOME: All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 2/2 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating[23, 24]
5.1.1	Number of States Parties meeting and sustaining International Health Regulations (IHR) requirements for core capacities	6/35	35/35	In progress (10 achieved + 22 in progress)

Ten countries are meeting and sustaining IHR requirements: ARG, BRA, BRB, CAN, CHL, COL, CRI, SLV, URY, USA.

In addition, 22 countries are progressing toward achieving the indicator: ATG, BHS, BOL, DMA, DOM, ECU, GRD, GTM, GUY, HTI, HND, JAM, KNA, LCA, NIC, PAN, PER, PRY, SUR, TTO, VCT, VEN.

Confirmation of the final assessment from two countries was pending at the time of this report.

Belize is working toward the implementation of IHR capacities, but challenges remain in persuading major stakeholders to undertake this responsibility. A total of 22 countries in the Americas requested and were granted the 2014-2016 extension (Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, Dominica, Dominican Republic, Ecuador, Grenada, Guyana, Haiti, Honduras, Jamaica, Panama, Paraguay, Peru, St. Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Venezuela), and technical cooperation has been provided to develop and monitor implementation plans in the context of the EVD preparedness framework. It is important to stress that core capacities under the IHR are nothing more than essential public health functions that sustain a dynamic and continuous preparedness process, as strongly highlighted by the IHR Review Committee in 2014.

[23] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached.
- **In progress:** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way/on track to achieve the target set in the Strategic Plan by 2019.
- **No progress:** There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and progress toward achieving the indicator target by 2019 could be in jeopardy.

[24] The regional indicators are assessed by the responsible regional entity/Category and Program Area Network (CPAN) based on the latest available information, according to criteria defined in the compendium of indicators.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating[25, 26]
5.1.1	Countries enabled to develop the core capacities required under the International Health Regulations (2005)	Number of countries provided with direct technical cooperation that enabled them to meet and sustain IHR core capacities within the biennium	3	11	Partially achieved (7 achieved + 5 partially achieved)
Seven countries achieved the indicator: ARG, BRA, CHL, COL, DMA, SLV, URY. An additional five countries partially achieved the indicator: BHS, CRI, MEX, PER, VCT. Two countries were pending at the time of this report. Given that the 2014-2016 extensions were approved by the WHO Director General in November 2014, this indicates that the 2012-2014 extension plans were successfully monitored and implemented. Moreover, a total of 22 countries requested and were granted the 2014-2016 extension (see Outcome 5.1.1). Support has been provided to develop and monitor implementation plans, including updates in the context of the EVD preparedness framework. Also, mechanisms to facilitate the exchange of good practices and information between countries were applied in an effort to strengthen preparedness and response to EVD and other emerging pathogens. Regional meetings and country-specific missions were also implemented. Considering that public health preparedness is a continuous process, similar work will continue during the 2016-2017 biennium.					
5.1.2	PAHO has the capacity to provide evidence-based and timely policy guidance, risk assessment, information management, and communications for all acute public health emergencies	Proportion of potential public health emergencies of international concern for which information is made available to IHR National Focal Points in the Region within the first 48 hours of completing the risk assessment	40%	80%	Partially achieved (60%)
For 60% of public health emergencies of international concern, information was made available to National IHR Focal Points in the Region within the first 48 hours of completing the risk assessment. Information concerning events of public health risk was disseminated to PAHO/WHO's Member States through 38 Epidemiological Alerts and Updates, 39 postings on the Event Information Site (9 related to Zika virus), 21 Disease Outbreak News postings, and 34 reports distributed by e-mail to the IHR NFPs during the biennium. In addition, Member States were informed of public health risks by e-mail on 594 occasions in 2014-2015.					

[25] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set in the Program and Budget (PB) 2014-2015 (number of countries/territories, number or % for regional indicators) has been reached. Indicator targets that have been exceeded are noted as such.
- **Partially achieved**: Progress was made over the baseline value set in the PB (number of countries/territories, number or % for regional indicators), but the target for 2015 was not achieved.
- **No progress:** There was no increase over the baseline value set in the PB (number countries/territories, number or % for regional indicators).

[26] The regional indicators are assessed by the responsible regional entity/CPAN based on the latest available information, according to criteria defined in the compendium of indicators.

Program Area 5.2: Epidemic- and Pandemic-Prone Diseases **OUTCOME: All countries are able to build resilience and adequate preparedness to mount a rapid, predictable, and effective response to major epidemics and pandemics** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 1/3 Achieved, 2/3 Partially Achieved	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
5.2.1	Number of countries with installed capacity to effectively respond to major epidemics and pandemics	6/35	35/35	In progress (10 achieved + 18 in progress)

Ten countries achieved the indicator: BRA, CAN, CHL, COL, CRI, CUB, PAN, SLV, TTO, USA.

Another 18 countries and territories made progress toward meeting their targets for preparedness and response to major epidemics and pandemics: ARG, ATG, BHS, BOL, BRB, DMA, DOM, ECU, GTM, GUY, HTI, KNA, LCA, NIC, PER, SUR, VCT, VEN. Seven countries were pending at the time of this report. In the context of the Framework for Strengthening National Preparedness and Response for Ebola Virus Disease in the Americas, technical cooperation was provided to strengthen surveillance and laboratory capacity in response to the recent outbreaks in the Region, such as chikungunya (CHIKV) and, most recently, Zika virus (ZIKV). Flowcharts for chikungunya and Zika were updated to strengthen surveillance based on laboratory evidence. Therefore, technical cooperation to ministries of health will continue in the next biennium to build capacity in dealing with emerging infectious diseases.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
5.2.1	Countries enabled to develop and implement operational plans in line with WHO recommendations on strengthening national resilience and preparedness to cover pandemic influenza and epidemic and emerging diseases	Number of countries and territories implementing a national preparedness plan for major epidemics and pandemics	15	23	Partially achieved (16 achieved + 2 partially achieved)

Sixteen countries achieved the indicator: ARG, BRA, BRB, CAN, CHL, CRI, CUB, DMA, DOM, JAM, MEX, PER, SLV, TTO, USA, VEN.

Additionally, two countries and territories partially achieved the indicator: BHS, CUW.

Confirmation of the final assessment from 11 countries was pending at the time of this report.

Mexico reviewed its National Influenza Pandemic Plan with the PAHO Influenza Laboratory and Surveillance Team,

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
and recommendations were generated for the country. The Bahamas has partially achieved this indicator, and it has reviewed all national health emergency plans. Core activities coordinated during the biennium included the EVD preparedness and response efforts, chikungunya response activities, IHR technical cooperation to countries, and laboratory strengthening, as well as the management of new outbreaks such as Middle East respiratory syndrome (MERS). Emphasis was placed on the Zika outbreak response and cooperation to affected countries in the last semester of 2015.					
5.2.2	Countries with improved disease control, prevention, treatment, surveillance, risk assessment, and risk communications	Number of countries and territories with a surveillance system for influenza based on international standards	14	18	Achieved (18 achieved + 8 partially achieved)
Eighteen countries and territories achieved the indicator: AIA, ARG, BRA, BRB, CAN, CHL, COL, CRI, CUB, DMA, HND, JAM, MEX, NIC, PRY, SLV, URY, USA. Another eight countries and territories partially achieved the indicator: CUW, GUY, LCA, PAN, PER, SXM, TTO, VCT. Costa Rica has strengthened its country information system to monitor influenza and other respiratory virus activity through periodic submissions to the PAHOFlu information system. Nicaragua has strengthened its surveillance capacity through training workshops on SARI surveillance and unusual respiratory events. Also, both countries have carried out sentinel site surveillance assessments. In general, there were many accomplishments in 2015 related to the strengthening of influenza surveillance systems, and many more countries are reporting linked epidemiologic-laboratory data on a weekly basis to PAHO/WHO.					
5.2.3	Mechanisms in place to strengthen country capacity for risk management of emerging zoonotic diseases	Number of countries and territories with risk management mechanisms for emerging zoonotic diseases	10	28	Partially achieved (10 achieved + 10 partially achieved)
Ten countries achieved the indicator: BRA, CAN, COL, CUB, DMA, JAM, MEX, SLV, URY, USA. Another 10 countries and territories partially achieved the indicator: BON, CHL, CUW, ECU, GUY, KNA, PAN, PRY, TTO, VEN. Confirmation of the final assessment from two countries was pending at the time of this report. Planned goals in the strengthening of countries' capacities to identify, evaluate, and respond to emerging zoonoses were achieved. PANAFTOSA organized and coordinated meetings with the Permanent Veterinary Committee (CVP) of the Southern Cone (Argentina, Bolivia, Brazil, Chile, Paraguay, Uruguay) to define priorities and needs against the risk of a possible occurrence of highly pathogenic avian influenza (HPAI) in the subregion. Paraguay was trained on management of emerging zoonotic diseases, and strategies for the country's Brucellosis and Tuberculosis National Program were discussed. Trinidad and Tobago held a national workshop on alert and response to zoonotic disease occurrence.					

Program Area 5.3: Emergency Risk and Crisis Management **OUTCOME: Countries have an all-hazards health emergency risk management program for a disaster-resilient health sector, with emphasis on vulnerable populations** OCM Indicator Assessment: 2/2 In Progress OPT Indicator Assessment: 5/5 Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
5.3.1	Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies	19	36	In progress (18 achieved + 15 in progress)
Eighteen countries and territories achieved the indicator: ABW, BON, BRA, CAN, CHL, CRI, CUW, DMA, DOM, GLP, GUF, HND, JAM, MEX, MTQ, PAN, PER, USA. An additional 15 countries and territories are in progress: ARG, BLZ, BOL, BRB, GRD, GTM, NIC, PRI, SAB, SLV, STA, SUR, TTO, VCT, VGB. Confirmation of the final assessment from four countries was pending at the time of this report. Many countries are making efforts to achieve minimum capacities to effectively manage public health risks associated with emergencies. Interventions to develop national and subnational capacities include the establishment and training of health response teams on emerging risks and diseases, integration of emergency and disaster risk management with the health sector's programming and planning, and development of local capacity of health networks for the coordination and management of health emergencies, among others.				
5.3.2	Number of countries and territories implementing disaster risk reduction interventions for health facilities	11	35	In progress (19 achieved + 4 in progress)
Nineteen countries and territories have already achieved at least four of the six goals included in the Plan of Action on Safe Hospitals: BON, BRA, CAN, CHL, COL, CRI, CUW, DMA, DOM, GUY, HND, KNA, MEX, PAN, PER, PRY, SLV, USA, VCT. Another four countries and territories are in progress: ARG, GTM, SXM, TCA. Confirmation of the final assessment from ten countries was pending at the time of this report. Disaster risk reduction remained a strategic priority for PAHO and Member States over the biennium, and many countries and territories have progressed in the implementation of disaster risk reduction interventions for health facilities. Thirty-five countries and territories are applying the Hospital Safety Index, and many are implementing improvement measures based on evaluation recommendations (Anguilla, Antigua and Barbuda, Bahamas, Barbados, Belize, Bolivia, Brazil, British Virgin Islands, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela).				

Ten countries have adapted the virtual application developed by PAHO for monitoring progress on the HSI, or have developed their own monitoring platforms (Barbados, Colombia, Dominica, Dominican Republic, Ecuador, Grenada, Guatemala, Jamaica, Peru, Suriname).

While making efforts to strengthen and sometimes redynamize programs and policies for safe hospitals, several Caribbean countries are now moving toward the integration of standards and mitigation measures for safety and climate change resilience under the SMART Hospitals Initiative.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
5.3.1	Country health clusters reformed in line with the Transformative Agenda of the Inter-Agency Standing Committee	Number of countries and territories with a health emergency coordination mechanism that meets minimum requirements for satisfactory performance	5	11	Exceeded (12 achieved + 6 partially achieved)

Twelve countries and territories achieved the indicator: BRB, CAN, CHL, COL, CUW, DOM, GTM, JAM, KNA, MEX, PER, USA.

An additional six countries and territories partially achieved the indicator: ARG, GUY, MSR, SLV, STA, TTO.

Confirmation of the final assessment from two countries was pending at the time of this report.

All target countries have implemented actions to strengthen national and subnational health emergency coordination mechanisms. The countries that have achieved this indicator have met minimum requirements for satisfactory performance with respect to the coordination of health emergency and humanitarian assistance.

Some specific activities/achievements during the biennium are worth noting:

- Ten countries (Argentina, Brazil, Chile, Colombia, Costa Rica, El Salvador, Guatemala, Mexico, Paraguay, and Peru) developed or enhanced their national health disaster response teams with the support of PAHO. Guatemala conducted its first national workshop for rapid response teams, and in coordination with the risk management unit of the Ministry of Health, has completed the preparation of risk plans. This will allow Guatemala to mobilize national professionals within its own territory and to provide better emergency assistance to neighboring countries.
- Several countries have also developed capacities at subnational level through training of local response teams and decentralization of emergency management capacities (Colombia, Guatemala, Peru).
- The Dominican Republic achieved close coordination and engagement between the Ministry of Health, Ministry of Foreign Affairs, and National Emergency Commission and updated the national plan for emergencies and disasters, including the chapter on humanitarian assistance, to introduce health considerations. PAHO's Representation in the Dominican Republic also contributed to an evaluation of the health component of the emergency and civil security system (911) and provided recommendations on priority areas for improvement.
- Guatemala has advanced in the consolidation of the health cluster by mobilizing national actors, the UN system, and nongovernmental organizations to participate. A simulation exercise was carried out with the cluster.
- PAHO's Representation in Argentina has established a new area of cooperation with the White Helmets

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating

Commission of the Ministry of Foreign Affairs for the Foreign Medical Teams strategy in the Americas.

- A manual for the Caribbean Medical Assistance Teams (CariMAT) was drafted and includes standards for public health interventions with gender and cultural considerations.
- Andean countries have developed a mechanism/guide for mutual assistance in case of disasters.
- CEPREDENAC, the regional disaster organization for Central America, developed an emergency health task force for Central America with PAHO's support.
- Changes in some management positions within the ministries of health, and in the roles and tasks of some key personnel, have affected progress, particularly in some Central American countries.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
5.3.2	Health established as a central component of global multisectoral frameworks for emergency and disaster risk management; national capacities strengthened for all-hazard Emergency and Disaster Risk Management for Health (ERMH)	Number of countries and territories conducting an ERMH capacity assessment	1	13	Exceeded (22 achieved + 3 partially achieved)

Twenty-two countries and territories achieved the indicator: BHS, BLZ, BOL, BMU, CHL, COL, CRI, DMA, DOM, ECU, GLP, GRD, GUF, HND, JAM, KNA, LCA, MTQ, PER, SLV, SUR, VCT.

Another three countries and territories partially achieved the indicator: BRB, GUY, STA.

Confirmation of the final assessment from four countries was pending at the time of this report.

These countries have completed a global survey on country capacities for emergency and disaster risk management for health, which was launched in 2015, or a similar assessment instrument validated by PAHO.

Independently of the application of evaluation tools, most countries have implemented actions to strengthen their emergency and risk management capacities:

- Many countries (Argentina, Bahamas, Bermuda, Bolivia, Chile, Colombia, Cuba, Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Peru) have developed sectoral and/or inter-institutional contingency and response plans for facing disasters with potential public health impact. Examples include the El Niño phenomenon and related events (droughts and floods), migratory crises (Haiti and Dominican Republic), as well as emerging or potential outbreaks (EVD, chinkungunya, dengue, Zika).
- Haiti has strengthened the integration of the health sector within the disaster management system managed by the civil protection agency in three of the most vulnerable departments, and it has improved local capacities for coordination and management of health emergencies by those three departmental health directorates. There is currently strong interest from the Ministry of Public Health and Population in scaling up this strategy to the national level.
- Similarly, the Dominican Republic and Haiti have progressed in developing binational cooperation for the management of health emergencies, starting with the establishment of parallel emergency management structures and joint response protocols in border provinces.
- Capacity-building and simulation exercises have been conducted to develop and test emergency management capacities, including a mass-casualty management training and SIMEX organized in Bermuda and facilitated by PAHO.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
5.3.3	Mechanisms in place to ensure organizational readiness to fully implement the WHO Emergency Response Framework (ERF) and PAHO Institutional Response to Emergencies and Disasters	Number of PAHO/WHO offices fully complying with WHO readiness checklist	Data not currently measured	13	Exceeded (16 achieved + 3 partially achieved)

Sixteen PWR Offices achieved the indicator: ARG, BRA, BOL, BRB, COL, CUB, DOM, ECU, GTM, HND, JAM, MEX, PAN, PER, SLV, SUR.

PWR Offices in another three countries partially achieved the indicator: CHL, HTI, VEN.

In total, 19 PWR Offices were assessed for this indicator, 16 of which complied with at least four items on the WHO readiness checklist. Although only 19 offices were assessed, all PWR Offices took actions to strengthen their readiness and capacity to face emergencies and disasters during the 2014-2015 biennium.

The late availability of the WHO readiness checklist posed a challenge in terms of achieving full compliance, as for a long time the country offices did not know the exact criteria with which they needed to comply. Nevertheless, many have developed and/or reviewed their business continuity and/or emergency response plans during the biennium. Keeping plans updated remains a challenge.

With a view to further strengthening the Organization's readiness and emergency management capacity, PAHO launched an e-learning course on the Institutional Response to Emergencies and Disasters (IRED). The course introduces participants to existing frameworks for emergency and disaster management (PAHO, WHO, UN) and covers PAHO's response management procedures and good practices within the institutional framework of the IRED. It is currently available to all staff in English on PAHO's Virtual Campus of Public Health, while the Spanish version is to be launched in early 2016.

Regional surge capacity was also strengthened through the organization of two regional trainings. One, on health disaster response and coordination, drew 32 participants from 23 countries, including PAHO disaster focal points, ministry of health staff, and members of partner organizations. The other, on PAHO's IRED policy, was attended by 38 PAHO administrators and disaster focal points from 26 countries. During these trainings, ERF and IRED procedures and performance standards were discussed. Ecuador, El Salvador, Guatemala, and Jamaica also conducted training of country office staff related to the business continuity plans and IRED.

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
5.3.4	Development, implementation, and reporting on health sector strategy and planning in all targeted protracted-emergency countries by an in-country network of qualified and trained PAHO emergency staff	Percentage of protracted-emergency countries meeting PAHO performance standards	Data not currently measured	70%	Exceeded (100%)

100% of protracted-emergency countries meet PAHO performance standards.

- Throughout the biennium, PAHO continued to support response and recovery operations in the two countries

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
with protracted emergencies, Colombia and Haiti, and met performance standards in both countries. • In each of these countries, PAHO supported the Ministry of Health in leading the health cluster/sectoral group and led the development of the health component of Humanitarian Assessments, Evaluations and Response Plans, in coordination with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and the Humanitarian Country Team. These included, for Colombia, the Strategic Response Plan 2014, Humanitarian Needs Overview 2015, and Strategic Response Plan 2015 within the framework of the health cluster; and for Haiti, the Humanitarian Needs Overview 2015, Transitional Appeal 2014-2015, Urgent Request for Humanitarian Funding 2015, and Strategic Response Plan 2016. • During 2014-2015, the Organization mobilized over $4.4 million for response to cholera and over $2.8 million for DRR in Haiti, and over $1.5 million to assist internally displaced people in Colombia. • In Haiti, PAHO supported implementation of the National Plan for the Elimination of Cholera and strengthened the leadership and operational capacities of the Ministry of Health to coordinate and participate in the response to cholera alerts and outbreaks. Over the biennium, the Ministry of Public Health and Population (MSPP) established its own departmental rapid response teams (équipes mobiles d'intervention rapide) and strengthened their integration within the response system. The MSPP also developed its own cholera coordination unit and established a network of departmental cholera coordinators directly supported by PAHO. Investigation and data management by the Directorate of Epidemiology and supply stock management were also improved, although progress remains fragile. • In Colombia, PAHO redynamized the health cluster mechanism, co-led with the Colombian Red Cross. In coordination with the Ministry of Health, the organizations also supported intersectoral work with other members of the Humanitarian Country Team and local humanitarian teams. PAHO continuously supported the delivery of humanitarian health assistance from both governmental and non-state actors through a permanent field presence and the opening of humanitarian space in areas controlled by armed groups and guerrillas.				
5.3.5	Implementation of the Plan of Action on Safe Hospitals, in accordance with specific national priorities and needs	Number of countries and territories with a safe hospitals program to ensure continuity of health services for the population in need	16	25	Exceeded (21 achieved + 8 partially achieved)
Twenty-one countries and territories achieved the indicator: BHS, BON, BRB, CHL, COL, CYM, DMA, DOM, GLP, GTM, GUF, HND, KNA, MEX, MTQ, PER, PRY, SUR, USA, VEN, VGB. An additional eight countries and territories partially achieved the indicator: ABW, BOL, BRA, CRI, CUW, PAN, SLV, SXM. Confirmation of the final assessment from six countries was pending at the time of this report. All 16 baseline countries and 9 target countries implemented actions during the biennium toward the establishment of a safe hospital program. However, not all countries have progressed at the same rate. Two baseline countries, Bolivia and Venezuela, experienced setbacks in the implementation of the Plan of Action on Safe Hospitals. Over the past five years, countries of the Region have made immense efforts to carry out the Plan of Action on Safe Hospitals (Resolution CD50.R15), which ended in December 2015. Numerous activities under the plan were implemented during this biennium:					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating

- The Hospital Safety Index was adapted for small and medium hospitals, and an HSI application was developed for mobile devices. The online hospital safety database was revised and updated.
- Standards were revised for construction of health facilities in El Salvador.
- Design and construction guidelines for health facilities in the Dominican Republic were developed and published, comprising four products: architectural design guidelines for health facilities; guidelines for architectural finishes in health facilities; guidelines for the design and structural/nonstructural construction of health facilities; and a manual for the design and structural/nonstructural construction of health facilities.
- Eight countries (Barbados, Colombia, Dominica, Ecuador, Grenada, Jamaica, Peru, and Suriname) adopted the virtual HSI application developed by PAHO to monitor and evaluate implementation of their safe hospitals programs. Others have developed their own management tool (Dominican Republic) or have integrated data on application of the HSI within an existing monitoring platform for health services (Guatemala).
- HSI was applied again in facilities in Grenada (2), Jamaica (3), St. Lucia (1), and Suriname (2) and applied for the first time in the British Virgin Islands (9), Guatemala (42), Guyana (2), and Honduras (17). El Salvador also continued working toward achievement of commitments related to evaluation of health facilities.
- On-site HSI field trainings were held in Grenada, Guyana, St. Lucia, Jamaica, and Suriname to strengthen the network of hospital safety evaluators. In some countries, the activity provided a venue for refresher trainings.
- Eight countries (Grenada, Guatemala, Guyana, Honduras, Jamaica, Panama, St. Lucia, and Suriname) established committees, drafted plans of action and national policies, and implemented safety improvement plans.
- Chile, Colombia, Ecuador, and Peru continued implementing safe hospital actions, including trainings, hospital evaluations, and safety improvements.
- Antigua and Barbuda developed a safe hospital policy with the involvement of a private sector engineer.
- Colombia developed a course on safe hospitals at the diploma level (intermediate level between a certificate and a degree), as well as an application for monitoring implementation of the safe hospital strategy in the country.
- Trainings included a base isolation course in Jamaica (16 participants), a safe building course in the British Virgin Islands (20 participants), and HSI workshops in Panama for the social security agency.

Program Area 5.4: Food Safety **OUTCOME: All countries have the capacity to mitigate risks to food safety and respond to outbreaks** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 1/4 Achieved, 3/4 Partially Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
5.4.1	Number of countries and territories that have adequate mechanisms in place for preventing or mitigating risks to food safety and for responding to outbreaks, including among marginalized populations	4	20	In progress (9 achieved + 11 in progress)
Nine countries achieved the indicator: CAN, CHL, COL, CUW, MEX, PAN, STA, USA, VEN.				

An additional 11 countries and territories are in progress, with good possibilities of reaching the indicator during the 2016-2017 biennium: ABW, ARG, BON, CRI, DOM, GUY, HND, PER, PRY, SLV, TTO.

Confirmation of the final assessment from one country was pending at the time of this report.

Emphasis will be placed on developing national burden of disease studies for foodborne diseases as a step toward mitigating the risk of the most relevant food hazards.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
5.4.1	Countries enabled to implement the Codex Alimentarius Commission guidelines and recommendations	Number of countries and territories having adopted the international standards and recommendations to promote their implementation	13	21	Partially achieved (15 achieved + 5 partially achieved)
Fifteen countries and territories achieved the indicator: ABW, BON, BRA, CAN, CHL, COL, CRI, DOM, HND, PAN, PRY, SLV, STA, SXM, USA. Another five countries and territories partially achieved the indicator: CUW, GUY, KNA, PER, VEN. Confirmation of the final assessment from two countries was pending at the time of this report. Aruba has conducted workshops to strengthen the capacity of the competent authorities. Colombia has incorporated a good food safety policy. The Dominican Republic has revised its legislation to adopt the Codex Alimentarius Commission guidelines. Honduras, Paraguay, and Peru have been very proactive in promoting their standards related to the Codex Alimentarius. PAHO worked jointly with countries and with the FAO/WHO Codex Coordinating Committee for Latin America and the Caribbean (CCLAC) to achieve more effective participation in Codex Alimentarius. Also, technical cooperation has been provided to adopt the Codex Alimentarius texts into national legislation and policies.					
5.4.2	Multisectoral collaboration mechanisms in place to reduce foodborne public health risks, including those arising at the animal-human interface	Number of countries and territories with a mechanism for multisectoral collaboration on reducing foodborne public health risks, including among marginalized populations	6	10	Exceeded (11 achieved + 11 partially achieved)
Eleven countries and territories achieved the indicator: ARG, CAN, COL, CUW, JAM, PAN, PRY, STA, SXM, USA, VEN. In addition, 11 countries and territories partially achieved the indicator: ABW, BON, CHL, DOM, ECU, GUY, KNA, PER, SLV, TCA, TTO. Confirmation of the final assessment from one country was pending at the time of this report. Colombia has a national policy on food safety that offers the perfect conditions for good collaboration between					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
health and agriculture. Costa Rica is implementing IHR capacities for food safety and zoonotic diseases, creating the conditions for multisectoral collaboration. Jamaica has established a commission to work on integrated surveillance of antimicrobial resistance, strengthening cooperation between the Ministry of Agriculture and Ministry of Health. Therefore, PAHO has played an important role in facilitating interaction between National IHR Focal Points and International Food Safety Authorities Network (INFOSAN) emergency contact points through the implementation of the INFOSAN Regional Strategy. Also, in collaboration with the Inter-American Institute for Cooperation on Agriculture and the UN Food and Agriculture Organization, technical cooperation has been provided to strengthen multisectoral collaboration to reduce food safety hazards affecting public health.					
5.4.3	Countries enabled to establish risk-based regulatory frameworks to prevent, monitor, assess, and manage foodborne and zoonotic diseases and hazards along the entire food chain	Number of countries and territories with risk-based policies and regulatory and institutional frameworks for their food safety systems	5	16	Partially achieved (12 achieved + 12 partially achieved)
Twelve countries and territories achieved the indicator: BRA, CAN, CHL, COL, CUB, JAM, NIC, PAN, PRY, SXM, USA, VEN. Additionally, 12 countries and territories partially achieved the indicator: ABW, ARG, BON, CRI, CUW, DOM, GUY, KNA, PER, SLV, SUR, TTO. Confirmation of the final assessment from one country was pending at the time of this report. PAHO has worked to strengthen country capacity to manage food safety risks by building capacity in risk analysis for the Caribbean, conducting regional analysis of the burden of disease, supporting national authorities in adapting and adopting guidelines such as total diet studies, and improving risk inspection services and laboratory capacity toward the application of whole genome systems.					
5.4.4	Implementation of the Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA)	Number of countries and territories implementing prevention, control, and elimination programs for foot-and-mouth disease (FMD) in accordance with the timeline and expected results established in the PHEFA Plan of Action 2011-2020	1	9	Partially achieved (8 achieved)
Eight countries achieved the indicator: ARG, BOL, BRA, COL, ECU, PER, PRY, VEN. Additionally, confirmation of the final assessment from one other country was pending at the time of this report. Direct technical cooperation has been provided to key countries (Bolivia, Brazil, Ecuador, Paraguay, Suriname, Venezuela) for strengthening national FMD eradication programs in order to achieve the FMD-free status recognized by the World Organisation for Animal Health (OIE). In the case of Suriname, technical cooperation helped lay the foundation of the information and surveillance system as a step toward preparation of a dossier for FMD-free status recognition by OIE. PANAFTOSA continues to provide technical cooperation to Venezuela on FMD program management, field and laboratory strategies, and capacity-building on laboratory techniques. A survey to					

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
assess the FMD immunity at herd level is being conducted by Venezuela with the support of PANAFTOSA. Technical cooperation has been also provided to Paraguay, the country that reported the last occurrence of FMD in the region. SENACSA veterinary personnel were trained in surveillance and rapid response to FMD emergencies; all veterinarians of Paraguay's 20 Animal Health Commissions, which carry out the FMD vaccination program, were trained in vaccination procedures; and eight veterinarians from SENACSA's laboratory and its experimental farm were trained in the management and implementation of FMD vaccine quality control systems, according to international standards. Technical cooperation was provided to Agrocalidad, Ecuador, for designing and implementing both a population immunity survey and an FMD viral circulation survey for 2015. Additionally, PANAFTOSA provides assistance in the elaboration of the five-year (2016-2020) FMD control/eradication plan for Ecuador. PANAFTOSA also provides its expertise to the working group established by the Brazilian Ministry of Agriculture for updating the national eradication program of Brazil, which will submit its recommendations during the first semester of 2016.					

Program Area 5.5: Outbreak and Crisis Response **OUTCOME: All countries adequately respond to threats and emergencies with public health consequences** OCM Indicator Assessment: 1/1 Achieved OPT Indicator Assessment: 1/1 Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator	Baseline 2013	Target 2019	Assessment Rating
5.5.1	Percentage of countries that demonstrated adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within 72 hours of onset	n/a	100%	Achieved (100%)

100% of affected countries demonstrated adequate all-hazard response to all 10 acute emergencies experienced in the biennium, with a coordinated initial assessment and a health sector response plan within 72 hours of the onset of the emergency.

The 10 acute emergencies with potential health impacts that occurred during the biennium were as follows: floods in Paraguay (2014 and 2015), Bolivia (2014), and Chile (2015); the Christmas Trough that impacted Dominica, St. Lucia, and St. Vincent in the last days of 2013; a food insecurity crisis in Honduras and Guatemala (2014 and 2015); Tropical Storm Erika in Dominica (2015); Hurricane Joaquin in the Bahamas (2015); and the repatriation crisis in Haiti and the Dominican Republic (2015). All received an adequate and timely response from PAHO through the rapid mobilization of response experts to the field to conduct early damage/needs assessments and develop action plans within 72 hours of onset.

Response to certain emergencies fostered direct South-South cooperation among countries in the provision of humanitarian health assistance. This was illustrated, for instance, by the direct collaboration between the ministries of health in Haiti and the Dominican Republic, facilitated by PAHO, to donate and transport essential medicines and response supplies to assist the Bahamas in its response to Hurricane Joaquin.

Assessment of output indicators

OPT #	Output Title	OPT Indicator	Baseline 2013	Target 2015	Assessment Rating
5.5.1	Implementation of the WHO Emergency Response Framework (ERF) in acute emergencies with public health consequences	Percentage of Grade 2 and Grade 3 emergencies from any hazard with public health consequences, including any emerging epidemic threats, in which the WHO Emergency Response Framework (ERF) has been fully implemented	N/A	100%	Achieved (100%)

In 100% of Grade 2 and Grade 3 emergencies from any hazard with public health consequences, including any emerging epidemic threats, the WHO Emergency Response Framework (ERF) was fully implemented.

Grade 3: Although there was no Grade 3 emergency in the Region of the Americas during the biennium, the Organization's IRED was activated at Level/Grade 3 during the Ebola outbreak to support the UN's response in affected West African countries as well as to facilitate technical cooperation for readiness to respond in Member States. The Region also provided support to Nepal following the Grade 3 earthquake in 2015. ERF performance standards relevant in those contexts and emergencies have been implemented.

Ten emergencies occurred during the 2014-2015 biennium that met Grade 2 criteria (see Outcome 5.5.1 for details). It is considered that the ERF was fully implemented in all these emergencies. Support provided for the response to these events included the following highlights:

- Dominica, St. Lucia, and St. Vincent and the Grenadines: support was provided for rapid assessments and coordination. Over $1 million was mobilized to support vector control, water and sanitation, and restoration of access to health services. PAHO provided support and leadership to ensure inclusion of "build back better" principles, including the incorporation of disabled access in facilities in Dominica and St. Lucia.
- Bolivia floods: over $500,000 was provided to respond to urgent health and water, sanitation, and hygiene needs.
- Paraguay floods: support was provided for rapid assessments and coordination. Over $900,000 was mobilized from the UN Central Emergency Response Fund to support restoration of safe water and adequate sanitation and hygiene in flood-affected departments of Asunción and Alto Paraguay and to ensure access to basic health care and continuity of treatment as well as outbreak prevention.
- Guatemala food insecurity crisis: over $500,000 was mobilized for management and treatment of acute malnutrition.
- Honduras food insecurity crisis: over $600,000 was mobilized for management and treatment of acute malnutrition.
- Tropical Storm Erika in Dominica: about $800,000 was mobilized to support vector control, water and sanitation, and restoration of access to health services.
- Hurricane Joaquin in the Bahamas: support was provided for rapid assessment and coordination, water, sanitation, and hygiene, vector control, and health services restoration ($120,000 from regular budget).
- Haiti and Dominican Republic repatriation crisis: support was provided for the development of a contingency plan under which the health sector would attend health needs of Haitians deported from the Dominican Republic; for pre-positioning of health emergency kits and essential health and cholera supplies; and for installation of advanced health posts near border-crossing points.

2014-2015 End-of-Biennium Assessment
Category 6 Report

CATEGORY 6: **CORPORATE SERVICES AND ENABLING FUNCTIONS**	**OVERALL CATEGORY ASSESSMENT RATING[27]** **Partially met expectations**

CATEGORY PROGRAMMATIC AND BUDGET OVERVIEW

Table 1. Category 6 Programmatic and Budget Summary

Program Area	Approved Budget (PB 14-15) (US$ millions)	Funds Awarded (US$ millions)	Awarded to PB (%)	Budget Implementation against PB (%)	Budget Implementation against Awarded (%)	Output Indicator Rating	Outcome Indicator Status
6.1 Leadership and Governance	58.47	61.82	105.7	103.4	97.8	3/4 achieved, 1/4 partially achieved (1 output cancelled)	3/3 in progress
6.2 Transparency, Accountability, and Risk Management	4.84	4.65	96.1	95.6	99.5	2/4 Achieved, 1/4 Partially Achieved, 1/4 Not Assessed.	1/1 in progress
6.3 Strategic Planning, Resource Coordination, and Reporting	49.54	25.87	52.2	51.2	98.1	1/3 achieved, 2/3 partially achieved	2/2 in progress
6.4 Management and Administration*	77.43	92.93	120.0	115.1	95.9	2/4 achieved, 2/4 partially achieved	1/1 in progress
6.5 Strategic Communications	13.07	11.40	87.2	87.6	100.4	2/2 achieved	1/1 in progress
TOTAL	**203.36**	**196.67**	**96.7**	**93.9**	**97.1**	**9/17 achieved, 8/17 partially achieved**	**8/8 in progress**

Notes:
** Includes $10 million for PMIS.*

[27] Assessment ratings for the overall category and for program areas/outcomes are determined by the PAHO category and program area facilitators, respectively, taking into consideration the programmatic and budget implementation, analysis of resources (human and financial), and operational and programmatic risks. Ratings are defined as follows:

- **Met expectations** (Green): achieved 90% to 100% of the results for the period being assessed. Progress is on track, as expected; no impediments or risks that affect the achievement of results are foreseen.
- **Partially met expectations** (Yellow): achieved 75% to 89.9% of the results for the period being assessed. Progress may be at risk, and action is required to overcome delays, impediments, and risks.
- **Insufficient progress** (Red): achieved <75% of the results for the period being assessed. Progress is in jeopardy due to impediments or risks that could preclude the achievement of results. Immediate corrections are required.

Table 2. Category 6 Budget Overview by Functional Level

Functional Level	Funds Awarded (US$ millions)	Awarded by Level (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
Country	68.67	34.92	66.50	96.8
Intercountry	34.59	17.59	33.63	97.2
Subregional	11.51	5.85	11.25	97.8
Regional	81.90	41.64	79.65	97.3
Total	**196.67**	**100.00**	**191.03**	**97.1**

CATEGORY PROGRAMMATIC ANALYSIS

Overall Category Assessment Summary

Steady progress was made in Category 6 during the biennium to maintain an enabling environment that allows the Organization to efficiently and transparently implement technical cooperation and have a measurable positive impact in countries. In the area of leadership, PAHO strategically positioned itself at the regional and global levels and laid the groundwork for an effective political and technical response to the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs). PAHO also strengthened its institutional response to increasingly prevalent large-scale emergencies, disasters, and outbreaks with health and humanitarian consequences.

The Organization strengthened its commitment to Country Focus, creating a new framework for cooperation among countries for health development, and updated a strategy for the eight key countries in the Region. Plans were developed and resources identified to reinforce subregional technical cooperation in Central America (CAM) and South America (SAM), modeled on the subregional structure already in place in the Caribbean. The expansion of the CAM and SAM subregional offices will better aid PAHO's collaboration with the subregional mechanisms but will also ensure that priorities in these subregions are strategically addressed. Partnerships for leadership in health continued with the United Nations (UN) Country Teams, while coordination mechanisms were strengthened in countries with the ministries of health.

The Organization continues to participate actively in the World Health Organization (WHO) reform process and is on track in the implementation or adaptation of reforms to align with WHO in several key areas such as strategic planning, budgeting, financing, human resource management, risk management, project management, Governing Bodies, and Country Focus. PAHO Member States are actively involved in reform efforts to harmonize governance practices and procedures and to establish a framework for engagement with non-state actors while protecting the Organization from conflicts of interest.

Results-based management (RBM) continues to be the cornerstone of planning, budgeting, and program management and monitoring across the Organization. The new Strategic Plan 2014-2019 and Program and Budget 2016-2017, closely aligned with WHO's 12th General Programme of Work 2014-2019, were built using a bottom-up approach that engaged national counterparts in identifying programmatic priorities. PAHO/WHO Representative (PWR) Offices provided support and guidance to countries, and regional Category and Program Area Networks consolidated country inputs to formulate the approved Program and Budget 2016-2017. The new Strategic Plan Monitoring System (SPMS) was developed with Member States to involve countries in the first joint measurement and reporting with the Pan American Sanitary Bureau (PASB) on the progress made toward achieving the outcomes in the PAHO Strategic Plan 2014-2019 and the outputs of the Program and Budget 2014-2015.

The Region was able to mobilize additional resources and reverse a declining trend in external funding during the biennium. To intensify efforts in this area, a new Resource Mobilization Strategy was adopted. Its aims are to ensure that the Organization is able to fully finance its Program and Budget, fill gaps in under-resourced programs, and respond to emerging priorities.

The Region adopted and configured the new PASB Management Information System (PMIS), using Enterprise Resource Planning software, during the biennium to replace its obsolete and disconnected legacy systems for information technology (IT), human resources, planning, budgeting, procurement, and finance. Phase I of PMIS, which focused on human resources, went live in 2014. Phase II, covering all other areas, was fully developed during 2015 and ready to go live in 2016. The PMIS project was completed on time and within budget.

An Enterprise Risk Management (ERM) system was launched during the biennium; among other things, it will identify corporate risks to be regularly monitored by PASB Executive Management. In addition, a simplified risk registry tool for use by all PAHO offices was deployed during 2014-2015 to capture risks and define mitigation plans that will be implemented in 2016-2017.

In order to realize cost savings and operational efficiencies, the PASB established Service Level Agreements with Key Performance Indicators (KPIs) in the areas of Financial Resources Management, Human Resources Management, Information Technology Services, Procurement and Supply Services, and General Services Operations. Positive results include a reduction in the time between receipt of a purchase authorization and issuance of a purchase order by the Procurement Department; shortening of the response time needed by the IT Department to resolve service requests; an increase in the number of first-time human resources (HR) transactions that were processed without error; and a lowering of utility and other operating costs by 2% to 3% during the biennium. The latter was achieved through office consolidations, upgraded and more efficient building materials, and more careful scheduling of utility usage.

The PASB also continued to employ innovative technologies and communication platforms to facilitate its technical cooperation in an effective and efficient manner. These included the use of virtual conferencing, reducing the need to print material for meetings, as well as increased distribution of materials through the website. Digital communication and user engagement were expanded through use of social media networks such as Facebook, Flickr, Twitter, and YouTube, and the use of new technologies was optimized. Media outreach has also been stepped up through targeted messaging and direct responses to press queries. Consolidated efforts in both media outreach and website view development have contributed to stronger positioning and ranking of the Organization within the international community.

Programmatic Summary by Program Area

6.1 Leadership and Governance

This program area includes key functions and interventions to strengthen PAHO's leadership and management role in the Region, enabling many different actors to play active and effective roles in championing health and development.

Achievements

- Throughout the biennium, the PASB advocated for implementation of the PAHO Strategic Plan with national counterparts and with key stakeholders in the UN system, inter-American bodies, and integration mechanisms such as ALBA (Bolivarian Alliance for the Peoples of Our America), COMISCA (Council of Ministers of Health of Central America and Dominican Republic), CARICOM (the Caribbean Community), MERCOSUR (Southern Common Market), and UNASUR (Union of South American Nations). This engagement

promoted government-wide approaches to health, universal health, integrated primary care services, sustainable development and equity, access to medicines, and emergency preparedness and response.

- Country engagement was strengthened through increased promotion of the Country Focus policy, and the PAHO Key Country Strategy was updated to support targeted technical cooperation in Bolivia, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Suriname.
- A new framework for a more strategic approach to technical cooperation was defined in the Cooperation among Countries for Health Development (CCHD) strategy. Furthermore, countries engaged in active multi-partner country coordinating mechanisms to facilitate effective development cooperation on matters related to health during the biennium.
- Progress was made in the formulation of Country Cooperation Strategies (CCS) for Central American, South American, and Caribbean countries and territories. The CCSs for Mexico, Nicaragua, and Panama were completed. Others were initiated and are expected to be completed during 2016, including those for Belize, Brazil, Dutch Sint Maarten, El Salvador, Guyana, Haiti, Honduras, Paraguay, Trinidad and Tobago, and the multi-country strategy with the United Kingdom Overseas Territories in the Caribbean (Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat, and Turks and Caicos).
- Four instruments were developed to help with the rollout of the Guide for the Formulation of the WHO Country Cooperation Strategy (2014): (a) a tool for mapping CCS implications; (b) a matrix for linking the CCS strategic agenda to the PAHO Strategic Plan 2014-2019; (c) criteria for the participation of technical entities in the CCS missions; and (d) a format for the documentation of good practices.
- All 27 PAHO/WHO Representative Offices completed the WHO country presence survey and contributed to the renewed WHO Country Focus Strategy anchored in WHO reform.
- The structure for subregional technical cooperation was redefined to strengthen the political, strategic, and technical positioning of the Organization and ensure that health is at the center of the agenda for integration processes across the Region. A memorandum of understanding (MOU) was renewed with MERCOSUR for strengthening technical cooperation in the South American subregion. Additionally, the Caribbean Cooperation in Health Phase III and the PAHO Subregional Cooperation Strategy were evaluated, and work on their successor strategies began. PAHO also continued to partner with and support the Caribbean Public Health Agency (CARPHA) in its efforts to address priority health programs in the Caribbean, and with the Institute of Nutrition of Central America and Panama (INCAP) to address key noncommunicable diseases (NCDs) and risk factors in Central American countries.

Challenges

- Inconsistent development and updating of CCSs upon expiration prevents their use as the PAHO/WHO strategic medium-term framework for effectively responding to national health priorities.
- Applicability and use of the multi-partner country coordinating mechanisms varies depending on the national context and the presence of development and aid agencies in countries and territories.
- Efforts to increase resource mobilization with non-state actors in the Americas are currently restricted by the ongoing efforts to finalize the WHO framework of engagement with non-state actors in the context of WHO governance reform. Additionally, the WHO framework once approved will need separate ratification by the PAHO Governing Bodies before it can be implemented in the Region.

Lessons Learned

- The development of capacities, skills, and tools is essential to facilitate inter-programmatic and cross-functional collaboration across the Organization.
- The Organization needs to strengthen its capacity to respond effectively to emergencies and disasters without jeopardizing its ability to discharge routine functions.

- The CCS development process provides an opportunity to strengthen PAHO's leadership in matters relating to health at the national level; toward this end, consultative processes to jointly define health priorities should be emphasized.
- Expanding strategic alliances beyond traditional health stakeholders has contributed to strengthening PAHO's visibility and its role as a "broker" and should be systematized.

6.2 Transparency, Accountability, and Risk Management

This program area seeks to strengthen existing mechanisms and introduce new measures designed to ensure that the Organization continues to be accountable, transparent, and adept at effectively managing risks. It promotes a coordinated approach to evaluation across all levels of the Organization, using tools and guidelines in accordance with the evaluation policy.

Achievements

- In this program area, PAHO worked to reinforce existing mechanisms and introduce new instruments to improve accountability, transparency, and risk management. The Enterprise Risk Management program was established and helped inculcate a culture of risk management and strengthen internal controls. ERM will continue to be closely coordinated with the established audit mechanisms of the Organization. These actions will contribute to mitigating risks that may affect the reputation and strategic positioning of the Organization.
- Eighty-seven percent of internal audit recommendations were closed during the biennium, compared to the 2012 baseline of 80%.
- More than 50% of the 31 internal audit recommendations accepted by the Director were implemented during the biennium. The Audit Committee reviewed and reported its findings to the Director of the PASB and the Executive Committee on 47 issues related to auditing, accountability, risk management, and transparency.
- The Office of Internal Oversight and Evaluation Services (IES) provided advice and guidance to PASB management on evaluation methodology to encourage compliance with the PAHO Evaluations Policy. The evaluation of the Mais Médicos project is an example of an evaluation for which IES provided extensive advice. IES has also updated the register of planned, ongoing, and completed evaluation assignments; the register of evaluations and the major lessons learned have been reported to the Director of the PASB at six-month intervals.
- The Respectful Workplace (RWP) initiative was launched across the Organization in 2015. To date, 315 staff have taken the respectful workplace pledge and 24 PWR Offices have committed to advancing the RWP initiative. In addition, 260 employees across the Organization have been trained in conflict management skills.

Challenges

- Establishing and implementing an internal control framework that clearly specifies accountability details for the different managerial levels remains a challenge. Although internal controls are clearly articulated in a variety of disparate documents, an integrated internal control framework document was not produced in 2015 because of demands on staff time for the development of PMIS.
- More progress is pending in the area of evaluation, where an integrated approach needs to be applied in order to consolidate lessons learned from evaluation reports and other means.
- Deferral of the corporate survey has delayed the measurement of staff satisfaction with the Organization's ethical climate and internal justice system until 2016.

Lessons Learned

- Ongoing support and engagement from top-level management has been instrumental in advancing mechanisms for accountability across the Organization. For instance, with respect to risk management the convening of the Senior Standing Committee and the consideration of corporate risks at the level of PASB Executive Management has enabled the implementation of ERM.
- Increased engagement and investment by Member States in the development and assessment of the Program and Budget has highlighted the need to enhance mechanisms to keep Member States abreast of current implementation of the Program and Budget, including programmatic and financial risks.

6.3 Strategic Planning, Resource Coordination, and Reporting

This program area advances and consolidates results-based management as the central operating framework for the improvement of the Organization's effectiveness, efficiency, alignment with programmatic results, and accountability. It also addresses resource mobilization, external relations, and partnerships to increase the visibility of health in the development agenda and improve health outcomes.

Achievements

- In the 2014-2015 biennium, the Organization continued its efforts to further consolidate results-based management in the implementation of the new PAHO Strategic Plan 2014-2019 and its Program and Budgets. In this regard, a new joint assessment process involving national counterparts and all functional levels of the Organization was developed and implemented. A new online assessment tool, the PAHO Strategic Plan Monitoring System (SPMS), was introduced to facilitate the joint assessment. The process began with country inputs; these were validated by the Category and Program Area Network after consultations with the countries and then consolidated into Organization-wide results. In this process, launched in November 2015, the Secretariat and Member States collectively assessed performance in the biennium through a detailed examination of indicators in the Program and Budget and Strategic Plan. Results of this exercise informed the finalization of this report.
- PAHO has pioneered a robust and scientific programmatic prioritization methodology as an integral part of strategic planning and Program and Budget development. This innovative approach is the result of intense and productive collaboration with key public health experts from the national health authorities in the Region. It is expected that the new methodology will be applied to the Program and Budget 2018-2019 and to resource allocation and mobilization efforts. This methodology will also be published and peer-reviewed as a contribution to regional and global public health knowledge and scientific evidence.
- PAHO obtained an 8.8% increase for Base Programs in the Program and Budget 2016-2017, after taking a budget reduction in 2014-2015. The Organization's application of the bottom-up planning approach was further strengthened for the 2016-2017 planning and budget cycle through consultations with Member States. This approach has ensured that the Organization's technical cooperation in health is both country-focused and responsive to programmatic priorities.
- The PAHO Program and Budget 2014-2015 was 99.8% funded (US$ 561.8 million of $563.1 million). The number of donors contributing at least 10% of the PAHO voluntary contributions budget increased from two to three in the biennium. Progress has been made in mobilizing external resources to implement the Program and Budget, partly through intensified outreach to new potential donors, including non-traditional partners and the private sector.
- The PAHO Resource Mobilization Strategy 2016-2019 was approved with the aim of expanding the donor base, attracting flexible funding, and improving the predictability of the flow of voluntary contributions that

will be available to implement the Program and Budget.

- Member States from the WHO Region of the Americas (AMRO) participated in the WHO global Working Group on Strategic Budget Space Allocation, which was convened to develop a transparent and objective formula by which to determine the allocation of the WHO budget to its regions and countries. As a result of the revised needs-based methodology for the Strategic Budget Space Allocation, AMRO's budget allocation will increase, beginning in the 2016-2017 biennium.
- The PAHO Category and Program Area Network (CPAN) was activated to coordinate planning, budgeting, monitoring, and assessment in the Region. This has led to improved programmatic coherence, ownership, and coordination across the three levels of the Organization. Additionally, the Program Management Network (with representatives from all functional levels) was reactivated in 2015 and is expected to strengthen results-based planning, budgeting, and project management functions within the Secretariat.
- For the first time, the Organization developed a comprehensive compendium of impact and outcome indicators that was validated by health planners and public health experts from Member States and the CPAN to improve the objective measurement of programmatic performance based on defined criteria.

Challenges

- The validation of the Program and Budget 2014-2015 output indicators could not be completed in the biennium. This affected the quality and consistency of the joint assessment process with Member States. As a result, the joint assessment process required additional guidance, time, and resources. Experiences will be reviewed in 2016 to improve the criteria that guide the assessment process and the Strategic Plan Monitoring System.
- Mobilizing sufficient external resources to fully finance the increase in the Program and Budget proved difficult. Additionally, the implementation of the Resource Mobilization Strategy was delayed until late in the 2014-2015 biennium. This affected the Secretariat's ability to cover funding gaps for certain program areas and its ability to attract flexible funds that could be strategically allocated to areas of greatest need or highest priority.
- Obtaining full financing for the AMRO portion of the WHO Programme Budget continues to be a challenge. The AMRO portion of the 2014-2015 budget for Base Programs was 85% funded ($139.0 million/$164.5 million).
- Vacancies in key leadership and technical positions, as well as staff deployment to respond to emergencies and provide support to PMIS, collectively affected the implementation of the approved operational plans and consequently of the Program and Budget.

Lessons Learned

- The bottom-up planning and prioritization processes used to develop the PAHO Strategic Plan and the Program and Budgets contributed substantially to more realistic plans and budgets, with increased focus on priorities defined jointly with Member States. The unprecedented participation of Member States and staff from across the PASB in the planning and budgeting processes of the Organization should result in increased ownership of and commitment to the implementation, monitoring, and assessment of the approved Strategic Plan 2014-2019 and the three corresponding Program and Budgets.
- The adaptation and application of a robust and scientific methodology for programmatic prioritization will enable PASB to more strategically and objectively allocate resources to areas where the Organization's technical cooperation adds value and will have greatest impact.
- The new joint monitoring and assessment process and system implemented for PAHO's Strategic Plan and Program and Budget with Member States and the PASB enhanced accountability and transparency in the Organization and further embedded results-based management across PAHO.

- The compendium of indicators led to the development of sound technical criteria for the measurement of indicators and facilitated the joint assessment with Member States, as it provides standard criteria for measurement, dialogue, and resolution of discrepancies. The experience also revealed the need to replicate this good practice to all plans developed by the Organization in order to ensure systematic and objective assessment of results.
- Uncertainty about the availability of funds, and the significant portion of the Organization's flexible funds reserved to cover fixed-term positions (>75%), affected the rate of program implementation. Furthermore, the late arrival and disbursement of funds often left insufficient time for program implementation.
- The implementation of an integrated budget approach should provide additional flexibility in the strategic allocation of resources to address such challenges.

6.4 Management and Administration

This program area covers the core administrative services that underpin the effective and efficient functioning of the Secretariat: Financial Resources Management, Human Resources Management, Information Technology Services, Procurement and Supply Services, and General Services Operations. It also reflects the coordination and implementation of the new PASB Management Information System (PMIS) aimed at simplifying administrative processes and improving performance controls and indicators.

Achievements

Financial

- PAHO received an unqualified audit opinion on the 2013 and 2014 Financial Statements.
- A new policy on the receipt of small contributions from donors was developed to simplify technical cooperation and capacity-building at the national level.
- Standardized definitions and processes for general operating expenses were developed for PWR Offices.

Efficient human resources management

- There was successful implementation of the Human Capital Management module in PMIS during 2015, including widespread training at corporate level.
- Human resources planning was fully integrated into operational planning in 2014-2015; all HR Plans were reviewed, revised where necessary, and approved as part of the operational planning process. This supported the integration of financial and human resources within the framework of the Strategic Plan.
- A new HR strategy (the "PAHO People Strategy") was developed through a participatory process involving all areas and levels of the Organization. Member States approved the new People Strategy and funding for its implementation, starting in 2016.

Efficient and effective computing infrastructure and communication services

- The PASB Management Information System (PMIS) was developed and deployed on time and within budget.
    - Phase I of the project, including the Human Capital and Payroll module, was completed and launched in January 2015.
    - Phase II, which includes finance, budget, and procurement, was launched on 1 January 2016. The implementation of the second phase will have significant impact on the business culture of PAHO and will continue to require change management. By the end of the biennium, $17.4 million (of the $20.2 million approved for the project) was spent. The remaining budget will be used to implement non-go-live critical components, post-go-live enhancements, custom reports, and the Recruitment module, which was not included in the original scope. Two Key Performance Indicators that assessed the PMIS

rollout have been achieved.

- Information technology:
  - A new IT strategy was developed and approved during 2015.
  - Information Technology Services provided critical support for the development stage of PMIS, as well as planning for phase-out of the legacy systems and the maintenance of historic data for future use in financial reporting and planning.
  - Significant progress was made in the modernization of IT infrastructure, including core systems, Internet connectivity, and deployment of an upgraded SharePoint platform.

Efficient operational, logistical, and procurement support

- General services:
  - A full assessment of the condition of PAHO's Headquarters (HQ) building and PWR Office buildings, including security and safety, was presented to Member States, along with short- and long-term options and costing.
  - The Master Capital Investment Fund, including its subfunds for real estate maintenance, IT, and vehicle purchases, was augmented with surpluses approved by the Directing Council.
  - A new self-financing mechanism for purchase of vehicles by PWR Offices was developed and will be implemented in 2016.
  - Office operating costs were lowered by 2% to 3%.

- Procurement:
  - The use of e-tendering solutions was maximized in PAHO/HQ for the sake of efficiency and economy.
  - Training was provided to all administrators and procurement focal points in procurement processes, which reduced the requisition cycle time.
    - An automated system for shipping management was developed with the collaboration of In-tend. It will be deployed in 2016 to enhance support for the Revolving and Strategic Funds.

Challenges

- A major challenge was the significant staff time dedicated to the development and testing of PMIS, even asstaff worked to fulfill their ongoing programmatic and administrative responsibilities. As a result, there were many delays that affected different areas of the Organization. However, careful management protected key business services such as contracting of staff, payroll, and procurement.
- The level of savings to be realized from the full implementation of PMIS has been difficult to document and assess and is not yet fully known. It is anticipated that as the system stabilizes, its cost efficiencies will become evident.

Lessons Learned

- PASB management support was key to Organization-wide acceptance of the transition to the new Enterprise Resource Planning software system known as PMIS.
- Successful implementation of PMIS will require continued commitment from staff and management, adaptation of processes, and investment of additional time and resources to fully realize the benefits of the new system.
- Failure to address the problem of an aging building infrastructure could have significant cost implications and could undermine the Organization's capacity to deliver technical cooperation and enabling services.

6.5 Strategic Communications

This program area seeks to position the Organization more strongly within the international community by promoting a proactive approach that works with the news media and social media to better communicate the Organization's role and impact. It develops and shares evidence-based information and knowledge produced by Member States and the PASB to promote awareness about the Region's achievements in health.

Achievements

- The new communication strategy lays the groundwork for enhanced integration of communication activities and practices across the Organization to position PAHO as the authoritative leader in public health in the Americas. Implementation of standard operating procedures will enable PAHO to connect effectively with stakeholders and targeted or new audiences to convey accurate and timely health information.
- A new organizational publication policy was developed and approved.
- The PASB also continued to employ innovative technologies and communication platforms to facilitate its technical cooperation in an effective and efficient manner.
- Digital communication and user engagement were expanded through the use of social media networks (e.g., Facebook, Flickr, Twitter, and YouTube). Additionally, user participation via the website was increased to optimize the use of new technologies and increase webpage views.
- Media outreach has also been increased via targeted messaging and direct response to press queries. Consolidated efforts in both media outreach and webpage view development have contributed to increased positioning and ranking of the Organization within the international community.

Challenges

- Varying levels of communication capacity in PAHO/WHO Representative Offices impedes the delivery of consistent and high-quality communication support.
- There is limited capacity in the PWR Offices and Centers to work on knowledge management and related areas.

Lessons Learned

- To raise the Organization's visibility and communication for health, the Organization needs to continue its investments in the strategic communication component of technical cooperation programs, accompanied by the appropriate financial and human resources.

Risks

The most relevant risks identified for Category 6 in the PAHO Strategic Plan 2014-2019 are listed below, with information regarding their status and any mitigation actions taken to address them. New risks identified during the biennium are also highlighted.

- Further reduction in the assignment of resources from WHO could severely compromise the ability of PAHO to deliver the results set out in the Strategic Plan.
  - While the nominal allocation increased for the Region, it represented 85% of the total approved AMRO portion of the WHO base program budget ($139.0 million/$164.5 million).
- There is a continuing decline in the level of international assistance to the Region.

- Unpredictable and often earmarked voluntary funding, coming mainly from a small core of large donors, continues to constrain PAHO's ability to address existing and emerging priorities. The newly approved Resource Mobilization Strategy and the application of the programmatic prioritization framework will better focus resource mobilization efforts. In addition, the Organization needs to position itself strategically to generate support from traditional and non-traditional partners. Its leadership role in South-South and triangular cooperation provides opportunities to mobilize resources from within the Region, create new alliances, and increase the recognition of PAHO's role as a leader and key partner for CCHD in the Region.

- In the absence of a framework for engaging with non-state actors, potential conflicts of interest exist with private partners that could damage the image and reputation of the Organization.
  - The PASB and Member States from the Americas are actively involved in the development of the WHO framework of engagement with non-state actors. Once approved, the applicable components will be presented to PAHO's Governing Bodies for adoption.
- Failure to implement a modern management information system could impede the simplification of administrative processes and prevent the use of more efficient and cost-saving measures.
  - While Phases I and II of the PMIS project were completed on schedule and within budget, the materialization of the full potential of the system will require continued commitment from staff and management, adaptation of processes, and investment of additional time and resources.
- The limited availability and reliability of information hinders timely decision-making.
  - The implementation of PMIS coupled with the planned development of the PAHO Program and Budget Portal will make information more readily available to PASB management and Member States and will facilitate reporting of relevant information for the Region of the Americas in WHO's information systems and platforms.

Budget Implementation Analysis

Category 6 had an approved budget (PB 2014-2015) of $203.4 million, which includes the cost of country presence, reflected in Program Areas 6.1 (Leadership and Governance) and 6.4 (Management and Administration).

Approximately $196.67 million was awarded, representing 96.7% of the approved budget for this category. Overall, the category achieved an implementation level of 97% against funds awarded and 94% against the approved Program and Budget. As illustrated in Table 1, four of five program areas were awarded 85% or more of their approved PB levels. Three were awarded 95% or more of their budgets: Program Areas 6.1 (Leadership and Governance, 106%), 6.2 (Transparency, Accountability, and Risk Management, 96%), and 6.4 (Management and Administration, 120%). Program Area 6.4 includes an allocation for PMIS of $10 million. Meanwhile, Program Area 6.3 was awarded 52% of the approved budget. This was due primarily to over-budgeting of Program Area 6.3 (and corresponding under-budgeting of Program Area 6.4); this has been remedied in the Program and Budget 2016-2017.

Table 2 disaggregates allocations to Category 6 by functional level. Funds awarded to the regional level accounted for 41.6% of the total category allocation;; 34.9% went to country level, 17.6% to intercountry level, and 5.9% to subregional level. This is closely aligned with the targeted distribution defined in the PAHO Budget Policy. The subregional level attained an implementation rate of 98% of funds awarded, and all other functional levels reached 97% implementation.

Table 3 provides additional information on funds awarded and is disaggregated by both program area and functional level. All program areas in this category achieved implementation rates greater than 95%. As expected, and given the inclusion of country presence, Program Areas 6.1 (Leadership and Governance) and 6.4 (Management and

Administration) received the largest portions of the Category 6 budget, representing 31.4% and 47.3% respectively. The other program areas accounted for between 2% and 13% of the category budget.

Program Areas 6.2 (Transparency, Accountability, and Risk Management) and 6.5 (Strategic Communications) achieved the highest implementation rates, with more than 99% implementation of funds awarded. Program Areas 6.3 (Strategic Planning, Resource Coordination, and Reporting) and 6.1 (Leadership and Governance) achieved 98% implementation. Program Area 6.4 (Management and Administration) had the lowest rate of implementation in this category, at 96%.

When analyzed by functional level, the country level achieved 96% to 100% implementation in all program areas, with the lowest implementation rate in Program Area 6.4. The intercountry level, which represented additional support to countries, achieved upwards of 95% implementation in all program areas. The subregional level had the highest implementation in Program Areas 6.1, 6.2, and 6.5, where implementation levels were at or above 99%. The regional level achieved 99% to 100% implementation in three program areas, and slightly less in Program Areas 6.3 (98%) and 6.4 (96%).

Table 3: Category 6 Budget Overview by Program Area and Functional Level

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
6. Corporate Services/Enabling Functions	**196.67**	**100.00**	**191.03**	**97.1**
6.1 Leadership and Governance	**61.82**	**31.43**	**60.44**	**97.8**
Country	33.22	16.89	32.08	96.6
Intercountry	7.34	3.73	7.27	99.1
Subregional	3.84	1.95	3.82	99.4
Regional	17.42	8.86	17.27	99.1
6.2 Transparency, Accountability, and Risk Management	**4.65**	**2.37**	**4.63**	**99.5**
Country	0.30	0.15	0.30	100.0
Intercountry	1.20	0.61	1.19	99.4
Subregional	0.31	0.16	0.31	99.4
Regional	2.84	1.45	2.83	99.4
6.3 Strategic Planning, Resource Coordination, and Reporting	**25.87**	**13.15**	**25.36**	**98.1**
Country	6.21	3.16	6.14	98.8
Intercountry	5.36	2.72	5.24	97.8
Subregional	1.58	0.80	1.55	98.0
Regional	12.72	6.47	12.44	97.8

Category, Program Area, and Functional Level	Funds Awarded (US$ millions)	Awarded by Program Area (%)	Total Expenditure (US$ millions)	Budget Implementation (%)
6.4 Management and Administration	**92.93**	**47.25**	**89.15**	**95.9**
Country	27.13	13.79	26.16	96.4
Intercountry	18.06	9.18	17.28	95.7
Subregional	5.08	2.59	4.88	96.0
Regional	42.66	21.69	40.83	95.7
6.5 Strategic Communications	**11.40**	**5.80**	**11.45**	**100.4**
Country	1.82	0.92	1.82	100.4
Intercountry	2.64	1.34	2.65	100.4
Subregional	0.69	0.35	0.69	100.4
Regional	6.26	3.18	6.28	100.4

Category 6, as an enabling category, does not traditionally attract donor resources. Thus, unearmarked funds such as Assessed Contributions and Program Support Costs were primarily used to advance the work under this category during the 2014-2015 biennium.

Recommendations

- Support the identification, promotion, and implementation of CCHD projects in the 2016-2017 biennium, as this new modality of technical cooperation is fully rolled out in the Region.
- Recognizing that the PAHO/WHO Representatives are the cornerstone of the Organization's leadership, take steps to *(a)* improve representation of candidates from the Region of the Americas in the WHO global roster selection process; *(b)* improve the diversity and quality of applicants to the global roster, especially individuals from countries of the Americas, through active recruitment; and *(c)* implement timely and thorough selection of PWRs in the Region.
- Improve, simplify, and streamline administrative processes for effective implementation of technical cooperation, including recruitment of staff, procurement, and IT/PMIS support. This is of particular importance to PWR Office operations.
- Support the establishment of the new subregional offices for Central America and South America, including staff recruitment and administrative arrangements, as a means to enhance technical cooperation in countries and enlarge PAHO's role in established subregional bodies.
- Document the bottom-up planning process and joint assessment with Member States as best practices and promote them with WHO for implementation in other regions.
- Complete the refinement of the PAHO-adapted Hanlon methodology for programmatic prioritization and publish it in a scientific journal.

Assessment by Program Area

Program Area 6.1: Leadership and Governance **OUTCOME: Greater coherence in regional health, with PAHO/WHO playing a leading role in enabling the many different actors to contribute effectively to the health of all people in the Americas** OCM Indicator Assessment: 3/3 In Progress OPT Indicator Assessment: 3/4 Achieved, 1/4 Partially Achieved (1 Cancelled)	**Rating: Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator Text	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[28, 29]
6.1.1	Level of satisfaction of stakeholders with PAHO/WHO's leading role on global and regional health issues	High	High	In progress
The results of the WHO stakeholder perception survey for 2015 are currently being finalized. Only five countries represent the AMRO region in the survey (Barbados, Dominican Republic, Guatemala, Honduras, Suriname). However, initial indications for WHO HQ are that 68% of respondents have a positive opinion of WHO. Given the periodicity of the WHO stakeholder survey and the fact that it does not fully measure PAHO's relationship with its stakeholders and its leadership role in the Americas, PAHO is proposing the implementation of a Region-specific survey to better assess its performance in this area.				
6.1.2	Number of countries that reflect in their national health and/or development strategies or plans the regional health priorities defined in the PAHO Strategic Plan 2014-2019	n/a	20/35	In progress (13 achieved + 20 in progress)
Thirteen countries achieved the indicator: ARG, BRB, CAN, CHL, COL, CUB, DMA, HND, JAM, PAN, PER, SLV, URY. An additional 20 countries are on track to achieve the indicator by 2019: ATG, BHS, BLZ, BOL, CRI, DOM, ECU, GRD, GTM, GUY, HTI, KNA, LCA, MEX, NIC, PRY, SUR, TTO, VCT, VEN. Assessment of this indicator is based on the criterion that at least 13 of the 25 areas of the PAHO Strategic Plan are reflected in the country's health and/or development strategies. In the joint assessment exercise, some				

[28] Overall achievement is assessed as follows:

- **Achieved:** The indicator target set for 2019 (number of countries/territories, number or % for regional indicators) in the PAHO Strategic Plan has already been reached.
- **In progress:** There has been an increase over the indicator baseline value defined in 2013 (number of countries/territories, number or % for regional indicators), and work is under way/on track to achieve the target set in the Strategic Plan by 2019.
- **No progress:** There has not been an increase over the baseline value set in 2013 (number of countries/territories, number or % for regional indicators), and progress toward achieving the indicator target by 2019 could be in jeopardy.

[29] The regional indicators are assessed by the responsible regional entity/CPAN based on the latest available information, according to criteria defined in the compendium of indicators.

OCM Ind. #	OCM Indicator Text	Baseline 2013	Target 2019	Assessment Rating *(Rate as achieved, in progress, no progress)*[28, 29]
countries quantified the number of program areas of the PAHO Strategic Plan reflected in their national health and/or development strategies or plans.				
6.1.3	Number of regional initiatives or action plans of the Inter-American and United Nations systems dealing with health and development designed or implemented with PAHO support to advance the health priorities of the Region	n/a	8	In progress (7)

In the 2014-2015 biennium, seven initiatives and/or action plans were developed to advance health priorities in the Region:

- PAHO successfully negotiated, during the Seventh Summit of the Americas process, the inclusion of eight paragraphs on health in the summit's Mandates for Action document. These included commitments to work for universal access to health and universal health coverage; to prevent, detect, and respond to outbreaks of emerging infectious diseases and other public health emergencies; and to make progress in the areas of NCDs, water and sanitation, food and nutrition, and reduction of maternal and child mortality.
- Proposals moved forward to create an inter-American fund for disease outbreak preparedness as a joint project of PAHO, the Organization of American States (OAS), and the Inter-American Development Bank (IDB). In addition, the Inter-American Task Force on NCDs was successfully launched in June 2015.
- PAHO and the OAS entered into an agreement to expand the OAS scholarships program to the health sector. As a result of this successful partnership, 181 professionals from 23 countries in the Region (including the United States and Canada) have been offered training in graduate (master's and doctoral) programs in Brazil and Mexico. The partnership has also resulted in specific agreements to advance the regional Policy on Research for Health (e.g., with the Coimbra Group of Brazilian Universities) and contributions to regional dialogues on internationalization of universities and social innovation in health.
- PAHO was actively involved in shaping the SDG agenda, particularly with regard to SDG3 on health, and participated in the UN General Assembly Special Session for the Adoption of SDGs.
- Negotiations took place with the Ibero-American General Secretariat (SEGIB) for a formal agreement on South-South cooperation. An agreement with UNASUR for an MOU in support of the health priorities of Member States was negotiated, and an MOU with MERCOSUR for cooperation in health was signed.
- In the framework of the XIV Ibero-American Conference of Ministers of Health, it was agreed to develop a strategy to analyze how technological innovations and the use of massive data (Big Data) can contribute to the strengthening of public health policy, particularly aimed at prevention and control of NCDs.
- PAHO reestablished relations with the UN Office for South-South Cooperation and participated in a high-level stakeholders' meeting on South-South cooperation and discussions on the post-2015 development agenda.

Assessment of output indicators

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
6.1.1	Effective PAHO/WHO leadership and management in place	Number of countries and territories with country cooperation strategies in which at least 50 percent of the implications of the CCS have been addressed	14	35	Partially achieved (20 achieved)
Twenty countries and territories have CCSs aligned with national plans at the end of 2015: ABW, ARG, BHS, BOL, CAN, CUB, CUW, DOM, GTM, GUY, JAM, MEX, NIC, PAN, PER, PRI, SLV, SUR, SXM, URY. In addition, 12 CCSs that expired at or before the end of 2015 will be updated in 2016: BLZ, BOL, BRA, ECU, GUY, HND, HTI, PRY, SLV, SXM, TTO, and the multi-country strategy with the United Kingdom Overseas Territories in the Caribbean (covering AIA, BMU, CYM, MSR, TCA, VGB). As a result, there will be 35 countries and territories with CCSs valid to 2016 and beyond. The tool for monitoring CCS implications has been tested with the support of three PWR Offices (Brazil, Nicaragua, and Peru). However, for appropriate use of the tool, countries are required to have formulated their CCS implications based on the new CCS guide (2015). This indicator is being assessed based on the number of CCSs that were in effect during the biennium and beyond. However, the indicator requires revision to facilitate better measurement and monitoring of the effectiveness of PAHO's leadership and management. It is therefore proposed that the output be assessed against the CCSs and the leadership priorities as independent indicators. For the CCS indicator, the revision allows CCSs to be measured independently of how the CCS implications are presented, and the indicator is not likely to be affected by any possible changes in the format as a result of the revision of the guidelines that is currently under way. In this regard, the PASB proposes the assessment of the 2016-2017 output using the following measurements in the SPMS: • *6.1.1a: Number of countries with current CCSs developed according to approved guidelines* • *6.1.1b: Number of countries and territories where PAHO's leadership priorities are assessed as effectively addressed*				
6.1.2	Effective engagement with other stakeholders in building a common health agenda that responds to the priorities of the Member States	Number of countries and territories having an active multi-partner country coordinating mechanism for implementation of the principles of the Busan Partnership for Effective Development Cooperation that affect health	26	35	Achieved (33)
Thirty-three countries and territories achieved the indicator: ARG, ATG, BHS, BLZ, BOL, BRA, BRB, CHL, COL,CRI, CUB, DOM, ECU, GTM, GUY, HND, HTI, JAM, MEX, NIC, PAN, PER, PRY, SLV, SUR, TTO, URY, VEN. The Organization of Eastern Caribbean States (OECS) countries of DMA, GRD, KNA, LCA, and VCT also participate in the Eastern Caribbean coordinating mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria. This indicator is measured based on countries that have roundtables, cooperation groups, Global Fund coordinating mechanisms, peer review groups, theme groups, and other similar mechanisms that coordinate,					

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
monitor, and evaluate the implementation and effectiveness of development partner cooperation for national health development.					
6.1.3	Strengthened PAHO governance with effective oversight of the meetings of the Governing Bodies	Proportion of agenda items of PAHO Governing Bodies aligned with the PAHO Strategic Plan	n/a	90%	Exceeded (95%)
95% of PAHO Governing Bodies agenda items aligned with the PAHO Strategic Plan 2014-2019. A total of 89 agenda items were considered by the Directing Council in 2014 and 2015, of which 85 are aligned with the PAHO Strategic Plan. All the program and policy matters on both agendas were aligned with the Strategic Plan. Furthermore, all strategies and plans of action are peer-reviewed to ensure alignment with the PAHO Strategic Plan.					
6.1.4	WHO reform integrated into the work of the Organization	Proportion of items relevant to PAHO from the WHO reform completed or on track	n/a	100%	Achieved (100%)
100% of the items relevant to PAHO from the WHO reform are completed or on track (15/29 items completed and 14/29 on track). The report on PAHO's implementation of WHO reform is presented to the Governing Bodies in 2016.					
6.1.5	Implementation of the Health Agenda for the Americas (HAA) 2008-2017	Number of countries and territories monitoring implementation of the HAA	n/a	n/a	Canceled
This indicator was cancelled based on the revision of the PAHO Strategic Plan 2014-2019 indicators with the Countries Working Group.					

Program Area 6.2: Transparency, Accountability, and Risk Management **OUTCOME: PAHO operates in an accountable and transparent manner and has well-functioning risk management and evaluation frameworks** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 2/4 Achieved, 1/4 Partially Achieved, 1/4 Not Assessed	**Rating:** **Partially met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator Text	Baseline 2013	Target 2019	Assessment Rating
6.2.1	Proportion of corporate risks with approved response plans implemented	n/a	100%	In progress (80%)
During 2015 Executive Management identified 10 corporate risks for the Organization; after application of a prioritization criteria, eight of these were identified as top priority. Mitigation plans were developed and are currently in the process of being implemented. The ERM Standing Committees and Executive Management will follow up, every six months, the progress and evolution of the top risks in coordination with the risk owners. Additionally, the Audit Committee will monitor the status of the institutionalization of ERM in PAHO and the top risks, as well as the implementation of their mitigation plans.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
6.2.1	Increased accountability through strengthened corporate risk management and evaluation at all levels of the Organization	Proportion of entities in the Organization with completed risk assessment and approved mitigation response plans implemented	12%	75%	Achieved
90% of entities completed their risk registry and mitigation plans. The registry tool was enhanced and data standardized to produce reports.					
6.2.2	PAHO/WHO evaluation policy implemented across the Organization	Percentage of Director-approved evaluations' lessons learned implemented during the biennium	Data not currently measured	70%	Partially achieved (67%)
67% of Director-approved evaluations' lessons learned were implemented during the biennium. The Office of Internal Oversight and Evaluation Services (IES) continues to collaborate with WHO's evaluation function to promote a systematic and harmonized approach to evaluative work. IES has distributed and promoted the WHO Evaluation Practice Handbook in the PASB. IES also facilitated the PASB aspects of the WHO country presence evaluation, for which Mexico was one of eight countries worldwide selected for in-depth case studies.					
6.2.3	Improved ethical behavior, respect within the workplace, and due process across the Organization	Level of staff satisfaction with the ethical climate and internal recourse procedures of the Organization	Data not currently measured	High	Not assessed (ND)
A survey to assess the ethical climate and work environment was piloted in two PWR Offices (Guatemala and Paraguay) in 2015, and further refinements are presently being made to the survey by PAHO's Integrity and Conflict Management System with the goal of issuing it to all HQ units, PWR Offices, and Centers in 2016. This survey will be used to assess the level of staff satisfaction with the ethical climate and internal recourse procedures of the Organization and will establish a baseline that can be used in the future for comparative purposes and to identify trends. However, at the end of 2015 no data was available to assess this indicator.					

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
Although the survey was not fully implemented, steps were taken to improve ethical behavior in the Organization, including the implementation of a Respectful Workplace initiative, Zero Tolerance for Fraud and Corruption policy, Prevention and Resolution of Harassment in the Workplace policy, and policies on gifts and hospitality, conflicts of interest, and outside employment and activities. Moreover, the Organization continued to implement its mandatory requirement that all new employees complete a course on the PAHO Code of Ethical Principles and Conduct.					
6.2.4	Strengthened audit function	Proportion of internal audit recommendations accepted by the Director closed within the biennium	80%	85%	Exceeded (87%)
87% of internal audit recommendations accepted by the Director were closed within the biennium. Progress continues to be made in this area, with gradual and continuing improvements to internal controls.					

Program Area 6.3: Strategic Planning, Resource Coordination, and Reporting **OUTCOME: Financing and resource allocation aligned with priorities and health needs of the Member States in a Results-based Management framework** OCM Indicator Assessment: 2/2 In Progress OPT Indicator Assessment: 1/3 Achieved, 2/3 Partially Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator Text	Baseline 2013	Target 2019	Assessment Rating
6.3.1	Percentage of approved PAHO budget funded	90%	100%	In progress (97.6%)
97.6% of the Program and Budget 2014-2015 was funded ($549.4 million/$563.1 million approved budget). The number of donors contributing at least 10% of the PAHO voluntary contributions budget increased from two to three in the biennium. Progress has been made in mobilizing external resources to implement the Program and Budget, partly through intensified outreach to new potential donors, including non-traditional partners and the private sector.				
6.3.2	Percentage of outcome indicator targets of the PAHO Strategic Plan 2014-2019 achieved	91%	≥90%	In progress (6% achieved + 84% in progress)
Based on the joint assessment with Member States, 6% (5/83) of the outcome indicators were assessed as achieved (3) or exceeded (2), 84% (70/83) as in progress, and 8% (7/83) as having made no progress. One indicator (2.1.2a) was not assessed due to measurement challenges. This assessment may change after the confirmation of pending country assessments. Changes will be reflected in the final version of the report to be presented to the Directing Council. It is worth noting that the organization has two more Program and Budget periods in the Strategic Plan to achieve the outcome indicator targets.				

Assessment of output indicators

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
6.3.1	Consolidation of the PAHO Results-based Management framework, with emphasis on the accountability system for corporate performance assessment	Percentage of outputs achieved	75%	90%	Partially achieved (50% achieved + 50% partially achieved)
Out of the 114 output indicators assessed, 50% (57/114) were achieved (21) or exceeded (36), and another 50% were partially achieved. Two outputs were not assessed; one was cancelled and the other had no data available. This assessment may change after the confirmation of pending country assessments. Changes will be reflected in the final version of the report to be presented to the Directing Council. Note that in this output, the indicator does not fully reflect the work of the Organization regarding RBM. To build on the continued efforts in RBM and on the good practices of joint accountability with Member States, the Secretariat is proposing, for the assessment of the 2016-2017 output, to use the following measurements in the SPMS: • *6.3.1a: Percentage of outputs achieved* • *6.3.1b: Results-based planning and budgeting implemented across the Organization in collaboration with Member States (measured by PB development using bottom-up approach, implementation of prioritization methodology, joint end-of-biennium assessment)*					
6.3.2	Alignment of PAHO allocation of resources and financing with agreed priorities facilitated through strengthened resource mobilization, coordination, and management	Percentage of program areas with funded budgets of 75% or greater	75%	75%	Exceeded (76%)
76% of program areas (22/29) were 75% or more funded in the biennium. The overall funding of the Program and Budget 2014-2015 was 97.5% of the total approved budget ($549.4 million/$563.1 million). The additional funding for Outbreak and Crisis Response ($9.8 million) is excluded from this analysis as it is outside the Base Programs.					
6.3.3	PAHO resource mobilization strategy implemented	Number of partners contributing at least 10% of the PAHO Voluntary Contributions budget	2	4	Partially achieved (3/4)
3 partners (U.S. Centers for Diseases Control and Prevention, U.S. Agency for International Development, and Government of Brazil) each contributed at least 10% ($11 million) of the PAHO voluntary contributions budget in 2014-2015. Four additional partners (European Commission, Government of Spain, Global Affairs Canada, and United Nations Development Programme) each contributed at least $5 million of the PAHO voluntary contributions. The PASB continued its efforts in resource mobilization and expanded ongoing technical dialogue with partners to include resource mobilization (Canada, Spain). It further worked to establish partnerships with multiple potential					

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating

and non-traditional development partners such as the Korea International Cooperation Agency (KOICA), Japan International Cooperation Agency (JICA), Development Bank of Latin America (CAF), Federal Ministry for Economic Cooperation and Development (GIZ/BMZ, Germany), and Ministry of Foreign Affairs (Singapore), and with government agencies and ministries and private sector entities (São Paulo and Brasilia). These efforts have resulted in expansion and diversification of the portfolio of donors. Additionally, although not all new donors have contributed at least 10% of the PAHO voluntary contributions, there has been significant success in mobilizing increased resources for the Organization. The PASB remains committed to engaging with new potential donors, including non-traditional and private sector partners such as those mentioned above.

An important achievement in the biennium was the development and approval by the PASB of the PAHO Resource Mobilization Strategy 2016-2019. This strategy, which aims to fully fund the two remaining biennia of the Strategic Plan, defines the guiding principles and lines of action to create a corporate enabling environment to track, negotiate, mobilize, execute, and report on external resources.

The Project Review Process is also being reviewed and aligned with efforts to strengthen the resource mobilization efforts of the PASB. A total of 198 proposals were reviewed between January and December 2015. In the last quarter of 2015 alone, the PASB reviewed 25 potential initiatives, which if successful will represent a flow of approximately $11.4 million in voluntary contributions and $29.6 million in National Voluntary Contributions (excluding *Mais Médicos*).

Program Area 6.4: Management and Administration **OUTCOME: Effective management and administration across the three levels of the Organization** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 2/4 Achieved, 2/4 Partially Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator Text	Baseline 2013	Target 2019	Assessment Rating
6.4.1	Proportion of management and administration metrics, as developed in Service Level Agreements, achieved	n/a	95%	In progress (80%)

80% (16/20) of the Key Performance Indicators defined for the Secretariat were met.

The KPIs are being used as a proxy measure for the achievements of Service Level Agreements in all components of this outcome and its outputs, where applicable. The KPIs include two specific indicators for the PMIS project.

Assessment of output indicators

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
6.4.1	Sound financial practices in place through an adequate control framework, accurate accounting, expenditure tracking, and timely recording of income	Unqualified audit opinion	Yes	Yes	Achieved
Two unqualified audit opinions (2013 and 2014) were completed in the biennium. PAHO has received an unqualified audit opinion on the 2014 Financial Statements compliant with International Public Sector Accounting Standards (IPSAS).					
6.4.2	Effective and efficient human resources management in place to recruit and support a motivated, experienced, and competent workforce in an environment conducive to learning and excellence	Proportion of HR-agreed Service Level Agreements achieved	Data not currently measured	95%	Partially achieved (50%)
50% (1/2) of HR-agreed Service Level Agreements achieved. The Key Performance Indicator related to the HR Plans was achieved. The Department of Human Resources provided extensive guidance and support to all entities in the preparation, review, and approval of their respective HR Plans. In light of the upcoming implementation of the Human Capital Management module of PMIS, the KPI related to the process and accuracy of human resources transactions will not be introduced until 2016-2017, following go-live of the new system.					
6.4.3	Efficient and effective computing infrastructure, network and communications services, corporate and health-related systems and applications, and end-user support and training services	Proportion of end-user support provided according to Service Level Agreements	80%	95%	Exceeded (100%)
100% of end user support was provided according to Service Level Agreements. All three KPIs were achieved. The target is measured using three KPIs grouping different types of services: new service requests, high-priority service requests, and mainstream service requests received from the user community. Response time and outcome exceeded the targets, which are set at a range of one to three days depending on the service type.					
6.4.4	Effective and efficient operational and logistic support, procurement, infrastructure	Proportion of agreed Service Level Agreements reached	Data not currently measured	95%	Partially achieved (67%)

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
	maintenance, asset management, and secure environment for PAHO/WHO staff and property				

67% (4/6) of agreed Service Level Agreements achieved.

KPI (1) for General Services Operations (GSO) agreements was defined with a targeted reduction of 5% in the cost of electricity, gas, and maintenance. Even though progress was made, the unusually harsh winter conditions as well as the transition to a new facilities management provider prevented GSO from fully achieving this target. It is anticipated that the KPIs will be met in 2016 and beyond.

The operations of the Procurement and Supply Management Department were assessed through five KPIs, which measured the use of e-tendering solutions in HQ, the requisition cycle time, processing of top LTAs training on policies and processes, and cost reductions. With the exception of the KPI for cost savings, which was partially achieved, all the KPIs were fully met.

Program Area 6.5: Strategic Communications **OUTCOME: Improved public and stakeholders' understanding of the work of PAHO/WHO** OCM Indicator Assessment: 1/1 In Progress OPT Indicator Assessment: 2/2 Achieved	**Rating:** **Met expectations**

Assessment of outcome indicators

OCM Ind. #	OCM Indicator Text	Baseline 2013	Target 2019	Assessment Rating
6.5.1	Percentage of Member States and other stakeholder representatives evaluating WHO/PAHO performance as excellent or good	77%	100%	In progress

PAHO is awaiting results of the 2015 WHO stakeholder perception survey to assess this indicator and to report on AMRO participation in the global survey. However, five AMRO Member States participated in the 2015 survey, namely Barbados, Dominican Republic, Guatemala, Honduras, and Suriname.

Status for 2014-2015 should show noticeable improvement in the perception of PAHO/WHO performance. It is noted that this indicator does not fully measure the perception of PAHO's overall performance.

Assessment of output indicators

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
6.5.1	Improved communication by PAHO/WHO staff, leading to a better understanding of the Organization's action and impact	Number of PAHO/WHO offices having completed the training component of the Organization's knowledge management and communication strategy	4	12	Exceeded (27)

27 PWR Offices have completed the training component of the Organization's knowledge management (17) and communication (10) strategies:

- 17 in the knowledge management strategy: ARG, BOL, BRA, CHL, CUB, DOM, ECC , ECU, GTM, HND, JAM, MEX, PAN, PER, PRI, PRY, SLV.
- 10 in the communication strategy: HQ plus BOL, BRB, CUB, DOM, ECU, MEX, PRY (2 sessions) SLV, TTO.

Following approval of the Program and Budget 2014-2015, an independent strategy was approved for knowledge management and a separate strategy for communication. Therefore, the results are reported against the individual strategies.

The following offices received training and were supported for development and implementation of the components of the knowledge management strategy:

- Scientific writing, literature search, and access to information: ARG, BOL, DOM, PAN, PRI, PRY.
- PAHO's Institutional Repository for Information Sharing: ARG, BRA, CUB, ECU, DOM, FEP, MEX, PER, PRY. Periodical virtual meetings/trainings were held with the focal points in the Knowledge Centers during the biennium.
- Guidance related to PAHO/WHO Collaborating Centers: ARG, BRA, CHL, CUB, HND, MEX.
- Institutional Memory/Library: BOL, ECC, ECU, JAM, MEX, PER, PRY.
- Knowledge management workshops: ARG, CUB, GTM, HND, JAM, MEX, PAN, PER, SLV.
- Development of National eHealth Strategies: ARG, GTM, PAN, PER, SLV.

Training and support was provided for development and implementation of the components of the communication strategy:

- The Communications Unit established a new communication strategy and a publication policy for the Organization that were approved during the biennium.
- A total of 12 training sessions were administered during 2014 and 2015:
    - 69 entity managers (from 27 PWR Offices and 42 HQ entities) received the training component of the Organization's communication strategy during the annual Managers' Meeting in 2014.
    - Communication for PAHO staff (Bolivia, HQ, Trinidad and Tobago).
    - Risk communication training on Ebola (Barbados, Cuba, Paraguay) and risk communication training in the Caribbean on chikungunya (Dominican Republic, Paraguay).
    - Communication and social media (Ecuador).
    - Communication for health and communication strategies (El Salvador).
    - Communication and social media (Family, Gender and Life Course technical department).

OPT #	Output Title	OPT Indicator Text	Baseline 2013	Target 2015	Assessment Rating
6.5.2	Effective and innovative communication platforms, policies, and networks	Number of PAHO/WHO offices having completed the platform, policy, and network component of the Organization's knowledge management and communication strategy	3	25	Exceeded (42)

A total of 42 trainings took place in PWR Offices to implement the platform, policy, and network components of the Organization's knowledge management and communication strategy.

- 15 in knowledge management: ARG, BOL, BRA, CHL, COL, CRI, DOM, ECC (LCA), GTM, HND, MEX, PAN, PER, PRI, SLV.
- 27 offices in communication strategy components (updated Web, Intranet).

Following approval of the Program and Budget 2014-2015, separate platforms were developed to implement the communication strategy and the knowledge management strategy. Accordingly, the results are reported against the individual strategies.

Key achievements related to the communication strategy:

- The PAHO publication policy was approved and adopted in 2015.
- Each PWR Office has a working, maintained, and updated Internet site.
- The PAHO website was upgraded and redesigned to enhance mobile access and information delivery.
- Steps were taken to strengthen the corporate image on the Intranet, which serves as the main hub of the PAHO corporate identity system for internal staff.
- Social network activities were established and consolidated to improve efficiency.
- Communication training was offered at the 2014 Managers' Meeting on "cutting the jargon" and on use of social media.
- Multi-session series at Headquarters were offered to all staff on communicating effectively and cutting the jargon.

Key achievements related to knowledge management:

- Knowledge translation and evidence mechanisms were strongly advanced as a result of the iPIER initiative (Improving Programme Implementation through Embedded Research) (ARG, BOL, BRA, CHL, COL, LCA, MEX, PAN, PER).
- National guidelines and programs were strengthened by establishing standards, improving implementation strategies, supporting guideline development, and providing trainings in guideline development (ARG, CHL, COL, CRI, DOM, GTM, HND, PAN, PER).
- Guidance and public health ethics training was conducted for the first time at regional and national levels (CHL, COL, PRI) and for PAHO staff.
- Methodologies were developed on: (a) communities of practice; (b) lessons learned; (c) effective virtual meetings; (d) how to write scientific papers; (e) virtual forums; (f) how to build and preserve institutional memory/institutional repositories; (g) information society in health; (h) scientific communication in public health.

The PAHO-OAS scholarships program has offered 188 scholarships for graduate studies in health (mainly at the master's and doctoral levels) in Brazil and Mexico, with the information being shared and disseminated locally through PWRs in beneficiary countries: ARG, BOL, BRA, CAN, CHL, COL, CRI, DOM, ECU, GTM, HND, HTI, JAM, MEX, NIC, PAN, PER, PRY, SLV, URY, USA, VEN. Scholars and university staff in Brazil and Mexico have been offered tools to better use and produce research for health through the OAS site.

Annex B: Examples of the Compendium of Indicators

Outcome Indicator

Code and title of the indicator	OCM 1.1.1 Antiretroviral Therapy (ART) Coverage
Name of the indicator	Number of countries and territories that have 80% coverage of antiretroviral therapies (ART) in eligible populations[1].
Definition of the indicator	This indicator measures the coverage of access to ART. A coverage of 80% or higher among those eligible to receive treatment is internationally defined as universal access. Baseline 2013: 6 Target 2019: 22
Purpose of the indicator	The proposed indicator is meant to monitor access to ART, a key element in the prevention-treatment-care continuum that has a strong impact on public health outcomes, including a reduction of HIV-related morbidity and mortality, and prevention of transmission.
Technical note	Calculation at the country level: For country-level calculation, the numerator is the number of persons on antiretroviral therapy, and it is derived from reports provided by the ministries of health. The denominator is the estimate of the number of people in need of ART.[7] Country denominators are generated using standardized statistical modeling methods and tools, and are provided by UNAIDS. Calculation at the regional level: Having calculated the percentage of coverage at the country level, the regional indicator is obtained by counting the number of countries and territories with 80% coverage or higher. Multiple data sources are used, because not all countries are covered in the various reports. Country-level data collection is continuous, with country coverage being calculated at the end of the year.
Type of indicator	Absolute.
Measurement units	Number of countries and territories.
Frequency of measurement	Annual, measured at the end of the year.

[1] Until mid-2013, the eligibility criteria were persons living with HIV who had a CD4 count of 350 cells/mm3 or lower. Based on the new WHO guidelines, published in June 2013, the recommended threshold for initiation of ART has been raised to a CD4 count of 500 cells/mm3 or lower, meaning that the number of eligible persons (denominator) will increase.

PASB unit responsible for the indicator	Communicable Diseases and Health Analysis/HIV, Hepatitis, Tuberculosis, and Sexually Transmitted Infections (CHA/HT).
Data source	UNAIDS and WHO, and the country Universal Access reports and in Global AIDS Response Progress Reporting.
Limitations	There are some uncertainties regarding the accuracy of the statistical modeling when applied to smaller countries with concentrated epidemics. It is very difficult to arrive at reliable estimates for denominators in very small populations. UNAIDS is also not generating denominators for all countries, including small-island states. The recommended change in eligibility criteria from a CD4 threshold of 350 cells/mm3 to 500 cells/mm3 will increase the estimated number of eligible persons (denominator), resulting in an apparent drop in coverage. The impact of this change will need to be factored into the monitoring of this indicator. This indicator measures the overall coverage of antiretroviral treatment, but does not measure inequities in coverage, particularly related to key populations such as MSM, sex workers, and transgender persons. Local issues, such as undocumented immigrants, will also influence the accuracy of the indicator. It is critical to continue monitoring the access of these key populations to treatment, as well as the quality of care they receive.
References	Pan American Health Organization. HIV Continuum of Care Monitoring Framework, 2014, Addendum to meeting report: Regional consultation on HIV epidemiologic information in Latin America and the Caribbean. Washington, DC: PAHO; April 2014. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=25746&Itemid.

Output indicator

Code and Output	OPT 1.1.1. Implementation and monitoring of the regional HIV/STI plan through technical cooperation at the regional and national levels.
Name of the indicator	Number of countries and territories implementing the national HIV/STI strategies in accordance with the WHO global regional health sector strategy on HIV/AIDS 2011-2015 and the regional HIV/STI plan for the health sector 2006-2015.
Definition of the indicator	This indicator monitors how many countries have developed or updated their national HIV/STI plan or strategy in line with regional and global priorities and programmatic guidance.
Purpose of the indicator	This indicator measures the level of uptake of global and regional guidance for an effective HIV/STI health sector response.

Technical note	A country will be considered to have achieved the indicator, if it fulfills the following requirements: a) It has developed or updated a national health sector HIV strategy/plan or multisectoral HIV strategic plan after the mid-term evaluation of the Regional HIV/STI Plan for the Health Sector in 2012; and b) The HIV/STI national strategy or plan addresses at least three of the following key points: i. Treatment optimization ii. Elimination of mother-to-child transmission of HIV and congenital syphilis iii. Prevention and care for key populations iv. Strengthening strategic information v. Health systems strengthening, integration, and decentralization Countries will be asked to report on this indicator, followed by desk review of the recently developed or updated national HIV strategic plans and strategies.
Type of indicator	Absolute.
Measurement units	Number of countries and territories.
Frequency of measurement	Annual.
PASB unit responsible for the indicator	Communicable Diseases and Health Analysis/HIV, Hepatitis, Tuberculosis, and Sexually Transmitted Infections (CHA/HT).
Data source	Direct reporting from countries to the regional level. The development or updating of national strategies is monitored by the PAHO/WHO country offices and the subregional HIV/STI focal points; the contents will be validated by the Regional Office.
Limitations	This indicator measures the inclusion of priorities in the national plans or strategies, but will not capture the actual implementation and the level of resources allocated to these priorities.
References	Pending.

Annex C

Indicators Not Achieved

Outcome Indicators

Outcome Indicator	Baseline 2013	Target 2019	Achieved by end of 2015	Comments (progress to date and reasons for non-achievement)
1.2.3 Percentage of new TB patients diagnosed in relation to the total number of TB incident cases	79%	90%	77%	Despite noted progress in countries, this represents a slight decline. One possible explanation is related to how WHO updates estimates of the TB burden in the Region. In the first semester of 2016, the Regional TB program has planned a meeting to review these estimates.
1.5.1 Regional average coverage with three doses of the diphtheria, tetanus, and pertussis (DPT)-containing vaccine	92%	94%	90%	Some Member States have not shown the expected progress or have reported decreases in coverage for various reasons, including operational and financial challenges, thereby significantly affecting the average coverage of the Region. This calls to attention the situation of one country that reported a decrease in their coverage of vaccination of more than 15% between 2014 and 2015 compared to 2013 due to a change in their immunization registry systems. While such changes were considered as a good practice by the Strategic Advisory Group of Experts in Immunization in the evaluation of the Global Vaccination Action Plan, it significantly impacted the regional immunization coverage average.
2.1.1b - Prevalence of alcohol-use disorders among adolescents and adults, as appropriate within the national context	6.0% for ICD 10 codes (2.6% for harmful use and 3.4% for alcohol dependence) in 2010	5% reduction	Not available	This indicator was originally assessed with data from 2010, and the baseline data provided are the estimates from WHO published in 2014. No other estimation has been carried out by WHO to assess progress or project 2019 figures. This target is unlikely to be achieved, given estimated trends showing an increase in consumption and heavy consumption among women and the limited reach of health services.

2.1.1c - Age-standardized prevalence of heavy episodic drinking (HED)	13.7%	5% reduction	Not available	This indicator was first assessed with data from 2010, and the baseline data provided are the estimates from WHO as published in 2014. No other estimation has been carried out by WHO to assess progress or project 2019 figures. Given estimated trends showing an increase in heavy episodic drinking in adolescents and adults, this target is unlikely to be achieved if no policy changes are implemented.
3.5.3 Number of countries and territories in which the proportion of population relying on solid fuels is reduced by 5%	14	20	5	Although some countries show decreasing trends in solid fuel use (SFU), including Honduras (−1%), Peru (−2%), and Paraguay (−7%), overall progress was insufficient to what was expected. Countries that increased their SFU are Guatemala (+7%), Mexico (+1%), and Haiti (+1%). All countries in progress are likely to achieve the 2019 target; however, Guatemala and Haiti face challenges and will require high commitment to scale up national programs to achieve the target. Among the baseline countries, all sustained decreasing trends in SFU. Additionally, Colombia had no change, at 14% SFU; Dominican Republic had an increase of +2%; and El Salvador decreased from 22% to 19% but remains at significant risk. Finally, there are challenges with data collection and measuring.
4.1.2 - Number of countries and territories with public expenditure in health of at least 6% of gross domestic product (GDP)	6	20	5	Even though several countries in the Region developed strategies to increase public health expenditure, it is important to note that more time is necessary to see increases in public health expenditure and that it is too early in the six-year period of the Strategic Plan to assess progress. Countries in the baseline should continue working to protect the gains made in advancing toward universal access to health and universal health coverage. This indicator would benefit from further and continuous work on the institutionalization of the production of health accounts to ensure proper resource and expenditure tracking.

Annex D: Summary of indicators with proposed changes for 2016-2017

(Additions in *italics*, removed text in ~~strike-through~~. Changes will be introduced in the Strategic Plan Monitoring System (SPMS) and will be used for the final assessment of the Program and Budget 2016-2017.)

Output number	Original text in Program and Budget 2016-2017, approved by Directing Council in September 2015	Proposed text validated by the PASB in the end-of-biennium 2014-2015 assessment, May 2016
2.1.2e[1]	**Indicator:** Number of countries implementing policies, strategies, or laws in line with the Framework Convention on Tobacco Control **Definition of the indicator:** Number of countries which have implemented at least three out of the four core measures in tobacco control at its highest level of achievement at the national level **Baseline 2015:** 8 **Target 2017:** 12	**Indicator:** Number of countries implementing policies, strategies, or laws in line with the WHO Framework Convention on Tobacco Control (FCTC) **Definition of the indicator:** Number of countries which have implemented at least three out of the four core measures in tobacco control *included as "best buys" for NCD prevention and control* at its highest level of achievement at the national level **Baseline 2015:** ~~8~~ *4* **Target 2017:** ~~12~~ *7*
2.1.5[2]	**Indicator:** Number of countries and territories with high-quality dialysis and a transplantation registry for chronic kidney disease cases	**Indicator:** Number of countries and territories with *a registry* for high-quality dialysis and ~~a~~ transplantation ~~registry~~ for chronic kidney disease cases
2.3.3	**Output title:** Countries enabled to develop and implement a national protocol for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines	**Output title:** ~~Countries enabled to develop and implement a national protocol for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines~~ *Development and implementation of policies and programs to address violence against*

[1] NB: In the Program and Budget 2014-2015, the code for this output was 2.1.6. In 2016-2017 it has been changed to 2.1.2e.

[2] NB: In the Program and Budget 2014-2015, the code for this output was 2.1.7. In 2016-2017 it has been changed to 2.1.5.

	Indicator: Number of countries and territories that create or adjust national standard operating procedures/protocols/guidelines for the health system response to intimate partner and sexual violence, consistent with WHO's guidelines	*women and children facilitated.* **Indicator:** Number of countries and territories that create or adjust national standard operating procedures / protocols / guidelines for the health system response to intimate partner and sexual violence, consistent with WHO's guidelines

Annex E: Abbreviations

Abbreviation	Description
AIDS	acquired immunodeficiency syndrome
AMEXCID	Mexican Agency for International Development Cooperation
AMR	antimicrobial resistance
AMRO	WHO Regional Office for the Americas
APC	alcohol per capita
ART	antiretroviral therapy
ARV	Antiretroviral
BFHI	Baby-Friendly Hospital Initiative
BIREME	Latin American and Caribbean Center on Health Sciences Information
BMD	Brazil *Mais Médicos*
BPG	benzathine penicillin G
BWP	Biennial Work Plan
CAM	Central America subregion
CARICOM	Caribbean Community
CCHD	Cooperation among Countries for Health Development
CCS	Country Cooperation Strategy
CCTs	cross-cutting themes
CDC	Centers for Disease Control and Prevention (United States)
CKD	chronic kidney disease
COHSOD	Council for Human and Social Development
COP21	2015 UN Climate Change Conference
COPAIA	Pan American Commission on Food Safety
COSALFA	South American Commission for the Fight Against Foot-and-Mouth Disease
CPAN	PASB Category and Program Area Network
DRR	disaster risk reduction
DTP	diphtheria, tetanus, and pertussis
EC	European Commission
EMTCT	elimination of mother-to-child transmission (of HIV)
ERF	Emergency Response Framework
ERM	Enterprise Risk Management
EVD	Ebola virus disease
EXM	PASB Executive Management
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Administration (United States)
FIOCRUZ	Oswaldo Cruz Foundation
FMD	foot-and-mouth disease
GDP	gross domestic product
GSO	General Services Operations
HiAP	Health in All Policies
HIV	human immunodeficiency virus
HPV	human papilloma virus
HQ	Headquarters
HR	human resources
HRH	human resources for health

Abbreviation	Description
HSI	Hospital Safety Index
ICD	International Classification of Diseases
IDB	Inter-American Development Bank
IES	Office of Internal Oversight and Evaluation Services
IHR	International Health Regulations
IHSDN	integrated health service delivery network
IMF	International Monetary Fund
IMS-Dengue	Integrated Management Strategy for Dengue Prevention and Control
INFOSAN	International Food Safety Authorities Network
IRED	Institutional Response to Emergencies and Disasters
iPIER	Improving Programme Implementation through Embedded Research
IPV	inactivated polio vaccine
IT	information technology
KPI	Key Performance Indicator
MDGs	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
MERCOSUR	Southern Common Market
MoH	Ministry of Health
MOU	memorandum of understanding
MSM	men who have sex with men
MSPP	Ministry of Public Health and Population (Haiti)
MTCT	mother-to-child transmission (of HIV)
NCD	noncommunicable disease
ND	no data
NFP	National IHR Focal Point
NID	neglected infectious disease
NRAr	National Regulatory Authorities of Regional Reference
NVC	National Voluntary Contribution
OAS	Organization of American States
OCM	Outcome
OCR	Outbreak and Crisis Response
OIE	World Organisation for Animal Health
OPT	Output
OS	Other Sources
PAHO	Pan American Health Organization
PALTEX	Expanded Program on Textbooks and Instructional Materials
PANAFTOSA	Pan American Foot and Mouth Disease Center
PASB	Pan American Sanitary Bureau
PB	Program and Budget
PCV	pneumococcal conjugate vaccine
PEP	post-exposure prophylaxis
PHEFA	Hemispheric Program for the Eradication of Foot-and-Mouth Disease
PIP	Pandemic Influenza Preparedness
PMA	performance monitoring and assessment
PMIS	PASB Management Information System
PRAIS	PAHO Regional Platform on Access and Innovation for Health Technologies
PWR	PAHO/WHO Representative

Abbreviation	Description
RB	Regular Budget
RBM	results-based management
RedETSA	Regional Network of Health Technology Assessment for the Americas
REDIPRA	Meeting of Directors of National Programs for Rabies Control in Latin America
RELACSIS	Latin American and Caribbean Network for the Strengthening of Health Information Systems
REMSAA	Ministers of Health of the Andean Area
RWP	Respectful Workplace
SAM	South America subregion
SDG	Sustainable Development Goal
SENACSA	National Service for Animal Quality and Health (Paraguay)
SF	Strategic Fund
SFU	solid fuel use
SICA	Central American Integration System
SisLeish	Regional Information System of Leishmaniasis
SPAG	Strategic Plan Advisory Group
SPBA	Subcommittee on Program, Budget, and Administration
SPMS	Strategic Plan Monitoring System
STI	sexually transmitted infection
TAG	Technical Advisory Group
TB	tuberculosis
UHC	universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASUR	Council of Ministers of Health of the Union of South American Nations
UNEP	United Nations Environment Programme
USAID	United States Agency for International Development
VC	Voluntary Contribution
VHL	Virtual Health Library
VPD	vaccine-preventable disease
WHO	World Health Organization
WSP	water safety program

Annex F: List of Countries and Territories with their Acronyms

	Country	Acronym
	Member States	**35**
1	Antigua and Barbuda	ATG
2	Argentina	ARG
3	Bahamas	BHS
4	Barbados	BRB
5	Belize	BLZ
6	Bolivia	BOL
7	Brazil	BRA
8	Canada	CAN
9	Chile	CHL
10	Colombia	COL
11	Costa Rica	CRI
12	Cuba	CUB
13	Dominica	DMA
14	Dominican Republic	DOM
15	Ecuador	ECU
16	El Salvador	SLV
17	Grenada	GRD
18	Guatemala	GTM
19	Guyana	GUY
20	Haiti	HTI
21	Honduras	HND
22	Jamaica	JAM
23	Mexico	MEX
24	Nicaragua	NIC
25	Panama	PAN
26	Paraguay	PRY
27	Peru	PER
28	Saint Kitts and Nevis	KNA
29	Saint Lucia	LCA
30	Saint Vincent and the Grenadines	VCT
31	Suriname	SUR
32	Trinidad and Tobago	TTO
33	United States of America	USA
34	Uruguay	URY
35	Venezuela	VEN

	Country	Acronym
	Associate Members	**4**
36	Aruba	ABW
37	Curaçao	CUW
38	Puerto Rico	PRI
39	Sint Maarten	SXM
	Participant States	**3**
	France	**4**
40	French Guiana	GUF
41	French St. Martin	MAF
42	Guadeloupe	GLP
43	Martinique	MTQ
	Kingdom of the Netherlands	**3**
44	Bonaire	BON
45	Saba	SAB
46	Sint Eustatius	STA
	United Kingdom of Great Britain and Northern Ireland	**6**
47	Anguilla	AIA
48	Bermuda	BMU
49	British Virgin Islands	VGB
50	Cayman Islands	CYM
51	Montserrat	MSR
52	Turks and Caicos	TCA