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Strategic Plan

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PAHO STRATEGIC PLAN

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PAN AMERICAN HEALTH ORGANIZATION
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Foreword by the Director

As the Pan American Health Organization (PAHO) ushers in its 106th year of serving the peoples of the Region of the Americas, let us reflect on the achievements made and prepare for the challenges that lie ahead. For this purpose, it is with great pleasure that I present to you the second Strategic Plan for PAHO in the 21st Century. This Plan is an instrument to transform these challenges into opportunities and build on the accomplishments of the past, while we work as part of both the United Nations and the Inter-American Systems, to increase our value-added to our Member States.

For the first time in many years, the countries of the Americas have developed a long-term Health Agenda for the Americas, a collective call to action, and an instrument to "guide the collective action of national and international stakeholders who seek to improve the health of the peoples of this Region." This Strategic Plan is the Bureau's answer to that call.

The public health challenges faced in the Region are many—from ongoing concerns about existing communicable and non-communicable diseases, environmental hazards, natural and man-made disasters and other public health threats, to new and emerging threats from pathogens known and unknown. The continent is also experiencing an epidemiological transition, where traditional diseases have not completely disappeared, but coexist with emerging diseases and those related to living conditions, representing a new challenge for public health. Thus, while we have achieved many milestones in improving the health status of the people of the Americas, accomplishments of which we can be justly proud, much remains to be done. Among other priorities, we must continue to improve public health leadership, equitable access to health services, and the capacity of Member States to respond in a prompt and effective manner to new challenges. We must also remain vigilant to protect and maintain the gains of the past as we face the challenges of the future.

This document is necessarily complex, as it reflects the broad panorama of our work and lays out in detail how we plan to respond to each public health challenge that the Bureau can address. The document also reflects our efforts to make the Organization more effective and accountable in its operations by institutionalizing results-based management methodologies in the planning, implementation and evaluation processes.

While this Plan will guide us for the next several years, the strategic dialogue should not stop here. It is increasingly evident that the issues of public health can only be addressed effectively through multisectoral approaches and with strategic partnerships. Therefore, I encourage and welcome an ongoing dialogue with PAHO many stakeholders—from Member State governments to international and national partners, and civil society—about how we can best serve the people of the Americas.

The Strategic Plan 2008-2012 is a statement of our commitment to be accountable to our Governing Bodies and partners, and to work to improve the health of the people of the Americas.

Mirta Roses Periago
Director

Executive Summary

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

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

3. This planning cycle has been re-designed in a results-based management (RBM) framework to allow for the aggregation of results throughout the Organization, with unprecedented vertical integration among all levels of planning. The common results and indicators set out at the global, regional, subregional and country levels will allow for simplified and more transparent planning, monitoring and reporting of the Bureau's work. This is a key element in the full implementation of results-based management.

4. The strategic direction of the Bureau is set out herein, based on the Health Agenda for the Americas 2008-2017 and on WHO Eleventh General Programme of Work 2006-2015. The Bureau seeks to maintain a balance between programmatic alignment with WHO and the regional specificity demanded by PAHO Member States, notably in the Health Agenda. The Bureau has adopted WHO six Core Functions, which will allow for analysis of expenditures from a new and managerially useful perspective.

5. The 16 Strategic Objectives, based on WHO, are the programmatic core of this Plan, and are meant as common objectives for PAHO Member States as well as the Bureau. Each Strategic Objective incorporates several Region-wide Expected Results (RERs) that the Bureau is accountable for achieving. The Strategic Objectives and RERs are based on the Region's known public health concerns—as analyzed in the Situation Analysis—but are sufficiently flexible to allow the Bureau to respond to emergent issues and threats as they arise.

6. The final section of the Plan lays out the Bureau's implementation strategy, programmatic prioritization, financing, and the means for performance monitoring and assessment, and independent evaluation.

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

   (a) Increase the Bureau's accountability to its Member States, as well as the transparency of its operations;
   (b) Further the implementation of results-based management by applying results based planning in a comprehensive, integrated fashion;
   (c) Maximize participation by Member States, partner organizations and PASB staff in the development of planning instruments;
   (d) Further align the Bureau's work with that of WHO;
   (e) Emphasize the country focus policy of the Organization; and
   (f) Integrate and simplify the planning process in order to reduce the planning, monitoring and reporting burden on the PASB's entities.

8. While innovation is essential, it is based on our vision, mission and values. These are included here as a reminder of the fundamental nature of the PASB as it moves forward.

Vision

The Pan American Sanitary Bureau will be the major catalyst for ensuring that all the peoples of the Americas enjoy optimal health and contribute to the well being of their families and communities.

Mission

To lead strategic collaborative efforts among Member States and other partners to promote equity in health, to combat disease, and to improve the quality of, and lengthen, the lives of the peoples of the Americas.

Values

Equity – Striving for fairness and justice by eliminating differences that are unnecessary and avoidable.

Excellence – Achieving the highest quality in what we do.

Solidarity – Promoting shared interests and responsibilities and enabling collective efforts to achieve common goals.

Respect – Embracing the dignity and diversity of individuals, groups and countries.

Integrity – Assuring transparent, ethical, and accountable performance.

A New Planning Process

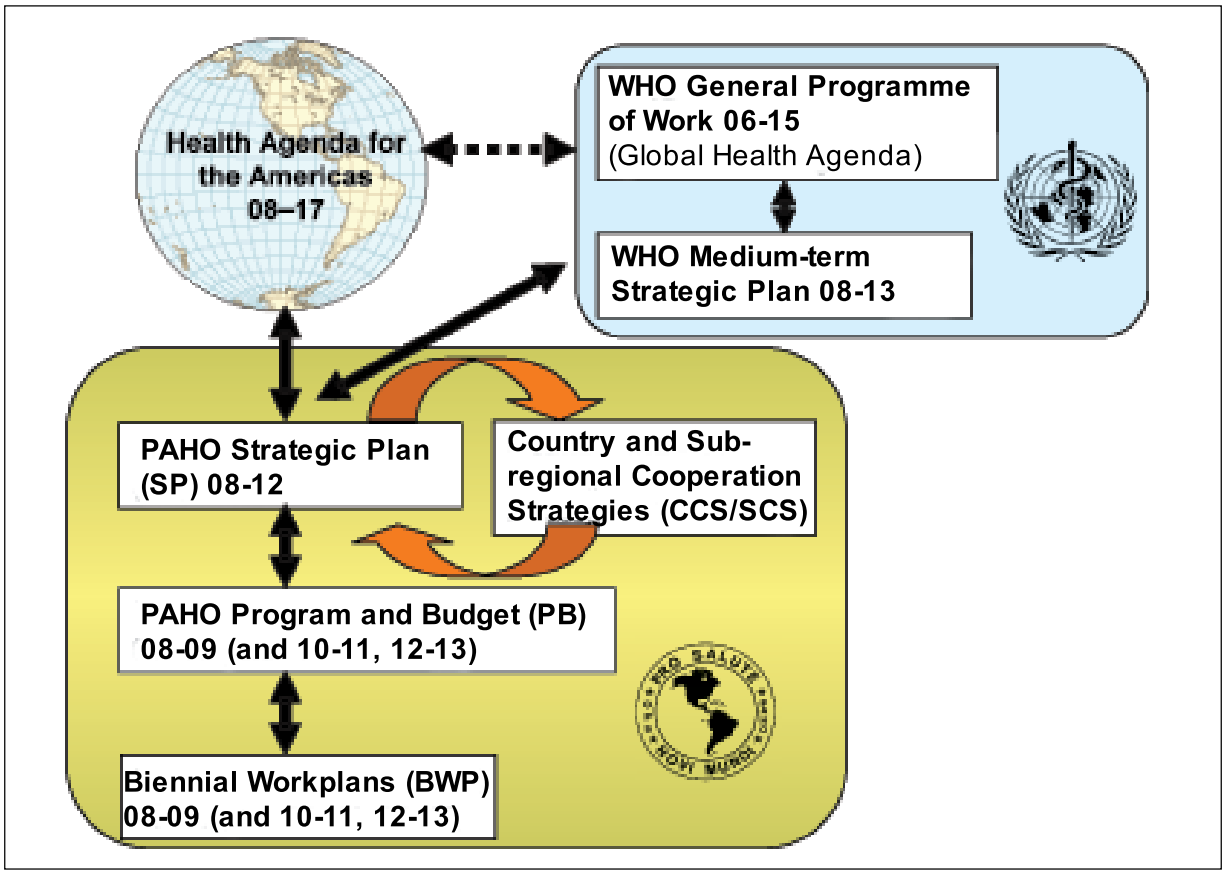
9. For the first time, the PAHO Strategic Plan contains Strategic Objectives that align directly with those of WHO. This Strategic Plan will cover three biennia and, for the first time, defines the Bureau's Region-wide Expected Results (RERs) and indicators. Future Program and Budget documents (2008-2009, 2010-2011, and 2012-2013) will define where resources will be expended in order to achieve the results defined in the Strategic Plan. These Program and Budget documents will be shortened and simplified, as their RERs and their justification will be identical to those in this Plan. Thus the need for extensive program planning every two years is greatly reduced. At the same time, end-of-biennium assessments of each Program and Budget will serve as progress reports on the implementation of the SP 08-12, since the RERs and their indicators in these documents will be identical. This concept is further elaborated in the section Performance Monitoring and Assessment, and Independent evaluation, (page 106).

10. While PAHO Governing Bodies do not review the Biennial Workplans of individual PASB entities, Member States may wish to note that operational planning at this level has also been reformulated to allow for its full integration with the Strategic Plan and Program and Budget through the use of common RERs and common indicators. The Biennial Workplans feed the Program and Budget; this process represents the "bottom-up" aspect of the planning process. Biennial Workplans are developed in concert with the Program and Budget 2008–2009, so that the latter can accurately reflect the work to be done at country level.

11. Vertical integration of all levels of the planning process is a crucial step in full implementation of results-based management, where expected results indicators from all entities—country offices, centers, and regional headquarters—aggregate to Region-wide Expected Results indicators, which in turn aggregate to WHO Organization-wide Expected Results indicators at the global level.

12. The following diagram depicts the key elements in PAHO planning process for 2008 onward, and their alignment with the Health Agenda for the Americas 2008–2017 and WHO high-level planning instruments.

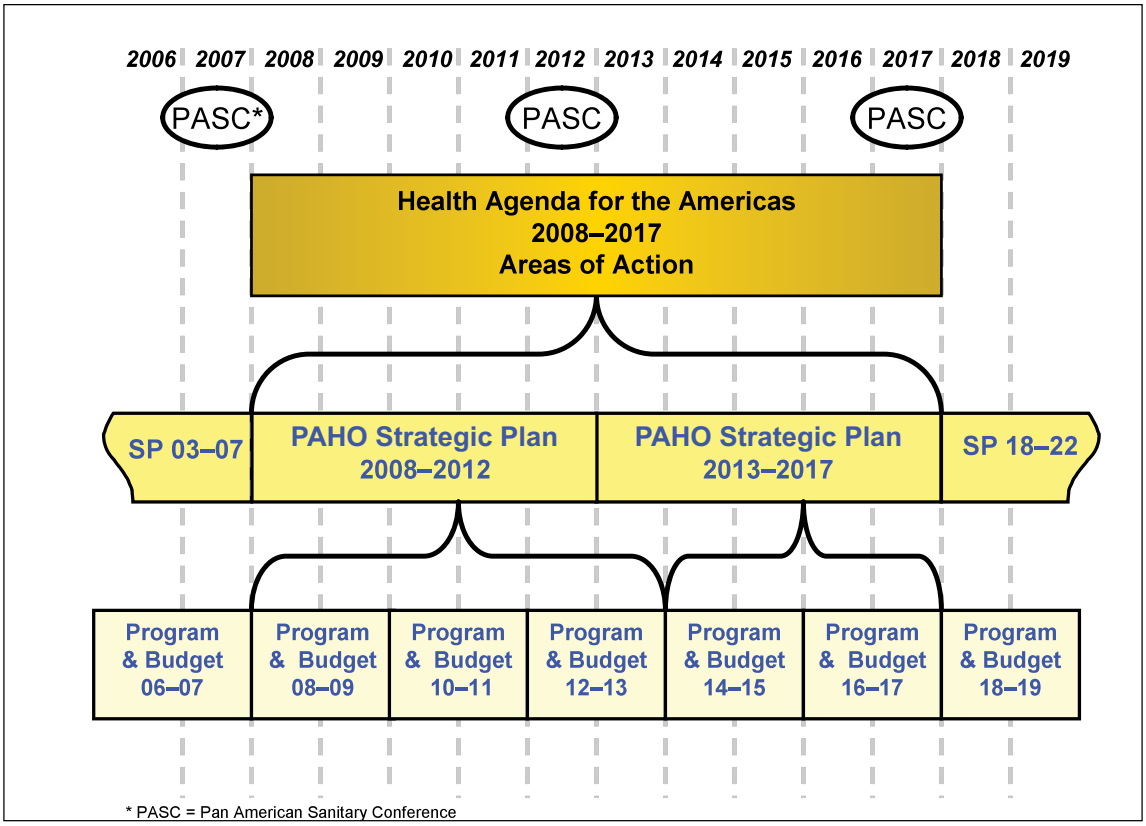
Diagram 1. PAHO Planning Instruments for 2008 Onward



Five Years, Three Biennia

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

Diagram 2. PAHO Planning Instruments – Timeline



14. Thus, the programmatic expected results contained in each Program and Budget are clearly linked to only one strategic plan, which is essential for coherent monitoring and reporting. Consequently, from a programmatic perspective the strategic plans will de facto cover alternating six- and four-year periods. This system also allows for programmatic alignment with WHO. Aggregated results will be reported through the Program and Budget assessments, to be completed every two years. This is depicted in Diagram 3 in the section on alignment with WHO, (page 14).

Economic and Social Trends

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

16. After years of stagnation, economic growth in the Region resumed: as of 2007, nearly one-third of the countries had growth rates in excess of 6%. The per capita gross national income (GNI)[1] in the Region (2004 data) is among the highest in the world. While the average income in Latin America and the Caribbean (LAC) is $7,811, in some of its subregions—notably the Latin Caribbean, the Andean Area, and Central America—the values are 20, 40, and 65% lower, respectively. The per capita GNI of the richest countries is up to 23 times that of the poorest countries. Economic crisis had a serious impact in 2002, especially in Argentina, Uruguay, and Venezuela, a situation that turned around in the majority of the countries by 2005. Notwithstanding economic growth, inequality in income distribution has increased. Income distribution in the Region (measured by the Gini coefficient) is one of the most unequal in the world and did not improve between 1990 (Gini of 0.383) and 2002 (Gini of 0.403). Inequalities drive poverty and are manifested in different segments of the population, such as households headed by women, certain ethnic groups, or rural populations. An estimated 41% of the population in LAC is poor and 17% is indigent.

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

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

19. Population growth has slowed, although it ranges from 0.4% in the English-speaking Caribbean to 2.1% in Central America. Unequal socioeconomic development drives people to move to urban areas in search of jobs and a better life. Thus, the urban proportion of the population in LAC grew from 65% to 78% between 1980 and 2005, with a lesser rate in Central America (53.2%) and the Spanish-speaking Caribbean and Haiti (59.7%). Urbanization poses challenges for health in terms of the availability of resources and basic services, clean water, waste and refuse management, transportation, and violence prevention. Rural areas suffer from the ongoing problems of poverty, limited resources, and lack of access to health services. Factors such as the chaotic growth of cities, indiscriminate industrial development, the rapid increase in the number of vehicles, and migration from rural to urban areas adversely impact the environment, health, and quality of life of the population, contributing to marginalization. This marginalization is characterized by makeshift housing, poverty, environmental pollution, and higher levels of disease and violence. Makeshift housing in urban areas in LAC increased by 14% between 1990 and 2001, affecting 127 million people. In response to this trend, efforts have been made to address health determinants by creating healthy and sustainable public policies, healthy spaces, and public-private partnerships; strengthening support networks; mobilizing the media; and encouraging action by local governments in health promotion and development.

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

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

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

Trends in Health Problems and Risk Factors

20. Thanks to improvements in living conditions, including education, access to water and sanitation and to primary maternal and child health care, average life expectancy in the countries of the Region increased to 74.6 years in 2005. Other important changes are related to environmental degradation and pollution, new lifestyles and behaviors, greater information dissemination, and the erosion of social and support structures in the population. These contribute to obesity, hypertension, increase in injuries—including road traffic injuries—and violence, problems related to smoking, alcoholism, drug abuse, and exposure to chemical substances.

21. The Region's morbidity and mortality profile is changing, with communicable diseases replaced by chronic diseases as their leading causes, a phenomenon attributable to advances in technology and the aging of the population. Communicable diseases are still a major cause of mortality, with 58 deaths per 100,000 population in 2000-2004,[4] and are a heavy burden in poorer countries: for example, in Haiti the incidence of tuberculosis (TB) is seven times that of the Region. Added to this are challenges such as TB/HIV co-infection and multi- and extreme resistance to TB drugs. In 2006, 50% of dengue cases occurred in Brazil,[5] while malaria is endemic in 21 countries. Neglected[6] diseases cause anemia, malnutrition, memory loss and lower IQ, stigma and discrimination, permanent disability, and premature death. Several of these diseases often go hand in hand, multiplying their impact on health and the social and economic conditions of individuals and populations. The threat posed by potentially epidemic and pandemic diseases, such as pandemic influenza is a challenge, since maintaining governments' commitment to address a problem that has not yet materialized is a complex undertaking.

22. Human rabies transmitted by dogs decreased by 95% in the last 25 years of active control programs; however, few actions have been implemented for other zoonoses. Eradication of foot-and-mouth disease is important for food security and socio-economic development, and the Region is moving toward this goal. Travel and trade allow the dissemination of infectious agents from their natural foci. Food safety is another public health and economic issue. Modernization of inspection services, strengthening of reference services, harmonization of legislation and Codex Alimentarius support, are occurring to address food safety issues.

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

24. The Region's population is aging, and older adults are demanding new services. At the same time, older adults manifest greater dependency on the economically active population. In 2006, over 50 million people in LAC were 60 years or older, a group growing 2.5 times faster than the overall population. Studies show that more than 50% of this elderly group report poor health, 20% report limitations in daily living activities, and 60% have a CD. Their access to health services is also limited and more than 30% report that their health needs are unmet. Nevertheless, few LAC countries have health promotion goals for older adults. Shifts in funding can result in large impacts, since cost-effective solutions exist, from promotion to prevention and disease management.

25. Smoking prevalence in the Americas varies by country, but exposure to second-hand smoke is both universal and high in most countries, implying a significant burden of mortality and morbidity for the Region. The WHO Framework Convention on Tobacco Control (FCTC) was developed to give countries an instrument to face the challenges that could not be solved solely through national legislation. It has been ratified by 60% of the Member States. There has been significant and relatively fast progress in recent years, notably in countries such as Brazil and Uruguay, and at the subnational level in the United States of America, Canada and Argentina. The future presents two clear challenges for the Region: on one hand, ratification of the FCTC by those Member States where it has not been ratified, and on the other hand, implementation of the measures contained in the Convention, especially the inclusion of strong health warnings on tobacco packages within three years of

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

entry into force of the Convention in that country, development of smoke free environment policies, and a comprehensive ban on advertisement, promotion and sponsorship of tobacco products.

26. In LAC, comprehensive and integrated actions are needed to achieve the health-related Millennium Development Goals (MDGs) by 2015, particularly among vulnerable groups. Where governments and social systems fail to reach, families and communities often perform strategic health functions, and are a source of support and protection for the health and well-being of citizens. Such local mechanisms need to be empowered, supported and strengthened.

27. In LAC, poor nutrition, the underlying cause in 42% to 57% of deaths among children under five years of age, exacerbates the impact of illnesses. Stunting and anemia are the most prevalent problems affecting growth and nutrition with 25% and 70% of infants and young children affected, respectively. At the same time, overweight and obesity in the general population affect approximately 140 million people. Limited access to enough food to meet energy requirements affects about 53 million people in the Region. Maternal nutrition, breastfeeding, complementary feeding practices, and infectious diseases are also critical to infant and young children's health and nutrition. Reduced access and consumption of micronutrient-rich foods are responsible for the high prevalence of anemia in women and children. In rural and poor urban areas, overweight and obese parents, often suffering from specific deficiencies such as Vitamin A, iron, calcium, folate, and zinc, are frequently found to have stunted and anemic children. A dominant dietary pattern of over-consumption of high-energy foods, commonly associated with low micronutrient intake and a downward trend in the consumption of fruit, vegetables and whole grains, is increasingly common. The consumption of foods that are rich in saturated fats, sugar and salt is also increasing, and is linked to lower prices of processed foods, new marketing strategies and changes in diet from traditional to processed foods.

28. In 2005, 450,000 children under the age of five died in LAC. One third of the countries had under-5 mortality rates of 30 per 1,000 live births; these countries accounted for 60% of deaths, with perinatal and infectious diseases accounting for more than 60% and 25% of them, respectively. Half of the mortality reduction between 1990 and 2000 is attributed to childhood immunization; thus, the use of new vaccines may expand gains, but vaccination coverage needs to be maintained. The lifetime maternal mortality risk of 1 in 160 translates into 22,000 annual deaths, 10% to 50% of them occurring among young women. Young women under the age of 20 are estimated to account for 18 out of every 100 births in the Region, with 34% being unplanned. Fertility rates among adolescents are greater than 100 per 1000 live births in Honduras, Nicaragua, Guatemala, El Salvador, and the Dominican Republic. Most maternal mortality results from preventable causes, but in some countries essential obstetric and neonatal services are of poor quality or not in place, or are under-used because of access barriers or a lack of skilled personnel. Notable urban-rural disparities exist: fewer rural women attend four or more antenatal consultations and large proportions do not have access to skilled birth care.

29. The HIV/AIDS epidemic remains a serious public health threat in the Americas. The most recent estimates on HIV show a slow increase in estimated cases from 2004 through 2006. At the end of 2006, it was estimated that 3,350,000 people were living with HIV in the Americas, 51% in Latin America, 42% in Canada and the United States, and 7% in the Caribbean. The Caribbean is the second most affected geographic area worldwide, with an estimated adult HIV prevalence of 1.2% and where HIV/AIDS is the leading cause of death among young adults. In this subregion, it is estimated that 1.6% of women and 0.7% of men between the ages of 15 and 24 are infected with HIV. North and Latin America present epidemics concentrated among the most vulnerable groups (e.g. men who have sex with men, sex workers, injecting drug users, ethnic minorities and migrants, among others) with estimated adult prevalence of 0.8 % and 0.5% respectively. In 2006 in LAC, 167,000 new HIV infections occurred and 84,000 people died of AIDS. Evidence suggests that around 80% of the transmission of HIV is through unprotected sex. Women are increasingly affected although men still account for a significant proportion of infections. Gender is a determinant factor for vulnerability, exposure to risk, and the ability to carry out health-seeking practices. Vulnerable and affected people face rejection, stigma and discrimination. The spread of sexually transmitted infections (STIs) increases the risk of HIV transmission. Each year it is estimated that there are 50 million new cases of STIs in the Region, but the true magnitude of the epidemic is difficult to measure due to deficient surveillance systems. Additionally, in LAC, 330,000 pregnant women are diagnosed with syphilis every year but are not treated adequately, resulting in 110,000 infants being born with congenital syphilis yearly.

30. Mental illness imposes a high burden on the countries of the Americas. In 2002 it accounted for an estimated 25% of the total disability-adjusted life years lost to all diseases, with unipolar depression being a significant component. Only a minority of people suffering from mental illness receive treatment, despite the impact of the problem. In 80% of the countries, the

majority of beds are located in psychiatric—rather than general—hospitals, and 25% of the countries have yet to provide community care. Nevertheless, mental health is on the countries' agendas; there are successful local and national experiences, user and family associations are emerging, and advocacy is growing. Cost-efficient interventions exist, which can allow for an adequate response using limited resources.

31. Road traffic crashes are responsible for over 130,000 deaths and 1,200,000 injuries each year in the Region. The leading causes are driving under the influence of alcohol, speeding, poor road and vehicle maintenance, and failure to use seat belts and helmets. The increasing use of motorcycles, not only for private transportation but also as a means of transporting goods and delivery, is also contributing to the increasing trends in mortality and injuries in many countries. Countries such as Chile, Costa Rica, Colombia and Cuba, have implemented policies that have reduced mortality from road traffic crashes.

32. Violence remains a critical problem for populations in some countries of the Region, notwithstanding the interest of governments and society to deal with it; laws, when enacted, are not always enforced. Measuring and assessing the impact of legislation is a challenge. Homicides increased in several countries, with men under 35 years of age being the most affected group; in Colombia, however, homicides decreased by 40% between 2001 and 2006. The percentage of women suffering violence from their partners during their lifetime ranges from 10% to 60% across countries. Juvenile gang violence spread in the Region, especially in El Salvador, Honduras, Guatemala, Jamaica, Brazil, Colombia, Mexico and the United States. Urban violence is endemic in Latin America and the Caribbean, and impacts diverse sectors. Health is critically affected by insecurity. The incorporation of human security in the planning and implementation of projects has had an added value for the success of violence prevention, road safety and health promotion interventions. There is a need to increase human security as part of public policies aimed at reducing violence and crime and at improving road safety and human health.

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

34. In 2004, the economically active population was estimated at 414 million workers, or 46% of the Region's population. According to WHO (2005), 60% of workers are exposed to hazardous and unhealthy working conditions that entail a variety of risks that impact health. It is estimated that accidents in the workplace, which account for 8% of global accidents, result in 312,000 deaths and 10 million disability-adjusted years of life lost. Activities such as agriculture, construction, and mining are the most dangerous. Informal employment is associated with greater occupational risk and unstable working conditions with no legal protection (especially at the national level), worker's compensation, or health benefits. Women, children, and older adults are the least protected groups working in this informal sector.

35. The epidemiological profile of the majority of the approximately 45 million indigenous peoples in the Region is strongly shaped by the effects of socioeconomic and environmental determinants such as poverty, unemployment, illiteracy, migration, marginalization, discrimination, inequalities, lack of ownership of their territories and lands, destruction of the ecosystem, and geographical isolation. This disadvantageous situation also affects their capacity to access and utilize needed health care services, which results in health indicators worse than the national average. For example, maternal and infant mortality rates are 2 to 3 times higher than the national averages, and diseases such as trachoma, onchocerchiasis, Chagas disease and plague, which have been controlled for other population groups, are still present in areas populated by indigenous peoples.

Trends in the Health System Response

36. Overall, an estimated 20% to 25% of the population in LAC (200 million people) do not have regular and timely access to the health system.

37. The architecture of health systems in the Region, with their un-integrated arrangement of subsystems serving different population groups and strata, has led to segregation, segmentation and fragmentation. The health service delivery networks created followed the pattern of the subsystems, with limited integration and communication among health units, and within and among subsystems at different levels. In many countries, service delivery tended to be concentrated in more affluent urban areas and among the salaried population, resulting in inefficient resource utilization and leaving the economically and socially marginalized population unprotected. Countries reformed their health systems to increase cost-effectiveness and achieve financing sustainability, giving the private sector an important role. These reforms were centered on financial and management changes, deregulation of the labor market, and decentralization, not always considering countries' geographic, social, demographic, and political structure, or the degree of institutional development in the health sector.

38. These reforms resulted in the creation of insurance and health service delivery markets that in some cases were not well-regulated, and in the proliferation of intermediaries in health service delivery, accentuating the fragmentation of health systems. Thus, multiple, uncoordinated and competing agents operate, often creating overlap and duplication of service delivery networks, without complementarity of services or continuity of care. This situation tends to hinder comprehensive care and in some cases resulted in low quality health services. Although the goal was to achieve greater pluralism, efficiency, and quality in health service delivery, in some cases the national health authority lost its steering capacity, health system operations were undermined, and public health issues were neglected. Segmentation in the financing of the health services accentuated segregation, with the emergence of benefits plans that differed in quality and quantity among population groups, depending on financial circumstances. This situation has contributed to increased out-of-pocket expenditures and catastrophic risks for the financial security of families.

39. Public health expenditure is a basic public policy instrument for improving health status, reducing inequalities in the population's access to health services, and protecting people from the adverse effects of disease. Public health expenditure as a percentage of GDP in LAC rose from 2.6% in the 1980s to 3.6% in 2005-2006, below the figures of 7.3% to 8.6%, respectively, in developed countries of the Organization for Economic Cooperation and Development (OECD). In 2005-2006 public health expenditure as a percentage of GDP in the LAC region ranged from 1.3% to 4.5%. In OECD countries with health systems that provide universal coverage it ranged from 7.5% to 10%. Part of the growth of public expenditure in health has been for insurance systems, but with modest gains in coverage. Public expenditures in health through social health insurance schemes increased from $14.7 billion in 1990 to $27.7 billion in 2004-2005 (in constant year 2000 dollars). Average expenditure per (potential) beneficiary of social health insurance programs increased from $129 in 1990 to $209 in 2004-2005 (in constant year 2000 dollars). The total population covered under social health insurance schemes increased from 114.7 million people in 1990 to 132.7 million in 2004-2005; however, as a percentage of the total population, this entailed a decline from 26% in 1990 to 24% in 2004-2005. Critical measures for improving health status and reducing inequalities in access to health services include: greater public expenditure on health, including public health and health care; improvements in the distributive impact of that expenditure; and expansion of the coverage of public health insurance and social protection programs.

40. Health systems are based on the availability and competency of personnel who offer accessible, quality services. Numerous studies and WHO World Health Report 2006 indicate the need for an optimal number and high quality of health workers to meet public health targets. In the year 2000, WHO estimates the total health workforce in the Americas—defined as all people engaged in actions whose primary intent is to enhance health—at 21.7 million people, approximately 2.6% of the total population of the Region. Of these, 57% (12.5 million) are classified as health services providers, directly involved in the delivery of personal and non-personal services, while 43% (9.2 million) are health management and support workers. In the year 2000, there were 1,771,200 physicians and 3,426,000 nurses in the Region; the United States had 68% (over 3.5 million) of the total number of physicians and nurses. Great differences exist in the distribution of health care providers between countries, as well as within countries, in proportion to population. The range of physician-population ratios was 59.6 per 10,000 in Cuba, while seven countries of the Region recorded ratios of 5 per 10,000 or less. With respect to nurses, in 2000 North America recorded a ratio of 95 nurses per 10,000 population, more than double the figure for the Americas

as a whole. Physician supply in urban areas is eight to ten times higher than it is in rural areas. Women constitute almost 70 percent of the health workforce and represent a disproportionately high percentage of unemployed health workers in a sample of two-thirds of the countries in the Region. Over 163 million people in the Americas resided in areas where the human resources density (doctors and nurses per 10,000 population) was below the optimal target level of 25, identified by WHO as a threshold to ensure 80% coverage of basic public health interventions. No information is currently available on the public health workforce regionally, or on administrative and support staff.

41. Access to health services continues to be an important challenge for all Member States. Profound inequities in access exist among and within the different countries of the Region. It is estimated that 125 million people in Latin America and the Caribbean do not have access to basic health services (about 27% of the population). Cultural, social, economic, organizational, and geographical barriers impede access to health services by a large proportion of the population.

42. There are also inequalities in access to essential health technologies and services in the Region. Many countries have inadequate or deteriorating physical infrastructures, lack of adequate specifications for purchasing new technologies, inappropriate organization of health services and insufficient qualified health personnel. As a result, there are many areas with nonfunctioning technologies, under-used services, minimally trained staff, insufficient prevention policies, ineffective diagnostic and therapeutic protocols, and unsafe conditions for patients. For many technologies, it is critical to ensure that their incorporation and use be undertaken with supervision by regulatory authorities, guided by national legislation. National policies are needed to cover all aspects of health technologies and services, but will be successful only if supported by regulatory mechanisms. While the advantages of health technologies and services are many, they can represent an unnecessary cost if the quality and management of services provided are unacceptable. For health care to have the greatest impact, particularly where resources are limited, priority should be given to the selection, establishment and procurement of essential health technologies and services. Control of health problems and achievement of health-related MDGs will depend on the correct use of technologies and services.

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

Integration of Strategic and Operational Planning

44. In an era when results-based management is mainstreamed and accountability for achievements is the norm, all planning efforts in the Organization must speak to each other. The Mid-term Assessment of the 2003-2007 Strategic Plan (CD46/8) highlighted this issue for the Bureau, in that the planned results of the Biennial Workplans did not aggregate to the respective Program and Budget documents, which in turn did not aggregate to the objectives set out in the 03–07 Strategic Plan. The new 08-12 Plan rectifies this, enabling true results based planning for the Bureau from the strategic to the operational contexts. This will not only facilitate monitoring and reporting, but will also increase accountability and transparency.

A Complete and Comprehensive Plan

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

Strategic Alliances and Partnerships

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

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

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

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

Key Countries and Vulnerable Groups

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

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

- The Highly Indebted Poor Countries (HIPC): Bolivia, Guyana, Honduras, and Nicaragua;
- Haiti, while not an HIPC, has maternal and infant mortality rates—two of the most sensitive health development indicators—that are the highest in the Region and among the highest in the world.

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

Resource Estimation

53. Previous strategic plans did not attempt to assign resource estimates or "envelopes" to strategic priorities, avoiding the very real issue of which activities should receive more or fewer resources. In order to ensure that the SP 08-12 sets out realistic and achievable Strategic Objectives and supports them with resources, it includes an analysis of funding sources and levels needed to meet expected results. The resource levels included allow Member States to quickly see the relative cost of different Strategic Objectives, and will also directly inform the Program and Budget for each period.

54. The Strategic Plan 2008-2012 is aligned with WHO's General Programme of Work (GPW) and Medium-term Strategic Plan (MTSP). Alignment with WHO has been carried out gradually over past planning cycles; with this SP 08-12, the process of programmatic integration is complete.

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

56. Therefore, this Strategic Plan addresses both of these roles simultaneously, responding to the global GPW (via the MTSP), and the regional Health Agenda for the Americas. Both of these documents determine the strategic direction of the Pan American Health Organization and its Bureau.

57. In addition, the PASB responds through this Strategic Plan to the mandates of its Governing Bodies and other important international fora, including the Millennium Summit, where the Millennium Declaration was made.

The Health Agenda for the Americas 2008-2017

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

    (a) Strengthening the National Health Authority;
    (b) Tackling Health Determinants;
    (c) Increasing Social Protection and Access to Quality Health Services;
    (d) Diminishing Health Inequalities among Countries, and Inequities within Them;
    (e) Reducing the Risk and Burden of Disease;
    (f) Strengthening the Management and Development of Health Workers;
    (g) Harnessing Knowledge, Science, and Technology;
    (h) Strengthening Health Security.

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

Table 1. Contribution of PAHO Strategic Objectives to the Areas of Action of the Health Agenda for the Americas

PAHO Strategic Objectives	Health Agenda Areas of Action							
	a) Strengthening the National Health Authority	b) Tackling Health Determinants	c) Increasing Social Protection and Access to Quality Health Services	d) Diminishing Health Inequalities among Countries, and Inequities within them	e) Reducing the Risk and Burden of Disease	f) Strengthening the Management and Development of Health Workers	g) Harnessing Knowledge, Science, and Technology	h) Strengthening Health Security
1. To reduce the health, social and economic burden of communicable diseases	X			X	X		X	X
2. To combat HIV/AIDS, tuberculosis and malaria	X			X	X	X	X	X
3. To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries	X	X	X		X	X		X
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals	X		X	X		X	X	X
5. To reduce the health consequences of emergencies, disasters, crisis and conflicts, and minimize their social and economic impact	X		X		X	X		X
6. To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions		X			X			X
7. To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches		X		X	X			
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	X	X		X	X	X		X
9. To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development	X				X	X		X
10. To improve the organization, management and delivery of health services	X		X	X		X		X
11. To strengthen leadership, governance and the evidence base of health systems	X			X		X	X	X
12. To ensure improved access, quality and use of medical products and technologies	X			X		X	X	X
13. To ensure an available, competent, responsive and productive health workforce to improve health outcomes	X		X	X		X		X
14. To extend social protection through fair, adequate and sustainable financing	X		X	X		X		X
15. To provide leadership, strengthen governance and foster partnership and collaboration with Member States, the United Nations system and other stakeholders to fulfill the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO Eleventh General Programme of Work, and the Health Agenda for the Americas	**Contributes to all**							
16. To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	**Supports all**							

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

WHO Eleventh General Programme of Work 2006-2015

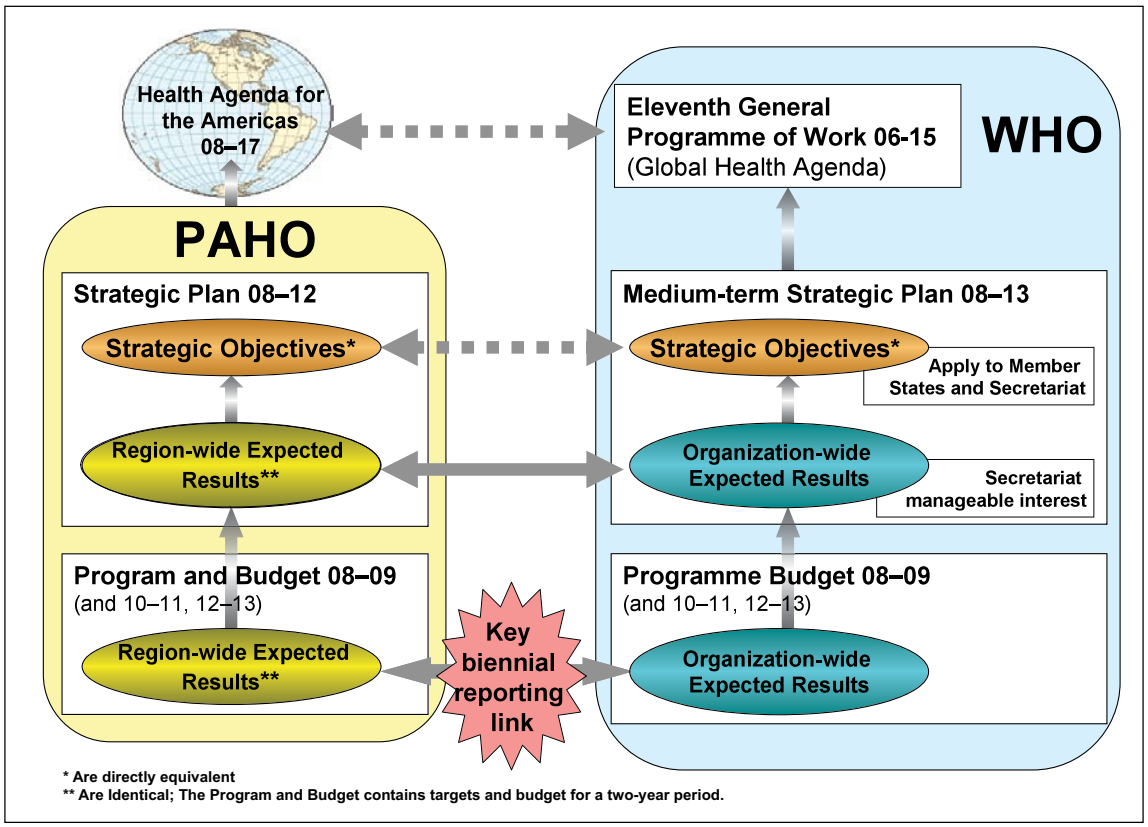
61. As noted, the Bureau seeks to harmonize the programs and objectives of the PASB and the WHO Secretariat, while at the same time maintaining the regional specificity that addresses PAHO Member States' concerns and priorities, summarized in the Health Agenda for the Americas.

62. At the time of its development, this Strategic Plan directly adopted the 16 Strategic Objectives (SOs) that were included WHO MTSP until January 2007. Subsequently, based on input from WHO Member States during the January 2007 Executive Board meeting, WHO combined SOs 10, 11, 13 and 14 into one SO. Based on consultation with Member States at the March 2007 meeting of the Subcommittee on Program, Budget and Administration (SPBA), and internal discussion, the PAHO has decided to continue with the original 16 SOs. A crosswalk approach will be used for reporting on the four SOs combined by WHO. The PAHO contribution to WHO Organization-wide Expected Results (OWERs) is explicit in the Region-wide Expected Results (RERs). This is the first time that RERs have been developed with indicators that aggregate directly to the global level.

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

64. The relationship between the planning mechanisms of PAHO and WHO is graphically represented in the following diagram.

Diagram 3. Relationship between PAHO and WHO Strategic Planning



The Millennium Development Goals

65. In September 2000, the United Nations Millennium Declaration committed countries to a global partnership to reduce poverty and improve health and education, along with promoting peace, human rights, gender equality, and environmental sustainability. Attainment of the Millennium Development Goals (MDGs) in the Americas remains a key priority for the Pan American Health Organization. The Organization's vision on the MDGs was approved by member countries during the 45th Session of the Directing Council in September 2004 (see CD45/8), and led to an official resolution (CD45/R3) calling for countries and the PASB to use the MDGs as a guide for national and international efforts towards better health for the peoples of the Region.

66. Achieving the MDGs in LAC is a complex undertaking as conditions vary not only among countries but also within countries. Even when countries on average appear to be on track to achieve some or all of the MDGs, a closer look at the sub-national level reveals that great inequities remain. In some countries, minorities and vulnerable groups lag behind favorable national averages where most MDGs will or have been met, while in others, it is likely that they will achieve only one or two MDGs. Thus, achieving the MDGs in LAC requires more than merely focusing on poor countries, focusing efforts on peoples living in poverty, as 90% of the poor live in middle income countries. At the same time subregions such as the English-speaking Caribbean have already achieved or are very close to achieving most of the MDGs—with the exception of target 7—and therefore require an MDG plus framework (non-communicable diseases and violence) that addresses their burden of disease specifically. A common thread is the need for a synergistic approach that addresses the determinants of health through inter-sector and inter-agency collaboration and the inclusion of individuals, civil society and grass roots as producers of health.

67. Six of the eight Millennium Declaration's goals, seven of its 16 targets and 18 of its 48 indicators relate directly to health. Health is also an important contributor to several other goals. The significance of the MDGs lies in the linkages between them: they are a mutually reinforcing framework to improve overall human development. These have been adopted by the PASB due to their value as a time-specific set of goals with the highest level of political support worldwide to advance human development from the perspective of health:

- **Goal 1: Eradicate extreme poverty and hunger**
  - Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger
- **Goal 4: Reduce child mortality**
  - Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
- **Goal 5: Improve maternal health**
  - Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
- **Goal 6: Combat HIV/AIDS, malaria and other diseases**
  - Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS
  - Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
- **Goal 7: Ensure environmental sustainability**
  - Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
- **Goal 8: Develop a global partnership for development**
  - Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Strategic Framework for Cooperation

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

69. Each country gives these three components a different weight, according to its health needs. Joint, synergistic and synchronized action by the Member States, orchestrated and enhanced by the PASB is needed to reach the Region's common goals.

70. **To complete the unfinished agenda**, the Organization will focus on:

(a) Reducing high and unjustifiable maternal, infant, and child mortality rates;
(b) Reducing the unacceptable health indicators of the poorest sectors of society, and among these, indigenous peoples and Afro-descendants;
(c) Tackling the persistence of preventable or curable diseases that we refer to as "neglected," among them filariasis, trachoma, parasite infections, plague, Chagas disease, brucellosis, and yellow fever;
(d) Reducing malnutrition and food insecurity in the Hemisphere's poorest communities;
(e) Extending coverage in water and sanitation.

71. **To protect the achievements** in health in the Region, the Organization will emphasize:

(a) Expansion of vaccination coverage;
(b) Improved local health development and governance;
(c) Improved border health and subregional integration on health concerns;
(d) Enhanced primary health care;
(e) Sound public policies designed to improve people's quality of life.

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

(a) The spread of HIV/AIDS;
(b) Increasing violence;
(c) The control of diseases with pandemic potential, such as severe acute respiratory syndrome (SARS), and influenza viruses including pandemic (H1N1) 2009;
(d) The smoking epidemic (notably among women and youth);
(e) The epidemic rise of non-communicable diseases;
(f) Disasters as they occur.

73. Each action listed above is integrated into the Region-wide Expected Results of the PAHO, and resources have been allocated according to its priority.

Core Functions

74. The PAHO has adopted WHO core functions as its own, with minimal modifications, for example substitution of the term "technical support" of WHO for "technical cooperation". Technical cooperation implies joint, agreed action between the PASB and Member States for health development. The core functions were included in the Eleventh General Programme of Work, with their origin in WHO Constitution. They clarify the Organization's role in responding to the global health agenda laid out in the 11th GPW, building on WHO mandate and an analysis of its comparative advantage.

75. The main reasons for including the core functions in the PAHO Strategic Plan, and for monitoring their implementation, are as follows:

(a) To assess whether the PASB is expending its resources to perform the functions its Member States deem to be priorities. This may include a discussion of the allocation of resources for "normative work" versus "technical cooperation", keeping in mind that the two are complementary.
(b) To analyze and strengthen the functional role the PASB takes in its engagement with Member States and with other partners, including UN agencies. Analysis of the implementation of core functions can determine differences among the three levels of the PASB (regional, subregional and country) and among countries.
(c) To contribute to the global effort to group products and services by core function and enable WHO-wide analysis of expenditures.

76. Therefore, beginning in 2008 the PASB will classify its expenditures by core function, monitoring these expenditures and reporting to Governing Bodies on a periodic basis. The PAHO/WHO core functions are as follows:

i. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;

ii. Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;

iii. Setting norms and standards, and promoting and monitoring their implementation;

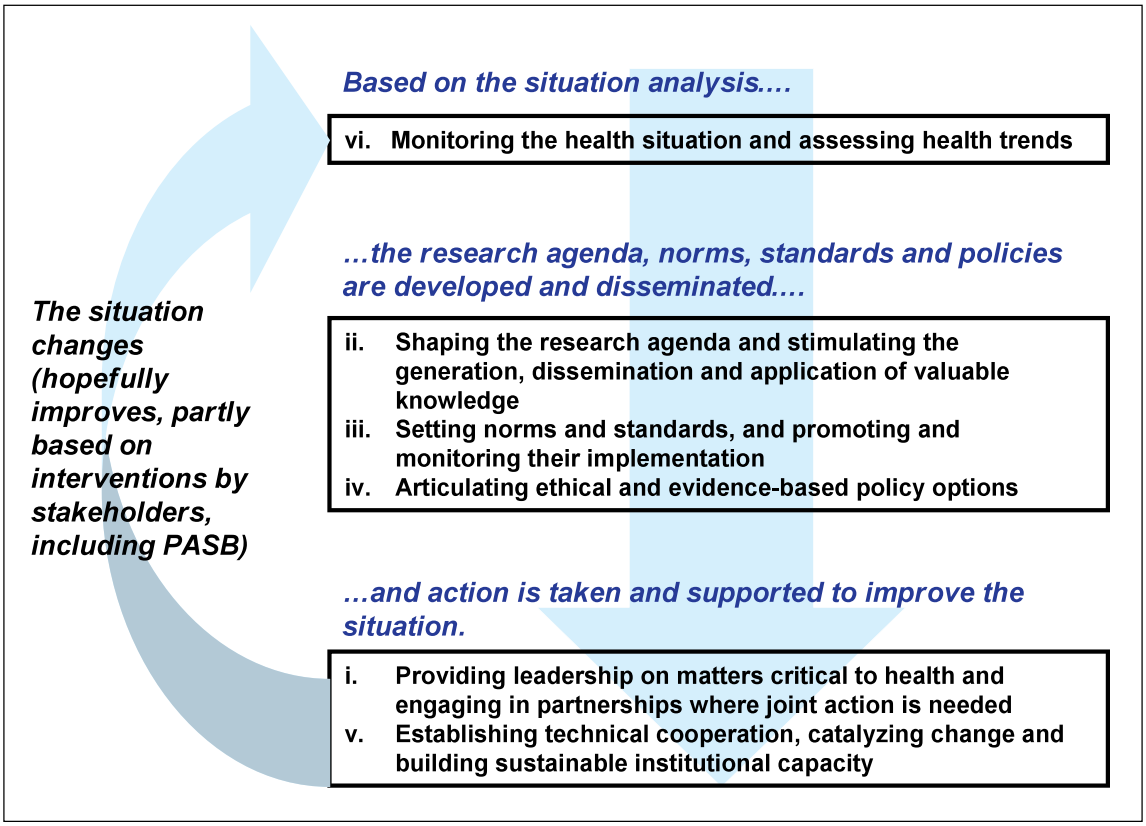
iv. Articulating ethical and evidence-based policy options;

v. Establishing technical cooperation, catalyzing change and building sustainable institutional capacity;

vi. Monitoring the health situation and assessing health trends.

77. The following diagram depicts the logical and sequential flow among the core functions of PAHO/WHO.

Diagram 4. Sequential Relationship among PAHO/WHO Core Functions



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

79. The WHO Bureau is accountable for achievement of the Organization-wide Expected Results (OWERs, also set out in the WHO MTSP). Similarly, the PASB is accountable for achievement of the Region-wide Expected Results (RERs). RERs contribute directly to all OWERs that apply to this Region; indeed, RER indicators have been developed to aggregate directly to applicable OWER indicators. Some RERs are specific to the Region, and relate only to the broader SO, not to a specific OWER.

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

A Note Regarding Baselines and Targets

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

    (a) For the purposes of the PAHO Strategic Plan's RERs and indicators, in order to facilitate operational planning and programming, the PASB shall be considered to operate in 40 programmatic units corresponding to countries, territories or geographic areas where the Bureau works. This classification is meant for programmatic purposes only. It should not be confused with the classification utilized by PASB in its reports to Member States and WHO.

    (b) These 40 "countries and territories" include:

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

82. In all indicators measuring the "number of countries…" the universe of countries (denominator) is 40 unless an alternative denominator is specified. In the latter case, the baseline and targets are presented as a fraction, e.g. "15/21". This denominator may refer to only the countries where a disease is endemic, a special group of countries (key countries, countries of Latin America and the Caribbean, countries of the Americas only, and other combinations) or other conditions. The specific reason of a denominator different from 40 will be expressed at the bottom of the table where the indicator is shown.

83. "Maintenance indicators" are those that have already been achieved, but require the investment of PASB resources (human or financial) to be maintained. In many cases, these indicators have the same figures in the 2007 baseline and the targets for 2009, 2011 and 2013. These indicators are used to emphasize the importance of PASB's efforts in maintaining key achievements related to given RERs.

84. Detailed baseline information for each RER indicator is contained in the American Region Planning and Evaluation System (AMPES), notably for the "number of countries…" type indicator. This baseline information allows the PASB to track achievements more accurately, ensuring that duplication or omissions do not occur in measuring progress during the planning period.

85. The term "entity" or "AMPES entity" is used in this document to describe a PASB managerial, programming and executing unit responsible for developing and implementing a Biennial Workplan (BWP) and its associated budget. The PASB entities are located at the regional (executive management offices and areas), subregional and country level (PAHO/WHO Representative Offices). In total the PASB has 69 entities.

Strategic Objective 1

To reduce the health, social and economic burden of communicable diseases

Scope

The activities related to this Strategic Objective (SO) focus on prevention, early detection, diagnosis, treatment, control, elimination, and eradication measures to combat communicable diseases that disproportionately affect poor and marginalized populations in the Region of the Americas. The diseases to be addressed include, but are not limited to: vaccine-preventable, tropical (including vector-borne), zoonotic and epidemic-prone diseases, excluding HIV/AIDS, tuberculosis and malaria.

Indicators and Targets

- Reduction of the mortality rate in children under five years old due to vaccine-preventable diseases in the Region. Baseline: 47 per 100,000 children under five years old in 2002. Target: 31 per 100,000 by 2013.
- Number of countries maintaining certification of poliomyelitis eradication in the Region. Baseline: 38 countries in 2006. Target: 38 countries by 2013.
- Number of countries achieving and maintaining the elimination of measles, rubella, congenital rubella syndrome and neonatal tetanus in the Region. Baseline: 0 countries in 2006. Target: 38 countries by 2013.
- Number of countries that have fulfilled the core capacity requirements in surveillance, response and points of entry, as established in the 2005 International Health Regulations. Baseline: 0 countries in 2007. Target: 35 countries by 2013.
- Reduction in the lethality rate due to dengue (dengue hemorrhagic fever/dengue shock syndrome) in the Region. Baseline: 1.3% in 2006. Target: 1.0% by 2013.
- Number of countries with certification of Chagas disease vector transmission interrupted, in the 21 endemic countries in the Region. Baseline: 3 countries in 2006. Target: 15 countries by 2013.
- Number of endemic countries in the Region with onchocerciasis elimination certification. Baseline: 0 of the 6 endemic countries. Target: 1 country by 2013.

ISSUES AND CHALLENGES

In Latin America and the Caribbean more than 210 million people live below the poverty line, and they bear the greatest burden of communicable diseases. Communicable diseases account for 13.5% of deaths in all age groups, and 74% of deaths in children in the Region. The burden of communicable diseases is significant; WHO estimates that this group of diseases accounted for the loss of 25,000 Disability Adjusted Life Years (DALYs) in 2005. Indigenous populations are especially vulnerable to this group of diseases; they deserve culturally appropriate interventions.

Vaccine-Preventable Diseases: Although national immunization programs (NIPs) have achieved high coverage at regional and country levels, reflected in a major impact on the reduction of cases and deaths due to vaccine-preventable diseases, NIPs must be prepared to face the following challenges: (1) maintaining achievements (poliomyelitis eradication, endemic measles elimination, and epidemiological control of diphtheria, pertussis, and Haemophilus influenza of type B pneumonias); (2) completing the unfinished agenda (improving coverage and the quality of immunization services, eliminating rubella and congenital rubella syndrome, eliminating neonatal tetanus, moving from child to family immunization, and administering vaccines against seasonal influenza and yellow fever); and (3) facing new challenges (strengthening operational capacity, epidemiological surveillance, including the laboratory network, information systems, and evidence-based decision-making; promoting technical excellence; strengthening the Revolving Fund to adjust to new market mechanisms, introducing new vaccines in support of MDG achievement, and promoting the sustainability of NIPs).

Emerging and Re-emerging Infectious Diseases: The international spread of infectious diseases continues to pose a problem for global health security due to factors associated with today's interconnected and interdependent world, such as: population movements, tourism, migration, or as a result of disasters; growth in international trade in food and biological products; social and environmental changes linked with urbanization, deforestation, and alterations in climate; and changes in methods of food processing, distribution, and consumer habits. These factors have reaffirmed that infectious disease events in one country or region are potentially a concern for the entire world. No country in the Region has all required core capacities to respond to these challenges. The need for a collective rapid response in the Region, especially for potential pandemics and outbreaks is a major challenge. Strategic planning in the Region is needed to avoid a drain on available resources, staff, and supplies away from well-defined public health priorities and routine disease control activities. PAHO has verified over 200 epidemics of international concern over the last five years.

Detection and response to epidemic-prone diseases – including pandemic (H1N1) 2009, SARS, and neuro-invasive syndromes caused by arboviruses such as West Nile – need to be addressed within the framework of the International Health Regulations (IHR).

Between 2001 and 2006, more than 30 countries of the Americas reported a total of 3,832,160 cases of dengue, of which 79,716 cases were **dengue** hemorrhagic fever and 93 deaths were reported.

Neglected diseases directly or indirectly influence the capacity of many countries of the Region to fulfill the Millennium Development Goals (MDG). These diseases, which arise from environmental problems, have adverse effects in the health and the well-being, in addition to increasing the school absenteeism and the poverty. Lack of routine epidemiological surveillance and data recordings of the neglected diseases in the Region makes it difficult to accurately estimate the disease burden. However, national surveys and special studies shed light on the burden of disease in some populations. PAHO/WHO estimated that 20% to 30% of Latin American are infected with one or more intestinal helminths or has schistosomiasis, two very important neglected diseases; among the most vulnerable populations are women and children who live in poor areas. Lymphatic filariasis puts at risk up to 11 million people; while onchocerciasis endangers 500,000 people in the Region. Both diseases are targeted for elimination. Chagas disease, leishmaniasis, trachoma, leprosy (Hansen's disease), and other skin infections and parasitic zoonoses also contribute to the heavy burden of the neglected diseases in many countries of the Region. A study of cystic echinococcosis noted an estimated total of 52,693 Disability Adjusted Life Years (DAILYs) lost in the Region, while economic losses total more than $120 million per year. Today, there is better knowledge of the extrinsic determinants of neglected diseases and the focalized distribution of several of the neglected diseases; furthermore, its prevention, control, and even elimination are now more feasible than ever due to the existence of new, safe and low-cost methods for monitoring these diseases and treating the infected people.

Key Communicable Diseases; the number of registered **leprosy** cases in the Region at the beginning of 2006 was 32,904, with a prevalence rate of 0.39 per 10,000 people. The number of new cases reported in 2005 was 41,789, around 20% less than in 2004. The global strategic target for leprosy elimination is less than one case detected per 10,000 people. All of the countries of the Region are under this rate, with the exception of Brazil, which traditionally accounted for the highest burden of leprosy in the Region and is now moving toward the goal of elimination.

The number of **Chagas**-infected persons in the Americas is estimated at 16 to 18 million. The estimated yearly incidence of vector-borne Chagas is 41,800 cases in the Region, while congenital Chagas is 13,550 cases. General seroprevalence in regional blood banks averages 1.28%. It is estimated that different chagasic cardiopathies occur in 4,600,000 patients, and 45,000 people die per year as a consequence of this disease.

Despite the challenges noted, major progress has been achieved in the Region: (a) Transmission of *T. infestans* has been interrupted in 80% of the endemic geographic surface of the Southern Cone countries; (b) in the country with highest domiciliary infestation (Bolivia), there has been a significant reduction in *T. infestans* infestation and pediatric seroprevalence; (c) transmission, by *R. prolixus* has been interrupted in some areas of Guatemala, Honduras and El Salvador; (d) the Andean countries are working on new (Ecuador, Colombia and Peru) and reactivated (Venezuela) national control programs; (e) Mexico has declared Chagas disease as a public health priority and is now implementing prevention and control activities; (f) Chagas-endemic countries have achieved a 98% coverage in blood bank serological screening; and (g) Amazonian countries have developed Chagas disease surveillance systems.

Zoonotic Diseases: There has been a reduction of 90% in the number of cases of **rabies** transmitted by dogs as a result of 20 years of effective control efforts. During 2005, only 11 cases were reported. However, some countries, mostly low income ones, have still not achieved these results. Other zoonotic diseases need to be addressed in the Region as well, due to the important link between human and animal health.

STRATEGIC APPROACHES

- Implementing the International Health Regulations (2005), this took effect in June 2007, in the Region.
- Implementing existing Regional plans and strategies agreed with Member States, including PAHO Directing Council Resolutions.
- Establishing or maintaining effective coordination with other partners and across all relevant sectors at the country, subregional and regional levels, including other agencies in the United Nations and Inter-American Systems.
- Strengthening the network of WHO Collaborating Centers located in the Americas.
- Promoting research through adequate investment, capacity strengthening and effective partnership between the academic and public sectors.
- Exploring mechanisms to encourage transfer of technology and new modalities of technical cooperation (e.g. south-to-south).
- Implementing the PAHO/WHO *Integrated Strategy for Dengue Prevention and Control in the Region*, that includes six key components: mass communication, entomology, epidemiology, laboratory, patient care and environment.
- Making efforts to further reduce the leprosy burden through implementation of the WHO *Global Leprosy Strategy,* with emphasis on early detection and an integrated approach in primary health services.

ASSUMPTIONS AND RISKS

Assumptions:

- Member States will invest in human, political and financial resources to ensure and expand equitable access to high quality and safe interventions for the prevention, early detection, diagnosis, treatment and control of communicable diseases.
- Member States' political support to guarantee the sustainability of immunization programs will stay the same or increase.
- Member States fully utilize the PAHO Revolving Fund for the procurement of vaccines and syringes.
- The entry into force of the International Health Regulations in 2007 will translate into a renewed commitment by all Member States to strengthen their national surveillance and response systems.
- In developing and strengthening national health systems, the aim will continue to be universal and equitable access to essential health interventions.
- There will be a receptive and positive attitude towards coordination and harmonization of actions among the increasing number of actors in global public health.
- Effective communications mechanisms will be in place to maintain a strong and interactive coordination of efforts at the global, regional and subregional levels.
- Political commitment and resources will be in place to secure effective surveillance and adequate preparedness to prevent and control pandemics and vaccine-preventable actions related to threats of national and international concern.

Risks:

- Emergence of parallel, uncoordinated health agendas.
- Low or insufficient investment in research activities that might impact adversely on health interventions.
- Influenza or other pandemic-prone diseases may cause unprecedented morbidity and mortality, as well as grave economic harm in the countries.

Region-wide Expected Results

RER 1.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies; strengthen immunization services; and integrate other essential family and child health interventions with immunization.	1.1.1	Number of countries achieving more than 95% vaccination coverage at national level (DPT3 as a tracer)	17	20	22	25
	1.1.2	Percentage of municipalities with vaccination coverage level less than 95% in Latin America and the Caribbean (DPT3 as a tracer using baseline of 15,076 municipalities in 2005)	38%	36%	34%	32%
	1.1.3	Number of countries that have included pneumococcal and/or rotavirus sentinel surveillance in their national epidemiological system	0	5	10	15
	1.1.4	Number of countries that purchase the vaccines for their National Immunization Program through the PAHO Revolving Fund for Vaccine Procurement	32/38*	32/38	33/38	34/38

** Denominator excludes Puerto Rico and the US Mexico-Border*

RER 1.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to maintain measles elimination and polio eradication; and achieve rubella, congenital rubella syndrome (CRS) and neonatal tetanus elimination.	1.2.1	Number of countries with surveillance activities and vaccination to maintain the polio eradication	38/38*	38/38	38/38	38/38
	1.2.2	Number of countries that have implemented interventions to achieve rubella and Congenital Rubella Syndrome (CRS) elimination	35/38*	36/38	38/38	38/38

** Denominator excludes Puerto Rico and the US-Mexico Border*

RER 1.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to provide access for all populations to interventions for the prevention, control, and elimination of neglected communicable diseases, including zoonotic diseases.	1.3.1	Number of countries that have eliminated leprosy at national and sub-national levels as a public health concern	16/24*	17/24	19/24	24/24
	1.3.2	Number of countries that have eliminated human rabies transmitted by dogs	11	14	16	18
	1.3.3	Number of countries that maintain surveillance and preparedness for emerging or re-emerging zoonotic diseases	11	12	19	23
	1.3.4	Number of countries with Domiciliary Infestation Index by their main Triatominae vectors lower than 1%	3/21**	11/21	15/21	18/21
	1.3.5	Number of countries which have adopted programs or strategies for the surveillance, prevention, control or elimination of the neglected diseases	0	3	7	11

** Denominator refers to countries where Leprosy is endemic*
*** Denominator refers to countries where Chagas disease is endemic*

RER 1.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to enhance their capacity to carry out communicable diseases surveillance and response, as part of a comprehensive surveillance and health information system.	1.4.1	Number of countries with a surveillance system for all communicable diseases of public health importance for the country	14	16	18	20
	1.4.2	Number of countries that submit the joint reporting forms on immunization surveillance and monitoring to the Pan American Sanitary Bureau, in accordance with established timelines	15/38*	18/38	19/38	20/38
	1.4.3	Number of countries routinely implementing antimicrobial resistance (AMR) surveillance and interventions for AMR containment, including health care associated infections	17/35**	22/35	24/35	27/35

** Denominator excludes Puerto Rico and the US-Mexico Border*
*** Denominator refers to the PAHO Member States (countries of the Americas)*

RER 1.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to enhance their research capacity and to develop, validate and make available and accessible new knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases.	1.5.1	Number of countries that have implemented operational research in accordance with the research priorities in communicable diseases	0/33*	2/33	3/33	5/33

** Denominator refers to PAHO Member States excluding USA and Canada*

RER 1.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to achieve the core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.	1.6.1	Number of countries that have achieved the core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005)	0	10	17	25
	1.6.2	Number of countries that maintain training programs focusing on the strengthening of outbreak response capacities	16	17	21	23

RER 1.7	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States and the international community equipped to detect, contain and effectively respond to major epidemic and pandemic-prone diseases (e.g. influenza, dengue, meningitis, yellow fever, hemorrhagic fevers, plague and smallpox).	1.7.1	Number of countries that have national preparedness plans and standard operating procedures in place for rapid response teams against pandemic influenza	17/35*	23/35	31/35	35/35
	1.7.2	Number of countries with basic capacity to detect epidemic prone viral pathogens according to the PAHO/ WHO epidemiological surveillance guidelines	2	4	10	12
	1.7.3	Number of countries implementing interventions and strategies for dengue control according to PAHO/WHO guidelines	14	19	21	23

** Denominator refers to the PAHO Member States (countries of the Americas)*

RER 1.8	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Regional and Subregional capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.	1.8.1	Percentage of public health events of international importance verified in the time recommended by the International Health Regulations	85%	90%	95%	98%

RER 1.9	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Effective operations and response by Member States and international community to declared emergencies situations due to epidemic and pandemic prone diseases.	1.9.1	Percentage of PASB International Health Regulations compliant responses based on requests for support from Member States during emergencies or epidemics	90%	100%	100%	100%

Strategic Objective 2

To combat HIV/AIDS, tuberculosis and malaria

Scope

This Strategic Objective (SO) focuses on interventions for the prevention, early detection, treatment and control of HIV/AIDS, sexually transmitted infections (STI), tuberculosis and malaria, including elimination of malaria and congenital syphilis. Emphasis is placed in those interventions that can reduce regional inequities, addressing the needs of vulnerable and most at-risk populations.

Indicators and Targets

- Reduction of the incidence rate of HIV infections in the Region. Baseline: 24 new HIV infections per 100,000 inhabitants (2006 data for estimated new infections using 2005 population data). Target: 23/100,000 or less by 2013 (in accordance with MDGs).[7]
- Access to antiretroviral treatment in Latin America and the Caribbean, based on needs assessments. Baseline: Access to antiretroviral treatment was 72% in 2006. Target: 80% by 2013 (per Regional HIV/STI Plan for the Health Sector 2006-2015).[8]
- Number of countries that have achieved less than 5% incidence of mother-to-child transmission of HIV. Baseline: 3 countries in 2006. Target: 16 countries by 2013 (Per Regional HIV/STI Plan for the Health Sector 2006-2015).
- Number of countries that have an incidence of congenital syphilis of less than 0.5 cases per 1,000 live births. Baseline: 2 countries in 2006. Target: 26 countries by 2013 (Per Regional HIV/STI Plan for the Health Sector 2006-2015).
- Reduction of tuberculosis incidence in the Region. Baseline: 39 cases per 100,000 inhabitants in 2005. Target: 27 per 100,000 by 2013 (in accordance with MDGs).
- Reduction of the number of annually reported cases of malaria in the Region. Baseline: 903,931 cases in 2006. Target: 402,536 by 2013.
- Number of countries retaining their malaria non-endemic status. Baseline: 19 countries in 2007. Target: 19 countries by 2013.

ISSUES AND CHALLENGES

HIV/AIDS

To halt and reverse the spread of the HIV epidemic by 2015 will only be possible when a comprehensive response to the epidemic is developed and implemented in each Member State. This requires addressing the growing demands for health care services. Within the health sector, this translates into a commitment to achieve universal access to comprehensive prevention, care and treatment for HIV that can be met with the implementation of the WHO Public Health Approach, consisting in the provision of integrated and decentralized HIV/AIDS services and interventions, with particular emphasis on prevention and treatment in vulnerable populations.

[7] This indicator relates to Target 1 in the Regional HIV/STI Plan for the Health Sector 2006-2015, for which data is not currently available: "By 2010, there will be a 50% reduction in the estimated number of new HIV infections followed by a further 50% reduction in new infections by the end of 2015"

[8] This indicator relates to Target 2 in the Regional HIV/STI Plan for the Health Sector 2006-2015, for which data is not currently available: "By 2010, there will be universal access to comprehensive care including prevention, care, and antiretroviral treatment." A WHO monitoring and evaluation framework for universal access is under development

In addition, primary and secondary prevention actions have not yet been adequate to halt or bring down the growing trend in new HIV infections, including reinfections, and co-infections, that are being reported in several countries in the Region. In LAC, an estimated 167,000 new HIV infections occurred in 2006, representing 8.6% of the total population with HIV, and underscoring the need for scaling-up prevention. Comprehensive and effective means of HIV prevention include preventing, diagnosing and adequately treating STIs.

Morbidity and mortality associated with HIV infection in Latin America and the Caribbean have not declined as expected, given the effectiveness of treatments and other interventions for HIV/AIDS. In spite of efforts to expand access to antiretroviral treatment and comprehensive care, in 2006 an estimated 84,000 people died of AIDS-related conditions in Latin America and the Caribbean. Limited access to affordable drugs and commodities to reduce sexual, blood-borne and perinatal transmission persists, as well as insufficient reorientation of services to the needs of members of vulnerable groups, and incomplete or inadequate capacity of care providers.

Limitations exist in monitoring, forecasting, and understanding the dynamic of the epidemic due to inadequate use of strategic information, including insufficient surveillance, and monitoring and evaluation of the response.

The persistence of stigma and discrimination (including attitudes and values arising from healthcare providers) hamper prevention efforts and constitute barriers to care and treatment. Social attitudes and values neglect or disregard the risk associated with certain behaviors and practices, leading to insufficient awareness of the problem and possible solutions among the general public.

The engagement of communities, affected persons, civil society organizations, the private sector and other relevant stakeholders in a coordinated and unified response continues to be a challenge, and is necessary to ensure effectiveness, local ownership and sustainability.

Interventions to improve sexual and reproductive health are incomplete and insufficient, despite the fact that the majority of infections result from unprotected sex. Gender inequities and inequalities lead to augmented vulnerability to HIV and reduced access to comprehensive care.

In 2005, a rationale for the division of labor within UN agencies in the area of HIV response was agreed upon, signifying improved coordination and alignment of efforts for regional, subregional and national responses to HIV. In this context, the PASB, as the UNAIDS cosponsor for the health sector response, focuses on scaling up HIV/AIDS services to achieve universal access. This effort encompasses prevention and treatment, as well as monitoring and evaluation of the health sector response. Nevertheless, the challenge remains to attain greater alignment and harmonization of actions at the various levels, in order to ensure that the global and regional efforts to support national responses are adequate and timely. The harmonious implementation of existing UN directives (e.g. the Three Ones) will prove to be a critical factor in the overall efficiency, effectiveness and impact of the UN system's efforts to support national responses.

There are many partners working to control HIV/AIDS in the Americas, such as UNAIDS, United Nations agencies, the World Bank, USAID, and the Global Fund (GF), among others. The main challenge is the coordination and harmonization of the programs of these institutions.

Malaria

Malaria is a preventable and treatable vector-borne disease that afflicts approximately a million people in the Americas each year. Thirty percent of the inhabitants of the Region are considered at risk of infection. Five percent of the Region's inhabitants live in moderate and high risk areas. Twenty-one countries in the Region have areas where malaria is considered endemic, while other nations report imported cases which can potentially cause re-introduction of local transmission if not managed appropriately.

Pregnant women and children are considered vulnerable to malaria worldwide. In addition, the vulnerable population in the Americas includes people with HIV/AIDS, travelers, miners, loggers, banana and sugarcane plantation workers, indigenous groups, and populations in areas of social or armed conflict and border areas.

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

Control and prevention efforts need to be maintained, because the nature of the disease, its vectors, and other factors that affect transmission are complex. A proactive approach and better foresight is needed so that emerging and re-emerging challenges related to the disease are averted, including outbreaks and epidemics. Advocacy to control malaria must be intensified so that stakeholders are able to act, contribute concretely, and effect positive changes within their spheres of influence. Furthermore, stakeholders must align and harmonize efforts, practice intersectoral approaches, and actively engage the community and affected populations to ensure local ownership and sustainability of efforts.

There are many stakeholders working to control malaria in the Region, such as United Nations Agencies, the Global Fund, USAID, CIDA, WHO Collaborating Centers, CDC, the United States Pharmacopeia, the Special Program for Research and Training in Tropical Diseases, and the International Development Research Center, among others. The main challenge is maintaining the coordination and harmonization of these institutions' programs.

Tuberculosis

Tuberculosis (TB) is a preventable and curable disease that is far from being eliminated as a public health problem in the Region. Despite progress in the Americas in the last decade, estimates indicate more than 447,000 cases and approximately 50,000 deaths occur every year. TB predominantly affects the economically-productive adult population: 61% of the 2005 reported infectious cases were among 15 to 44-year-olds. Even though TB can affect everyone, there are specific vulnerable groups with the highest burden of the disease: the poor, migrants, marginalized populations, prisoners, people with HIV/AIDS and the indigenous population. There are marked differences in the burden of disease among countries in the Region; twelve countries accounted for 80% of the total burden of TB in the Americas.

The implementation of the DOTS strategy has contributed to advances in controlling TB. A total of 33 countries applied this strategy in 2005, reaching 88% coverage. The challenge is to reach 100% coverage in high burden countries like Brazil and Colombia.

The main identified challenges for TB control in the Region are the HIV/AIDS epidemic, TB multi-drug resistance (MDR) and extensively multi-drug resistant TB, along with weaknesses in the health systems and the human resource crisis. In new cases of TB, HIV prevalence ranges from 8% to 10%, and the primary TB-MDR is 1.2%, with important variations among countries. These challenges are negatively impacting national programs for TB control, since the burden of the disease may increase, including its mortality.

An important challenge is the poor engagement of communities, affected persons and civil society organizations in TB control, as well as the weak participation of the private sector and some institutions of the public sector in not adhering to the International Standards for Tuberculosis Care (ISTC).

In 2006, WHO adopted the new strategy STOP TB to deal with the identified problems. Several partners and donors have come together under the new Stop TB strategy to support the countries in the Region, such as USAID, the Union (former International Union against Tuberculosis and Lung Disease), Centers for Disease Control (CDC), KNCV Tuberculosis Foundation, the Tuberculosis Coalition for Technical Assistance (TBCTA), Academy for Educational Development (AED), American Thoracic Society, the Spanish Agency for International Cooperation (AECI), and the Global Fund, among others. Despite their support, there are still challenges in coordinating and harmonizing their programs, as well as involving potential national partners that do not follow national norms and ISTC.

STRATEGIC APPROACHES

- Implementing the Regional HIV/STI Plan for the Health Sector, 2006-2015; the Regional Plan for Tuberculosis Control, 2006-2015; and the Regional Plan for Malaria in the Americas, 2006-2010. These plans inform the approaches below, and are to be implemented at all levels.

- Enhancing strategic decision-making at the national level through strengthening and promoting the development and use of information on HIV/AIDS, TB and malaria, including surveillance, and monitoring and evaluation systems, as well as improved information and knowledge management. This includes promoting the exchange of strategic information among key health partners.

- Strengthening health systems to effectively combat HIV/AIDS/STI, TB and malaria.

- Participating in global, regional, subregional and country-level mechanisms established by WHO, UNAIDS and the Regional Director's Group on HIV.

- Ensuring the availability of data to measure trends in the HIV/AIDS epidemic in the Region, including data to establish base lines for the indicators in the Regional HIV/STI Plan for the Health Sector, 2006-2015.

- Strengthening health services by:
  - Expanding, integrating and reorienting services for the delivery of gender-sensitive, cost-effective interventions addressing HIV, TB and malaria through prevention, diagnosis, treatment, care and support.
  - Ensuring services for hard-to-reach populations and vulnerable groups, including indigenous populations.
  - Addressing human resources issues.
  - Ensuring the availability and proper use of high quality medicines, quality laboratory networks, diagnostics, and health commodities, with continued support from the Strategic Fund for public health supplies.
  - Strengthening the national capacity to prepare and implement projects for which resources can be mobilized for HIV/AIDS, TB and malaria control from partners such as the Global Fund.
  - Providing technical cooperation for the development and implementation of approved Global Fund proposals, contributing to the relationship between the principal recipient and sub-recipients, while ensuring coherence with national programs.
  - Strengthening national and international alliances and partnerships to combat HIV/AIDS, tuberculosis, and malaria at the regional, subregional, national and local levels.

ASSUMPTIONS AND RISKS

Assumptions:

- HIV/AIDS, TB and malaria will continue to be recognized as priorities in the national, subregional, regional and global health agendas, and receive adequate resource allocations.

- National health systems will correspondingly be strengthened to realize universal access to essential health services and care.

- Strategic approaches are based on the hypothesis that interventions can be scalable, even in the most resource-challenged settings, with sound planning, sustainable financing and well-supported infrastructures; as well as intersectoral actions.

Risks:

- Effective leadership and coordination of programs may not be maintained because of the growing number of partners and increasing competition for resources.

Region-wide Expected Results

RER 2.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for the prevention of, and treatment, support and care for patients with HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, hard-to-reach and vulnerable populations.	2.1.1	Number of countries that provide prophylactic antiretroviral treatment to at least 80% of the estimated HIV positive pregnant women	9	10	12	17
	2.1.2	Number of countries that provide antiretroviral treatment to at least 80% of the population estimated to be in need as per PAHO/WHO guidelines	6	7	12	15
	2.1.3	Number of countries implementing components of the Global Malaria Control Strategy, within the context of the Roll Back Malaria initiative and PAHO Regional Plan for Malaria in the Americas 2006-2010	20	23	28	33
	2.1.4	Number of countries detecting 70% of estimated cases of pulmonary tuberculosis through a positive TB smear test	12/27 *	20/27	23/27	26/27
	2.1.5	Number of countries with a treatment success rate of 85% for tuberculosis cohort patients	6/27 *	11/27	16/27	23/27
	2.1.6	Number of countries that have achieved the regional target for elimination of congenital syphilis	2	7	15	26
	2.1.7	Number of countries with quantifiable targets in their health plans for prevention and control of HIV and other sexually transmitted infections	4	6	11	14

** Denominator refers to countries where tuberculosis is endemic*

RER 2.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop and expand gender-sensitive policies and plans for HIV/AIDS, malaria and TB prevention, support, treatment and care.	2.2.1	Number of countries with health sector policies and medium-term plans in response to HIV in accordance with the Universal Access Framework	40	40	40	40
	2.2.2	Number of countries implementing the WHO 12 collaborative activities against HIV/AIDS and tuberculosis	3	9	20	30

RER 2.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop and implement policies and programs to improve equitable access to quality essential medicines, diagnostics and other commodities for the prevention and treatment of HIV, tuberculosis and malaria.	2.3.1	Number of countries implementing WHO revised/ updated diagnostic and treatment guidelines on tuberculosis	0/27*	3/27	10/27	14/27
	2.3.2	Number of countries that participate in the Strategic Fund mechanism for affordable essential medicines for HIV/AIDS	19	19	20	21
	2.3.3	Number of countries implementing quality-assured HIV screening of all donated blood	32	34	37	40

** Denominator refers to countries where tuberculosis is endemic*

RER 2.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Regional and national surveillance, monitoring and evaluation systems strengthened and expanded to track progress towards targets and resource allocations for HIV, malaria and tuberculosis control; and to determine the impact of control efforts and the evolution of drug resistance.	2.4.1	Number of countries reporting HIV surveillance data disaggregated by sex and age to PAHO/WHO	25	27	32	33
	2.4.2	Number of countries reporting tuberculosis surveillance data disaggregated by sex and age to PAHO/WHO	27	30	34	37
	2.4.3	Number of countries reporting malaria surveillance data disaggregated by sex and age to PAHO/WHO	21/21*	21/21	21/21	21/21
	2.4.4	Number of countries reporting HIV drug resistance surveillance data to PAHO/WHO, as per PAHO/WHO guidelines	1	2	7	16
	2.4.5	Number of countries reporting tuberculosis drug resistance surveillance data to PAHO/WHO, as per PAHO/WHO guidelines	14/27**	19/27	22/27	27/27
	2.4.6	Number of countries reporting malaria drug resistance surveillance data to PAHO/WHO, as per PAHO/WHO guidelines	9/21*	13/21	17/21	20/21

** Denominator refers to countries where malaria is endemic*
*** Denominator refers to countries where tuberculosis is endemic*

RER 2.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to: (a) sustain political commitment and mobilization of resources through advocacy and nurturing of partnerships on HIV, malaria and tuberculosis at country and regional levels; (b) increase the engagement of communities and affected persons to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programs.	2.5.1	Number of countries with functional coordination mechanisms for HIV/AIDS	40	40	40	40
	2.5.2	Number of countries with functional coordination mechanisms for tuberculosis	5/27*	8/27	12/27	15/27
	2.5.3	Number of countries with functional coordination mechanisms for malaria	21/21**	21/21	21/21	21/21
	2.5.4	Maintain the number of countries involving communities, persons affected by the disease, civil-society organizations and the private sector in planning, design, implementation and evaluation of programs against HIV/AIDS	40	40	40	40

** Denominator refers to countries where tuberculosis is endemic*
*** Denominator refers to countries where malaria is endemic*

RER 2.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
New knowledge, intervention tools and strategies developed, validated, available, and accessible to meet priority needs for the prevention and control of HIV, tuberculosis and malaria, with Latin American and Caribbean countries increasingly involved in this research.	2.6.1	Number of new or improved interventions and implementation strategies for tuberculosis whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions	1	2	2	3
	2.6.2	Number of new or improved interventions and implementation strategies for malaria whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions	0	1	2	2

Strategic Objective 3

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

Scope

This Strategic Objective (SO) focuses on prevention and reduction of the burden of disease, disabilities, and premature deaths from the major chronic non-communicable diseases, including cardiovascular diseases, cancer, chronic respiratory diseases, diabetes; hearing and visual impairment; oral diseases; mental disorders (including psychoactive substance use); violence; and injuries, including road traffic injuries.

Indicators and Targets

- Reduction in the estimated annual number of deaths related to major chronic non-communicable diseases (cardiovascular diseases, cancer, chronic respiratory diseases and diabetes) in Latin America and the Caribbean. Baseline: 2.4 million deaths in 2000. Target: 2.1 million deaths by 2013.

- Reduction in the treatment gap in persons suffering from mental disorders (psychosis, bipolar disorder, depression, anxiety, and alcoholism). Baseline: 62% of persons suffering from mental disorders who do not receive treatment. Target: 47% by 2013.

- Halt the current increasing trends in mortality rates due to road traffic injuries in the Region. Baseline: 16.7 per 100,000 inhabitants in 2000-2004 (estimated average). Target: 14.7 per 100,000 inhabitants by 2013.

- Number of countries/territories in the Region that have reduced the Decayed, Missing, Filled, Teeth at age 12 Score (DMFT-12). Baseline: DMFT-12 scores of >5: 2 countries/territories, 3-5: 8 countries/territories, <3: 29 countries/territories, in 2004. Target: DMFT-12 scores of >5: 0 countries/territories, 3-5: 2 countries/territories, <3: 37 countries/territories, by 2013.

ISSUES AND CHALLENGES

Chronic non-communicable diseases, (including cardiovascular diseases, cancer and diabetes), mental disorders, violence and injuries are rapidly increasing and are the major causes of death and disability in the Region.

Data and information for setting baselines and monitoring progress, especially for risk factors, are not well developed. Furthermore, country capacities to collect, analyze, report, and use non-communicable disease data in developing programs and policy varies widely.

In some countries, the true magnitude of the non-communicable disease burden, as well as the opportunities to improve health promotion and disease prevention, are unknown. In addition to political will, international partnerships and multisectoral collaboration are necessary to generate increased synergies and ultimately additional resources.

Chronic diseases account for over 60% of all deaths and a large proportion of the healthcare costs. Low- and middle-income countries and poor populations in the Region are the most affected. Disease management is fragmented and third level care still consumes most of the resources. There is a wide range of cost-effective and proven solutions to deal with health promotion, disease prevention and management that have not been implemented.

The burden of chronic diseases is increasing with an ageing population, changing lifestyles, and interventions which often do not have a public health approach. The problem is caused by shared risk factors – unhealthy diet, physical inactivity, tobacco use, and harmful use of alcohol, associated with socio economic and environmental trends, some public policies and private sector practices, and lack of access to quality health services.

Countries have only limited capacity to respond to the chronic disease burden and have competing public health priorities. The challenge is to improve the effectiveness of chronic disease programs so that interventions for prevention, early detection and disease management can have an impact on disease burden.

There are more than 1 million deaths annually due to **cancer,** and this is expected to double by 2020. Thirty-five million people in the Region have **diabetes**, and an estimated 70,000 annual deaths are attributable to this disease. Predictions are for a near tripling of **cardiovascular disease** (CVD) deaths in the next 20 years. It is estimated that 80% of CVD and diabetes type 2 and 1/3 of all cancers can be prevented, and an additional 1/3 of cancers controlled, using available cost-effective public health policy, prevention and early detection and treatment interventions.

According to relevant epidemiological studies in **mental health** conducted in Latin America and the Caribbean in the past 20 years, non-affective psychoses (among them schizophrenia) have an estimated average prevalence of 1.0%, major depression 4.9%, and anxiety disorders 3.4%. However, more than one third of the people affected by non-affective psychoses, more than half of those affected by major depression and almost two thirds of those who suffer anxiety disorders do not receive any specialized treatment, whether from a psychiatric service or other type of general or primary care service. The challenge is to reduce these treatment gaps in the Region.

Lack of data and adequate information on mental disorders in the majority of the countries does not allow for the establishment of appropriate policies and plans with well-defined baselines and targets. The challenge is to establish baselines in the countries of the Region based on a broad and comprehensive assessment of mental health systems, using a standardized methodology and indicators.

More than 70% of the countries in the Region have policies and national mental health plans, often with greater emphasis on health services than on prevention. In many cases the implementation rate of these plans is low. The challenge is to strengthen the prevention component and improve the plans' implementation with emphasis on the decentralization of specialized services, and the insertion of mental health as a component of primary health care.

In most countries in the Region, health care models for people with **disabilities** continue to be essentially institutional, at the third level of care. The challenge is to develop networks of rehabilitation services, incorporating community health care systems, for individuals at risk or with disabilities; these networks should support caregivers, be organized per the therapeutic cycle, and promote social inclusion. Reorganization of integrated health services should be structured from the third level of care, basically biomedical, to the first level of care, where not only health promotion and prevention and treatment of disabilities are developed, but also where individual inclusion is effectively advanced.

With respect to **violence and injuries**, in the last decade nearly 120,000 homicides were reported annually in the Region, with an estimated underreporting of 10%. More than 12 countries of the Region have homicide rates higher than 100 per 100,000 inhabitants. Males aged 15-34 are the most significant victims. Surveys and studies have found that some 20% to 60% of households in the Region are the scene of physical and psychological violence against women, girls, and boys. Between 3% and 28% of children are subjected to corporal punishment in the Region, and the increase of violent youth gangs is of great concern in many countries.

Although laws to protect women and children from intra-family violence have been enacted in every country, they are not being fully enforced. Some progress has been made in the development of reliable information systems on violence; however, data and collection criteria need standardization. Governments at national and municipal level should define plans and allocate resources for violence prevention based on successful experiences in reducing homicides and increasing safe environments. The health sector must improve its capacity to care for victims of violence.

In developing countries, the design of traffic environments can be dangerous, from a road safety point of view, for pedestrians, cyclists and motorcyclists. Transport and traffic planners often neglect wider social approaches. This deeply influences the nature and quantity of crashes. Solutions better linked to road safety problems and population needs should be identified.

Another challenge for improving road safety is the lack of reliable data from different sectors, such as transport, police and health. Enforcement strategies mainly focus on traffic fluidity, rather than the prevention of road traffic injuries.

STRATEGIC APPROACHES

- Advocating with governments to prioritize chronic disease prevention and control through education, policies and a communication plan, emphasizing intersectoral action and public-private partnerships.
- Enhancing capacity to advance the Regional Strategy on Non-communicable Diseases in the Caribbean, Central America, the Andean subregion, and the Southern Cone.
- Providing evidence-based public health policies, guidelines and tools to strengthen health services for prevention, screening and early detection, diagnosis, treatment, rehabilitation, and palliative care.
- Building capacity of the public health workforce through training and continuing education opportunities to reinforce competencies in public health interventions and high quality health care.
- Strengthening the surveillance, research and information base for policy, planning and evaluation, especially pertaining to risk factors, by using the PAHO/WHO STEPwise approach to Surveillance (STEPS) methodology (a simple, standardized method for collecting, analyzing and disseminating data in WHO member countries).
- Prioritizing evidence-based, cost-effective policies, programs and interventions.
- Applying an inter-programmatic approach to address violence, unintentional injuries and road safety.
- Implementing comprehensive policies to strengthen road safety and allow safer traffic and circulation space.
- Fostering exchange of lessons learned among Member States.

ASSUMPTIONS AND RISKS

Assumptions:

- Data and information are available for effective policy, planning, monitoring and independent evaluation.
- Ability exists to secure high-level multisectoral collaboration in countries, individually and collectively.

Risks:

- Partners in and out of the Organization do not respond to and embrace the Regional Strategy for Non-communicable Diseases.
- Insufficient resources are allocated to address this topic.

Region-wide Expected Results

RER 3.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to increase political, financial and technical commitment to address chronic non-communicable conditions, mental and behavioral disorders, violence, road safety, and disabilities.	3.1.1	Number of countries implementing institutional development mechanisms (human/budget resources, training, inter-sectoral partnerships) related to violence	9	15	20	24
	3.1.2	Number of countries implementing institutional development mechanisms (human/financial resources, training, inter-sectoral partnerships) related to mental health	24	27	27	29
	3.1.3	Number of countries implementing institutional develop-ment mechanisms (human/financial resources, training, inter-sectoral partnerships) related to chronic diseases	21	24	31	38
	3.1.4	Number of countries implementing institutional development mechanisms (human/financial resources, training, inter-sectoral partnerships) related to disabilities	10	14	19	24
	3.1.5	Number of countries implementing institutional development mechanisms (human/financial resources, training, inter-sectoral partnerships) related to road safety	9	15	18	21

RER 3.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for the development and implementation of policies, strategies and regulations regarding chronic non-communicable conditions, mental and behavioral disorders, violence, road safety, disabilities, and oral diseases.	3.2.1	Number of countries implementing a multisectoral national plan to prevent interpersonal and gender based violence aligned with PAHO/WHO Guidelines	15	17	20	23
	3.2.2	Number of countries implementing a national plan on disability management and rehabilitation, according to PAHO/WHO guidelines	5	7	16	25
	3.2.3	Number of countries implementing a national mental health plan, according to PAHO/WHO guidelines	26	29	29	30
	3.2.4	Number of countries implementing a national plan for the prevention and control of chronic non-communicable diseases, according to the PAHO Integrated Chronic Disease Prevention and Control Approach, including Diet and Physical Activity	15	30	32	36
	3.2.5	Number of countries implementing a national plan for the prevention of blindness and visual impairment, according to PAHO/WHO guidelines	8	14	21	26
	3.2.6	Number of countries implementing a national plan for the prevention of oral diseases, according to PAHO/WHO guidelines	26	28	31	35
	3.2.7	Number of countries implementing a multisectoral national plan to prevent road traffic injuries, aligned with PAHO/WHO Guidelines	15	17	20	23

RER 3.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to improve capacity to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries and disabilities.	3.3.1	Number of countries that have a national health information system that includes indicators of interpersonal and gender based violence	12	16	18	22
	3.3.2	Number of countries that have a national health information system that includes indicators of mental health	8	10	14	20
	3.3.3	Number of countries that have a national health information system that includes indicators of disabilities	18	22	23	26
	3.3.4	Number of countries that have a national health information system that includes indicators of chronic, non-communicable conditions and their risk factors	14	27	31	33
	3.3.5	Number of countries that have a national health information system that includes indicators of road traffic injuries	12	16	18	22

RER 3.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Improved evidence compiled by the Bureau on the cost-effectiveness of interventions to address chronic non-communicable conditions, mental and behavioral disorders, violence, road traffic injuries, disabilities, and oral health.	3.4.1	Number of cost analysis studies on interventions related to mental and neurological disorders	1	2	2	3
	3.4.2	Number of countries with cost analysis studies on violence conducted and disseminated	8	10	12	15
	3.4.3	Number of countries with cost analysis studies on oral health conducted and disseminated	4	6	8	9
	3.4.4	Number of countries with cost analysis studies on chronic non-communicable conditions conducted and disseminated	9	11	14	18
	3.4.5	Number of countries with cost analysis studies on road safety conducted and disseminated	6	8	10	12

RER 3.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for the preparation and implementation of multisectoral, population-wide programs to promote mental health and road safety and prevent chronic non-communicable conditions, mental and behavioral disorders, violence, and injuries, as well as hearing and visual impairment, including blindness.	3.5.1	Number of countries implementing multisectoral, population-wide programs to prevent disabilities	5	6	11	15
	3.5.2	Number of countries implementing interventions to promote mental health and the prevention of mental disorders and substance abuse	0	5	11	15
	3.5.3	Number of countries implementing multisectoral, population-wide programs to promote the prevention of chronic diseases	2	10	21	31

RER 3.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen their health and social systems for the integrated prevention and management of chronic non-communicable conditions, mental and behavioral disorders, violence, road traffic injuries, and disabilities.	3.6.1	Number of countries implementing integrated primary health-care strategies to improve quality of care for chronic non-communicable diseases according to WHO innovative Care for Chronic Conditions	12	19	24	32
	3.6.2	Number of countries with tobacco cessation support incorporated into primary health care services according to the WHO Global Report of the Tobacco Epidemic	4	6	8	9

Strategic Objective 4

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

Scope

This Strategic Objective (SO) focuses on reduction of mortality and morbidity to improve health during key stages of life, ensuring universal access to coverage with effective interventions for newborn, child, young people (adolescents 10-19 and youth 15-24), reproductive age, and older adults, using a life-course approach and addressing equity gaps. Strengthening policies, health systems and primary health care is fundamental to achieving this SO, which contributes to the achievement of Millennium Development Goals 4 (reducing infant mortality), and 5 (improving maternal health).

Indicators and Targets

- Proportion of births attended by skilled birth attendants in Latin America and the Caribbean (LAC). Baseline: 85% in 2006. Target: 90% by 2013.
- Reduction in the number of countries in the Region reporting a maternal mortality ratio above 100 per 100,000 live births. Baseline: 10 countries in 2006. Target: 6 countries by 2013.
- Number of countries in LAC with an under-5 mortality rate of 32.1 per 1,000 live births or less. Baseline: 21 countries in 2006. Target: 26 countries by 2013.
- Number of countries in LAC with a contraceptive prevalence rate above 60% (as a proxy measure for access to sexual and reproductive health services). Baseline: 13 countries in 2006. Target: 21 countries by 2013.
- Number of countries in LAC with an adolescent fertility rate (defined as the annual number of live births per 1,000 females aged 15-19) of 75.6/1,000 or less. Baseline: 8 countries in 2006. Target: 13 countries by 2013.
- Number of countries in the Region where 50% or more of the older adult population (60 years or older in LAC, 65 or older in the US and Canada) receive services adapted to their health needs. Baseline: 9 countries in 2006. Target: 15 countries by 2013.

ISSUES AND CHALLENGES

While there have been improvements in infant and child mortality rates in the Region, the situation is worsening for some conditions (e.g. the incidence of sexually transmitted infections and high fertility among adolescents in some countries), and stagnating for others (e.g., maternal and neonatal mortality). Most countries are not on track to meet the internationally agreed goals and targets for family and child health.

Child and Infant Mortality - The region of the Americas has made great strides in reducing child (under five years old) and infant mortality. During 1990-2005 the child mortality rate in children under five years old decreased by 44%. Despite this, large disparities continue among and within countries; e.g. in many Latin American and Caribbean countries the high newborn death rate has not improved to the degree expected. Several countries have experienced a marked reduction in infant mortality, but without an equivalent reduction in neonatal mortality. For example, Bolivia's infant mortality rate fell by 29% between 1989 and 1998, while the decrease in neonatal mortality was only 7% in the same period.

Each year nearly 12,000,000 babies are born in LAC. Of these, 400,000 die annually before the age of 5 years; within this group 270,000 die before 1 year, and of these 180,000 die during the first month of life. Neonatal mortality, defined as death in the first 28 days of life, is estimated at 15 per 1,000 live births. Newborn mortality accounts for 60% of infant deaths and 36% of under-5 mortality; the majority of these deaths are avoidable. Contributing factors to high neonatal mortality include: low visibility of newborn deaths and of newborn health in national priority-setting; inequalities in access to skilled birth attendants and primary health care; and poor maternal health, which adds significantly to the risk of neonatal death. In addition, interventions that directly target babies to further improve outcomes are either deficient or absent.

The leading causes of neonatal death in LAC include infections (32%), asphyxia (29%), prematurity (24%), congenital malformations (10%), and others (7%). While some are direct causes, others, as in most cases of prematurity/low birth weight, may constitute predisposing factors. PAHO estimates that approximately 8.7% of newborns suffer from low birth weight (less than 2,500 grams at birth). Low birth weight is closely associated with increased neonatal morbidity, and it is estimated that between 40% and 80% of infants who die during the neonatal period suffer from this condition. Other indirect causes include socioeconomic factors such as poverty, poor education (especially maternal education) and lack of empowerment, poor access and some traditional practices that are harmful. The rural and urban poor, other marginalized communities, indigenous and afro-descendent populations experience disproportionately high neonatal mortality.

Evidence suggests that the first week of life is the most vulnerable in terms of neonatal mortality risk, and that appropriate care in the first 24 hours of life is an important determinant for the future of the child. In countries where the infant mortality rate is not extremely high, about two-thirds of infant deaths take place in the first month of life.[9]

Collective actions are lacking, not only through the health systems and services, but also at the household level, to promote interventions that can be effectively delivered at low cost. Examples of these interventions include the promotion of breastfeeding, oral rehydration therapy, and the consumption of micronutrients, as well as education on complementary feeding. One major challenge is to reorient health services towards a model of care that encourages health promotion and disease prevention, with a family and community approach, and the development of managerial capacity at local levels.

Many national and international agencies (UNICEF, UNF, CIDA, and the Spanish bilateral agency AECI), prominent NGOs, and civil society are working in Latin America in the child health arena. This presents a challenge in terms of coordination to avoid duplication and build on synergies.

Young People's Health

Most of the national adolescent health plans and programs do not use an integrated approach to address the main health issues (adolescent pregnancy, STI/HIV, drug abuse, and violence) that affect a rapidly expanding youth population in the Region. Most of these programs remain as pilot interventions and there is a great need to scale them up using lessons learned from successful experiences. This situation is complicated by the fact that youth health, and in particular adolescent sexual and reproductive health, is not a priority in the political agenda of most countries in the Region. In many countries policy and legislation promoting access to adolescent and youth health services are not enforced and national programs remain fragmented. There is a deficiency of trained human resources to provide quality care to this population, adequate information systems and monitoring and evaluation.

While mortality and morbidity is generally low during adolescence, according to the Global Burden of Disease 2004 update[10], total deaths in the Region for 15-29 year olds was 287,920. The main causes of mortality for this age group are injuries (63%), non communicable diseases (22%), and communicable, maternal, perinatal and nutritional conditions (15%). These causes affect young men and women differently. For example, the distribution of deaths from injuries, including violence and homicides (43% of total deaths in the group) was 92% among males and 8% among females; deaths from road traffic accidents (26%), 79% among males and 21% among females; deaths from suicide (11%), 78% among males and 22% among females; and deaths from all other injuries (20%) AIDS makes up for 47% of all deaths by infectious and parasitic diseases for young people (15-29) in the Americas, 67% for young men and 33% for young women. In 2006, 20% of diagnosed and reported HIV cases in the Region corresponded to young people 15-24 years old.[11]

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[9] Neonatal Health in the Context of Maternal, Newborn and Child Health for the Attainment of the Millennium Development Goals of the United Nations Millennium Declaration. 47th Directing Council of the Pan American Health Organization. 58th Session of the Regional Committee. Washington, D.C., USA, 25-29 September 2006. OPS/FCH/CA/07.08OPS/FCH/CA/07.08.

[10] The Global Burden of Disease: 2004 update (2008 publication of 2004 updated dataset): Available at: http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html

[11] Pan American Health Organization, HIV/AIDS database, FCH/AI Project

In LAC, females under 20 years of age are estimated to account for 18% of births, 30% to 40% of which are unwanted pregnancies. It is estimated that there is a 40% unmet need for contraception. Adolescent mothers (aged 10 to 19) are two times more likely than older mothers to die from pregnancy-related causes, and account for 30% to 50% of maternal mortality in the countries with higher maternal mortality ratios. The risk of dying is 4 times higher among adolescents under 15 years old. Fifty percent of unsafe abortions occur among women 20-29. More than five countries in the Region have fertility rates in adolescents aged 15-19 of more than 100 per 1,000; 12 countries have fertility rates greater than the regional average (76 per 1,000).

Violence disproportionately impacts youth with an estimated 101.7 per 100,000 men and 60.4 per 100,000 women age 15 to 29 in middle and low income countries in LAC dying from intentional injuries. The dominant conceptual framework used to respond to youth violence centers on punitive and not preventive approaches, and focuses on youth as perpetrators of violence, without addressing the underlying causes.[12]

Alcohol and drug abuse, and tobacco use are increasing among adolescents in the Region, and are highly associated with early pregnancy, sexually transmitted infections, HIV, and violence.

The disproportionate impact of these issues on low income, poorly educated, indigenous, migrant, and ethnic minority young people needs to be specifically addressed.[13]

Several actors are working in the field of adolescent health, such as UNICEF, UNFPA, UNIFEM, USAID, many major NGOs (PLAN, Pathfinder, Red Cross, Alan Guttmacher) and bilateral organizations (CIDA, SIDA, GTZ, NORAD, CIDE), posing a challenge in the coordination of efforts and the harmonization of programs.

Maternal Mortality - Some countries have made strides in reducing maternal mortality (MM), while in others the situation has worsened. Great disparities remain among countries (MM of 630 per 100,000 live births in Haiti vs. 17.3 in Chile) and within countries (in Argentina, MM of 7 per 100,000 live births in the Autonomous City of Buenos Aires versus 150 in La Rioja province). The population that has access to skilled birth attendants is particularly low in the poorest countries and in rural settings. In some countries a large proportion of women (69% of women in Bolivia and 89% of women in Haiti) do not have access to skilled birth care. In Central America, skilled attendance at birth is available to no more than 55% of pregnant women, and in Haiti such skilled care is only available to 26% of urban women. The majority of MM results from preventable causes such as hemorrhage (21%), pregnancy-induced hypertension (26%), sepsis (8%), obstructed and prolonged labor (12%), and abortion-related complications (13%). In some countries, essential obstetric and neonatal services are either not in place or of poor quality, or under-utilized because of cultural or physical barriers and lack of skilled personnel, especially in remote areas.

The coverage of prenatal control attention (normally referred to as one contact) is 89.1%; delivery coverage by trained staff is 88.2%. Five countries with figures above 90% of prenatal control or delivery attention by qualified staff have a MM ratio above 91.1 per 100,000 live births, which shows quality problems in maternal and perinatal health services.

Health and well-being among older persons - In 2006, 9% of Latin America's population was 60 or older (over 50 million people) and 7 million were 80 years old or older. While the population in general is growing by 1.5% annually, the population over 60 is growing at an annual rate of 3.5%. This demographic shift means that by around 2025, the Region will have 100 million people over 60 years old. This fact underscores that active and healthy aging will be one of the biggest challenges that Latin American and Caribbean societies face during the 21st century. Expansion of primary health care coverage to the older adult population and greater participation of this group in their health care are important issues to be addressed by health systems.

Overall Challenges - Political will to make a difference in this Strategic Objective is declining in some countries of the Region, and resources are insufficient. Those most affected (e.g. poor women and children in developing countries) have limited influence on decision-makers and are often excluded from care. Communities need to be empowered to improve local decision-making and action. In addition, some issues are politically and culturally sensitive and complicate the consensus needed to improve public health. Furthermore, efforts to improve the quality of health care and to increase coverage rates are insufficient. Competing health priorities among organizations, vertical program approaches, and lack of coordination among governments and development partners result in program fragmentation, missed opportunities, and an inefficient use of limited financial resources. Better coor-

[12] "Políticas públicas y marcos legales para la prevención de la violencia relacionada con adolescentes y jóvenes. Estado del arte en América Latina 1995-2004." (Spanish only) Pan American Health Organization, and German Technical Cooperation (GTZ)

[13] For the extensive situation analysis, please refer to the Regional Strategy for Improving Adolescent and Youth Health. http://www.paho.org/english/gov/cd/CD48-08-e.pdf

dination among various partners and harmonization with UN agencies is an important factor for the achievement of this strategic objective. Additionally, interventions must be implemented within a primary health care setting, in a culturally sensitive context.

In the Region, technical knowledge and program experience indicate that effective and affordable interventions exist for most of the problems covered by this Strategic Objective. Consensus exists on the need to reach universal access using key interventions. The PAHO Directing Council set out agreed actions in Resolution CE124.R4 (IMCI) and Resolution CD47/12 (Neonatal health in the context of maternal, newborn and child health) to achieve universal access. To this end, adopting a life-course approach that recognizes the influence of early life events and inter-generational factors on future health outcomes will serve to bridge gaps and build synergies among program areas, while providing effective support to ensure active and healthy aging.

In summary, the crucial challenge of this strategic objective is to ensure the conditions that allow all pregnant women, infants, children, adolescents and adults to develop their human potential, and to achieve their maximum physical and cognitive development and the highest quality of life.

STRATEGIC APPROACHES

- Implementing the *Integrated Management of Childhood Illness* (IMCI) strategy, formulated to focus on the care of children under five, not only in terms of their overall health status but also on the diseases that may occasionally affect them; scaling-up efforts to expand the coverage of clinical, household, and community interventions to the most vulnerable populations, including the indigenous groups, and linking community actions with health services and systems.

- Promoting integral child development, emphasizing psychosocial development of the child, affective development, early stimulation, physical activity and healthy feeding practices, prevention of child abuse, mental health disorders, among others, through the Community IMCI Strategy.

- Implementing the Regional Strategy for Improving Adolescent and Youth Health (CD48/8) to ensure that young people receive timely and effective health promotion, prevention and care through integrated health systems. The Strategy will support Member States to establish national adolescent and youth health objectives that integrate interventions of the main health issues[14] affecting young people using promotion and prevention strategies.

- Implementing the *Integrated Management of Adolescent and Adult Illness* (IMAI) strategy, this addresses the overall health of the patient, focusing on the management of chronic disease and prevention, rather than just the treatment of acute illness.

- Implementing the *Regional Strategy for Maternal Mortality and Morbidity Reduction* to reduce the burden of disease, unnecessary disability, and death that are associated with pregnancy, puerperium and childbirth; and expanding the coverage of clinical, household, and community interventions to the most vulnerable populations, including indigenous groups, and linking community actions with health services and systems.

- Implementing the *Regional Initiative for Maternal Mortality Reduction* to strengthen the regional technical and national capability and political environment in favor of the reduction of maternal mortality.

- Implementing the *WHO Global Strategy* for Reproductive Health directed to governments, normative agencies of international organizations, professional associations, nongovernmental organizations, and other institutions.

- Provide technical cooperation to Member States to develop integrated and comprehensive health systems and services to address the needs of mothers, newborns, children, and young people, and older adults with an emphasis on primary health care, gender inequality, and growing health inequities that fuel the high levels of mortality and morbidity.

[14] See Issues and Challenges section of this document

- Integrating and harmonizing programs and interventions throughout a continuum of care that runs through the life course and spans the home, the community, and different levels of the health system and services.

- Promoting community-based interventions with the active participation of the community to increase the demand for services and to support appropriate care in the home across the life course.

- Improving surveillance, and monitoring and evaluation systems; these will include audits of all the deaths of children under the age of 1, medical certification of deaths, appropriate registries by services and geographical units and the availability of statistics and epidemiology services to facilitate better decision making.

- Promoting partnerships with bilateral and UN agencies to harmonize actions that scale–up interventions and maximize the use of resources.

- Developing policies and programs that expand human resources in gerontology and geriatrics education for family as well as community caregivers in order to promote active and healthy aging and to prevent early deterioration (both physical and mental).

ASSUMPTIONS AND RISKS

Assumptions:

- Overall strengthening of health systems and services will occur, including the development and maintenance of a suitable infrastructure, a reliable supply of essential drugs and commodities, functional referral systems, and a competent and well-motivated workforce.

- Key processes will be pursued, such as the improved harmonization of the work performed by UN agencies at the country level and the integration of health issues in national planning and implementation instruments.

- Political will for these activities will be reflected in additional technical and financial resources for making progress towards the Millennium Development Goals.

Risks:

- Threats posed by the possibility of a flu pandemic in the Region, diverting financial and human resources.

- Political instability, economic crisis, and natural disasters may lead to the reversal of direction in some indicators.

- Lack of political commitment by donor agencies and governments to properly address family and community health needs.

- A healthcare workforce weakened by strikes, migration, frequent changes in political appointments, and high turnover of trained personnel.

Region-wide Expected Results

RER 4.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop comprehensive policies, plans, and strategies that promote universal access to a continuum of care throughout the life course; to integrate service delivery; and to strengthen coordination with civil society, the private sector and partnerships with UN and Inter-American system agencies and others (e.g. NGOs).	4.1.1	Number of countries that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health	0	2	3	4
	4.1.2	Number of countries that have a policy of universal access to sexual and reproductive health	7	11	13	16
	4.1.3	Number of countries that have a policy on the promotion of active and healthy aging	11	15	17	18

RER 4.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen national/local capacity to produce new evidence and interventions; and to improve the surveillance and information systems in sexual and reproductive heath, and in maternal, neonatal, child, adolescent and older adult health.	4.2.1	Number of countries that implement information systems and surveillance systems to track sexual and reproductive health, maternal, neonatal and adolescent health, with information disaggregated by age, sex and ethnicity	10	15	17	20
	4.2.2	Number of PASB systematic reviews on best practices, operational research, and standards of care	0	5	7	10

RER 4.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods.	4.3.1	Number of countries adapting and utilizing PAHO/WHO-endorsed technical and managerial norms and guidelines for increasing coverage with skilled care at birth, including prenatal, post-natal, and newborn care	10	12	19	23

RER 4.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to improve neonatal health.	4.4.1	Number of countries with at least 50% of selected districts implementing interventions for neonatal survival and health	4	6	12	18
	4.4.2	Number of guidelines and tools developed and disseminated to improve neonatal care and survival	4	6	6	9

RER 4.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to improve child health and development, taking into consideration international agreements.	4.5.1	Number of countries that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts	8	10	11	13
	4.5.2	Number of countries implementing the WHO/PAHO Key Family Practices approach at the community level to strengthen primary health care	9	10	11	13

RER 4.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for the implementation of policies and strategies on adolescent health and development.	4.6.1	Number of countries with a functioning adolescent and youth health and development program[15]	10	12	16	17
	4.6.2	Number of countries implementing a comprehensive package of norms and standards to provide adequate health services for young people's health and development (e.g. Integrated Management of Adolescent Needs [IMAN])	3	10	14	15

RER 4.7	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to implement Reproductive Health Strategies to improve prenatal, perinatal, postpartum, and neonatal care, and provide high quality reproductive health services.	4.7.1	Number of countries that have adopted strategies to provide comprehensive reproductive health care	5	8	11	15
	4.7.2	Number of countries that have reviewed public health policies related to sexual and reproductive health	7	10	11	12

RER 4.8	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to increase advocacy for aging as a public health issue, and to maintain maximum functional capacity throughout the life course.	4.8.1	Number of countries that have implemented multisectorial community-based programs with a focus on strengthening primary health-care capacity to address healthy aging	5	7	10	12

[15] Functioning National Adolescent and Youth Health Programs, defined as one that is at least 2 years old, has a medium or long-term plan of action that has been implemented in the last year has a person in charge, has an assigned budget

Strategic Objective 5

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

Scope

This Strategic Objective is designed to contribute to human well-being, minimizing the negative effects of disasters and other crisis by responding to the health needs of vulnerable populations affected by such events. It focuses on strengthening the institutional capacity of the health sector in preparedness and risk reduction, while promoting an integrated, comprehensive, multisectoral and multidisciplinary approach to reduce the impact of natural, technological or manmade hazards on public health in the Region.

Indicators and Targets

- Crude daily mortality. Target: Daily mortality of populations affected by major emergencies maintained below 1 per 10,000 during initial emergency response phase.
- Access to functioning health services. Target: Affected health networks become operational within one month following a natural disaster.

ISSUES AND CHALLENGES

Countries of the Region are not sufficiently prepared to manage the consequences of disasters. Ensuring that international assistance complements the national response remains a challenge. National disaster plans continue to focus on single hazards instead of being multi-hazard and multi-institutional.

Natural hazards remain the most common threat to Latin American and Caribbean countries. Regardless of their frequency and severity, it is generally admitted that the countries' vulnerability is on the rise as a result of unsafe development practices and the deterioration of existing infrastructure. Following Hyogo Framework of Action for 2005-2015, safe hospitals will be an indicator on the level of vulnerability in the health sector.

Technological disasters are perhaps the most overlooked risk factors for countries that have reached a certain level of industrial development. Little has been done in terms of regulation and prevention, and the health sector is poorly prepared to face a large-scale chemical, radiological and other technological disasters. This risk will likely increase with economic development in the countries and the globalization of trade.

Internal conflicts have a direct impact on the health of the population. Despite the relatively stable situation of the Region there have been a number of individual internal conflicts. A certain number of crisis are to be anticipated over the next five-year period.

The emerging threat of pandemic influenza in 2005 revealed that epidemics that result in humanitarian crisis do not constitute a sufficiently important part of national disaster plans. Despite recent planning, health institutions are still inadequately prepared to face these kinds of threats.

Due to the proliferation of actors in disaster preparedness and response, coordination is becoming a challenge and competition for funding is progressively increasing. The main actors in the field of disaster reduction and response are: United Nations (UN) agencies such as the Office for the Coordination of Humanitarian Affairs (OCHA), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM); regional and subregional organizations: Organization of American States (OAS), Coordination Center for the Prevention of Natural Disasters in Central America (CEPREDENAC), The Andean Committee for Disaster Prevention and Assistance (CAPRADE), The Caribbean Disaster Emergency Response Agency (CDERA), International and National NGOs, National Red Cross Societies and The International Federation of Red Cross and Red Crescent Societies (IFRC), among others.

National emergency response needs to be improved in a wide range of areas, including mass-casualty management; water, sanitation and hygiene; nutrition; response to chemical and radiological accidents; communicable and non-communicable diseases;

maternal and newborn health; mental health; pharmaceuticals; health technologies; logistics; health information services; and restoration of the health infrastructure.

The procedures of UN organizations are not particularly suited for field operational response activities.

STRATEGIC APPROACHES

- Ensuring the coordination, effectiveness and efficiency of activities concerning preparedness, response and recovery in relation to health action in crisis, PAHO/WHO will be the Health Cluster Leader for the Western Hemisphere when called upon; this will be done in PAHO/WHO capacity in the United Nations Humanitarian Reform Process.
- Building national preparedness and capacity to manage risk and reduce vulnerability through: advocacy, updated policies and legislation, training, appropriate structures, scientific information, plans and procedures, resources and partnerships.
- Strengthening technical guidance and leadership and better coordination will be needed to ensure that there are no shortcomings in future emergencies.
- Compiling a roster of appropriately trained experts who can be called on in case of an emergency. Criteria and procedures should be agreed for collaboration involving all sectors.
- Collaborating with partners within and outside the health sector, including governments and civil society, other UN Agencies, as well as with mechanisms and networks, in order to ensure timely and effective interventions.
- Mainstreaming disaster management within the PASB by developing technical and operational capacities across PAHO/WHO in support of countries in crisis, particularly for conducting health assessments, mobilizing resources, coordinating health action, tackling shortcomings, providing guidance and monitoring the performance of humanitarian action in relation to the health and nutrition of affected populations.

ASSUMPTIONS AND RISKS

Assumption:

- Disaster preparedness and risk reduction receive strong political support and resources at all levels.

Risks:

- The risk of distracting PAHO staff from development priorities due to their involvement in disaster response activities is real, since humanitarian response is very demanding in terms of expert time and administrative support.
- Large multi-country disasters, such as those that occurred during the strong hurricane seasons of 2004 and 2005, may affect the implementation of the activities of this Strategic Objective.
- Work in the area of emergency preparedness and response may be incorrectly perceived as an additional responsibility that is secondary to the Organization's regular work.

Region-wide Expected Results

RER 5.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States and partners supported through technical cooperation for the development and strengthening of emergency preparedness plans and programs at all levels.	5.1.1	Number of countries that have developed and evaluated disaster preparedness plans for the health sector	23	30	34	35
	5.1.2	Number of countries implementing programs for reducing the vulnerability of health infrastructures	9	20	24	30
	5.1.3	Number of countries that report having a health disaster program with full time staff and specific budget	10	12	14	15

RER 5.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Timely and appropriate support provided to Member States for immediate assistance to populations affected by crisis.	5.2.1	Number of Regional training programs on emergency response operations	4	6	7	7
	5.2.2	Percentage of emergencies where a response to emergencies is initiated within 24 hours of the request	100%	100%	100%	100%

RER 5.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for reducing health sector risk in disasters and ensuring the quickest recovery of affected populations.	5.3.1	Percentage of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component	100%	100%	100%	100%
	5.3.2	Percentage of humanitarian action plans for complex emergencies and consolidated appeals with strategic and operational components for health included	100%	100%	100%	100%

RER 5.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through coordinated technical cooperation for strengthening preparedness, recovery and risk reduction in areas such as communicable disease, mental health, health services, food safety, and nuclear radiation.	5.4.1	Percentage of emergency-affected countries where a comprehensive communicable disease-risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies	90%	100%	100%	100%
	5.4.2	Percentage of emergencies where coordinated technical cooperation (PASB task force) is provided, when needed	100%	100%	100%	100%

RER 5.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen national preparedness and establish alert and response mechanisms for food safety and environmental health emergencies.	5.5.1	Number of countries with capacity to respond to food safety emergencies	15	19	24	30
	5.5.2	Number of countries with national plans for preparedness, and alert and response activities in respect to chemical, radiological and environmental health emergencies	20	24	26	28
	5.5.3	Number of countries with focal points for the International Food Safety Authorities Network	28	29	30	32

RER 5.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Effective communications issued, partnerships formed and coordination developed with organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.	5.6.1	Percentage of emergencies where the United Nations Health Cluster, as defined by the UN Humanitarian Reform, is operational, if called upon	100%	100%	100%	100%
	5.6.2	Number of emergency-related Regional interagency mechanisms and working groups where PAHO/WHO is actively involved	4	8	9	10
	5.6.3	Percentage of disasters in which UN and country-originated reports include health information	100%	100%	100%	100%

RE 5.7	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Acute, rehabilitation, and recovery operations implemented in a timely and effective manner, when needed.	5.7.1	Percentage of emergencies for which PAHO/WHO mobilizes national and international resources for operations, when needed	100%	100%	100%	100%
	5.7.2	Percentage of recovery operations for which health interventions are implemented, when needed	100%	100%	100%	100%

Strategic Objective 6

To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions

Scope

The work under this Strategic Objective (SO) focuses on integrated, comprehensive, multisectoral and multidisciplinary health promotion and disease prevention strategies to improve public health and well-being; and the development of social and public health policies for the reduction or prevention of the six major risk factors.

Indicators and Targets

- Number of countries reporting a 10% reduction in the prevalence rate of tobacco use. Baseline: 3 countries in 2007. Target: 10 countries by 2013. (Applies to 20 countries that have information in the WHO Database.)
- Number of countries that have stabilized or reduced the prevalence of adult obesity among males and females. Baseline: 0 countries in 2007. Target: 5 countries by 2013. (This indicator applies to 15 countries with current national representative data in the WHO Global Database on Obesity.)
- Number of countries that have decreased the non-desirable outcomes of unprotected sex, as measured by a reduction in the estimated prevalence rate of HIV cases in young people aged 15–24 years to 0.46/100 or less for females and 0.79/100 or less for males in Latin America, and 3.30/100 or less for females and 2.51/100 or less for males in the Caribbean. **Latin America-Baseline**: 11 countries in 2006. Target: 20 countries by 2013. **Caribbean**-Baseline: 4 countries in 2006. Target: 7 countries by 2013.

ISSUES AND CHALLENGES

The major six risk factors: tobacco use, unhealthy diet, physical inactivity, alcohol consumption, drug and psychoactive substance use and unsafe sexual behaviors, account for more than 60% of the mortality and at least 50% of the morbidity burden worldwide and in the Americas. Environmental and social determinants play an important role. The challenge in the Region is to implement integrated intersectoral action and to promote public policies against risk factors.

Poor populations in low- and middle-income countries are predominantly affected. While emphasis has been placed on the treatment of the adverse effects of these risk factors, much less attention has been devoted to prevention and how to effectively modify the determinants.

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

In 2002, alcohol consumption was responsible for 5.4% of all deaths and 10% of all Disability Adjusted Life Years (DALYs) lost in the Region, with most of the burden in Central and South America. It is estimated that alcohol consumption accounted for at least 323,000 deaths in that year. Intentional and unintentional injuries accounted for about 60% of all alcohol-related deaths and almost 40% of alcohol-related disease burden. Most of the alcohol related disease burden (83.3%) affects men. Also noteworthy is that 77.4% of the burden comes from the population aged 15-44, affecting mostly young people and young adults in their most productive years of life. Illicit drug use and misuse of prescription drugs are growing problems in the Region. However, there is

very limited information available to help public policy decision regarding prevention and treatment of such problems. In some countries of the Region injection drug use is a significant force behind the rapid spread of HIV and other blood-borne infections. The challenge is to emphasize prevention, create health services for drug users, combat stigma and discrimination, and allocate adequate resources.

A worrisome decrease in physical activity levels is widespread in the Region. While the physically active (30 minutes of physical activity at least five times a week) population in the United States has remained at 30% for more than a decade, in Latin America and the Caribbean (LAC) it is between 40-60%. Physical inactivity in the Region has been driven by increased urbanization, motorized transportation, urban zoning polices that promote car dependence, and lack of infrastructure for pedestrians as well as cyclists. In addition, leisure time is increasingly spent in activities, such as watching television and playing electronic games.

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

Unsafe sexual behavior significantly contributes to negative health consequences such as unintended pregnancy, sexually transmitted infections (including HIV/AIDS), and other social, emotional and physical consequences that have been severely underestimated. WHO estimates that unsafe sex is the second most important global risk factor to health in countries with high mortality rates. Globally, each year 80 million women have an unwanted pregnancy, 46 million opt for termination, and 340 million new cases of sexually transmitted infections and 5 million new HIV infections are reported. Risky behavior does not often occur in isolation; for example, hazardous use of alcohol and other drugs and unsafe sexual behaviors frequently go together. Many of these behaviors are not the result of individual decision-making but reflect existing policies, social and cultural norms, inequities, inequalities, and low education levels. Thus, PAHO/WHO recognizes the need for a comprehensive integrated health promotion approach and effective preventive strategies.

Significant additional investment in financial and human resources is urgently needed at all levels to build capacity as well as to strengthen national, regional and global interventions. The Member States should be very active in promoting awareness and political commitment to act decisively to promote health and healthy lifestyles, and prevent and reduce risk factor occurrence.

STRATEGIC APPROACHES

- Implementing an integrated approach on health promotion and the prevention and reduction of major risk factors to enhance synergies, improve the overall efficiency of interventions and dismantle the current vertical approaches to risk-factor prevention.
- Strengthening leadership and stewardship of Ministries of Health to ensure the effective participation of all sectors of society.
- Strengthening national capacities for surveillance, prevention and reduction of the common risk factors.
- Improving leadership and health promotion at regional, national and local levels and, scaling up activities across all relevant health programs.
- Ensuring that every country of the Region implements the Regional Strategy and Plan of Action for Integrated Prevention and Control of Chronic Non-communicable Diseases endorsed by the Member States.

ASSUMPTIONS AND RISKS

Assumptions:

- There is additional investment in financial and human resources to build capacity for health promotion and risk factor prevention.
- Effective partnerships and multisectoral and multidisciplinary collaborations in relation to policies, mechanisms, networks and actions are established involving all stakeholders at national, regional and international levels.
- There is a commitment to comprehensive and integrated policies, plans and programs addressing common risk factors.
- Investment in research, especially to find effective population-based prevention strategies, is increased.

Risks:

- Working or interacting with the private sector presents risks associated with the competing interests of industries, such as tobacco, alcohol, sugar, processed food and non-alcoholic drinks, and requires that guidelines for appropriate conduct be followed in all cases.
- Integrated approaches to prevention and reduction may also compromise organizational and country capacity to provide specific disease and risk-factor expertise unless the critical mass of expertise is protected and the required level of resources obtained.

Region-wide Expected Results

RER 6.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen their capacity for health promotion across all relevant programs; and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.	6.1.1	Number of countries that have health promotion policies and plans with resources allocated	11	15	18	20
	6.1.2	Number of countries with Healthy Schools Networks (or equivalent)	7	10	13	15
	6.1.3	Number of countries that adopt the PAHO/WHO urban health conceptual framework	0	2	4	5

RER 6.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination.	6.2.1	Number of countries that have developed a functioning national surveillance system using Pan Am STEPs (Pan American Stepwise approach to chronic disease risk factor surveillance) methodology for regular reports on major health risk factors in adults	6	10	15	20
	6.2.2	Number of countries that have developed a functioning national surveillance system using school-based student health survey (Global School Health Survey) and are producing regular reports on major health risk factors in youth	11	15	23	30
	6.2.3	Number of countries that have implemented the standardized indicators for chronic diseases and risk factors in the PAHO Regional Core Health Data and Country Profile Initiative	3	8	10	12

RER 6.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation on evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing tobacco use and related problems.	6.3.1	Number of countries that have adopted a smoke-free legislation which includes all public places and all workplaces (public and private), consistent with the WHO Framework Convention on Tobacco Control	1	3	5	7
	6.3.2	Number of countries that have adopted bans on advertisement, promotion and sponsorship of tobacco products consistent with the WHO Framework Convention on Tobacco Control	0	2	3	4
	6.3.3	Number of countries with regulations on packaging and labeling of tobacco products consistent with the WHO Framework Convention on Tobacco Control	8	10	17	23
	6.3.4	Number of countries that have updated at least one of the components of the Global Tobacco Surveillance System (GTSS)	9	20	28	35

RER 6.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing alcohol, drugs and other psycho-active substance use and related problems.	6.4.1	Number of countries that have implemented policies, plans, or programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use	11	13	16	20

RER 6.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing unhealthy diets and physical inactivity, and related problems.	6.5.1	Number of countries that have implemented national policies to promote healthy diet and physical activity according to PAHO/WHO guidelines	8	10	15	20
	6.5.2	Number of countries that have created pedestrian and bike-friendly environments, as well as physical activity promotion programs in at least one of their major cities	7	10	13	18

RER 6.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for promoting safer sex.	6.6.1	Number of countries that have implemented new or improved interventions at individual, family and community levels to promote safer sexual behaviors	7	9	10	11

Strategic Objective 7

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

Scope

This Strategic Objective focuses on the development and promotion of intersectoral action on the social and economic determinants of health, understood as the improvement of health equity by addressing the needs of poor, vulnerable and excluded social groups. This understanding highlights the connections between health and social and economic factors such as income, education, housing, labor, and social status.

Indicators and Targets

- Number of countries with national health indicators disaggregated by sex and age, and including the Gini coefficient and the Lorenz curve. Baseline: 3 countries in 2007. Target: 6 countries by 2013.
- Number of countries that have developed public policies for non-health sectors that address health conditions. Baseline: 7 countries in 2007. Target: 20 countries by 2013.
- Number of countries that have national development and poverty reduction plans integrating health, nutrition and education. Baseline: 3 countries in 2007. Target: 6 countries by 2013.

ISSUES AND CHALLENGES

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

This situation raises challenges for ministries of health, which must work in innovative ways to foster intersectoral collaboration. This includes working on the social and economic determinants of health and their relationship with the MDGs, and aligning key health sector-specific programs to better respond to the needs of vulnerable populations. Effective strategies to promote health gains for vulnerable groups include the integration into health sector policies and programs of equity-enhancing, pro-poor, gender-responsive, ethnic/racial-sensitive, and ethically sound approaches. Human rights law, as enshrined in international and regional human rights conventions and standards[16], offers a unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders involved.

The crucial challenges for achieving the above include: (1) developing sufficient expertise on the social and economic determinants of health and their relationship with the MDGs, as well as regarding ethics and human rights at the global, regional, and country levels; (2) ensuring that all the technical areas at PASB headquarters reflect the perspectives of social and economic determinants (including gender, ethnic origin and poverty), ethics, and human rights in their programs and normative work; and

[16] Under current international law, human rights instruments include regional/international "treaties" or "conventions" negotiated and formulated by UN and/or OAS Member States and international/regional "standards" which are guidelines enshrined in declarations, recommendations and reports issued by the UN/OAS General Assembly, UN High Commissioner for Human Rights, UN Human Rights Council and UN/OAS treaty bodies, among others. See PAHO Directing Council, Technical Document CD 47/15 of 16 August, 2006, 47th session of the Directing Council, p.10-13. Available at http://www.paho.org/english/gov/cd/CD47-15-e.pdf

(3) adopting the correct approach for measuring effects. This final challenge is especially great, since results in terms of increased health equity and equality among the most vulnerable groups are seldom rapidly apparent or easily attributable to particular interventions. Innovative means of evaluation are required for assessing how policies, programs, plans, laws and interventions are designed, vetted and implemented. New means are also needed to assess whether interventions are effective in bringing about change, in addition to measuring health outcomes.

Indigenous peoples are culturally heterogeneous and reside in a variety of locations that often include two or more countries, complicating interventions designed to address their health needs. Other challenges are: creating or increasing awareness among decision makers; promoting effective participation of indigenous peoples in decision-making; and fostering a concerted effort to identify, develop, resource and implement an intercultural approach to address indigenous health needs, rather than imposing a single model of care. The main challenge remaining is to increase the access and utilization of health services for the indigenous peoples, at both the local and national levels.

There is a lack of vital and health statistics disaggregated by ethnicity, gender and age groups, which impedes the development of appropriate evidence-based decision-making and adequate evaluation of the health situation.

STRATEGIC APPROACHES

- Strengthening national strategies and plans to address all forms of social disadvantage and vulnerability that have a negative impact on health and produce social exclusion; involving civil society and relevant stakeholders through, for example, community-based initiatives.
- Redressing the root causes of health inequities, discrimination and inequality with regard to the most vulnerable groups will need coordinated integration by both the Bureau and Member States to support the incorporation of gender equality, ethnic/racial, poverty, ethics- and human rights-based perspectives into health guideline preparation, policy-making and program implementation.
- Focusing technical cooperation on: (1) the five priority countries (Bolivia, Guyana, Haiti, Honduras and Nicaragua), (2) urban areas in middle income countries where the highest concentration of poor people reside, and (3) indigenous peoples, in order to achieve the MDGs.
- Implementing the "Faces, Voices, and Places of the Millennium Development Goals" initiative, the goal of which is to help the most vulnerable communities achieve the MDGs by reducing inequity through the empowerment of communities in Latin America and the Caribbean.

ASSUMPTIONS AND RISKS

Assumptions:

- Ministries of Health will exercise leadership to address the broader determinants of health, moving towards a multisectoral approach, prioritizing those sectors with the greatest impact on health.
- Health program designers and implementers will be willing and able to incorporate equity-enhancing, pro-poor, gender-responsive, ethnic/racial sensitive strategies into their programs despite technical and political complications.
- The governments adopt and implement the recommendations of the Global Commission on the Social Determinants of Health.
- The health and well-being of the indigenous peoples will be a high priority for national governments and national and international agencies.

Risks:

- Lack of effective consensus among partners in countries—including agencies within the UN System, other international partners and non-governmental organizations—on policies and frameworks for action.
- Economic, gender, ethnic/racial and poverty analysis may not be widely available.
- Lack of appropriate response from governments to address the health needs of indigenous peoples; paucity of cooperative efforts between indigenous peoples and governments in this regard.

Region-wide Expected Results

RER 7.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Significance of determinants of health and social policies recognized throughout the Organization and incorporated into normative work and technical cooperation with Member States and other partners.	7.1.1	Number of countries that have implemented a national strategy for addressing key policy recommendations of the Commission on the Social Determinants of Health	0	4	10	12

RER 7.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Initiative taken by PAHO/WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.	7.2.1	Number of published country experiences on tackling social determinants for health equity	6	8	10	12
	7.2.2	Number of countries implementing at least one systematized intervention for the most vulnerable communities, as defined by the PASB's MDGs Cross-Organizational Team	0	0	6	12
	7.2.3	Number of countries which have implemented the "Faces, Voices and Places" initiative	6	12	13	15

RER 7.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Social and economic data relevant to health collated and analyzed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).	7.3.1	Number of countries that have published reports incorporating disaggregated health data at sub national level to analyze and evaluate health equity	2	4	6	9

RER 7.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Ethics- and human rights-based approaches to health promoted within PAHO/WHO and at national, regional and global levels.	7.4.1	Number of countries using: 1) international and regional human rights norms and standards; and 2) human rights tools and technical guidance documents produced by PAHO/WHO to review and/or formulate national laws, policies and/or plans that advance health and reduce gaps in health equity and discrimination	9	10	11	18

RER 7.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Gender analysis and responsive actions incorporated into PAHO/WHO normative work and technical cooperation provided to Member States for formulation of gender sensitive policies and programs.	7.5.1	Number of countries that are implementing plans for advancing gender in the health sector	0	6	12	18
	7.5.2	Number of tools and guidance documents developed or updated by PASB to include gender equality in health analysis, programming, monitoring, or research	8	15	22	28
	7.5.3	Number of PASB entities that include gender perspectives in their situation analysis, plans, or monitoring mechanisms	3	10	15	20

RER 7.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop policies, plans and programs that apply an intercultural approach based on primary health care and that seek to establish strategic alliances with relevant stakeholders and partners to improve the health and well-being of indigenous peoples and racial/ethnic groups.	7.6.1	Number of countries that implement policies, plans or programs to improve the health of indigenous peoples	3/21*	9/21	12/21	19/21
	7.6.2	Number of countries that include ethnic variables within their health information systems	3	9	13	15
	7.6.3	Number of countries that implement policies, plans or programs to improve the health of specific ethnic/racial groups	10	12	14	16

** Denominators refers to countries with significant indigenous population*

Strategic Objective 8

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

Scope

The work under this Strategic Objective (SO) focuses on achieving safe, sustainable, and health-enhancing human environments - protected from social, occupational, biological, chemical, and physical hazards - and promoting human security and environmental justice to mitigate the effects of global and local threats.

Indicators and Targets

- Proportion of urban and rural populations with access to improved water sources in the Region. Baseline: 95% of urban and 69% of rural populations in 2002. Target: 96% of urban and 77% of rural populations by 2013 (per the Millennium Development Goals).

- Proportion of urban and rural populations with access to improved sanitation in the Region. Baseline: 84% of urban and 44% of rural populations in 2002. Target: 90% of urban and 48% of rural populations by 2013 (per the Millennium Development Goals).

- Number of countries implementing national plans on Workers Health (based on the WHO *Workers' Health: Global Plan of Action*, 2007). Baseline: 10 countries in 2007. Target: 20 countries by 2013.

- Number of countries with toxicological information centers. Baseline: 14 countries in 2006 (estimated). Target: 24 countries by 2013.

- Reduction in the attributable factor of the burden of diarrheal diseases among children/adolescents age 0-19 years, due to environmental causes. Baseline: 94% in 2002 (estimated). Target: 84% by 2013. (Methodology for Assessment of Environmental Burden of Disease developed by WHO, measured by the attributable factors in DALYs)

- Number of environmental health policies on chemical substances, air quality and drinking water adopted by countries of the Region. Baseline: 11, 7, 13, respectively, in 2007. Target: 20, 12, 20, respectively, by 2013.

ISSUES AND CHALLENGES

Environmental and occupational risks contribute to a large portion of morbidity and mortality in the Region, but few countries have comprehensive policies to perform analysis and establish public policies to manage them. Modern production processes introduce new or magnify old chemical, physical, biological and psychological health risks in the Region. Countries do not have policies on urban development that promote health, social equity, and environmental justice. These risks affect not only the present generation, but also future generations due to their long-term health effects.

Rapid changes in lifestyle, increasing urbanization, production and energy consumption, climate change and pressures on ecosystems could, in both the short and long terms, have consequences for public health and health costs. These consequences will be even worse if the health sector fails to act on currently existing occupational and environmental hazards to health. For effective health sector action, risks have to be reduced in the settings where they occur: homes, schools, workplaces and cities; and in sectors such as energy, transport, industry, agriculture, as well as water, sanitation and solid waste.

Of particular concern in the Region are the needs of agricultural workers, workers in small-scale enterprises, workers in the informal sector, and migrant workers. These workers are at high risk and often have no access to occupational health services.

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

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

More than five million children die each year from environment-related diseases and conditions, such as diarrhea, respiratory illnesses, malaria, and unintentional injuries. Millions more are debilitated by these diseases or live with chronic conditions linked to their environment, ranging from allergies to mental and physical disabilities. Most of the environment-related diseases and deaths can be prevented using effective, low-cost, and sustainable tools and strategies.

Latin America is one of the areas of the world with the greatest use of pesticides. Central America, for example, imports 1.5 kg of pesticides per inhabitant, which is 2.5 times higher than the world average. Banned pesticides are still imported into many Latin American countries. More stringent national and international legislation and comprehensive interventions are needed.

The deleterious health effects from persistent organic pollutants (POPs) and heavy metals, such as lead, mercury, and others, are increasingly recognized. However, there are no information systems to track these POPs, and disseminate knowledge about the identification, control, and elimination of related risks.

Climate change and other global environmental risks add to the current health burden. Negative impacts include increased health hazards, poor nutrition profiles, water scarcity, and increased vector-borne diseases.

Accidental release or the deliberate use of biological and chemical agents, or radioactive material requires effective prevention, surveillance, and response systems to contain or mitigate harmful health outcomes.

The use of consumer products has changed in the Region and in many cases poses new risks to health. Revision of sanitary surveillance and regulatory processes in the Region has been the main tool to respond to consumers' health hazards.

It has been estimated that every year 5 million occupational accidents occur in Latin America, of which 90,000 are fatal, equivalent to approximately 250 deaths per day.

Local governments are challenged to find suitable, sanitary, sound solutions for 360,000 tons of garbage produced daily in Latin America. Although water coverage has reached 90.3%, and 84.6% of the population has access to drinking water in Latin America (2004 data), the most vulnerable populations—those living in rural areas and urban slums—still lack access.

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

STRATEGIC APPROACHES

- Improving the health and environment ministries' strategic alliance to build stronger links between the health and environmental sectors in national policy planning and implementation.

- Promoting the achievement of the MDGs through Children's Environmental Health strategies in response to the Joint Action Plan on Health and Environment agreed upon by the Ministers of Health and Environment in 2005 in Mar del Plata.

- Strengthening the networks and promoting the participation of Collaborating and Reference Centers from several sectors to promote interprogrammatic and interinstitutional integration.

ASSUMPTIONS AND RISKS

Assumptions:

- Health sector personnel become increasingly cognizant of the mounting burden of disease from environmental health risks in light of new evidence.

- Decision-makers (such as policymakers, banks and civil society in sectors of the economy with the greatest impact on public health) will increasingly prioritize health, putting the health costs and benefits of their actions at the center of their decision-making processes.

- Development partners (collaborating centers, cooperation agencies, foundations, recipient countries and banks) will increasingly recognize that reducing environmental hazards to health contributes significantly to the achievement of the relevant Millennium Development Goals.

- United Nations system reform will allow PAHO/ WHO to show more global leadership in public health and the environment, prioritizing health in humanitarian responses and environmentally sustainable economic development.

Risks:

- Expectations from other sectors for quick results and reductions of environmental health risks may exceed the capacity of the health sector to provide support for their actions.

- Information about the best options for sectoral interventions to improve occupational and environmental health is inaccessible.

- Global leaders and partners in the arenas of development and/or the environment show weak or transient commitment to improving environmental health.

- Health systems continue to respond weakly in reducing the range of occupational and environmental health risks and rooting out their causes.

Region-wide Expected Results

RER 8.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, electro-magnetic fields (EMF), radon, drinking water, waste water re-use) disseminated.	8.1.1	Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year	2	3	4	7
	8.1.2	Number of international environmental agreements whose implementation is supported by PASB	5	5	5	6
	8.1.3	Number of countries implementing WHO norms, standards or guidelines on occupational or environmental health	13	18	21	24
	8.1.4	Number of countries implementing WHO guidelines on drinking water towards MDG 7	6	8	11	14

RER 8.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for the implementation of primary prevention interventions that reduce environmental health risks; enhance safety; and promote public health, including in specific settings and among vulnerable population groups (e.g. children, older adults).	8.2.1	Number of countries implementing primary prevention interventions for reducing environmental risks to health in workplaces, homes or urban settings	4	7	8	10

RER 8.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.	8.3.1	Number of countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance	10	15	17	20
	8.3.2	Number of national organizations or collaborating or reference centers implementing PAHO/WHO-led initiatives at country level to reduce occupational risks	2	4	5	6

RER 8.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Guidance, tools, and initiatives created to support the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture), assess health impacts, determine costs and benefits of policy alternatives in those sectors, and harness non-health sector investments to improve health.	8.4.1	Number of regional, subregional and national initiatives implemented in other sectors that take health into account, using PASB technical and logistical support	2	3	3	4
	8.4.2	Number of PAHO/WHO guidelines and tools produced inter-sectorally for global environmental health protection	0	2	3	4

RER 8.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Health sector leadership enhanced to promote a healthier environment and influence public policies in all sectors to address the root causes of environmental threats to health, by responding to emerging and re-emerging environmental health concerns from development, evolving technologies, other global environmental changes, and consumption and production patterns.	8.5.1	Number of regular high-level fora on health and environment for regional policymakers and stakeholders supported by PASB	1	2	3	4
	8.5.2	Number of current PASB five-year reports on environmental health available, including key health drivers and trends, and their implications	1	1	1	2

RER 8.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop evidence-based policies, strategies and recommendations for identifying, preventing and tackling public health problems resulting from climate change.	8.6.1	Number of studies or reports on the public health effects of climate change published or copublished by PAHO or peer reviewed publications of authors/institutions based in Latin America and the Caribbean	N/A	0	1	2
	8.6.2	Number of countries that have implemented plans to enable the health sector to respond to the health effects of climate change	N/A	0	3	5

Strategic Objective 9

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

Scope

The work under this Strategic Objective (SO) focuses on improving nutrition and health throughout the life course, especially among the poor and other vulnerable groups, and achieving sustainable development in line with the Millennium Development Goals. The SO addresses food safety (ensuring that chemical, microbiological, zoonotic and other hazards do not pose a risk to health) as well as food security (access and availability of appropriate food).

Indicators and Targets

- Proportion of underweight children under 5 years of age in Latin America and the Caribbean. Baseline: 7.5% in 2002 (using period of 7 years, 1995-2002). Target: 4.7% by 2013.
- Proportion of stunted children under 5 years of age in Latin America and the Caribbean. Baseline: 11.8% in 2005. Target: 8.8% by 2013.
- Proportion of children under 5 years of age with anemia in Latin America and the Caribbean. Baseline: 29.3% in 2005. Target: 25.3% by 2013.
- Proportion of overweight and obese children under 5 years of age in Latin America and the Caribbean in those countries where information is available. Baseline: 4% in 2003 (using periods of 3 years, 2000–2003). Target: 4% or less by 2013.
- Reduction in the number of foodborne diarrheal disease cases per 100,000 inhabitants in the Region. Baseline: 4,467 in 2006. Target: 4,020 by 2013.

ISSUES AND CHALLENGES

Most countries face a double burden of disease where obesity and under-nutrition coexist, thus jeopardizing efforts to achieve development goals. This double burden of disease affects the poor and the wealthy, both in relative and in absolute terms, and places enormous demands on governments, individuals and families, due to the high financial and social costs of disease and disability days, loss of quality of life and productivity. In addition, suboptimal nutrition in all its forms, including micronutrient deficiencies, seriously compromises the effectiveness of other social and economic interventions, because of its direct impact on the immune system and its effects on increasing the risk of disease, disability and death. There are, moreover, critical policy-making and implementation issues that need to be addressed:

Public policies, plans and programs do not effectively address all nutrition needs at the regional, sub regional, national and local levels. Most social and economic policies at national and local levels do not include food and nutrition components and activities. Insufficient financial resources are allocated to address nutrition priorities in a sustainable fashion. Functional networks of stakeholders (public, private and civil society organizations, universities, research centers) to mobilize and allocate human and financial resources to improve health and nutrition are weak or non-existent. In addition, most countries face deficiencies in terms of human resources competences and skills in policy analysis, planning and evaluation.

The shortcomings in planning and implementation of training programs are associated with deficiencies in food and nutrition analysis for systematic policy decision-making. Overall, food and nutrition components and activities in plans and programs at national and local levels are not being adequately monitored and evaluated. The science and technology research agenda for policy-making at the national level does not include relevant food and nutrition topics with appropriate resource allocation, which hinders the dissemination of best practices in health and nutrition. In terms of setting priorities, nutrition is not included in local government initiatives as a strategy that fosters and contributes to comprehensive local development.

The challenge is to promote the public and social policies that unequivocally address nutrition needs with a life course approach and nutrition transition problems at the regional, subregional, national, and local levels. This will require building capacities in policy design, formulation, monitoring and evaluation to enable the sustainability of these policies.

Implementation of effective prevention and treatment strategies targeted to vulnerable groups to eliminate nutritional deficiencies and suboptimal nutrition is often defective, decreasing its potential benefits. While the number of programs to implement nutrition interventions has increased, the standard "golden rule" norms and guidelines to manage, monitor and evaluate the effects of nutrition interventions on vulnerable groups are not being disseminated and followed systematically. In the Region, there is evidence that the training and technology transfer models are not actually improving the capacity of health and non-health personnel to manage and control suboptimal nutrition and nutritional deficiencies. Overall, the absence of systematic monitoring and evaluation of interventions to prevent and control suboptimal nutrition and nutritional deficiencies that produce data, information and knowledge for decision-making is a constant issue.

Additionally, there is insufficient information on nutritional deficiencies and risk factors of suboptimal nutrition that is reliable, updated, comparable and employed at national and subnational levels to monitor the nutrition conditions of different population groups. In general, activities to identify, assess and exchange best practices and lessons learned on the reduction of suboptimal nutrition and nutritional deficiencies need to be strengthened.

The challenge is to eliminate nutritional deficiencies and suboptimal nutrition through prevention and treatment strategies targeted to vulnerable groups throughout the life course and in the event of disasters.

The promotion of healthy dietary habits, active lifestyles and the adequate control of obesity—and nutrition-related chronic diseases remains a low priority for governments, agencies and society. Regional networks, partnerships and agreements to prevent obesity—and nutrition-related chronic diseases and promote adequate nutrition and physical activity have not expanded to include medium- and low-income countries undergoing the nutrition transition. In most countries, the promotion of healthy eating and physical activity based upon norms and guidelines is not integrated into existing food and nutrition initiatives. Deficiencies in the design, implementation and evaluation of communication and awareness campaigns to promote healthy eating and physical activity have failed to create awareness and expertise at the national level about the need to improve the capacity of health and non-health public and private sectors and civil society organizations for promoting healthy lifestyles. Moreover, there is a lack of databases and health information systems that produce reliable, valid and quality information on overweight and obese children and adolescents for decision-making. Best practices and lessons learned from experiences to reduce obesity- and nutrition-related chronic diseases are not being identified, documented and disseminated.

The challenge is to promote the adoption of healthy dietary habits, active lifestyles, and the adequate control of obesity and nutrition-related chronic diseases.

In the Americas, food safety activities are fragmented and developed by various actors whose mandates are often not clearly defined.

The challenge is to reduce the burden of food-born diseases develop integrated effective food safety systems, which are vital to maintain consumer confidence in the food system and which provide a sound regulatory foundation for national and international trade in food, which supports economic development.

STRATEGIC APPROACHES

- Adopt the life course approach, the social determinants, human rights and support multisectoral and interprogramatic interventions.
- Develop and disseminate multisectoral interventions to address the social determinants of nutrition.
- Strengthening health promotion (including healthy life styles and physical activity), primary health care and the social protection.
- Strengthening capacity throughout the health and non-health sectors based on standards.

- Supporting risk assessments and risk communication.
- Support information systems, program monitoring and evaluation, research, systematization and dissemination of best practices and evidence based interventions.
- Strengthening alliances, partnerships, networks, and a regional forum in food and nutrition.
- Strengthening resource mobilization.

ASSUMPTIONS AND RISKS

Assumptions:

- Adequate nutrition will continue to be recognized as a fundamental prerequisite for health and development.
- Health promotion and prevention will support modifications in individual behaviors, and provide supportive environments that help individuals to make more informed choices to prevent malnutrition and diseases arising from unsafe food.
- Access to adequate and safe food is prominent in policy agendas; Member States are committed to comprehensive and integrated policies and plans, and to the development and strengthening of their national food security, nutrition and food safety programs, based on reliable and current evidence.
- National and international stakeholders will have a positive attitude towards harmonization of actions that will facilitate working in synergy towards common agendas.

Risks:

- Emergence of parallel health, nutrition, and food security and safety agendas due to lack of communication and coordination among partners.
- Low investment and political commitment from governments concerning nutrition, food security and food safety.
- Large multi-country natural disasters, such as hurricanes, droughts, volcanic eruptions, which seriously affect the food and nutrition situation of vulnerable populations, and the implementation feasibility of basic nutrition, food security and food safety interventions.

Region-wide Expected Results

RER 9.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, to promote advocacy and communication, stimulate intersectoral actions, and increase investment in nutrition, food safety and food security.	9.1.1	Number of countries that have coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security and nutrition	18	23	26	30
	9.1.2	Number of countries that have implemented nutrition, food-safety and food security interventions	10	15	20	25

RER 9.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.	9.2.1	Number of countries implementing nutrition and food safety norms, and guidelines according to global and regional mandates	15	20	25	30

RER 9.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Monitoring and surveillance of needs, and assessment and evaluation of responses in the area of food security, nutrition and diet-related chronic diseases strengthened, and ability to identify suitable policy options improved.	9.3.1	Number of countries that have adopted and implemented the WHO Child Growth Standards	0	16	20	25
	9.3.2	Number of countries that have nationally representative surveillance data on one major form of malnutrition	12	15	20	22
	9.3.3	Number of countries that produce evidence based information in nutrition and food security	11	15	20	22

RER 9.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for the development, strengthening and implementation of nutrition plans and programs aimed at improving nutrition throughout the life-course, in stable and emergency situations.	9.4.1	Number of countries that have implemented at least 3 high-priority actions recommended by the Global Strategy for Infant and Young Child Feeding	5	12	17	20
	9.4.2	Number of countries that have implemented strategies to prevent and control micronutrient malnutrition	11	16	21	25
	9.4.3	Number of countries that have developed national programs that implement strategies for promotion of healthy dietary practices in order to prevent diet-related chronic diseases	11	16	19	25
	9.4.4	Number of countries that have incorporated nutritional interventions in their comprehensive response programs for HIV/AIDS and other epidemics	11	14	20	25
	9.4.5	Number of countries that have national preparedness and response plans for food and nutrition emergencies	11	16	20	25

RER 9.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Zoonotic and non-zoonotic foodborne diseases, and foot-and-mouth disease surveillance, prevention and control systems strengthened and food hazard monitoring programs established.	9.5.1	Number of countries that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne diseases	16	21	23	30
	9.5.2	Number of South American countries that have achieved at least 75% of the Hemispheric Foot-and-mouth Disease Eradication Plan objectives	4/11*	6/11	9/11	11/11

RER 9.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Technical cooperation provided to National Codex Alimentarius Committees and the Codex Commission of Latin America and the Caribbean.	9.6.1	Number of countries adopting Codex Alimentarius Meetings' resolutions	40	40	40	40

** Denominators refers to countries with significant indigenous population*

Strategic Objective 10

To improve the organization, management and delivery of health services

Scope

This Strategic Objective (SO) focuses on strengthening health services to provide equitable and quality health care for all people in the Americas, especially the neediest populations. The Regional Declaration on the New Orientations for Primary Health Care and PAHO position paper on Renewing Primary Health Care in the Americas (CD46/13, 2005) provide the framework to strengthen the health care systems of the countries in the Americas.

Indicators and Targets

- Percentage of rural population living more than one hour away from a first level of care center, in six countries of the Region where a study was completed. Baseline: 10.6% in 2004. Target: 7% by 2013.
- Percentage of population covered by the healthcare network in six countries of the Region where a study was completed. Baseline: 30% in 2004. Target: 40% by 2013. (The healthcare network includes all health services {public, social security, community, private, etc.} in the respective country.)

ISSUES AND CHALLENGES

The Region of the Americas is one of the most unequal regions of the world, not only in terms of income distribution, but also in terms of access to social services. Profound inequities and inequalities in access to health services exist among the different countries of the Region, as well as within each one of them. It is estimated that 125 million people living in Latin America and the Caribbean do not have access to basic health services (about 27% of the population). While in Canada 100% of children are delivered by trained health personnel, this figure is only 24.2% in Haiti, 31.4% in Guatemala, and 60.8% in Bolivia. Within countries, inequities affect primarily low-income, rural and indigenous populations. Although average rates of utilization of health services have improved in recent years, inequities still persist or have worsened.

Several types of barriers explain inequities in access to, and utilization of, health services. Some of these are social and cultural (e.g. education level, language, cultural beliefs), economic (ability to pay, having health insurance), geographical (e.g. distance from adequate services), organizational (hours of operation, availability of medicines and of trained personnel to meet the needs, preferences, and demands of the population attitudes and behaviors of providers) and individual (e.g. lifestyle choices, health beliefs).

Until now, most efforts by governments, NGOs, donors, bilateral and multilateral agencies have addressed inequities in access to health services by expanding coverage of basic services in underserved areas. Although positive, this approach has been supply-driven, often neglecting local cultural preferences and social realities. Users and consumers have been left out of important decision-making regarding their health services. Moreover, some of these efforts have been hindered by organizational problems such as lack of personnel, shortages of medicines and inadequate hours of operation.

Another important challenge in the Region is the poor quality of health care, which leads to ineffective, inefficient and costly health services, as well as low user satisfaction. Quality problems affect all levels of the system, from the individual provider to the facility and system levels.

A frequent problem in most countries is the poor resolution capacity of primary care services. In addition to their poor effectiveness and efficiency, most primary care services are reactive, fragmented, disease-oriented and predominantly curative. Primary care services have little or no individual and community participation, poor intersectoral collaboration and weak accountability for results.

Another important problem is the poor performance of hospitals in terms of clinical outcomes and patient safety. Hospitals are not doing enough in terms of providing the best care possible to their patients. Patients are often submitted to ineffective, unnecessary, or even harmful diagnostic and therapeutic procedures. This situation contributes to inefficient use of resources, high fatality, hospital infection and early readmission rates. The levels of variation observed in the use of procedures in hospitals of similar characteristics represent a measure of ineffective or unnecessary care.

The lack of coordination among the different levels of care and points of service leads to duplication of services, unnecessary increment in health costs, as well as fragmented and inopportune care.

A particular problem of organizing and managing services relates to emergency care systems. In many cities of the Region, emergency services have not been systematically organized and are not properly managed. Although the development of emergency service systems is not a priority for most countries (only five of the twelve PAHO-surveyed countries provide public funding for emergency services), the increased incidence of motor vehicle and other severe injuries, in addition to the burden of acute medical conditions, indicate the pressing need to improve the effectiveness of emergency care systems.

The main foundation for promoting effective health services with good management practices is the availability of reliable, timely and accurate information for decision-making and the translation of information into knowledge and action. Situation analyses, best practices, and evidence on health services and population health needs are essential for exposing underlying factors related to the services being delivered and the basis for modifying the status quo and improving the health of populations.

STRATEGIC APPROACHES

- Implementing the Primary Health Care (PHC) approach in all health systems and services of the Region based on PAHO/WHO Working Document CD46/13 and the Regional Declaration of the New Orientations for Primary Health Care.
- Building the institutional development of the health sector to improve national capacity for implementation of health policies to increase health services coverage.
- Promoting universal access to information and knowledge to overcome existing asymmetries in access and to share vital information among countries of the Region.
- Building on lessons learned, and the exchange of experiences and best practices among the countries.
- Establishing partnerships, alliances and networks with governments, universities, research centers, collaborating centers, professional associations and others.

ASSUMPTIONS AND RISKS

Assumption:

- Social and political stability will continue in the Region.

Risks:

- A large portion of the increase in health funding from external sources will be directed to disease-specific interventions, reducing the resources available for system-wide approaches, and reinforcing separate vertical programs.
- The persistence of segmentation will hinder the efficiency of the healthcare delivery system and will compromise its potential to decrease exclusion.
- Health authorities will concentrate on the first level of care at the expense of addressing disparities and inefficiencies at the second and third levels of care.

Region-wide Expected Results

RER 10.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen health systems based on Primary Health Care, promoting equitable access to health services of good quality, with priority given to vulnerable population groups.	10.1.1	Number of countries that document the strengthening of their health systems based on Primary Health Care, in accordance with the Declaration of Montevideo and PAHO/WHO Position Paper	14	18	21	23
	10.1.2	Number of countries that show improvement in the performance of the steering role as measured by the assessment of Essential Public Health Functions	3	8	11	14
	10.1.3	Number of countries that integrate an intercultural approach in the development of policies and health systems based on PHC	0	3	5	8
	10.1.4	Number of countries that use the Renewed Primary Health Care strategy in their population-based programs and priority disease control initiatives	0	0	6	12

RER 10.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen organizational and managerial practices in health services' institutions and networks, to improve performance and to achieve collaboration and synergy between public and private providers.	10.2.1	Number of countries that have implemented strategies to strengthen health services management	3	14	17	20
	10.2.2	Number of countries that have adopted PAHO/WHO policy recommendations to integrate health services networks, including public and non-public providers	3	8	10	13

RER 10.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen programs for the improvement of quality of care and patient safety.	10.3.1	Number of countries that show progress in programs for the improvement of quality of care, including patient safety	11	19	22	24

Strategic Objective 11

To strengthen leadership, governance and the evidence base of health systems

Scope

This strategic objective aims at improving the leadership and governance of the health sector and the capacity of the national health authority to exercise its steering role, which includes policy making, regulation, and performance of the essential public health functions. Paramount to the achievement of this objective is the improvement of national health systems and the production of quality data, information and knowledge for planning and decision-making.

Indicators and Targets

- Number of countries with legislation aimed at increasing access to health (non-personal services and public health) and health care. Baseline: 5 countries in 2007. Target: 15 by 2013.
- Number of countries that have established national health objectives to improve health outcomes. Baseline: 3 countries in 2007. Target: 10 countries by 2013.
- Number of countries that have implemented monitoring and performance evaluation of the health information systems according to the standards of PAHO/WHO and the Health Metrics Network. Baseline: 3 countries in 2007. Target: 15 countries by 2013.
- Number of countries incorporating knowledge management and technology-based health strategies to strengthen their health systems. Baseline: 10 countries in 2007. Target: 20 countries by 2013.
- Number of countries that fulfill the Mexico Summit commitment to devote at least 2% of the public health budget to research. Baseline: 0 countries in 2006. Target: 10 countries by 2013.

ISSUES AND CHALLENGES

Uncertainty, complexity and turbulence in a highly networked but unequal world define a challenging landscape for health systems in the Region. Policy agendas have become more intricate, and policy arenas more crowded with expanded policy and epistemic communities, networks and advocacy coalitions that exercise power and influence through collective action. This fluid environment affects the overall capacity of the public sector to formulate and implement policies, as well as the quality of its governance and leadership. For the health sector and health systems, this translates into an often weakened ability of the national health authority to discharge its essential public health functions, to anticipate issues, establish priorities vis-à-vis competing demands, influence and negotiate, and to manage complex relationships with a growing number of agents. Thus, the crucial challenges are to increase the capacity of the health sector, and the capacity of the national health authority to exercise its steering role. Lack of universal access and poor utilization of health services disproportionately affect vulnerable population groups and increase exclusion in health. Segmentation and fragmentation of health systems and of the delivery networks remain the most salient features of health systems and delivery networks. Therefore, reducing inequalities in health conditions and increasing access to personal and non-personal health services represent significant challenges for the health systems.

Legal frameworks and regulations (obligations, roles, functions, and definition of interactions among public, private and social actors at national and international levels) are insufficient to support the implementation of nationally-defined guarantees. Moreover, some critical requisites for increasing access, ensuring social protection and respect for patient's rights are not always safeguarded. Enforcement capacity is also weak. The challenge is to improve the performance of the health systems by strengthening strategic planning, policy-making and analysis, legislation, and regulation, as well as to strengthen enforcement capacity.

Health information systems are fragmented, and production of quality data is uneven and often unreliable. Moreover, availability and use of scientific evidence and quality data for planning and decision-making, including reliable vital and health statistics and epidemiological data, is limited. This reflects the existing difficulties that some countries face in identifying and satisfying their own knowledge and information needs. This also results from the limited analytical capacity of many countries, as well as their

inability to tackle new metrics. The nature of current health problems requires quality, timely health and non-health data disaggregated by sex, age and place of residence, and robust analytical capacity. The challenges are to consistently produce reliable quality data with appropriate periodicity, increasing the analytical capacity, and promoting its use for decision-making.

Research for health is essential for development, yet the national health research systems are often incipient or too weak to address priority needs in health research, and to translate products into meaningful contributions that improve health systems. The paucity of regional scientific production reflects inadequate priority setting for health research, low investment and the lack of needs-driven research agendas. The challenges are to develop, implement or strengthen national health research policies with political support and funding; to improve capacity to conduct health research of national interest, including public health and health systems research; and to translate research findings into policy and practice.

STRATEGIC APPROACHES

- Developing and maintaining a comprehensive approach, customized to fit the political, cultural, social and technological national contexts that: encourages the participation and establishment of partnerships with relevant stakeholders; develops sustainable structures, processes, and capacities to achieve national goals and objectives; and strengthens the steering role of the national health authorities.
- Expanding and improving access to information and knowledge, and bridging the gap between knowledge and practice through sharing and dissemination of health information, knowledge and communication technologies.
- Establishing or strengthening national health information systems to generate, analyze, and utilize reliable information from public and private sources (e.g. administrative data sources, disease registries, surveillance, screening data, clinical [unless privacy protected] and laboratory, vital records, census, surveys, etc), including concrete efforts to secure technical and financial support, and the meaningful collaboration of relevant stakeholders and partners.
- Building and sustaining the necessary capacity for conducting research on issues of national interest in the areas of public health, health policies and health systems, and translating the findings into policy and practice. An important component of this approach is the formulation of a regional policy of health research.

ASSUMPTIONS AND RISKS

Assumptions:

- All relevant stakeholders are committed to achieving health equity while dynamic leadership and governance is maintained.
- External partners change the way they operate in terms of financing and execution to strengthen national activities, and they put in practice the principles of the Paris Declaration on Aid Effectiveness.
- Strategic partnerships are established or strengthened, while the participation of stakeholders at the national, subregional and regional levels is maintained and expanded.
- Member States and development partners make increasing use of quality data for resource allocation, priority setting and policy and program development.

Risks:

- Lack of international and national investment in health systems, especially in the middle-income countries, where the majority of the Region's poor reside.
- Equity-enhancing public policies are unsustainable and intersectoral coordination is weak.
- A preference for short-term solutions, rather than applying greater foresight and investing in long-term, sustainable measures.

Region-wide Expected Results

RER 11.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen the capacity of the national health authority to perform its steering role; improving policy analysis, formulation, regulation, strategic planning, implementation of health system changes; and enhancing intersectoral and inter-institutional coordination at the national and local levels.	11.1.1	Number of countries that have updated their legislations and regulatory frameworks	5	8	10	12
	11.1.2	Number of countries that have formulated policies, mid-term and long-term plans or defined national health objectives	9	17	29	35

RER 11.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for improving health information systems at regional and national levels.	11.2.1	Number of countries that have implemented processes to strengthen the quality and coverage of their health information systems	3	7	10	15
	11.2.2	Number of countries that have implemented the PAHO Regional Core Health Data	9	16	19	27

RER 11.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to increase equitable access to, and dissemination and utilization of, health-relevant information, knowledge and scientific evidence for decision-making.	11.3.1	Number of countries that update their health situation analysis at least every two years	5	7	9	10
	11.3.2	Number of countries that participate in initiatives tending to strengthen the appropriation, production and use of results from research to inform in policies and practices	0	3	6	8
	11.3.3	Number of countries that have access to essential scientific information and knowledge as measured by access to Virtual Health Libraries (VHL) at national and regional levels	10	15	21	25
	11.3.4	Number of countries monitoring the health related Millennium Development Goals	23	25	34	36

RER 11.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation for facilitating the generation and transfer of knowledge in priority areas, including public health and health systems research, and ensuring that the products meet WHO ethical standards.	11.4.1	Number of countries that have a national health research system with the characteristics (indicators) defined by PAHO	0	2	4	5
	11.4.2	Number of countries with national commissions aimed at monitoring compliance with ethical standards in scientific research	12	15	18	20

RER 11.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
PAHO is the authoritative source and broker of evidence-based public health information and knowledge, providing essential health knowledge and advocacy material to Member States, health partners and other stakeholders.	11.5.1	Number of hits to PAHO web page	20 million	30 million	35 million	40 million
	11.5.2	Maintain the number of countries that have access to evidence-based, health information and advocacy material for the effective delivery of health programs as reflected in the country cooperation strategies	33	33	33	33
	11.5.3	PAHO Regional Information Platform created, integrating all the PASB technical health databases and information from health and development partners	Core data and MAPIS	Integration of all PASB technical health databases	Integration of health and development partners information	Platform created and fully operative
	11.5.4	Number of Communities of Practice established and in use in the PASB entities	2	10	15	20

Strategic Objective 12

To ensure improved access, quality and use of medical products and technologies

Scope

Medical products include chemical and biological medicines, vaccines, blood and blood products, cells and tissues mostly of human origin, biotechnology products, traditional medicines and medical devices. Technologies include, among others, those for diagnostic testing, imaging, radiotherapy and laboratory testing. The work under this Strategic Objective (SO) will focus on more equitable access (as measured by availability, price and affordability) to essential medical products and technologies of assured quality, safety, efficacy and cost-effectiveness, and on their sound and cost-effective use.

Indicators and Targets

- Number of countries in Latin America and the Caribbean (LAC) where access to essential medical products and technologies is recognized in national constitutions or legislations. Baseline: 6 countries in 2006. Target: 14 countries by 2013.
- Number of countries in LAC where quality of medical products and technologies is monitored by the national regulatory authority. Baseline: 5 countries in 2006. Target: 10 countries by 2013.
- Number of countries in LAC where public sector procurement systems include planning, procurement and distribution of quality medical products and technologies. Baseline: 6 countries in 2006. Target: 16 countries by 2013.
- Number of countries in LAC where the national regulatory authorities have the capacity to perform the following basic functions, as measured by international standards: (a) licensing; (b) pharmaco-surveillance; (c) lot release system; (d) access to a quality control laboratory; (e) inspection of manufacturers; and (f) evaluation of clinical results. Baseline: 14 countries with basic-level, 6 with intermediate level, 2 with high-level regulatory functions in place in 2006. Target: 10 countries with basic-level, 7 with intermediate level and 7 with high-level regulatory functions in place by 2013.

ISSUES AND CHALLENGES

Health technologies form the backbone of health services, yet the level of access to health technologies differs greatly between rich and poor countries. Some technologies are inherently safe, but the vast majority are not, and require systematically established quality assurance and quality control measures if undesired effects are to be avoided in their application. Even though most developing countries cannot afford the vast variety of health technologies, if they are carefully chosen, a country may still be able to offer its citizens a safe and reliable health service, even with limited resources.

The cost of medical products and technologies is substantial, especially in developing countries. While spending on pharmaceuticals represents less than one-fifth of total public and private health spending in most developed countries, it represents 15% to 30% of health spending in transitional economies and 25% to 66% in developing countries. In most low income countries pharmaceuticals are the largest public expenditure on health after personnel costs, and the largest household health expenditure. Despite the potential positive health impact of essential drugs, lack of access to these drugs remains an issue. Although there is substantial spending on drugs in general, irrational use of drugs and poor drug quality remain serious global public health problems. The free trade agreements that are being negotiated or implemented in subregions, and their impact on the population's access to new products launched in the market, constitute an additional concern to Member States.

Most national immunization programs in the Region utilize vaccines that have been procured through PAHO Revolving Fund. The quality of these vaccines is assured by the WHO prequalification system, including both assessments of the manufacturer and of the National Regulatory Authority (NRA) of the country. Responsibility for oversight is delegated to the NRA.

Assessment of NRAs, using WHO standard methodology, has become an important tool in identifying NRA strengths and weaknesses in performing basic regulatory functions. The principal causes of noncompliance are: lack of organizational and independent structures, lack of qualified human resources, lack of coordination of activities, and poor infrastructure.

The World Health Organization (WHO) and the International Federation of Red Cross and Red Crescent Societies (IFRCRCS) have estimated that, for a community to have enough blood to cover its needs, 50 blood units per 1,000 inhabitants must be collected each year. The aggregated donation rate for the Region of the Americas is 24.5 blood units per 1,000 inhabitants, with 20 million units of blood collected for a population of 815 million. Inequity in the availability of blood among countries of the Region of the Americas is also manifested within the countries, with some major urban areas having access to the majority of blood available. Voluntary blood donation not only ensures the availability of blood, but also contributes to blood safety. Voluntary blood donors are less likely to be infected with transfusion-transmitted infections (TTIs), especially if they donate repeatedly. The high prevalence rates of TTI markers among blood donors and the number of unscreened blood units result in the transmission of infections to patients. There is a strong correlation of blood safety with availability and efficiency of the national blood system.

Access to image diagnosis services in LAC is much lower than in most developed countries, where the annual frequency is above 1,000 diagnostic explorations per 1,000 inhabitants. In 22 countries of our Region the frequency is around 150 per 1,000 inhabitants, while in five countries this value is approximately 20 per 1,000 inhabitants, representing 50 times less diagnostic explorations than what happens in high income countries. Access is also unequal, due to the costs of these services, poor insurance coverage and concentration in large urban areas; quality is essential to achieving the expected results of diagnoses.

Access to radiotherapy services is critical. Developed countries have 4 to 5 high-energy radiotherapy units per million inhabitants, while most countries in our Region have less than one, and few radiotherapy professionals.

Costs associated with these services, diagnostic imaging and radiotherapy, both in terms of the capital investment and operational costs for working and maintenance; require adequate planning and management, which is not present in most countries. This can be more critical when dealing with more complex equipment, such as computerized tomography, Nuclear Magnetic Resonance, linear accelerators and high dose brachytherapy.

The physical infrastructure and technology for health services has not improved significantly during 2006-2007. There is a continuous deterioration and outdating of infrastructure and equipment, and health authorities do not have a clear idea of the situation in the private sector. Several donors and banks are working simultaneously in this area, sometimes duplicating efforts. Most governments lack specific programs to regulate the importation, distribution, use and disposal of equipment.

The public health role of the laboratory includes the sustainable implementation of a system for quality assurance within the laboratory networks, strong interaction with epidemiologic surveillance in disease control, an integrated response to outbreaks and follow-up of the epidemiologic investigation process. National laboratory networks should be supported and reoriented towards a more intensive role in health surveillance and care by providing evidence for health interventions.

STRATEGIC APPROACHES

- Providing advocacy and support to Member States in the development, implementation and monitoring of national policies that facilitate access to, and affordability of, medical products and technologies.
- Implementing tools for improving cost-efficient medicine supply systems with emphasis in the public health services and targeted population groups through PAHO Strategic Fund.
- Applying evidence-based international norms and standards, developed through rigorous, transparent, inclusive and authoritative process.
- Promoting a public health approach to innovation and intellectual property rights issues, and adapting interventions that have proved successful.
- Identifying, supporting and expanding regional networks to facilitate the implementation of new technology.

ASSUMPTIONS AND RISKS

Assumptions:

- Access to medical products and technologies will continue to be an important strategic issue for ministries of health.
- Subregional integration schemes will implement harmonized regulatory frameworks ensuring the circulation of quality products and technologies within the Region.
- Procurement systems will ensure appropriate availability of health products and technologies.
- Interagency coordination and joint efforts will continue.

Risks:

- Investments in technology and infrastructure without proper assessments and evaluation of needs.
- Negotiation and implementation of free trade agreements introduce restrictive issues that hamper access to medical products and technologies in the Region.

Region-wide Expected Results

RER 12.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to promote and assure an equitable access to medical products and health technologies and the corresponding technological innovation.	12.1.1	Number of countries that have implemented policies promoting the access to, or technological innovation for medical products	17/36*	23/36	25/36	27/36
	12.1.2	Number of countries that have established or strengthened their national systems of procurement, production or distribution of medical products	15/36*	18/36	21/36	24/36
	12.1.3	Number of countries with 100% voluntary non-remunerated blood donations	8	10	12	17
	12.1.4	Number of countries that have tools to evaluate access to health technologies	5	10	15	20
	12.1.5	Number of countries using the PAHO Strategic Fund of Essential Public Health Supplies	10	11	15	18

** Denominator excludes USA, Canada, Puerto Rico and the US-Mexico border*

RER 12.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to promote and assure the quality, safety and efficacy of medical products and health technologies.	12.2.1	Number of countries evaluated in their regulatory functions for medical products	0	3	9	13
	12.2.2	Number of countries that have implemented international rules, norms, standards or guidelines on quality, safety and efficacy of health technologies	4	7	10	14

RER 12.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to promote and assure the rational and efficacious use of cost-effective medical products and health technologies based on the best evidence available.	12.3.1	Number of countries that have norms to define the incorporation of health technologies	11/36*	14/36	17/36	20/36
	12.3.2	Number of countries that use a list of essential medicines updated within the last five years as the basis for public procurement	19	24	27	28

** Denominator excludes USA, Canada, Puerto Rico and the US-Mexico border*

Strategic Objective 13

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

Scope

The challenges of the Health Agenda for the Americas, the Toronto Call to Action (2005), the frame of reference for developing national and subregional plans and the regional strategy for the Decade of Human Resources in Health (2006-2015) guide the work under this Strategic Objective. It addresses the different components of the field of human resource development, management operations and regulation, and the different stages of workforce development — entry, working life and exit — focusing on developing national workforce plans and strategies.

Indicators and Targets

- Number of countries where the density of the health workforce (disaggregated by, rural-urban, gender and occupational classification, where possible) reaches 25 health workers per 10,000 inhabitants. Baseline: 12 countries (2006). Target: 35 (100%) countries by 2013.

ISSUES AND CHALLENGES

Most of the countries in the Region of the Americas face imbalances in density, distribution and competencies of the health workforce. This contributes to the prevalence of social inequities and limits access to health services. The imbalances and deficits in human resources, the added problem of migration, the weakness of regulation and the steering role of the national health authority, the deficits in education and training in primary health care (PHC) and others issues make up the overview of the difficulties in health workforce development in the Region.

Weak stewardship of the national health authority and a paucity of policies and plans for human resources plague most of the countries. The challenge is to define policies and long-term plans to adapt the health workforce to the health needs of the population and develop the institutional capacity to implement these policies and review them periodically.

In 2000, over 163 million people in the Americas resided in areas where the human resources density was below the desirable target level of 25 per 10,000 inhabitants identified by the World Health Organization. Twelve countries have a density below 25 health workers per 10,000 inhabitants. Although 60% of the countries have an apparently sufficient number of health workers, the proportion settling in urban areas is disproportionate, creating critical shortages in rural areas. Even when the necessary number of professionals exists in many countries, health team composition is often off balance: 19 countries have more doctors than nurses. The challenge is to place the right people in the right places, obtaining an equitable distribution of health workers in the different localities based on the different health needs of the population.

Over 72% of the countries of the Americas have experienced a net loss of health workers due to migration leading to a particularly acute nursing shortage. This migration is from less developed to more developed countries, and has especially affected the Caribbean where there is a 35% nursing vacancy rate. In North America the actual shortage of nurses has been indicated as over 200,000. The challenge is to promote national and international initiatives for developing countries to retain their health workers and avoid personnel deficits.

Poor work conditions and unhealthy work environments that encourage migration and shortage exist in many countries. In a sample of 13 countries throughout the Region, the average unemployment rate for health workers was 6.2%, with the highest rate being 16.8%. The challenge is to generate labor relations between health workers and health organizations that promote healthy work environments and encourage commitment to the institutional mission in order to guarantee quality health services for the entire population.

Attrition rates in many health professional training programs are over 75% for doctors, nurses and other health professionals. The orientation of education in health sciences toward PHC is weak. There is a gap between health services requirements and the competencies of graduates in health sciences. The challenge is to develop mechanisms for collaboration and cooperation between the academic/training sector (universities, schools) and the health services to adapt the education of health professionals to a model of universal care that provides equitable, quality services that meet the health needs of the entire population.

STRATEGIC APPROACHES

- Implementing the Toronto Call to Action in which 29 countries of the Region and a significant number of international agencies agreed to request all countries to mobilize political will, resources and institutional actors to contribute to developing human resources in health. This is a way of achieving the Millennium Development Goals and universal access to quality health services for all populations in the Americas by 2015.

- Responding to countries affected by crisis in human resources and working to improve the health workforce in the Region. This will be done through strengthening and expanding the Observatories of Human Resources, maintaining information systems, developing policy, designing, implementing, monitoring and evaluating national, subregional and regional plans and strengthening national capacities for comprehensive human resource management, in the context of the Decade of Human Resources in Health 2006-2015 to ensure that they are responsive to health needs.

- Expanding capacities and improving the quality of educational and training institutions through the strengthening of national educational systems, especially schools and universities; and supporting training for health workers to develop appropriate skills and competencies.

- Ensuring an equitable and balanced skill mix and a geographical distribution of the health workforce through the development of effective deployment and retention measures, specific incentives and creative management strategies. Promoting and establishing partnerships at all levels, facilitating agreements with other agencies, creating networks of institutions of excellence, strengthening the training of human resources managers in all the countries and developing a regional network, setting indicators, norms and standards based on internationally agreed-upon definitions and supporting efforts for horizontal integration and cooperation among countries.

ASSUMPTIONS AND RISKS

Assumptions:

- Regional, subregional and national efforts to promote the health workforce development, included in the Toronto Call to Action, will continue.

- Cross-sector and interagency partnerships in support of health workforce development will continue to promote the active participation of all direct stakeholders, including civil society, professional associations, and the private sector.

Risks:

- Financing of health workforce development will decrease to such a low level that it will affect budgets and incentives for deployment to underserved areas.
- Countries affected by human resources crisis remain unable to take the lead and manage responses by themselves.
- Market forces continue to exert excessive pressure in favor of the exodus of professionals ("brain drain") to other countries and urban areas, as well as a shift to other professions.

Region-wide Expected Results

RER 13.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop human resources plans and policies to improve the performance of health systems based on primary health care and the achievement of the Millennium Development Goals (MDGs).	13.1.1	Number of countries with national policies for strengthening the health workforce, with active participation of stakeholders and governments.	12	16	19	28
	13.1.2	Number of countries with horizontal cooperation processes for the fulfillment of regional goals in human resources in health	2	3	4	6

RER 13.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to establish a set of basic indicators and information systems on human resources for health.	13.2.1	Number of countries that have established a database to monitor situations and trends of the health workforce, updated at least every two years	10	18	23	29
	13.2.2	Number of countries participating in the Human Resources for health Observatories network for the production of information and evidence for decision making	18	29	31	36

RER 13.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to formulate and implement strategies and incentives to recruit and retain health personnel in order to attend to the needs of health systems based on renewed primary health care.	13.3.1	Number of countries that have established a career path policy for health workers	4	7	10	14
	13.3.2	Number of countries with human resources management policies and systems to improve the quality of employment in the health sector	4	9	13	17

RER 13.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to strengthen education systems and strategies at the national level, with a view to develop and maintain health workers' competencies, centered on Primary Health Care.	13.4.1	Number of countries with joint planning mechanisms between training institutions and health services organizations	4	10	15	23
	13.4.2	Number of countries with policies that reorient health sciences education towards primary health care	4	7	10	13
	13.4.3	Number of countries that have established learning networks to improve the public health competencies of their staff	5	9	12	15
	13.4.4	Number of countries participating in the PAHO leaders in international health program	0	18	25	25
	13.4.5	Number of countries with accreditation systems for health sciences education programs	13	13	16	20

RER 13.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported with technical cooperation regarding the international migration of health workers.	13.5.1	Number of countries that analyze and monitor the dynamics of health worker migration	5	10	15	20
	13.5.2	Number of countries that participate in bilateral or multilateral agreements that address health worker migration	4	7	10	16

Strategic Objective 14

To extend social protection through fair, adequate and sustainable financing

Scope

This Strategic Objective (SO) will focus on sustainable collective financing of the health system and social protection, and safeguarding households against catastrophic health expenditures. The principles set out in resolution WHA58.33 and PAHO Resolution CSP26.R19 in 2002, "Extension of Social Protection in Health: Joint PAHO-ILO Initiative," will guide this SO.

Indicators and Targets

- Increase the percentage of population covered by any type of social protection scheme in the Region. Baseline: 46% in 2003. Target: 60% by 2013.
- Increase in the percentage of public expenditure for health, including primary health care expenditure for the countries where this information is available. Baseline: 3.1% in 2006. Target: 5% by 2013.
- Decrease in the out-of-pocket expenditures in health as percentage of the total health expenditure for those countries where this information is available. Baseline: 52% of the national expenditure in health in 2006. Target: 40% by 2013 (the Organization for Economic Cooperation and Development's [OECD] average for industrialized countries is 20%).

ISSUES AND CHALLENGES

The organization and financing of a health system are important determinants of the population's health and well-being. However, prevailing health system segmentation and fragmentation lead to inequality and inefficiency in the use of sector resources, while further restricting the access of poorer and more vulnerable populations. The challenge is to extend social protection in health efficiently.

Expenditure levels, especially public expenditure, are still insufficient—or used inefficiently—to ensure an adequate supply of health services, which means that families are forced to make out-of-pocket payments that affect household finances and lead to an increased risk of poverty. Reducing financial burden to individuals and families is a significant challenge.

Many regional, subregional, and national actors are involved in the work under this SO. Dealing with multiple actors is a major challenge. Principal actors include the private sector, international financial institutions, Economic Commission for Latin America and the Caribbean (ECLAC), International Labor Organization (ILO), International Social Security Association (ISSA), Inter-American Conference on Social Security (CISS), Inter-American Center for Social Security Studies (CIESS), subregional integration agencies such as Central American Integration System (SICA), Southern Common Market (MERCOSUR), Caribbean Community (CARICOM), Bolivarian Alternative for the Americas (ALBA); and bilateral development partners, ministries of labor/social security, finance/treasury, planning, central banks, and national statistics institutes, as well as universities and research centers.

STRATEGIC APPROACHES

- Engaging in advocacy to increase political will to secure predictable, sustainable, and collective funding for social protection in health at the national and international level.
- Developing reliable data and knowledge including strategic health intelligence to inform policy decisions on equitable collective funding mechanisms to reduce out-of-pocket expenditures.
- Strengthening national capacities, especially in the Ministries of Health and social security institutions, to promote social dialogue with civil society and relevant stakeholders, and to improve social protection in health.
- Strengthening national government capacity to align and harmonize international cooperation resources, per the Paris Declaration.

ASSUMPTIONS AND RISKS

Assumptions:

- Universal, equitable access to health services remains the most important objective for the governments of the Region, with gradual implementation in accordance with each country's capacity.
- Human, financial and technological resources for social protection are allocated, available and used efficiently in the health sector.

Risks:

- Recent increases in the countries' funding for health could be directed to a few vertical health programs at the expense of financing universal care.
- Greater funding from external sources could increase system segmentation and weaken sector institutions, undermining the steering role of the health authority due to parallel and segmented financing, insurance, and service delivery mechanisms.

Region-wide Expected Results

RER 14.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to develop institutional capacities to improve the financing of their health systems.	14.1.1	Number of countries with institutional development plans to improve the performance of financing mechanisms	7	10	12	15

RER 14.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to evaluate the relationship between catastrophic expenses in health and poverty; and to design public policies or financing schemes in health to reduce the financial risks associated with diseases and accidents.	14.2.1	Number of completed country studies applying the PAHO evaluation framework to assess household capacity to meet health expenditures	0	3	5	7
	14.2.2	Number of countries with studies on catastrophic expenses in health, poverty and inequalities	1	1	3	6
	14.2.3	Number of countries with public policies or financing schemes for the reduction or elimination of the financial risk associated with diseases and accidents	2	2	4	8

RER 14.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Technical cooperation provided to Member States in the development and use of national health expenditure and health system financing information.	14.3.1	Number of countries reporting up-to-date information on financing and health expenditure to the Regional-PAHO Core Data Initiative and the Statistical Annex of WHR/WHO	24/35*	31/35	33/35	35/35
	14.3.2	Number of countries that have institutionalized the periodic production of Health Accounts/National Health Accounts harmonized with the UN statistical system	3	16	21	24
	14.3.3	Number of countries with studies on expenditure and financing of public health systems or social health insurance	0	0	10	15

** Denominator refers to PAHO Member States only (countries of the Americas)*

RER 14.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to reduce social exclusion, extend social protection in health, strengthen public and social insurance, and improve programs and strategies to expand coverage.	14.4.1	Number of countries with insurance schemes and other mechanisms to expand social protection in health	8	10	11	12
	14.4.2	Number of countries with updated information to formulate policies for the expansion of social protection in health	11	13	15	16

RER 14.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Member States supported through technical cooperation to align and harmonize international health cooperation.	14.5.1	Number of countries that show improvement in levels of harmonization and alignment of international health cooperation, as measured by internationally agreed standards and instruments	3	5	7	8

Strategic Objective 15

To provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the United Nations system and other stakeholders to fulfill the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO Eleventh General Programme of Work, and the Health Agenda for the Americas

Scope

This Strategic Objective (SO) facilitates the work of the PASB in order to ensure the achievement of all other SOs. This objective covers three broad, complementary areas: (1) leadership and governance of the Organization; (2) the PASB's support to the Member States through its presence in the countries, and its engagement with each of them, the United Nations and Inter-American Systems, and other stakeholders; and (3) the Organization's role in mobilizing the collective energy and the experience of Member States and other actors to influence health issues of global, regional and subregional importance.

Indicators and Targets

- Number of countries implementing at least 30% of health policy-related resolutions adopted by the Pan American Sanitary Conference and Directing Council in the 2007-2011 period. Baseline: 0 countries in 2007. Target: 19 countries by 2013.
- Number of countries reporting a Country Cooperation Strategy (CCS) agreed by the government, with a qualitative assessment of the degree to which PAHO/WHO resources are harmonized with partners and aligned with national health and development strategies. Baseline: 0 countries in 2007. Target: 30 countries by 2013.
- Number of countries in Latin America and the Caribbean that achieve the targets of the Official Development Assistance for Health of the Paris Declaration on harmonization and alignment, as adapted by WHO and partners.[17] Baseline: 0 countries. Target: 5 countries by 2013.

ISSUES AND CHALLENGES

The PAHO Governing Bodies need to be supported effectively, and their decisions implemented in a responsive and transparent way. To ensure this occurs, the challenge for PASB is to establish clear lines of authority, responsibility and accountability in the Organization, particularly when decisions and resources are being decentralized to locations where programs are implemented.

There is not enough information on the degree of implementation of the PAHO Governing Bodies' resolutions in the Region. The PASB's challenge is to establish a monitoring system to follow up on implementation of resolutions at the regional, subregional, and country levels.

Providing reliable and timely health information is a crucial problem in the Region. The Organization's capabilities need to be strengthened to cope with the ever-growing demand for information on health, and communicate internally and externally in a timely and consistent way at all levels.

[17] Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results and Mutual Accountability, Paris, 2March 2005. WHO is working with OECD, the World Bank and other stakeholders to adapt the Paris Declaration to health. The following targets will gradually become more health-focused as the process evolves: 50% of Official Development Assistance implemented through coordinated programs consistent with national development strategies; 90% of procurement supported by such Assistance effected through partner countries' procurement systems; 50% reduction in Assistance not disbursed in the fiscal year for which it was programmed; 66% of Assistance provided in the context of program-based approaches; 40% of WHO country missions conducted jointly; 66% of WHO country analytical work in health conducted jointly

The regional level mechanisms to allow stakeholders to tackle health issues in a transparent, equitable and effective way should be strengthened. PASB should help to ensure that national health policymakers and advisers are involved in international fora where health-related issues are discussed. The numerous actors in public health, outside government and in intergovernmental bodies, need to have fora to allow them to contribute in a transparent way to global and national debates on health-related policies, as well as to play a part in ensuring good governance and accountability.

The PASB faces the ongoing issue of how to better focus its work to meet country health needs. This requires clearly articulated Country Cooperation Strategies (CCS) that reflect country priorities and are consistent with this Strategic Plan. The challenge is to ensure that all levels of the PASB (global, regional, subregional and country) are included in the CCS. The Bureau's presence must match the needs and level of development of the country concerned.

A number of health issues require subregional health interventions. In addition, subregional integration processes cover many topics crucial to public health. The PAHO Regional Program Budget Policy established the allocation of resources to the subregional level, and Biennial Workplans have been developed for all subregions. The challenge is to create Subregional Cooperation Strategies (SCS), which emulate the CCS, represent strategic planning for the PASB at this level, and guide the subregional Biennial Workplans.

A major concern is ensuring equity of access to information and knowledge by all audiences in light of the digital divide. Particularly affected are indigenous and rural populations, with special consideration to the multilingual peculiarities of these populations. The challenge is to ensure that decisions and action taken are based on the most up-to-date, relevant information. This requires regional efforts to improve equitable access to information taking into consideration the language and culture of the respective audiences as well as the open access and use of the existing instruments of information. A related challenge is the need for a paradigmatic shift in our beliefs, attitudes and behaviors regarding sharing of information and knowledge.

Although there has been an increase in the availability of external resources for health at the global level, most countries in Latin America and the Caribbean are considered middle or upper middle income level, and as such are either ineligible or in a low priority among the traditional resource providers. In addition, many traditional partners have decentralized their funding operations to the country level. The challenge is how to steer the PASB into a role of supporting the countries to tap into new emerging and non traditional partners such as the Global Fund against Aids, TB and Malaria or the Gates Foundation. The PASB faces the dual challenge of mobilizing resources for itself as well as for Member States.

The growing number of actors involved in supporting the health sector creates several challenges, including the risks of duplicated efforts, high transaction costs and varying accountability requirements at both government and partner levels, as well as weak alignment with country priorities. PAHO/WHO needs to continue to play a proactive role, and to devise innovative mechanisms for managing or participating in global, regional, subregional and national partnerships in order to make the international health architecture more efficient and responsive to the needs of Member States.

STRATEGIC APPROACHES

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

- Collaborating with countries to advance the global and regional health agendas, and bringing country realities and perspectives into regional policies and priorities. The different levels of the Bureau will be coordinated on the basis of an effective country presence that reflects national needs and priorities and integrates common principles of gender equality and health equity. At national level the Bureau will promote multisectoral approaches; build institutional capacities for leadership and governance, as well as for health development planning; and facilitate technical cooperation among countries (TCC).

- Promoting development of functional partnerships and alliances that ensure equitable health outcomes at all levels; encourage harmonized approaches to health development and health security with organizations of the United Nations and the Inter-American systems, other international bodies, and stakeholders. PAHO will continue to actively participate in the debate on the United Nations system reform. Promoting the role of PAHO as an agent for the mobilization of resources for the Member States, in addition to the more conventional mobilization for the Secretariat. Among other implications, this entails: 1) the need to prepare the country entities for new functions which include resource mobilization at the country level from international as well as national sources, and 2) ensuring that participation by PAHO in coordination mechanisms at the country level uses a comprehensive multidisciplinary and multisectoral approach

- Promoting PAHO as an authoritative source and broker of evidence-based research, policies and knowledge through broad and nontraditional partnerships, collaboration, and integrated data systems. PAHO will act as a convener of dialogue on health issues of global, regional, subregional and national importance.

- Addressing the information and knowledge problems at the level of people, processes, and technology in the areas of knowledge sharing, content management, policies and technology, thereby resulting in PASB being (1) an authoritative source of public health information, (2) a learning organization, (3) a networking and partnership organization, and (4) a collaboration-based organization.

ASSUMPTIONS AND RISKS

Assumptions:

- Managerial accountability for implementation of decisions will be strengthened in the context of the results-based management framework.

- Changes in the external and internal environment over the period of the PASB Strategic Plan will not fundamentally alter the role and functions of PAHO/WHO. Notwithstanding, PAHO/WHO must be able to respond and adapt to external changes, such as those stemming from reform of the United Nations system.

Risks:

- Reform of the United Nations system may have implications for PASB programmatic implementation.

- The increasing number of partnerships may give rise to duplication of efforts between initiatives, high transaction costs to government and donors, unclear accountability, and lack of alignment with country priorities and systems.

- The level of international cooperation in the Region continues to decline.

- Lack of political will to implement major health-related initiatives in the Region.

- The Region may not be a funding priority for the institutions providing resources for health.

Region-wide Expected Results

RER 15.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Effective leadership and direction of the Organization exercised through the enhancement of governance, and the coherence, accountability and synergy of PAHO/WHO work to fulfill its mandate in advancing the global, regional, subregional and national health agendas.	15.1.1	Percentage of PAHO Governing Bodies resolutions adopted that focus on health policy and strategies	40%	45%	50%	55%
	15.1.2	Percentage of all oversight projects completed which evaluate and improve processes for risk management, control and governance	0%	40%	70%	90%
	15.1.3	Number of PASB entities implementing leadership and management initiatives (coordination and negotiation of technical cooperation with partners, technical cooperation among countries [TCC], advocacy for the PAHO/WHO mission, and Biennial Workplans, and reports) on time and within budget	43/69*	57/69	61/69	69/69
	15.1.4	Percentage of Governing Bodies and Member States legal inquiries addressed within 10 working days	70%	90%	95%	100%
	15.1.5	Number of PASB entities that have linked each cross-cutting priority to at least 30% of their products and services in their Biennial Workplans	N/A	N/A	40/54**	54/54**

** Denominator refers to the total number of PASB entities*

*** Denominator includes all PASB country, subregional, and technical and strategic regional entities. It does not include administrative or executive management entities.*

RER 15.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Effective PAHO/WHO country presence established to implement the PAHO/WHO Country Cooperation Strategies (CCS) which are (1) aligned with Member States' national health and development agendas, and (2) harmonized with the United Nations country team and other development partners.	15.2.1	Number of countries using Country Cooperation Strategies (CCS) as a basis for defining the Organization's country presence and its respective Biennial Workplan	26	30	32	35
	15.2.2	Number of countries where the CCS is used as reference for harmonizing cooperation in health with the UN Country Teams and other development partners	26	30	32	35
	15.2.3	Number of countries where the Biennial Workplan (BWP) is evaluated jointly with government and other relevant partners	17	20	30	35
	15.2.4	Number of PASB subregions that have a Subregional Cooperation Strategy (SCS)	0/5*	1/5	3/5	4/5
	15.2.5	Number of PASB country and subregional entities with improved administrative support, physical infrastructure, transport, office equipment, furnishings and information technology equipment as programmed in their Biennial Workplans	20/29**	25/29	27/29	29/29
	15.2.6	Number of PASB country and subregional entities that have implemented policies and plans to improve personnel health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) compliance	20/29**	25/29	27/29	29/29

** Denominator refers to the number of PASB subregions*

*** Denominator refers to PASB entities outside WDC: 27 country entities plus 2 subregional entities (CPC and USMBFO)*

RER 15.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Regional health and development mechanisms established, including partnerships, international health and advocacy, to provide more sustained and predictable technical and financial resources for health, in support of the Health Agenda for the Americas.	15.3.1	Number of countries where PAHO/WHO maintains its leadership or active engagement in health and development partnerships (formal and informal), including those in the context of the United Nations system reform	27/27*	27/27	27/27	27/27
	15.3.2	Number of agreements with bilateral and multilateral organizations and other partners, including UN agencies, supporting the Health Agenda for the Americas	0	10	17	25
	15.3.3	Percentage of Summit's Declarations reflecting commitment in advancing the Health Agenda for the Americas 2008-2017	N/A	50%	70%	75%
	15.3.4	Percentage of country requests for PAHO support to mobilize technical and financial resources from external partners, which PAHO has fulfilled	75%	85%	90%	95%

** Denominator refers to countries where a PAHO/WHO Representation exists*

Strategic Objective 16

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

Scope

This Strategic Objective covers the services that support the work of the Bureau at all levels, enabling the programmatic work covered under SOs 1-15 to occur efficiently and effectively. It includes strategic and operational planning and budgeting, performance, monitoring and evaluation, coordination and mobilization of resources, management of human and financial resources, organizational learning, legal services, information technology, procurement, operational support and other administrative services.

Indicators and Targets

- Percentage of Region-wide Expected Results (RERs) achieved under Strategic Objectives 1-15, as measured by the RER indicators. Baseline: not applicable. Target: 80% of Region-wide Expected Results achieved by 2013.

- Cost-effectiveness of the enabling functions of the Organization, measured by the percentage this SO represents of the total PAHO budget. Baseline: 17% in 2006-2007 biennium. Target: 15% by 2013.

ISSUES AND CHALLENGES

Partners and contributors are expecting increasing transparency and accountability in terms of both measurable results and use of financial resources. PASB continues its elaboration of Results-based management (RBM) as the central operating principle to improve organizational effectiveness, efficiency, alignment with results, and accountability. There are some enabling frameworks, processes, and tools in PASB for RBM. These include WHO Results-based management Framework; and the new PAHO strategic and operational planning framework, including improvements to the AMPES. Despite this progress, management processes do not fully incorporate an RBM approach. Key tools that are missing to ensure managers use results based performance data and analyses include management and accountability frameworks.

Major reforms have been implemented in the PAHO planning process to ensure alignment with WHO General Programme of Work and the Health Agenda for the Americas, and to enhance accountability and transparency to Member States. The principle challenge remaining for the planning period is to change the Organization's culture and management processes to fully implement an RBM approach, including performance monitoring and assessment, as well as accountability for results.

PASB technical and administrative entities tend to work in a vertical and uncoordinated fashion, resulting in duplication, omission and inefficient use of resources. The challenge is to ensure managers work inter-programmatically.

Although periodic monitoring and reporting on resources across the Organization has improved, the increasing percentage of the Organization's budget that comes from voluntary contributions (as opposed to regular budget) presents challenges, especially given the high ratio of staff costs to non-staff costs.

Greater flexibility is required in resource management, together with more effective internal use of resources to ensure alignment with the Program and Budget, and a reduction of transaction costs.

Regarding human resource management, a number of key challenges exist. Recruitment of females for professional positions and of applicants from under-represented countries needs to be strengthened. Implementation of the country-focused policy requires increased staff movement from one location to another, yet PAHO does not have a formal rotation and mobility policy/program. The average age of professional staff is 50 years old and approximately 31% will be retiring over the next five to seven years; PASB faces the challenge of improving succession planning.

The PASB procurement function is undergoing a major change from primarily supporting PASB headquarters and country office administrative and technical area requirements to primarily supporting large health-related procurements for Member States. This requires fundamental changes in the structure, staffing and processes for this function.

The PASB's information systems, while independently functional and supportive of RBM, are not integrated. The challenge posed by the new planning process is to achieve a higher level of integration and coherence among all of the PASB's systems, while gradually upgrading its aging portfolio of applications. At the same time, administrative processes must be simplified, with better performance controls and indicators. This should contribute to improved efficiency, transparency, accountability, decentralization, and delegation of authority. WHO is implementing a Global Management System (GSM) that will function as an enabling IT platform for Results-based management and knowledge management, providing a global view of WHO public health programs. The PASB information systems will respond to GSM requirements.

Potential threats, such as pandemic flu or terrorism, have increased. The PASB requires considerable resources to address these threats and ensure the continuity of its operations. The challenge is to mobilize these resources, given that these events may never materialize.

Several initiatives have been launched that have made recommendations to adjust PASB's structures and procedures to enable the Organization to more effectively respond to the evolving needs of Member States. The challenge is to ensure that the necessary institutional development actions to implement these proposals and their impacts have buy in, are understood, implemented promptly and without unnecessary disruption to ongoing activities.

STRATEGIC APPROACHES

- Ensuring full implementation of RBM throughout the PASB, for the entire cycle of planning, implementation (performance monitoring and assessment), independent evaluation, and programmatic adjustment.
- Supporting greater delegation of authority and accountability for results in the context of RBM, ensuring that decision-making and resource allocation occur closer to where programs are implemented.
- Providing incentives for increased inter-programmatic work at all levels of the Organization.
- Implementing a human resources strategic planning program, focusing on succession planning, competency-based and needs-based staff placement, rotation and mobility, and staff development.
- Implementing an institutional development strategy to ensure that the PASB better responds to the needs and mandates of its Member States during the planning period and beyond, including a system for monitoring progress.
- Ensuring that resource mobilization for the PAHO is fully subordinate to, and consistent with, the overall Strategic Objectives of the Organization.
- Strengthening the resource coordination function, to ensure full resourcing of Program and Budget periods.
- Fully implementing the Regional Program Budget Policy as approved by PAHO Governing Bodies.
- Implementing the recommendations of the 11 ROADMAP teams to achieve the Five Strategic Objectives for Organizational Change.
- Strengthening of managerial and administrative capacities and competencies at all levels in the PASB.

ASSUMPTIONS AND RISKS

Assumptions:

- The changes in the external and internal environment that are likely to occur over the six-year period of the plan will not fundamentally alter the role and functions of PAHO.
- Member States will continue to support the work of the PASB through timely and adequate funding through the Organization's Program and Budget, including voluntary contributions.

Risk:

- The PASB's continued efforts to "do more with less" may affect programmatic implementation, possibly compromising the quality of its services. This may result in the detriment of institutional knowledge, quality of technical cooperation, appropriate controls, and accountability.

Region-wide Expected Results

RER 16.1	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
PASB is a results-based organization, whose work is guided by strategic and operational plans that build on lessons learned, reflect country and subregional needs, are developed jointly across the Organization, and are effectively used to monitor performance and evaluate results.	16.1.1	PAHO Results-based management (RBM) framework implemented	In progress	RBM framework approved by Executive Management	PASB personnel training in RBM completed	RBM framework implemented
	16.1.2	The PAHO Strategic Plan (SP), and Program and Budget documents (constructed with the RBM framework, taking into account the country-focus policy and lessons learned, and with the involvement of all levels of PAHO) are approved by the Governing Bodies	In progress	PB2* 10-11 approved by Governing Bodies	PB 12-13 approved by Governing Bodies	SP 13-17 approved by Governing Bodies
	16.1.3	Percentage of progress towards the resource reallocation goals among the three PASB levels per PAHO Regional Program Budget Policy	33%	67%	100%	100%
	16.1.4	Percentage of PASB entities that achieve over 75% of their OSERs	N/A	50%	75%	90%
	16.1.5	Percentage of performance monitoring and assessment reports on expected results contained in the Strategic Plan and Program and Budget documents submitted in a timely fashion to the PASB executive management, after a peer review	50%	80%	90%	100%

RER 16.2	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Monitoring and mobilization of financial resources strengthened to ensure implementation of the Program and Budget, including enhancement of sound financial practices and efficient management of financial resources.	16.2.1	International Public Sector Accounting Standards (IPSAS) implemented in PAHO	IPSAS not imple-mented	IPSAS approved by Member States	IPSAS imple-mented	IPSAS imple-mented
	16.2.2	Percentage of strategic objectives meeting at least 75% of their unfunded gap at the end of the biennium	N/A	50%	60%	70%
	16.2.3	Percentage of Voluntary Contributions that are un-earmarked (funds that are flexible with restrictions no further than the SO level)	5%	10%	13%	15%
	16.2.4	Percentage of PAHO Voluntary Contribution (earmarked and un-earmarked) funds returned to partners	1%	0.80%	0.70%	0.50%
	16.2.5	Sound financial practices as evidenced by an unqualified audit opinion	Unquali-fied Audit Opinion	Unquali-fied Audit Opinion	Unquali-fied Audit Opinion	Unquali-fied Audit Opinion
	16.2.6	Percentage of PASB entities that have implemented at least 90% of their programmed amount in their Biennial Workplans	70%	75%	80%	90%

RER 16.3	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Human Resource policies and practices promote (a) attracting and retaining qualified people with competencies required by the Organization, (b) effective and equitable performance and human resource management, (c) staff development and (d) ethical behavior.	16.3.1	Percentage of PASB entities with human resources plans approved by Executive Management	15%	75%	98%	100%
	16.3.2	Percentage of staff assuming a new position (with competency based post-description) or moving to a new location during a biennium in accordance with HR strategy	15%	50%	70%	75%
	16.3.3	Percentage of Selection Committees working with new framework approved by the Executive Management, which includes psychometrical evaluation for key positions	N/A	100%	100%	100%
	16.3.4	Percentage of PASB workforce that have filed a formal grievance or been the subject of a formal disciplinary action	<1%	<1%	<1%	<1%
	16.3.5	Number of queries received per year raising ethical issues which reflect a higher level of awareness regarding ethical behavior	40	80	120	150

RER 16.4	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Information Systems management strategies, policies and practices in place to ensure reliable, secure and cost-effective solutions, while meeting the changing needs of the PASB.	16.4.1	Percentage of significant IT-related proposals, projects, and applications managed on a regular basis through portfolio management processes	0%	40%	60%	80%
	16.4.2	Level of compliance with service level targets agreed for managed IT-related services	0%	50%	60%	75%
	16.4.3	Number of PAHO/WHO country and subregional entities, and Pan American centers using consistent, near real-time management information	35/35*	35/35*	35/35*	35/35*

** Denominator refers to the 27 country entities, 2 subregional entities and 6 Pan American Centers*

RER 16.5	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
Managerial and administrative support services, including procurement, strengthened to enable the effective and efficient functioning of the Organization.	16.5.1	Level of user satisfaction with selected managerial and administrative services (including security, travel, transport, mail services, health services, cleaning and food services) as measured through biennial surveys	Low (satisfaction rated less than 50%)	Medium (satisfaction rated 50%-75%)	High (satisfaction rated over 75%)	High (satisfaction rated over 75%)
	16.5.2	Percentage of standard operating procedures utilized by PASB personnel during regional emergencies	0%	50%	75%	100%
	16.5.3	Percentage of internal benchmarks met or exceeded for translation services	60%	70%	75%	80%
	16.5.4	A new procurement management system, to measure and monitor compliance with procurement best practices, including targeted training, improved statistical reporting, expanded bidder lists, service level agreements and procedural improvements, implemented	N/A	Guiding principles elaborated	Business rules elaborated	Procurement Management System implemented
	16.5.5	Percentage of PASB internal requests for legal advice and services acted upon within 10 working days of receipt	70%	90%	95%	100%

RER 16.6	Ind.	RER Indicator text	Baseline 2007	Target 2009	Target 2011	Target 2013
PASB strengthened through institutional development reforms and a physical working environment that is conducive to the well-being and safety of staff.	16.6.1	Corporate performance scorecard implemented	N/A	Score-card devel-oped	Score-card imple-mented	Score-card imple-mented
	16.6.2	Percentage of contracts under the PASB infrastructure capital plan for approved project(s) for which all work is substantially completed on a timely basis	100%	100%	100%	100%
	16.6.3	Percentage of HQ and Pan American Centers physical facilities that have implemented policies and plans to improve personnel health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) compliance	65%	75%	80%	100%
	16.6.4	Percentage of PASB regional entities and PAHO Pan American Centers that improve and maintain their physical infrastructure, office equipment, furnishings, information technology equipment and transport, as programmed in their Biennial Workplans	75%	90%	95%	100%
	16.6.5	Number of HR policies and practices that address work-life balance, health and safety of the PAHO workforce have been developed and implemented	2	6	10	14
	16.6.6	New HR performance planning and evaluation system which enables effective performance management and integrated with PAHO Strategic Plan implemented	N/A	Software pur-chased and imple-menta-tion plan in place	Imple-menta-tion in all PAHO entities linked to Staff Develop-ment plans	360 degree evalu-ations imple-mented

86. During the past five years, the PASB has implemented several institutional change initiatives that comprise a fundamental shift in the way the Bureau carries out its duties. The five organizational change objectives established by the Director (see below) led to the establishment of cross-functional teams mandated to determine how best to meet these objectives. These teams were called "roadmap teams for the PASB transformation" and their work has largely been completed.

87. In addition, the PASB remains committed to ensuring that the findings of PAHO in the 21st Century, the recommendations of the 2004 External Auditor's Special Report, and the Report on the Activities of the Internal Oversight Services continue to be implemented during the 2008-2012 planning period.

Organizational Change Objectives and the Roadmap Teams

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

(a) Enhance Country Focus;
(b) Establish a Regional Forum;
(c) Become a Learning Knowledge-Based Organization;
(d) Enhance Management Practices—notably through results-based management;
(e) Adopt new modalities of technical cooperation.

89. The Roadmap teams have concluded their work and made recommendations to Executive Management. The resultant changes to working modalities and management approaches are being mainstreamed during 2007. The 11 ROADMAP teams worked on the following themes: Country Focused Cooperation, Regional Public Health Plans, External Communication, Internal Communication, Knowledge Management Implementation, Leadership Learning and Development, Standards for Accountability and Transparency, Regional Forum, Resource Mobilization, Country Focus Support (CFS) Organizational Review, and the Human Resource Strategy.

90. In keeping with the comprehensive nature of this Plan, it incorporates and supersedes prior organizational change and institutional strengthening initiatives. Reporting on the implementation of this Plan will constitute the principle means of PASB accountability to Member States in this area.

Country Cooperation Strategy (CCS)

91. For decades, the PASB has worked in a decentralized way at country level, with Biennial Workplans (formerly called "biennial Program and Budget" or BPB) in every country entity. In recent years, the Country Cooperation Strategy was introduced. The Country Cooperation Strategy (CCS) is the PAHO/WHO strategic planning mechanism at country level. It has proven to be a key component of the country focus policy. A CCS reflects a medium-term vision for PAHO/WHO´s technical cooperation with a given country and defines a strategic framework for working together. This framework states the jointly agreed priorities for the country and PAHO/WHO, highlighting what the PASB will do.

92. In line with national health development objectives, the CCS represents a balance between country priorities and regional (as well as global) strategic orientations and priorities. The CCS directly guides the Biennial Workplans of PAHO/WHO country entities. The Biennial Workplan is a true "One Country Plan" where the efforts of all levels (global, regional, subregional and national) of the Organization convene.

93. As of mid-2007, 11 CCSs were completed, 7 were in the final stages, and 9 were planned for completion in 2007 or early 2008.

94. The Member States have acknowledged the value-added of the Bureau's country presence, as set out in the CCS and led by the PWR. This Strategic Plan recognizes and builds on these strengths. The relation between the PAHO Strategic Plan and the Country Cooperation Strategies is reciprocal.

Subregional Cooperation Strategy (SCS)

95. The Subregional Cooperation Strategy (SCS) is the PAHO/WHO strategic planning mechanism at subregional level. A SCS reflects the medium-term vision for PAHO/WHO´s technical cooperation with a given subregion of the Americas and defines a strategic framework for working together. This framework states the jointly agreed priorities for the subregion and PAHO/WHO, highlighting what the PASB will do.

96. The SCS is a vital PAHO/WHO instrument for alignment with subregional integration processes in the Americas, including plans and strategies, and harmonization with partners at the subregional level. The SCS is used as a basis for dialogue, advocacy, resource mobilization and planning. It is generally developed with a four to six year vision but it may be shorter. The SCS directly guides the Biennial Workplans of the PASB subregional entities.

Results-based Management

97. The ongoing implementation of results-based management (RBM) in the PASB has two main goals, (1) to ensure the Bureau consistently focuses on results in the planning, implementation and assessment of its programs and (2) to improve accountability and transparency to Member States.

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

    (a) The expected results of the Organization are consistent from the highest to the lowest level of planning. The chain of results can be seen in diagram 5 below. Aggregation of results indicators is possible through the different levels for the first time, enabling improved performance monitoring and reporting (see below on Performance Monitoring and Assessment, and Independent Evaluation).
    (b) Each entity's Office-Specific Expected Results (OSERs) contribute to the achievement of the Region-wide Expected Result (RER) through aggregation of their indicators. Thus each RER represents the collective institutional work of the Pan American Sanitary Bureau, for which it is accountable. This is a new modality (see diagram 6, below).
    (c) Specific result-based management indicators are included in SO 16.
    (d) The Accountability Framework will be developed and implemented in congruence with the revised WHO Accountability Framework.
    (e) Accompanying the Accountability Framework, a new Delegation of Authority will be issued, aligning levels of authority with accountability for results.
    (f) The Managerial Framework will be finalized in order to provide guidance to managers at all levels to perform their jobs in the most effective and efficient manner.
    (g) The Strategic Assessment and Resources Alignment (SARA) exercise will ensure that resources (including staff) are being deployed optimally to achieve the Organization's objectives and expected results.
    (h) The creation of an evaluation function will allow for more objective measurement of programmatic achievements post-implementation, and contribute to PASB's development as a learning organization.

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

Diagram 5. PAHO's Chain of Results

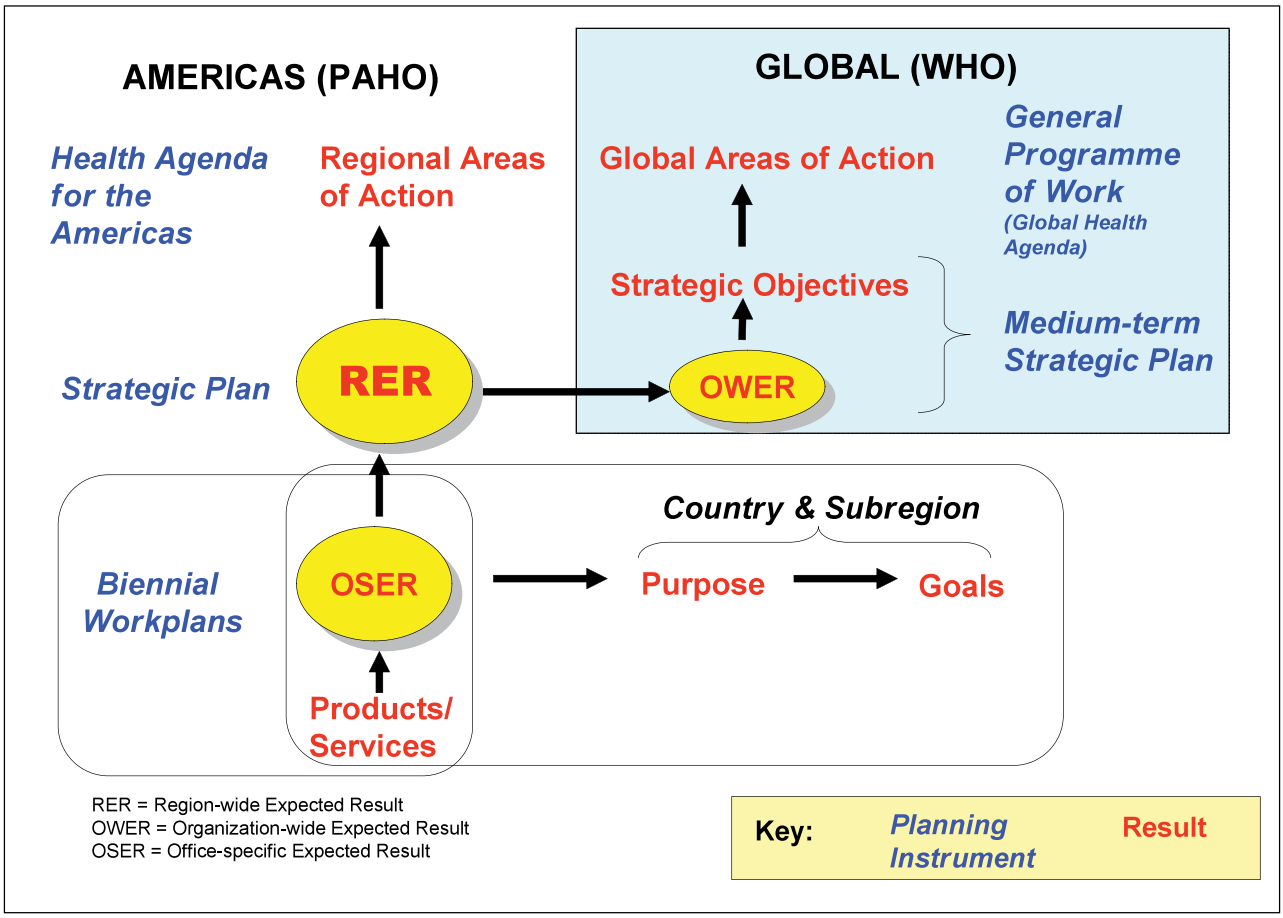
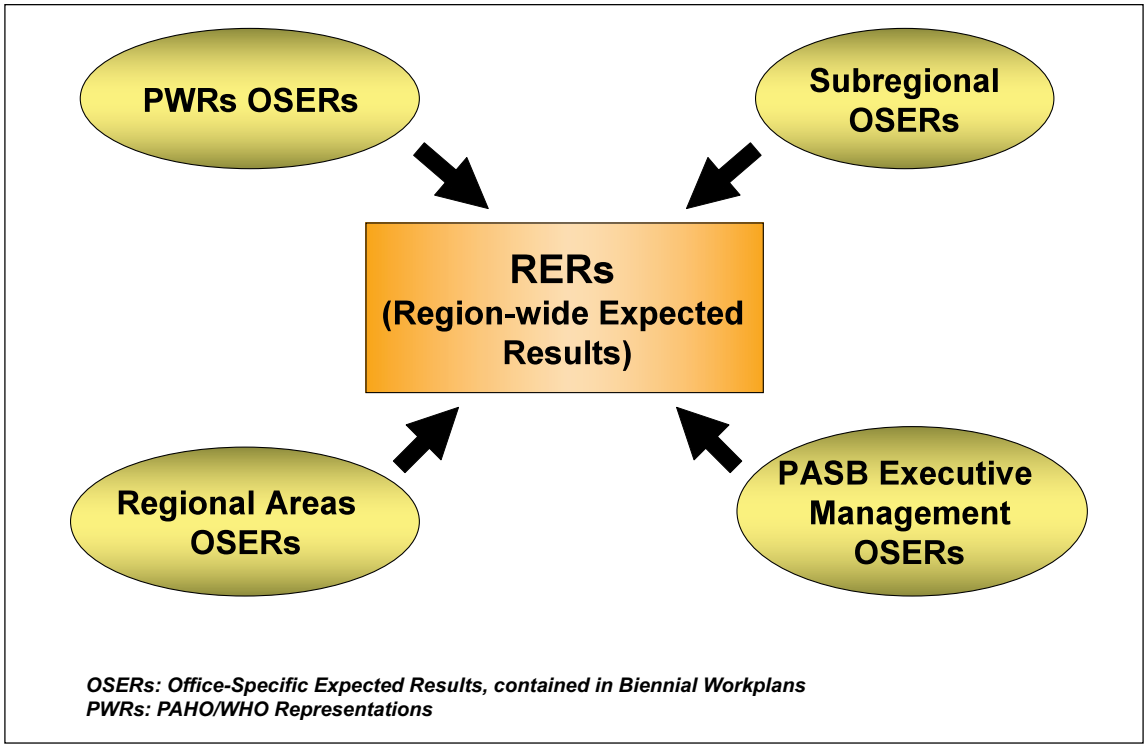


Diagram 6. All Results Aggregate to RERs

RERs represent the PAHO's collective corporate efforts



100. The Bureau conducted two prioritization exercises during the elaboration of this Plan, in order to determine the ranking of the Strategic Objectives. The findings from the first exercise (limited to PASB headquarters) were used to inform the budget allocations in the draft Strategic Plan presented to the Executive Committee. The results of the second exercise, where all the managers of the Organizations were invited to participate, have been used in establishing the budget priorities in this final version of the Plan. Although a similar methodology was applied to both exercises, the specific criteria and results described below apply to the second exercise.

Methodology

101. The prioritization exercise was designed to obtain a ranking of the Strategic Objectives by a variety of PASB managers, per agreed-upon criteria, using a modified Delphi methodology.

102. First, a draft set of criteria were developed (based on those used in the first exercise, plus input received after that exercise), with weighting to reflect the relative importance of the criteria. These were vetted among all PASB managers, including country representatives, center directors, headquarters Area Managers and Executive Management. There was a high level of participation, and changes to the criteria and their weighting were made based on the feedback received.

103. Second, each Strategic Objective was rated on a scale of 1 to 5 (5 being the highest priority) for each of the agreed-upon criteria. All managers were given the opportunity to rate the SOs via email. Their responses were collated and analyzed, providing a ranking of the SOs.

Criteria

104. The following were the criteria used in the exercise, reflecting inputs received from throughout the Bureau. The weights given in parentheses reflect the relative importance of each criterion.

(a) Supports the Health Agenda for the Americas and other regional mandates (x4)
(b) Addresses the burden of disease in the Region (x2)
(c) Supports vulnerable population groups or key countries, promoting equity (x3)
(d) Contributes to global health security (x2)
(e) Supports achievement of the health-related MDGs (x2)
(f) PAHO technical cooperation is a cost-effective means to improve health outcomes (x2)
(g) Supports universal access to health related goods and services (x2)
(h) Countries have low access to non-PAHO resources and difficulty in replacing PAHO technical cooperation (x1)
(i) Has potential for successful cross-cutting collaboration: inter-programmatic, inter-country, inter-sectoral, inter-regional or inter-agency (x1)
(j) Difficult to access voluntary contributions (x1) (additional criterion, used only for assignment of regular budget amounts with respect to the total budget)

Results

105. The results of the second exercise were analyzed along with those from the first (more limited) exercise, considering comments made by Member Countries in the Governing Bodies. The resultant ranking of the Strategic Objectives follows, with the first SO listed being the highest priority for the Bureau.

Ranking	SO#	Strategic Objective text
1	SO4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals
2	SO1	To reduce the health, social and economic burden of communicable diseases
3	SO2	To combat HIV/AIDS, tuberculosis and malaria
4	SO3	To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries
5	SO7	To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches
6	SO13	To ensure an available, competent, responsive and productive health workforce to improve health outcomes
7	SO10	To improve the organization, management and delivery of health services
8	SO8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
9	SO6	To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions
10	SO14	To extend social protection through fair, adequate and sustainable financing
11	SO11	To strengthen leadership, governance and the evidence base of health systems
12	SO12	To ensure improved access, quality and use of medical products and technologies
13	SO5	To reduce the health consequences of emergencies, disasters, crisis and conflicts, and minimize their social and economic impact
14	SO9	To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development

106. This ranking has been used to inform budgetary priorities for the 2008-2009 biennium, and will be used for subsequent biennia, with possible changes based on changes in external or external circumstances.

107. PAHO is engaged with WHO in a results based budgeting approach to determine the resource requirements to carry out its work. The cost of achieving Region-wide Expected Results over a given period of time is expressed through an integrated budget comprising all sources of funding.

108. PAHO receives funding from three main sources:

(a) the **PAHO Regular Budget**, which comprises assessed contributions (quotas) from PAHO Member States plus estimated miscellaneous income;

(b) the **AMRO Share**, which is the portion of the WHO regular budget approved for the Region of the Americas by the World Health Assembly;

(c) **Other Sources**, which mainly comprises voluntary contributions mobilized by PAHO or through WHO, program support-generated funds, and funding from the Master Capital Investment Fund; among other categories.

109. While funding sources (a) and (b) above are considered unearmarked, voluntary contributions (included in (c)) can be categorized as either earmarked or unearmarked. Effective financing of the Strategic Plan 2008-2012 and associated Programs and Budgets will require careful management of the different sources and types of income to ensure complete funding of planned activities. Unearmarked funding provides a flexible resource base that facilitates financing the core work of the Organization. Earmarked funding—which accounts for the majority of voluntary contributions currently negotiated—is less flexible and, thus, may not be available for use in under-funded programmatic areas.

110. Earmarked funding continues to pose a challenge for ensuring alignment between the Organization's planned activities and actual resources mobilized. Earmarked Voluntary Contributions that do not contribute to reduce the planned programmatic financial gap will not be accepted. To the extent that donor partners can be persuaded to provide increased levels of unearmarked voluntary contributions—also being referred to as 'core voluntary contributions' by WHO—the Organization will become more successful in fully financing its Strategic Plan and all Program and Budget periods, consequently increasing the probability of achieving its expected results. To this end, the Bureau fully supports WHO efforts in actively seeking to increase the proportion of the Program and Budget financed with core voluntary contributions and will similarly continue its own efforts in this area.

111. Table 2 below summarizes the estimated resource envelope for the PAHO Strategic Plan.

Table 2. Estimated Resource Envelope for PAHO Strategic Plan

	PB 2006-2007	PB 2008-2009	PB 2010-2011	PB 2012-2013
PAHO	333,094,000	347,566,000	682,000,000	743,000,000
WHO	198,018,000	278,501,000		
Total	531,112,000	626,067,000	682,000,000	743,000,000

112. The Strategic Plan has an estimated resource envelope of just over $2 billion for the three-biennium period ending in 2013. This projection begins with a proposed budget of $626 million (which includes all sources of funding) for 2008-2009 and contemplates biennial increases of roughly 9%, commensurate with the proposed costing of the WHO MTSP and expectations for inflationary costs in the Region.

113. The significant increase in the cost of international transactions to U.S. dollar-based budgets is being felt worldwide, and for PAHO there is no exception. A thorough analysis of current costs and trends points to an expected cost increase of between 13% and 15% for the 2008–2009 biennium. For the PAHO regular budget, this translates to roughly $37 million for cost increases alone, of which approximately $24 million are related to the cost of fixed-term posts.

114. An alternative, more optimistic scenario, which considers a curbing of the U.S. dollar devaluation effect over the short term, yields a projected cost increase of about 10% for the next biennium. In a Zero Real Growth scenario, this translates to roughly $23 million for the regular budget, of which approximately $17 million are related to the cost of fixed-term posts. However, an additional 12 fixed-term posts have been reduced so far in the biennium (in addition to the 41 positions abolished during 2004-2005) thus containing the estimated cost increase to about $14 million for fixed-term posts for 2008-2009, an increase of 8.3% compared with the budget component for fixed-term posts for 2006-2007.

115. Table 3 below compares the proposed budget 2008-2009 with the approved budget for 2006-2007.

Table 3. Financing of the Program and Budget 2008-2009

Source	2006-2007	2008-2009	% change
Assessed contributions from Member States	173,300,000	180,066,000	3.9%
+ Miscellaneous income	14,500,000	17,500,000	20.7%
= Total PAHO share (Regular Budget)	187,800,000	197,566,000	5.2%
+ WHO share (Regular Budget)	77,768,000	81,501,000	4.8%
= Total Regular Budget	265,568,000	279,067,000	5.1%
+ Estimated Other Sources *	265,544,000	347,000,000	30.7%
= Total Resource Requirements	531,112,000	626,067,000	17.9%

** Represents primarily the combined total estimated voluntary contributions from PAHO donor partners as well as from WHO.*

116. The proposed budget for 2008-2009 of $626 million represents an increase of 17.9% compared to the $531 million budget approved for 2006-2007. The largest source of the budget increase comes from the estimated Other Sources of $347 million, representing a 30.7% increase, of which $197 million is budgeted to come from WHO. The $197 million estimate was developed jointly with WHO/HQ and the other WHO Regions by teams of staff working together globally, grouped by Strategic Objective.

117. The regular budget share of the budget of $279 million represents an increase of $13.5 million, or 5.1%, compared to the biennium 2006-2007, and is all attributable to the projected increase in the cost of fixed-term staff. The budget increase of $13.5 million will largely fund the $14 million cost increase of fixed-term staff, with the remainder $.5 million of costs being absorbed by a nominal reduction in the proposed non-staff budget.

118. It should also be noted that the proposed budget level, in addition to not allowing for inflationary non-staff costs, does not make provision for several significant administrative costs expected to be incurred over the next few years; these include, for instance, UN mandatory implementation of International Public Sector Accounting Standards (IPSAS), PAHO possible involvement with the Global Management System (GSM) being implemented by WHO, and expenditure related to the Master Capital Investment Plan.

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

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

121. The situation explained above is compounded by the fact that the Regional Program Budget Policy will progressively allocate a larger share of the budget to the countries over the next two biennia, as was the case for 2006-2007—the first implementation biennium of the Budget Policy. The further reduction of the regular budget for regional activities creates a challenge for the Bureau in carrying out its statutory and normative work and for the ability of regional entities to respond to backstopping needs of countries.

122. Given the regular budget situation, effective resource mobilization becomes increasingly important for the Organization. And since voluntary contributions provided by donor partners are generally earmarked for specific objectives and are less predictable, the Bureau will continue to make every effort to manage these contributions in light of the overall expected results contained in the Strategic Plan and Program and Budget documents. Thus, regular budget funds become essential for securing many of the Organization's statutory and normative core functions.

123. Finally, in consideration of the expressed position of many Member States regarding their ability to accept assessment increases, the Bureau is prepared to take the "optimistic" scenario forward in projecting cost increases for the proposed 2008-2009 Program and Budget; it should be understood, however, that the economic reality may worsen and may require significant adjustments to planned programmatic targets contained in the Region-wide expected results.

124. A breakdown of the budget by Strategic Objective and other budget details are included in the Proposed Program and Budget 2008-2009.

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

126. As discussed elsewhere in this Plan, this issue has been thoroughly addressed for the planning period beginning in 2008, where there is vertical integration of expected results and indicators among all levels of planning, from the global WHO Medium-term Strategic Plan to this PAHO Strategic Plan to the respective Program and Budget documents and in turn to the Biennial Workplans in the American Region Planning and Evaluation System (AMPES).

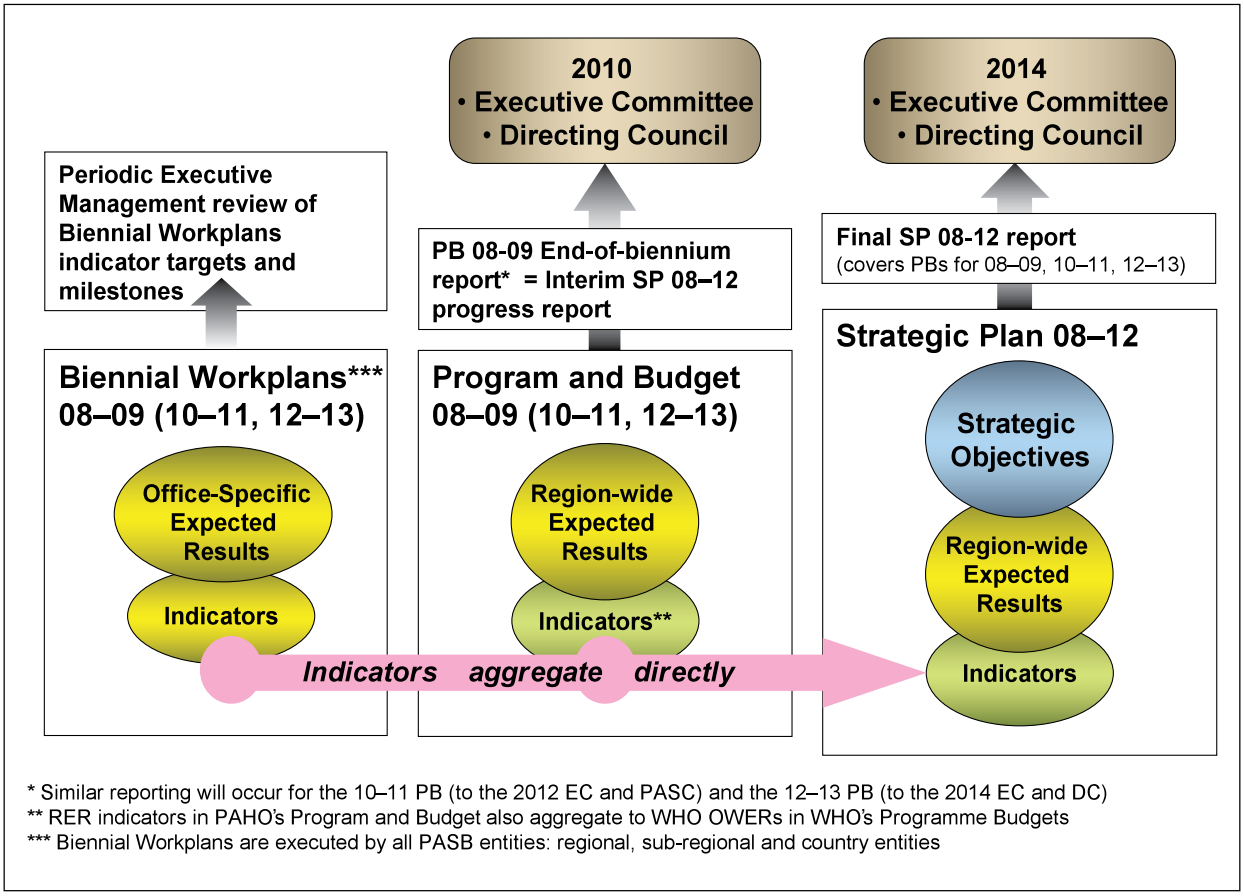
127. The AMPES forms the core of internal results monitoring and reporting in the PASB. The Strategic Objectives and Region-wide Expected Results (RERs) in this Plan are imported directly to the AMPES. The RERs then form a menu of programmatic options from which countries, Centers and regional headquarters entities can choose when elaborating their Biennial Workplans. No work will be performed that is outside the scope of the RERs in this Plan. When choosing the RERs on which they will work, and adapting them to the country level, entities also choose to which RER indicators they will contribute. In the case of country entities (PWRs), they can become one of the "number of countries" targeted in the vast majority of RER indicators.

128. Each organizational entity establishes its own indicators for its Office-Specific Expected Results (OSERs), which correspond to those for the RERs. Progress towards these OSER indicators is measured by six-month milestones, developed during operational planning. While milestones can be customized to meet the needs of an individual entity's work, they serve as a consistent means to evaluate progress in achieving OSER indicators, and by aggregation, RER indicators.

129. Significant time and effort has been dedicated to improving the AMPES system to incorporate required changes, allowing for quality control through monitoring of SMART indicators. The regular monitoring and reporting of results in a systematic fashion will allow managers to assess and adjust their implementation strategies and Workplans as needed – a key element of the full implementation of results-based management in the Organization.

130. The principal innovation for the 2008-2012 Strategic Planning period is that the achievement of expected results (as measured by SMART – specific, measurable, achievable, realistic and time-bound – indicators) can be aggregated directly, and in most cases automatically, in the AMPES system from the country level to the regional and global levels on a biennial basis. Since the Region-wide Expected Results in the Program and Budget documents will be exactly the same as those in this Strategic Plan, the end-of-biennium Program and Budget reports will serve as progress reports for the Strategic Plan; programmatic performance monitoring and assessment will focus on Biennial Workplans and, via aggregation, the Program and Budget for periods 2008-2009, 2010-2011 and 2012-2013. The sum of the three biennia covered under this Plan will form the basis for the final report on this Strategic Plan, to be presented to Governing Bodies in 2014. The monitoring and reporting relationship among planning instruments is presented here graphically, with key submissions to Governing Bodies highlighted.

Diagram 7. Monitoring and Reporting



131. Member States can look forward to receiving progress reports on the implementation of this Strategic Plan in the form of Program and Budget end-of-biennium assessments, which will be provided every two years. The reports for the 10-11 and 12-13 biennia will be supplemented by a cumulative performance assessment against the six-year targets set in this Strategic Plan.

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

133. With regard to core functions discussed earlier in this Plan, expenditure levels for each core function will also be monitored through AMPES. Managers will classify their products and services and corresponding expenditures by core function when developing their Biennial Workplans. During implementation, this will enable monitoring and reporting of expenses by core function, per WHO global guidelines. The PASB will also report this information to its Governing Bodies, allowing them to see which functions are receiving the greatest resources in the Bureau.

134. The experience gained during implementation of this Plan (as reported in Program and Budget performance assessments) may require adjustments to the RERs. External changes in the environment may also require changes in PAHO´s strategic objectives. Whenever such changes are needed at the level of RER or above, they will be provided to the Governing Bodies for review and approval.

135. A fully elaborated performance monitoring and assessment framework and an independent evaluation framework are under development by the Bureau during 2007, to be employed during the three biennia covered by this Plan.

136. The independent evaluation function will be separated organizationally from the planning and performance monitoring and assessment functions, in order to foster impartiality in the conduct of evaluations. The independent evaluation function (and respective staffing) is being put in place in 2007; therefore the working modalities with respect to periodicity and scope are still under development.

137. The implementation of this Plan will require a high level of programmatic discipline and training of staff throughout the Bureau. This process has begun and will continue during the implementation period.

Acronyms and Abbreviations

AECI	Spanish Agency for International Cooperation
AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
ALBA	Bolivarian Alternative for the Americas
AMPES	American Region Planning and Evaluation System
AMR	Antimicrobial resistance
AMRO	WHO Regional Office for the Americas
BWP	Biennial Workplan
CAPRADE	Andean Committee for Disaster Prevention and Assistance
CARICOM	Caribbean Community
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CD	Chronic disease
CDC	U.S. Centers for Disease Control and Prevention
CDERA	Caribbean Disaster Emergency Response Agency
CEPREDENAC	Coordination Center for the Prevention of Natural Disasters in Central America
CIDA	Canadian International Development Agency
CIDE	Center for Research and Development Education
CIESS	Inter-American Center for Social Security Studies
CISS	Inter-American Conference on Social Security
CRS	Congenital rubella syndrome
CVD	Cardiovascular disease
DALYs	Disability-Adjusted Life Years
DHG	Dengue Hemorrhagic Fever
DMFT-12	Decayed, Missing, Filled, Teeth at Age 12
DOTS	Directly Observed Therapy Short-Course
EBD	Environmental burden of disease
ECLAC	Economic Commission for Latin America and the Caribbean
EMF	Electro-magnetic fields
FCTC	WHO Framework Convention on Tobacco Control
GDP	Gross domestic product
GF	Global Fund
GNI	Gross national income
GPW	WHO General Programme of Work
GSM	Global Management System
GTZ	German Agency for Technical Cooperation
HAA	Health Agenda for the Americas
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations

ILO	International Labor Organization
IMAI	Integrated Management of Adolescent and Adult Illness
IMAN	Integrated Management of Adolescent and their Needs
IMCI	Integrated Management of Childhood Illness
ISSA	International Social Security Association
ISTC	International Standards for Tuberculosis Care
LAC	Latin America and the Caribbean
MDG	Millennium Development Goals
MDR	Multi-drug resistance
MERCOSUR	Southern Common Market
MM	Maternal mortality
MOSS	Minimum Operating Safety Standards
MTSP	WHO Medium-term Strategic Plan
N/A	Not applicable
NDs	Neglected diseases
NGO	Nongovernmental organization
NIP	National immunization programs
NNT	Neonatal tetanus
NORAD	Norwegian Agency for Development Cooperation
NRA	National Regulatory Authority
OAS	Organization of American States
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organization for Economic Cooperation and Development
OSER	Office-Specific Expected Result
OWER	Organization-wide Expected Result
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
PASC	Pan American Sanitary Conference
PB	Program and Budget
PHC	Primary Health Care
POP	Persistent organic pollutant
PWR	PAHO/WHO Representative or Representation
RBM	Results-based management
RER	Region-wide Expected Result
SARA	Strategic Assessment and Resources Alignment
SCS	Subregional Cooperation Strategies
SICA	Central American Integration System
SIDA	Swedish International Development Cooperation Agency
SMART	Refers to indicators with the following characteristics: Specific, Measurable, Achievable, Realistic and Time-bound
SO	Strategic Objective
SP	Strategic Plan
SP 08–12	Strategic Plan 2008–2012
SPBA	PAHO Subcommittee on Program, Budget and Administration
STEPS	PAHO/WHO STEPwise approach to surveillance
STH	Soil-transmitted helminthiasis
STI	Sexually transmitted infection
TB	Tuberculosis
TBCTA	Tuberculosis Coalition for Technical Assistance

TCC	Technical cooperation among countries
TTI	Transfusion-transmitted infection
UN	United Nations
UNAIDS	The United Nations Joint Program on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization
WHR	World Health Report

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