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PROPOSED STRATEGIC PLAN 2008-2012

Introductory Note

The Proposed Strategic Plan 2008-2012 (OD328) is submitted to the Executive Committee as a further iteration of the draft submitted to the first Subcommittee on Program, Budget and Administration that met earlier this year.

With regard to this iteration, the Bureau notes the following:

- Comments made by Member States at the SPBA are reflected in this version.
- Work to improve and refine the document has continued, with significant changes throughout the document.
- The development process for this Strategic Plan continues to be highly participative, with inputs received from the regional, subregional and country levels.
- Prior to the Pan American Sanitary Conference, further refinement will be made to complete and improve the indicators in the Plan; similarly, the situation analysis will be updated and improved to reflect the latest available data and events.
- The initial phase of a programmatic prioritization exercise has been completed and is reflected in the Strategic Objective budget levels provided in this plan. However, further refinement of the criteria used for prioritization will be part of the next phase of the exercise, which may further impact budget allocations by Strategic Objective.
- Other refinements may be made to reflect the outcome of the biennial Workplan exercise being carried out in June, particularly with regard to the subregion-level indicators, as well as any related adjustments made to the 2008-2009 Program Budget.

With the incorporation of improvements as noted in the last three bullets, and any changes needed to reflect comments from Member States in the Executive Committee, this document will be finalized for submission to the Pan American Sanitary Conference in October of this year.

The Bureau welcomes input from Member States on how to further improve this document, which will guide the work of the Organization for the next five years.

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PROPOSED STRATEGIC PLAN 2008-2012

FOREWORD BY THE DIRECTOR

This is the second Strategic Plan for the Pan American Sanitary Bureau in the 21st Century. This year, 2007, the Organization is 105 years old. These two facts conveniently juxtapose the challenges faced by the Bureau as we build on the accomplishments of the past and work within the structures of the United Nations and the Inter-American System, while at the same time we implement the changes necessary to increase our value-added to Member States and ensure our position as the international leader in public health in the Region of the Americas.

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 as well as with life-style related ones, 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 capacity in Member States. 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 multi-sectoral approaches and with strategic partnerships. I therefore encourage and welcome an ongoing dialogue with PAHO's 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 PASB Strategic Plan 2008-2012 is a significant statement of our commitment to work for the improvement of the health of our people and to be accountable to our governing bodies and partners. I therefore take great pleasure in presenting it.

Director

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EXECUTIVE SUMMARY

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

2. 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 Organization from 2008 to 2012. The document will not only guide the Pan American Sanitary Bureau's work, but is a comprehensive sum of the work to be carried out by the Bureau during this period.

3. 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 and country level 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's Eleventh General Programme of Work. The Bureau seeks to maintain a balance between programmatic alignment with WHO and the regional specificity demanded by PAHO Member States in the Health Agenda. The Bureau has adopted WHO's six Core Functions, which will allow analysis of expenditures from a new and managerially useful perspective.

5. The 16 Strategic Objectives, based on WHO's, are the programmatic heart of this Plan, and are meant as common objectives for PAHO – Member States as well as the Bureau. Each Strategic Objective incorporates several Regionwide 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, and the means for monitoring and reporting on performance to Member States.

INTRODUCTION

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 and 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 strategy 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 country offices and technical areas.

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 Organization 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.

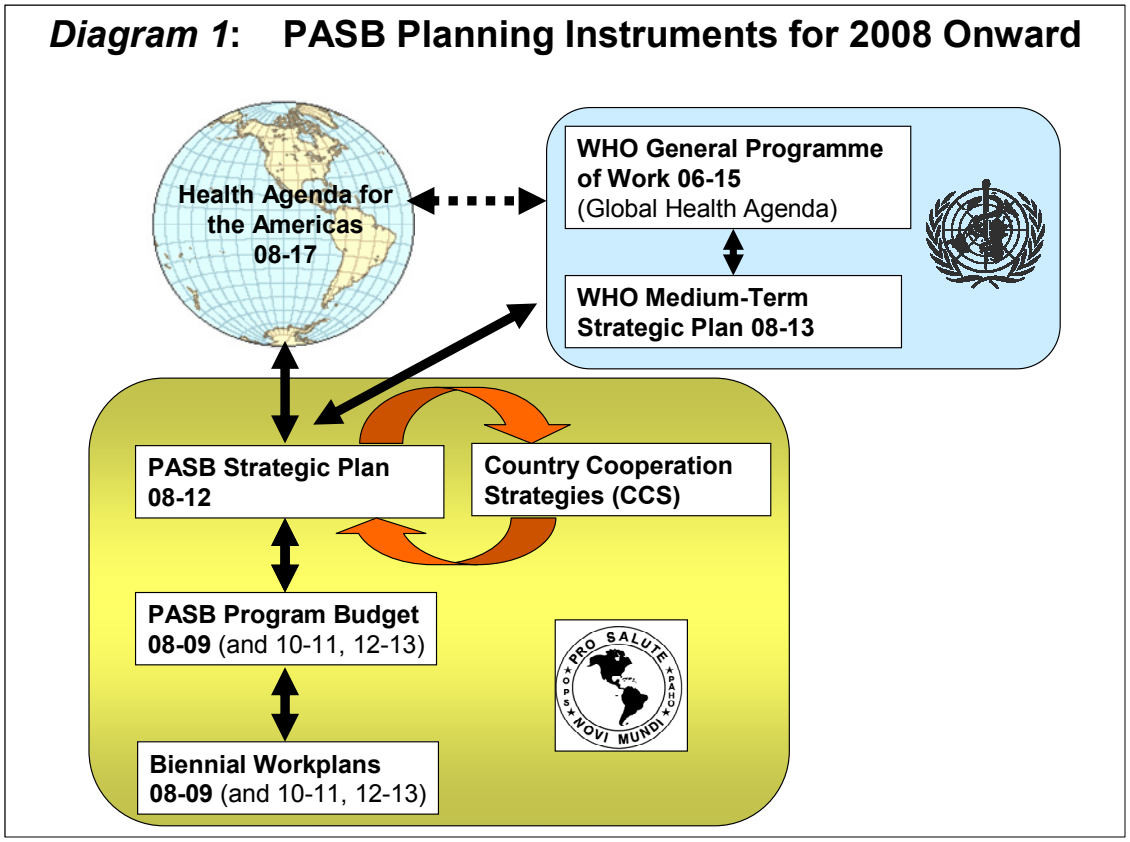
A NEW PLANNING PROCESS

9. For the first time, the PASB Strategic Plan contains Strategic Objectives that align directly with those of WHO. The Strategic Plan will cover three biennia and, for the first time, defines the Bureau's Region-wide Expected Results (RERs) and indicators. The Program Budgets for the period (2008-2009, 2010-2011 and 2012-2013) will define where resources will be expended in order to achieve the results defined in the Strategic Plan. These Program Budgets will be shortened and simplified, 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 the Program Budgets 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 *Monitoring, Assessment and Evaluation*, below.

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

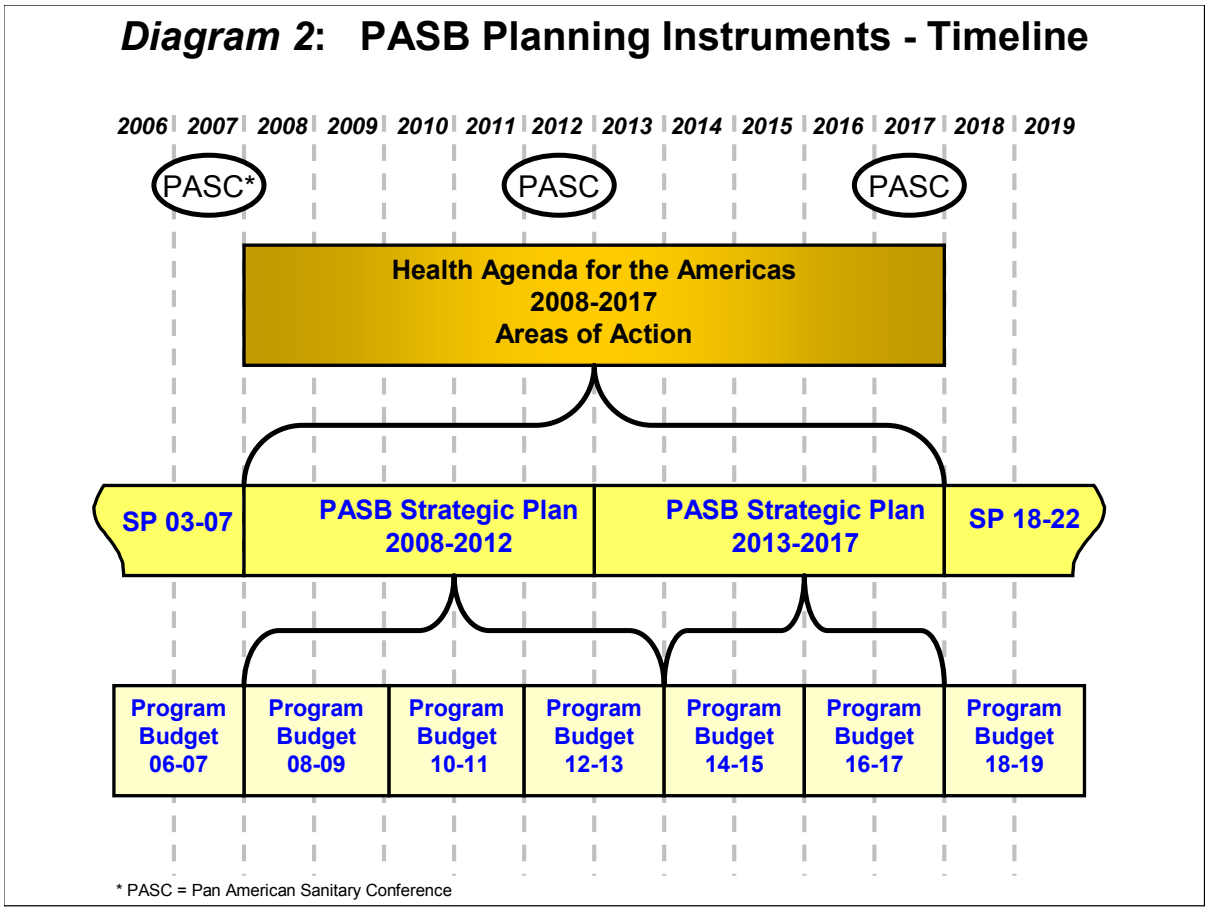
11. Vertical integration of all levels of the planning process is a crucial step in full implementation of results-based management, where expected results indicators from all entities – country offices, centers, and regional headquarters – aggregate to Region-wide Expected Results indicators, which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

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



FIVE YEARS, THREE BIENNIA

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



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

SITUATION ANALYSIS IN THE REGION

ECONOMIC AND SOCIAL TRENDS

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

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

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

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

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, waste and refuse management, transportation, and violence prevention. Rural areas suffer from the ongoing problems of poverty, limited resources, and lack of access to health services. Factors such as the chaotic growth of cities, indiscriminate industrial development, and migration from rural to urban areas adversely impact the environment, health, and quality of life of the population, contributing to marginalization—characterized by makeshift housing, poverty, environmental pollution, and

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

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

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

higher levels of disease and violence. Makeshift housing in urban areas increased by 14% between 1990 and 2001, affecting 127 million people. In response to this trend, efforts have been made to address health determinants factors by creating healthy and sustainable public policies, healthy spaces, and public-private partnerships; strengthening support networks; mobilizing the media; and encouraging action by local governments in health promotion and development.

TRENDS IN HEALTH PROBLEMS AND RISK FACTORS

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

21. The Region's morbidity and mortality profile is changing, with communicable diseases replaced by chronic diseases as the leading causes, a phenomenon attributable to advances in technology and the aging of the population. Communicable diseases are still a major cause of mortality, with 58 deaths per 100,000 populations in 2000–2004,[4] and they are a heavy burden in poorer countries: for example, in Haiti the incidence of tuberculosis (TB) is seven times that of the Region. Added to this are challenges such as TB/HIV co-infection and multi - and extreme resistance to TB drugs. In 2006, 50% of dengue cases occurred in Brazil,[5] while malaria is endemic in 21 countries. Neglected[6] diseases cause anemia, malnutrition, memory loss and lower IQ, stigma and discrimination, permanent disability, and premature death. Several of these diseases often go hand in hand, multiplying their impact on health and the social and economic 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. Sixty percent of diseases affecting humans over the last ten years were caused by pathogens that originated in animals or their products, so prevention and control is needed. Human rabies transmitted by dogs decreased by 95% in the last 25 years of active control programs; however, for other zoonoses few actions have been implemented. Eradication of foot-and-mouth disease is important for food security and socioeconomic development; the Region is moving toward this goal. Travel and trade allow dissemination of infectious agents from their natural foci. Food safety is another public health and economic issue. Modernization of inspection services, strengthening of reference services, harmonization of legislation and *Codex Alimentarius* support, are in place to address food safety.

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, hyperglycaemia and hyperlipidemia, caused by lifestyle and behavioral actors. Trends forecast a two-fold or more increase of ischemic heart disease, stroke and diabetes in LAC; mortality from lung, breast and prostate cancers is also increasing. Chronic diseases affect men and women

[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

differently; racial/ethnic minority groups and the poor are more likely to be affected. Annual costs of CD are enormous; for diabetes, the estimated was US$65 billion for LAC in 2000.

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

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

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

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

28. In 2005, the under-5 child mortality rate in LAC meant that 450,000 children died. One third of countries had 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, 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 20 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 of maternal mortality results from preventable causes, but in some countries essential obstetric and neonatal services are of poor quality or not in place, or are under-used because of access barriers or a lack of skilled personnel. Notable urban-rural disparities exist: fewer rural women attend 4 or more antenatal consultations and large proportions do not have access to skilled birth care.

29. Adult HIV prevalence shows that the epidemic is concentrated in North America (0.8 %) and Latin America (0.5%) and generalized in the Caribbean (1.2%), where it is the leading cause of death among young adults. In the Region, 1.6% of women and 0.7% of men between the ages of 15 and 24 are infected with HIV. In 2006 in LAC, 167,000 new HIV infections occurred and

84,000 people died of AIDS, with more women affected. Affected people continue to live in environments of stigma and discrimination.

30. Mental illness imposes a high health burden in the Americas. In 2002 it accounted for an estimated 25% of the total disability-adjusted life years lost to all diseases, with unipolar depression a significant component. Only a minority of people suffering from mental illness receive treatment, despite the impact of the problem. In 80% of the countries, the majority of beds are located in psychiatric—rather than general—hospitals and 25% of the countries have yet to provide community care. Nevertheless, mental health is on the countries' agendas; there are successful local and national experiences, user and family associations are emerging, and advocacy is growing. Cost-efficient interventions are possible, which can make the limited response satisfactory over time.

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

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

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

34. In 2004, the economically active population was estimated at 414 million workers, or 46% of the Region's population--a 13% increase over the year 2000. According to WHO (2005), 60% of workers are exposed to hazardous and unhealthy working conditions that entail a variety of risks that impact health. It is estimated that accidents in the workplace, 8% of global accidents, result in 312,000 deaths and 10 million disability-adjusted years of life lost. Activities such as agriculture, construction, and mining are the most dangerous. Informal employment is associated

with greater occupational risk and unstable working conditions with no legal protection, compensation, or health benefits; women, children, and older adults are the least protected groups working in this sector.

TRENDS IN THE HEALTH SYSTEM RESPONSE

35. 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; it ranges from 1.3% in poor countries to 4.5% in those with high levels of public health service coverage, and from 7.5% to 10% in countries with health systems that provide universal coverage. Part of the growth of public expenditure in health has been for insurance systems, but with modest gains in coverage. Public expenditures in health through social health insurance schemes increased in real terms; in constant dollars of the year 2000, from US$ 14.7 billion in 1990 to 27.7 billion in 2004-05. Average expenditure per (potential) beneficiary of social health insurance programs increased from US$ 129 in 1990 to US$ 209 in 2004-05 (in constant dollars of the year 2000). The total population covered under social health insurance schemes increased from 114.7 million people in 1990 to 132.7 million in 2004-5; however, as percentage of the total population, the potential beneficiaries of social health insurance schemes declined from 26% in 1990 to 24% in 2004-05. Critical measures for improving health status and reducing inequalities in access to health services include: greater public expenditure on health, public health, and health care; improvements in the distributive impact of that expenditure; and an expansion of the coverage of public health insurance and social protection programs.

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

37. There are inequalities in access to essential health technologies and services in the Region; an estimated 125 million people living in LAC do not have access to them. Many countries have inadequate and/or deteriorating physical infrastructures, lack of adequate specifications for purchasing new technologies, inappropriate organization of health services and insufficient qualified health personnel. As result, nonfunctioning technologies, under-used services, minimally trained staff, insufficient prevention policies, ineffective diagnostic and therapeutic protocols, and unsafe conditions for patients occur. For many technologies, it is critical to ensure that incorporation and use be done under legislation and supervision by regulatory authorities. National policies are needed to cover all aspects of health technologies and services, but will be successful only if supported by regulatory mechanisms. While the advantages of health technologies and services are many, they can represent an unnecessary cost if the quality provided and its management are unacceptable. For health care to have greatest impact, particularly where resources are limited, priority should be given to the selection, establishment

and procurement of essential health technologies and services. Control of health problems and achievement of health-related MDGs will rely on their correct use.

OTHER CHALLENGES FOR THE FUTURE

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

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

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

LESSONS LEARNED FROM PREVIOUS PLANS

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

INTEGRATION AMONG ALL LEVELS OF PLANNING, FROM STRATEGIC TO OPERATIONAL

41. 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 Budgets, which in turn did not aggregate to the objectives set out in the 03-07 Strategic Plan. The new 08-12 Plan rectifies this, enabling true results-based planning for the Organization from the strategic to the operational levels. This will enable not only ease of monitoring and reporting, but also increased accountability and transparency.

A COMPLETE AND COMPREHENSIVE PLAN

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

STRATEGIC ALLIANCES AND PARTNERSHIPS

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

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

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

46. 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

47. 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.

48. 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.

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

RESOURCE ESTIMATION

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

FRAMEWORK FOR TECHNICAL COOPERATION

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

STRATEGIC DIRECTION

52. The Proposed 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.

53. 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.

54. 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 Sanitary Bureau.

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

THE HEALTH AGENDA FOR THE AMERICAS 2008-2017

56. 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 International Health Security.

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

	Health Agenda´s Areas of Action							
PASB´s Strategic Objectives	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 International Health Security
1. To reduce the health, social and economic burden of communicable diseases	**X**				**X**			**X**
2. To combat HIV/AIDS, tuberculosis and malaria	**X**				**X**			**X**
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	**X**	**X**	**X**		**X**	**X**		**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, crises 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 for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex		**X**			**X**			**X**
7. To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches		**X**		**X**				
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	**X**	**X**			**X**			**X**
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	**X**				**X**			**X**
10. To improve the organization, management and delivery of health services	**X**		**X**	**X**				**X**
11. To strengthen leadership, governance and the evidence base of health systems	**X**						**X**	**X**
12. To ensure improved access, quality and use of medical products and technologies	**X**					**X**	**X**	**X**
13. To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes	**X**					**X**		**X**
14. To extend social protection through fair, adequate and sustainable financing	**X**		**X**	**X**				**X**
15. To provide leadership, strengthen governance and foster partnership and collaboration with countries in order to fulfill the mandate of WHO/PAHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	**Contributes to all**							
16. To develop and sustain WHO/PAHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	**Supports all**							

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

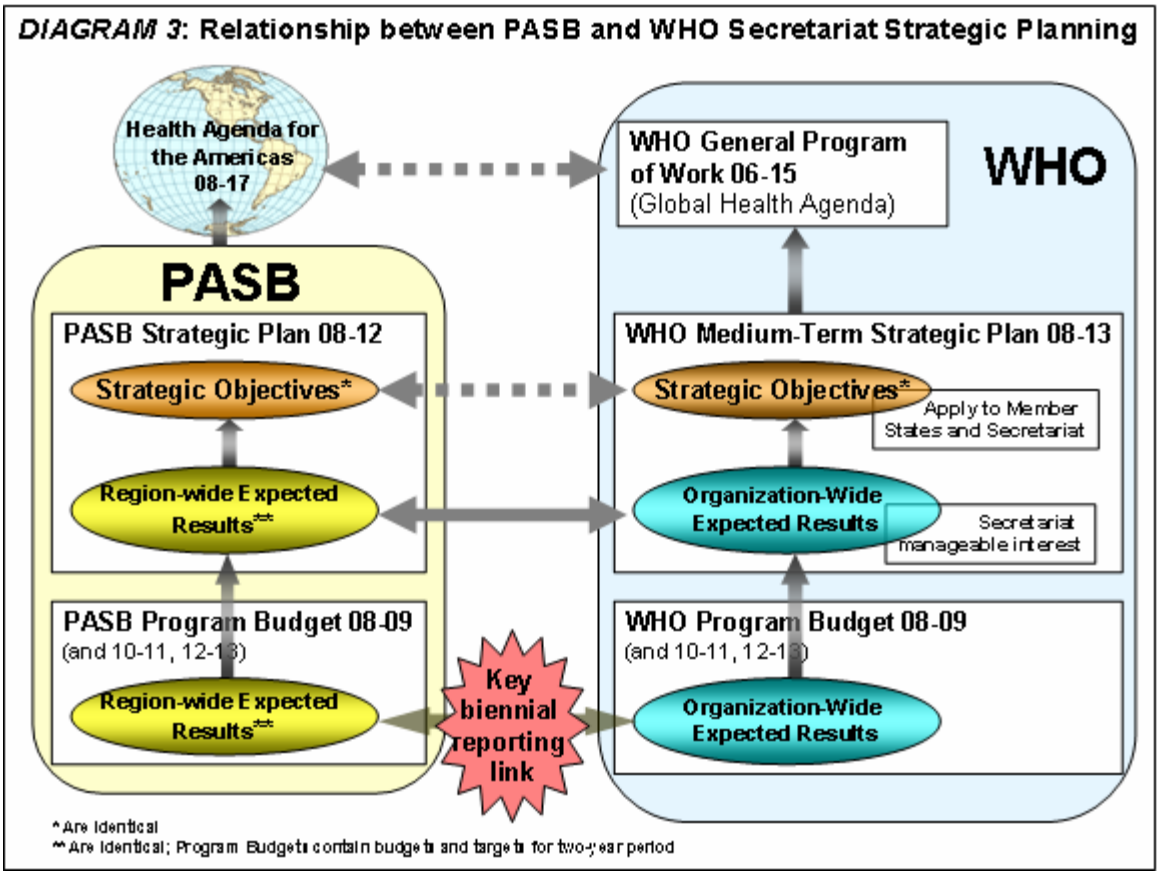
WHO General Programme of Work 2006-2015

59. 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.

60. At the time of its development, this Strategic Plan directly adopted the 16 Strategic Objectives (SOs) that were included WHO's MTSP until January 2007. Subsequently, based on input from WHO Member States during the January 2007 Executive Board, 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 PASB 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 PASB's contribution to WHO's organization-wide expected results (OWERs) is explicitly quantified in the region-wide expected results (RERs). This is the first time that RERs have been developed with indicators that aggregate directly to the global level.

61. With respect to WHO's 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.

62. The relationship between the Bureau planning mechanisms of the PASB and WHO is graphically represented in the following diagram.



STRATEGIC FRAMEWORK FOR COOPERATION

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

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

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

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

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

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

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

(e) Extending coverage in water and sanitation.

66. 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.

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

(a) The spread of HIV/AIDS;

(b) Increasing violence;

(c) SARS;

(d) The avian flu virus;

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

(f) The epidemic rise of non-communicable diseases;

(g) Disasters as they occur.

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

CORE FUNCTIONS

69. The PASB has adopted WHO's core functions as its own, with minimal modification of the term "technical support" to "technical cooperation" as used in the Region. The core functions were included in the Eleventh General Programme of Work, with their origin in WHO's Constitution. They clarify the Organization's role in responding to the global health agenda laid out in the 11th GPW, building on WHO's original mandate and an analysis of its comparative advantage.

70. The main reasons for including the core functions in the PASB 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 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 activities by core function and enable WHO-wide analysis of expenditures.

71. Therefore, beginning in 2008 the PASB will classify its expenditures by core function. The 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, translation and dissemination of valuable knowledge;

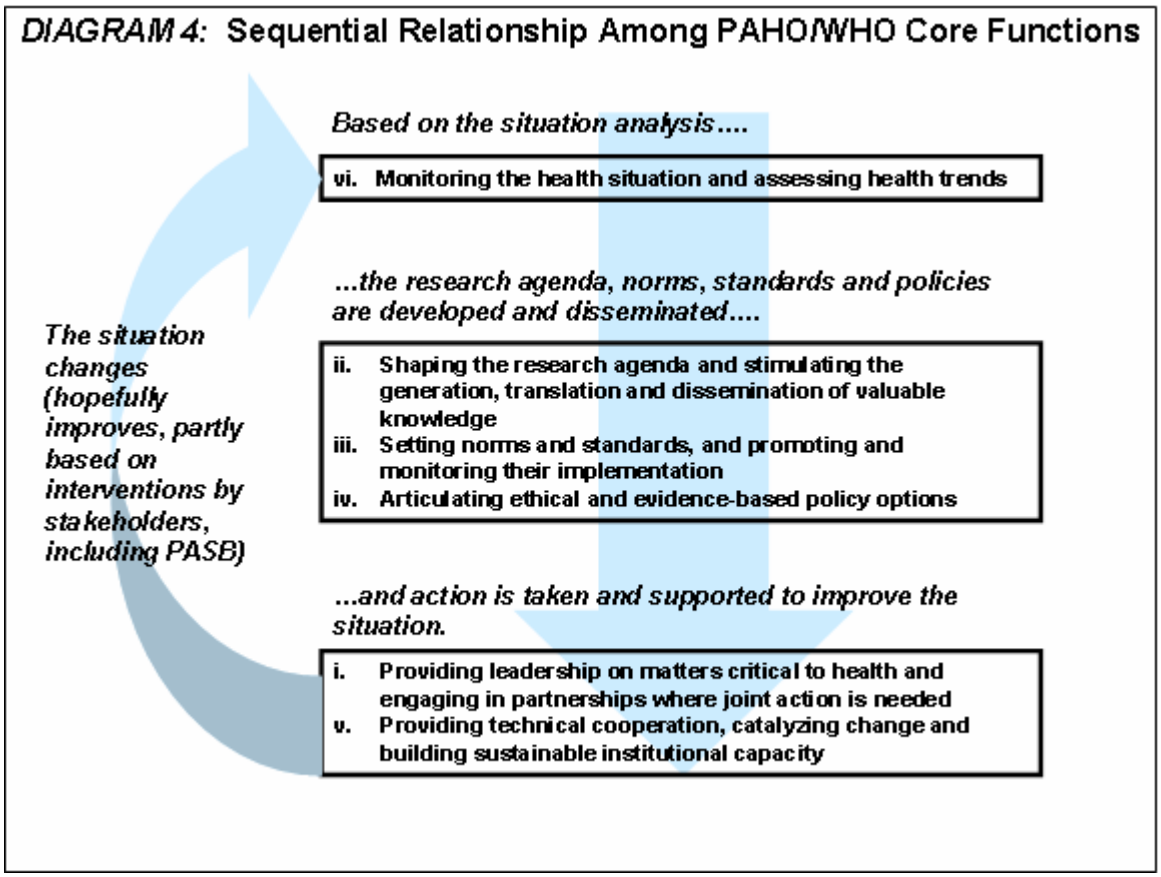
iii. Setting norms and standards, and promoting and monitoring their implementation;

iv. Articulating ethical and evidence-based policy options;

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

vi. Monitoring the health situation and assessing health trends.

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



THE MILLENNIUM DEVELOPMENT GOALS

73. Attainment of the MDGs in the Americas remains a key priority for the PASB. 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.

74. 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, focalizing efforts on peoples living in poverty as 90% of the poor live in middle income countries. At the same time sub-regions 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 citizens, civil society and grass roots as producers of health. The PASB's main focus in this respect is the "Faces, Voices and Places of the MDGs" 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.

75. The Faces, Voices, and Places initiative analyzes local realities, develops critical interventions, and provides targeted technical cooperation with the support of the PASB to help communities achieve the eight MDGs from the health perspective. This will be accomplished through the empowerment of individuals and the community as a whole via a horizontal exchange partnership between local communities and providers of technical cooperation.

76. 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 OBJECTIVES AND REGION-WIDE EXPECTED RESULTS

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

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

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

A note regarding baselines and targets

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

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

(b) These 40 countries and territories include:

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

(c) For reporting against the PASB Strategic Plan and respective Program Budgets, the Bureau will report achievements in these 40 countries and territories. However, when

reporting against WHO OWERs, the Bureau will aggregate results only from the 35 Member States.

81. 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".

STRATEGIC OBJECTIVE 1

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

Scope

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

INDICATORS AND TARGETS

- The mortality rate due to vaccine-preventable diseases. Target: one third reduction by 2015.
- Coverage of interventions targeted at the control, elimination or eradication of tropical diseases. Target: 80% of the susceptible population in 25 countries (21 in Latin America and 4 in the Caribbean) with emphasis on the five key countries by 2013.
- Coverage of interventions targeted at the control of epidemic prone diseases. Target: 80% of the susceptible population in the 40 countries/territories by 2013.
- Fulfillment of core capacities requirements in surveillance, response and points of entry, as established in the 2005 International Health Regulations. Target: 100% of the 40 countries/territories by 2013.
- The proportion of countries achieving and maintaining certification of poliomyelitis eradication and destruction or appropriate containment of all polioviruses, as well as for measles, rubella, congenital rubella syndrome and neonatal tetanus elimination. Target: 100% by 2010.

ISSUES AND CHALLENGES

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

In Latin America and the Caribbean more than 210 million people live below the poverty line, and they bear the 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 25,000 Disability Adjusted Life Years (DALYs) in 2005. Indigenous populations are especially vulnerable to this group of diseases; they deserve culturally appropriate interventions.

National **immunization** programs have reached approximately 90% vaccination coverage for all of the childhood vaccines, and they strive to achieve greater than or equal to 95% coverage in all municipalities. This is one of the best ways to ensure equitable access to existing vaccines and ultimately provide new life-saving vaccines that address important public health priorities to the people who need them most. Despite the success of polio eradication and measles elimination, pockets of unvaccinated susceptible persons still persist, leading to outbreaks of diseases like diphtheria and pertussis (whooping cough), which carry high case-fatality rates. The rubella elimination initiative, endorsed by two Resolutions of PAHO's Directing Council (CD44.R1 and CD47/11.Rev.1), strengthens measles elimination efforts in the Region by reducing susceptible populations, decreases disability due to vaccine-preventable diseases, and increases access to health services.

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

High quality surveillance will allow adequate preparedness for pandemics and vaccine-preventable actions related to threats of national and international concern to be in place. Surveillance systems for vaccine-preventable diseases need urgent upgrading, with emphasis on capacity development.

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

Neglected diseases (NDs), directly or indirectly, affect the capacity of many countries in the Region to meet the MDGs. NDs have adverse effects not only on health and well-being but also contribute to low levels of school attendance, to poverty, and stem from environmental problems. Lack of routine epidemiological surveillance and data-recording for the NDs in the Region make it difficult to accurately estimate disease burden. However, national surveys and special studies shed light on the burden in some populations. PAHO/WHO estimates that 20-30% of Latin Americans are infected with one of several intestinal helminths and/or schistosomiasis, two very important NDs. Lymphatic filariasis affects approximately 750,000 people while onchocerciasis puts 500,000 people at risk in the Region; both diseases are targeted for elimination. A study of cystic echinococcosis noted an estimated total of 52,693 Disability Adjusted Life Years (DALYs) 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; furthermore new safe and inexpensive methods to monitor these diseases in populations and treat infected persons make their prevention, control, and even elimination more feasible than ever before.

The number of prevalent cases registered of **leprosy** in the Region of the Americas at the beginning of 2006 was 32,904 cases, 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 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 is close to it. Brazil, which traditionally accounted for the highest burden of leprosy in the region, has improved toward the goal of elimination. Countries that have achieved this goal are making efforts to further reduce the leprosy burden with the *WHO Global Leprosy Strategy*, with emphasis on early detection and an integrated approach in primary health services.

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, and 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.

Major progress achieved in the Region:

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

Between 2001 and 2005, more than 30 countries of the Americas reported a total of 2,879,926 cases of **dengue,** of which 65,235 cases were dengue hemorrhagic fever. The Regional Dengue Program seeks to promote public health policies through a multi-sectoral, integrated management and interdisciplinary approach (Integrated Strategy for Dengue Prevention and Control), making it possible to prepare, implement, and consolidate a strategy at the subregional and national levels. This strategy comprises six key components: mass communication, entomology, epidemiology, laboratory, patient care and environment.

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, still have not achieved these results. Many other zoonotic diseases need to be addressed in the Region as well.

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

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

STRATEGIC APPROACHES

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

- The establishment and maintenance among Member States of effective coordination with other partners and across all relevant sectors at the country level.
- Research promotion through adequate investment, capacity strengthening and effective partnership between the academic and public sector (programs). Mechanisms should be explored to encourage transfer of technology and new modalities of technical cooperation (e.g. south-to-south).
- Compliance of Member States with World Health Assembly (WHA) 2005 established target dates for the implementation of the International Health Regulations.
- The establishment of collaborative relationships with other agencies in the United Nations and Inter-American Systems, as well as the establishment of multilateral and national agreements to develop these interventions.
- The network of WHO Collaborating Centers located in the Americas, which provides support to PASB technical cooperation activities.

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

- Strengthening collaboration with regional health stakeholders, partnerships and the civil society.
- Securing community access to existing and new tools and strategies, including vaccines and medicines; that meet acceptable standards of quality, safety, efficacy and cost-effectiveness, while reducing disparities.
- Strengthening its capacity to provide technical cooperation, and build capacity of Member States to better respond to commitments as per World Health Assembly resolutions related to communicable diseases and the International Health Regulations. This includes facilitating national and international resource mobilization and advocacy efforts.
- Moving from vertical to horizontal approaches and; on the basis of a thorough assessment of past successes and failures in the creation of strategies for integrated health systems development; build on past strengths and address weaknesses, capitalizing, among others, on subregional spheres, including economic fora (e.g. Caribbean Community – CARICOM; Meeting of the Health Sector of Central America and the Dominican Republic - RESSCAD, etc.).
- Expanding institutional networks to improve public health.
- Maintaining and strengthening an effective international system for alert and response to epidemics and other public health emergencies, and facilitating public health preparedness in collaboration with other stakeholders, including private and civil society organizations as appropriate.

- Providing Member States with tools, strategies and technical cooperation to evaluate and strengthen monitoring and surveillance systems.
- Coordinating integrated surveillance systems at global and regional levels to inform policy decisions and public health responses.
- Shaping the research agenda for use in the formulation of ethical and evidence-based policy options and for direct application to public health interventions.

ASSUMPTIONS AND RISKS

This SO would be achieved under the following assumptions:

- The entry into force of the International Health Regulations in 2007 will translate into a renewed commitment by all Member States to strengthen their national surveillance and response systems, and a sustained interest in and support for PAHO/WHO's activities on the part of donors and technical partners, including networks and partnerships.
- 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 level.
- Political commitment and resources will be in place to secure effective surveillance and adequate preparedness for pandemics and vaccine-preventable actions related to threats of national and international concern.

The following risks may adversely affect the achievement of this SO:

- Diversion of resources either away from the Region of the Americas (e.g. pandemic influenza), or away from communicable diseases and towards other aspects of health and development; and the fact that prevention and control of communicable diseases are not recognized and visibly maintained as a health priority, particularly in the least developed countries.
- Emergence of parallel health agendas due to lack of communication and coordination among partners.
- Low investment and/or political commitment concerning the International Health Regulations and the fragmented approach of governments towards their implementation.
- Low or insufficient investment in research activities that might impact adversely on health interventions.
- Influenza or other pandemic-prone disease that could cause unprecedented morbidity and mortality, as well as grave economic harm. Advanced planning for appropriate detection and rapid response strategies will be required.

REGION-WIDE EXPECTED RESULTS

RER 1.1 **Policy and technical cooperation provided to Member States to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies, and to integrate other essential child health interventions with immunization.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.1.1	Number of countries achieving more than 95% DPT3 coverage at national level.	17	20	25
1.1.2	Proportion of municipalities with coverage level for DPT3 less than 95% in Latin America and the Caribbean.	38% (5,729)	35% (5,277)	30% (4,523)
1.1.3	Number of countries supported to make evidence-based decisions for the introduction of new vaccines.	9	10	20
1.1.4	Number of essential child and family health interventions integrated with immunization for which guidelines on common program management are available.	4	6	8
1.1.5	Number of counties that have established either legislation or a specified national budget line in order to ensure sustainable financing of immunization.	30	32	35
1.1.6	Number of subregions with action plans for the introduction of new vaccines according to the agreements of the subregional integration mechanisms (RESCCAD, CARICOM, ORAS y MERCO SUR).	0	2	4
1.1.7	Number of subregions with border immunization activities (vaccination and vaccine-preventable disease {VPD} surveillance).	3	3	3
1.1.8	Percentage of countries supported to develop an updated immunization plan of action.	60%	70%	90%
1.1.9	Percentage of countries supported to develop vaccine safety plans of action.	53%	70%	100%

RER 1.2 **Effective coordination and technical cooperation provided to Member States to maintain measles elimination and achieve rubella, Congenital Rubella Syndrome (CRS) and neonatal tetanus elimination; while sustaining the polio free status and the appropriate containment of polioviruses, leading to a simultaneous cessation of oral polio vaccination globally.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.2.1	Number of countries using oral polio vaccine (OPV) according to an internationally agreed time-line and process for cessation of routine use of OPV.	35	35	35
1.2.2	Percentage of final country reports or updates on polio containment certified by Regional Commission for the Americas.	100%	100%	100%
1.2.3	Number of facilities storing poliovirus in the Americas.	1	1	1
1.2.4	Number of countries with sustained surveillance of acute flaccid paralysis.	40	40	40
1.2.5	Number of countries with integrated measles / rubella and Congenital Rubella Syndrome (CRS) surveillance.	35	40	40
1.2.6	Number of countries that have implemented interventions to achieve rubella and Congenital Rubella Syndrome (CRS) elimination.	37	40	40
1.2.7	Number of countries achieving neonatal tetanus (NNT) elimination.	39	40	40
1.2.8	Number of countries that have implemented epidemiological surveillance system for the new vaccines (RV, NEUMO, INF, YF, HPV).	0	5	15

RER 1.3 **Effective coordination and technical cooperation provided to Member States to provide access for all populations to interventions for the prevention, control, and elimination of neglected communicable diseases, including zoonotic diseases.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.3.1	Number of countries achieving dracunculiasis eradication certification.	40	40	40
1.3.2	Number of countries that are implementing WHO Global Strategy for further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities, especially Brazil, which is the only country in Americas with high leprosy burden.	1/24	9/24	16/24

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.3.3	Population at risk (in millions) of lymphatic filariasis in four endemic countries receiving mass drug administration (MDA) or preventive chemotherapy.	2.4	4.7	6
1.3.4	Coverage of at-risk school-age children in endemic countries with regular treatment against schistosomiasis and soil transmitted helminthiasis (STH).	38%	50%	75% coverage
1.3.5	Number of countries that have incorporated a multidisease, interprogrammatic, inter-sectoral approach for the prevention, control or elimination of neglected communicable diseases.	1/35	4/35	10/35
1.3.6	Number of countries that have incorporated an inter-sectoral, interprogrammatic approach for the prevention, control or elimination of zoonoses of public health importance.	2/21	4/21	10/21
1.3.7	Number of countries in Latin America that eliminated human rabies transmitted by dogs.	11/21	12/21	16/21
1.3.8	Number of countries supported in the maintenance of control programs in equinococosis.	4	4	4
1.3.9	Number of countries in Latin America and the Caribbean assisted to maintain surveillance and preparedness for emerging or re-emerging zoonotic diseases (e.g. avian flu and bovine spongiform encephalopathy).	10/33	13/33	22/33
1.3.10	Number of countries with total interruption of Chagas Disease vector transmission (T infestans for South Cone, and Rhodnius prolixus in Central America).	3/21	11/21	15/21
1.3.11	Number of countries with total Chagas screening of blood banks for transfusional transmission.	14/21	20/21	20/21
1.3.12	Number of endemic countries with onchocerciasis elimination certification.	0/6	1/6	3/6
1.3.13	Technical norms or recommendations provided to countries for prevention and control of zoonotic diseases.	5	7	12
1.3.14	Regional rabies surveillance system functioning on an ongoing basis (number of countries reporting).	21	21	21
1.3.15	Number of technical guidelines published for the surveillance, prevention, control of neglected communicable diseases.	0	2	4

RER 1.4 **Policy and technical cooperation provided to Member States to enhance their capacity to carry out communicable diseases surveillance and response, as part of a comprehensive surveillance and health information system.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.4.1	Number of countries with enhanced surveillance for communicable diseases of public health importance.	13/39	15/39	18/39
1.4.2	Number of countries receiving technical cooperation from PASB to adapt generic surveillance and communicable disease monitoring tools or protocols to specific country situations.	2	20	30
1.4.3	Number of countries for which joint reporting forms on immunization surveillance and monitoring are received at regional level in accordance with established timelines.	15	18	20
1.4.4	Number of new and improved anti-microbial resistance (AMR) tools, interventions and implementation strategies whose effectiveness has been determined by appropriate institutions.	5	7	10

RER 1.5 **New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed, validated, available, and accessible.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.5.1	Number of consensus reports published on subregional, regional or global research needs and priorities for a disease or type of intervention.	0	3	6
1.5.2	Number of new and improved interventions and implementation strategies whose effectiveness has been evaluated and validated.	1	2	5
1.5.3	Proportion of peer-reviewed publications based on PAHO/WHO-supported research where the main author's institution is in a developing country.	15%	30%	60%
1.5.4	Number of countries with one or more institutions which have implemented Tropical Disease Research (TDR) new ten year vision, under the coordination of PAHO/WHO.	0	6	9

RER 1.6 **Technical cooperation provided to Member States 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.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.6.1	Number of countries that have completed the assessment of core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005).	3	32	40
1.6.2	Number of countries supported by PASB to develop national plans of action to meet minimum core capacity requirements for early warning and response in line with their obligations under the International Health Regulations.	0	32	40
1.6.3	Number of countries whose national laboratory system is engaged in at least one internal or external quality-control program for communicable diseases.	20/36	24/36	30/36
1.6.4	Number of countries participating in training programs focusing on the strengthening of early warning systems, public health laboratories or outbreak response capacities.	38/38	38/38	38/38

RER 1.7 **Member States and the international community equipped to detect, contain and effectively respond to major epidemic and pandemic-prone diseases (e.g. influenza, dengue, meningitis, yellow fever, hemorrhagic fevers, plague and smallpox).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.7.1	Number of countries having national preparedness plans and standard operating procedures in place for major epidemic prone diseases (e.g. pandemic influenza, yellow fever, dengue, meningitis).	22	28	36
1.7.2	Number of countries that have tested their national preparedness plans and standard operating procedures for pandemic influenza through simulation exercises.	10	20	36
1.7.3	Number of international support mechanisms for surveillance, diagnosis and mass intervention (e.g. international laboratory surveillance networks and vaccine-stockpiling mechanisms for meningitis, hemorrhagic fevers, plague, yellow fever, influenza, smallpox).	5	6	7

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.7.4	Number of countries with basic capacity in place for safe laboratory handling of dangerous pathogens and safe isolation of patients who are contagious.	22	25	40
1.7.5	Number of countries implementing interventions and strategies for dengue control (Estrategias de Gestión Integrada {EGI} or Communication for Behavior Impact {COMBI}).	15	17	19
1.7.6	Number of tools (guidelines, protocols, training modules) developed to assist countries in the development and implementation of national preparedness plans for major epidemic-prone diseases (e.g. pandemic influenza).	2	5	10

RER 1.8 **Global, 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**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
1.8.1	Number of PASB offices (regional and country) with the global event management system in place to support coordination of risk assessment, communications and field operations among headquarters, regional and country offices.	1/28	10/28	28/28
1.8.2	Number of countries with at least one participating partner institution in the global outbreak alert and response network, and other relevant regional sub-networks.	26	35	40
1.8.3	Proportion of requests for support from Member States for which 'PASB mobilizes comprehensive and coordinated international support for disease-control efforts, investigation and characterization of events, and sustained containment of outbreaks.	100%	100%	100%
1.8.4	Median time (in days) to verification of outbreaks of international importance, including laboratory confirmation of etiology.	7 days	5 days	3 days

STRATEGIC OBJECTIVE 2

To combat HIV/AIDS, tuberculosis and malaria

Scope
This Strategic Objective (SO) focuses on interventions for the prevention, early detection, treatment and control of HIV/AIDS, 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

- 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 (baseline: 2006). (Per Regional HIV/STI Plan for the Health Sector)
- By 2010, there will be universal access to comprehensive care including prevention, care, and antiretroviral treatment. (Per Regional HIV/STI Plan for the Health Sector)
- By 2015, incidence of mother to child transmission of HIV will be less than 5% and incidence of congenital syphilis will be less than 0.5 cases per 1000 live births. (Per Regional HIV/STI Plan for the Health Sector)
- Reduction of tuberculosis incidence and prevalence in all countries. Target: by 2013, to halt and begun to reverse the incidence of tuberculosis (baseline: 39 cases per 100,000 inhabitants – 2005 data) and to reduce the prevalence from 6 per 100,000 inhabitants in 2005 to 5 in 2013 (in accordance with MDGs)
- Reduce the burden of malaria in the Americas by 2010 and further by 2013. Target: 50% reduction in morbidity and mortality by 2010; with a further 50% reduction by 2013 (baseline: 2000 morbidity and mortality figures)
- By 2013, at least 1 additional country in the region certified or enrolled in a WHO certification process for malaria elimination
- All malaria transmission-free countries retain their status

ISSUES AND CHALLENGES

HIV/AIDS/STI

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 North America and 7% in the Caribbean. The Caribbean is the second most affected region in the world after sub-Saharan Africa. The major modes of transmission in the Americas are well known:

- Men who have unprotected sex with men account for a large proportion of cases of HIV and AIDS.
- Unprotected heterosexual sex is responsible for an increasing proportion of infections.

- Injecting drug use accounts for a significant proportion of cases in North America and in some other countries (mainly Brazil, Argentina and Uruguay).

Sex work is also implicated in the spread of HIV, with varying prevalence among countries. Some sex workers (SW) also form a bridge between IDUs and clients of sex workers, given a significant proportion of SW, in some areas, who use sex work to finance their drug habit.

In 2006, it was estimated that 30% of the total population living with HIV in the region were women. In the Caribbean women represent 50% of those affected by HIV, while in North America and Latin America they represent 26% and 31% respectively. Additionally, more and more young people are being affected by the epidemic; in Latin America and the Caribbean (LAC), the estimated number of children under 15 years old with HIV/AIDS increased from 130,000 in 2003 to 140,000 in 2005.

It is estimated that there are 50 million of new cases of sexually transmitted infections (STI) each year in the region. 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.

In agreement with the 2005 rationale for the division of labour of UN agencies in the area of HIV response, PASB effort will focus on the scaling up of HIV/AIDS services to achieve universal access that encompass prevention and treatment. Assuring the engagement of civil society as well as the reduction of stigma and discrimination related to HIV/AIDS are also essential. The promotion of a public health approach for integrated and decentralized HIV/AIDS interventions with particular emphasis on prevention and treatment for vulnerable populations continues to be a major challenge.

Malaria

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

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

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

Control and prevention efforts need to be maintained as the nature of the disease, its vectors, and other factors that affect transmission is complex. A pro-active approach and better foresight is needed so that emerging and re-emerging challenges related to the disease are averted, including outbreaks and epidemics. Furthermore, advocacy on malaria must be intensified so that stakeholders are able to act, contribute concretely, and effect positive changes within their spheres of influence.

In the Americas, partners who work alongside the countries and their peoples in combating malaria include UN Agencies; multilateral and development partners (The Global Fund to Fight

AIDS, Tuberculosis, and Malaria, and the United States Agency for International Development); the research and academic community (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); non-governmental organizations; foundations; and the private sector.

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 every year. It predominantly affects the adult population in reproductive age: 61% of the 2005 reported infectious cases were between 15 to 44 years old. Even though TB can affect everyone, there are specific vulnerable groups with the highest burden of the disease: the poor, migrants, marginalized populations, prisoners, people living with HIV/AIDS and the indigenous population. There are marked differences in the burden of disease 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 the control of this disease. A total of 33 countries had applied this strategy in 2005 with 88% coverage.

The main identified challenges for TB control in the Region are the HIV/AIDS epidemic, the TB multi-drug resistance (MDR) and the TB extremely multi-drug resistant along with the weaknesses of 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.

Several partners and donors come together under the new Stop TB strategy to support the countries in the Region and the rising challenges. Among them 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 (TBCAP), Academy for Educational Development (AED), American Thoracic Society, the Spanish Agency for International Cooperation (AECI) and the Global Fund.

CHALLENGES FOR THE THREE DISEASES

- Limited resources with the need to optimize efforts.
- The engagement of communities, affected persons, civil-society organizations, the private sector and other relevant stakeholders in the response to ensure local ownership and sustainability.
- Greater alignment and harmonization of programs at the various levels.

STRATEGIC APPROACHES

The strategic approaches for the implementation of this SO are comprehensively discussed in the Regional HIV/STI Plan for the Health Sector, 2006-2015; the Regional Plan for Tuberculosis Control, 2006-2015; and the Regional Plan for Malaria in the Americas, 2006-2010. Strategic approaches are based on the hypothesis that interventions can be expanded even in the most resource-challenged settings, with sound planning, sustainable financing and well-supported infrastructures.

In this context, the PASB will provide policy, technical and programmatic support to countries in the following areas:

- Strengthening health systems to effectively combat HIV/AIDS/STI, TB and malaria through the development of relevant supportive gender sensitive national and local policies, leadership and management, including sustainable financing.
- Strengthening health services by:
    - Expanding, integrating and reorienting services for the delivery of gender sensitive, cost-effective interventions for prevention, diagnosis, treatment, care and support for HIV, TB and malaria.
    - Ensuring services for hard to reach populations and vulnerable groups, including indigenous populations.
    - Capacity building and strategic management of human resources.
    - Ensuring the availability and proper use of high quality medicines, quality laboratory networks, diagnostics, and health commodities with continued support to the Strategic Fund for public health supplies.
- Strengthening Surveillance and Monitoring and Evaluation Systems and promoting the use of strategic information.

The following general strategic approaches will be utilized by the PASB:

- Regional advocacy for equitable universal access to prevention, care and treatment for HIV/STI, TB, and malaria and for the elimination of stigma and discrimination against people with HIV and TB, and vulnerable groups.
- Strengthening alliances and partnerships at regional, sub-regional and country levels, particularly with networks of affected individuals.
- Country driven technical cooperation, prioritization of countries according to magnitude of the problem and the nature of the health sector response and intensifying direct support to countries. Country offices will strengthen their responses to address comprehensively these diseases, identifying mechanisms to create synergies and harmonization of resources, including technical support in development and implementations of projects submitted and approved by the Global Fund. Technical cooperation between countries and knowledge hubs will also be promoted.
- Sub-regional action to respond to the diversity of the Region. Collaborative work with subregional entities and coordinating mechanisms.
- Mainstreaming HIV/AIDS, TB and malaria in PASB by developing mechanisms for inter-programmatic and interdisciplinary action to tackle these diseases, identifying synergy and pooling of resources and expertise as required.
- Collaborative actions for Tuberculosis control through partners will include financial support through projects in some cases (e.g. Tuberculosis Control Assistance Program and United States Agency for International Development) as well as joint technical cooperation and monitoring visits, (e.g. The Union and KNCV Tuberculosis Foundation).
- Collaboration with other organizations, UN agencies and programs (United Nations Children's Fund -UNICEF, Joint United Nations Program on HIV/AIDS - UNAIDS, World Bank, United Nations Population Fund -UNFPA, International Organization for Migration - IOM), multilateral and development partners, academic partners and non-governmental organizations (NGOs) in order to advocate, increase resources available for HIV and provide technical guidance and cooperation to countries for universal access to comprehensive care, prevention and treatment for HIV.

ASSUMPTIONS AND RISKS

The following assumptions and prerequisite conditions are essential in achieving this SO:

- HIV/AIDS, TB and malaria will continue to be recognized as a priority in the national, subregional, regional and global health agendas and receive adequate resource allocations.
- National health systems will correspondingly be strengthened towards realizing universal access to essential health services and care.
- Stakeholders will work in synergy towards the attainment of common goals and targets.

The following risks have been identified that may hinder achievement of the SO:

- Raising and sustaining of the necessary resources may be difficult, both for the Bureau and Member States, as more competing priorities emerge and the cost of services increase due to the life-time chronic condition of HIV and the treatment of emerging resistance (AVR-DR, TB-MDR and TB-XDR); particularly, attracting resources to the Region will become increasingly difficult.
- Health gains in combating HIV/AIDS, tuberculosis and malaria may not be sustained in the least developed countries, without increased political and financial commitment.
- PAHO/WHO's leadership among the growing number of partners, and the interaction among them, may be difficult to sustain, especially in the face of increasing competition for resources and special problems raised by coordination and harmonization

REGION-WIDE EXPECTED RESULTS

RER 2.1 **Guidelines, policy, and strategy developed for 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, and hard-to-reach and vulnerable populations.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.1.1	Number of countries that have achieved the national intervention targets for HIV/AIDS, consistent with the goal of universal access to HIV/AIDS prevention, treatment and care.	10	12	15
2.1.2	Number of malaria endemic countries implementing all components of the Global MALARIA control strategy within the context of the Roll Back MALARIA initiative and PAHO's Regional Plan for MALARIA in the Americas, 2006-2010 and national intervention targets. Within the same context, for non endemic countries, the number involved in activities to prevent re-emergence.	20	31	33

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.1.3	Number of countries detecting 70% of estimated cases of pulmonary TUBERCULOSIS with a positive TB smear test.	13/27	21/27	27/27
2.1.4	Number of countries with a treatment success rate of 85% for TUBERCULOSIS cohort patients.	10/27	21/27	25/27
2.1.5	Number of countries that have achieved targets for prevention and control of sexually transmitted infections (70% of persons with sexually transmitted infections at primary point-of-care sites diagnosed, treated and counseled).	5	25	40
2.1.6	Number of countries that have achieved regional targets for elimination of congenital syphilis.	1	15	42
2.1.7	Number of subregions that have implemented advocacy strategies to overcome barriers to universal access for HIV for the poor, hard to reach and vulnerable populations.	0	3	4
2.1.8	Number of frameworks, policy briefs and case studies made available to countries in order to achieve targets on prevention, treatment and comprehensive care for HIV in vulnerable groups.	1	6	10

RER 2.2 **Policy and technical cooperation provided to Member States towards expanded gender -sensitive delivery of prevention, support, treatment and care interventions for HIV/AIDS, malaria and TB; including integrated training and service delivery; wider service provider networks; strengthened laboratory capacities and better linkages with other health services, such as reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.2.1	Number of targeted countries with integrated / coordinated gender-sensitive policies on HIV/AIDS.	40	40	40
2.2.2	Number of targeted countries that have developed integrated/ coordinated gender sensitive policies on TUBERCULOSIS.	0/27	8/27	15/27

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.2.3	Number of targeted countries with integrated or coordinated gender-sensitive policies on MALARIA, particularly in pregnant women.	0/21	8/21	12/21
2.2.4	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by HIV/AIDS.	3	20	40
2.2.5	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by TUBERCULOSIS.	0/27	10/27	25/27
2.2.6	Number of countries with sound national strategic plans for the health workforce, including policies and management practices on incentives, regulation and retention, with attention to the specific issues raised by MALARIA.	0/21	10/21	21/21
2.2.7	Number of countries monitoring access to gender-sensitive health services for HIV/AIDS.	3	20	40
2.2.8	Number of countries monitoring access to gender-sensitive health services for TUBERCULOSIS.	0/27	8/27	15/27
2.2.9	Number of countries monitoring access to gender-sensitive health services for MALARIA.	8/21	18/21	21/21
2.2.10	Number of countries with plans for monitoring provider-initiated HIV testing and counseling in sexual and reproductive health (sexually transmitted infection and family planning services).	18	20	24
2.2.11	Number of health professionals and decision makers trained through courses (including virtual self-conducted) in comprehensive gender sensitive services for prevention, treatment and care for HIV/AIDS.	0	60	200

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.2.12	Number of subregions implementing and monitoring plans with defined subregional targets for Universal access in the context of the Regional HIV/STI Plan for the Health Sector 2006-2015.	3	3	4

RER 2.3 **Regional guidance and technical cooperation provided on policies and programs to promote equitable access to essential medicines of assured quality for the prevention and treatment of HIV, tuberculosis and malaria, and their rational use, including appropriate vector control strategies, by prescribers and consumers; and uninterrupted supply of diagnostics, safe blood and other essential commodities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.3.1	Number of global standards related to HIV/AIDS and congenital syphilis reviewed, adapted to regional needs and/or adopted.	3	8	10
2.3.2	Number of countries implementing revised / updated diagnostic and treatment guidelines on TUBERCULOSIS.	0/25	15/25	25/25
2.3.3	Number of countries implementing revised / updated diagnostic and treatment guidelines on MALARIA.	16/21	21/21	21/21
2.3.4	Number of countries with endemic MALARIA conducting regular surveys of anti-MALARIAL drug quality.	8/21	20/21	20/21
2.3.5	Number of countries with high incidence of P. falciparum MALARIA using artemisinin-based combination therapy from a pre-qualified manufacturer.	6/13	10/13	13/13
2.3.6	Number of countries receiving support to increase access to affordable essential medicines for TUBERCULOSIS whose supply is integrated into national pharmaceutical systems.	27	33	37

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.3.7	Number of malaria-endemic countries receiving support to increase access to affordable medicines for MALARIA whose supply is integrated into National pharmaceutical systems.	21/21	21/21	21/21
2.3.8	Number of countries receiving support to increase access to affordable essential medicines for HIV/AIDS whose supply is integrated into national pharmaceutical systems, with prices negotiated through the strategic fund.	18	19	21
2.3.9	Cumulative number of patients with TUBERCULOSIS treated with support from the Global Drug Facility.	40,000	60,000	100,000
2.3.10	Number of countries implementing quality-assured HIV screening of all donated blood.	32	35	40
2.3.11	Number of countries with plans to monitor the administration of all medical injections with safe equipment (e.g. disposable needles) as part of strategy to prevent transmission of HIV associated with health care.	0	4	10

RER 2.4 **Global, regional and national surveillance, evaluation and monitoring systems strengthened and expanded to keep track of 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.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.4.1	Number of countries that regularly collect, analyze and report surveillance coverage, outcome and impact data on HIV using PAHO/WHO's standardized methodologies, including appropriate age and sex dis-aggregation.	27	30	40
2.4.2	Number of countries that regularly collect, analyze and report surveillance coverage, outcome and impact data on TUBERCULOSIS using WHO/PAHO's standardized methodologies, including appropriate age and sex dis-aggregation.	28	30	40

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.4.3	Number of countries that regularly collect, analyze and report surveillance coverage, outcome and impact data on malaria using WHO/PAHO's standardized methodologies, including appropriate age and sex dis-aggregation.	21	21	21
2.4.4	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of HIV/AIDS.	35	40	40
2.4.5	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of Tuberculosis, and the achievement of targets.	27/40	30/40	40/40
2.4.6	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of, and the achievement of targets for TB/HIV co-infection.	18/40	30/40	40/40
2.4.7	Number of countries providing PAHO/WHO with annual data on surveillance, monitoring and financial allocation data for inclusion in the annual global reports on control of MALARIA and the achievement of targets.	21/21	21/21	21/21
2.4.8	Number of countries reporting on sex and age disaggregated surveillance and monitoring of HIV drug resistance.	0	20	35
2.4.9	Number of countries reporting on sex and age disaggregated surveillance and monitoring of TUBERCULOSIS drug resistance.	0/27	12/27	25/27
2.4.10	Number of countries reporting on sex and age disaggregated surveillance and monitoring of MALARIA drug resistance.	9/21	20/21	20/21
2.4.11	Regional and subregional networks developed for HIV drug resistance including lab networks.	1	2	4
2.4.12	Regional and subregional reports published on HIV epidemic profile.	1	3	6

RER 2.5 **Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnership on HIV, malaria and tuberculosis at country, regional and global levels; technical cooperation provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programs.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.5.1	Number of countries with functional partnerships for HIV control.	40	40	40
2.5.2	Number of countries with functional partnerships for Tuberculosis control.	5/27	8/27	15/27
2.5.3	Number of targeted countries with functional partnerships for malaria control.	21/21	21/21	21/21
2.5.4	Number of countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for HIV.	12	15	20
2.5.5	Number of countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for TUBERCULOSIS.	14/27	18/27	25/27
2.5.6	Number of countries that receive PAHO/WHO support in accessing financial resources or increasing absorption of funds for malaria.	13/21	17/21	19/21
2.5.7	Number of countries that have involved communities, academia and under represented sectors, persons affected by the diseases, civil society organizations, private sector in planning, design, implementation and evaluation of HIV programs.	40	40	40
2.5.8	Number of countries that have involved communities, academia and under represented sectors, persons affected by the disease, civil society organizations, private sector in planning, design, implementation and evaluation of Tuberculosis programs.	3/27	10/27	25/27
2.5.9	Number of countries that have involved communities, academia and under represented sectors, persons affected by the disease, civil society organizations, private sector in planning, design, implementation and evaluation of malaria programs.	13/21	21/21	21/21
2.5.10	Number of regional and subregional partnerships initiated and established by the PASB for HIV/AIDS control.	7	9	11

RER 2.6 **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 developing countries increasingly involved in this research.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
2.6.1	Number of new and improved interventions and implementation strategies for HIV whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	1	2	3
2.6.2	Number of new and improved interventions and implementation strategies for tuberculosis whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions.	3	5	6
2.6.3	Number of new and 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
2.6.4	Number of peer-reviewed publications arising from PAHO/WHO-supported research on HIV/AIDS which the main author's institution is based in a developing country.	0	3	6
2.6.5	Number of peer-reviewed publications arising from PAHO/WHO-supported research on malaria for which the main author's institution is based in a developing country.	0	2	5
2.6.6	Number of countries with a clear and well-implemented HIV research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	4	6	10
2.6.7	Number of countries with a clear and well-implemented MALARIA, research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	8/21	13/21	15/21
2.6.8	Number of countries with a clear and well-implemented TUBERCULOSIS research agenda that gives adequate focus on health systems strengthening and country-level capacity building.	0/25	5/25	15/25

STRATEGIC OBJECTIVE 3

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

Scope

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

INDICATORS AND TARGETS

- A 2% annual reduction in chronic disease death rates from the major chronic diseases over and above current trends.
- To halt and begin to reverse current increasing trends of mental, behavioral, neurological and psychoactive substance use disorders. Target: TBD.
- To halt and begin to reverse current increasing trends in mortality from injuries (2% reduction in mortality rate from injuries per year).

Issues and Challenges

- Chronic diseases, mental disorders, violence and injuries are the major causes of death and disability in almost all countries, responsible for 75% of all deaths and most of the health costs. They are rapidly increasing, and some affect men and women differently; additionally they disproportionately affect some racial/ethnic groups.
- A major part of this increasing burden will be borne by low- and middle-income countries and poor populations in all countries.
- Management is fragmented and tertiary care still consumes most of the resources.
- A wide range of cost effective, proven solutions exist from promotion to prevention and disease management.
- Most major chronic disease determinants lie outside the health sector (diet, physical activity, alcohol, tobacco).
- Insufficient sensitization among audiences that matter about the human and economic impact and the availability of cost-effective interventions; Insufficient awareness about the link between chronic diseases and poverty; not on the MDGs explicitly.
- Resources available in the Organization are not proportional with magnitude of problem and are fragmented.

- Data and information for setting baselines and monitoring progress, especially risk factors, are not well developed; and capacities of countries to collect, analyze, report, and use non-communicable disease data in developing programs and policy vary widely.
- The challenges in this context are to increase awareness of the magnitude of the problem and the potential for health promotion and disease prevention; to increase the political will and international partnerships to address the problem; to initiate/deepen appropriate multi-sectoral collaboration; to synergize such resources as are available in the Organization, and to generate the necessary additional resources in an environment of competing interests; to develop the data and information systems for improved policy making, planning and monitoring and evaluation, especially those pertaining to modifiable risk factors, such as behaviors and the related cost data; and to re-orient the health services towards prevention and care providers' attitudes on stigmatization of mental health problems, cultural competency, etc.

STRATEGIC APPROACHES

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

ASSUMPTIONS AND RISKS

- Data and information availability for effective policy, planning, monitoring and evaluation.
- Ability to secure high-level multi-sectoral collaboration in countries, individually and collectively.

- Partners in and out of the Organization respond and embrace approach.
- The MDGs will be adapted to reflect the importance of addressing chronic diseases in combating poverty and under-development.
- Options analysis will be used in planning and prioritization processes to take into account evidence-based interventions that have been proven successful or promising.
- Options analysis also has to monitor development and use, and costs of appropriate biotechnology (e.g. vaccine for HPV), genetic involvement in the etiology of some chronic diseases, leveraging use of other developments; such as using cell phone networks for collecting risk factor data, disseminating health messages, and improving compliance with necessary medications.

REGION-WIDE EXPECTED RESULTS

RER 3.1 **Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable conditions, mental and behavioral disorders, violence, injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.1.1	Number of countries whose health ministries have a focal point or a unit for injuries and violence prevention with its own budget.	9	14	24
3.1.2	Number of countries whose health ministries have a unit for mental health and substance abuse with its own budget.	24	28	30
3.1.3	Number of countries whose health ministries have a unit or department for chronic noncommunicable conditions and with its own budget.	21	36	38
3.1.4	Number of countries where an integrated chronic disease and health promotion advocacy campaign has been taken to stimulate multiple sector involvement in healthy public policy implementation.	3	10	20
3.1.5	Number of countries that have a unit or focal point in the MoH (or equivalent) on disabilities prevention and rehabilitation.	10	19	27
3.1.6	Partners Forum for prevention and control of chronic diseases established including public, private sector and civil society.	0	1	1
3.1.7	Sub-regional Forums to asses and discuss the implementation of National Health Policy and Plan.	3	3	6

RER 3.2 **Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable conditions, mental and behavioral disorders, violence, injuries and disabilities, and oral diseases.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.2.1	Number of countries that have and are implementing national plans to prevent unintentional injuries and violence.	15	17	23
3.2.2	Number of countries that are implementing national plans for disability, including prevention, management and rehabilitation according to PAHO/WHO guidelines and Directing Council resolutions.	5	15	24
3.2.3	Number of countries that are implementing a national Mental Health plan according to PAHO/WHO guidelines and Directing Council Resolutions.	26	29	30
3.2.4	Number of countries that have and are implementing a nationally approved policy and plan for the prevention and control of chronic, noncommunicable conditions, including genetic diseases.	15	32	36
3.2.5	Number of countries in the CARMEN network (Conjunto de Acciones para la Reducción Multifactorial de Enfermedades Notransmissibles).	22	30	36
3.2.6	Number of countries that have and are implementing comprehensive national plans for the prevention of blindness and visual impairment.	7	11	20
3.2.7	Number of countries that have and are implementing comprehensive national oral health plans for the prevention of oral diseases.	27	35	35

RER 3.3 **Improved capacity in countries to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries, and disabilities, as well as their risk factors and determinants**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.3.1	Number of countries that have a published a document containing a national compilation of data on the magnitude, causes and consequences of injuries and violence.	12	16	22
3.3.2	Number of countries that have a published document containing a national compilation of data on the prevalence and incidence of disabilities.	8	15	19
3.3.3	Number of countries with national information systems and annual report that includes mental, neurological and substance abuse disorders.	20	24	28
3.3.4	Number of countries with a national health reporting system and annual reports that include indicators of chronic, noncommunicable conditions.	15	28	32
3.3.5	Number of countries documenting the burden of hearing and visual impairment including blindness.	8	14	21

RER 3.4 **Improved evidence compiled by the Bureau on the cost-effectiveness of interventions to address chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries, disabilities, and oral health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.4.1	Number of cost-effective interventions for the management of selected mental and neurological disorders (depression, psychosis, and epilepsy) prepared and made available.	1	2	4
3.4.2	Availability of summarized evidence on the cost-effectiveness of a core package of interventions for chronic noncommunicable conditions together with an estimate of the regional cost of implementation in the Americas.	Not available	Package available and disseminated to countries and subregions	Package in use by countries and subregions
3.4.3	Number of countries with cost analysis studies on violence and/or injuries conducted and disseminated.	8	12	17

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.4.4	Number of countries with best practice models to deliver oral health services, including cost-effective analysis.	4	10	35
3.4.5	Number of cost-effective oral health interventions with an estimate of the regional cost of implementation in the Americas.	2	2	3

RER 3.5 **Guidance and technical cooperation provided to Member States for the preparation and implementation of multi-sectoral, population-wide programs to promote mental health and prevent mental and behavioral disorders, injuries and violence, as well as hearing and visual impairment, including blindness.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.5.1	Number of countries implementing strategies recommended by PAHO/WHO for population wide prevention of disabilities, including hearing and visual impairment and blindness.	6	15	24
3.5.2	Number of countries for which guidance and support has been provided for the preparation and implementation of multi-sectoral population-wide programs to prevent violence and injuries.	13	15	21
3.5.3	Number of countries having program of mental health promotion, and mental, behavioral and substance abuse prevention integrated into the National Mental Health Plan.	0	9	17
3.5.4	Number of countries implementing the Regional Strategy on an Integrated approach to prevention and control of Chronic Diseases, including Diet and Physical Activity.	2	10	30
3.5.5	Regional Guidelines on mental health promotion and mental, behavioral, substance abuse and neurological disorders prevention.	0	1	1

RER 3.6 **Support provided to countries to strengthen their health and social systems for integrated prevention and management of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.6.1	Number of countries that apply guidelines for violence and /or injuries in their health care services.	12	15	22
3.6.2	Number of countries that strengthened their rehabilitation services using the recommendations in The World Report on Disability and Rehabilitation and related PAHO/WHO guidelines and resolutions.	5	15	24
3.6.3	Number of countries with a systematic assessment of their mental health systems using the WHO-AIMS assessment instrument for mental health systems and utilizing the information to strengthen national mental health services.	8	15	25
3.6.4	Number of targeted countries implementing integrated primary health-care strategies recommended by WHO in the management of chronic, noncommunicable conditions.	10	20	36
3.6.5	Number of targeted countries that have established demonstration sites for integrated prevention and control of Chronic Disease.	16	24	30
3.6.6	Number of targeted countries that have elaborated and are implementing National Guidelines and Protocols for Chronic Disease.	6	24	36
3.6.7	Number of targeted countries with universal access to medication for major NCDs.	5	8	10
3.6.8	Number of countries with strengthened health-system services for the treatment of tobacco dependence as a result of using WHO's policy recommendations.	6	12	24

RER 3.7 **Strengthened inter-programmatic approach for improved synergy and impact in the prevention and control of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.7.1	Number of countries that have applied an Inter-programmatic approach to address violence and/or injuries.	23	28	35
3.7.2	Inter-programmatic group on chronic diseases prevention established and functioning.	0	1	1

RER 3.8 **Countries supported to develop monitoring and evaluation instruments to measure advances in the prevention and control of chronic noncommunicable conditions, mental and behavioral disorders, violence and injuries and disabilities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
3.8.1	Number of countries that have significantly increased their capacity to deal with violence and/or injuries.	13	15	20
3.8.2	Integrated regional information system for countries and the Bureau developed for monitoring and evaluation including mortality, morbidity and risk factors, costs, programmatic coverage and input/policy indicators, for chronic diseases and risk factors (diet, physical activity, tobacco, alcohol), health promotion, mental health and injuries and violence.	System under development in collaboration with WHO Geneva	System approved by Governing Bodies	System in use
3.8.3	Number of countries that improved the measures of disabilities prevention according UN Standard Rules, PAHP/WHO Guidelines, Directive Council Resolutions, the World Report on Disabilities and Rehabilitation and others regional standard.	0	5	15

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 in life and ensuring universal access to coverage with effective interventions for maternal, newborn, child, adolescent, and sexual reproductive health, using a life-course approach and addressing equity gaps. Work will be undertaken to support actions to strengthen health systems, formulate and implement policies and programs that promote healthy and active aging for all individuals

INDICATORS AND TARGETS

- Proportion of births attended by skilled attendants at birth. Target: at least 90% in the Americas; and a 10% increase in each country with less than 60% of births attended by skilled attendants at birth.
- Maternal mortality ratio. Target: less than 8 countries with maternal mortality ratio above 100 per 100,000 live births.
- Under-5 mortality rate. Target: 28 countries having met or on track to meet Millennium Development Goal Target 4 (reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate).
- Access to reproductive health services, as measured by unmet need for family planning or contraceptive prevalence rate; the fertility of women aged 15-19 years as a proportion of total fertility among women of all ages; and syphilis screening and treatment for pregnant women. Target: 25 countries having met or on track to meet their national targets for all three indicators.
- Adolescent health, as measured by fertility proportions, HIV prevalence in young people aged 15–24 years, obesity and overweight, tobacco use and injury rate. Target: 25 countries having met or on track to meet their national targets for two of the five indicators and showing no deterioration in the three other indicators.
- Older persons receiving health and social service protection. Number of countries in which more than 50% of the population over 60 years old receives health and social service protection (in CAN and USA over 65 years). Target: 18 countries (EV)

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

ISSUES AND CHALLENGES

In the Region of the Americas, the situation is worsening for some conditions (e.g., the incidence of sexually transmitted infections, fertility among adolescents in some countries), and is stagnating for others (e.g., maternal and neonatal mortality). At this time, most countries are not on track to meet the internationally agreed goals and targets.

Some countries have made great strides in reducing maternal mortality; however in others have worsened and great disparities remain between and within countries. Skilled attendance at birth is particularly low in the poorest countries and in rural settings. More than 5 countries in the region have fertility rates in adolescents aged 15-19 of more than 100 per 1,000. Several actors are working in the field of adolescent health, including UNICEF, UNFPA, UNIFEM, USAID, and many major NGOs (PLAN, Pathfinder, Red Cross, Alan Guttmacher) and bilateral originations (CIDA, SIDA, GTZ, NORAD, CIDE).

Infant mortality in children has dropped 24.3% regionally, but 10 countries had a childhood mortality rate of 40 or more per 1.000 lives birth, and huge disparities continue between and within countries.

In the child health area, many national and international agencies are working in Latin America to reach full coverage with interventions that will increase a child's chance for survival and healthy development. The Region collectively needs to intervene, not only through the health system but also at the household level to promote interventions that can be effectively delivered at low cost; these include breastfeeding, oral re-hydration therapy, education on complementary feeding, among others. These interventions could jointly prevent more than one-third of all deaths.

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 year old, underscoring that the healthy aging of its population will be one of the biggest challenges that Latin American and Caribbean society must face during this century

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

In the Region, technical knowledge and program experience indicate that effective and affordable interventions exist for most of the problems covered by this SO. Consensus exists on the need to reach universal access using key interventions. 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 between program areas while also providing effective support to ensure active and healthy aging.

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

Maternal and child health services, as well as some other reproductive health services, have long served as the backbone of primary health care and as a platform for other health programs, especially for poor and marginalized populations; but they are now overburdened. Scaling-up implies the development of a functioning health system that maintains good information systems, a suitable infrastructure, a reliable supply of essential drugs and commodities, functional referral systems, competent and well-motivated health workers, and cooperation with community leaders.

Lessons learned show that:

- The interventions that need to be scaled up are cost-effective and can be applied to scale even in resource-constrained settings, if sufficient attention is placed on developing an enabling policy environment and addressing key gaps in health systems;
- The programs concerned contribute to narrowing gaps in equity as they reach out to the most vulnerable and marginalized populations, including children, adolescents and women, indigenous populations, and serve as critical entry point and platform for other key public health programs.

STRATEGIC APPROACHES

Achieving the SO will require Member States and the Bureau to work closely together.

- This SO will require a country-led planning and implementation process for scaling up towards universal access to and coverage of maternal, newborn, child adolescent, sexual and reproductive health care, while addressing gender inequality and growing health inequities that fuel the high levels of mortality and morbidity.
- In collaborating with Member States to advance the regional health agenda, PAHO will contribute to national strategies and priorities, and incorporate country realities and perspectives into global and regional policies and priorities.
- PAHO will also provide leadership and advocacy for investing in children and adolescents. A continuum of care that runs through the life course and spans the home, the community and different levels of the health system must be ensured. This needs to occur within the broader framework of strengthening health systems to ensure adequate and equitable financing and delivery of quality health support services, with marginalized and underserved groups receiving priority attention.
- This approach will also require the promotion of community-based interventions and participation of community leaders to increase the demand for services and to support appropriate care in the home across the life course. The Region is conducting work at the family and community level within the context of primary health care and has documented best practices and lessons learned. The sexual and reproductive health of women and men outside the reproductive process should also receive consideration/attention.
- Supporting systems for improving information, decision making and emphasizing good monitoring, evaluation, and generation of evidence and best practices, and formulating strategies, including case management and integrated interventions for prevention and health promotion in an ecological model, will all ensure that the strategic objective is achieved.

- Building national capacity to reduce vulnerability and improve health calls for advocacy, update policies and legislation, training human resources, appropriate structures, knowledge management resources and partnership.
- Coordination ensures effectiveness and efficacy of activities harmonizing UN activities and leveraging impacts maximizing the participation with WHO/PAHO Collaborating Centers and PAHO Centers is needed.
- Accomplishing the strategic objective also means ensuring PAHO/WHO Country Representatives and Member States prioritize this work and allocate country funds appropriately.
- Achieving the SO also involves strengthening the promotion of active and healthy aging to prevent early deterioration (both physical and mental) and expanding human resources for education in gerontology and geriatrics for family as well as community caregivers. In addition, it will be necessary to develop, implement, and evaluate policies and programs that promote healthy and active aging and the highest attainable standard of health and well-being for their older citizens.

Partnership and harmonization with UN agencies is a key issue for the achievement of the target of this strategic objective. UNFPA support the countries in sexual and reproductive health, gender issues, information gathering, family planning, policies development and access to sexual and reproductive services UNICEF support countries in a more broad perspective of rights and health component has several entry points including nutrition, services, IMCI, PMCT and prevention of HIV among adolescents, UNIFEM is supporting policy development and women.

ASSUMPTIONS AND RISKS

The following assumptions underlie achievement of the SO:

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

The following risks have been identified that may adversely affect the achievement of this SO:

- Threats posed by the continued possibility of a pandemic of Avian Flu in the Region, HIV and AIDS pandemic and setbacks in malaria and dengue control.

- In some countries, increasing poverty, natural crises, political instability and food insecurity may lead to the reversal of direction in some indicators.
- Lack of funds and political will.
- A debilitated healthcare force including strikes and brain-drain.

REGION-WIDE EXPECTED RESULTS

RER 4.1 **Support provided to Member States to develop comprehensive policies, plans and strategies promoting universal access to effective interventions in collaboration with other programs and sectors, paying attention to gender inequality and gaps in health equity, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector and partnerships with UN agencies and others (NGOs).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.1.1	Number of countries that have policies, plans and programs that promote universal access to effective interventions in maternal, neonatal, child health.	9	12	24
4.1.2	Number of countries that have a policy of universal access to sexual and reproductive health.	7	11	16
4.1.3	Number of countries that have a policy on the promotion of active and healthy aging.	11	15	18
4.1.4	Number of functional partnerships and alliances (with NGO's, civil society, collaborating centers, national institutions of excellence and private partnerships) to advance maternal, newborn, child and adolescent health.	12	15	20

RER 4.2 **National/local capacity strengthened to produce evidence, technologies, and interventions and to improve national/local surveillance and information systems to improve sexual and reproductive heath, maternal, neonatal, child and adolescent health, and promote active and healthy aging.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.2.1	Number of institutions that have functioning information systems (such as the perinatal information system), surveillance systems and others, to track sexual and reproductive health, maternal, neonatal, child and adolescent health - with information disaggregated by age, sex and ethnicity.	50	75	100

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.2.2	Number of new or updated systematic reviews on best practices, operational research, policies and standards of care.	0	5	10
4.2.3	Number of guidelines and tools developed for monitoring and evaluation systems for child care and survival.	3	4	5
4.2.4	Regional database system(s) in Adolescent Health functioning on an ongoing basis.	0	10	15
4.2.5	Number of centers of excellence (in research, service delivery and training courses) that build national capacity (pre-service and in service), and are supported by regional programs in maternal, neonatal, child and adolescent health.	12	15	20

RER 4.3 **Guidelines, approaches and tools for improving maternal care in use at the country level, with technical support provided to Member States to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.3.1	Numbers of countries that have implemented national strategies to ensure skilled care at birth, including ante- and post-natal care.	10	12	22
4.3.2	Number of countries adapting and utilizing IMPAC (integrated management of pregnancy and childbirth) policy, technical and managerial norms and guidelines and perinatal technologies to improve the quality of care for mother and newborns.	5	9	16
4.3.3	Number of countries that have a functioning network of basic emergency obstetric and neonatal care at all levels of referral.	6	10	15
4.3.4	Number of countries that have implemented evidences base normative guides and perinatal technology to improve the quality of care for mother and newborn.	8	12	27

RER 4.4 **Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.4.1	Number of countries with breast milk banks and at least 50% of targeted districts implementing strategies for neonatal survival and health including neonatal Integrated Management of Childhood Illnesses (IMCI).	4	8	18
4.4.2	Number of countries that have adopted and implemented evidence-based guidelines and norms (including WHO Growth Standards) for the continuum of maternal care and IMCI, including newborns.	9	15	20
4.4.3	Number of guidelines, approaches and tools on effective interventions and/or monitoring and evaluation systems developed to improve neonatal care and survival.	4	6	9

RER 4.5 **Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.5.1	Number of countries implementing strategies for increasing coverage using a rights-based approach in child development and health interventions.	6	11	21
4.5.2	Number of countries that have adopted integrated management of childhood illness (IMCI) guidelines and where 75% or more of targeted districts are implementing them, including a micronutrient package.	5	10	20
4.5.3	Number of countries that have implemented community-based policies using an IMCI methodology based on social actors to strengthen primary health care including key family and practices (e.g. promotion of exclusive breastfeeding, complementary feeding and prevention of micronutrients deficiencies).	9	15	20

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.5.4	Number of guidelines, tools and approaches to tools develop and implement policies and plans promoting the implementation of effective interventions to improve child health and scale-up universal coverage.	8	12	15

RER 4.6 **Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.6.1	Number of countries with functioning national programs in adolescent health and development.	10	12	17
4.6.2	Number of countries in the region implementing integrated strategies and a comprehensive package of services in adolescent health and youth development (Integrated Management of Adolescent Needs - IMAN).	3	10	15
4.6.3	New guidelines, approaches and tools to support the implementation of evidence-based policies and strategies on adolescent health and development.	2	4	6
4.6.4	Number of Regional Training Programs supplied by PAHO to build capacity on Adolescent health and development including advocacy events and different methodologies (online-CD Rom-Modules).	2	5	10

RER 4.7 **Guidelines, approaches and tools available, with technical support provided to Member States for accelerated action towards implementing the Global Reproductive Health Strategy, with particular emphasis on ensuring equitable access to good quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.7.1	Number of countries that have adopted the WHO Global Strategy of Reproductive Health.	5	8	15
4.7.2	Number of countries that have reviewed - and updated as necessary - national laws, regulations and policies related to and in support of sexual and reproductive health.	2	4	6
4.7.3	Number of countries that have implemented evidence based normative guides and programs in sexual and reproductive health.	8	11	26

RER 4.8 **Guidelines, approaches, tools, and technical cooperation provided to Member States for increased advocacy for aging and health as a public health issue; for the development and implementation of policies and programs to maintain maximum functional capacity throughout the life course; and to train health care providers in approaches that ensure healthy aging.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
4.8.1	Number of countries that have implemented community-based policies with a focus on strengthening primary health-care capacity to address healthy aging.	5	7	12
4.8.2	Number of countries that have multi-sectoral programs for strengthening primary heath care capacity to address healthy aging.	9	10	14
4.8.3	Number of countries in which more than 50% of the population over 60 years old receive health and social service protection (in CAN and USA over 65 years).	12	13	15

STRATEGIC OBJECTIVE 5

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

Scope

The focus of this Strategic Objective (SO) is on an integrated, comprehensive, multi-sectoral and multidisciplinary approach to reduce the impact of natural, technological or manmade hazards on public health in the Western Hemisphere. This is achieved primarily by strengthening the institutional capacity of the health sector, and in particular the Ministries of Health, in preparedness, risk reduction and in assuming its operational and regulatory responsibilities promptly and appropriately in response to any type of disaster. Main activities encompass: advocacy, technical cooperation, knowledge management and training.

INDICATORS AND TARGETS

- Access to functioning health services. Target: following a natural disaster 90% of the affected populations enjoy levels of access similar to, or better than, pre-emergency conditions, within one year.
- Formal Health Disaster Program. Target: 15 Member States have a health disaster program with full time staff and specific budget.
- Resource mobilization. Target: In all major disaster situations, human, technological, and financial resources are mobilized and coordinated at the national and regional levels within 48 hours.

ISSUES AND CHALLENGES

- This SO is designed to contribute to human wellbeing, minimizing the negative effect of disasters and other humanitarian crises by responding to the health needs of vulnerable populations affected by such events.
- Disaster response will depend on the national capacity to manage disasters. International assistance only complements the national response. All efforts of the Organization must be directed to building national capacity and ensuring that international humanitarian health assistance supports the national structure.
- Disaster plans still focus on single hazards. They must be multi-hazard and multi-institutional.
- Natural hazards remain the most common threat to Latin American and Caribbean countries. Regardless of 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 can only increase with economic development in the countries and the globalization of trade.

- Internal conflicts have a direct impact on the health of the population. Despite the relatively stable situation of the Region there have been a number of individual internal conflicts. A certain number of crises are to be anticipated over the next five-year period.
- The emerging threat of pandemic influenza in 2005 revealed that epidemics do not constitute a sufficiently important part of national disaster plans. Despite recent planning, health institutions are still inadequately prepared to face these kinds of threats.
- The main actors in the field of disaster reduction and response are: United Nations (UN) agencies such as Office for the Coordination of Humanitarian Affairs (OCHA), United Nations Children's Fund (UNICEF), World Food Program (WFP), United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM); sub-regional 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.

STRATEGIC APPROACHES

- As part of the United Nations humanitarian reform process, WHO has been asked to ensure the coordination, effectiveness and efficiency of activities concerning preparedness, response and recovery in relation to health action in crises. WHO leads the United Nations Inter-Agency Standing Committee Health Cluster. PAHO/WHO is the Health Cluster leader for the Western Hemisphere.
- Preparedness is a prerequisite for effective emergency response. Building national capacity to manage risk and reduce vulnerability calls for the following: advocacy, updated policies and legislation, training, appropriate structures, scientific information, plans and procedures, resources and partnerships.
- National emergency response needs to be improved in a wide range of areas, including mass-casualty management; water, sanitation and hygiene; nutrition; response to chemical and radiological accidents; communicable and non-communicable diseases; maternal and newborn health; mental health; pharmaceuticals; health technologies; logistics; health information services; and restoration of the health infrastructure. Strong technical guidance and leadership and better coordination will be needed to ensure that there are no shortcomings in those areas in future emergencies.
- The right people with the right skills need to be identified immediately after a disaster; the faster the response, the better the outcome. It is important to build national capacity and compile a roster of appropriately trained experts on call. Criteria and procedures should be agreed for collaboration involving all sectors.
- Collaborate with partners within and outside of 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.
- Mainstream disaster management within the PASB by developing technical and operational capacities across PAHO/WHO in support of countries in crises, particularly for conducting health assessments, mobilizing resources, coordinating health action, tackling shortcomings, providing guidance and monitoring the performance of humanitarian action in relation to the health and nutrition of affected populations.

- There is a proliferation of global actors working in the field of disasters reduction and response –each with an organized response capacity and mandate, which has translated into the "internationalization" of a number of emergencies that otherwise, might have been handled locally.

ASSUMPTIONS AND RISKS

Assumption:

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

Risks:

- Humanitarian response is very demanding in terms of expert time and administrative support. The procedures of UN organizations are not particularly suited for field operational response activities. The risk of distracting PAHO staff from development priorities due to their involvement in disaster response activities is real.
- Large multi-country disasters, such as occurred during the strong hurricane seasons of 2004 and 2005, seriously affect the implementation of the Program's Workplan. However, they also offer great opportunities for new ideas, political support and creative initiatives.
- Work in the area of emergency preparedness and response may be incorrectly perceived as an additional responsibility that is secondary to the Organization's regular normative and developmental work.

REGION-WIDE EXPECTED RESULTS

RER 5.1 **Standards developed, capacity built and technical support provided to all Member States and partners for the development and strengthening emergency preparedness plans and programs at all levels.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.1.1	Number of countries in which disaster preparedness (including risk communication) plan for the health sector are developed and evaluated.	23	30	35
5.1.2	Number of countries where comprehensive mass-casualty management plans are in place.	14	16	22
5.1.3	Number of countries developing and implementing programs for reducing the vulnerability of health, water and sanitation infrastructures.	9	20	30
5.1.4	Number of countries with a health disaster program with full time staff and specific budget.	10	11	15

RER 5.2 **Timely and appropriate support provided to all Member States in providing immediate assistance to populations affected by crisis.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.2.1	Proportion of emergencies for which health and nutrition assessments are being implemented.	40%	65%	85%
5.2.2	Number of Regional training programs on emergency response operations.	4	6	7
5.2.3	Proportion of emergencies for which interventions for maternal, newborn and child health are in place.	50%	75%	85%
5.2.4	Number of countries where a response to emergencies is initiated within 24 hours.	10/10	TBD based on occurrence of emergencies	TBD based on occurrence of emergencies

RER 5.3 **Standards developed, capacity built and technical support provided to Member States for reducing health sector risk in disasters and ensuring the quickest recovery of affected populations.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.3.1	Proportion of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component.	100%	100%	100%
5.3.2	Proportion of humanitarian action plans for complex emergencies and formulation processes for consolidated appeals with strategic and operational components for health included.	100%	100%	100%
5.3.3	Proportion of countries in transition or recovery situations benefiting from needs assessments and technical support in the areas of maternal and newborn health, mental health and nutrition.	100%	100%	100%

RER 5.4 **Coordinated technical support on all technical areas such as communicable disease, mental health, health services, food safety, radio nuclear, in response to most likely public health threats provided to all Member States in preparedness, recovery and risk reduction.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.4.1	Proportion of emergency-affected countries where a comprehensive communicable disease-risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies.	90%	100%	100%
5.4.2	Proportion of situations involving acute natural disasters or conflicts for which a disease-surveillance and early-warning system has been activated and where communicable disease-control interventions have been implemented.	90%	100%	100%
5.4.3	Number of countries where coordinated technical support is provided as needed by the PASB in emergency responses (universe of countries varies per biennium based on occurrence of emergencies).	10/10	TBD based on occurrence of emergencies	TBD based on occurrence of emergencies

RER 5.5 **Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.5.1	Number of countries where expert networks are in place for responding to food-safety and environmental public health emergencies.	8	10	15
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	28
5.5.3	Number of countries with focal points for the International Food Safety Authorities Network and for environmental health emergencies.	28	29	32
5.5.4	Proportion of food-safety and environmental health emergencies benefiting from inter-sectoral collaboration and assistance.	25%	65%	100%
5.5.5	Number of countries achieving a state of preparedness and completing stockpiling of necessary items in order to ensure a prompt response to chemical and radiological emergencies.	8	10	15

RER 5.6 **Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
5.6.1	Number of affected countries in which the United Nations Health Cluster is operational.	40	40	40
5.6.2	Number of emergency-related Regional interagency mechanisms and working groups where PAHO/WHO is actively involved.	4	8	10
5.6.3	Proportion of disasters in which UN and country-originated reports following a disaster include health information.	100%	100%	100%

STRATEGIC OBJECTIVE 6

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

Scope

The work under this Strategic Objective (SO) focuses on integrated, comprehensive, multi-sectoral and multidisciplinary health promotion processes and approaches across all relevant PAHO/WHO and country programs, and the prevention and reduction of the major risk factors listed.

INDICATORS AND TARGETS

- Proportion of Member States reporting a 10% reduction in the prevalence rate of tobacco use. Target: 50% of Member States reporting a 10% reduction by 2013.
- Number of Member States that have stabilized or reduced the level of harmful use of alcohol. Target: A 10% increase in number of Member States reporting a stabilized or reduced level by 2013.
- Proportion of Member States with a high burden of adult obesity that have stabilized the prevalence. Target: 10% of Member States with a high burden that have stabilized the prevalence of adult obesity by 2013.
- Proportion of Member States that are collecting population based information on major risk factors: low fruit and vegetable intake, physical inactivity, tobacco use, and alcohol abuse; and anthropometry. Target: 75% of Member States collecting information by 2013.
- Increase in the proportion of youth who can correctly describe at least three ways of preventing non-desirable outcomes of unprotected sex. Target: 30% increase among youth aged 15-24 in the Americas by 2013.

ISSUES AND CHALLENGES

The 2002 World Health Report "Reducing Risks, Promoting Healthy Life"[8] reports that in 26 countries of the Americas the attributable mortality (number of deaths per 1,000) by risk factor and sex rank is the following:

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

(a) Males

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

(b) Females

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

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

The major risk factors addressed in this SO are responsible for more than 60% of the mortality and at least 50% of the morbidity burden worldwide. 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 a highest mortality rate from smoking related causes. Tobacco use and poverty are closely linked and prevalence rates are higher among the poor. Fortunately, effective and cost-effective measures are available to reduce tobacco use. The WHO Framework Convention on Tobacco Control is an evidence-based treaty designed to help reduce the burden of disease and death caused by tobacco use.

In 2000, alcohol consumption was responsible for 4.8% of all deaths and 9.7% of all Disability Adjusted Life Years (DALYs) in the region, with most of the burden in Central and South America. It is estimated that alcohol consumption accounted for at least 279,000 deaths in that year. Intentional and unintentional injuries accounted for about 60% of all alcohol-related deaths and almost 40% of alcohol-related disease burden. Most of the alcohol related disease burden (83.3%) affects men. Also it is noteworthy 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. In some countries of the Region, injection drug use is a significant force behind the rapid spread of HIV infection. Despite evidence of the substantial burden on heath and society arising from alcohol and other psychoactive substance use, there are limited resources at PAHO and in countries for preventing and treating substance use disorders, even though US$1 invested in prevention and treatment produces at least US$ 7 of savings in health and social costs

A worrisome decrease in physical activity levels is widespread in LAC. Between 30-60% of the population in LAC does not achieve the minimum recommended levels of physical activity. This has been driven by increased urbanization, motorized transportation, urban zoning polices that promote car dependence in suburbs, and lack of infrastructure for pedestrians as well as cyclists.

The "nutrition transition" in the Region is characterized by low consumption of fruits and vegetables, whole grains, cereals and legumes. This is coupled with high consumption of food rich in saturated fat, sugars and salt, among them milk, meat, refined cereals and processed foods. This dietary pattern is a key factor leading to 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 five million new HIV infections are reported. Risky behavior does not often occur in isolation; for example, hazardous use of alcohol and other drugs and unsafe 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 and low education levels. Thus, PAHO-WHO recognizes the need for a comprehensive integrated health promotion approach and effective preventive strategies.

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

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.

Significant additional investment in financial and human resources is urgently needed at all levels within WHO, Region of the Americas and, Member States to build capacity as well as strengthen national and global interventions.

STRATEGIC APPROACHES

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

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

Leadership and capacity in health promotion need to be significantly scaled up in line with increased needs and activities across all relevant health programs. There is a need to implement

resolutions at global (WHO 2005), regional (PAHO 2001 and PAHO 2006) and subregional levels (REMSAA and RESSCAD 2002) as country commitments, which incorporate both the Mexico Declaration and the Bangkok Charter, respectively (see health promotion document DC 47.16, 2006).

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

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

- Providing global and regional leadership, coordination, communication, collaboration and advocacy for health promotion to improve health, reduce health inequalities, control major risk factors and contribute to national development objectives.
- Providing evidence-based ethical policies, strategies and technical guidance and support to countries for the development and maintenance of national systems for surveillance, monitoring and evaluation, giving priority to countries with the highest or increasing burdens.
- Encouraging increased investment at all levels and building internal PAHO/WHO capacity, especially in subregional and country offices, in order to respond effectively to organizational and Member States' needs in health promotion and risk-factor prevention and reduction.
- Supporting countries to build multi-sectoral national capacities in order to mainstream gender and equity perspectives and strengthen institutional knowledge and competence in relation to the major risk factors.
- Supporting the establishment of multi-sectoral partnerships and alliances throughout Member States and building international collaboration for the generation and dissemination of research findings.
- Leading effective action to address policy and structural barriers, strengthen household and community capacity and ensure access to education and information in order to promote safe sexual behaviors and manage the consequences of unsafe sexual behaviors and practices.
- Leading effective actions to control alcohol consumption and related harms and providing direct technical cooperation in the development, review and evaluation of alcohol policies which can have the most impact at the population level.
- Providing direct technical cooperation in the implementation of the WHO Framework Convention on Tobacco Control, in collaboration with the permanent secretariat of the Convention, as well as to non-Parties to enable them to strengthen their tobacco control policies and become Parties to the Convention.
- Promote and urge investment in urban planning within an urban sustainable development framework. More specifically, priority should be given to areas that: promote clean air, promote walking and biking, create incentives for Mass Public Transportation systems, defense of public spaces, develop more recreational areas and promote road safety and crime-free streets.

- Facilitate a common understanding of evidence-based practice, and the need to strengthen the evaluation of health promotion effectiveness.
- Providing direct technical cooperation in the implementation of the WHO Global Strategy on Diet, Physical Activity and Health (DPAS) on a regional, subregional and national level in collaboration with multiple actors; such as governments, sports and food industry, and media.
- Provide direct technical cooperation in the implementation of the Regional Strategy and Action plan for integrated prevention and control of chronic noncommunicable diseases (CNCDs).

ASSUMPTIONS AND RISKS

This SO would be achieved under the following assumptions:

- There is additional investment in financial and human resources to build capacity for health promotion and risk factor prevention;
- Effective partnerships and multi-sectoral 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, and recognition that integrated approaches to major risk-factor prevention result in benefits across a range of health outcomes;
- That investment in research, especially to find effective population-based prevention strategies, is increased.

The following risks may adversely affect achievement of the SO:

- Working or interacting with the private sector presents risks associated with the competing interests of industries, including the tobacco, alcohol, sugar and processed food and non-alcoholic drinks industries, and requires that the rules of engagement are followed in all cases. Improvements in public health are of paramount importance.
- Health promotion and risk-factor prevention may be adversely affected by the low priority afforded to this area and hence the scarcity of resources allocated by WHO, Region and countries. Continued advocacy for increased investment is essential in order to minimize this risk.
- Integrated approaches to prevention and reduction may also compromise organizational and country capacity to provide specific disease and risk-factor expertise unless the critical mass of expertise is protected and the required level of resources obtained. Adequate resources for integrated approaches, as well as critical mass of expertise in major areas, must be maintained.

REGION-WIDE EXPECTED RESULTS

RER 6.1 **Facilitate technical cooperation and support to countries to strengthen their health promotion capacities in all the pertinent programs and forge inter-sectoral, interagency, decentralized, and effective interdisciplinary alliances, with the intention to promote healthy public policies and prevent and reduce the presence of principal risk factors.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.1.1	Number of countries that have health promotion policies and plans with a budget.	11	15	20
6.1.2	Number of countries with Healthy Schools Networks (or equivalent).	7	10	15
6.1.3	Number of countries that enact the PAHO/WHO Urban Health Conceptual framework.	0	2	5
6.1.4	Number of countries that use evidence-based policies for health promotion.	6	10	15
6.1.5	Number of subregions that promote the partnerships among Ministers of Health and Ministers of Education to strengthen Health Promoting Schools networks.	0	1	4
6.1.6	Regional network of healthy municipalities, cities and communities that incorporate the urban health conceptual framework and stimulate healthy public policies.	0	1	1

RER 6.2 **Provide technical cooperation to strengthen the national surveillance systems with an integrated focus on the principal risk factors, preparing, validating, promoting, and strengthening frameworks, instruments and operational procedures for the countries.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.2.1	Number of countries supported that have developed a functioning national surveillance mechanism 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	20
6.2.2	Number of countries supported that have developed a functioning national surveillance mechanism using school-based student health survey (Global School Health Survey) methodology for regular reports on, major health risk factors in youth.	11	20	34

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.2.3	Functional Regional Non-communicable Disease and Risk Factor information database (NCD INFO base).	Inter programmatic working group formed and active	Demo developed and tested	CARMEN network countries all included

RER 6.3 **Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent related public health problems.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.3.1	Number of countries that have adopted legislation or its equivalent in relation to smoking bans in health-care and educational facilities consistent with the Framework Convention on Tobacco Control.	4	14	28
6.3.2	Number of countries that have adopted legislation or its equivalent in relation to bans on direct and indirect advertising of tobacco products in national media consistent with the Framework Convention on Tobacco Control.	0	5	10
6.3.3	Number of countries that have adopted legislation or its equivalent in relation to health warnings on tobacco products consistent with the Framework Convention on Tobacco Control.	8	21	28
6.3.4	Number of countries with comparable national data – disaggregated by age and sex – on prevalence of tobacco use.	33/36	35/36	35/36
6.3.5	Regional Surveillance System on Tobacco with comparable prevalence data disaggregated by age and sex.	0	1	1
6.3.6	Number of countries that have established or reinforced a national coordinating mechanism or focal point for tobacco control.	18	20	28

RER 6.4 **Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent related public health problems.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.4.1	Number of countries that have developed policies, plans, advocacy and programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use.	11	13	20
6.4.2	Number of policies, strategies, recommendations, standards and guidelines provided to Member States for the prevention and reduction of public health problems caused by alcohol, drugs and other psychoactive substance use.	3	6	9
6.4.3	Information systems established and maintained for implementation and evaluation of global policies, strategies, recommendations, standards and guidelines to reduce or prevent public health problems caused by alcohol, illicit drugs and other psychoactive substances.	Under development	Info systems in place	Info systems in place

RER 6.5 **Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent related public health problems.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.5.1	Number of countries that have developed national guidelines to promote healthy diet and physical activity including DPAS (Diet and Physical Activity Strategy).	8	10	20
6.5.2	Number of countries (with cities above 500,000 inhabitants) that have initiated or established programs on rapid mass transportation systems.	7	12	25
6.5.3	Number of countries (with cities above 500,000 inhabitants) that have initiated or established programs on clean fuels in transport.	3	7	20
6.5.4	Number of countries (with cities above 500,000 inhabitants) that have initiated or established programs on pedestrian-friendly environments, bicycle-friendly cities, and crime control.	7	30	40

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.5.5	Number of countries that have initiated policies to phase-out trans-fats, reached agreements with food industry to reduce sugar, salt and fat in processed foods.	4	15	30
6.5.6	Number of countries that have initiated policies to eliminate direct marketing/publicity of food to children under 12 years.	2	7	12
6.5.7	Number of countries that have initiated policies to initiate programs to increase consumption of low fat dairy, fish and fruits and vegetables.	10	20	30

RER 6.6 **Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
6.6.1	Guidelines developed on the determinants and consequences of unsafe sex to identify effective interventions and to develop guidelines accordingly.	Not available	Research implemented on determinants and consequences of unsafe sex in order to develop three evidence based guidelines for promoting safe sexual behaviors.	3 new or adapted guidelines validated and implemented in 10 countries with WHO-PAHO technical support.
6.6.2	Number of countries supported that have initiated or implemented new or improved interventions at individual, family and community levels to promote safe sexual behaviors.	5	10	10

STRATEGIC OBJECTIVE 7

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

Scope

This strategic objective focuses on the development and promotion of inter-sectoral 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; education, housing, labor trade, and social status among others. In the region, the social determinants of health need to be addressed in relation to the MDGs and require the formulation of policies and programs that are ethically sound, responsive to gender inequalities, effective in meeting the needs of poor people and other vulnerable groups, and consistent with human-rights norms international and regional human rights conventions and standards.

INDICATORS AND TARGETS

- Number of countries with national health indicators disaggregated by sex and age and at least two other determinants (ethnicity, place of residence, and/or socioeconomic status) and available for exploratory research. Target: By 2013, at least 15 countries.
- Number of countries that have developed social and economic indicators on conditions favorable to health, disaggregated by sex, race-ethnicity and place of residence (e.g. education levels, agricultural production, infrastructure, housing and employment conditions, criminal or violent events, community development, and household income). Target: By 2013, 15 countries. 15 countries in LAC have undertaken censuses between 2000 and 2005 that have being validated by CELADE, data desegregation work will take place with these countries.
- Number of countries that have developed policies and Workplans for priority non-health sectors (e.g. agriculture, energy, education, finance, transport) incorporating health targets. Target: By 2013, 10 countries.
- Number of countries that have health-related policies, plans, programs, legislations, and national mechanisms for protection (e.g. national constitutions and health sector strategies) that explicitly address and incorporate gender, ethnic and socioeconomic equity, and human rights in their design and implementation, consistent with international and regional human rights conventions and standards. Target: By 2013, 15 countries

- Number of countries that have undertaken critical interventions to address the needs of the poorest and most vulnerable communities under the Faces, Voices and Places of the MDGs initiative to advance the MDGs within the framework of the social determinants of health. Target: By 2013, 10 countries.

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

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

The crucial challenges for achieving the above include; 1) developing sufficient expertise regarding the social and economic determinants of health and their relationship with the MDGs as well as regarding ethics and human rights at the global, regional, and country levels to be able to support Member States in collecting and acting on relevant data and acting on an inter-sectoral basis; 2) ensuring that all the technical areas at PASB HQs reflect the perspectives of social and economic determinants (including gender and poverty), ethics, and human rights in their programs and normative work.; and 3) to adopt the correct approach for measuring effects. This final challenge is especially great because results in terms of increased health equity and equality with regard to the most vulnerable groups will seldom be rapidly apparent or easily attributed to particular interventions. Distinctive modes of evaluation are required for assessing processes—how policies and interventions are designed, vetted and implemented. One must assess whether the steps taken are known to be effective in bringing about change, rather than measuring health outcomes themselves. The relationship of the health sector as a whole with other parts of government and society is also an important indicator.

STRATEGIC APPROACHES

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

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

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

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

The PASB's strategic approaches in LAC are as follows;

- Develop national and sub national data bases disaggregated by gender and ethnicity on the social determinants of health and the human rights that have an impact the quality of life and the well being of citizens.

- Create a social observatory to study and highlight social discrepancies

- Foster social dialogue and consensus building on the determinants of health and the generation of public policies through the Health Social Forum

- Promote the creation strategic inter-sector alliances and the creation of social policies aimed at reducing social, economic and cultural inequities in order to increase social investment and mobilize resource to promote sustainable advances in health from the perspective of local development

- Establish a regional evidence base on social policies with an emphasis on the social determinants of health

ASSUMPTIONS AND RISKS

The principal assumptions underlying this strategic objective are:

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

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

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

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

REGION-WIDE EXPECTED RESULTS

RER 7.1 **Significance of determinants of health and social policies recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.1.1	Number of countries that have implemented national strategies that address key policy recommendations of the Commission on the Social Determinants of Health.	2/12	7/12	12/12
7.1.2	Number of countries whose PAHO/WHO Country Cooperation Strategy documents (CCS) include explicit strategies at the national and local level that address the social and economic determinants of health.	0/12	5/12	12/12
7.1.3	PAHO has a Regional Plan of Public Health for action on the determinants of health and social policy.	0	1	1
7.1.4	Number of subregions that are taking action to strengthen integrated approaches to determinants of health and social policies.	0	1	4
7.1.5	Number of countries supported to build capacity to take action on determinants of health and social policies.	0	11	40
7.1.6	Regional model developed to promote community empowerment, inter-sectoral alliances and social policies at the local level taking as a point of departure healthy settings (homes, schools, municipalities).	0	1	1

RER 7.2 **Initiative taken by PAHO/WHO in providing opportunities and means for inter-sectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.2.1	Number of countries whose public policies target the determinants of health and social policy on an inter-sectoral, interprogrammatic basis.	0/12	7/12	12/12
7.2.2	Number of subregional fora organized for relevant stakeholders on inter-sectoral actions to address determinants of health, social policies and achievement of the Millennium Development Goals.	0	1	3
7.2.3	Number of tools developed and disseminated for assessing the impact of non-health sectors on health and health equity (such as Faces, Voices and Places).	1	1	3
7.2.4	Number of countries that have implemented Faces, Voices and Places in at least one of their poorest municipalities.	8	10	15

RER 7.3 **Social and economic data relevant to health collected, collated and analyzed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.3.1	Number of countries having health data of sufficient disaggregation and quality to assess and track health equity among key population groups.	8	15	36
7.3.2	Number of institutional mechanisms, supported by PAHO, that are installed in countries to develop and/or support the development and monitoring of gender equity in health.	8	10	13
7.3.3	Number of countries with at least one national policy on health equity that incorporates an analysis of disaggregated data.	TBD	TBD	TBD
7.3.4	Number of countries with a national program on health equity that uses disaggregated data.	0	3	6

RER 7.4 **Ethics-and rights-based approaches to health promoted within PAHO/WHO and at national, regional and global levels.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.4.1	Number of countries using: 1) international and regional human rights norms and standards; and 2) 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	18
7.4.2	Number of countries using tools and guidance documents produced for Member States and other stakeholders on use of ethical analysis to improve health policies.	TBD	TBD	TBD

RER 7.5 **Gender and ethnicity analysis and responsive actions incorporated into PAHO/WHO's normative work and technical cooperation provided to Member States for formulation of gender-and ethnic-sensitive policies and programs.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.5.1	Number of publications that contribute to building evidence on the impact of gender and ethnic/racial equity on health and on effective strategies to address it	8	12	16
7.5.2	Number of tools and guidance documents developed for Member States on using gender and/or ethnic/racial analysis in health.	0	1	2
7.5.3	Number of PWR that include expected results, indicators, and specific budgetary resources for the implementation of the Gender Equality Policy and ethnic groups in their biennial Workplans.	4	9	15
7.5.4	Number of entities (technical areas and PWRs) whose biennial Workplan includes gender and ethnic/racial considerations as applicable.	TBD	40/80	80/80
7.5.5	Number of subregions that apply the PAHO Gender Equality Policy in its biennial Workplan.	0	1	4
7.5.6	Number of subregions with an analysis of the health situation of ethnic groups.	0	1	3
7.5.7	Number of methodological, validated and widespread conceptual tools developed for the implementation of the Gender Equality Policy.	10	13	16

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
7.5.8	Number of countries with national plans to specifically improve the health of ethnic/racial groups.	11/21	13/21	19/21
7.5.9	Number of subregions that are working through plans and health programs to improve the health of ethnic/racial groups within the framework of the social determinants of health and the MDGs (Millennium Development Goals).	0/3	1/3	2/3
7.5.10	Number of units in the regional and subregional offices that have incorporated the ethnic/racial perspective in its biennial Workplan.	7	10	19
7.5.11	Percentage of technical documents produced for the Governing Bodies related to the MDGs that include the ethnic/racial perspective.	20%	50%	70%

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, biological, chemical, and physical hazards, and promoting human security and environmental justice from the effects of global and local threats.

INDICATORS AND TARGETS

- Proportion of urban and rural populations with access to improved water sources and improved sanitation. Target: according to the Millennium Development Goals, by 2013 96.2% of urban populations and 76.9% of rural populations will have access to improved drinking water sources (2002 baseline estimates 95% and 69% respectively); by 2013 90.1% of urban populations and 48% of rural populations will have access to improved sanitation facilities (2002 baseline estimates 84% and 44% respectively).
- Burden of disease measured by years of life expectancy lost from poisoning due to environmental risks. Target: by 2013, 46% for adults and 60% for children (2002 baseline estimates 68% and 85% respectively).
- Burden of disease from selected occupational risks measured by percentage of hepatitis B infections in health workers due to inappropriate handling of syringes. Target: by 2013, estimated 20% (2002 baseline estimate 40%).
- Proportion of population with access to toxicological information services. Target; by 2013, 60% of countries (2006 baseline estimate 35%).
- Burden of disease from diarrheal diseases with environmental causes among children. Target: by 2013, reduce burden of disease to 84% for diarrheal diseases (2002 baseline estimates 94%).

ISSUES AND CHALLENGES

Environmental and occupational risks contribute to a large portion of morbidity and morality in the Region, but few countries have comprehensive policies to perform analysis and establish public policies to manage them. Modern production processes introduce new or magnify old chemical, physical and biological health risks in the Region. 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 term, have even greater consequences for public health and health costs than is already the case if the health sector fails to act on currently existing environmental hazards to health. For effective health sector action, risks have to be reduced in the sectors and the settings where they occur – homes, schools, workplaces and cities, and in sectors such as energy, transport, industry, agriculture, as well as water, sanitation and solid waste.

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 in treatment of the individual, thus need to be better equipped with skills and methods for monitoring and synthesizing health and environmental data, proactively guiding strategies for public awareness, protection and prevention, and responding to emergencies.

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

Latin America is one of the areas of the world with the greatest consumption of pesticides. Central America, for example, imports 1.5kg of pesticides per 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 in place so that risks can be analyzed and knowledge disseminated about the identification, control, and/or elimination of these risks.

Climate change and other global risks add to the current health burden. Some impacts include an increase in current health hazards, from changed nutrition profiles, water scarcity, to patterns of vector-borne diseases.

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

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

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

Political, legislative, and institutional barriers to improving environmental conditions are numerous and the human resources with adequate specialization on risk assessment and management are still lacking in many countries. National and local health authorities are thus often unable to collaborate with other 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.

Through a strategic alliance with the areas of education and labor, a Joint Action plan on Health and Environment was agreed upon by the Ministers of Health and Environment at a June 2005 meeting in Mar del Plata. The Action Plan will develop strategic programs in response to the Millennium Development Goals with three main priorities: Integrated water resource and waste management, sound management of chemicals, and children's environmental health. All ministers expressed the urgent need for PAHO, the Organization of American States and the United Nations Environmental Program to work together on these issues. PAHO will take the lead on Children's Environmental Health as an integrated strategy to achieve the MDGs.

STRATEGIC APPROACHES

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

ASSUMPTIONS AND RISKS

The following assumptions underline the achievement of this SO:

- 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 and put 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 makes a major contribution to the achievement of the relevant Millennium Development Goals.
- The climate remains favorable, in the context of United Nations system reform, for WHO/PAHO to show more global leadership in public health and the environment, setting health more explicitly in humanitarian response and goals of environmental sustainability and economic development.

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

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

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

REGION-WIDE EXPECTED RESULTS

RER 8.1 **Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, electro-magnetic fields (EMF), radon, drinking water, waste water re-use) developed and updated; technical cooperation provided for the implementation of international environmental agreements and for monitoring the Millennium Development Goals (MDGs).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.1.1	Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year.	2	4	8
8.1.2	Number of international environmental agreements whose implementation is supported by PASB.	5	5	6
8.1.3	Number of countries implementing PAHO/WHO guidelines on chemical substances.	11	15	20
8.1.4	Number of countries implementing PAHO/WHO guidelines on air quality.	7	8	12
8.1.5	Number of countries implementing PAHO/WHO guidelines on drinking water.	13	16	20
8.1.6	Number of countries implementing WHO guidelines on recreational waters.	0	5	10

RER 8.2 **Technical cooperation and guidance provided to countries for the implementation of primary prevention interventions that reduce environmental health risks; enhance safety; and promote public health, including in specific settings and among vulnerable population groups (e.g. children, elderly).**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.2.1	Establishment of regional strategies for primary prevention of environmental health hazards under the health determinants and health promotion framework implemented in specific settings (workplaces, homes, schools, human settlements and health-care settings).	2	4	6
8.2.2	Number of countries where global or regional strategies for primary prevention of environmental health hazards are implemented in specific settings (workplaces, homes, schools, human settlements and health-care settings).	10	14	20

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.2.3	Number of new or maintained global or regional initiatives to prevent occupational and environmentally-related diseases (e.g. cancers from ultraviolet irradiation or exposure to asbestos, and poisoning by pesticides or fluoride) that are being implemented with PASB technical and logistics support.	1	4	5
8.2.4	Number of studies evaluating the costs and benefits of primary prevention interventions in specific settings that have been conducted and whose results have been disseminated.	1	2	4
8.2.5	Number of countries following WHO's guidance to prevent and mitigate emerging occupational and environmental health risks, promote equity in those areas of health and protect vulnerable populations.	0	1	2
8.2.6	Regional Initiatives on Children's Environmental Health promoted and disseminated.	2	3	4

RER 8.3 **Technical cooperation provided to countries for strengthening occupational and environmental health policy- making, planning of preventive interventions, service delivery and surveillance.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.3.1	Number of countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational, basic sanitation, and environmental health services and surveillance.	10	15	20
8.3.2	Number of national organizations or universities implementing PAHO/WHO-led initiatives to reduce occupational risks (e.g. among workers in the informal economy, to implement the WHO global strategy for occupational health for all, or to eliminate silicosis).	2	4	6

RER 8.4 **Guidance, tools, and initiatives supporting the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture); assessing health impacts; costs and benefits of policy alternatives in those sectors; and harnessing non-health sector investments to improve health, environment and safety.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.4.1	Number of initiatives implemented in countries to develop and implement health-sector policies at the regional and national levels.	0	2	4
8.4.2	Production and promotion in target countries of sector-specific guidance and tools for assessment of health impacts and economic costs and benefits and promotion of health and safety.	Use of tools and guidance produced	Use of tools and guidance produced in 2 sectors	Use of tools and guidance produced for 4 sectors
8.4.3	Establishment of networks and partnerships to drive change in specific sectors or settings, including an outreach and communications strategy.	Use of networks established by WHO/PAHO	Use of networks established by WHO/PAHO in 2 countries	Use of networks established for 4 sectors, with com-munications strategy implemented
8.4.4	Number of regional or national events conducted with PASB's technical cooperation with the aim of building capacity and strengthening institutions in health and other sectors for improving policies relating to occupational and environmental health in at least 3 economic sectors.	1	2	4

RER 8.5 **Enhanced health sector leadership for 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, global environmental change, as well as consumption and production patterns.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.5.1	Number of citations by mass media, of outreach and communications strategy on occupational and environmental issues implemented regionally and in partnership.	TBD	TBD (5% increase in citations)	TBD (10% increase over baseline in citations)

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
8.5.2	Number of regular high-level fora on health and environment for global and regional policy-makers and stakeholders.	0	1	2
8.5.3	Number of quinqennial reports available on trends, scenarios, and key development issues and their health impacts.	1	1	2

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 nutritional status, throughout the life course, especially among the poor and other vulnerable groups, towards the achievement of the Millennium Development Goals; especially the reduction of poverty and hunger, diminishing the impact of infant morbidity and mortality, and achieving sustainable development. 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. Target: all countries in Latin America and the Caribbean having met or on track to meet Millennium Development Goal Target 2 ("Halve, between 1990 and 2015, the proportion of people who suffer from hunger" as measured by indicator 4 "Prevalence of underweight children under five years of age"). Baseline in 1990: 10.3%
- Proportion of children under 5 years of age with anemia. Target: regional average prevalence of anemia in children under 5 years of age is reduced by 0.5 percentage points per year. Baseline in 1990: 43%
- Proportion of women of reproductive age with anemia. Target: regional average prevalence of anemia in women of reproductive age is reduced by 0.5 percentage points per year. Baseline in 1990: 26%
- Proportion of overweight and obese children under 5 years of age. Target: all countries in Latin America and the Caribbean where the observed incremental trend of overweight and obesity in both groups will stabilize or decline.
- Proportion of overweight and obese adult women. Target: all countries in Latin America and the Caribbean where the observed incremental trend of overweight and obesity in adult women will stabilize or decline.
- 10% reduction in morbidity attributable to food-borne diseases by 2013, measured by a combination of syndromic and etiologic agent-specific burden of food-borne diseases studies. Estimated baseline 2007: 50 %.

ISSUES AND CHALLENGES

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

Limited access to enough food in order to meet energy requirements affects about 53 million people in the Region. Poor dietary quality, alone and in association with infectious diseases, is a determinant of growth failure, cognitive and intellectual impairment and other deficiencies. Maternal nutrition during the reproductive period is essential to infant and young child nutrition; and breastfeeding merits special recognition because of its short- and long-term effects on maternal and infant health and nutritional status. Its benefits during infancy and early childhood in all socioeconomic groups are indisputable. Inadequate complementary feeding practices are also critical to children's health and physical growth, particularly between the ages of 6 and 24 months. Reduced access and consumption of micronutrient-rich foods are responsible for the high prevalence of anemia in women and children in the Region.

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

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

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

STRATEGIC APPROACHES

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

- **Development and Dissemination of Macro policies Targeting the Most Critical Nutrition-related Issues:** nutrition-relevant public policies will be assessed with a view to identify and improve their contribution to optimal nutrition, healthy eating, physical activity, overall health outcomes and enabling institutional environments.
- **Strengthening Resource Capacity through the Health and Non health Sectors Based on Standards:** Activities will encourage scaling-up of services for the provision of quality comprehensive care for preventive health and nutrition, with emphasis on maternal and child care, nutrition in adolescents, the elderly, patients with HIV/AIDS, innovative supplementation and fortification initiatives, and the prevention of obesity in vulnerable groups.
- **Information, Knowledge Management and Evaluation Systems:** Support surveillance and evaluation of changes in dietary habits, food purchasing behaviors, macronutrient contents of diets, patterns of physical activity, obesity, and protective and risk factors for suboptimal nutrition and obesity and nutrition-related chronic diseases.
- **Development and Dissemination of Guidelines, Tools, and Effective Models:** Activities will encourage the dissemination of guidelines, norms and state-of-the-art papers on the improvement of service delivery, successful interventions and research findings.
- **Mobilizing Partnerships, Networks, and a Regional Forum in Food and Nutrition:** Foster horizontal cooperation among countries and sharing regional expertise, dissemination of lessons learned, and regional networks to move forward nutrition in health and development agenda.

Cooperation at national, subregional, regional and global levels is required to improve effectiveness and thus protection of the health of the consumer and enhance opportunities for trade and tourism. The PASB should facilitate bilateral and multilateral cooperation for viable agreements, joint projects, and missions, through the mobilization of trained national human resources, technical cooperation among countries, and, food safety experts in specific areas, where national capacity does not exist.

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

- To work with national governments to strengthen foodborne disease surveillance systems and undertake burden of disease studies.
- To enhance institutional and human capacity in conducting systematic epidemiological approaches to make decisions based on scientific evidence such as systematic reviews, meta-analysis and risk assessments.

- To enhance institutional and human capacity to develop leadership in public health to design integrated food safety systems based on risk analysis approach.
- To build partnerships, alliances and effective interactions with agencies of the UN and OAS System, as well as with National Public Health Agencies and NGOs to achieve sustainable and effective food safety policy implementation and increase technical support and external resources.
- To strengthen relationships between the health, agricultural, and private sectors to ensure that food safety interventions are planned and executed in an integrated manner from farm to fork.
- To enhance risk communication and education in food safety and the application of basic WHO guidelines for implementation of the five keys to safer food and the healthy food market within the strategy of healthy settings.

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ASSUMPTIONS AND RISKS

This SO can be achieved under the following assumptions:

- Access to adequate nutrition, food security and food safety are acknowledged by governments to be human rights and necessary prerequisites for health and development.
- Individual behavior will be backed up by health promotion and prevention, and supportive environment to allow the public to make informed choices directed to prevent malnutrition and diseases arising from unsafe food;
- Member States are committed to comprehensive and integrated policies and plans, and to the development and strengthening of their national food security, nutrition and food safety programs, on the basis of reliable and updated evidence.
- Effective networks and partnerships with other technical cooperation agencies are established and fostered, involving all stakeholders at international, regional, subregional and national levels.
- Inter-programmatic coordination of PAHO/WHO resources will be carried out with increased in-house support, through the preparation of feasible projects and tapping voluntary contributions from developed countries to WHO.
- Effective decision-making and communication mechanisms will be in place to maintain strong and interactive coordination of efforts at the global, regional and subregional levels. guided by PAHO's Regional Strategy on Nutrition in Health and Development, the Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet, Physical Activity, and Health, and WHO's Global Food Safety Strategy.
- Scaling up of cost-effective food safety interventions for the management of food hazards/risks.

The following risks may adversely affect achievement of the SO:

- Emergence of parallel health, nutrition, and food security and safety agendas due to lack of communication and coordination among partners.
- Low investment and/or political commitment of governments concerning nutrition, food security and food safety.

REGION-WIDE EXPECTED RESULTS

RER 9.1 **Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, to promote advocacy and communication, stimulate inter-sectoral actions, and increase investment in nutrition, food safety and food security.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.1.1	Number of countries assisted by PASB that have achieved at least 2 of the following: (1) legislation, (2) functional coordination mechanisms (national development policies and plans, food and nutrition policies and plans, poverty reduction strategies), and (3) financial resources allocation to support inter-sectoral approaches and actions in the areas of food safety, food security and nutrition.	18	22	30
9.1.2	Number of countries that have included nutrition, food safety and food security activities in their sector-wide strategies (health, education, and agriculture), including a funding mechanism to support nutrition, food security and food safety activities in health and non-health sectoral programs.	10	15	25
9.1.3	Number of countries with social marketing campaigns recognizing and disseminating best practices in health, nutrition and food safety (targeted to general population, public, private, and civil society organizations, and professionals, among other groups).	14	18	25
9.1.4	Number of countries where local governments apply strategies to integrate food safety, nutrition and food security (including access to safe livestock products) in at least 2 of the following local processes: (1) sectoral planning in health, education or agriculture; (2) integrated development multi-sectoral plans; (3) social mobilization campaigns; or (4) municipal and community level projects.	20	24	35
9.1.5	Number of subregions with subregional plans of action derived from the Regional Strategy on Nutrition in Health and Development in operation, that are successfully monitored and evaluated, and lessons disseminated.	0	3	4

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.1.6	Number of countries that are successfully implementing, within the framework of MDGs commitments, progress and challenges, at least 2 of the following local level initiatives: Food and Nutrition in Faces and Places; WHO 5 Keys to Safer Food in Healthy Schools (WHO 5 Keys) ; Healthy Food Markets Initiatives (WHO HFMI); Central American Network of Municipalities for Development.	7	10	20

RER 9.2 **Norms, including references, requirements, research priorities and agenda, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.2.1	Number of improved and updated guidelines for implementation, training manuals and educational materials on topics related to new nutrition, food security and food-safety standards.	4	8	15
9.2.2	Number of countries successfully implementing standards and recommendations included in global and regional strategies, according to national needs and priorities.	15	20	30
9.2.3	Number of countries incorporating improved food security, nutrition, and food safety standards, norms, and guidelines for Primary Health Care in health service delivery systems.	17	20	30
9.2.4	Number of new norms, standards, guidelines, tools and training materials for prevention and management of zoonotic and non-zoonotic foodborne diseases.	0	1	5

RER 9.3 **Monitoring and surveillance of needs, and assessment and evaluation of responses in the area of food security, nutrition and diet-related chronic diseases strengthened, and ability to identify best policy options improved.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.3.1	Number of countries that have adopted and implemented the WHO Child Growth Standards.	0	15	30
9.3.2	Number of subregions with operational Observatories in Food Security, Nutrition and Food Safety.	0	2	3
9.3.3	Number of countries that have nationally representative surveillance data on major forms of malnutrition at national and local levels.	13	18	26
9.3.4	Number of guidelines and tools for surveillance, monitoring and evaluation of: nutritional deficiencies and risk factors; socioeconomic determinants; cost analysis; overweight and obesity trends; effectiveness of key practices to improve nutrition throughout the life course.	3	7	11
9.3.5	Number of countries that produce and publish sound scientific evidence and reliable information for public policy and programs on these topics: • Nutritional deficiencies and risk factors in different population groups • Social, economic and health determinants of food and nutrition insecurity • Overweight and obesity in children and adolescents. • Program effectiveness	11	20	32

RER 9.4 **Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans and programs aimed at improving nutrition throughout the life-course, in stable and emergency situations.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.4.1	Number of countries supported by PASB that have developed national programs that implement at least 3 high-priority actions recommended in the Global Strategy for Infant and Young Child Feeding.	5	12	20
9.4.2	Number of countries with PASB support that have developed national programs that have implemented strategies for prevention and control of micronutrient malnutrition.	11	16	25

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.4.3	Number of countries with PASB support that have developed national programs that implement strategies for promotion of healthy dietary practices in order to prevent diet-related chronic diseases.	11	16	25
9.4.4	Number of countries with PASB support that have developed national programs that include of nutrition in comprehensive responses to HIV/AIDS and other epidemics.	11	16	25
9.4.5	Number of countries with PASB support that have strengthened national preparedness and response to food and nutrition emergencies.	11	16	25
9.4.6	Number of tools for monitoring and evaluation of national programs in food security, nutrition and food safety.	3	6	7
9.4.7	Number of countries with undergraduate and graduate academic programs that develop a competent workforce, in health and non-health sectors, for public policy, plan and program design, implementation, monitoring and evaluation in nutrition, food security and food safety, in stable as well as humanitarian crisis situations.	16	20	30

RER 9.5 **Foodborne diseases surveillance, prevention and control systems strengthened and food hazard monitoring programs established.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.5.1	Number of countries with established operational and inter-sectoral collaboration for the surveillance, prevention and control of foodborne diseases.	16	22	30
9.5.2	Number of countries that have initiated or strengthened programs for the surveillance and control of at least one major foodborne zoonotic disease.	2	9	20
9.5.3	Number of South American countries that have achieved at least 75% of the Hemispheric foot and mouth disease Eradication Plan objectives.	4/11	11/11	11/11

RER 9.6 **Capacity built and support provided to National Codex Alimentarius Committees and the Codex Commission of Latin America and the Caribbean.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
9.6.1	Number of Latin American and Caribbean countries receiving support from the FAO/WHO Codex Trust Fund to participate in relevant Codex Meetings.	36/36	36/36	36/36
9.6.2	Number of countries receiving PASB support to build national integrated food safety systems with a component of foodborne diseases surveillance and food contamination monitoring with links to WHO networks: International Food Safety Authorities Network (INFOSAN) and Global Outbreak Alert and Response Network (GOARN).	18	22	30

STRATEGIC OBJECTIVE 10

To improve the organization, management and delivery of health services

Scope

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

INDICATORS AND TARGETS

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

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

ISSUES AND CHALLENGES

The Region of the Americas is one of the most unequal regions of the world, not only in terms of income distribution, but also in terms of access to social services. There are profound inequities in access to health services among the different countries of the Region, as well as within individual countries. It is estimated that 125 million people living in Latin America and the Caribbean do not have access to basic health services (about 27% of the population). While in 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 health services. The most common ones are cultural (language, lifestyles, health beliefs), social (level of education), economic (ability to pay, having health insurance), organizational (hours of work, availability of personnel and medicines, availability of personnel trained to meet the health needs of population groups such as older adults, etc.) and geographical (distance) barriers. These barriers account for a large proportion of people that do not utilize health services and instead self-medicate, consult with a pharmacist, go to a traditional healer, or do nothing about their health problems.

Until now, most efforts of governments, NGOs, donors, bilateral and multilateral agencies have been tackling inequities in access to health services by expanding coverage of basic services in underserved areas. Although positive, this approach has been supply-driven, paying little attention to local cultural preferences and social realities. Users and consumers have been left 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/or inadequate hours of operation.

Another important challenge in the Region of the Americas is the poor quality of health care. The lack of quality leads to ineffective, inefficient and costly health services, as well as to low satisfaction with services. The problems of quality can be found at all levels of the system, from the individual provider level all the way up to the facility and system levels.

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

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

The lack of coordination among the different levels of care and points of service is another frequent problem of health services. This leads to fragmented and inopportune care, to duplication of services and unnecessary increases in health costs.

A particular problem of organizing and managing services relates to emergency care systems. In many cities of the Region, emergency services have not been systematically organized and are not properly managed. A recent survey done by PAHO in 12 countries of the Region, found that eight of those countries have pre-hospital care administered mainly by voluntary organizations. Even though the development of emergency service systems is not a priority for most countries (only five of the countries surveyed provide state funding for emergency services), the increased incidence of motor vehicle and other severe injuries together with acute medical conditions are placing more demands for having an effective emergency care system.

The main foundation 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. Information and knowledge are essential for exposing underlying factors related to services being delivered, and the basis for modifying the status quo and improving the health of populations. Health services which utilize information resources to promote better organization and management of their resources, improve access, eliminate inequity, and promote effectiveness are better equipped to achieve the MDGs.

There is a plethora of information available that consolidates knowledge and evidence on provision of health services. However, these resources are not always available to those who need them or organized to guide decisions regarding the management and provision of health services for the population. On the other hand, needs-based knowledge on countries' health services status is scarce. The inequity that exists in access to health services information and knowledge must be addressed so that knowledge is accessible, disseminated and shared among countries. Understanding of the countries' health services status is essential for the delivery of sound technical cooperation projects.

STRATEGIC APPROACHES

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

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

ASSUMPTIONS AND RISKS

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

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

REGION-WIDE EXPECTED RESULTS

RER 10.1 **Countries supported to provide equitable access to quality health care services, with special emphasis on vulnerable population groups, and with health services that reflect recognized standards, best practices and available evidence.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
10.1.1	Number of countries that have increased access to basic health care services as a result of PASB's initiatives on Extending Social Protection in health and Primary Health Care renewal.	14	18	21
10.1.2	Number of countries that have strengthened national programs for quality improvement of service delivery.	11	19	24
10.1.3	Guideline for patients' rights and duties and assessing quality of health care services developed; and new strategies for health services delivery in hardship and distant locations developed.	In progress	Developed and validated	In use at country level

RER 10.2 **Organizational and managerial capacities, including information systems, of service delivery institutions and networks in Member States are strengthened with a view to improving service delivery performance.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
10.2.1	Number of countries that have incorporated health services productive management methodologies.	5	14	23
10.2.2	Management information tools that enable evidence-based decision making, performance evaluation developed, such as the Windows Managerial Information System – WINSIG.	In progress	Tools developed and validated	Tools in use throughout region

RER 10.3 **Mechanisms and regulatory systems are in place in Member States to ensure collaboration and synergies between public and non-public service delivery systems that lead to better overall performance in service delivery.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
10.3.1	Number of assisted countries that have adopted PASB's policy options and mechanisms for integrating the health care delivery network, including public and non-public providers.	3	20	24
10.3.2	Tools for integrating health services delivery systems developed.	In progress	Tools developed and validated	Tools in use throughout region

RER 10.4 **Service delivery policies and their implementation in Member States increasingly reflect the Primary Health Care approach, particularly in relation to social participation, inter-sectoral action, emphasis in promotion and prevention, integrated care, family and community orientation, and respect for cultural diversity.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
10.4.1	Number of countries that report progress in implementing PHC-based Health Systems according to PAHO's Position Paper and Regional Declaration on PHC.	1	15	23
10.4.2	Standards and self-evaluation methodology for evaluation of primary care developed and applied in countries.	In progress	Standards developed and validated	Standards in use throughout region

STRATEGIC OBJECTIVE 11

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

Scope

PAHO/WHO technical cooperation will be geared to boosting the policy-making and technical capacity of Member States to ensure a single orientation consistent with the social values and objectives that guide health systems. This will ensure improved governance of their health systems, and enable the national health authority to competently exercise its role as the steering agency, and to adopt a multi-sectoral approach, including the incorporation of non-governmental stakeholders. This work is essential, as the main characteristic of the majority of systems in the Region of the Americas is institutional and organizational fragmentation and segmentation, which result in exclusion and inequity.

INDICATORS AND TARGETS

- Number of countries that have established national health commissions (or equivalent) that set health-related priorities at national level, with multi-sectoral participation. Target: TBD
- Reduction of social exclusion in health and inequities in access to health systems. Target: TBD
- Existence of regulatory and oversight mechanisms in the health systems. Target: TBD
- Methodological instrument for evaluating performance at the different levels of the health systems and performance evaluation exercises conducted in the systems. Target: TBD
- Progress in bridging the knowledge gap and increasing the use of scientific knowledge in public health policy-making from its currently low levels. Target: TBD

ISSUES AND CHALLENGES

- Experience shows that managing health systems in the best interest of citizens requires vision, leadership, and policies that strike a balance among the many demands on the systems; but what is needed above all is a complex series of institutional measures that at present are only partially available.
- The majority of the countries of the Region are encountering technical and political problems in the definition, governance, sustainability, and evaluation of public health policies and in clearly defining health objectives, creating sector development plans, and intervening in the regulation of sector markets in defense of their citizens. In many countries, the Ministry of Health has little capacity to manage the growing number of actors and agents, the financing and execution networks with which it must deal, relations with public agencies (ministries of finance and planning, national legislative bodies, etc.), international agencies, multilateral, bilateral and nongovernmental organizations, and the different types of private companies and civil society organizations.

- During the five year period 2001-2005 PAHO/WHO addressed the development of theory and practice in regard to the steering role in health as a priority challenge in State modernization. The Organization has promoted a profound regional and subregional debate and exchange of views on the conceptualization, sphere of activity, and mechanisms for strengthening the steering capacity in health, using as a basic input the wealth of experience amassed by the countries of the Region of the Americas, particularly during the reform processes in the 1990s.
- Strengthening of the steering role in the health sector should be guided by the goal of reducing inequities in health conditions within the framework of integral sustainable development, and of eliminating unjust inequalities in terms of access to personal and non-personal health services and the financial burden that access to them implies. According to the 2003 calculation of the HP/HSS Unit, 230 million people in LAC have no health insurance and 125 million lack permanent access to basic health services.
- Part of the problem is the limited availability and use of quality scientific knowledge and information for decision-making including reliable vital and health statistics and epidemiological data. Many countries in the Region lack the mechanisms and information necessary for responsible, transparent management. There is limited capacity to conduct health research of national interest, including health systems research, or to set up and maintain a reliable health information system and translate research findings into policy and practice; the countries have difficulty striking a balance between responding to the international demand for health information and attention to their own knowledge and information needs.
- There are difficulties reconciling the competing demands for the limited resources available for health services and programs, and making decisions on how to organize them to maximize resource utilization and make it possible to perform the essential public health functions.
- It is necessary to increase the health authority's capacity to effectively interact with other sectors (including civil society) that influence social, economic, and environmental health determinants.

STRATEGIC APPROACHES

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

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

One of the main conditions will be building and sustaining the necessary capacity for conducting research on public health and on health policies and health systems of national interest, including health systems research, in order to set up and maintain reliable health information systems and

translate research findings into policy and practice. It is necessary to improve mechanisms to ensure that the right knowledge reaches the right people (policymakers, administrators, experts, development partners, and the general public) to develop an effective decision-making process and monitor performance throughout the health system.

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

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

ASSUMPTIONS AND RISKS

The following assumptions apply:

- There is political commitment and a basic consensus that the State is responsible for the health of the entire population.
- There is a change in the way external partners operate in terms of financing and execution, in particular by putting the principles of the Paris Declaration on Aid Effectiveness into practice, so that they strengthen, rather than undermine, national activities aimed at improving governance/the steering role.
- Effective partnerships are created and effective participation of stakeholders at the national, subregional, and regional level is maintained; especially important in this regard are the international and regional organizations that invest in information, as well as a number of bilateral donors.
- Progress is made in governance, the State steering capacity, and the strategic management of development in general, not simply in the health sector.

- The countries and development partners make increasing use of objective data for resource allocation.

The following risks could adversely affect attainment of the SO:

- Lack of international and national investment in this area, especially in the middle-income countries, where the majority of the Region's poor reside.
- Unsustainable public policies and lack of inter-sectoral coordination.
- Poor coordination and harmonization among the major international partners.
- A preference for investing in short-term unsustainable solutions.
- Lack of reliable data and information for decision-making and monitoring and evaluation of policies and programs.

REGION-WIDE EXPECTED RESULTS

RER 11.1 **Strengthen the capacity of the national health authority to perform its steering role, improving the preparation of policies, regulation, strategic planning, orientation, and execution of the reforms, and the inter-sectoral and inter-institutional coordination in the health sector in the national and local areas.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
11.1.1	Number of countries which demonstrate an improvement in the performance of the steering role (policy-making, strategic planning, execution of reforms and inter-institutional coordination in the health sector at the national and local levels) through the existing mechanisms (Essential Public Health Functions).	TBD	TBD	TBD
11.1.2	Number of countries that have institutionalized regulatory agencies of sector operation (such as authorities) and generated regulatory frameworks.	TBD	TBD	TBD
11.1.3	Number of countries that have generated medium and long term sectoral plans or defined National Health Objectives.	7	TBD	TBD
11.1.4	Number of subregions implementing a strategy of promotion and support for processes of social dialogue and consensus-building of public policies for the strengthening of the health systems based on primary health care.	0	2	5

RER 11.2 **Contribute to the improvement of health information systems at regional, subregional, and national levels; for the analysis, management, monitoring, and evaluation of the public policies and health systems to achieve the health objectives at all levels.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
11.2.1	Number of countries that have implemented the monitoring and performance evaluation process of the health information systems based on the standards of WHO/PAHO and the HMN supported by the Bureau.	3	7	15
11.2.2	Number of countries that have permanent and active plans to strengthen the vital health statistics, including the production of information and the use of international classifications (ICD) in accordance with international standards established by PAHO/WHO and the Metric Health Network.	3	8	40
11.2.3	Number of countries that have implemented the Regional Core Health Data Initiative and that steadily produce and publish the basic health indicators at sub-national level (first or second administrative level).	9	13	21

RER 11.3 **Contribute to the access, equitable dissemination, and utilization of knowledge and scientific evidence in the decision-making processes.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
11.3.1	Number of countries that use the basic health indicators and other available statistical information to support the analysis of priority evidence-based health problems.	40	40	40
11.3.2	Number of countries that have improved their analysis capacities for generating information and knowledge in health with technical cooperation from PAHO.	5	7	10
11.3.3	Number of effective research activities on coordination methods and leadership in the area of the health.	0	2	4

RER 11.4 **Facilitate the generation of knowledge in priority areas, including research on health systems, with participation of different stakeholders of society, ensuring they meet the high methodological and ethical standards.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
11.4.1	Number of countries whose national health research systems meet the internationally agreed upon minimum standards (to be defined by WHO).	TBD during 2007	TBD during 2007	TBD during 2007
11.4.2	Number of countries that adhere with the Mexico Summit commitment to devote at least 2% of the health budget to research.	TBD during 2007	TBD	TBD
11.4.3	Number of LAC countries with Ethical- Bioethical National Commissions aimed at monitoring compliance with ethical standards in scientific research.	14/36	20/36	30/36
11.4.4	Functional Regional Advisory Committee on Health Research.	The Regional ACHR is being revitalized	Functional Regional ACHR meeting regularly	Alignment and coordination between the Regional and Global ACHR

RER 11.5 **Contribute to the opening and strengthening of dialogue mechanisms and social and political consensus-building, at different levels, with participation from the relevant stakeholders for the improvement of policies and health systems.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
11.5.1	Number of countries (health ministries and schools of public health) adopting knowledge-management strategies to bridge the gap between knowledge and its application.	10	15	25
11.5.2	Number of countries that have access to essential scientific information and knowledge.	TBD	10	20
11.5.3	Number of countries that have cyber health frameworks and services based on scientific data.	TBD	12	30

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, and laboratory testing. The work undertaken under this Strategic Objective (SO) will focus on making 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. For the sound use of products and technologies, work will focus on building appropriate regulatory systems; evidence-based selection; information for prescribers and patients; appropriate diagnostic, clinical and surgical procedures; supply systems, dispensing and injection safety; and blood transfusion. Information includes clinical guidelines, independent product information and ethical promotion.

INDICATORS AND TARGETS

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

ISSUES AND CHALLENGES

From the simplest of health care systems to the most advanced, in rich and poor countries alike, health technologies form the backbone of health services. Yet access to health technologies is at the same time one of the most distinct differences between rich and poor countries in all regions of the world, including the Americas. The highest disparities in income distribution are seen within countries in the Americas, which are reflected in the access to health technologies. Strong health systems invariably rely heavily on access to and use of health technologies. Together, they form a dense mesh throughout the health services into which they are interwoven. A strong mesh of health technologies is one of the most fundamental prerequisites for the sustainability

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

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

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

Most national immunization programs in the region utilize vaccines that have been procured through PAHO's revolving fund. These vaccines have their quality assured by the WHO prequalification system that includes not only the assessment of the manufacturer and the vaccines but also the assessment of the National Regulatory Authority (NRA) of the country as the responsibility for the oversight is delegated to the NRA. Assessment of NRAs has become an important tool to identify their strengths and weaknesses in the compliance with the 6 regulatory functions: a) registration; b) surveillance of vaccine use; c) lot release system; d) access to a quality control laboratory; e) inspection of manufacturers; and f) evaluation of clinical results. The strengthening of NRAs will also help towards the creation of a network of regulatory authorities that can serve as a basis for product quality in the region. So far two NRAs have been declared fully compliant (Brazil and Cuba) and five have undergone preliminary assessments. Several causes have been identified as problems for non-compliance: the lack of organizational and independent structures, lack of qualified human resources, lack of coordination of activities and poor infrastructure.

Few countries have invested in improving their vaccine production facilities: Brazil, Cuba, Mexico and Venezuela. Two manufacturers are already pre-qualified to supply vaccines to UN agencies: Biomanguinhos in Brazil for yellow fever and CIGB in Cuba for hepatitis B. A second Brazilian manufacturer has requested prequalification of two of its products: DTP and DTP+hepB. PAHO is

identifying how to collaborate with these manufacturers to address the issue of regional vaccine self-sufficiency and production of certain vaccines of regional or local public health relevance such as pandemic flu vaccine or Argentinean hemorrhagic fever vaccine.

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

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

There is a strong correlation of blood safety and availability and efficiency of the national blood system. Data from countries in the Region, including Canada and the United States, indicate that those countries with higher donation rates per 1,000 inhabitants have blood services that process higher number of blood units per year, are more likely to have high proportions of voluntary blood donors, and to have universal testing.

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

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

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

As communicable diseases are an important burden of morbidity and mortality, jointly with low levels of development and scarce local resources, national laboratory networks should be supported and reoriented towards a more intensive role in health surveillance. The public health role of the laboratory includes the sustainable implementation of a system for quality assurance within the laboratory networks, a strong interaction with epidemiologic surveillance in disease control, an integrated response over outbreaks and follow-up of the epidemiologic investigation process, besides registration and authorization for clinical laboratories, the development of external evaluation programs and voluntary access to accreditation.

STRATEGIC APPROACHES

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

- Support Ministries of Health in the regulation and operation of medical devices and medical equipment in general.
- Support the institutional development of Public Health Laboratories and strengthen quality of clinical laboratory operations.

ASSUMPTIONS AND RISKS

The principal assumptions underlying this SO are that:

- Access to medical products and technologies will continue to be a strategic issue in overall Health Agenda of Ministries of Health.
- Decentralization of financial resources from WHO will ensure sustainability to major issues related to ensuring access to quality products and technologies.
- Strengthening of Regulation within a sub-regional approach will ensure circulation of quality products and technologies in our Region.
- Strengthening of supply systems will ensure appropriate delivery of health products and technologies.
- Strengthening of regional initiatives, such as the PAHO Strategic Fund and PANDRH.
- Inter-agency coordination and joint efforts dealing with the issue are to be continued.
- Human resources capacity is being enhanced in the Region to confront major challenges regarding access to products and technologies.

The key risks for progress are identified as:

- The sub-regional approach is not sustainable and there is lack of operational funds for supporting Member States.
- Lack of political will in certain countries as to maintain this issue in the political agenda.
- 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.
- Difficulties in harmonizing procedures and standards regarding quality of products and technologies.

REGION-WIDE EXPECTED RESULTS

RER 12.1 **Development and monitoring of comprehensive national policies on access, quality and rational use of essential public health supplies (including medicines, vaccines, herbal medicines, blood products, diagnosis services, medical devices and health technologies) advocated and supported.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
12.1.1	Number of countries supported to develop and implement Policies and Regulations for essential medical products and technologies.	15/36	23/36	27/36
12.1.2	Number of countries receiving support to design or strengthen comprehensive national procurement and supply systems.	20/36	21/36	21/36
12.1.3	Regional norms and guidelines for the operation of the Strategic Fund to support the strengthening of supply systems in countries.	In progress	Developed and validated	In use by countries
12.1.4	100% voluntary non-remunerated blood donation.	36%	90%	100%

RER 12.2 **International norms, standards and guidelines for the quality, safety, efficacy and cost-effectiveness of essential public health supplies developed and their national/ regional implementation advocated and supported.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
12.2.1	Regional assessments of countries to measure their capacity for regulation of essential medical products and technologies.	2	5	7
12.2.2	Norms and guidelines for pre-qualification of providers and products in the region.	In progress	Developed and validated	In use by countries

RER 12.3 **Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported in regional and national programs.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
12.3.1	Number of national or regional programs receiving support for promoting sound and cost-effective use of medical products and technologies.	2	4	6
12.3.2	Number of countries provided with support to promote sound and cost effective use of medical products and technologies.	11/36	16/36	20/36
12.3.3	Number of countries with a national list of essential medical products and technologies updated within the last five years and used for public procurement and/or re-imbursement.	30	31	34
12.3.4	Number of regional guidelines for national policies on safe and effective use of essential medical products and technologies.	0	4	6

RER 12.4 **Support development of policies and legal frameworks, and enhance human resource capacity to reduce barriers to access to essential public health supplies.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
12.4.1	Number of countries supported with the necessary tools to develop policies and legal frameworks and enhance human resource capacity to reduce barriers to access to essential public health supplies.	11	20	24
12.4.2	Guideline and tools (including roster of experts) to address barriers to access in countries.	In progress	Available	Implemented

STRATEGIC OBJECTIVE 13

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

Scope

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

INDICATORS AND TARGETS

- Density of the health workforce (disaggregated by country, gender, and occupational classification, where possible). Target: TBD
- Equitable distribution of health workers (disaggregated by country, sex, and occupational classification, where possible). Target: TBD
- Number of countries facing critical health workforce shortages. Target: Reduction of 25% by 2013.

ISSUES AND CHALLENGES

Data from the Region of the Americas show:

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

A clear correlation exists between the density of health workers and attainment of adequate levels of coverage with essential health interventions, such as immunization and skilled care in delivery. The more health workers there are per inhabitant, the higher the likelihood of infant, child, and maternal survival. Many countries have not met the expected targets of intervention coverage established in the Millennium Declaration. The *World Health Report 2006*, for example, has identified many countries in which the density of health workers falls below the minimum level established. In the Americas the scarcity is not as acute or as huge as in Africa, but serious problems exist in some professional categories and in distribution.

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

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

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

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

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

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

- Brazil - Doctors comprise 66% of total health professionals.
- El Salvador - There in only one nurse for every two doctors.
- Dominican Republic - There is only one nurse for every eight doctors.
- Uruguay - 66% of all doctors are specialists.
- Nineteen Latin American Countries have more doctors than nurses.

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

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

- Strengthen leadership in public health.
- Increase investment in human resources.
- Coordinate and integrate actions in all areas.
- Ensure the continuity of supportive policies and interventions.
- Improve information gathering for decision-making.

Main Objectives for the Decade 2006-2015:

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

STRATEGIC APPROACHES

- Fulfilling this SO implies ensuring effective technical cooperation to advance the development of an available workforce, in the right places, in adequate numbers, and with the skills necessary to meet the health needs of the population, within the context of each country's health system.
- This will require the improvement of the health workforce through national, subregional and regional plans, strengthening national capacities for comprehensive human resource management, and creating and promoting partnerships at all levels. It is essential to maintain information systems on health personnel for evidence-based formulation of integrated policies and national strategic plans on human resources in health. Information on best practices should be compiled and disseminated, based on scientific criteria, for development, training, and management of health personnel. Similarly, sufficient funds are needed to finance the health workforce, which will call for consultations and negotiations with the ministries of finance, labor, and education as well as international development agencies.
- It will also be necessary to expand capacities and improve the quality of educational and training institutions; and ensure an appropriate skill mix and equitable geographical distribution of the health workforce through effective deployment and retention measures, through context-specific incentives.
- In supporting Member States' efforts, PAHO will gather and share the knowledge (data, information, and evidence) needed to change current practices, so that health workforce challenges are addressed and guarantee continuous improvement of health workers' general performance. Specifically, the Bureau will:

- Support the strengthening of national health workforce leadership, to mobilize resources for the health workforce, and design, implement, monitor, and evaluate health workforce policies and plans in the context of the Decade of Human Resources in Health (HRH) 2006-2015, and ensure that they are responsive to health needs.
- Support the establishment of HRH monitoring in the countries, ensuring its sustainability.
- Respond to countries in HRH crisis.
- Facilitate agreements with other agencies, to have more effective financial mechanisms for health resources development and the management of domestic and international migration.
- Strengthen national educational systems, especially schools and universities, to support training for all types of health workers, developing appropriate skills and competencies.
- Strengthen the knowledge base, supporting national capacity to develop health workforce information systems and promote human resources research.
- Support mechanisms for creating subregional networks of institutions of excellence, for example, to develop health workforce observatories, to generate information for evidence-based policy-making, monitoring, and evaluation.
- Collaborate on setting norms and standards for the health workforce, including development of internationally agreed-upon definitions, classification systems, and indicators.
- Support efforts for horizontal integration and cooperation among countries to implement joint strategies and address health workforce migration issues.

ASSUMPTIONS AND RISKS

- 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.
- The following risks may adversely affect achievement of the SO:

    - Financing of health workforce development remains at low levels.
    - The issue of human resource development continues to be neglected.
    - Affected countries remain unable to take the lead and manage responses to crises by themselves.
    - Developed countries continue active recruiting, thus provoking uncontrolled migration.
    - Market forces continue to exert excessive pressure in favor of out-migration and the exodus of professionals (brain drain).

REGION-WIDE EXPECTED RESULTS

RER 13.1 **Plans, policies, and regulations of human resources developed; at the national, subregional, and regional levels; in order to improve the performance of health systems based on primary care.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
13.1.1	Number of countries with 10-year Action Plans for strengthening the health work force, with active participation from stakeholders and governments.	13	16	28
13.1.2	Number of countries that have a unit in the government responsible for the planning and preparation of policies for the development of human resources for health.	3	12	20
13.1.3	Number of countries with programs for an increase in production of human resources for health with priority on the strengthening of Primary Health Care.	8	11	15
13.1.4	Number of countries with regulation mechanisms (quality control) for education and health practices.	12	16	20
13.1.5	Number of subregions with regulation mechanisms (quality control) for education and health practices.	1	2	3

RER 13.2 **Set of baseline data and information systems in human resources developed at the national, subregional, and regional levels.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
13.2.1	Number of countries that have a database for situation and trends of the health workforce, which is updated at least every two years.	10	22	29
13.2.2	Number of countries that will participate in a Regional Indicators System on Human Resources for Health (including indicators of geographical distribution, migration, labor relations and the development trends of health professionals).	0	13	27
13.2.3	Number of countries with a national group integrated in the network of Human Resources for Health Observatories.	18	29	40
13.2.4	Number of countries that develop promotion strategies for research in human resources for health.	5	8	14

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
13.2.5	Development of a regional indicator system to monitor the progress of critical challenges and development of regional profiles of the situation of RHS within the Health Agenda for the Americas framework.	0	1	1

RER 13.3 **Strategies and incentives developed to generate, attract, and retain the health workers (with the appropriate competencies) in relation to the individual and collective health needs, especially considering the neglected populations.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
13.3.1	Number of countries with recruitment and retention policies for health workers to strengthen Primary Health Care.	6	15	20
13.3.2	Number of countries that have implemented incentive systems and strategies to achieve the geographical redistribution of its health workers toward unprotected areas.	6	10	20

RER 13.4 **Capacity for management strengthened in the countries, in order to improve the performance and the motivation of the health workers, including the development of healthy and productive working conditions and environments.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
13.4.1	Number of countries with which PASB has forged strategic alliances for the development of national and subregional plans in human resources, within the Toronto appeal for action framework.	2	4	6

RER 13.5 **Education strategies and systems strengthened at the national level, for developing and maintaining health workers' skills in the context of health practice and the health status of the population, focusing on Primary Health Care.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
13.5.1	Number of countries with joint planning inter-institutional Commissions of training institutions and health services for the continuous update of labor competencies.	12	25	35
13.5.2	Number of countries with explicit national policies for the adaptation of pre and post graduate education with the health priorities and Primary Health Care.	4	10	15

RER 13.6 **Increased understanding of and solutions to the problems facing national health systems as a result of the international migration of health workers in the medium and long terms.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
13.6.1	Number of subregions that participate in a monitoring network of health worker migration.	2	3	4

STRATEGIC OBJECTIVE 14

To extend social protection through fair, adequate and sustainable financing

Scope

This Strategic Objective (SO) reflects the guiding principles set out in resolution WHA58.33 and PAHO Resolution CSP26.R19 in 2002: Extension of Social Protection in Health: joint PAHO-ILO initiative. Work will focus on:

- Sustainable collective financing of the health system and social protection.
- Protection of households against catastrophic health expenditures.
- Elimination or reduction in economic, geographical, cultural, ethnic, and gender barriers to access arising from the organization of the system.
- Elimination of (a) the differences in guaranteed rights to access products, services, and opportunities in health and (b) discrimination based on ethnicity, gender, age, religion, or sexual preference.
- Elimination or reduction of institutional segmentation in systems and operational fragmentation of the service network.
- Adequate and timely access to quality health services with equity.
- Advocacy to put health on government agendas.
- Alignment, harmonization and coordination of the international cooperation to support national efforts for health development (in the orientation of Rome's Declaration and the Paris High Level Forum directives)

INDICATORS AND TARGETS

- Increase in the percentage of public expenditure for health, with emphasis on primary care expenditure. Target: TBD
- Decrease in the proportion of households that fall below the poverty line due to health expenditure. Target: TBD
- Decrease in the number of countries with a high proportion of out-of-pocket expenditure in health. Target: TBD
- Increase in the percentage of the population with explicit ensured rights of access to products, services, and opportunities in health. Target: TBD
- Increase in the percentage of the population with regular and timely access to health services. Target: TBD
- Increase in the number of countries with research capacity to assess social exclusion and inequities in health in addition to system financing and expenditure, as a strategic measure to increase efficient and equitable public expenditure and establish collective, universal social protection policies. Target: TBD
- Increase in the number of countries able to coordinate, harmonize, and align international cooperation in health. Target: TBD

ISSUES AND CHALLENGES

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

STRATEGIC APPROACHES

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

ASSUMPTIONS AND RISKS

Achieving this SO requires that:

- Regional, subregional, and national partnerships are established, particularly with 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 on 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 American People

(ALBA); and bilateral development partners and ministries of labor/social security, finance/treasury, planning, central banks, and national statistics institutes, as well as universities and research centers.

- Countries undertaking health system reforms are interested in the search for universal, equitable access to health services for their people and want the resources for this purpose to be allocated and available to the health sector.
- Countries' experiences vary, and the lessons learned in national processes can serve as valuable input for technical cooperation among countries.

Potential risks are:

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

REGION-WIDE EXPECTED RESULTS

RER 14.1 **Support to the Member States in the development of institutional capacities for the analysis of policy options in economic and financing, political, social and sanitary matters; in order to improve the performance of the financing mechanisms of the health system and of social protection in order to eliminate/to reduce economic barriers of access, to promote financial protection, equity and solidarity in financing of services and health actions, and the efficient utilization of resources.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.1.1	Number of countries with institutional development plans for policy and regulations to improve the performance of financing mechanisms for the health system and social protection.	7	10	15
14.1.2	Number of countries with Units of Analysis in economic, financial and functional health expenditure, which use that information in order to develop relevant policies in regard to the elimination/reduction of economic barriers of access, increase in financial protection, equity and solidarity in financing of services, and efficiency in the utilization of resources.	10	13	18
14.1.3	Number of countries that have conducted characterization studies of social exclusion in health at national or sub-national levels.	11	15	20
14.1.4	Number of countries with extension policies of social protection in health with the objective of universal coverage.	8	10	12

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.1.5	Number of policy-briefs, analytical documents, applied research, innovative and/or comparative case studies, methodologies, and instruments on exclusion / social protection, economy / financing / health systems expenditure, equity / efficiency in the utilization of developed and disseminated resources.	20	28	40

RER 14.2 **Implemented measures of promotion, information, and technical cooperation at regional, subregional, and national levels to raise stable and additional funds allocated to health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.2.1	Number of countries that have developed/improved processes of planning and/or monitoring of international cooperation in regards to Poverty Reduction Strategy Papers, Sector-Wide Approaches, Medium Term Expenditure Frameworks and other long-term financing mechanisms.	6	9	12
14.2.2	Regional promotion strategy of the ongoing exchange of information, knowledge, and lessons learned about coordination and alignment of the formulated and implemented international cooperation.	Consultation process for countries with high dependency on international cooperation and respective PWRs.	Regional strategy formulated and agreed upon by 40% of the countries of the region with high dependency on international financial assistance	Regional strategy formulated and agreed upon by 70% of the countries of the region with high dependency on international financial assistance

RER 14.3 **Develop and implement a methodological and analytical framework in Member States to evaluate sustainability, solidarity, equity, and capacity for household financial stability in the social protection system in health, based on available secondary information.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.3.1	Methodological and analytical framework to evaluate the sustainability, solidarity, equity, and capacity for household financial stability in the social protection system in health, developed and validated by experts and national authorities, and necessary secondary information identified in the information systems from the countries.	Methodological and analytical framework not available	Methodological and analytical framework developed and validated, with necessary information identified in 5 countries	Necessary information identified in 3 additional countries (total 8 countries)
14.3.2	Number of country studies finalized with a methodological and analytical framework to evaluate sustainability, solidarity, equity, and household financial stability in the social protection system in health.	0	3	5

RER 14.4 **Development and periodic dissemination of information on financing and health expenditures, including a strategy to apply existing knowledge, incorporated in the regional Plan and national research agendas on health systems and policies, with an emphasis on the extension of social protection in health.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.4.1	Regional-PAHO Core Data Initiative and the Statistical Annex of WHR/WHO with up-to-date information on financing and health expenditure for 100% of the region.	80%	90%	100%
14.4.2	Number of countries with national research agendas on systems and health policies, with emphasis on the extension of social protection in health, and utilization of information on financing and health expenditure.	6	10	15

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.4.3	Regional research agenda established and under way, on systems and policies of health, with emphasis on the extension of social protection in health, based on the utilization of information on financing and health expenditure.	0	Regional research plans on health systems and policies developed and approved by Member States	Regional research plans on health systems and policies being implemented
14.4.4	Number of countries that have institutionalized the periodic production of National Health Accounts aligned with the U.N. system.	13	18	25

RER 14.5 Technical cooperation developed for insurance processes and mechanisms and/or expansion of coverage; and experiences and lessons learned shared among Member States.

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.5.1	Number of countries that have shared experiences and lessons learned regarding insurance and/or expansion of coverage.	37	41	41
14.5.2	Number of policy-briefs, analytical documents, applied research, innovative and/or comparative case studies, methodologies and strategic instruments, programs, insurance plans and mechanisms and/or the expansion of coverage that have been developed and disseminated.	10	16	25
14.5.3	Regional and subregional comparative studies on experiences in insurance and/or expansion of coverage, with the objective of reaching universal protection.	0	Regional comparative study completed and disseminated	Comparative subregional studies of (1) North America, (2) Central America and the Caribbean, and (3) South America completed and disseminated

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.5.4	Number of professionals from countries and international cooperation agencies trained by PAHO in development strategies, programs, insurance plans and mechanisms, and/or expansion of coverage, with the objective of reaching universal protection.	220	300	400

RER 14.6 **Improve regional coordination of international cooperation in health and strengthen country capacity for coordination at the subregional and national levels in order to meet national health development targets.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
14.6.1	Number of countries in which actions by primary donors to the health sector are in line with and conform to governmental plans and priorities.	3	5	8
14.6.2	Number of countries in which the coordination of international cooperation in the Ministries of Health has been strengthened.	7	8	10

STRATEGIC OBJECTIVE 15

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

Scope

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

INDICATORS AND TARGETS

- Number of countries implementing health-related resolutions and agreements adopted by the Health Assembly and PAHO Governing Bodies. Target: more than half the Member States (19 countries) by 2013.
- Number of countries that have a Country Cooperation Strategy (CCS) agreed by the government, with a qualitative assessment of the degree to which PAHO/WHO resources are harmonized with partners and aligned with national health and development strategies. Target: 30 by 2013 (baseline: 0 in 2006-2007).
- Degree of attainment by Official Development Assistance for Health of Paris Declaration benchmarks on harmonization and alignment.[9] Target: 100% of benchmarks met by 2013.

ISSUES AND CHALLENGES

PAHO's governing bodies – the Pan American Sanitary Conference, the Directing Council, the Executive Committee and its Subcommittee of Program, Budget and Administration (SPBA) – provide strategic and policy direction for the PASB, which is lead and managed by the Director and senior officers at regional and country level.

[9] Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability, Paris, 2 March 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 programmes consistent with the national development strategies; 90% of procurement supported by such Assistance effected through partner countries' procurement system; 50% reduction in Assistance not disbursed in the fiscal year for which it was programmed; 66% of Assistance provided in the context of programme-based approaches; 40% of WHO country missions conducted jointly; 66% of WHO country analytical work in health conducted jointly.

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

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

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

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

The growing number of others involved in health work has also led to gaps in accountability and an absence of synergy in coordination of action. Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society groups, in tackling health problems and inequities.

With an increasing number of sectors, actors and partners involved in health, PAHO/WHO's role and strengths need to be well understood and recognized.

In this context, 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 the 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 support; and effectively communicating the work and knowledge of PAHO/WHO to Member States, other partners, stakeholders and the general public.

In collaborating with countries to advance the global and regional health agendas, PAHO/WHO will contribute to the formulation of equitable national strategies and priorities, and bring country

realities and perspectives into global policies and priorities. The different levels of the Bureau would 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 multi-sectoral approaches; build institutional capacities for leadership and governance, and for health development planning; and it will also facilitate technical cooperation among countries (TCC).

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

ASSUMPTIONS AND RISKS

The following assumptions underlie achievement of the SO:

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

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

REGION-WIDE EXPECTED RESULTS

RER 15.1 **Effective leadership and direction of the Organization through the enhancement of governance, and coherence, accountability and synergy in PAHO/WHO´s work to fulfill its mandate in advancing the global, regional and subregional health agendas.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.1.1	Proportion of PAHO Governing Bodies resolutions adopted that focus on policy and strategies to be implemented at regional, subregional and national levels.	40%	45%	55%

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.1.2	Proportion of documents submitted to governing bodies within constitutional deadlines, in all official languages.	95%	100%	100%
15.1.3	Percentage of oversight projects completed under the biennial Workplan which seek to evaluate and improve processes for risk management, control and governance.	90%	98%	100%
15.1.4	Development and implementation of a monitoring system for institutional development.	None	System developed and approved by EXM	System fully implemented
15.1.5	Corporate policies and staff performance reflect use of institutional development approaches: results-based management, knowledge-sharing, inter-programmatic teamwork, and gender/ethnic equity, among others.	Baseline survey conducted	20% over baseline	50% over baseline
15.1.6	The Organization is functioning within its legal framework as mandated by the Governing Bodies and established rules and regulations.	95%	100%	100%
15.1.7	An Accountability Framework to support Delegation of Authority to country level approved and implemented.	In progress	Approved by Governing Bodies	Full implementation

RER 15.2 **Effective PAHO/WHO country presence established to implement the PAHO/WHO Country Cooperation Strategy (CCS) that is 1) aligned with Member States' national health and development agendas, and 2) harmonized with the United Nations country team and other development partners.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.2.1	Number of countries using Country Cooperation Strategies (CCS) as a basis for planning the PASB's country work and for harmonizing cooperation with the United Nations CCA/UNDAF.	20/35	30/35	35/35

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.2.2	Number of countries where PAHO/WHO's presence reflects the respective Country Cooperation Strategy.	20/35	30/35	35/35
15.2.3	Number of countries in which a joint (PASB, government and other stakeholders) assessment of the biennial Workplan is performed to define the contribution of the PASB to national health outcomes.	10/35	30/35	35/35
15.2.4	Number of subregions that have a Subregional Cooperation Strategy (SCS).	0/4	1/4	4/4
15.2.5	Number of Technical Cooperation among Countries (TCC) projects .	TBD	TBD	TBD
15.2.6	Framework for key countries implemented.	Framework developed	Fully implemented in 5 key countries	Ongoing
15.2.7	Number of Subregional Fora conducted that develop position papers and policy recommendations for the improvement of public health in the respective subregion.	0	3	5

RER 15.3 **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.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.3.1	Proportion of trade agreements in the Americas that appropriately reflect public health interests.	4%	10%	20%
15.3.2	Number of countries where PAHO/WHO is leading or actively engaged in health and development partnerships (formal and informal), including in the context of reforms of the United Nations system.	38/38	38/38	38/38

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.3.3	Number of agreements with bilateral and multilateral organizations and other partners, including UN agencies, supporting the Health Agenda for the Americas.	TBD during 2007	10	25
15.3.4	Proportion of Summit's Declarations reflecting commitment in advancing the Health Agenda for the Americas.	60%	65%	75%
15.3.5	Number of position papers and policy recommendations developed and adopted by Regional, Subregional and National Health Fora.	3	5	5
15.3.6	Number of well-regarded regional partners on the board of the Regional Public Health Forum for the Americas.	0	5	10

RER 15.4 **PAHO is the authoritative source of public health information and knowledge, with essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.4.1	Number of countries that have access to relevant health information and advocacy material for the effective delivery of health programs as reflected in the country cooperation strategies.	TBD	TBD	TBD
15.4.2	Content, information processing, and utilization data available for web pages, blogs, list servers, virtual health library, WHO's Health InterNetwork Access to Research Initiative (HINARI) and Global Information Full Text (GIFT) projects, News Agency, OpenLink, and other corporate knowledge management tools.	TBD	TBD	TBD
15.4.3	Number of multilingual pages available on the PAHO web site.	TBD	TBD	TBD
15.4.4	Number of information products (Journal, books, CDs, web pages, catalogs/fliers) published and disseminated for free or sold per biennium.	TBD	TBD	TBD

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
15.4.5	Number of Communities of Practice using synchronous and asynchronous technologies for technical areas and administrative units designed, implemented, and supported.	2	TBD	TBD
15.4.6	The organization synthesizes knowledge and translates into contextually appropriate Policy and tools for Member States and institutional strengthening.	TBD	TBD	TBD
15.4.7	PAHO Journal of Public Health recognized as first among Public Health Publications by Peer Reviews.	TBD	TBD	TBD
15.4.8	Content, information processing, and utilization data available for Lessons Learned and Staff Travel and Consultant Report System.	TBD	TBD	TBD

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

The scope of this objective covers the functions that support the work of the Bureau in countries, technical centers, subregions, and technical and administrative areas at headquarters. It includes strategic and operational planning and budgeting, performance, monitoring and evaluation; coordination and mobilization of resources, management of financial resources, and other administrative functions. The entities implementing this SO ensure the efficient flow of available resources throughout the Organization; management of human resources; provision of operational support, including procurement services; the management of information technology; and legal services.

INDICATORS AND TARGETS

- Achievement of RERs under SOs 1-15 (the main function of SO 16 is to enable the programmatic work covered under SOs 1-15 to occur efficiently and effectively). Target: 80% of Regional wide Expected Results indicators achieved (at least 75%) by 2013
- Cost-effectiveness of the enabling functions of the Organization, i.e. the share of overall budget spent on this SO relative to the total PASB budget. Target: TBD

ISSUES AND CHALLENGES

As noted, the functions performed under SO16 exist principally to enable the efficient and effective operation of the functions culminating in SOs 1-15. Therefore, the issues and challenges that affect the entire Organization also apply to this SO. That being said, there are some specific challenges faced by the "support functions":

- Partners and contributors are expecting increasing transparency and accountability in terms of both measurable results and use of financial resources.
- PAHO's implementation of result-based management remains incomplete; while results-based planning and budgeting are in place, the extent to which managers are incorporating performance data and analysis into their day-to-day decision-making processes must be enhanced.
- Financial management is a challenge in a situation in which near 50% of the budget are voluntary contributions. Regular monitoring and reporting on resources across the Organization has improved. However, more flexibility is required in the financing together with more effective use of funds internally for better alignment of resources with the program budget and lowering of transaction costs.

- The increasing percentage of the Organization's budget that comes from voluntary contributions (as opposed to regular budget) presents challenges, especially given the high ratio of staff costs to non-staff costs.
- Human resource management is an issue when the average age of professional staff is 50 years old and approximately 31% will be retiring over the next five to seven years.
- Gender balance and geographic representation at all levels.
- Delegation and accountability models that ensure efficiency while maintaining controls are being developed, and will be implemented during the period.

STRATEGIC APPROACHES

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

ASSUMPTIONS AND RISKS

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

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

Active support is needed from Member States through, for instance, timely funding of the Organization's program budget, including voluntary contributions.

REGION-WIDE EXPECTED RESULTS

RER 16.1 **PASB is a result based organization, whose work is guided by strategic and operational plans that build on lessons learnt, reflect country and subregional needs, are developed jointly across the Organization, and are effectively used to monitor performance and evaluate results.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
16.1.1	Results Based Management strategy approved by Governing Bodies and applied throughout the Organization.	In progress	Approved by Governing Bodies	Full implement ation
16.1.2	The PASB Strategic Plan (SP) and respective Program Budgets (PBs) are results-based, take into account the country-focus strategy and lessons learnt, are developed by all the levels of the Organization, and approved by the Governing Bodies.	In progress	PB 10-11 developed with these characteristi cs	SP 13-17 and PB 12-13 developed with these characteris tics
16.1.3	Percentage of Regional Program Budget Policy final targets fully implemented.	30%	65%	100%
16.1.4	Number of PASB entities whose biennial Workplans are results-based and explicitly address the country focus strategy as defined in CCSs.	0/80	20/80	80/80
16.1.5	For each biennium, proportion of monitoring and assessment reports on Expected Results contained in the Strategic Plan and Program Budget submitted in a timely fashion, after a peer review.	50%	80%	100%
16.1.6	Percentage of PASB entities where the Strategic Alignment and Resource Allocation (SARA) exercise aligns staff competencies and resources to the strategic direction of the Organization.	6%	60%	100%
16.1.7	Proportion of Regional Public Health Plans elaborated and implemented by Member States, with the collaboration of the PASB, as per established guidelines.	0%	100%	100%
16.1.8	Proportion of managers and project officers trained and certified on RBM, planning, project management, and operational planning and monitoring and accountability mechanisms.	0%	50%	100%
16.1.9	Model for PASB subregional level management mechanism approved by Member States.	In progress	Approved by Governing Bodies	N/A
16.1.10	Number of PASB subregional levels fully functional based on model agreed with Member States.	1/4	2/4	4/4

RER 16.2 **Monitoring and mobilization of financial resources strengthened to ensure implementation of the Program Budget, including enhancement of sound financial practices and efficient management of financial resources.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
16.2.1	PASB compliance with International Public Sector Accounting Standards.	International Public Sector Accounting Standards not implemented	International Public Sector Accounting Standards approved by Member States, analysis completed, and financial systems ready for implementa-tion in 2010.	International Public Sector Accounting Standards fully implemented
16.2.2	Proportion of strategic objectives/regional wide expected results (RERs) with expenditure levels meeting or exceeding program budget targets.	TBD	50%	100%
16.2.3	Proportion of voluntary contributions that are un-earmarked.	TBD	15%	20%
16.2.4	Proportion of unfunded Program Budget planned amounts met during the biennium, by RER.	TBD	TBD	TBD
16.2.5	Amount of voluntary contributions funds returned to partners (in US$).	TBD	TBD	TBD
16.2.6	Sound financial practices as evidenced by an unqualified audit opinion.	TBD	Unqualified Audit Opinion	Unqualified Audit Opinion
16.2.7	Overall return on the investment portfolio of the Organization.	TBD	TBD	TBD
16.2.8	Proportion of voluntary contributions proposals requiring major revisions.	TBD	TBD	TBD
16.2.9	Proportion of PWRs empowered to mobilize resources.	0%	50%	100%

RER 16.3 **Human Resource policies and practices promote a) attracting and retaining qualified people with competencies required by the organization's plans, b) effective and equitable performance and human resource management, c) staff development and d) ethical behavior.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
16.3.1	Proportion of entities with approved human resources plans for a biennium, linked to the corporate HR strategy.	15%	75%	100%
16.3.2	Proportion 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%	75%	100%
16.3.3	New recruitments reflect UN standards on gender balance and geographic representation.	TBD	TBD	TBD
16.3.4	Human resources performance evaluation system utilized by all staff, and linked to biennial Workplans, competency model and staff development plans.	No	Yes	Yes
16.3.5	Proportion of staff with appeals, grievances and disciplinary actions to the size of the workforce.	TBD	TBD	TBD

RER 16.4 **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.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
16.4.1	Proportion of significant IT-related proposals, projects, and applications tracked on a regular basis through portfolio management processes.	0%	40%	80%
16.4.2	Level of compliance with service level targets agreed for managed IT-related services.	0%	50%	75%
16.4.3	Number of country offices and centers using consistent, near real-time management information.	36	36	36

RER 16.5 **Managerial and administrative support services, including procurement, enabling the effective and efficient functioning of the Organization.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
16.5.1	Level of user satisfaction with select managerial and administrative services (including security, travel, transport, mail services, cleaning and food services).	Low (satisfaction rated less than 50%)	Medium (satisfaction rated 50%-75%)	High (satisfaction rated over 75%)
16.5.2	Proportion of standard operating procedures utilized by PASB staff during regional emergencies.	0%	50%	100%
16.5.3	Proportion of Internal benchmarks met or exceeded for specialized services, such as translation.	60%	70%	80%
16.5.4	Proportion of procurement actions, service contract agreements and administrative (delegation of authority) processes completed within benchmark limits.	60%	80%	95%

RER 16.6 **A physical working environment that is conducive to the well- being and safety of staff in all entities.**

Indicator #	RER Indicator text	RER Indicator Baseline (end-2007)	RER Indicator Target 2009	RER Indicator Target 2013
16.6.1	Proportion of contracts under the PASB infrastructure capital plan for approved project(s) for which all work is substantially completed on a timely basis.	100%	100%	100%
16.6.2	Proportion of PASB entities that have implemented policies and plans to improve staff health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) compliance.	65%	75%	100%
16.6.3	Proportion of entities (HQs, PWRs, and Centers) that improve and maintain their physical infrastructure, transport, office equipment, furnishings and information technology equipment as programmed in their biennial Workplans.	75%	90%	100%

ENSURING EFFICIENT AND EFFECTIVE IMPLEMENTATION

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

ORGANIZATIONAL CHANGE OBJECTIVES AND THE ROADMAP TEAMS

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

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

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

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

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

COUNTRY COOPERATION STRATEGIES

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

88. The CCS represents a balance between country priorities and regional (as well as global) strategic orientations and priorities in line with national health development objectives. It constitutes a framework for PASB cooperation in and with the country or group of countries concerned, highlighting what the organization will do, how will do it and with whom. The CCS directly informs the biennial Workplans of PAHO/WHO Representatives (PWRs); the biennial

Workplan is a true "One Country Plan" where the efforts of all levels (global, regional, subregional and national) of the Organization convene.

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

90. The Bureau's country presence, as set out in the CCS and led by the PWR, is valued by the Member States and is what makes our Organization unique; this Strategic Plan recognizes and builds on these strengths. The relation between the PASB Strategic Plan and the Country Cooperation Strategies is reciprocal: CCSs have been analyzed for input to this Strategic Plan and the reverse will be true once the Plan is approved (see diagram 1, above).

RESULTS-BASED MANAGEMENT

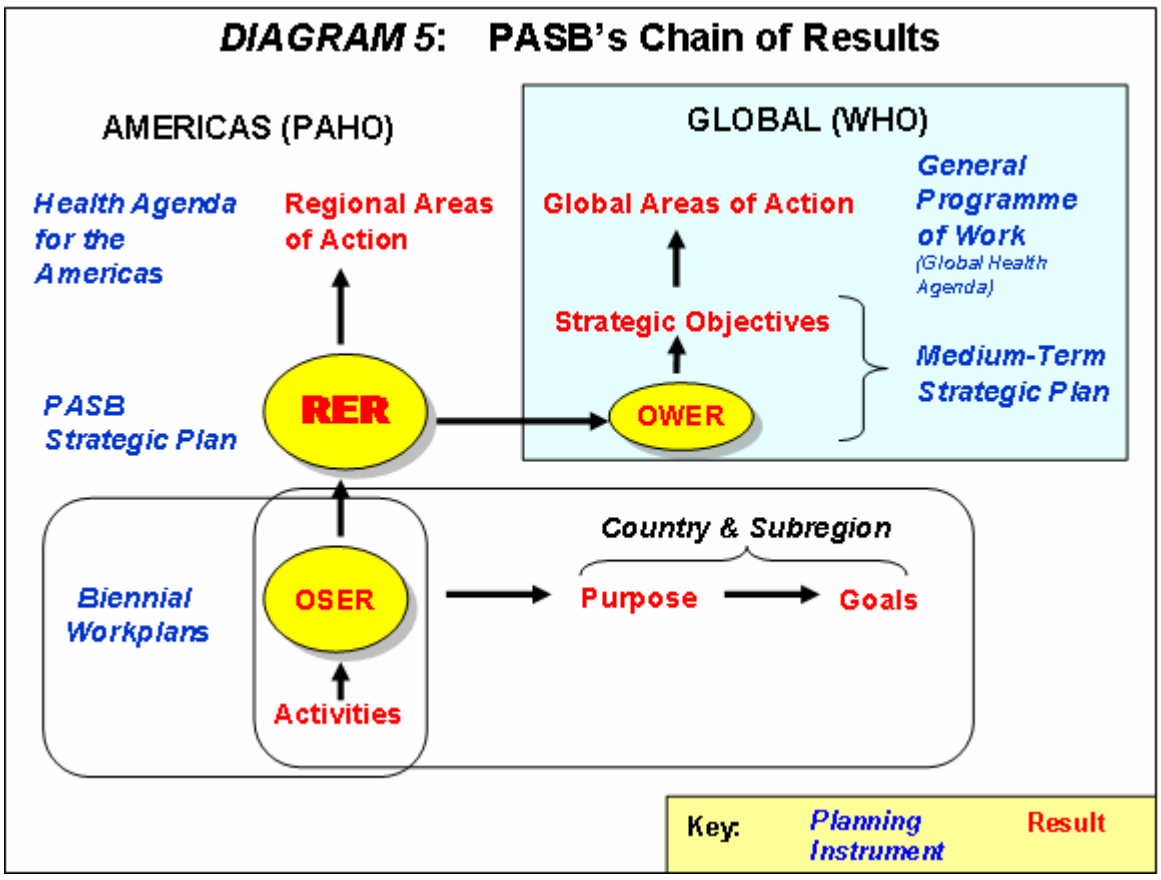
91. The ongoing implementation of results-based management as a management tool in the PASB has two main goals, 1) to ensure the Organization focuses on results in the planning, implementation and assessment of its programs and 2) to improve accountability and transparency to Member States.

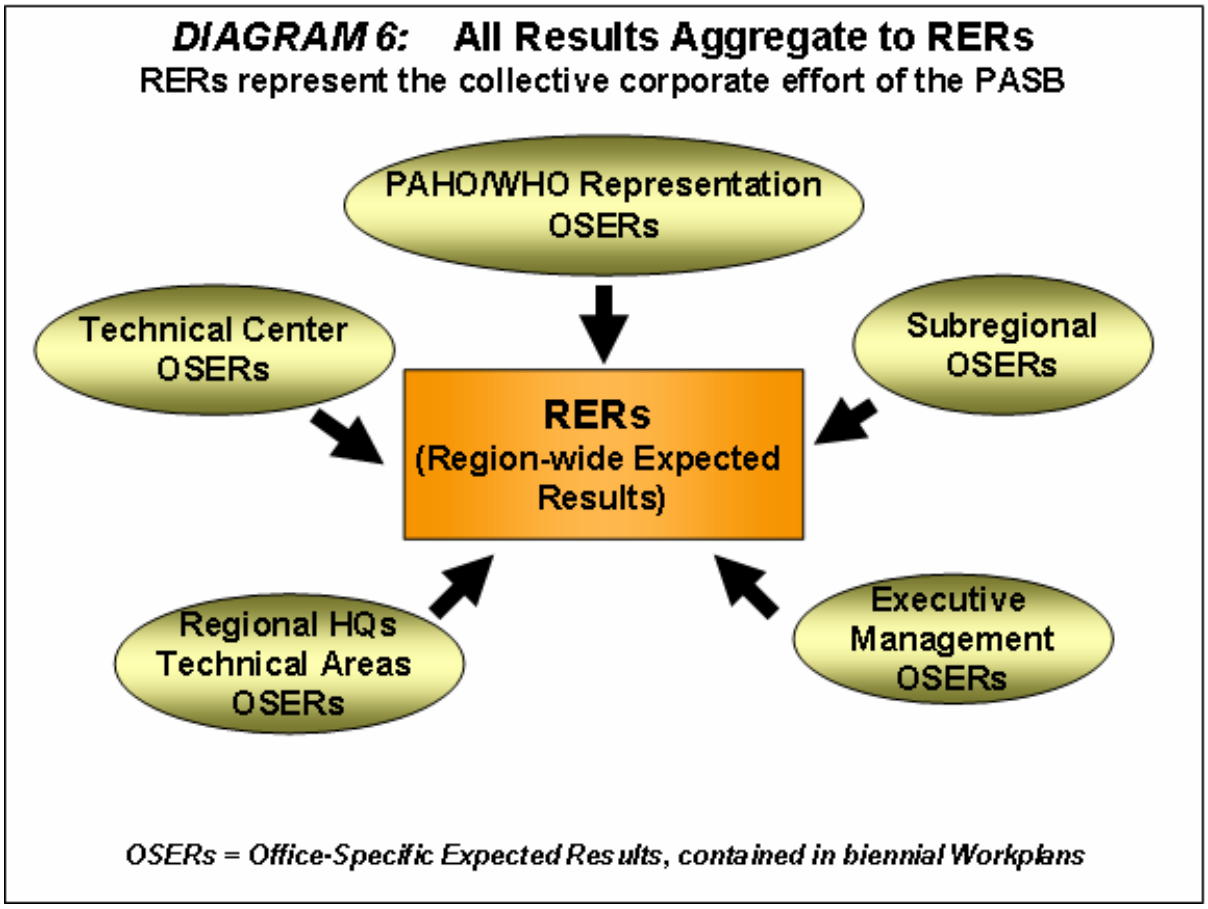
92. For nearly two decades the PASB has planned and budgeted for results – the American Region Planning and Evaluation System (AMPES) itself is based on the Logical Framework (LOGFRAME) approach used in result-based management. The culture of working for results is not new to the PASB; what is new for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

(a) The expected results of the Organization are consistent from the highest (global) level to the lowest (Workplan, country) level and vice-versa. The chain of results can be seen in diagram 5 below. Aggregation of results indicators is possible through the different levels for the first time, enabling improved performance monitoring and reporting (see below on Monitoring, Assessment and Evaluation).
(b) Each entity's Office Specific Expected Results (OSERs) contribute to the achievement of the Region-wide Expected Result (RER) through aggregation. Thus each RER represents the results of the collective work of the Pan American Sanitary Bureau, for which it is accountable. This is a new modality in the Organization (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 assigned to a specific entity in the PASB will allow for more objective evaluation of programmatic achievements post-implementation.

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





STRATEGIC ASSESSMENT AND RESOURCE ALIGNMENT

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

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

95. The SARA exercise is based on a self-assessment and is highly participative. It may result in revisions to the Organizations structure, and/or the shifting of resources among functional areas. It is estimated that the exercise will be completed for all entities in PAHO by 2008.

A STRONGER PASB FOR 2008 AND BEYOND

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

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

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

FUNDING THE STRATEGIC PLAN

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

100. PAHO receives its funding from three main sources:

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

(b) Portion of the WHO regular budget approved for the Region of the Americas: referred to as the AMRO share;

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

101. While funding sources from (a) and (b) above are considered un-earmarked, voluntary contributions (c) can be categorized as either earmarked or un-earmarked. Effective financing of the PASB Strategic Plan and associated Program Budgets will require careful management of the different sources and types of income to ensure complete funding of planned activities. Un-earmarked funding, such as assessed contributions, provides a predictable and flexible resource base that facilitates financing of the Organization's core activities. Earmarked funding—which accounts for the majority of voluntary contributions currently negotiated—is less flexible, and less predictable, thus are more likely to contribute to funding gaps in relation to Program Budget requirements.

102. Earmarked funding received from donor partners continues to pose a challenge for ensuring alignment between the Organization's planned activities and actual resources mobilized. To the extent that donor partners can be persuaded to provide increased levels of un-earmarked voluntary contributions—also being referred to as 'negotiated core voluntary contributions' by WHO—the Organization will become more successful in fully financing its Strategic Plan and Program Budgets, consequently increasing the probability of achieving its expected results. To this end, the Bureau fully supports WHO's efforts in actively seeking to increase the proportion of the program budget financed with negotiated core voluntary contributions and will similarly continue its own efforts in this area.

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

Table 1

		Strategic Plan		
	PB 2006-2007	**PB 2008-2009**	**PB 2010-2011**	**PB 2012-2013**
PAHO	333,094,000	344,566,000	679,000,000	740,000,000
WHO	198,018,000	278,501,000		
	531,112,000	623,067,000	679,000,000	740,000,000

104. The PASB Strategic Plan has an estimated resource envelope of just over $2 billion for the three-biennium period ending in 2013. This projection begins with a proposed budget of $623 million (which includes all sources of funding) for 2008-2009 and contemplates biennial increases of roughly 9%, commensurate with the proposed costing of $14 billion for the WHO MTSP and expectations for inflationary costs in the Region.

105. 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 staff.

106. 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 staff. However, the Bureau has reduced an additional 12 fixed-term positions so far in the biennium (in addition to the 41 positions abolished during 2004-2005) thus containing the estimated cost increase to about $14 million for fixed-term staff for 2008-2009, an increase of 8.3% compared with the budget component for fixed-term staff for 2006-2007.

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

Table 2. Financing of the Program Budget 2008-2009

Source	2006-2007	2008-2009	% change
Assessed contributions from Member States	173,300,000	180,066,000	3.9%
+ Miscellaneous income	14,500,000	14,500,000	0.0%
= Total PAHO share (Regular Budget)	187,800,000	194,566,000	3.6%
+ WHO share (Regular Budget)	77,768,000	81,501,000	4.8%
= Total Regular Budget	265,568,000	276,067,000	4.0%
+ Estimated Voluntary Contributions *	265,544,000	347,000,000	30.7%
= Total Resource Requirements	531,112,000	623,067,000	17.3%

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

108. The proposed budget for 2008-2009 of $623 million represents an increase of 17.3% compared to the $531 million budget approved for 2006-2007. The largest source of the budget increase comes from the estimated voluntary contributions of $347 million, representing a 30.7% increase, of which $197 million is budgeted to come from WHO. This budget was developed

jointly with WHO/HQ and the other WHO Regions by teams of staff working together globally, grouped by Strategic Objective.

109. The regular budget share of the budget of $276 million represents an increase of $10.5 million, or 4.0%, compared to the biennium 2006-2007, and is all attributable to the projected increase in the cost of fixed-term staff. This increase is proposed to be funded by an increase to the portion from PAHO assessed contributions of 3.9%, and the remainder from the 4.8% increase in the AMRO share of the regular budget ($81.5 million for AMRO included in the WHO regular budget presented to the World Health Assembly in May 2007).

110. It should also be noted that the proposed budget level, in addition to not allowing (purposely) for inflationary non-staff costs, does not make provision for several significant 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's expected involvement with the Global Management System (GSM) project being implemented by WHO, and expenditure related to the Master Capital Investment Plan.

111. 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.

112. The purchasing power of the Organization's operating budget for program activities has suffered over the last several biennia 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, despite efforts made to reduce fixed-term positions.

113. 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 Organization in carrying out its statutory and normative work and for the ability of regional entities to respond to backstopping needs of countries.

114. 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. Thus, regular budget funds become essential for securing many of the Organization's statutory and normative core functions.

115. Finally, in consideration of the expressed position of many Member States regarding their ability to accept budget increases, and in trying to keep budget increases to an absolute minimum, the Bureau is prepared to take the "optimistic" scenario forward in constructing the proposed 2008-2009 program budget with the understanding that the economic reality may be

different and may require significant adjustments to planned programmatic targets contained in the Region-wide expected results.

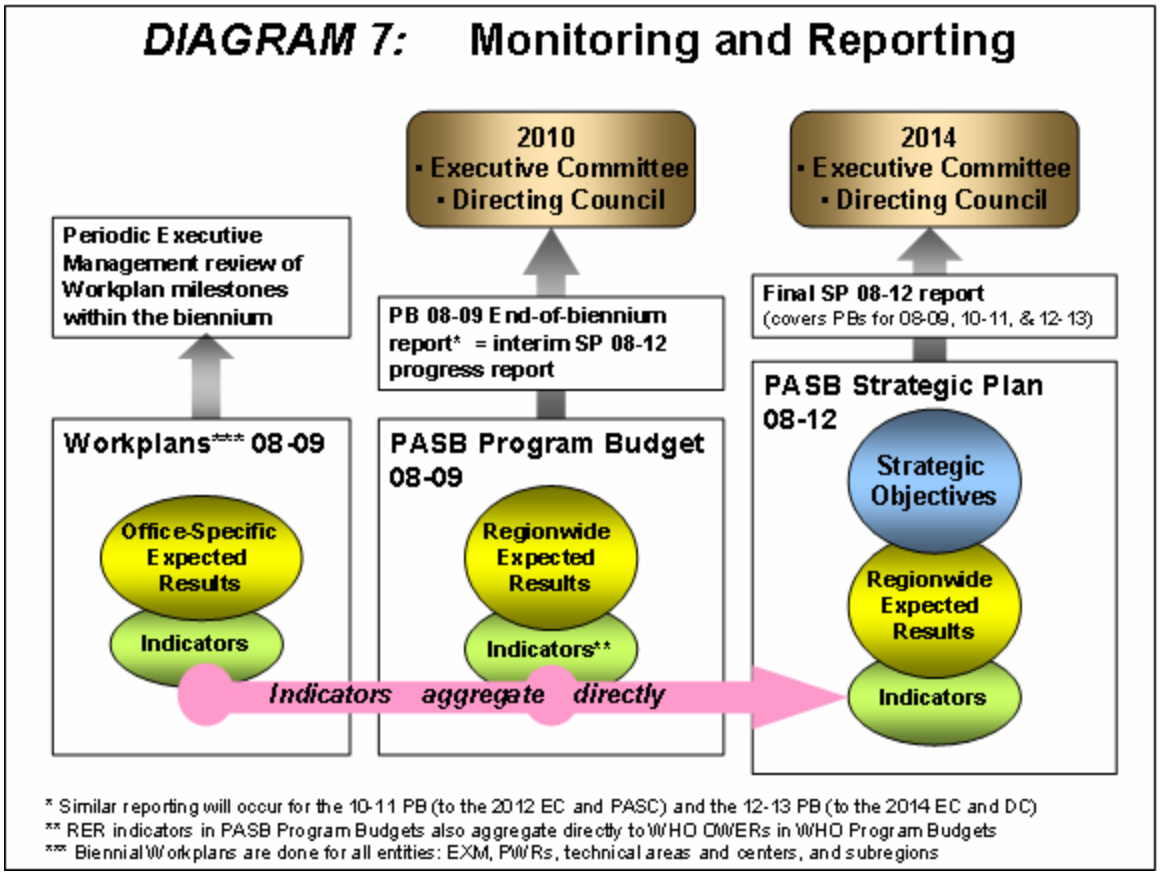
116. A breakdown of the budget by Strategic Objective is included in the Proposed Program Budget 2008-2009.

MONITORING, ASSESSMENT AND EVALUATION

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

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

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



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

121. 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.

122. The experience gained during implementation of this Plan (as reported on in Program Budget assessments) may require adjustments to the RERs. External changes in the environment may also require changes in the PASB's strategies and expected results. Whenever such changes are needed at the level of RER or above, they will be provided to the Governing Bodies for review and approval.

EVALUATION

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