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%