II

Areas of Work

COMMUNICABLE DISEASES PREVENTION AND CONTROL

ISSUES AND CHALLENGES

Communicable diseases disproportionably affect poor and marginalized populations of the countries of Latin America and the Caribbean. Global strategies are generally available to address the most important of these, although effective technical cooperation programs must be adapted not only to meet the financial, social, and cultural conditions of the country but also the specific characteristics of this most affected population.

The number of cases of dengue, although varying by country, has continued its upward trend since the second half of the 1970s, with the potential for a greater number of cases of dengue hemorrhagic fever. Dengue has reestablished itself as a major cause of infectious disease morbidity in the Region. In PAHO resolutions, countries have stressed the importance of addressing dengue and have promoted an integrated strategy.

Infestation rates of *T. infestans*, the principal vector of Chagas' disease in the Southern Cone, have been drastically reduced in the last 10 years. However, subregional initiatives are still being developed by the Central American and Andean countries to eliminate transmission of *T. cruzi*. Chagas' disease surveillance and leprosy diagnosis and treatment must be integrated into health services.

There are WHO and PAHO resolutions for the elimination of onchocerciasis and lymphatic filariasis, and an initiative to address these in an integrated manner as "neglected diseases" along with geohelminths is under way. Among the neglected diseases, geohelminthiasis and schistosomiasis are serious public health problems affecting primarily the school-age population and women of childbearing age. There has been steady progress in achieving these goals; however, sustainability of the programs depends on the political will, and significant advocacy is required. To interrupt transmission of onchocerciasis, treatment coverage of no less than 85% must be maintained over a period of 12 to 14 years, and treatment coverage above 80% over a period of five years is critical to interrupting the transmission of lymphatic filariasis in endemic countries.

Countries of the Region need to improve surveillance (including laboratory diagnosis), the assessment of the burden and technical guidelines for detecting and treating infectious diseases (SARS, emerged zoonotic diseases, and influenzas, among others) including antimicrobial resistance.

Early detection of cases of arenavirus hemorrhagic fevers is crucial to the implementation of timely outbreak control measures and appropriate patient-care management. The dissemination of West Nile virus to Central America and the Caribbean regions emphasizes the importance of developing local capabilities to detect and respond to outbreaks due to arboviruses that cause neuroinvasive diseases in humans.

Marginalized population groups live under environmental conditions in urban and rural settings that expose them to vector-transmitted diseases and to the emergence and reemergence of zoonoses. Efforts need to be made by the countries in local development, particularly in rural areas, combining health, veterinarian, and agriculture efforts to reduce the burden of neglected diseases. There is a need to adapt foot-and mouth disease and zoonosis control programs to the municipal level in accordance with the decentralization policies adopted by Member States which emphasize capacity building in small communities. Special efforts are required to reach control targets set for the rabies and foot-and-mouth diseases regional programs.

GOAL

To reduce the negative impact of communicable diseases on health and on the social and economic well-being of all people in the Americas.

OBJECTIVES

To reduce morbidity, mortality, and disability through the prevention, control and, where appropriate, eradication or elimination of communicable diseases.

STRATEGIC APPROACHES

Formulating and implementing evidence-based strategies; updating and adapting national policies and strategies towards prevention, control and/or elimination of communicable diseases; providing technical cooperation to countries with an emphasis on capacity building of national institutions, and promoting cooperation among countries; formulating integrated, multidisease-, interprogrammatic-, and intersectoral-based disease-prevention, control, and elimination strategies with a clear vision towards fulfillment of the MDGs and the development of a neglected diseases agenda.

Cooperating with the Member States to mobilize resources for the elimination, prevention, and control of targeted diseases.

Partnering with technical counterparts as well as collaborating extensively with complementary service providers as an integral part of communicable disease technical cooperation, especially in countries facing epidemiological emergencies or at high risk of exposure to complex emergencies.

Developing strategies in communicable diseases prevention, control, and/or elimination to strengthen national health infrastructure and services in order to expand their coverage.

Adopting and encouraging implementation of an innovative information- and knowledge-sharing strategy in accordance with current global and regional challenges and PAHO's new vision on information management, sharing, and knowledge exchange, while maintaining existing outbreak information and surveillance systems and networks.

Linking communicable disease subregional mechanisms (e.g. subregional meetings of technical counterparts) to existing subregional institutions, such as MERCOSUR, OTCA, CARICOM, RESSCAD, RIMSA, COHEFA, among others.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. The integrated strategy to prevent and control dengue will be implemented, on the basis of Resolution CD43.R4 and Resolution CD44.R9, adopted by the Directing Council in September 2001 and 2003 respectively.	. Number of countries adopting and implementing an integrated dengue prevention and control strategy; promoting a change in the approach of the national program towards health promotion activities	2	12
	. Number of countries where an external evaluation of the national plan for dengue prevention and control based on an integrated strategy has taken place	3	10
	. Number of countries in the Region that have participated in training activities on the COMBI (communication for behavioral impact on dengue) methodology, which seeks to change behaviors that will lead to the elimination of vector breeding sites)	16	20
	. Number of countries where a COMBI plan has been implemented	0	6
	. Number of countries where the processing of epidemiological information has been standardized to generate uniform data on dengue statistics reporting to DENGUE NET	4	20

2. Programs will be promoted to contain resistance to antimicrobial drugs, consistent with the international strategy on the topic.	• Number of countries that have plans in place to contain antimicrobial resistance in the community and/or hospitals	3	10
	• Number of countries that routinely evaluate infection control activities in hospitals	3	9
	• Number of countries that provide surveillance data on antimicrobial resistance in gonococci	2	8
	• Number of countries that use cost and health information to promote health policies	2	5
	• Number of countries with at least two health care institutions that follow defined clinical guidelines for treatment with antibiotics	0	2
3. Strategies will be promoted and implemented to eliminate lymphatic filariasis, and onchocerciasis.	• Number of countries where national programs for the elimination of lymphatic filariasis have launched the full Mass Drug Administration (MDA) component according to WHO's guidelines	2	4
	• Number of countries where national programs for the elimination of lymphatic filariasis have launched a comprehensive morbidity component	3	4
	• Validation exercise of tools to verify interruption of transmission in lymphatic filariasis	0	1
	• Number of onchocerciasis endemic countries attaining required treatment coverage rates of ≥85%	5	7
	• Number of countries where external evaluations of the program to eliminate onchocerciasis have taken place	2	4
4. Conditions will be created to carry out integrated health management/care, and multi-disease based strategies to control geohelminthiasis and schistosomiasis.	• Number of countries where integrated, multi-disease based plans of action to control geohelminths and schistosomiasis have been prepared	8	15
	• Number of countries where integrated, multidisease-based pilot interventions to control geohelminths and schistosomiasis have been implemented	4	7

5.	Activities to eliminate leprosy as a public health problem, as well as the consolidation and sustainability of those activities, will be promoted and evaluated.	• Number of municipalities in Brazil where adequate logistics to implement multidrug therapy (MDT), achieving 100% treatment coverage of cases will be in place	3,557	4,028
		• Number of countries where adequate logistics to implement MDT, achieving 100% coverage will be in place	10	20
		• Number of countries where the disease will be have been eliminated at the national level	16	19
		• Number of countries where a leprosy elimination program electronic monitoring process will be in place	0	5
		• Number of countries sharing information on leprosy program surveillance through a regional system based on a newsletter/homepage.	0	19
		• Number of external program evaluations that will have taken place.		
		• Number of countries that have met the WHO goal of integrating leprosy into health services.	0	2
6.	Areas of interruption of the transmission of Chagas by T. infestans in the Southern Cone and by Rhodnius prolixus in Central America will be expanded and consolidated, and the initiatives of Mexico, the Andean countries, and the Amazon basin will be fully operational, with control results.	• Number of countries where interruption of transmission by T. infestans is feasible and has been achieved.	3	5
		• Number of countries where interruption of transmission by T. infestans is not feasible but where transmission has been reduced.	0	1
		• Number of countries where interruption of transmission by R. prolixus is feasible and has been achieved.	1	3
		• Number of countries where transmission by R. prolixus is not feasible but where transmission has been reduced.	0	2
		• Number of functional subregional initiatives with national control and/or surveillance results.	3	5
		• Number of countries recording an increase in the coverage and quality of blood bank screenings for Chagas.	15	20

7. The countries will have an epidemic alert system in place to detect, investigate, report, and respond to the occurrence of cases and outbreaks of human neuroinvasive disease caused by arboviruses, including West Nile virus and viral hemorrhagic fevers.	• Number of countries implementing surveillance, laboratory diagnosis, and response plan for febrile neuroinvasive diseases and hemorrhagic fevers.	3	5
	• A regional guideline for the prevention, surveillance, diagnosis, treatment, and control of South America arenavirus hemorrhagic fever developed.	0	1
8. The countries will have an epidemic alert system in place to detect, investigate, report, and respond to the occurrence of cases and outbreaks of acute respiratory diseases, including influenza and SARS.	• Number of countries implementing surveillance of acute respiratory infections and reporting influenza viral isolations regularly to the FluNet.	3	6
	• Number of countries that have developed Influenza Pandemic Preparedness Plans	0	3
9. Human rabies transmitted by dogs will be almost eliminated; sylvatic rabies will be epidemiologically monitored; and countries will be supported in the implementation of control programs concerning bovine tuberculosis, brucellosis, and parasitic zoonoses that affect animal and human health.	• Rabies elimination will be maintained in those Latin American countries that have already attained it.	14	14
	• Reduction in the number of countries that have yet to eliminate human rabies transmitted by dogs	8	3
	• Number of countries in Latin America with rabies surveillance systems in operation	17	22
	• Number of countries in Latin America with risk of human rabies transmitted by dogs that have achieved 80% coverage in targeted dog population vaccination campaigns	3	5
	• Number of countries in Latin America and the Caribbean in which there is an established zoonoses program in operation according to PAHO guidelines, including at least two disease control activities	12	23

10. Conditions will be fostered for eradicating foot-and-mouth disease, protecting free areas, and keeping the Region free of "mad cow" disease (bovine spongiform encephalopathy – BSE).	• Number of countries of the Southern Cone and Brazil (except for Amazon region) free of foot-and-mouth disease	3	5
	• Number of countries of the Andean area that have operational eradication plans	3	5
	• Number of countries with epidemiological surveillance systems for vesicular disease that will be sustained throughout the Region	35	35
	• Latin America and the Caribbean will maintain BSE-free status	33	33
	• Number of countries where foot-and-mouth disease programs have been audited	7	12
	• Number of countries where risk analyses for BSE have been carried out	5	9
11. Systems will be structured for surveillance and response preparedness of some priority emerging animal diseases.	• Surveillance systems structured and operational in priority countries for zoonotic diseases that impact human health in accordance with epidemiological needs	3	7
	• Number of countries provided with a scientific orientation and basis for policy decision-making and preparation of national standards for zoonoses that impact public health and could potentially be used as bio-weapons	0	33

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	18,580,900	13,147,000	31,727,900
2006-2007	18,814,900	16,226,000	35,040,900
Of which:			
Country	5,533,400	6,344,700	11,878,100
Subregional	1,735,600	580,800	2,316,400
Regional	11,545,900	9,300,500	20,846,400

COMMUNICABLE DISEASE RESEARCH

ISSUES AND CHALLENGES

The extreme poverty that affects millions of people in the Region generates not only a heavy toll on human lives but also impedes economic development. A large group of diseases designated neglected diseases (viral, bacterial, and parasitic infections, often vector borne) affect this population.

Several organization and initiatives, among them PAHO have included the control of these diseases on their agenda, and a lot of effort has been expended for the prevention, control and/or elimination of infectious diseases.

Despite the continued resources and efforts put into their prevention, infectious diseases persist and constitute a major part of disease burden in developing countries. They continue to impede social and economic development and to affect disproportionately poor and marginalized populations and will therefore be major hindrances for achieving the Millennium Development Goals (MDG).

For several diseases the predominant problem is the lack of effective and affordable control measure. The principal outputs needed from research for this group are new and improved control tools and implementation strategies while other groups require more emphasis on the upstream of the research and development pipeline.

Numerous challenges remain:

- To better understand the bio-social, economic and political determinants for the persistence of the burden of communicable diseases.
- To capitalize on, or translate, the new knowledge being generated through modern science, such as genomics, to further develop new products (drugs, vaccines and diagnostics) that are acceptable, affordable, and applicable to the circumstances that prevail in developing countries.
- To ensure that appropriate evidence is generated to assist countries in defining how best to use these products and new methodologies and evaluate them for inclusion into policy.
- To identify mechanisms for scaling up those methodologies worthy of inclusion in policy.
- To build and utilize appropriate capacity in developing countries so that advances in knowledge and technology can be assimilated and utilized in developing countries in a sustainable manner; and
- To increase the awareness among resource contributors and development actors on the need for and role of health research to achieve the Millennium Development Goals and to mobilize the resources required.

GOAL

To foster research activities, generate knowledge, and create essential tools for preventing and controlling communicable diseases, with emphasis on but not limited to neglected diseases.

OBJECTIVES

To strengthen the capacities of endemic countries to use research to improve existing as well as develop new tools and approaches for preventing, diagnosing, treating, controlling, and eliminating communicable diseases, with emphasis on targeted diseases.

STRATEGIC APPROACHES

Establishing a comprehensive regional research development strategy that is based on a sound analysis of the Region's research priorities, defining the most critical areas of research within communicable diseases with emphasis on diseases targeted by UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases along with other neglected diseases, and where appropriate, across multiple diseases.

Organizing, funding, and managing research activities that take into account new knowledge on communicable diseases prevention, control, and elimination needs.

Placing particular emphasis on extending the scope of the research agenda so that it can better support implementation of disease prevention, control, and/or elimination programs as well as policies.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. New and improved intervention methods for applying existing and new tools at clinical and population levels developed and validated.	. Number of new and improved intervention methods validated for prevention, diagnosis, treatment, or rehabilitation, for the population affected by infectious diseases	0	2
2. New and improved public health policies and strategies framed and validated.	. Number of new and improved strategies and policies validated and recommended for use	0	1
3. Partnerships established and support provided for strengthening the capacity for research and its application in endemic countries.	. Number of institutions in key countries with developed capacity to propose and implement relevant research activity.	3	5
	. Proportion of significant research produced by endemic countries	30%	35%
4. Adequate technical information and research guidelines accessible to partners and users.	. Number of regional research priority-setting reports for neglected infectious diseases published	0	2

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	470,000	4,087,000	4,557,000
2006-2007	559,700	4,958,000	5,517,700
Of which:			
Country	52,600	991,600	1,044,200
Subregional	0	0	0
Regional	507,100	3,966,400	4,473,500

EPIDEMIC ALERT AND RESPONSE

ISSUES AND CHALLENGES

The threat posed by new, emerging, and reemerging infectious diseases has been given considerable attention in recent years. The magnitude of the problem is illustrated by the appearance of several new pathogens causing disease of marked severity, such as avian influenza (H5N1), arenaviruses, hantaviruses, and West Nile virus. Simultaneously, old pathogens, such as dengue hemorrhagic fever and yellow fever, have reemerged and are having considerable impact in the Americas. In addition, microorganism mutations leading to drug- and multidrug-resistant strains of *M. tuberculosis*, enterobacteria, staphylococci, pneumococci, gonococci, and malaria parasites have been occurring continuously and are becoming major obstacles to the control of these infections.

These also threaten regional and global health security because they frequently and unexpectedly challenge national health services and disrupt routine control programs, diverting attention and funds. Some of these infections exhibit a focal geographic distribution, whereas others are widely dispersed and, in some cases, are global in their extent. Outbreaks and epidemics do not recognize national boundaries and, if not contained, can rapidly spread internationally. Zoonosis represents the main presentation of emerging infectious diseases.

Unverified and inaccurate information on disease outbreaks often results in excessive reactions by both the media and politicians, leading to panic and inappropriate responses, which in turn may result in significant interruptions of trade, travel and tourism, thereby placing further economic burden on affected countries.

Preparedness is critical to improving health security. National alert and response systems should complement ongoing surveillance of important diseases, and also function effectively to provide information to guide interventions. To be sustainable, such systems should be integrated into national disease surveillance.

Subregional surveillance networks are set up to provide for reliable and rapid laboratory diagnostic support as a prerequisite for effective and prompt response to any outbreak. However, at present many outbreaks remain undiagnosed. Inability to determine the etiology of outbreaks has hampered early interventions, leading to enhanced morbidity and mortality which can be averted. Funding of sub-regional surveillance networks is a major obstacle to their active and effective operation.

The revised International Health Regulations provide a powerful tool for harmonizing public health action among Member States and a framework for the notification, identification and response to public health emergencies of international concern. The regional and subregional integration systems in the Americas represent legitimate fora to implement the IHR.

Despite considerable progress recently, major challenges for the biennium include: the need for strengthened regional partnership; the need to strengthen subregional networks including their resource base; the need to assess, update and implement national, regional, and global surveillance and containment strategies for known epidemic diseases and exploit new tools and knowledge; the reinforcement of mechanisms to detect, verify and respond rapidly and effectively to unexpected outbreaks and epidemics at local, national, regional, and international levels; the development, implementation and evaluation of national plans of action for epidemic alert and response integrated into national health systems, and, as far as possible, using a multidisease/syndromic approach; and the implementation of the revised International Health Regulations to provide a regulatory framework for global health security..

GOAL

To work towards global health security and foster action to reduce the impact of communicable disease epidemics on the health and social and economic well-being of all people worldwide.

OBJECTIVES

To ensure that Member States and the international community are better equipped to detect, identify, and respond rapidly to threats to national, regional, and global health security arising from epidemic-prone and emerging infectious diseases of known and unknown etiology, and to integrate these activities with the strengthening of their communicable disease surveillance and response systems, national health information systems, and public health programs and services of Member States.

STRATEGIC APPROACHES

- Strengthening regional surveillance networks for emerging and reemerging infectious diseases (EID) in the Americas, including through resource mobilization.
- Sustaining national and subregional interest and commitment for epidemic alert and response.
- Supporting policy and development of regional and national infrastructure for epidemic alert and response in accordance with the global strategy.
- Setting up appropriate mechanisms to implement the revised International Health Regulations.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Effective partnerships sustained through active subregional EID alert and response networks and adequate resources mobilized to support them.	• Number of operational subregional EID alert and response networks	3	4
	• Level of financial support for epidemic alert and response mobilized through partnerships	75%	10% increase
2. Subregional strategy formulated and/or updated for detecting and responding to regional health security in close collaboration with PAHO/WHO Collaborating Centers and international partners.	• Number of new or updated subregional plans for EID alert and response	3	4
3. Member States will be adequately implementing national plans for strengthening surveillance epidemic-prone diseases and enhancing readiness for response according to International Health Regulations guidelines.	• Proportion of countries of the Americas that are implementing national plans for strengthening surveillance of targeted major epidemic-prone diseases and enhancing readiness for response	26 %	60%
4. Procedures established for the administration of the revised International Health Regulations, and Member States supported for the implementation of the revised Regulations.	• Proportion of countries having implemented or starting to implement required core capacities for compliance with the Regulations	30%	80%
5. Subregional strategy formulated and/or updated for detecting and responding to regional health security in close collaboration with PAHO/WHO Collaborating Centers and international partners.	• Proportion of reported outbreaks that were investigated or followed up and verified through collaboration between Member States, the Secretariat, and partners in the Outbreak Alert and Response Network	30%	70%

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	1,292,000	5,000,000	6,292,000
2006-2007	2,144,900	5,422,000	7,566,900
Of which:			
Country	1,271,400	1,897,700	3,169,100
Subregional	0	500,000	500,000
Regional	873,500	3,024,300	3,897,800

MALARIA

ISSUES AND CHALLENGES

Malaria is endemic in 21 countries of the Region. During the past decade, approximately 1 million cases were reported annually. The disease represents an important social and economic burden to the population at risk, primarily those in the poorer communities. *Plasmodium falciparum* resistance to antimalarials has been reported. The Region faces the need to strengthen countries' capabilities to detect and monitor the resistance phenomenon. In countries where transmission has been interrupted, there is need to maintain surveillance to prevent reintroduction. All 21 endemic countries adopted the Roll Back Malaria initiative launched in 1998 and are implementing the Global Malaria Control Strategy.

One of the targets of the United Nations Millennium Summit is to combat malaria, and the decade 2001-2010 has been declared the decade to Roll Back Malaria in Developing Countries. While funding is available for qualifying countries from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, some countries need support in preparing proposals for these resources. Technical coordination and cooperation is also needed so that resources, once available, can be effectively and efficiently implemented. In order to make better progress, the feasibility of expanding the scope of the Global Malaria Control Strategy also needs to be determined in order to synergize the present scope of work with other ongoing or planned interventions, such as integrated vector management (IVM).

GOAL

To halve the burden of malaria by 2010 and reduce it further by 2015—the Millennium Development Goal states "halt and begin to reverse the incidence of malaria."

OBJECTIVES

To facilitate access of populations at risk to effective treatment of malaria; to promote the application of preventive measures against malaria for populations at risk; to build capacity for malaria control; to strengthen malaria-surveillance systems, and the monitoring and evaluation of control.

STRATEGIC APPROACHES

Following the elements of the Global Malaria Control Strategy through the Roll Back Malaria Initiative: supporting health ministries in essential public-health functions related to malaria prevention and control; promoting synergies with related health programs, especially those for environmental health, pharmaceuticals, and maternal and child health; promoting the participation of communities and civil society; engaging the private sector in delivery of prevention and treatment; identifying best practices, partnerships, and financing mechanisms for extending interventions; preparing tools and support measures for district-level management; expanding PAHO/WHO capacity at country level, together with HIV/AIDS and tuberculosis programs; and promoting collaboration among countries.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Malaria prevention and control strategy implemented and expanded in endemic countries, especially to prevent reintroduction of transmission where it has been interrupted.	. Of the 21 malaria endemic countries, number of countries implementing all components of the global malaria control strategy within the context of the Roll Back Malaria initiative	17	20
	. Number of countries undertaking joint activities in areas of common epidemiological interest	8	12
	. Of 21 malaria endemic countries, the number of countries that will have reduced malaria burden by over 25% in comparison with 1998	12	15

		. Number of countries with high P. falciparum burden implementing antimalarial treatment policies based on evidence of efficacy	6	8
2.	System of surveillance and routine monitoring of malaria and control measures functioning in malaria endemic countries.	. Number of endemic countries using epidemiologic indicators for monitoring and evaluating disease burden	15	18
		. Of the countries where malaria transmission has been interrupted, the number undertaking surveillance and reporting imported malaria cases	20	24
		. Number of endemic countries providing annual information on morbidity, mortality, progress, and outcomes	18	20
3.	Advocacy on the importance of malaria and efforts made to increase resources available for its control.	. Number of eligible malaria-endemic countries with approved PAHO-supported proposals to the Global Fund to Fight AIDS, Tuberculosis, and Malaria	6	8
		. Number of malaria endemic-countries supported by the Amazon Network for the Surveillance of Antimalaria Drug Resistance (RAVREDA)	8	10

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	904,700	12,606,000	13,510,700
2006-2007	1,101,900	12,909,000	14,010,900
Of which:			
Country	124,400	8,668,900	8,793,300
Subregional	0	0	0
Regional	977,500	4,240,100	5,217,600

TUBERCULOSIS

ISSUES AND CHALLENGES

Despite well known interventions, tuberculosis (TB) continues to be a major public health problem in the Region, with 230,000 reported cases annually. The internationally recommended tuberculosis-control strategy, DOTS (Directly Observed Treatment, Short-course Drug Therapy), is widely proven, highly cost effective, and coverage is expanding. However, further expansion of coverage is necessary, and both detection and cure rates need to be improved. Furthermore, special efforts are also needed to improve access for neglected and difficult-to-reach populations, including prisoners and indigenous groups.

The Stop TB initiative, a partnership for global action, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria both have financial and technical partners in the Region, and focus upon priority countries—those countries with high incidence rates, high case-detection rates, or a poor record of scaling-up DOTS implementation. Social mobilization is needed to tackle TB within high-prevalence countries. Technical support is also needed to ensure the effective and efficient use of the existing resources, and to promote other countries' access to financial support.

The long-term, successful response to the illness depends on expanded financial and political commitment, increased access to quality laboratory services, uninterrupted drug supplies, high patient compliance with long treatment periods, and effective reporting/follow-up systems. The effective expansion of DOTS demands a multi-sectoral and sustained response to address the social and environmental factors that increase the risk of developing TB. This requires TB control to be viewed broadly, as a component of international, national, and local strategies to alleviate poverty, with due consideration given to the right of every TB patient to access treatment.

Above and beyond the historical challenges of tuberculosis, the recent emergence of the dual TB-HIV epidemic together with multi-drug resistance (MDR) has added to the complexity of TB control and thus requires new strategies. In response to this increased burden, tuberculosis is prominent among the Millennium Development Goals' targets, with specific indicators relating to prevalence, death rates, detection, and persons cured.

GOAL

To assist all countries in reaching the global control targets of 70% detection and 85% treatment success rates and to sustain this achievement in order to halve the prevalence and death rates associated with tuberculosis by 2015.

OBJECTIVES

To introduce and accelerate sustainable DOTS expansion, especially in neglected populations.

STRATEGIC APPROACHES

- Closely monitoring DOTS coverage throughout the Region to facilitate its expansion.
- Promoting advocacy and national mobilization campaigns to sustain political commitment and secure financial resources.
- Promoting innovative approaches, such as PAL (Practical Approach to Lung Health) and PPM (Public–Private Mix for DOTS) and developing new policies and strategies to deal with the issue of TB-HIV coinfections.
- Scaling-up the DOTS-Plus strategy in selected countries with multidrug-resistant tuberculosis.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Expanded DOTS coverage throughout the Region.	. Percentage of population covered by DOTS throughout the Region.	73%	90%
	. TB case detection rate	44%	70%
	. Treatment success rate under DOTS	80%	85%
2. Increased access to treatment for neglected populations, and TB-HIV and MDR-TB patients.	. Number of countries with plans of action targeting incarcerated populations	6	12
	. Number of countries with active programs targeting prison inmates	4	9
	. Number of countries with plans of action targeting TB-HIV patients	10	16
	. Number of countries with active programs targeting TB-HIV patients	6	12
	. Number of countries with national plans of action targeting indigenous populations	4	8
	. Number of countries with active programs targeting indigenous populations	2	5
	. Number of countries applying DOTS-Plus strategy	6	12
3. Improved surveillance and program evaluation systems in place.	. Proportion of countries submitting accurate annual epidemiological surveillance reports	90%	98%
	. Proportion of countries submitting monitoring reports concerning HIV in TB patients	10%	40%
	. Proportion of countries presenting financial reports regarding TB programs	10%	50%

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	1,282,400	5,832,000	7,114,400
2006-2007	1,313,900	5,973,000	7,286,900
Of which:			
Country	446,700	2,987,000	3,433,700
Subregional	0	0	0
Regional	867,200	2,986,000	3,853,200

HIV/AIDS

ISSUES AND CHALLENGES

More than 2 million people are living with HIV/AIDS in the Region of the Americas. The spread of the HIV epidemic is increasing; an estimated of around 290,000 persons contracted the infection during 2004. About half of these infections are acquired by young people, most of them in the range 15-24 years. Geographically, countries in Central America, the English-speaking Caribbean, and the Hispaniola Island (Dominican Republic and Haiti) are the most affected by the epidemic. Various epidemiological patterns can be observed throughout LAC, but most infections are due to unprotected sexual intercourse, whether homosexual or heterosexual. Injecting drug use is a significant and growing factor in HIV transmission in several countries. Other sexually transmitted infections, in addition to being a public health problem per se, contribute to the transmission and further dissemination of HIV.

Whereas the reduction of new infections remains a paramount component of national plans and programs, the increasing access to treatments that are effective in reducing morbidity and mortality, the continuous increase in the number of people living with HIV/AIDS, and concerns about global health equity have created a demand for services intended to meet the medical, social, and economic needs of people living with HIV/AIDS (PLWHA) and their families and caregivers. All these services configure the framework of the approach known as "comprehensive care." Within this framework, STI control becomes a major preventive strategy to reduce HIV transmission.

As the Millennium Development Goals were adopted by 191 governments in September 2000, HIV/AIDS was recognized as a specific problem that required special attention globally; and in June 2001, the Secretary-General of the United Nations conveyed a Special Session of the General Assembly (UNGASS) to urge all governments to heighten their responses to HIV/AIDS. In September 2003 a follow-up session was held at which progress on the UNGASS commitments was evaluated. Heightened political commitment in the Americas was conspicuous at a Special Summit held in Monterrey, Mexico, in January 2004, in which attending Heads of State pledged their countries would provide universal treatment to all those in need, or treatment of at least 600,000 people by the end of 2005. Likewise, the WHO "3 by 5" initiative, has provided important opportunities for a more focused response on the part of PAHO, and for linking HIV/AIDS to health systems strengthening. Increased financial resources available to most countries through the Global Fund to Fight AIDS, TB, and Malaria and the existence of successful interventions to control HIV transmission, have set the stage for rapidly scaling-up comprehensive care and treatment, as well as for rekindling primary prevention efforts, in the AMRO Region.

Nevertheless, despite significant progress in many countries, overall progress in reducing the growth and impact of HIV/AIDS has not been as effective as expected. Renewed and better coordinated efforts are urgently required, especially in the areas of sustained prevention efforts, reduction of discriminatory practices, and greater access to comprehensive care, support, and treatment.

GOAL

To halt or have begun to reverse the spread of HIV/AIDS by 2015.

OBJECTIVES

To improve and expand the national and intercountry technical and managerial capacity to prevent and control HIV/AIDS/STI.

STRATEGIC APPROACHES

- Supporting the development of strategic and sectoral plans, as well as extrabudgetary initiatives for the prevention and control of HIV/AIDS/STI, at the regional, subregional, country, intercountry, and local levels.
- Placing special emphasis on groups with increased vulnerability.
- Working with partners and stakeholders, such as the Global Fund to Fight AIDS, TB, and Malaria and the United States President's Emergency Plan for HIV/AIDS Relief (PEPFAR) on areas of care and treatment. Promoting improved and simplified methods and tools that can be implemented at the community level in a decentralized manner. Using STI services as entry points for HIV/AIDS. Integrating maternal syphilis screening within prevention of mother-to-child transmission (PMTCT) programs, as a first step towards elimination of congenital syphilis. Seeking to enhance the quality of

training programs for the delivery of ART, the accreditation of training institutions, and the continued supply of well-trained human resources at all levels.

- Working with partners to reduce prices of second-line medicines through the use of cost-effective mechanisms, such as the Revolving Fund for Strategic Public Health Supplies.
- Supporting the implementation of the Central American Second-Generation Surveillance Plan for HIV/AIDS through training and technical cooperation in collaboration with other partners, including the World Bank, Centers for Disease Control, and United States Agency for International Development.
- Providing high-quality technical guidance to national HIV/AIDS programs and to PAHO focal points at the country level through the work of the Technical Advisory Committee on HIV/AIDS, founded in 2005. Supporting resource mobilization efforts for HIV/AIDS programs in countries.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Visible leadership and commitment to urgent action to reach the goal of universal access to antiretroviral therapy (ART) at national and regional levels.	. Number of countries that have in place legislation and/or policies to reduce stigma and discrimination against people living with HIV/AIDS	10	25
	. Number of countries assisted by PAHO to implement innovative HIV/AIDS communications strategies	20	30
	. Number of countries integrating a gender approach into HIV/AIDS programs	5	15
	. Number of consultations with United Nations, development partners, and other regional bodies in which PAHO leads deliberations on comprehensive care and treatment of HIV/AIDS	5	10
2. Health systems/services strengthening, including the adaptation and application of appropriate tools, supported.	. Number of countries assisted by PAHO to implement operational scaling-up plans	15	25
	. Number of countries assisted by PAHO to integrate care and treatment into primary care services and with other health services, including antenatal services, MCH, TB, etc	15	25
	. Number of countries that develop or update comprehensive care and treatment plans using PAHO guidelines	15	30

		. Number of countries implementing models of nonconventional entry points developed in collaboration with PAHO	2	10
3.	The effective and reliable supply of HIV-related medicines and other commodities supported.	. Number of countries that adopted and or adapted guidelines, protocols, and recommendations on care interventions and treatment schemes developed or facilitated by PAHO	20	30
		. Number of training centers in the Region provided with technical support to implement standardized training systems to support care and treatment	5	10
		. Number of laboratories assisted by PAHO to scale up treatment and monitor patient outcomes	3	6
		. Number of operational research studies under way to foster evidence-based interventions in health care delivery	2	5
		. Number of countries with updated policies to provide universal access to HIV/AIDS medicines	5	20
		. Number of countries implementing PAHO/WHO norms in good procurement, storage, and distribution practices	3	15
4.	The prevention of sexually transmitted HIV, with a focus on vulnerable groups supported, and the prevention of sexually transmitted infections (STI), including congenital syphilis, strengthened.	. Number of new models of prevention for vulnerable groups developed and tested in countries with the support of PAHO	3	5
		. Number of countries trained in new models of prevention for vulnerable groups	6	18
		. Number of countries implementing new models of prevention of sexually transmitted HIV and STI with the support of PAHO	6	18
		. Number of countries implementing, with the support of PAHO, training plans to increase the capacity of health teams to carry out prevention activities	2	8
		. Number of countries that have eliminated congenital syphilis with PAHO support	5	20

	. Number of countries with updated policies and programs linking prevention activities to care and treatment	5	15
5. The production of strategic information and dissemination of the lessons learned supported.	. Number of countries and institutions that will have strengthened their surveillance systems with the support of PAHO	8	16
	. Number of countries that, with the support of PAHO, updated their health information systems to reflect HIV/AIDS AIDS prevalence and ART needs	3	10
	. Number of countries supported by PAHO for their national capacity building in the production of strategic information	8	16

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	2,041,200	29,923,000	31,964,200
2006-2007	2,101,700	35,663,000	37,764,700
Of which:			
Country	386,400	20,000,000	20,386,400
Subregional	0	663,000	663,000
Regional	1,715,300	15,000,000	16,715,300

SURVEILLANCE, PREVENTION, AND MANAGEMENT OF CHRONIC DISEASES

ISSUES AND CHALLENGES

Non communicable disease (NCD) contributes almost 50% of the disability-adjusted life years lost (DALYS) in the countries of Latin America and the Caribbean. Of the approximately 3 million deaths which occur annually in the Region, 1.7 million are due to noncommunicable diseases. Approximately 45% of these deaths are caused by cardiovascular disease, of which ischemic heart disease and stroke are the leading causes. Cancer accounts for 20% of mortality, the majority attributed to stomach and lung cancer. Yet the incidence and mortality from cervical cancer is among the highest in the world and breast cancer incidence is increasing in almost all countries and surpassing cervical cancer in many of them. Although diabetes officially constitutes only 5% of deaths, it is underreported given that the recorded cause of death is usually one of it complications, such as cardiovascular and renal disease. The fact that cardiovascular diseases are the leading cause of premature mortality among women in the Region is noteworthy.

Despite the extent of the burden of NCDs, the public health infrastructure of the Region is more suited to infectious disease and reproductive health. Successful NCD programs require an intersectoral approach and major changes to the health care system. Resources for NCDs are limited at all levels, national through global. The challenge is to develop sustainable programs with a population basis that can extend benefits to vulnerable populations.

Integrated programs for noncommunicable diseases, particularly cardiovascular disease, have proven successful in several developed countries. Models are being adapted to our Region but require careful evaluation of their implementation to ensure effectiveness. Otherwise, countries may spend their scarce health resources on initiatives of unknown efficacy and effectiveness.

In addition, it is important to strengthen the regulatory role of the State since actions at the policy level reach a larger segment of the population and tend to be more effective when combined with individual-level action from health services.

PAHO has sponsored the CARMEN (strategies to reduce multifactor NCDs) Network to share information on integrated NCD prevention and control, which promotes action at three levels: policy, community, and health services. Nonetheless, a major hurdle to program development is that many countries still do not have basic information on the burden that NCDs and its risk conditions, and traditional data collection methods for health statistics are not suitable to assess the magnitude for NCDs. New surveillance systems are needed as well as regular analysis of their data for decision-making, programming, and evaluation.

At the level of health services, chronic diseases demand an approach that is quite different from that of acute diseases that can be resolved with limited contacts with the health care system. To address this problem a new model for care of chronic conditions has been evaluated resulting in improved care for persons living with diabetes at a very low marginal cost. The model is based on full participation and empowerment of persons living with the disease. At the same time, care is delivered as a team, in which the medical intervention is only one of the components.

Technical cooperation will focus on building public health capacity to develop the various facets of integrated NCD prevention and control programs.

GOAL

To reduce the burden of premature mortality and morbidity related to chronic, noncommunicable diseases.

OBJECTIVES

To assist countries in developing a public health approach to NCD prevention and control, based on appropriate health information, and in identifying attainable outcomes leading to the reduction of the burden on NCDs.

STRATEGIC APPROACHES

- Strengthening networks within and among countries, such as CARMEN, and promoting dialogue and sharing of best practices among stakeholders by involving government agencies, academic institutions, nongovernmental organizations, and civil society in NCD prevention and control strategies.
- Developing methodological approaches for the evaluation of new interventions and technologies, with a focus on programs addressing cardiovascular disease, diabetes, and cancers, to assess their cost-effectiveness in different contexts.
- Providing methods, tools, and technical assistance to Member States to strengthen local surveillance systems regarding the burden of NCDs and risk conditions; supporting the use of surveillance data for public health programming and policy formulation.
- Building national capacity to implement integrated prevention and control programs with a public health approach at all levels. Providing support and technical assistance to Member States in implementing population-based management models in primary health care settings for the detection and control of diabetes, hypertension, cervical cancer and other chronic diseases.
- Linking technical initiatives conducted at the subregional level with existing subregional institutions to provide sustainability.
- Developing new mechanisms for knowledge management and information dissemination by using information technology and intercountry cooperation, including the involvement of Collaborating Centers. Establishing strategic partnerships to mobilize resources and assist with technical cooperation activities.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Effective guidance and strategies provided for integrated NCD prevention programs, within the framework of the CARMEN network.	. Number of countries that have an approved plan of action for integrated NCD prevention and control	12	22
	. Number of countries implementing plans of action	12	18
	. Number of countries that have established training programs on NCD prevention and control (e.g. CARMEN schools)	1	1
2. Interventions and programs evaluated for integrated prevention, early detection, and management of NCDs.	. Number of countries participating in effectiveness evaluation projects of NCD prevention and control interventions	0	5
	. Number of countries using regulations and policies as a component of NCD prevention and control	0	3

3.	Local surveillance systems for NCDs and risk conditions established, with particular emphasis on behaviors.	. Number of countries that produce periodic reports on NCD and risk factor surveillance	4	8
		. Number of countries with information systems to monitor NCDs, their risk factors, and health services	4	4
4.	Population-based management models within primary health care, for the detection and control of chronic conditions applied at demonstration sites, with particular emphasis on diabetes, hypertension, and cervical cancer.	. Number of demonstration sites utilizing a package of change to improve care for diabetes, hypertension, and cervical cancer	1	4
		. Number of demonstration sites which have disseminated the results of the application of the population-based management model	1	4
5.	Increased advocacy for country investment in NCD prevention and control, and resource mobilization to support the development and evaluation of programs and plans for the prevention and control of noncommunicable diseases.	. Percentage of countries with a budget line for NCD prevention and control in their national health budgets	30%	60%
6.	Normative and operational strengthening of ocular health programs promoted within the framework of health service development.	. Number of countries that have formulated standards and policies for ocular health based on the knowledge generated from rapid surveys	0	2
		. Number of countries that have initiated, strengthened, or reviewed programs for the delivery of ocular services	1	4

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	4,643,700	5,104,000	9,747,700
2006-2007	5,268,000	5,217,000	10,485,000
Of which:			
Country	2,838,800	1,282,000	4,120,800
Subregional	374,600	2,091,600	2,466,200
Regional	2,054,600	1,843,400	3,898,000

HEALTH PROMOTION

ISSUES AND CHALLENGES

Health promotion is an essential public health function, yet most countries in the Region report low performance in this area and in social participation.

Improving capacity and performance in health promotion requires enabling individuals and communities to increase control over the determinants of health and social inequities, and involves all sectors of society in establishing healthy public policies, creating supportive environments, and reorienting health services.

To ensure that health services address the needs of individuals and of communities within their cultural environment, particularly of the poor and vulnerable, the health promotion strategy should be the guiding principle for health system development and strengthening health reform efforts in countries.

Policies and practices to promote health should be an integral part of country health and development planning, emphasizing the use of health promotion strategy in strengthening primary health care and enabling the development of social networks and social support systems, mainly targeted to priority populations in prioritized countries and settings.

The elderly are one such priority population, for which the proportion without a pension, income, or savings has increased dramatically throughout the Region. An estimated 80% are now considered to lack social or health protection as well as access to quality services.

The range of issues addressed by the health promotion strategy requires the integrated action of multi-disciplinary teams at all levels. Systematic collection, evaluation, and dissemination of best practices still need to be strengthened to highlight the effectiveness of health promotion.

Greater efforts are needed to highlight the linkages between health and its determinants and the imperative of concerted action and accountability of various sectors of government, and among government, civil society, and communities in the pursuit of health and social well-being.

GOAL

To improve equity in health, reduce health risks, promote healthy lifestyles and settings, and respond to the underlying determinants of health.

OBJECTIVES

To fully engage all relevant public and private sectors and civil society in promoting health, fostering healthy public policies, reorienting services, reducing social and environmental risk factors, and promoting healthy lifestyles and supportive environments, where people live, study, work, and play.

STRATEGIC APPROACHES

Mainstreaming health promotion as a crosscutting theme at PAHO, with increased capacity in the integration of the health promotion strategy into all relevant areas of work, along with an emphasis on priority populations, countries, and settings.

Advocating for greater commitment among partners at regional, subregional, and national levels for the promotion of health, and increased investment in capacity building for public policies, reorientation of health services, and concerted intersectoral action to address health determinants, equity, and the Millennium Development Goals.

Advocating for the inclusion of all key components of the health promotion strategy in national strategic and programmatic health and development agendas (Resolution CD43.R11, 2001).

Enhancing country-level capacity in designing, planning, setting targets, implementing, and evaluating multidisciplinary health promotion strategies and interventions to demonstrate effectiveness and contribute to sustainable local development and urban health.

Enabling networks of local authorities and civil society in promoting good health in homes, schools, workplaces, communities, cities, and municipality settings.

Systematically collecting, documenting, and widely disseminating best practices and evidence of health promotion effectiveness, especially in addressing priority populations, countries, and settings.

Developing and strengthening partnerships across sectors at the global, regional, and national levels, including civil society, using participatory methods in health education to foster healthy, supportive, and

protective environments and to enable investment and adoption of the health promotion strategy as a guiding principle in planning for development.

Supporting regional and subregional integration processes (RESSCAD, SICA, REMSAA, CAN, MERCOSUR, NAFTA, and others) in their initiatives to incorporate the health promotion strategies.

Building capacity, especially among Collaborating Centers, to evaluate and gather evidence of best practices and lessons learned and strengthen the use of information and surveillance in planning effective health education and health promotion interventions.

Developing and supporting the implementation of integrated community care of the elderly (ICCE) strategies.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Improved mainstreaming of the health promotion strategy within the Secretariat.	. Establishment of mechanisms for interprogrammatic coordination and planning of health promotion throughout the PAHO Secretariat	None	Systems mechanisms established
	. Development of criteria to evaluate the incorporation of the health promotion strategy in PAHO's technical cooperation portfolio	None	Criteria established
	. Number of PAHO Areas, Units, and Centers demonstrating good practices integrating health promotion framework and strategies	None	Criteria in use
2. Country capacity strengthened to foster healthy public policy with active participation of civil society and community-based organizations.	. Number of countries receiving support in public policy development to address and improve the determinants of health and equity	2	6
	. Number of health promotion 'centers of excellence'	6	12
	. Number of countries receiving support from PAHO in establishing mechanisms for community participation and public debate in support of healthy public policies	3	6
	. Number of countries using PAHO models, guidelines, tools, and resources to develop, implement, and evaluate healthy public policies with social participation	2	4

3. Country capacity improved for the design and implementation of countrywide plans of action to effectively promote health.	. Number of countries receiving PAHO support in the design and strengthening of countrywide plans of action with health targets, including the MDGs, to promote health	2	6
	. Number of subregional integration bodies receiving PAHO support in developing common health promotion plans of action	2	6
	. Number of priority countries using PAHO guidelines, methods, and tools for the monitoring and evaluation of health promotion plans of action	2	5
	. Number of PAHO reports document-ing good practices in health promo-tion, collected, published, and disseminated	3	6
4. Reorientation of health services to incorporate health promotion principles into health services management	. Number of PAHO countries implementing models and guidelines for reorienting health services	2	6
	. Number of PAHO countries incorporating community representatives in health services committees and working groups	2	6
	. Number of priority countries with intersectoral committees to implement new health services models that include health promotion strategies	2	6
	. Number of countries with PAHO support in training on health service providers, especially family health and/or community health teams in health promotion	2	6
	. Number of countries that have adapted and implemented integrated approaches for community health care of the elderly with PAHO's support	4	6

5. Country capacity enhanced to engage networks of local authorities, relevant sectors, and community organizations in creating healthy and supportive municipalities, cities, and communities (MCS).	. Number of priority countries developing, implementing, and evaluating healthy municipalities, cities, and communities (MCS) to address the health targets and the MDGs	2	6
	. Number of academic institutions in different countries engaged in supporting MCS processes in the countries	3	6
	. Number of regional and national networks developing healthy and supportive cities, municipalities, and communities	3	9
	. Number of countries receiving PAHO support (directly or indirectly through technical cooperation with other countries) to evaluate the MCS	6	10
6. Country capacity strengthened to promote healthy settings and lifestyles, fully engaging young people in and out of school, as well as teachers, parents, and communities.	. Number of priority countries receiving PAHO support in the implementation and evaluation of health promoting schools (HPS) with participation of stakeholders	3	8
	. Interagency partnerships actively supporting the HPS initiative	2	4
	. Number of priority countries receiving PAHO support to develop HPS plans of action with health targets and the MDGs	3	5
	. Number of countries receiving PAHO support to strengthen the major health-related risk factors among students	2	6
	. Number of academic institutions engaged in supporting HPS initiatives	3	8
	. Number of countries with national networks of health-promoting schools		6

7. Improved research, monitoring, and evaluation of health promotion strategies, interventions, best practices, and effectiveness.	. Number of PAHO/WHO Collaborating Centers that develop/disseminate criteria guidelines/tools for monitor-ing and evaluating the effectiveness of healthy settings to sustain local and urban development	4	6
	. Number of PAHO/WHO Collaborating Centers that collect and consolidate best practices, lessons learned, and results of health promotion effectiveness	4	6
	Number of PAHO/WHO Collaborating Centers engaged in developing models, guidelines, and tools, and training in health promotion research and evaluation	8	12

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	8,192,200	3,109,000	11,301,200
2006-2007	7,604,200	3,319,000	10,923,200
Of which:			
Country	3,836,200	1,943,000	5,779,200
Subregional	730,700	34,500	765,200
Regional	3,037,300	1,341,500	4,378,800

MENTAL HEALTH AND SUBSTANCE ABUSE

ISSUES AND CHALLENGES

Mental and neurological disorders are responsible for a significant part (24%) of the burden of disease in the Americas, and this contribution is expected to increase in the next few years, particularly in the developing countries. These figures do not include the contribution of alcohol, which is the leading risk factor for the burden of disease in the Region of the Americas, more than tobacco or lack of sanitation. In the Region, more than 300,000 deaths annually are directly attributable to alcohol consumption; and among those, three-fourths are males in Latin America and the Caribbean. The development of actions to control the use of illegal substances is also justified by their impact on the burden of disease and their association with problems of violence and social exclusion.

Since the Caracas Declaration in 1990, significant progress was made in the adoption of national mental health policies and legislation in the Region. At the same time, scientific progress made possible the development of new treatments and interventions recognized as effective in treating mental disorders and disorders related to alcohol and other drug abuse.

However, despite these advances, most of the populations (more than 80% according to the national survey recently completed in Mexico) do not have access to available mental health treatments and interventions; and mental health care continues to be based on old psychiatric institutions and involve serious violations of patients' human rights. The reasons for this situation include constraints on the implementation of mental health policies and plans, and lack of resources. Only three Latin American countries (15.5%) implemented more than 50% of their national mental health programs, and 42.1% of these countries do not have regular funds for the implementation of these programs.

To respond to these issues and challenges, a resolution on mental health was adopted by the PAHO Directing Council in 2001, based on the principles and recommendations of the *World Health Report 2001*. At the same time, several initiatives were undertaken to strengthen technical cooperation in the implementation of mental health and substance abuse policies and plans.

GOAL

To reduce the burden of mental disorders, improve the mental health of the populations, and reduce the damage attributable to the use of alcohol and illegal drugs.

OBJECTIVES

To support the Member States in implementing policies and plans and adopting the necessary measures to reduce the burden of mental disorders, improve the mental health of the populations, and reduce the damage attributable to alcohol and illegal drugs.

STRATEGIC APPROACHES

Collecting and disseminating information on the magnitude, burden, determinants, and treatment of mental and neurological disorders and substance abuse; supporting countries in the implementation of comprehensive mental health and substance abuse policies and plans; strengthening country capacities to develop programs to treat and prevent mental disorders and to meet the specific mental health needs of vulnerable groups; protecting and advocating for the human rights of people with mental health problems and supporting actions to mitigate stigma and discrimination against them; and strengthening country capacities to develop mental health policy and services research.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Improved capacities in countries to collect and disseminate data relevant to support the development of cost-effective interventions and policies in the mental health and substance abuse area.	. Number of countries in which mental health and substance abuse information systems have been developed or improved	3	6
	. Number of countries where the prevalence and burden of mental disorders and substance abuse have been collected and analyzed	8	12
	. Number of countries where information on delivery of services for mental health and substance abuse has been collected and analyzed	19	34
2. Increased capacity in countries to develop research supporting the implementation of mental health policy and services.	. Number of people from Latin America and the Caribbean (LAC) trained in mental health and substance abuse research through PAHO involvement	31	80
	. Number of mental health and substance abuse studies supported in LAC	6	9
3. Strengthened capacity in countries to implement mental health policies and plans.	. Number of people from LAC trained in mental health planning and management	20	24
	. Number of countries where mental health plans were implemented with the support of PAHO	16	20
4. Countries assisted to develop and evaluate programs to prevent and treat mental disorders and to meet the special needs of vulnerable groups.	. Number of countries that have developed, with PAHO assistance, programs to improve the prevention and treatment of men.	4	8
	. Number of countries that have developed, with PAHO's assistance, programs to meet the specific mental health needs of vulnerable populations, including indigenous people.	9	13
5. Strengthened capacity in countries to develop new mental health legislation and protect the human rights of people with mental disorders.	. Number of countries that have reviewed or updated mental health legislation with PAHO support.	7	12
	. Number of countries that have developed specific measures to protect the human rights of people with mental disorders with PAHO support.	8	13

6. Countries assisted to develop and evaluate programs to prevent and treat substance abuse disorders and to meet the special needs of vulnerable groups.	. Number of targeted countries that have adapted alcohol policy guidelines developed with PAHO support, according to their specific needs.	2	4
	. Number of countries that have improved services for substance abuse disorders with PAHO support.	2	4

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	2,406,700	2,041,000	4,447,700
2006-2007	2,662,500	3,680,000	6,342,500
Of which:			
Country	762,600	170,000	932,600
Subregional	0	104,000	104,000
Regional	1,899,900	3,406,000	5,305,900

TOBACCO

ISSUES AND CHALLENGES

Although tobacco use as a consumer health problem is responsible for a large proportion of preventable morbidity and mortality in most countries (one-third of all cancer and cardiovascular deaths in the Americas, for example), very few countries in the Region have implemented effective tobacco control policies.

The tobacco industry maintains a powerful political influence in many countries, while civil society advocacy for tobacco control is weak. The many myths promoted by tobacco companies are often repeated by government officials and the media, demonstrating the success of their public affairs strategies. This situation presents an obstacle to building the political will of governments to implement effective tobacco control policies.

The Framework Convention on Tobacco Control (FCTC), adopted unanimously by the World Health Assembly in 2003, and signed by nearly all of the countries of the Americas, with 10 having approved its ratification, offers a strong regulatory framework for tobacco control and provides a unique opportunity to strengthen government and civil society capacity to implement effective policies and programs.

GOAL

To protect present and future generations from the health, social, environmental, and economic consequences of tobacco consumption and exposure to tobacco smoke.

OBJECTIVES

To strengthen the capacity of the countries of the Region to implement cost-effective tobacco control policies and programs through promotion of guidelines, evidence, and technical cooperation.

STRATEGIC APPROACHES

- Emphasizing the creation of smoke-free environments as a public health entry point for more comprehensive tobacco control approaches.
- Providing training to strengthen the capacity of communities (national or subnational, consumer and health professional organizations) to advocate for smoke-free environments and for governments to implement effective policies.
- Developing guidelines, information, and evidence to support the implementation of effective policies and programs.
- Promoting the implementation of the Framework Convention on Tobacco Control as an opportunity to assess and strengthen current national tobacco control policies and programs.
- Supporting and strengthening the capacity for research directly relevant to achieving policy goals, and surveillance to monitor progress toward those goals.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Smoke-free environments extended in the Region.	. Number of countries with smoke-free health and education sectors as evidenced by written policies or legislation.	5	15
2. Increased notification, acceptance, approval, formal confirmation or accession by Member States to the Framework Convention partners.	. Number of Member States that are parties to the Framework Convention.	6	11

3.	Increased production of surveillance data pertaining to youth tobacco use, exposure to second-hand smoke, and/or tobacco control and consumer health policies.	. Number of countries participating in the second round of the Global Youth Tobacco Survey (GYTS).	12	20
		. Number of countries that have updated the Pan American Tobacco Information Online System (PATIOS).	0	30
		. Number of countries that have completed the Environmental Nicotine Exposure Surveillance System (ENESS).	7	14

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	827,900	1,070,000	1,897,900
2006-2007	907,900	1,235,000	2,142,900
Of which:			
Country	20,300	65,000	85,300
Subregional	0	35,000	35,000
Regional	887,600	1,135,000	2,022,600

NUTRITION

ISSUES AND CHALLENGES

Good nutrition is a fundamental prerequisite for good health, individual and national development, and achievement of the Millennium Development Goals (MDGs) for maternal mortality, child survival, eradication of hunger, prevention of HIV/AIDS, and educational attainment. In the Region, the quality of food consumed is a greater problem than the quantity consumed. Poor dietary quality and increasingly sedentary lifestyles, coupled with inadequate sanitation cause growth failure early in life, micronutrient deficiencies throughout the life cycle, and nutrition-related noncommunicable diseases (N-NCDs) among school children, adolescents, and adults. Poverty, resulting in lack of access to nutritious foods and safe environments in which to be physically active and that limits the ability of individuals and communities to act positively on health information, underlies both growth failure among the young and premature disability and death among adults. It also underlies the reemergence of severe malnutrition in some countries.

Cost-effective interventions are available to address these nutrition-related problems and, if widely implemented, will significantly reduce mortality and improve the health and development of all persons throughout the life cycle. Some of these interventions depend on properly functioning health services; however, others—particularly those related to N-NCDs—depend on integrated actions with other sectors including agriculture, education, transportation, and urban planning. The active involvement of the community and civil society is important to the success of nutrition-related interventions. The private sector also has key roles of action and responsibility.

The Global Strategy for Infant and Young Child Feeding (WHA55.25) supports interventions to improve feeding practices, reduce malnutrition, and improve growth and development. Growth failure occurs during the first two years of life and results in stunting and underweight. The prevalence of irreversible stunting (failure to achieve adequate linear growth) is twice that of low weight, illustrating the importance of the quality of the diet as distinct from the amount of calories consumed. Anemia, a cause of poor mental development and educational attainment, affects up to 70% of infants and young children and 50% of 3 to 5 year-olds. Vitamin A and zinc deficiency are also prevalent, although nationally representative data are not available.

The short duration of exclusive breast-feeding and poor complementary feeding practices, lack of access to high-quality, iron-rich complementary foods, and inadequate environmental sanitation leading to a high prevalence of diarrhea, are the immediate causes of growth failure, anemia, and other micronutrient deficiencies. The recent Lancet series on child survival shows that interventions to promote breast-feeding—particularly exclusive breast-feeding for the first six months of life—and complementary feeding are two of the top three most cost-effective interventions to prevent child mortality.

Micronutrient deficiencies are important causes of birth defects, maternal mortality because of post-partum hemorrhage, infections, impaired physical and mental development, and poor physical/work productivity. Anemia affects about 40% of pregnant women and 25% of preschool children, with even higher levels of up to 60% of pregnant women on some Caribbean islands. Inadequate folate status causes serious birth defects such as anencephaly and spinal bifida. Other micronutrient deficiencies include vitamin B12 among older adults and B12 and zinc among children in populations that do not regularly consume animal products. These deficiencies lead to anemia, diarrhea, pneumonia, and malaria. While the number of households consuming iodized salt is high (90%) and a low proportion of individuals have insufficient iodine intake, there is the need to sustain the programs that have led to the virtual elimination of iodine deficiency, the leading preventable cause of mental retardation.

Interventions, specifically food fortification and administration of prophylactic supplements to control and prevent vitamin and mineral deficiencies, offer an opportunity to improve lives and accelerate development at low cost and in a relatively short time. However, there are major challenges to increase coverage of at-risk groups and manage supplies of supplements, increase access and availability of adequately fortified foods of good quality, and monitor and evaluate interventions.

The Global Strategy for Diet and Physical Activity (Resolution WHA57.17) is a call to arms about the global crisis of N-NCDs such as stroke, diabetes, cardiovascular disease, and some types of cancer caused

by poor diet and lack of physical activity that now account for 60% of disability-adjusted life years (DALYs) in the Region. Overweight and obesity, the cause of many of these diseases, affect more than half of the adult population in many countries, and in both percentage and absolute terms affect the poor far more than the wealthy. Health services are not equipped to address such "lifestyle" diseases, which unlike acute illnesses, are not easily remedied through medical interventions. Treatment is expensive and increasingly burdens health systems. Preventing N-NCDs by improving dietary quality and increasing the level of daily physical activity is the new public health challenge. Priority actions to improve the quality of foods consumed include the development of policies to increase the availability of fruits and vegetables and voluntary or regulated reduction of salt, sugar, and saturated fat in processed foods, and elimination of transfats in processed foods. Priority actions to increase physical activity include the creation of public policies and environments for an active lifestyle, promotion of physical activity in the health and education sectors, and fostering a new paradigm that focuses on daily physical activity throughout the life cycle rather than an emphasis on sports. To be successful, these new actions require substantial intersectoral collaboration among health, agriculture, education, transportation, and urban planning, among others.

The HIV/AIDS epidemic poses another serious challenge to ensuring adequate nutrition. Nutrition interventions as part of a broader package of antiretroviral therapy during delivery can prevent mother-to-child transmission (MTCT) of HIV. Vitamin and mineral supplementation has also been shown to delay the need for antiretroviral therapy in HIV-positive individuals. Appropriate nutrition can also improve the quality of life for persons living with HIV/AIDS (PLWHA). Interventions to provide appropriate infant feeding and HIV counseling for HIV-positive women can support women to make informed infant-feeding decisions, thus reducing the risk of MTCT. Guidelines are also available for the nutritional requirements for PLWHA.

PAHO's fundamental role in addressing the nutrition problems of the Region is to strengthen the institutional capacity of Member States to implement intersectoral policies and programs that promote breast-feeding and complementary feeding, micronutrient interventions, and healthy diets and physical activity. PAHO has a unique role to set norms and standards and promote evidence-based programs to address regional nutrition needs and to provide technical cooperation to ensure their implementation and evaluation. It also has a role in fostering regional networks, partnerships, and alliances, disseminating information on cost-effective interventions, monitoring nutritional trends, documenting best practices, mobilizing resources, and generating exchange of experiences among countries.

GOAL

To improve the nutrition of all the people of the Americas as a basis for achieving the MDGs for maternal mortality, child survival, eradication of hunger, prevention of HIV/AIDS, and educational attainment; and to reduce the burden of morbidity and mortality caused by nutrition-related noncommunicable diseases.

OBJECTIVES

To promote optimal breast-feeding and complementary feeding practices, and optimal micronutrient nutrition and healthy diet and active living throughout the life cycle through the implementation, monitoring, and evaluation of evidenced-based national policies, plans, and programs.

STRATEGIC APPROACHES

Promoting the Global Strategy for Infant and Young Child Feeding, the Global Strategy for Diet and Physical Activity, and national nutrition policies, plans, and surveillance systems; developing evidenced-based norms, standards, and guidelines; strengthening of networks among governments, civil society, and development agencies; providing technical cooperation; and developing proposals for resource mobilization.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Improved health and nutrition status of populations through the development and use of national food and nutrition policies and plans, revision of food-based dietary guidelines, and installation of active nutritional surveillance national policies, plans, and systems.	. Number of countries with revised national food and nutrition plans based on national priorities and focused on specific interventions and indicators with allocation of resources	0	5
	. Number of countries with upgraded and active nutritional surveillance systems that monitor and evaluate trends so as to facilitate political decision-making and improvement of program effectiveness	1	
2. Improved infant and young child nutrition through implementation of the Global Strategy for Infant and Young Child Feeding (IYCF).	. Number of countries with national plans to implement the Global Strategy for IYCF	7	15
	. Number of countries implementing the WHO Growth Reference Standards	0	15
3. Improved micronutrient status of populations through the promotion, implementation, monitoring, and evaluation of programs on supplementation and food fortification with micronutrients of public health significance (i.e. iron, folic acid, vitamin A, zinc, and vitamin B12).	. Number of countries implementing fully active regulatory monitoring systems (QC/QA, food labeling, inspection, and product analysis) for food fortification	7	15
	. Number of countries implementing active household/individual monitoring and evaluation systems for food fortification (beyond salt iodization)	4	10
4. Improved diet and physical activity and reduction of nutrition-related noncommunicable diseases.	. Number of countries implementing the Global Strategy on Diet and Physical Activity	3	6
	. Number of countries implementing programs that promote physical activity	0	5
	. Countries implementing programs to promote a healthy diet	2	8
5. Improved nutrition for persons living with HIV/AIDS and young children with HIV/AIDS-infected mothers, and reduction of mother-to-child transmission of HIV/AIDS.	. Number of countries with strategies in place to provide nutritional support for people living with HIV/AIDS	0	5
	. Number of countries with comprehensive programs for infant feeding and HIV counseling	0	5

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	6,909,000	4,220,000	11,129,000
2006-2007	6,966,400	4,428,000	11,394,400
Of which:			
Country	789,500	1,208,000	1,997,500
Subregional	4,791,000	239,500	5,030,500
Regional	1,385,900	2,980,500	4,366,400

HEALTH AND ENVIRONMENT

ISSUES AND CHALLENGES

Environmental and occupational risks contribute to a large proportion of morbidity and mortality in the Region, but few countries have comprehensive policies to perform analysis and establish public policies to manage it. These risks affect not only the present generation but also future generations due to their long-term health effects.

Modern production processes introduce new or magnify old chemical, physical, and biological health risks in the Region. The countries do not have policies on urban development that promote health, social equity, and environmental justice.

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

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

The deleterious health effects from persistant organic pollutants (POPs) and heavy metals, such as lead, mercury, and others, are increasingly recognized. However, there are no information systems in place so that risks can be analyzed and knowledge disseminated about the identification, control ,and/or elimination of these risks.

Climate change and other global risks add to the current health burden. Some impacts include an increase in current health hazards, from changed nutrition profiles, water scarcity, to patterns in vector-borne diseases. Accidental releases or the deliberate use of biological and chemical agents, or radioactive material require effective prevention, surveillance, and response systems to contain or mitigate harmful health outcomes.

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

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

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

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

GOAL

To achieve safe, sustainable, and health-enhancing human environments, protected from social, biological, chemical, and physical hazards, and promoting human security and environmental justice from the effects of global and local threats.

OBJECTIVES To ensure effective incorporation of health dimensions into national policies and action for the environment and health, including legal and regulatory frameworks governing management of the occupational and human environment, and into regional and global policies affecting consumers and environmental health.

STRATEGIC APPROACHES

- Improving the development, training, and availability of technical human resources.
- Developing and improving methodologies to evaluate and manage risks and preventive services.
- Updating the normative and regulatory processes.
- Establishing information systems to identify, analyze, monitor, and control environmental and occupational risks.
- Promoting the adequate use of technology to improve the sensitivity and specificity of environmental surveillance.
- Developing and strengthening intersectoral and interagency networks.
- Improving data recording and indicators formulation systems.
- Promoting research projects.
- Implementing technical cooperation with the participation of centers of excellence and networks from several sectors to promote interprogrammatic and interinstitutional integration.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Evidence-based normative and good-practices guidance developed or updated and promoted that effectively provide support for countries in assessing health impacts and in decision-making across sectors in key environmental-health areas, including water and sanitation, air quality, workplace hazards, chemical safety, radiation protection, hygiene, and environmental change.	. Number of countries using PAHO guidance that have conducted risk assessment and management of key risk factors.	15	10
	. Number of countries receiving PAHO support that have developed legislation, standards, or guidelines related to environmental health.	18	24
2. Countries adequately supported in building capacity to manage sustainable development and environmental health information, and to implement intersectoral policies and interventions for protecting health from immediate and longer-term social and environmental threats.	. Number of countries implementing action plans on health and environment with PAHO's support.	11	26
	. Number of countries receiving PAHO support that have strengthened health-sector capacity to manage environmental risk factors.	11	16

3. Environmental health concerns of vulnerable and high-risk population groups (particularly children, workers, and the urban poor) addressed by regional-, country-, and local-level initiatives that are implemented through effective community participation, partnerships, alliances, and networks of centers of excellence.	. Number of countries that have implemented partnership initiatives to tackle environmental health concerns in relation to children, women, and workers.	3	7
	. Number of countries receiving PAHO support to accelerate achievement of health- and- environment-related regional or international goals.	3	7

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	19,310,300	7,443,000	26,753,300
2006-2007	18,757,200	8,492,000	27,249,200
Of which:			
Country	9,166,000	5,117,800	14,283,800
Subregional	309,600	131,500	441,100
Regional	9,281,600	3,242,700	12,524,300

FOOD SAFETY

ISSUES AND CHALLENGES

Acute diarrheal disease of bacterial origin continues to be one of the primary causes of morbidity in the Region with particular impact on poor and disadvantaged populations. There is poor epidemiological characterization of food hazards and food-borne diseases, and their direct and indirect impact on public health. With the rapid improvement in food technology and increased international food trade, consumers must now place more emphasis on food safety issues and basic safe food handling practices. The international food trade requires compliance with international standards.

Food legislation is outdated and fragmented and the participation of the countries of Latin America and the Caribbean in the Codex Alimentarius has been weak. Food safety and tourism are closely related, impacting economic development. Comprehensive policies are lacking that would promote intersectoral cooperation and shared responsibility of all stakeholders, including producers and consumers.

The leadership role of the health sector in the development of food safety policy, plans, and programs as an essential public health function needs to be strengthened. Also, institutional capacity, both managerial and technical, of national counterparts to develop and carry out comprehensive food safety programs, plans, and projects based on scientific epidemiological information needs to be enhanced.

GOAL

To reduce the health, social, and economic burdens from food-borne illness and food contamination.

OBJECTIVES

To enable the health sector, in cooperation with other official and private sectors and partners, to effectively assess, manage, and communicate information about food-borne risks.

STRATEGIC APPROACHES

- Evaluating progress on the development of the food safety regional plan of action according to recommendations emanating from the Pan American Commission for Food Safety (COPAIA); Inter-American Meeting, at the Ministerial Level, on Health and Agriculture (RIMSA); and PAHO Governing Bodies.
- Mobilizing resources to implement food safety education on the healthy-setting strategy (markets, schools, street food, among others), such as: (a) extrabudgetary-initiative financial resources; (b) human resources within the Region and among WHO Regions; (c) institutional PAHO/WHO and country resources; (d) Collaborating Centers and academic and research institutions; (e) strategic partnerships with other agencies—FAO; IICA; USDA; FDA; USAID; OAS, and OIRSA.
- Increasing awareness on food safety, using technical/political fora, such as COPAIA and RIMSA, and communication media. National capacity building to create partnerships and promote intersectoral collaboration at the country level.
- Evaluating and validating existing training materials primarily in priority countries.
- Preparing projects for cooperation among countries to facilitate the exchange of best practices, experiences, and expertise in food safety.
- Operational/community-base applied intervention research targeted to high-risk and vulnerable population groups.
- Increasing the use of the farm-to-fork inspection system approach, particularly in small- and medium-size industries.
- Developing and promoting the use of risk management and communication tools, and successful experiences.
- Conducting direct technical cooperation.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Strengthened national and regional programs in food-borne disease surveillance, and food hazards monitoring and response.	. Number of countries participating in regional food safety networks (VETA, RILAA, PULSE NET, and WHO's SALMSURV)	20	35
	. Number of countries implementing food hazard monitoring plans	6	12
	. Number of countries implementing food-borne diseases surveillance plans	6	12
	. Number of countries that have completed studies on the health and economic burdens associated with food-borne diseases	2	5
2. Integrated multisectoral food safety policy and systems focusing on health from farm to table promoted, and participation in Codex Alimentarius international standard-setting enhanced.	. Number of countries that have established multisectoral food safety systems and plans in place and operational	2	5
	. Number of countries that have established or amended policies, plans of action, or legislation for food safety	10	15
	. Number of countries that have implemented national Codex Alimentarius committees using PAHO/WHO guidelines	5	10
3. National capacity enhanced to implement Good Agricultural Practices (GAP), Standard Sanitary Operational Procedures (SSOP), and Hazard Analyses Critical Points Systems (HACCP).	. Number of countries implementing GAP, SSOP, and HACCP guidelines focusing on identified prevalent food/enteric pathogen matrixes, with emphasis on small- and medium-size industries	0	4
	. Number of countries implementing the Healthy Market Strategy in the context of healthy settings initiatives	5	10
4. National capacities strengthened in the areas of risk communication and food safety education.	. Number of countries that have used and evaluated food safety material based upon WHO's "five keys to safer food" in primary schools	0	4

. Number of countries that have used and evaluated food safety material in the curriculum of primary schools within the context of the healthy settings initiatives	2	5
. Number of countries in which guidelines for certification of food handlers based on training and education have been used and validated	0	35

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	3,969,900	2,858,000	6,827,900
2006-2007	3,030,600	3,851,000	6,881,600
Of which:			
Country	810,700	1,700,000	2,510,700
Subregional	20,000	864,000	884,000
Regional	2,199,900	1,287,000	3,486,900

VIOLENCE, INJURIES, AND DISABILITIES

ISSUES AND CHALLENGES

Violence of different types is a social and public health problem in the Region of the Americas. The burden of homicides, intrafamily violence, youth violence, and behavioral aggression represents one of the leading causes of death and injuries in many countries.

Road safety is an important problem in the Region, resulting in injuries and death, in particular by vulnerable groups of the population (pedestrians, cyclists, motorcyclists, and commercial drivers). It is a major cause for seeking care at hospitals and other governmental institutions and affects young people of productive age.

The cost of both traffic accidents and violence is extremely high for the families, health system, and society at large.

In past years there has been an increase in the awareness and demand for more prevention projects to tackle the problem of violence and road safety. Reliable and timely information systems and research are demanded.

About 85 million people in America have some type of disability. The principal conditions that favor the increase in disability in the Region are aging of the population, malnutrition, accidents of all types, alcohol abuse and drugs, social violence, communicable diseases, chronic diseases, emerging diseases, armed conflicts, displacements of population groups, and natural disasters.

In our Region, between 7% to 10% of the general population is a carrier of some type of disability, representing some 40 to 60 million people in Latin America and the Caribbean. The increase of life expectancy, advances in perinatal care, increase in chronic diseases, emerging and reemerging diseases, growing violence, armed conflicts, use and abuse of alcohol, tobacco and illicit substances, and accidents of all types are some of the principal causes of disability; and, thus, there is no evidence of a downward trend in its prevalence in the general population.

The quality of life of the persons with disability and of their family is affected by the conditions of poverty in which most of this population lives. Only 2% of the population with disability has access to programs and rehabilitation services. The rehabilitation component is not integrated into the health care model, and there is a deficit for rehabilitation services at the intermediate and primary levels of the health systems.

GOAL

To prevent violence, promote road safety, and enhance the quality of life for people with disabilities.

OBJECTIVES

To strengthen the national capacity for the promotion of peaceful coexistence, prevention of violence and disabilities, promotion of road safety, and promotion and strengthening of rehabilitation services.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Support provided to high-priority countries for the implementation and evaluation of surveillance systems for the major determinants, causes, and outcomes of violence and road safety.	. Proportion of targeted countries that use PAHO/WHO guidelines to collect data on the determinants, causes, and outcomes of road safety and violence	75%	100%
2. Support provided to selected countries on research to identify effective programs and policies to prevent violence and promote road safety.	. Number of targeted countries where policy and program research has been carried out with PAHO/WHO input	10	15

3.	Guidance provided for multisectoral interventions to prevent violence and promote road safety.	. Number of targeted countries that have national plans and implementation mechanisms to prevent violence and promote road safety	10	13
4.	Support provided for policy formulation in selected countries for prehospital and hospital care for victims of traffic injuries and violence.	. Number of targeted countries that have national policies for prehospital and hospital care of victims of traffic injuries and violence	5	8
5.	Regional and national initiatives supported to strengthen collaboration among health and other sectors, involving organizations in the United Nations system, Members States, private sector, and nongovernmental organizations.	. Number of regional and national multisectoral initiatives promoted to prevent violence and increase road safety	12	15
6.	Intersectoral policies and defined national care plans for the prevention, early intervention, and management of disabilities, developed in countries of the Region.	. Models of care for comprehensive rehabilitation reviewed in targeted countries in the Region	5	12
		. Number of targeted countries that have policies, plans, and programs on prevention and management of disabilities	5	12
		. Disability information systems implemented in targeted countries of the Region	3	8
		. Plans, standards, and programs for the prevention of disability from mines and for assistance to victims, in place for at-risk countries in the Region by the end of the biennium	2	3
7.	Support provided to countries to integrate comprehensive rehabilitation services into primary health care and to implement community-based rehabilitation strategies (CBR).	. Number of targeted countries supported to implement strategies for integrating rehabilitation services into primary health care and CBR	5	12

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	961,400	0	961,400
2006-2007	1,152,600	903,000	2,055,600
Of which:			
Country	181,500	355,000	536,500
Subregional	0	0	0
Regional	971,100	548,000	1,519,100

REPRODUCTIVE HEALTH

ISSUES AND CHALLENGES

As the Region seeks to address the health-related MDGs as a component of overall development, reproductive health becomes very important and must be seen as wider than a women's issue. There continues to be a lack of political support for the sexual and reproductive health rights of all sexes. In many countries there is a lack of an integrated approach in policies, plans, and programs for women's health care and very little offered to inform and encourage males to take a responsible approach in sexual and reproductive health matters. Health promotion, prevention, and services need to be tailored to address gender issues.

The contraceptive prevalence rates show severe disparity in access between rural and urban women, and the poorest have the least access. There is also a disparity between adolescent and adult populations. This unmet need in family planning continues to represent an unfulfilled basic right.

There is inadequate use of modern methods of contraception, high prevalence of unsafe abortion, and adolescent pregnancy. A new problem for the Region is the shortage of contraceptives. As USAID and UNFPA phase out subsidies for contraceptive supplies, countries must now find new mechanisms to ensure the continuity of the supply of contraceptives. This is important as poor women cannot afford to buy the necessary supplies at commercial prices. PAHO needs to explore the feasibility of including this in the revolving-fund mechanism.

Greater use needs to be made of evidence-based interventions in related health care programs. In addition, there remains the need to strengthen surveillance, focusing on the use of information for decision-making. More evaluations and other research are needed to guide practices in reproductive health.

GOAL

To make reproductive health services accessible to all men and women of appropriate ages through the primary health-care system by 2015.

OBJECTIVES

To provide the widest achievable range of safe and effective reproductive and sexual health services across the health system and to integrate them into primary health care.

STRATEGIC APPROACHES

- Supporting a health and rights approach to the development of public policies, plans, and programs for sexual and reproductive health.
- Strengthening reproductive health surveillance and evaluation systems and developing indicators to assist countries in monitoring the Millennium Development Goals, working interprogrammatically to also strengthen maternal and child health.
- Developing research that responds to regional and country needs in reproductive health. Strengthening partnership with other agencies and NGOs working in the area of reproductive health.
- Reorienting health services to provide reproductive health care in an integrated manner, empowering communities and families.
- Supporting human resource development in implementing evidence-based practice.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Public policies and plans on sexual and reproductive health (SRH), male involvement, and maternal mortality reduction developed at the national level.	. Number of countries that have developed policies and plans for the improvement of integrated sexual and reproductive health, using PAHO guidelines	5	8
	. Number of priority countries that have developed a plan to ensure contraceptive security availability	0	4
2. Evidence-based norms, standards, and guidelines on selected aspects of sexual and reproductive health, developed and disseminated.	. Number of norms, standards, and guidelines on SRH, including contraceptive technology and methods, and male reproductive health, adapted and disseminated to the countries in the Region	10	15
3. Alliances, networks, and interagency coordination at regional and country levels in SRH supported.	. Number of countries that have established national committees with stakeholders' participation, concerning SRH rights	3	5
	. Production of models for male involvement in SRH	0	2
4. Reorientation of services in SRH, including male involvement, and empowering women, families, and communities.	. Number of countries that have developed an SRH model of care for male involvement	0	2
	. Number of countries that have introduced services for males based on research	0	2

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	701,200	1,000,000	1,701,200
2006-2007	977,500	1,219,000	2,196,500
Of which:			
Country	174,300	925,000	1,099,300
Subregional	309,600	40,000	349,600
Regional	493,600	254,000	747,600

MAKING PREGNANCY SAFER

ISSUES AND CHALLENGES

Some countries have made great strides in reducing maternal mortality; however, in others, the situation has remained steady or worsened. Great disparities among and within countries remain. The lifetime risk of maternal mortality is 1 in 160 in Latin America and the Caribbean overall, but is 1 in 16 in Haiti versus 1 in 1,100 in Chile (WHO, 2003). Twelve countries still have over 100 maternal deaths per 100,000 live births, and approximately 22,000 women die from avoidable pregnancy-related causes each year, with even greater numbers suffering from the long-term sequelae of pregnancy-related morbidities. Four thousand of these deaths occur in the five PAHO Key Countries: Bolivia, Guyana, Haiti, Honduras, and Nicaragua.

The vast majority of maternal deaths is due to preventable causes and includes hemorrhage, pregnancy-induced hypertension, sepsis, obstructed and prolonged labor, and abortion-related complications. In some countries, essential obstetric and neonatal services are either not in place, of poor quality, or underutilized because of cultural or physical barriers and lack of skilled personnel, especially in remote areas. Four countries recently completed evaluations of the availability of essential obstetric and neonatal care (EONC) at different levels of care. While over 80% of establishments in El Salvador and Honduras provide comprehensive EONC, only 23.5% of those in Bolivia and a very low 8.7% of those in Nicaragua offer these services.

Domestic violence contributes significantly to maternal and perinatal morbidity, and in some cases is a cause of maternal deaths, with an increasing number of pregnant women being victimized by aggressive acts. The nutritional status of women is an important determinant for pregnant women and infants. Anemia is present in 40% of pregnant women in LAC, the majority of cases due to iron deficiency. Folate insufficiency, a risk factor for neural tube defects in newborns, is a devastating birth defect that causes mortality or life-long disability.

Significant efforts and investments have been made in improving antenatal care over the past 30 years. However, overall levels of antenatal care in LAC increased by only 14% from 1990-2000. Significant disparities exist by geographic area and by levels of education and income. Only 46% of rural pregnant women attend four or more antenatal consultations, compared to 74% of urban women. Differences by wealth are also great: 96% of the richest women in the Region have one or more prenatal visits, versus only 57% of the poorest women.

Skilled attendance at birth and referrals to hospitals for birth-related complications, which are crucial to the survival of women and their babies, vary widely among and within countries. It is very low in some areas and particularly low in rural settings. In Haiti, only 11% of rural women have access to institutional birth services, and nationally the total is only 26%. In Bolivia, only 31% of rural women have access to skilled care while in Central America no more than 55% of pregnant women have access.

The current lack of reliable data on maternal and perinatal health jeopardizes the monitoring of trends over time. In many countries, maternal and neonatal deaths are underreported or misclassified, and vital registration systems are still inefficient. High quality data is important not only for measurement but also for surveillance which includes translating data into information for better decision-making.

Resource constraints continue to be one of the key challenges for the Region. Efforts to address this issue are critical to ensuring success of policies, interventions, and their respective health outcomes.

The 26th Pan American Sanitary Conference approved the new Regional Strategy for Maternal Mortality Reduction, which provides a set of strategic directions that build on lessons learned. These directions involve promoting effective public policies and guidelines at the national and municipal levels, strengthening maternal and neonatal health care, such as providing high quality essential obstetric and neonatal care and skilled attendance at birth, empowering women, families and communities, building partnerships and coalitions, strengthening maternal morbidity and mortality surveillance systems, establishing an effective continuum of care for all pregnant women and their newborn infants through all the levels of the health-care system, and ensuring linkages between maternal and neonatal services and other primary health-care services.

GOAL

To achieve the Millennium Development Goal for maternal health by reducing maternal mortality by

75% from 1990 levels by the year 2015; and to contribute to lowering the infant mortality rate to below 35 per 100,000 live births in all countries through a reduction in perinatal mortality by 2015.

OBJECTIVES

To strengthen national efforts to implement specific interventions and strategies that are cost-effective so that health systems provide all women and newborn infants with a continuum of care throughout pregnancy, childbirth, and the postnatal period.

STRATEGIC APPROACHES

- Advocating for political commitment and financial backing to ensure the implementation of policies, plans, programs, and interventions for maternal and perinatal health and care.
- Strengthening national capacities in maternal and newborn surveillance systems and in the use of the information for better decision-making to support the monitoring of the achievements of the Millennium Development Goals.
- Promoting and strengthening alliances and partnerships, including agencies, women's groups, NGOs, and other stakeholders to implement common frameworks and advocate for safe motherhood and newborn health at regional, national, and local levels.
- Taking a health promotion approach, emphasizing the empowerment of women, families, and communities in order to ensure the availability and use of quality essential obstetric and neonatal care services and evidence-based interventions, skilled attendance at birth and capacity building of individuals, families, and communities to make healthy decisions.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Public policies and plans on safe motherhood and newborn health supported.	. Number of priority countries implementing a common conceptual regional framework on safe motherhood and newborn health	14	18
	. Number of case studies disseminated related to successful experiences of intercultural models of care at the primary health care level	3	6
	. Number of Key Countries having in place policies and programs towards improving maternal and neonatal health	1	6
2. Appropriate evidence-based standards and guidelines on maternal and perinatal health will be developed or updated, and disseminated.	. Number of standards and guidelines on maternal and perinatal health adapted, updated, and disseminated to the countries in the Region	15	20
	. Number of countries with high maternal mortality rates and where policy reform opportunity exists, that have received technical cooperation to implement maternal and newborn mortality standard norms and guidelines	11	15

		. Number of priority countries in which prevention of post-partum hemorrhage (PPH) interventions have been disseminated and implemented	5	10
3.	Monitoring, surveillance, and evaluation systems for maternal and perinatal programs strengthened and countries' progress towards the MDGs monitored.	. Number of countries that have established a monitoring system for maternal and neonatal health at national and subnational levels	2	6
		. Number of countries that have introduced epidemiological surveil-lance tools incorporating the Simplified Integrated Perinatal module (SIP) and maternal and neonatal deaths reviews	7	10
4.	Alliances, networks, and interagency coordination increased at regional and country levels in maternal and neonatal health for strengthened advocacy and political and financial commitment.	. Number of priority countries that have developed a plan of action with interagency support	5	10
		. Number of priority countries that have established national committees with stakeholders' participation to monitor maternal mortality reduction activities	6	11
		. Number of Key Countries with a functioning national committee to implement maternal and neonatal mortality reduction plans	2	5
5.	Strengthening the health system, emphasizing the provision of high-quality EONC at the first level of referral, ensuring skilled care during pregnancy and childbirth, and the empowerment women, families, and communities.	. Number of priority countries that have EONC assessments implemented nationally	5	10
		. Number of professional associations, such as FLASOG (Federación Latino Americana de Sociedades de Obstetricia y Ginecología), ICM, (International Congress of Midwives), FEPPEN (Federacion de Profesionales de Enfermería), ALAPE (Asociación Panamericana de Sociedades de Pediatría), that sign a memorandum of understanding supporting skilled attendance at birth in the Region	0	1

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	4,060,000	2,100,000	6,160,000
2006-2007	4,291,600	2,798,000	7,089,600
Of which:			
Country	2,135,800	1,323,900	3,459,700
Subregional	0	15,000	15,000
Regional	2,155,800	1,459,100	3,614,900

GENDER, WOMEN, AND HEALTH

ISSUES AND CHALLENGES

Numerous resolutions of WHO and other bodies of the United Nations system, PAHO Governing Bodies, particularly the Subcommittee on Women, Health, and Development, as well as the Beijing Platform for Action, have called for acceleration of efforts to achieve equity and equality between women and men, effective integration of gender into policies and programs in the U.N. system, and attention to broadening the global agenda of women's health throughout the life span. More recently, the Millennium Development Goals reconfirmed these commitments and emphasized gender equality and women's empowerment as a condition to attain sustainable development. The third MDG, "Gender equality and women's empowerment," has been underscored as an end in itself and the means to attaining the other seven MDGs. Nonetheless, despite these efforts and other calls for equity in health, gender inequalities remain throughout countries and social groups. Much remains to be learned and more action is needed to confront sex- or gender-specific health risks and vulnerabilities, and meet the health needs of both women and men.

The U.N. Conference against Racism, Discrimination, Xenophobia, and Related Intolerance had urged WHO to promote and develop activities for the recognition of ethnic/national origins as significant social determinants of physical and mental health status and access to health care. PAHO's Governing Bodies reviewed the situation in the Region and recommended that programs be implemented to promote disaggregated data collection, identification of best practices, advocacy, and mainstreaming of ethnic sensitivity in policy and projects formulation for a wide scope of ethnic groups, including African descent, displaced population, migrants, and indigenous peoples.

Differences in the roles and the responsibilities of men and women, the unequal power between them, and discrimination and violation of human rights are important factors influencing health and the burden of ill-health for women and men. Gender factors interact with biological characteristics and other social and economic variables, leading to different and sometimes inequitable patterns of exposure to health risk, differential access to and utilization of health information, care in services, and unequal health outcomes. Gender factors also play a decisive role in the unequal distribution of responsibilities and power in health development.

Gender inequities have been exacerbated in the Region by sectoral reform processes that promote privatization, reduction of public services, and regressive systems of financing care. Women in the lowest quintile of income of some countries of the Region frequently utilize fewer services than men in spite of their great need for care. In general, women have to pay more than men for protecting their health, and have to shoulder most of the unpaid care burden within families and communities. In four Latin American countries, household survey data shows that out-of-pocket expenditure in health was 16% to 40% higher for women than men. More than 80% of health care is provided informally by women without support and remuneration, and the economic contribution of this work is not recognized.

Evidence systematically reveals that some ethnic groups have lower life expectancy, higher infant and general mortality rates, and face additional barriers in accessing the health care system.

In line with its long-standing concern with health equity, PAHO is committed to formulating and implementing a Gender Equality Policy that will apply to technical cooperation and corporate policies, and that will help governments frame policies and dialogue with partners. In a similar crosscutting manner, PAHO is committed to addressing ethnic inequalities in health.

PAHO has been making systematic efforts in introducing gender considerations in research, policies, programs, and projects. Attention has been given to the collection, production, and dissemination of evidence demonstrating the impact of gender and health; the creation of instruments and materials for gender analysis and gender-responsive programming, monitoring, and evaluation; advocacy; and the provision of support to the countries in these areas. PAHO is also giving attention to collecting and analyzing health information disaggregated by ethnic groups from diverse origins.

Work is still needed to translate the growing understanding of the impact of these issues into more effective institutionalized gender- and ethnic-sensitive health programs. In the Region, challenges still remain related to: poor, disaggregated information and evidence to document gender and ethnic inequities in health; high staff turnover in ministries of health, and women's and ethnic affairs; weak advocacy and monitoring capabilities of women's groups around public policy; lack of institutionalized coordination channels between state and civil society; and diverse, strong, divergent opinions at play.

Since inequalities in health and its determinants disproportionably affect women and ethnic minorities, PAHO will continue to give special attention to issues that affect these groups. Among these issues, gender-based violence and women's and ethnic minority empowerment remain a priority. To this end, interagency, interinstitutional, and intersectoral alliances must be strengthened. Important emphasis needs to be given to the participation of civil society.

Special issues also exist with regard to women's health. Cervical cancer is a serious problem for women in the Region, and the age-standardized incidence and fatality rates for this disease are more than five times higher for Central American women than for those in North America. Population aging is also affecting women in specific ways, with larger numbers of older women suffering the consequences of poor reproductive health as evidenced by increasing dysfunctions and gynecological morbidities. Less than 20% of women aged 60 and over have had a mammogram, despite the prevalence of breast cancer. These issues create challenges for public health policies, programs, and health delivery systems that PAHO will seek to address interprogrammatically.

GOAL

To ensure that the policies and programs of PAHO and Member States are responsive to gender and ethnic differences and contribute to the reduction of gender and ethnic gaps in health status, health care, and participation in health development across life-cycle stages and socioeconomic groups.

OBJECTIVES

To foster the advancement of knowledge and understanding about gender and ethnic inequalities in health. To promote and support the integration of gender and ethnic equality perspectives in research, policies, and programs, both in PAHO and in Member States. To develop and support advocacy pro gender/ethnic equality in health.

STRATEGIC APPROACHES

- Working intersectorally to address determinants of health and inequality, and provide integrated responses.
- Strengthening the capacities of government and civil society for analysis/planning, and evidence-based advocacy with a gender/ethnic perspective.
- Fostering dialogue and coordinated action between government and civil society.
- Building networks, coalitions and partnerships involving the United Nations, and inter-American and other multilateral agencies, governments, and civil society.
- Promoting social participation and empowerment of women and ethnic minorities.
- Working interprogrammatically to address specific women's health issues.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Evidence base on gender and ethnic inequalities in health and development built and shared, and technical capacity of PAHO and Member States strengthened to incorporate a gender/ethnic perspective in the production and analysis of health information.	• Number of methodological documents, regional and country profiles, and statistic brochures on gender, health and development relevant to policies, produced and disseminated through electronic and printed media	7	13

		. Number of research proposals developed or executed, and experiences systematized.	3	7
		. Regional/country database electronically available and updated	3	4
		. Number of national workshops for producers and users of information to integrate gender analysis in health statistics	6	10
2.	Conceptual and methodological framework for the integration of a gender equality perspective into health sector reform policies developed and tested.	. Number of conceptual and advocacy documents produced or updated	6	12
		. Number of analytical and training tools produced or adapted	1	4
		. Number of training workshops for government and civil society held.	4	8
		. Number of reports by the Observatory of Gender Equality in Health Policy produced	1	3
		. Number of health policy proposals to promote gender equity prepared	1	2
3.	PAHO Policy on Gender Equality five-year plan of action implemented.	. Number of technical and administrative units applying the gender perspective to their areas of work	1	4
		. Number of policy instruments integrating the gender approach	4	8
		. Number of countries participating in the mainstreaming process	0	3
4.	Intersectoral models to address gender-based violence (GBV) consolidated and expanded in terms of formulation and monitoring of policies and legislation, development of norms and protocols of care, capacity building, and research development.	. Number of countries developing framework for advocacy and monitoring GBV policies and legislation	1	4
		. Number of countries integrating norms and protocols of sexual violence at sectoral level	4	8
		. Regional monitoring system (Observatory) of policies and programs on GBV implemented	0	3
		. Virtual course on intrafamily/sexual violence for service providers delivered		
		. Research on violence during pregnancy carried out in four countries, and disseminated		

5. Ethnic-sensitive policies and programs developed and mainstreamed within PAHO and Member States with the participation of stakeholders.	. Number of countries with mechanisms for integrating the ethnic approach in analysis, formulation, and evaluation of policies with participation of civil society	13	18
	. Number of technical units integrating the ethnic approach in analysis, formulation, and evaluation of selected best practices	0	4
	. Number of countries producing information on selected ethnic groups	13	18
	. Number of networks created to promote health equity from an ethnic perspective	3	6
	. Inventory of research projects and experiences systematized	0	1

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	2,307,300	1,500,000	3,807,300
2006-2007	2,697,100	1,808,000	4,505,100
Of which:			
Country	712,300	900,000	1,612,300
Subregional	0	19,500	19,500
Regional	1,984,800	888,500	2,873,300

CHILD AND ADOLESCENT HEALTH

ISSUES AND CHALLENGES

Newborns, children, and adolescents represent a large portion of the population in the Americas; and they are among the most vulnerable groups with health problems and diseases. All three age groups need safe and supportive environments in which to grow and develop.

The principal causes of mortality in children less than 5 years of age (acute respiratory infections, diarrheal diseases, malnutrition, etc.) account for almost 30% of total deaths in this age group, and 38% of these deaths are due to perinatal causes. Mortality in children under 5 years of age dropped from 32.5 per 1,000 live births in 1998 to 27.8 per 1,000 live births in 2000. Despite this reduction, 450,000 children die in the Americas each year. Eleven countries had a childhood mortality rate of 40 or more per 1,000 live births in 2002, constituting 60% of children's deaths in the Region (Bolivia, Brazil, Dominican Republic, Ecuador, Guatemala, Guyana, Haiti, Honduras, Paraguay, and Peru).

Diseases originating during the last weeks of gestation, delivery, and the first four weeks of life account for most childhood deaths in the Region of the Americas. On average, these causes are responsible for more than 60% of all deaths of children during the first year of life. However, infectious diseases and respiratory infections, together with malnutrition, continue to account for at least 25% of all deaths in children under 5. The proportion of childhood deaths from those causes vary among countries; countries with childhood mortality rates around 50 per 1,000 live births or more account for more than 40% of deaths (Bolivia, Dominican Republic, Ecuador, Guatemala, Guyana, and Haiti).

Adolescents (ages 10-19) make up 24% of the population in Latin America and the Caribbean, where approximately 152 million adolescents now live. The largest concentrations of youth are found in the poorest countries (31% in the Caribbean and 23% in Central America), and the adolescents most affected by poverty live in rural zones. Particularly among them are the indigenous adolescents, whose numbers reach almost 4 million among Bolivia, Guatemala, and Peru.

Annually, there are 40,000 births to mothers below the age of 15 and 2,200,000 births to mothers between the ages of 15-19. In the five PAHO Key Countries (Bolivia, Guatemala, Guyana, Haiti, Honduras, and Nicaragua), the percentage of teenage mothers ranges from 17% to 36%, respectively. Maternal mortality rates are three times higher among women less than 15 years of age than in the other age group of 20 to 24, caused mainly by hemorrhages, abortion, and infections. The highest rate of maternal mortality in adolescents is found in Honduras and Ecuador (270 per 100,000, 1999 figures). Prenatal control is low among adolescents and in some countries, 60% of adolescents have anemia. Skilled birth attention is variable, ranging from 99% in Uruguay to 44% in Guatemala, mainly in indigenous adolescents. Contraceptive use among the adolescent population is also very low in the Region.

Violence and traffic accidents, which take 25,000 lives per year, are the main causes of death in both male and female adolescents.

Of the total reported cases of HIV/AIDS in the Region, 31% of the reported cases of HIV/AIDS in the Region are among young people between the ages of 10 to 24; 36% in Haiti, 34% in Honduras, and 31% in Bolivia and Guyana, with a high percentage found in adolescents under the age of 15. In Brazil, 16,000 cases were reported in minors below the age 15 and more than 24,000 cases in 16 to 20 year-olds. Most recently, it is estimated that Haiti's 200,000 orphans are due to AIDS in minors under the age of 15.

Further reductions in childhood deaths and long-term disabilities cannot be achieved without making the health of the mother, newborns, and adolescents a higher priority. Fortunately, effective low-cost, preventive interventions exist to reduce child mortality and to reduce maternal mortality and HIV among youth. The major challenge is to expand their application, giving particular priority to countries with the greatest need in these areas, and especially to PAHO's five Key Countries.

GOAL

Within the context of the MDGs, to reduce by two-thirds the rate of infant and child mortality; to contribute to reducing HIV prevalence among young people aged 15 to 24 years by 25%; to reduce maternal mortality by 75%; and to promote the physical and mental health of children and adolescents.

OBJECTIVES To enable countries to pursue evidence-based strategies in order to reduce health risks, morbidity, and mortality along the life course; promote the health and development of newborn infants, children, and adolescents; and create mechanisms to measure the impact of those strategies.

STRATEGIC APPROACHES Working with countries to develop, field test, adapt, and fully implement integrated strategies suitable for use in primary health care, such as IMCI (Integrated Management of Childhood Illness) and IMAN (Integrated Management of Adolescent Needs). Combining, expanding, and scaling-up these strategies to include all evidence-based interventions for the prevention and treatment of children and adolescents' most prevalent diseases and risks. Promoting key family practices for healthy growth and development during childhood, adolescence, and youth to empower communities, health workers, and other local social networks.

Increasing the efficiency and responsiveness of the health system to provide services that respond to these needs and sustaining levels of coverage

Working with key partners to support countries in improving the environment where children and adolescents live, grow, learn, and play. Emphasis will be given to children and adolescents' active involvement, together with parents and families, to promote supportive environments, adopt healthy behaviors, strengthen technical cooperation in HIV/AIDS, essential drugs, nutrition, mental illness, health systems, and other priority areas, to deliver integrated cooperation to Member States.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Priority countries will implement cost-effective and evidence-based interventions, for the reduction of mortality in children under 5 years-old and for the reduction of malnutrition.	. Number of priority countries and countries with an infant mortality rate greater than 30/1,000 live births that are implementing the IMCI strategy with an expansion of coverage to vulnerable populations of at least 30%	10	15
	. Number of countries with infant mortality rates greater than 30/1,000 live births that will be implementing the IMCI neonatal component	6	10
2. Priority countries will have implemented cost-effective and evidence-based interven-tions for the achievement of maternal mortality reduction among youth.	. Number of priority countries that have programs for pregnancy prevention and utilize the IMAN/ IMAI approach	5	12 (of which 5 are Key Countries)
	. Number of priority countries that incorporate the community compo-nent and key family practices of the IMCI strategy in their programs strategies and policies	11	15 (of which 5 are Key Countries)
3. Priority countries will implement cost-effective and evidence-based interventions for the prevention of the transmission of HIV/AIDS in the population of 0-24 years- old.	. Number of countries with high prevalence of PMTCT (prevention of mother-to-child-transmission of HIV/AIDS) that are implementing prevention strategies in support of the 3 by 5 initiative in high-risk groups	6	10

	. Number of priority countries that have programs for the prevention of HIV/AIDS/STI for 10-24 year-olds in their national plans	5	10
	. Haiti has a PMTCT program functioning at the national level, as well as an HIV/AIDS prevention program for adolescents and young adults, implemented at the civil-society level	Programs under development	Programs fully functioning
4. Priority countries will have established programs for the promotion of the development of children and adolescents, the prevention of risks and the strengthening of the family and community in healthy environments.	. Number of priority countries that have established national early child development plans	3	8
	. Number of countries that have established national and municipal plans for the promotion of juvenile development and prevention of violence	0	5

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	4,560,900	8,102,000	12,662,900
2006-2007	4,507,500	10,130,000	14,637,500
Of which:			
Country	1,571,600	3,897,000	5,468,600
Subregional	0	20,000	20,000
Regional	2,935,900	6,213,000	9,148,900

IMMUNIZATION AND VACCINE DEVELOPMENT

ISSUES AND CHALLENGES

The Expanded Program on Immunization (EPI) has reached approximately 90% vaccination coverage for all of the vaccines in the National Immunization Programs (NIPs) in the Region, and strives to achieve greater than or equal to 95% coverage in all municipalities. During Vaccination Week in the Americas (WWA) 2004, of the 15 million children under 5 vaccinated, approximately 23% were zero-dose children, i.e. children who had never received a vaccine before. Despite these successes, pockets of unvaccinated susceptible persons persist, leading to outbreaks of diseases like diphtheria and pertussis, which carry high case-fatality rates. Furthermore, approximately 47% of the municipalities in the Region have not achieved measles vaccination coverage of greater than or equal to 95%, the level required to maintain interruption of indigenous measles transmission and prevent large outbreaks after importation. Therefore, efforts must be focused on interventions in these high-risk municipalities. This is a particular concern in the five priority countries—Bolivia, Guyana, Haiti, Honduras, and Nicaragua—where the percentage of municipalities with measles vaccination coverage less than 95% ranges from 29% (Honduras) to 93% (Haiti).

One of the EPI milestones was polio eradication from the Americas in 1991 and the dramatic reduction of neonatal tetanus (NNT), both diseases associated with high case-fatality rates, 8% to 10% for polio and 50% for NNT. In 2003, PAHO's 44th Directing Council adopted a resolution to eliminate rubella and congenital rubella syndrome (CRS) by 2010 and urged Member States to prepare national plans of action in support of that objective. While only 18 countries/territories in the Americas reported on CRS in 1998, by 2003 the entire Region was conducting CRS surveillance. In total, 44 cases were reported in 1998, 63 in 1999, 90 in 2000, 41 in 2001, 24 in 2002, and 14 in 2003. The sensitivity of CRS surveillance needs urgent attention.

PAHO has long used the strategies for immunization to spearhead the reduction in health inequities. PAHO promotes access to existing immunization services, while introducing new and underutilized vaccines in an affordable, sustainable fashion. Pneumococcal disease kills more children than HIV, malaria, and TB combined. Yet the vaccine at greater than US$ 40 per dose for a three-dose schedule does not allow countries to vaccine children who need this vaccine most. Rotavirus kills approximately 20,000 children and causes more than 77,000 hospitalizations per year in the Region. Human papilloma virus is the etiologic agent for cervical cancer. The Caribbean has some of the highest cervical cancer rates in the world. Influenza vaccine must be made available to protect the underserved against the impending pandemic.

Mortality from vaccine-preventable diseases is not distributed evenly in the Region, and not all countries have shared equally in the advances made at the regional level. The number of cases of NNT decreased 95% in the Region during 1987-2002. Since the case-fatality rate is 50% to 70%, this has represented an important reduction in infant mortality in the Region. However, this decrease was not shared by Haiti, which in the last four years has reported approximately 50% of all NNT cases in the Region. The introduction of new vaccines has contributed to a reduction in infant mortality from several diseases. For example, the introduction of *Haemophilus influenza* type B (Hib) vaccine resulted in a demonstrable decrease in pneumonia and meningitis in several countries.

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

GOAL

To protect all people at risk against vaccine-preventable diseases.

STRATEGIC APPROACHES

Providing technical and strategic support to strengthen national and regional capacity, advocacy, partnership and policy framing, preparedness for emerging disease threats, and formulation of evidence-based strategies for vaccination policy.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Countries are supported in achieving and maintaining equitable coverage for all vaccines.	. Number of countries where immunization coverage for DPT3, OPV3, MMR, HepB, Hib, and BCG is maintained where >95	All countries	All countries
	. Percentage of municipalities with DPT3 coverage <95% in children less than 1 year of age	45	
2. Capacity of countries to introduce new vaccines when available is supported.	. Percentage of countries that add new vaccines to their existing schedule		100%
3. Elimination of rubella and CRS progresses as planned with PAHO support.	. Percentage of countries implementing elimination strategies		
4. Improved surveillance and knowledge-sharing on immunization and vaccines.	. Number of countries participating in a web-based information system		
5. Improved preparedness for action related to vaccine-preventable threats of national and international concern.	. Number of countries participating in a plan of action related to vaccine-preventable threats of national and international concern		
6. Capacity of countries to guarantee the quality of vaccines and biologics for their populations strengthened.	. Number of countries supported in having national regulatory authorities operational and in compliance with basic regulatory functions according to PAHO/WHO guidelines	2	7

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	4,125,200	19,365,000	23,490,200
2006-2007	3,809,400	20,555,000	24,364,400
Of which:			
Country	1,013,100	4,905,700	5,918,800
Subregional	0	10,000	10,000
Regional	2,796,300	15,639,300	18,435,600

ESSENTIAL MEDICINES

ISSUES AND CHALLENGES

Inequities in terms of drug access remain widespread in the Americas. Access to all needed drugs continues to be the main focus of pharmaceutical policies, and updating policies remains a challenge for the countries in their search for legal frameworks and for strategies to optimize access to quality drugs, and their rational use. Effective strategies for improving drug access demand the consideration of all available resources, including the analysis of the application of TRIPS agreements, the development of generic drug policies, the search for drug financing strategies, and the implementation of price-approach measurements. In addition, drug supply in the public health system continues to be affected by the reform processes, especially privatization and decentralization. Central and local governments continue to debate financing and management strategies to guarantee the drug supply system and cost-efficient strategies in public health services.

Drug regulatory harmonization, based upon internationally accepted quality standards and guidelines adapted to the Region, as well as the combat of counterfeit drugs, are major challenges to improving the cost effective strategies for drug access, the quality of the pharmaceutical market in the Region, and common regulation and agreed-upon strategies to promote the rational use of medicines.

Economic integration efforts through subregional agencies and bilateral and multilateral relations provide opportunities for information exchange and support among the subregions of the Hemisphere.

GOAL

To help save lives and improve the health of the population of Region of the Americas by ensuring quality, efficacy, safety, and rational use of drugs within equitable, efficient, and financially sustainable strategies for drug access.

OBJECTIVES

To monitor national drug policy and strategies for improving drug access; a regulatory framework, adopting international norms and guidelines; and the rational use of medicines.

STRATEGIC APPROACHES

- Strengthening and developing strategic partnerships, improving institutional mobilization with international agencies, regulatory authorities, Collaborating Centers and regional institutions, the pharmaceutical industry, academia, and civil society organizations.
- Strengthening institutional capacities, including the promotion of information exchange networks among national institutions.
- Promoting and disseminating knowledge about medicines and health-related issues.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Member States supported in the development, implementation, and monitoring of national drug policies that facilitate accessibility and affordability of drugs.	• Number of countries in the Americas that have developed, implemented, and evaluated national drug policies	12	15
	• Regional studies on drug access strategies, including generics (generic substitutions at the pharmacy level), drug financing systems, and implications for drug access in economic agreements	Studies being developed	Studies completed and fully disseminated among Member States

		• Number of countries participating in drug access and drug-economics-related training activities	6	12
		• Number of countries participating in the Pharmaceutical Clearinghouse	2	8
		• Number of countries that have implemented harmonized regional proposals on drug regulation developed within the framework of the PANDRH: good manufacturing practices, bioequivalence, good clinical practices, drug registration, drug classification, and combat of drug counterfeiting	0	4
2.	Support to Member States and subregional integration initiatives in their efforts to advance drug regulatory harmonization by strengthening the Pan American Network for Drug Regulatory Harmonization (PANDRH) initiative.	• Number of countries with updated regulation for medicinal plants	4	6
		• Number of countries participating in a regional plan for drug monitoring pharmacovigilance	6	9
		• Number of countries in which the official drug quality control laboratory participates in a network for the external quality control program	21	21
3.	Member States supported in relation to the rational use of drugs, while awareness about this issue is increased.	• Number of countries with a National Essential Drug List updated during the biennium		6
		• Number of participants in rational drug use training activities during the biennium		30
		• Number of countries participating in regional pharmacy care projects		6
4.	Member States supported in their improvement of drug supply systems with emphasis on public health services, targeted populations, and cost efficiency.	• Number of countries in which the model for analysis of the supply system has been applied	3	10
		• Updated regional guideline for drug supply management for hospital drug supply system	Regional guideline being updated.	Regional guideline updated and disseminated

	. Regional assessment of national drug supply system, including the public and private sector	Regional assessment in progress	Regional assessment completed and disseminated
5. Strategic Fund for the Procurement of Public Health Supplies through PAHO strengthened to assure continuous availability of low-cost quality products for priority public health programs.	. Number of countries in which operating procedures and technical manuals for the Strategic Fund have been implemented	4	10
	. Number of countries participating in the Fund, using it as the procurement mechanism for essential public health supplies	4	10
	. The PAHO supplier prequalification system (PSPS) in place and updated database available on the Web page	PSPS being updated	PSPS in place and updated
	. Regional comparative study on price for the procurement of essential selected items	Study in progress	Study completed and fully disseminated

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	2,736,000	6,717,000	9,453,000
2006-2007	3,200,200	7,762,000	10,962,200
Of which:			
Country	1,241,300	3,658,900	4,900,200
Subregional	0	30,000	30,000
Regional	1,958,900	4,073,100	6,032,000

ESSENTIAL HEALTH TECHNOLOGIES

ISSUES AND CHALLENGES

Public health laboratories cannot fulfill their role in the health systems, because there is limited integration of laboratory and epidemiology services. The information generated is neither complete nor timely, limiting public health interventions—a situation that becomes critical when emergencies or unexpected events arise.

To improve quality in clinical laboratories and optimize intersectoral complementarity in an integrated fashion, it is essential to formalize accreditation processes and to operationalize and expand these processes to hospitals and the public health sector; this would include the certification of technical personnel and equipment.

Blood collection, processing, and transfusion centers are not coordinated. This results in insufficient blood for transfusion, untimely services, and inefficient testing. While coverage of screening for HIV, HBV, HCV, and *T. cruzi* markers in blood has increased, coverage has not yet reached 100%. Additionally, a high percentage of the blood used still comes from replacement donors when it should come from volunteers.

With the changes occurring in the population, the incidence of cardiovascular disease and cancer is growing, leading to heightened demand for diagnostic and radiotherapy services.

Most regulatory authorities in the area of radiation safety are atomic or nuclear energy agencies whose objective is to minimize exposure to radiation, rather than ensuring the proper use of ionizing radiation in medical procedures.

The main problems detected in terms of physical infrastructure and technology in the health services stem from the lack of institutional development to guarantee the planning, procurement, operation, maintenance, evaluation, retirement, and replacement of equipment; and from significant personnel deficits in terms of available resources and the training required for administration, program management, and technical support.

GOAL

To ensure that the population of the Region of the Americas has equitable, effective, efficient, and sustainable access to laboratories, blood banks, transfusion services, and appropriate medical technology.

OBJECTIVES

To strengthen national and subregional capacity for policy-making and quality assurance in public health and clinical laboratories, blood banks, and transfusion services and in the regulation and use of medical technology.

STRATEGIC APPROACHES

- Fostering human resources development.
- Developing national quality assurance programs.
- Strengthening and constructing strategic partnerships and interinstitutional coordination.
- Implementing standards and guidelines.
- Supporting studies of supply, demand, and costs for services.
- Promoting and coordinating collaborative projects among Member States.
- Working with Collaborating Centers, professional associations, scientific associations, and academia.
- Generating and disseminating information and knowledge.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Improved quality of clinical laboratory operations.	. The number of countries with official operational accreditation systems	3	13
	. Number of countries in which standard operating procedures for the diagnosis of 10 priority diseases are updated and in operation based on the minimum requirements developed and promoted by PAHO		20
2. Availability of quality blood improved and capacity for implementation of quality assurance programs increased.	. All the countries in the Region have donation rates above 3/1,000 inhabitants	40	41
	. Number of countries with donation rates over 10/1,000 inhabitants	18	23
	. In all the countries of the Region, 100% of blood transfused screened for HIV, HCV, HVB, and syphilis and in Latin America for *T. cruzi*	17	41
	. Number of countries in which national programs ensure that at least 50% of the blood is collected from voluntary, no remunerated donors	8	20
	. Number of countries in which distance education programs on quality are designed and implemented, and the establishment of national commissions is supported	0	15
3. Strengthened diagnostic imaging and radiation therapy services, enforcement of regulations to protect against ionizing and nonionizing radiation, and capacity to respond to radiological or nuclear emergencies.	. Number of countries with an evaluation of radiation therapy services	5	7
	. Number of countries with policies to protect patients undergoing medical procedures involving radiation	2	4
	. Education and training in quality diagnostic and therapeutic procedures, radiation protection, and radiological emergencies	2	4

4. Strengthened capacity to operate and maintain the physical plant and equipment of the health services network in the countries of the Region, and support ministries of health in the regulation and operation of medical devices.	. Number of countries with policies, norms, and standards and reviewed and updated procedures in management and assessment of technologies, regulation of medical devices, engineering and maintenance of health facilities and quality of syringes.	5	10
	. Number of methodologies and instruments for evaluation of programs, decision-making processes and assignment of resources for the physical infrastructure and the technology of health services, including regulation, patient safety, telemedicine, and quality.	0	3
	. Number of agreements with academic centers for training in clinical and biomedical engineering, hospital management of technology and biomedical and hospital equipment maintenance.	0	2
	. Number of networks in full operation for communication and information exchange on health care technology and regulation in the Region.	3	4

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	2,369,000	1,764,000	4,133,000
2006-2007	2,382,900	2,002,000	4,384,900
Of which:			
Country	183,300	273,900	457,200
Subregional	292,800	1,373,500	1,666,300
Regional	1,906,800	354,600	2,261,400

POLICY-MAKING FOR HEALTH AND DEVELOPMENT

ISSUES AND CHALLENGES

Recent global and international conferences concerned with health and development have reiterated the crucial importance for achieving the Millennium Development Goals of increasing the level and efficiency of investment in health and strengthening health systems performance and transformation to the benefit of excluded priority groups in each country. It is currently evident that good health status, as an end in itself for sustainable human development, is critical to escape from poverty.

Investing in health constitutes a key element of human security and development. However, it is necessary to advocate this social policy dimension among global and national decision-makers and to strengthen national will, capacities, and efforts towards objectives of social justice and equity.

The U.N. Millennium Declaration and the MDGs provide a significant opportunity for promoting the incorporation of health priorities in national and international agendas for poverty reduction, particularly for reducing health disparities and overcoming the situation of socially excluded groups. Health issues need to be placed at the center of poverty-alleviation policies and strategies advanced for a great number of Member States and international cooperation agencies.

PAHO/WHO faces great challenges to find effective, affordable, and practical ways of translating international commitment actions that positively influence people's lives. These challenges require developing policies and strategies oriented to improve national capacity to take advantage of funding opportunities through debt relief, poverty-reduction strategies, global funds, international redistribution, and the possibilities derived from global, regional, and subregional trade and integration processes.

GOAL

To maximize the positive impact of socioeconomic development on people's lives, and to maximize the positive impact of better health on socioeconomic development, for the attainment of the MDGs and the reduction of social exclusion.

OBJECTIVES

To maintain and further secure the centrality of health to a wide range of development processes, and of ethical, economic, and human-rights analysis to the achievement of just and coherent policies and laws at national, subregional, and regional levels.

STRATEGIC APPROACHES

- Advocating and supporting country, regional, and global policies and legislation for promoting health as a human right and the elimination of social, gender, and ethnic exclusion in the human development agenda.
- Identifying effective health system and intersectoral interventions for the attainment of the health-related MDGs.
- Promoting opportunities to advance the development and accessibility of national, regional, and global public health goods.
- Fostering the analysis and identification of opportunities and sources for investing in health at national, regional, and global levels, taking into account the institutional framework and possibilities of the Macroeconomics and Health Initiative.
- Promoting and supporting the participation of Member States in the Heavily Indebted Countries, Poverty Reduction Strategy Papers (HIPC-PRSPs) and other poverty reduction initiatives, as well as in the implementation of the recommendations of the U.N. Durban World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance.
- Promoting and advocating coherent policies related to international trade and public health goods and services in the context of globalization and integration processes.
- Taking into consideration the impact of macrodeterminants of health and human development for the formulation of public policies contributing to the reduction of health inequities, social exclusion, and poverty.
- Adopting a human rights approach to health development with priority attention to the needs and rights of vulnerable and excluded groups, such as Afro-descendants, indigenous people, and women.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Strengthened institutional capacity at the national and subregional levels in order to improve the political priority of health matters in the development agenda and increase investment in health according to the framework of the Commission of Macroeconomics and Health.	. Number of national and subregional macroeconomics and health initiatives supported to conduct research and policies oriented to improve the health participation in socioeconomic development	3 subregional initiatives (2 in the beginning)	4 subregional initiatives functioning
	. Number of national and subregional master plans of investment in health		6
2. Strengthened national capacity to assess and act on health implications of trade and globalization.	. Number of countries with ministerial mechanisms for trade and health		6
	. Staff time dedicated to issues related to trade and health		
3. Improved access and application of information, knowledge, and tools in essential technical and political areas of the relationship between health and human development.	. Number of countries applying national health development assessment tools	5	10
	. Number of PAHO staff at country and regional levels trained in the application of Sector Wide Approaches (SWAPs) and other tools for planning and decision-making process	10	35
	. Number of national health workers trained in the application of SWAPs, health sector analysis, and other tools for the planning and decisions-making process	50	200
4. Systematic monitoring of processes and outcomes for poverty reduction for the attainment of the MDGs at national and regional levels.	. National and regional reporting on the status of achievement of the Millennium Development Goals available according to relevant resolutions	10	35
5. The WHO Human Rights Strategy implemented, and increased capacity in the Region to provide technical support to Member States to integrate human rights in national health, poverty reduction, social inclusion, and human security policies and legislation.	. Reports of country institutions demonstrate follow-up and support for the commitments of the U.N. World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance	2	6
	. Human rights included in health and poverty reduction strategies, programs of extension of social protection in health, and plans for social development in the countries		5

• Legislation influenced that promotes gender and ethnic equality in countries.		4
• Special initiatives being implemented to accelerate and improve the access of priority social groups to social protection and health.	6	12

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	11,626,100	8,758,000	20,384,100
2006-2007	6,828,700	10,602,000	17,430,700
Of which:			
Country	2,211,400	1,645,300	3,856,700
Subregional	0	15,000	15,000
Regional	4,617,300	8,941,700	13,559,000

HEALTH SYSTEMS POLICIES AND SERVICE DELIVERY

ISSUES AND CHALLENGES

It has become increasingly evident that in many countries a vast array of effective interventions are not being provided and delivered, as a result of problems related to both access and quality of care. The impetus given by the Millennium Development Goals and growing interest in the health sector in general has led to a remarkable increase in disease-specific programs implemented by both international organizations and national bodies.

This trend is creating new and complex challenges to health systems. Although these programs are leading to considerable innovation and experimentation in strategies to increase coverage for specific diseases, governmental institutions responsible for the overall organization of the health sector are not being reinforced. Consequently, it has become necessary to understand and align better health-system planning with disease-specific initiatives in countries, and urgent for governmental institutions to exercise their steering function and ensure overall coherence of their health systems based on principles of primary health care.

This reinforcement is needed at several levels. At the policy level, there should be sufficient governance and regulatory capacity for governments effectively to exercise their steering role in the growing heterogeneity of most health systems. They need to play their part as "stewards" and maintain an overview of the entire health system; to plan and regulate coherently public and private delivery of health services; to ensure that public health functions are strengthened as well as health services; and to detect and counterbalance developments that will impact negatively on more vulnerable groups.

At managerial levels, such as subnational, district, and institutional levels, a massive reinforcement of capacity is needed in order to handle the increasing complexity of health-care delivery and boost efforts to promote health, prevent disease, and improve quality of care. Access to health services is limited, or in some cases, nonexistent, for large segments of the population. The supply of health services is not always adjusted to address the expectations, social values, and cultural preferences of the population. Health service delivery is frequently of poor quality and ineffective. Resources for service delivery are often inadequately allocated and used. The poor have less access to health services and receive worse quality care, as do other groups such as rural populations, socially excluded ethnic groups, and, in particular, indigenous populations. The lack of organized information precludes defining priorities and orienting the development of health service delivery systems in a particular direction.

GOAL

To improve the availability, quality, equity, and efficiency of health services by strengthening their links with the broader public health functions and by strengthening the governance, organization, and management of health systems.

OBJECTIVES

To strengthen health-system leadership and capability for effective policy-making in countries, and to enhance the planning and provision of health services that are of good technical quality, responsive to users, contribute to improved equity through greater coverage, and make better use of available resources.

STRATEGIC APPROACHES

- Mobilizing a network of international and bilateral entities, academic, and scientific associations, NGOs, and service, educational, and research agencies, among others.
- Prioritizing the poorer Member States of the Region.
- Advocating and discussing health policies with the Member States.
- Strengthening institutional capacity at all levels of the health system.
- Promoting technical cooperation among health services and the academic world.
- Promoting and coordinating collaborative projects among Member States, as well as collaboration with cooperating centers and with professional and scientific associations in the sector.

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Health systems performance improved aimed to achieve the Health Related MDGs and health sector reform processes oriented to Health for All vision, based on the strategy of Primary Health Care	. Number of countries in which Sector Analysis based on equity criteria has been carried out	8	12
	. Accessible and up-to-date system to disseminate relevant information and best practices on health sector reforms	Health System Profiles available for 35 countries	Health System Profiles updated for 35 countries
	. Number of countries in which the health Systems Performance assessment has been carried out	2 at the end of 2005	8
2. Institutional capacity improved to effectively perform the steering role of national health authorities and the Essential Functions of Public Health, including the improvement of infrastructure and the competencies in public health	. National reports reveal improvements in most countries in at least two Essential Public Health Functions	2	12
	. Number of countries having developed and implemented plans of actions to improve the capacity and performance of the public health systems	4	10
	. Number of countries in which a second Health Sector Steering Role Performance assessment has been carried out during the biennium	2	12
3. Selected countries supported to improve the effectiveness, efficiency, safety and user satisfaction of the care provided by the network of integrated health services.	. Number of countries in which a new accreditation system for primary care will have been tested		5
	. Patient safety strategies implemented in public hospitals of the Region.		In at least 12 hospitals in 3 countries
	. Number of countries in which tools for integrating health services delivery systems developed, tested and validated		At least 5
	. Number of Key Countries in which health service networks have been established or expanded		At least 5 countries
	. Number of countries with national programs for quality improvement and assurance increased		5 more than the 2005 number

4.	Managerial capacities within health facilities and health systems strengthened, including their information systems in selected countries.	. Number of countries in which modern management methods introduced into health services or manpower trained. . Number of countries in which information systems in health services updated and management begins to use information for management decisions routinely. . Basic health services indicators and information available in countries on timely basis	8	5 8
5.	Development of technical capacity to define and address inequalities that affect the health outcomes and needs of indigenous peoples with particular focus on access to appropriate health services.	. Number of countries with indigenous people in which intrasectoral and intersectoral cooperation networks and/or mechanisms support the development of indigenous centered health systems. . Number of countries with indigenous people, in which their health status is monitored routinely at the national and local levels and information reported in documents available to the population. . Countries with indigenous people that have created instruments for certification of intercultural approach to health care.	Less than half of the countries	Half of the countries

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	11,231,600	16,380,000	27,611,600
2006-2007	15,255,100	19,648,000	34,903,100
Of which:			
Country	11,485,900	10,167,900	21,653,800
Subregional	0	74,000	74,000
Regional	3,769,200	9,406,100	13,175,300

HUMAN RESOURCES FOR HEALTH

ISSUES AND CHALLENGES

Most countries of the Region are still facing significant problems in the distribution, composition, and competencies of their workforce, perpetuating severe social inequities and poor access to appropriate services. For large social groups, defined by geography, income or culture, the situation is plainly unacceptable. Although this unresolved agenda persists, the policy environment has changed considerably.

At the national level, the decentralization of the health sector has generated new actors and, therefore, new opportunities in the form of regional administrative units and municipal governments. The corresponding increase in the segmentation of the public health system, coupled with the coexistence of subsystems involved in the provision of services to specific population groups, demands a different leadership from the ministries of health and new dynamics in the formulation of human resources policies and in the planning, regulation, and management of the workforce, guided by strategies of inter-institutional cooperation and operational integration of health services.

Employment conditions in the health sector are precarious, with immediate implications for the motivation and performance of the workforce, causing severe repercussions to the quality of services and the overall governance of the sector. Important gaps are appearing in the capacities of health systems and their human resources to face the demographic and epidemiologic evolution of their populations. The growing intertwining of social and health problems partly related to the urbanization process and the aging of the population requires new profiles and different working relations among health professionals, technicians, and community and social agents in primary health care.

The contribution of families, especially women, and other community resources to the provision of care in the form of nonremunerated work, needs to be acknowledged. The development of the public health workforce to sustain effective public health systems and ensure an adequate performance of their essential functions is an imperative investment for the coming years, if only because of increasing external threats with potential dramatic consequences for their economy.

The concept of life-long learning for the workforce implies a greater integration of learning and acting, with closer loops and interactions between training institutions and areas of practice. The use of new communication technologies will have a significant impact in this regard.

The integration processes at the subregional level exert a strong influence in shaping the policy discussions on human resources. Although the differences and specificities of each process must be recognized, they generally raise issues related to the mobility of the workforce, and the corresponding need for shared quality standards and mechanisms to establish equivalences for professionals and academic institutions.

At the global level, migration of health personnel has considerable consequences on countries with small populations; new arrangements are being sought with recipient countries.

GOAL

To contribute actively to the national development of health and the achievement of Health for All and the Millennium Development Goals through the participatory formulation and implementation of human resources policies in health and the optimal management of education and work.

OBJECTIVES

To contribute to managing effectively and creatively the interaction between the supply and demand for health workers.

STRATEGIC APPROACHES

- Reorganizing the model of technical cooperation around subregions to ensure an active presence in all countries, promote a core thematic agenda, strengthen intercountry exchange, and support the integration agendas.
- Combining country-focused strategies, collaborating with Key Countries, and promoting subregional approaches for horizontal cooperation.

- Focusing on leadership and capacity-building of government institutions, especially in the ministries of health in the field of human resources, giving special attention to the greater institutionalization of human resources processes.
- Developing and supporting partnerships, alliances, and networking for knowledge-sharing and training.
- Improving access to relevant information and documentation and other resources.
- Leading the collaborative formulation of policy documents and frameworks of reference on key human resources issues.
- Developing instruments, tools, and guidelines.
- Intensifying the use of new information and communication technologies.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. National and intercountry capacities strengthened to formulate human resources policies, plan the development of the workforce, and regulate education and professional practice.	• Number of countries of the Region of the Americas that have in place interinstitutional participatory mechanisms such as the Observatory of Human Resources, to formulate HR policies.	21	26
	• A permanent forum established on strategies and incentives systems for a more equitable distribution of the workforce in relation to needs.	None	Forum established
	• Number of countries that have developed and use a set of core data on human resources.	12	18
	• A regional policy framework developed to guide the recognition of foreign-trained health professionals and their international mobility.	None	Framework developed and shared with all member states
	• Number of countries that have adopted and have begun implementation of a policy framework for responsible management of health human resources migration.	0	4
	• Number of operational research care studies involving policy-makers and researchers on priority human resources issues.	5	15
	• Number of case studies on coordinating mechanisms among the health, education, and labor sectors that have been shared with Member States.	None	4

2. Institutional capacity strengthened to design and operate effective human resource management systems and practices at the national and local levels.	. Number of countries that have established permanent coordinating mechanisms to address issues related to working conditions of health workers, including remuneration, health and safety, and career paths.	1	5
	. Number of learning programs on the management of human resources developed and implemented with educational partners available at the subregional and national levels.	None available	10
	. Number of case studies on better recruitment and retention practices that are disseminated and tested in different contexts.	0	5
	. Number of priority countries that initiated or have in place processes for institutional capacity building in the public and private health subsectors.	1	3
3. Institutional capacity and working mechanisms developed between health systems and academic institutions to design, implement, and evaluate permanent education strategy and programs.	. Number of countries that have developed and implemented concepts, methods, and systems of permanent education for PHC services.	0	5
	. Number of academic institutions in Latin America and the Caribbean with capacity for instructional design of distance education and on-line courses in public health.	3	5
	. Number of countries with capacity at the national level to design, manage, and evaluate in-service training programs.	3	5
4. Strategies, policies, and interinstitutional collaborations established for the development of public health and primary health care human resources.	. Number of countries that have implemented master plans for the development of the public health workforce.	2	10
	. Number of courses available on-line from the Virtual Campus of Public Health and associated institutions.	6	12
	. Number of academic public health institutions that have adopted quality improvement strategies in their public health curricula.		

	• Number of networks and alliances of academic institutions in public health constituted to strengthen the performance of the Essential Public Health Functions.		
	• Number of networks established for evaluation of human resources and primary health care.	None	One network established
	• Development of a model characterizing core capacities and competencies required by PHC teams.	0	One model developed
	• Number of analyses disseminated on how to train, attract, and retain PHC professionals.	1	4
	• Number of collaborative strategic plans/plans of action developed with at least one priority program (e.g. 3 by 5; expansion of DOTS/DOTS Plus; Roll Back Malaria ; other MDGs).	0	2
	• Number of developed and tested human resources models, approaches, strategies, and tools for scaling-up priority health programs.	0	2
5. Education and professional development of nursing human resources and health technicians supported within a public health orientation.	• Number of countries that have designed and implemented analyses, policies, plans, and regulations for the development of nursing human resources.	6	12
	• Number of countries that have developed and implemented plans for the professionalization of nursing.	4	12
	• Strategies and network established to reinforce public health/PHC in nursing education.	None	One network established
	• Number of countries that have adopted and implemented a strategic plan, following PAHO guidelines, to increase the production of information on nursing human resources development.		
	• Number of countries that have adopted and have begun implementation of a PAHO-led strategic plan to promote networking, develop regulation, and reorient education for health technicians and community health workers.		

6.	Reorientation of medical education towards PHC, family, and community health promoted and supported.	. Number of schools of medicine that have changed medical curriculum toward PHC.		
		. Number of countries that have developed and implemented regulations on access to medical specialties, supportive of family and community medicine.		
		. Systems, methods, and instruments developed to ensure quality of postgraduate training and continuing education programs in family and community medicine.	None	
7.	Increased capacity of health systems and services to acknowledge, promote, mobilize, and guide the contribution of individuals and social networks in health development.	. Framework and methodology developed to identify, characterize, and involve nonformal health workers, community groups, and social support networks in plans of action.	None	One framework developed
		. Best practices documented on culturally appropriate communication strategies to mobilize community resources for health.	None	One study produced and disseminated
		. Innovative training, mentoring, or coaching programs aimed at social support networks and caring family members documented.	None	One study produced and disseminated
8.	Development of leadership and training opportunities in health with focus on international health leadership.	. Number of young professionals trained in the International Health Program.		
		. Establishment of a regional network of centers of leadership development in international health.	None	One network established
		. Number of PALTEX titles directly related to PHC and public health.		
9.	Strengthened health human resources policy, regulations, and initiatives aimed at subregional integration processes and cooperation among countries.	. Number of subregional groups that have adopted guidelines on human resources policies and regulations.	1	2

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	9,266,600	3,474,000	12,740,600
2006-2007	9,123,800	4,934,000	14,057,800
Of which:			
Country	1,687,400	2,000,000	3,687,400
Subregional	1,290,800	1,119,000	2,409,800
Regional	6,145,600	1,815,000	7,960,600

HEALTH FINANCING AND SOCIAL PROTECTION

ISSUES AND CHALLENGES

The way the health system is financed and organized is a key determinant of population health and well-being. Health financing has become a central issue to many governments as they seek to move towards universal coverage or improve their health systems. Policy debates cover the questions of how funds should be raised, pooled to spread risks, and used to purchase or provide the services and programs needed by their populations, and the appropriate mix between the public and private sectors. In some regions, the level of spending is still insufficient to ensure universal access to basic and essential health services and interventions, so a major concern is to ensure adequate and equitable resource mobilization for health. Fragmentation is a constraint on the potential to cross-subsidize from the rich to the poor and from the healthy to the sick, and many financing systems do not provide adequate levels of social protection.

In many countries, health costs have been rising rapidly and a dominant concern is to reduce the rate of growth of health expenditure while maintaining the quality of the health system. All countries are concerned with ensuring that the resources available to health are used efficiently and that they are distributed equitably, yet disparities in access to services between rural and urban areas and between the sexes remain in many settings. In all but a handful of countries, health financing heavily relies on out-of-pocket payments, placing large, sometimes catastrophic, financial burdens on households which can be pushed into poverty, or further into poverty, as a result. Moreover, the need to make such payments prevents people, especially those who are poor, from obtaining necessary care. Each of these issues both impacts upon countries' capacity to achieve the Millennium Development Goals and threatens to either erode or stall progress toward positive health indicators.

Information on inequalities and social exclusion in health based on social class, gender, age, ethnicity, and geography is not sufficiently available to well inform and improve policies, training, advocacy, and research. This is especially the situation for programs focusing upon high-risk groups and neglected geographic areas.

Health sector reform has not overcome the segmentation, fragmentation, and inequity of health systems and has had a low impact on the significant differences in ensured rights, levels of expenditure, and degree of access to services between the various groups of population. Thus, it has not succeeded in either guaranteeing a universal level of social protection in relation to health, or improved health outcomes for vulnerable populations.

Based on the current context, now more than ever before, it is important to address the challenge of ensuring universal social and financial protection in health. It is critical to eliminate or reduce the avoidable inequities in financing, coverage, access, and utilization of services. In keeping with this, it is important to ensure that everyone receives care according to his/her needs and contributes to the financing of the system. The commitment of countries and the cooperation of the community toward the achievement of the MDGs provide a unique window of opportunity to address this challenge.

GOAL

To develop systems of health financing that are equitable and efficient, protect against financial risk, promote social protection, and can be sustained over time.

OBJECTIVES

To formulate health-financing strategies that ensure universal coverage and are based on principles of equity, efficiency, and social protection, and on the best available information and knowledge; to develop capacity to obtain key information and to use it to improve health financing and organizational arrangements as part of national policy.

STRATEGIC APPROACHES

- Reorganizing approaches and modalities of technical cooperation to ensure an active presence in all countries and promote a core thematic agenda.
- Focusing on leadership and capacity building of government organizations, especially the ministry of health and social security organizations to lead dialogues and build consensus with other stakeholders.
- Providing direct cooperation to develop and implement policies/strategies for national health development processes which aim to extend social and financial protection.

- Generating strategic intelligence through applied research, innovative and/or comparative studies, frames of reference, and analytical methodologies.
- Developing methodologies and tools, for diagnostic analysis of social exclusion in health, inequities in financing, access, coverage, and utilization of services.
- Promoting policy/social dialogue, public policies, and sectoral plans.
- Organizing clearinghouses for the collection, systematization, and dissemination of technical innovations, best practices, and other relevant evidence, information, and knowledge.
- Developing and supporting partnerships, alliances, and formal/informal networks for knowledge-sharing and the production of country-level conceptual, analytical, technical, administrative, and organizational innovations.
- Promoting cooperation among countries and providing opportunities to share national and international experiences and knowledge.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Improved availability of policy options for national authorities and other stakeholders regarding the extension of social and financial protection in health.	. PAHO institutional frames of reference on health financing and social protection are developed through policy documents/ publications and implemented in PAHO's cooperation plans and strategies	PAHO institutional frameworks being formulated at the end of 2005	Institutional frameworks disseminated and integrated into PAHO's cooperation
	. Technical cooperation modalities, approaches, and tools generating policy options to inform decision- making processes by national government and other stakeholders	Technical cooperation approaches and tools developed at the end of 2005	Technical cooperation approaches and tools formulated and mainstreamed in PAHO
2. Social exclusion and inequalities in health characterized and monitored, and information and knowledge on the issue made widely available.	. Frames of reference, guidelines, and tools to characterize and monitor social exclusion and inequalities in health available for use by national authorities and other stakeholders	Social exclusion characterized in 10 countries Frameworks and tools for monitoring inequalities being developed	Social exclusion characterized in 16 countries Frameworks and tools for monitoring inequalities formulated
	. Reports and publications on research and comparative studies	Reports/Publications available from 10 countries	Reports/publications Available from 20 countries

3.	Increased availability of economic, financial, and health expenditure information, and improved capacity for analysis and use in the decision-making process at country level.	. Conceptual, analytical, and methodological frameworks and tools for analysis of health expenditure and other economic issues, and studies, evaluations, and policy briefs on financing/insurance alternative schemes and methods developed and in use at country level	Tools for analysis being developed	Tools for analysis fully developed and made available to Member States
		. Number of Member States that have institutionalized economic/financial data/indicators for health protection	20	30
		. Number of Member States that have institutionalized economic/financial data/indicators for social protection	4	10
4.	Increased opportunities for policy/social dialogue regarding social and financial protection in health.	. Number of entities/fora for policy/social dialogue and consensus-building functioning at country level	6	12
		. Number of special initiatives and plans of action in place to improve universal and equitable access to comprehensive and quality health care	5	12
		. Conceptual frames of reference, and analytical tools and methodologies for strengthening interinstitutional coordination mechanisms available for use by different stakeholders	Frameworks and tools for social dialogue developed and tested in 3 countries; frameworks and tools for inter-institutional coordination being developed	Frameworks and tools made available to all Member States
		. Information on best practices and advantages/disadvantages of the different strategies, modalities, and schemes regarding extension of social/financial protection in health available to inform the policy dialogue	Information being identified and organized	Information on best practices available to all Member States

5.	Institutional, organizational, and human capacity building strategies/programs implemented in Member States to extend social and financial protection in health.	. Number of national plans of action developed and implemented to extend social and financial protection in health and to achieve the MDGs	2	6
		. Number of Member States that are using new analytical frameworks for developing alternative financing methods	2	8
		. Technical cooperation modalities, approaches and tools that support the reorganization of social security organizations available for use by national authorities and other stakeholders	New approaches and tools vis-à-vis social security in early stage of development	New approaches and tools regarding social security available to 2 sub-regions
		. Number of countries in which social security organizations have undergone reorganization and have extended their coverage		4
6.	Guaranteed portfolios of entitlements developed, and promoted within the framework of social/financial protection in health.	. Methodologies and tools produced to design and implement guaranteed portfolios of entitlements	Methodologies and tools in advanced stage of development	Methodologies and tools available for use by governments and stakeholders
		. Number of countries that have implemented new or improved guaranteed portfolios of entitlements	2	6

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	3,760,700	3,462,000	7,222,700
2006-2007	3,868,500	3,847,000	7,715,500
Of which:			
Country	1,346,300	1,923,500	3,269,800
Subregional	309,600	0	309,600
Regional	2,212,600	1,923,500	4,136,100

HEALTH INFORMATION, EVIDENCE AND RESEARCH POLICY

ISSUES AND CHALLENGES

Sound health information is the essential foundation of public health programming, which aims to promote greater equity among and within populations. In many countries in Latin America and the Caribbean, however, basic systems are not in place for counting births and deaths, identifying cause of death, monitoring health status, or tracking the use and effectiveness of programs. Program planners and managers do not have the information they need to use resources effectively and, at the same time, are beset with different demands from many external agencies to provide data for monitoring the use of their funds.

There is an urgent need for joint effort among agencies responsible for health and for official statistics to reform and strengthen the components of health information systems, including surveys, vital registration, surveillance and service statistics, which can meet the needs of planners, managers, and donors at country and international levels. Experience has shown sustainability systems have to be appropriately simple and not necessarily rely on the most sophisticated electronic technology. PAHO will play a key coordinating, operational, and technical role in this process.

PAHO/WHO plays a unique role in generating and consolidating knowledge and evidence on public health issues. All countries in the Region provide updates on the basic health indicators, and many countries now publish their national data, disaggregated by geographic region and socioeconomic parameters critical for monitoring the equity situation among populations. While the quality and timeliness of data for the (BHI) has improved overall, these improvements have been less evident in the English-speaking Caribbean. It will be important for the countries of the Region to participate fully in the WHO Health Metrics Network (HMN), in order to take advantage of the expertise and resources that will become available to, among other things, improve country health information systems and strengthen capacity for reporting on progress in achieving the health-related Millennium Development Goals.

The publication *Health in the Americas* continues to be the Organization's flagship publication and is now used widely at the national and international levels and increasingly among schools of public health in the Region. This report on the assessment of the Region's health is constitutionally required and the next publication is due in 2007.

Implementation of the *International Statistical Classification of Diseases and Related Health Problems* and the *International Classification of Functioning, Disability, and Health* is almost universal among the countries of the Americas. However, the use of the current *International Classification of Diseases, Revision X* (ICD X), is more widespread for the coding of mortality data than for morbidity conditions. PAHO needs to promote the establishment of more WHO Collaborating Centers in this technical area in this Region.

Research aimed at improving the public health approaches and health systems is a relatively neglected area compared to the huge investments made in the biomedical and clinical sciences. This imbalance was highlighted at the Ministerial Summit on Health Research (Mexico City, 16-20 November 2004) and needs to be corrected in order to make effective use of scientific knowledge to inform policy for improving health and health equity. The national health research systems are weak in many countries in LAC, and there is inadequate support from regional and global networks. There is limited collaboration among researchers and policy-makers or practitioners in setting the research agenda. Failure to put existing and new knowledge rapidly into practice is a key challenge for the health-research community. The response calls for tackling the inequity that exists in access to health information and knowledge, and assuring that knowledge derived from research is accessible, disseminated, and shared among the producers and users of research.

Related to this is the need for countries to understand and prepare for the ethical challenges related to new developments in technology and for the research involving human beings, especially at the community level. The necessary experts in this area are scarce in the developing countries.

GOAL To maximize the potential of health systems to improve health and to respond to health needs in a way that is equitable, effective, and efficient on the basis of sound health information and scientific knowledge.

OBJECTIVES To improve the availability, quality, and use of health information at country level; to strengthen the evidence base at regional and global levels in order to monitor and reduce inequalities in health; to develop health-research systems; to build research capacity; and to use research findings to strengthen national health systems.

STRATEGIC APPROACHES Reorganizing and reforming country health information systems, including epidemiological services, and health and vital statistics; monitoring the health situation in the Region; developing and enhancing the evidence base for health systems, by consolidation and publication of existing evidence and facilitation of knowledge generation in priority areas; advocating and promoting health research to build better health systems and strengthening its interface with health systems at national and subnational levels; fostering dialogue and coordination with interested partners at national and regional levels; carrying out policy, technical, and analytical activities in countries to strengthen health services research; advocating and building capacity for incorporating ethical dimension into health research and policy-making.

REGIONWIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Strengthened and reformed country health-information systems that provide and use quality and timely information for local health programming and for monitoring of major international goals.	. Number of countries with adequate health-information systems in line with international standards as defined within the Health Metrics Network	Number of countries currently meeting the standard	5 additional countries meeting the standard
	. Number of countries using data no older than 3 years to calculate half of the basic indicators	Number of countries meeting criterion for the 2005 PAHO publication	At least 10 additional countries meeting the criterion for the 2007 publication
2. Better knowledge and evidence for health decision-making, by consolidation and publication of existing evidence and facilitating knowledge generation in priority areas.	. Annual publication of PAHO basic health indicators disseminated widely	Publication in time for each Directing Council meeting	Publication in time for each annual Directing Council meeting
	. Number of PAHO publications in which new evidence to redirect health programs or reinforce existing priorities is evident	Number of publications meeting criterion in the biennium 2004-2005	Number of publications in the biennium 2006-2007

		. *Health in the Americas* available in hard copy and on the Internet	. Latest publication approved by the Directing Council in 2002	. New publication approved by Directing Council in 2007
3.	Research capacity strengthened and support given for research on regional health issues. Support for strengthened capacity of national health research for health-systems development.	. Number of nationals completing relevant course in the Virtual Campus	0	15 at the end of 2007
		. Number of countries with national research agendas updated in the past 4 years.		
		. Availability of health-system research priorities for PAHO/WHO.	Draft framework of priorities	Final list of priorities
		. Degree of effectiveness of PAHO/WHO regional program in research.	All PAHO-funded research programs executed as planned	All PAHO-funded research programs executed as planned
		. Number of initiatives commissioned by the Regional Advisory Committee on Health Research.	No significant initiatives developed or implemented	2-3 initiatives implemented in priority areas
4.	Networks and partnerships established or strengthened that improve international cooperation for health research.	. First time collaboration with national or regional institutions.	Number of new agreements signed in 2004-2005	At least 2 new agreements signed
		. Networks of national researchers operational.	Number of national task forces operating at the end of 2005	5 additional networks of research collaborators at national level
		. Increased networking between PAHO/ WHO Collaborating Centers and/or countries in high priority areas.	Number operating at the end of 2005	4 more than 2005 level
5.	Capacity for integrating bioethics in health policy/programs increased at national level.	. At least 75% of the countries have commisions or national committees in bioethics		

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	15,206,700	4,985,000	20,191,700
2006-2007	15,355,700	6,087,000	21,442,700
Of which:			
Country	6,357,700	3,043,500	9,401,200
Subregional	1,024,200	0	1,024,200
Regional	7,973,800	3,043,500	11,017,300

EMERGENCY PREPAREDNESS AND RESPONSE

ISSUES AND CHALLENGES

In addition to the Region's well known vulnerability to natural disasters, new challenges have emerged during recent years with the appearance of complex emergencies, such as those in Colombia and Haiti. PAHO and its staff must adapt their work to these new scenarios. Bioterrorism continues to be a concern.

The economic and social cost of disasters is significant and the recovery phase can be prolonged, often delaying development goals. Economic inequity in the Region further compounds the consequences of natural disasters and complex emergencies. Although country capacity to respond to disasters has improved, the high level of staff turnover makes it difficult and expensive to maintain trained groups of disaster managers in the Region.

Disaster mitigation continues to be a challenge. For example, due to economic and political factors, mitigation measures still do not get incorporated into new water systems or the health infrastructure. A coordinated effort among different international organizations, financial institutions, and governments is needed, but difficult to achieve.

GOAL

To reduce the impact of disasters on health and health systems in Latin America and the Caribbean.

OBJECTIVES

To strengthen the capacity of the countries of Latin America and the Caribbean to prepare for disasters; to improve their knowledge of effects of natural disasters on health facilities and water systems; and to enhance their ability to assess post-disaster health needs and efficiently manage the aftermath of disasters.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Improved disaster preparedness at country level.	. Human resources trained in disaster preparedness . Technical and multimedia materials, including print and electronic resources, developed, updated, and distributed . Multiple web sites maintained, improved, and updated, reflecting latest information on vulnerability reduction activities in the Region . Partnerships and alliances with others organizations and institutions working in disaster preparedness improved and/or increased		
2. Improved level of awareness of disaster mitigation issues and their link to development on the part of health facilities and water systems.	. Technical materials on disaster mitigation developed and distributed (in print and electronically) . Disaster mitigation measures incorporated into building codes in the Region . Vulnerability analysis of priority health facilities and water systems promoted . Country participation in regional and subregional activities		

3. Countries of the Region efficiently manage the aftermath of disasters.	• Dissemination of and training in the new Logistics Support System (LSS) software; LSS software adopted by an increased number of humanitarian agencies and countries • Support provided for the design and implementation of emergency health projects, together with the timely mobilization of financial and human resources • Coordination among agencies and government institutions improved • Timely deployment of human resources in case of emergencies
4. Improved partnerships with other organizations and awareness about health disaster preparedness improved within PAHO.	• PAHO response to disasters improved • Disaster mitigation measures incorporated in other unit/division projects • Training materials and publications developed in conjunction with other divisions/units • PAHO country offices strengthened in the management of disasters • Improved partnerships with other disaster-related institutions at all levels

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	1,435,200	31,619,000	33,054,200
2006-2007	1,625,400	27,175,000	28,800,400
Of which:			
Country	601,400	11,175,000	11,776,400
Subregional	68,200	11,000,000	11,068,200
Regional	955,800	5,000,000	5,955,800

COUNTRY COOPERATION LEADERSHIP AND COORDINATION

ISSUES AND CHALLENGES

There are 38 countries served by 27 country offices and the border office in El Paso Texas. The PAHO/WHO country presence needs to complement or supplement the capacity in the countries and ensure the strategic and equitable use of PAHO/WHO resources, both technical and financial, in support of national health in development objectives.

The health development process is challenged by increased inequalities in the health situation; mixed and complex epidemiological profiles; transitional stages of health sector reform; unclear roles of different institutions as a result of decentralization; proliferation of actors and stakeholders; reduction of resources; and the impact of integration processes.

The various reform processes taking place make more complex the planning and execution of technical cooperation: (a) the U.N. reform seeking for closer coordination and harmonization of all U.N. agency country programs; (b) the WHO reform seeking to strengthen organizational presence and performance at country level; (b) the state and health systems' reforms advancing decentralization and recognizing the multiplicity of players, including civil society and the private sector.

Numerous international commitments and mandates related to health have been made at many levels and within various sectors, such as the Millennium Development Goals; national health authorities need assistance in planning, monitoring, and staying apprised of developments as well as the application of various frameworks for development cooperation. In addition, national authorities from sectors other than health need to be sensitized to their important role in addressing issues that go beyond the health sector.

Country offices must assist countries to integrate the proliferation of planning frameworks and parallel projects competing for human and other resources—UNDAF, CDF, PRSP, CCS, sectorwide approach (SWAP)—and to participate in the complex negotiations with financial partners. Country offices must take the lead in helping countries to establish policy coherence, forge cooperative and harmonizing mechanisms, and maintain useful partnerships with other United Nations, multilateral, and bilateral agencies as well as NGOs. This challenge is particularly important for the five Key Countries in the Region: Bolivia, Guyana, Haiti, Honduras, and Nicaragua.

Meaningful participation of PAHO in UNAIDS, U.N. system technical or thematic groups, and donor coordinating mechanisms to promote synergy among a wide range of agencies is important and needs to be expanded, although it takes up a considerable and increasing amount of time and resources.

It is essential to increase the health ministries' knowledge and ownership of the Organization (PAHO and WHO) in order for them to participate effectively in the governance and normative functions of the Organization. The role and capacity of offices of international relations in the ministries of health (in LA) varies considerably and tend to be weakest in the Key Countries.

Decreased financial resources for technical cooperation (PAHO and WHO budgetary constraints; external cooperation changing focus; international financing institutions' conditions and policies), require that PAHO's cooperation be more strategically defined and that country offices increase support to efforts aimed at mobilizing external as well as internal resources for health, particularly, but not only, in the Key Countries.

The increased momentum in the subregional integration processes provides an opportunity for addressing health issues of common concern, such as harmonization of norms and standards aimed at decreasing barriers to trade; strengthening collaborating with development partners; and mobilizing resources. Strategies are needed for each subregion to determine the most effective way that PAHO can support Member States in advancing their common health development agendas through these integration processes.

GOAL

To position health issues at the center of the national development agenda, and have effective coordination of national, subregional, regional, and international efforts for the achievement of the national health development objectives.

OBJECTIVES To increase the capacity of the health sector in its steering role to address national health priorities in the framework of subregional, regional, and international collective agreements.

STRATEGIC APPROACHES

- Supporting the Ministry of Health (MOH) to play new roles, especially the lead role in coordinating international cooperation for health.
- Advocating and promoting consensus-building among national, subregional and international partners for addressing health priorities.
- Encouraging and enabling PAHO/WHO Representatives to negotiate and cultivate support to countries from the global/regional levels and among country offices and specialized centers in order to promote specificity and sensitivity in developing responsive TC programs.
- Working toward optimal country support and PAHO/WHO country presence in each country by carrying out analyses and facilitating the appropriate mix of political, technical, and managerial perspectives in the formulation and execution of corporate policies that have implications for country presence.
- Providing institutional memory and information clearinghouse functions regarding technical issues.
- Developing Country Cooperation Strategies (CCS) to define strategic cooperation for PAHO/WHO and linking these to operational plans throughout the Organization to ensure optimal support for the national health development process.

REGION-WIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Increased national capacity to manage and coordinate national and international cooperation to advance national health development.	. Regular national fora established or strengthened for ministers of health, MOH staff, and other national sectors, sub national levels, and partners to discuss and agree on international cooperation for national health development	5	28
	. Number of countries implementing new program to support the steering role of MOH in coordinating and monitoring work with external partners and resources for international cooperation in health	8	21
	. New ministers and selected national and sub regional health authorities briefed on PAHO's current policies and procedures	20	35
	. Percentage of briefings of new ministers and selected national health authorities regarding PAHO's current policies and procedures conducted within six months of entry on duty	16	21

2.	Strengthened strategic focus for PAHO/WHO programs of technical cooperation.	. Number of Member States for which a Country Cooperation Strategy (CCS) has been developed	15	28
		. Number of country offices with a staff reprofiling plan or Office Development Plan as a result of a CCS that is being implemented	3	28
		. Percentage of BPBs checked for coherence against CCSs	80	100% of country offices with CCSs
3.	Strengthened support provided to country offices in the design, implementation, and evaluation of appropriate technical cooperation programs.	. All Key Country Interprogrammatic Working Groups meeting at least quarterly	2	5
4.	Health and health-related components of subregional integration processes strengthened.	. Subregional cooperation strategies developed	7	28
		. Country BPBs reflect the technical cooperation and advocacy carried out to strengthen coordination with the United Nations and other agencies at national level		

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	19,154,900	5,018,000	24,172,900
2006-2007	23,067,700	4,010,000	27,077,700
Of which:			
Country	16,817,000	3,010,000	19,827,000
Subregional	3,801,300	1,000,000	4,801,300
Regional	2,449,400	0	0

KNOWLEDGE MANAGEMENT AND INFORMATION TECHNOLOGY

ISSUES AND CHALLENGES

Knowledge management is an organization-wide strategy which is required to enable the organization to be positioned as an authoritative source of information and knowledge for diverse publics on issues related to public health. It promotes a change by which all staff will recognize the enrichment which emanates from improved networking and collaboration in the processes related to the capture, generation, and sharing of information and knowledge among all levels of the Organization and among its partners.

This strategy requires a balance among the people, processes, and technology at all levels of the Organization and in all activities related to knowledge management. The capacity to communicate information and knowledge with diverse publics in itself would require that processes are in place to ensure that the explicit knowledge being made easily accessible and available via electronic and traditional means must be validated and of a high quality. Important to the work of the Organization is the experience of the staff. Different methods will have to be used to capture and share the tacit knowledge of the staff.

In addressing the issue of knowledge management, the role of information technology is important for capturing, sharing, and generating both explicit and tacit knowledge and learning. In this context, issues of security and assurance (reliability, stability) of networks and other technological infrastructures become critical. Processes and systems for planning and execution need streamlining and regular evaluation and refinement. New technology needs to be exploited in order to support the access to relevant information and knowledge and reduce the digital and content divide.

It is important to underscore that at the county level, policies and strategies are needed to support efficient health information systems coupled with information management technologies.

Additional challenges faced by the management of information and communication technology (ICT) include the need to constantly search for ways to reduce costs while still maintaining the required support in priority areas. PAHO's decentralized locations/duty stations add complexity to providing technology support, and ensuring reasonable connectivity to the many field locations is costly. There are significant costs both at Headquarters and in the field offices to replace old systems, hardware, and software to take advantage of new technology; and these costs must be balanced against other priority investments. Even maintaining the existing infrastructure in required software licenses, hardware support, ~~infrastructure~~ and telecommunications is costly; and each aspect is kept under constant review for possible efficiency measures.

A mechanism to prioritize information technology (IT) development, regardless of where the project is budgeted within the Organization, is needed to ensure the strategic use of the Organization's resources. Furthermore, stronger internal coordination is needed between business process owners and IT specialists to avoid redundancy of development and incompatibility of products developed. A PAHO IT strategy is currently under development, and a governance body is being established to recommend prioritization of information and communications technology investments organization-wide and to ensure sound IT input into product development.

GOAL

To foster, equip, and support an environment that encourages the generation, sharing, effective application, and dissemination of knowledge in Member States and within the Organization in order to promote health, using appropriate knowledge management and information and communication technology.

OBJECTIVES

To promote an organizational culture supported by an information technology infrastructure that responds to needs of users in Member States and within the Organization related to knowledge management and information technology.

STRATEGIC APPROACHES

- Marketing and sharing information on all knowledge repositories and products across the Organization.
- Promoting the development of policies and strategies to ensure that information and knowledge captured, generated, and shared would be validated and of a high quality.

- Establishing an organization-wide governance mechanism to guide and monitor strategic information and communication technology plans as a result of the IT strategy. This will include phased development and delivery systems and complementing resources and skills at Regional Offices and Headquarters by selective outsourcing.
- Promoting the use of cost-effective mechanisms for communication across the Organization that permit efficient functioning in support of administrative and technical efficiency and a response to the needs of different audiences.
- Conducting country ICT assessments and following up to ensure that recommendations made to country offices are implemented.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Improved mechanisms and capacity for information dissemination in support of increased access to knowledge.	. Organizational policies and implementation plans on the Virtual Health Library (VHL) defined for the Secretariat, 4 thematic areas, and 10 countries by the end of the biennium	10	15
	. Number of geographic and thematic VHLs. Secretariat staff and nationals of countries are trained	4	8
	. Marketing plan for WHO knowledge products completed and products available via the Internet and other traditional sources	0	1
	. Communication plans developed by Regional and Country Offices by the end of 2007		
	. Efficient search engine to support PAHO Intranet and Internet functioning by the end 2006		
	. Training program to improve the collaborative working capacity established by the end of 2006		
2. Strengthened management of public health information systems and analytical capacity.	. Strategies and policies on design, analysis, and evaluation of surveillance and information reports available by the end of 2007	0	2
	. Methodological guidelines for the conduct of situation analysis available and in use across the Organization by the end of 2006		

		. Mechanisms for the interoperability of databases defined by the end 2007		
		. Strategies and policies on design, analysis, and evaluation of surveillance and information reports available by the end of 2007		
3.	Global strategic and operational plans for information and communication technologies designed and implemented.	. Development of a strategy and implementation plan for services in support of the countries, "communities of practice," and country-focused PAHO applications (Sharepoint portal services, geographical information systems, Infocom, Virtual Campus)		
		. Evaluation of subregional IT delivery models conducted and plan developed for implementation of the most appropriate structure		
		. Number of locations in which bandwidth is improved where current connectivity is suboptimal	6	6
		. Framework is in place to ensure that there is no redundancy in IT products and services across the Organization		
4.	Mechanisms and policies related to knowledge management in support of integrative working; the country focus initiative, and knowledge transfer defined.	. Communities of practice in a number of technical areas functioning and linked to the CCS and MDGs by the end of 2006	3	12
		. Integrated groups and networks established	1	3
		. Organization-wide program for conceptual understanding of knowledge management developed and implemented by the end of 2007	0	1
		. Content management process defined and implemented by the end of 2006	0	1

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	18,998,200	4,902,000	23,900,200
2006-2007	19,531,800	9,896,000	29,427,800
Of which:			
Country	1,280,600	2,138,000	3,418,600
Subregional	0	5,000	5,000
Regional	18,251,200	7,753,000	26,004,200

PLANNING , RESOURCE COORDINATION, AND OVERSIGHT

ISSUES AND CHALLENGES

Given the constantly changing environment and ever-increasing mandates for health and development at the global, regional, and subregional levels, it is important that the Secretariat utilizes a robust but flexible planning and program management process. This is accomplished through developing and monitoring its five-year strategic plan (SP) and biennial program budgets (BPB). Driven by the urgency to assist countries to achieve their specific MDGs, the Secretariat will need to intensify the interprogrammatic and interagency work started in 2004-2005.

PAHO has a different planning cycle and approach than that used in WHO. As PAHO strengthens its results-based planning and management, it will align its managerial process and content and the associated management information systems as much as possible with those of WHO. It will be important to make sure that the objectives of the alignment are understood internally and externally. The challenge will be to synchronize and integrate the planning and reporting processes and ensure that the process improves the quality of the technical work in the countries. In addition, the Country Cooperation Strategies (CCS) must be mainstreamed into the PAHO planning process.

As 2006-2007 will be the last complete biennium within the current strategic plan period, it will be important to evaluate the degree of achievement of the objectives defined within the Plan and the related managerial strategy. In designing the next strategic planning process, the Secretariat will have to take into account, among other things, the new planning process at the global level in which there will be a strategic plan for the first time as well as the mandates emanating from the Working Group on PAHO in the 21st Century.

The trend in the donor community towards program support rather than the support of discreet, short-term projects is a major paradigm shift and will require some reengineering of the approach to plannning and managing technical cooperation. The development of "one program budget" for 2006-2007, which reflects the totality of the needs of PAHO to address the priorities of the countries, is a significant first step. New skills such as planning for the scaling-up of intiatives and reporting for a wide audience will have to be introduced urgently.

The AMPES and its electronic information systems for monitoring and reporting will have to be upgraded and adapted to accommodate program as well as project management. At the same time, getting managers to routinely use the information available in the AMPES system for more effective management of our technical cooperation programs continues to be a challenge, especially at the Regional Office level. This information support is critical to the effective implementation of results-based management.

The culture of and capacity for evaluation remains limited, and PAHO's efforts to strengthen the use of evaluation in its strategic work and in its results-based management must be further consolidated by increasing the organizational learning through routine conduct of a wide range of evaluations to guide strategic decision-making.

PAHO's work is funded by the assessments of Member States, directly to PAHO and indirectly through WHO, and by voluntary contributions from several sources. While health-related Official Development Assistance is expected to increase overall, if the commitments made at the 2002 U.N. Conference on Financing for Development materialize and if the MDG 8 goal is achieved, PAHO will have to design strategies to counter the trend among bilaterals and multilaterals of decreasing the regional funding envelopes. In the case of WHO, while more WHO voluntary contributions were received in the biennium 2004-2005, the Region still receives by far the lowest level voluntary contributions from WHO of all the Regions, and the WHO policy to decentralize resources particularly to the country level has not been evident. For 2004-2005, despite an increase the Region's WHO voluntary funding, PAHO/AMRO is still receiving four times fewer voluntary resources than any other WHO Region, and only 1% of total WHO voluntary funding.

There continues to be increasing numbers and types of health development partners and of funding. The private sector and civil society organizations are now recognized partners in development, and mechanisms such as the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS,

Tuberculosis, and Malaria (GFATM), and the Global Alliance for Improved Nutrition (GAIN) are expected to increase.

Among the challenges is the need to sensitize WHO and other partners to the reality that the Americas is the most inequitable Region. There is a need to increase resources mobilized for special groups and the Key Countries in order to reduce inequities among and between countries and people. In addition, PAHO needs to ensure that the process for resource mobilization is effective and the programmatic and financial execution of the voluntary contributions efficient. PAHO also needs to help countries understand the new types of governance and the logic of operation of the new funding mechanisms.

GOAL

To achieve national, subregional, and regional health development goals supported by effective technical cooperation.

OBJECTIVES

To mobilize and effectively plan resources for cooperation in health within an integrated program, and to execute them efficiently.

STRATEGIC APPROACHES

- Further aligning our programming and budgeting processes with WHO.
- Adapting best practices in results-based policy, program and project planning, management, and evaluation to PAHO's context.
- Building capacity in countries as well as in the Secretariat for program/project management.
- Promoting AMPES/OMIS/FAMIS as the system that integrates most monitoring and reporting needs of all partners.
- Positioning the Organization as a value-added partner in new mechanisms for funding and project management.
- Providing timely information on PAHO's resource base and on the status of programs internally and externally.
- Improving management of program/projects.
- Building capacity in planning and evalution techniques.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. PAHO's strategic directions aligned with WHO, and integrated into biennial program management cycle.	• Evaluation of the Strategic Plan for 2003-2007, reviewed by Governing Bodies, demonstrating a high level of achievement of objectives • Draft strategic plan for 2008-2012, reflecting the new WHO Strategic Plan and PAHO in the 21st Century mandates, approved by Directing Council • BPB 2008-2009 proposal approved by Governing Bodies reflects the new PAHO Strategic Plan • BPB management process incorporates results of CCS and lessons learned		

	• Annual Report of the Director, midterm reviews, and end-of-biennium-performance assessments (global and regional) reveal high level of achievement of regional expected results
2. Tools, material, and information systems for planning and program/project cycle management assist managers at all levels.	• Updated guidelines, manuals, and toolkits for development and management of the project cycle and for programmatic initiatives available on PAHO homepage • Training programs on program/ project development, and Roll Back Malaria completed by staff selected staff at all levels • More user friendly electronic program and project management information systems accessible to all levels of the Organization
3. More effective planning and execution of extrabudgetary initiatives (EBIs).	• Approved projects are aligned with the approved Biennial Program Budget • Increase in the number of programmatic initiatives • Decrease in the funds returned to donors annually • Successful evaluation of EBIs
4. Evaluation program implemented and capacity building in evaluation facilitated.	• Wide range of evaluations conducted at all levels of the Organization • Evaluation tools and methodologies adapted and disseminated • Country and PASB staff trained to conduct or manage evaluations • Evaluation design and results shared by Intranet and Internet
5. New Resource Mobilization Strategy defined and implemented.	• The number of institutional or umbrella agreements increased by 50% of the number at the end of 2005. • The amount of WHO extrabudgetary funding increased by 50% of the total for the 2004-2005 biennium. • Program support negotiated with 3 more partners.
6. Risks to the Organization identified and mitigated by controls designed to ensure good corporate governance.	• Level of implementation of annual audit plan.

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	4,551,100	500,000	5,051,100
2006-2007	4,490,700	1,045,000	5,535,700
Of which:			
Country	0	0	0
Subregional	0	0	0
Regional	4,490,700	1,045,000	5,535,700

HUMAN RESOURCES MANAGEMENT

ISSUES AND CHALLENGES

In 2006 -2007 PAHO will be consolidating its organizational transformation, and it is imperative that necessary human resource management changes be well on stream. One challenge is to attract and retain the most talented and well trained women and men from the Member States, who are committed to the mission of the Organization and can work effectively in the new environment for the delivery of technical cooperation. Retraining of current staff will also be important in support of the transformational goals.

Good planning of human resources, based on actual and projected needs, is essential to the effective management of staff. Managers need to have employment packages that are closely aligned to the type and duration of the function performed. The implementation of the regional program budget policy has created a range of human resource management challenges at both the country level where the resources may have been decreased or increased, and the regional level where the funding levels have been decreased.

To support the country focus strategy, more decentralization of staff and units is planned. The Secretariat will review the contractual, supervision, and reporting mechanisms to ensure that these are appropriate to the changing needs.

PAHO will continue to promote an organizational culture in which staff achieve high levels of performance through sound management and development. The Personal Performance Evaluation System (PPES) will be further evaluated and modified to suit the new way of working in teams and to enhance staff competencies.

PAHO will also continue to promote a culture of fair treatment through strengthening staff/management relations based on mutual trust and respect. Initiatives to create a healthy and enabling work environment will be expanded.

Another main challenge will be to ensure that human resources management fully assimilates the competencies and behaviors of the new management culture. PAHO has had an emphasis on staff development over the years. Further investment will be possible through participation in WHO's new global management and leadership development program. PAHO will implement a leadership and development component aimed at creating the competencies identified as critical to its transformation.

There needs to be increased participation in common U.N. system initiatives, such as the review in pay and benefits reforms, with a view to making the compensation package more responsive to and supportive of the current needs of Member States, U.N. organizations, and staff. The proposed reforms include introduction of performance-related pay, grouping of grade levels, and the establishment of a senior executive service.

A recruitment strategy designed to broaden the diversity and talent of the WHO workforce will be implemented. A more rigorous selection process, which will include competency-based interviewing and the technical and psychological testing of candidates, is being introduced; and there will be more active recruitment campaigns to increase the number of candidates and improve the representation from underrepresented states.

There are several ongoing initiatives but no comprehensive human resource strategy. Such a strategy needs to be developed and managers must understand its intent if they are to be expected to accept responsibility for planning and managing human resources as called for within results-based management.

GOAL

To apply best practices in all aspects of human resources management at all organizational levels in support of PAHO's leadership role in international health and the goal of high performance.

PAHO OBJECTIVE

To provide the strategic direction, policies, and procedures necessary to ensure that the best human resources are in place in a timely manner and supported in their efforts to promote and protect health.

STRATEGIC OBJECTIVES

Development of a comprehensive human resource strategy and updating of policies; redesign of systems, devolution of responsibility for selected processes to line managers, automation of work processes and use of web based support to improve efficiency of human resource services; continuous improvement of technical and people-management capabilities, processes and systems.

ORGANIZATION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. New human resources management strategy guidelines; streamlining of human resources procedures, and improving information systems and HRM in general.	. Degree to which new human resources strategy is understood by managers and administrators	Number of managers and administrators who complete HR strategy course	At least 60% more managers and administrators complete HR strategy course
	. Degree to which organizational units are reprofiled, and gap between required and available skills and competencies is known	Number of regional organizational units having completed the exercise for repro-filing at the end of 2005	All regional organizational units completed reprofiling exercise and plan of action developed to address gaps
	. Degree to which web-based procedures are used by line managers for recruitment	Number of recruitment transactions using web-based system	Increase by at least 30% number of recruitment transactions using web-based system
2. Effective learning programs that meet staff and organizational needs.	. Level of staff satisfaction with development opportunities offered at PAHO	Limited number of development opportunities	Expanded availability of learning programs based on assessed demand
	. Level of satisfaction with management and leadership capacity at PAHO reported by staff	Limited leadership and management learning programs available	Leadership and management learning programs implemented for all senior and middle managers
3. Work/life conditions improved and health of staff promoted.	. Implementation of additional new policies, programs, or conditions promoting or enabling healthy lifestyles, including work/life balance, among staff	The number and description of new policies, etc., introduced and operational in the biennium	The number and description of new policies, etc., introduced and operational in the biennium
	. Health of staff monitored		
	. Degree to which staff are aware of implementation of staff friendly policies		
	.		

4. Conditions of service improved, including WHO pay and benefits system brought into line with the U.N. field-oriented organiza-tions' system.	. Greater consistency with U.N. field-oriented organization systems	Current conditions of service	New conditions in line with U.N. field- oriented systems.
5. Procedures and systems maintained, enabling the Organization to recruit staff and meet its contractual obligations as an employer, while providing a caring and supportive environment for all staff. Meeting WHO contractual reform initiatives. for temporary staff.	. Proportion of timely and correct replies to queries and requests for assistance, and payments to staff and retirees according to their respective compensation/benefits package in accordance with entitlements rules	According to survey at end of 2005	100%
	. Frequency of appeals for non-compliance with the Organization's regulatory processes	Completed survey on organizational climate	Improved yearly survey results/reduced number of appeals/formal grievances
6. Reliable staff security management systems in place in PAHO to enable the effective and efficient conduct of activities while ensuring the security, safety, and well-being of staff.	. Percentage of PAHO staff, at regional and field levels, performing country duties, who are adequately trained in U.N. security management procedures and personal security	95% of staff who travel to or are assigned to countries in the security phase trained in basic security in the field	100%

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	6,630,200	1,000,000	7,630,200
2006-2007	7,068,800	4,295,000	11,363,800
Of which:			
Country	0	0	0
Subregional	0	0	0
Regional	7,068,800	4,295,000	11,363,800

BUDGET AND FINANCIAL MANAGEMENT

ISSUES AND CHALLENGES

Budget and financial management is a continuing, statutory function that must be efficient and allow for sound internal control to support the work of the Organization at all levels. In a decentralized environment, analysis of specific circumstances and consideration of the requirements of individual locations are needed in order to achieve consistency while ensuring the appropriate balance between service and control.

The current investment climate impacts the return on the Organization's investment portfolio to finance the Regular Budget, thus presenting a fiscal challenge. Along with an increased focus and desire to plan and implement a 'one program budget' with all sources of funds, appropriate strategies are therefore needed to ensure that the integrated program budget is financed on a sound, sustainable basis.

The management of a significant level of voluntary contributions committed to the Organization requires that staff have the commensurate skills, expertise, and capability to handle the volume of resources and associated budgeting and reporting requirements. The complexity of donor agreements challenges the review, oversight, and compliance capability of the Organization.

Timely, accurate, and relevant management information is vital to support the health activities of the Organization. Integrated reporting is necessary to improve the planning and monitoring processes of the Organization—meeting the needs of managers as well as the statutory and other requirements of Member States. As a result, there is a continuous challenge to maintain and develop information technology systems that are simplified and streamlined and that respond efficiently to both changing program requirements and the concerns of Member States.

GOAL

To maintain the financial viability of the Organization to ensure that the Secretariat can successfully contribute to the national, regional, and global objectives for technical cooperation, while ensuring the application of best practices in all aspects of budgetary and financial management.

OBJECTIVES

To ensure the efficient and effective management of financial resources entrusted to the Organization and the application of best practices in order to contribute to the Organization's leadership role in international health and to ensure a sound internal control framework.

STRATEGIC APPROACHES

- Providing, with a client focus, expected service efficiently, consistently, and in a collegial manner.
- Achieving identified results through the setting of clear objectives and levels of performance, monitoring that performance, and adjusting strategies and approaches based on the analyses of results (results orientation).
- Assigning staff members with the authority to make and implement decisions which are consistent with the Organization's strategic plan. In turn, staff are held accountable for results and for operating within the legal and ethical parameters established by the Organization (authority with responsibility).
- Establishing collaborative and collegial work relations among and between staff members and units, with mutual respect and a comfortable work environment guaranteed for all staff members (teamwork).
- Providing special attention to overseas administrative and finance staff members to ensure that the financial management activities of their offices are being performed effectively and that they receive the training required to meet their objectives and to implement specific initiatives that arise throughout the biennium (collaboration).

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Policies and guidance developed for integrated budgetary planning and implementation in line with a results-based management approach.	. Adherence to policies and guidelines observed in corporate work plans		

2. Efficient and effective management of the Organization's financial resources achieved while striving to maximize earnings within acceptable liquidity and risk parameters.	. Financial records and audit opinion confirm a sound financial position in terms of income and expenditure, and the earnings on investments meet the Organization's established benchmark
3. Compliance with established financial accounting standards, regulations, and rules ensured within a sound internal control framework.	. Financial regulations and rules are maintained current and consistent with U.N. standards and are followed for all financial management and accounting transactions
4. Effectiveness of information systems improved to manage the financial resources of the Organization and provide desired financial management information.	. Computer programs are enhanced and the hardware is made available to support the financial management and reporting requirements
5. Effective and responsive financial administration of supplier contracts, claims, staff salaries and entitlements, and staff members' and retirees' benefits.	. Payments to vendors, staff members, and retirees are processed in accordance with the financial regulations and rules of the Organization in a timely and accurate manner
6. The program budget managed in a timely, informed manner.	. Program budgets managed within the authorized appropriation and allocation levels . Required budgetary information and reports submitted to Governing Bodies, Executive Management, and financial partners

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	9,078,700	0	9,078,700
2006-2007	9,061,100	1,874,000	10,935,100
Of which:			
Country	0	0	0
Subregional	0	0	0
Regional	9,061,100	1,874,000	10,935,100

INFRASTRUCTURE AND LOGISTICS

ISSUES AND CHALLENGES

A key component of PAHO/WHO's ability to deliver its health programs in a decentralized manner is the provision of safe and adequate office space for its workforce in all the countries of the Region. In this age of expanded terrorism, the United Nations facilities are potential targets for attack; and the Organization must take all reasonable measures for the security of all staff. This is a continuing need which for some components can prove to be quite expensive. PAHO/WHO employees also require a myriad of support services to successfully perform their work. The challenge is for security and administrative support to be adequate, but economical and not divert unnecessary funding away from program activities.

Infrastructure services cover a range of internal and logistic support functions, including accommodations, office supplies, and all matters related to office services and concessions; general building management and maintenance, including provision of utilities; servicing of conferences and meetings; production, printing, and distribution of publications and technical, administrative, and conference documents; records management and archives; mail services; security and safety of grounds and premises; information on travel and travel policy; and contracting and procurement.

As the Organization seeks to become more connected and widen its stakeholders, the challenge will be to facilitate wide participation among our partners and clients through a balance in the use of electronic communication with cost-effective conference services. On the other hand, certain routine services, such as the storage of historical records, have inherently high costs.

In addition to the purchase of office supplies and equipment for its operations, the purchase of drugs, vaccines, and other medical and public health supplies is an essential part of the PAHO/WHO technical cooperation program in many areas. The PAHO/WHO procurement unit processed over $191 million for calendar year 2004. The challenge is to purchase these items at the most economical price, and ensure they are delivered on time to the needed recipients.

GOAL

To apply best practices in all aspects of infrastructure support at all levels of the Organization in support of WHO's leadership role in international health.

OBJECTIVES

To ensure timely access to effective infrastructure, supplies, and logistical services, in order to facilitate implementation of technical programs at all levels of the Organization.

STRATEGIC APPROACHES

Formulating long-term plans to minimize annual costs of accommodations; applying best practices identified across the Organization and from within the wider United Nations; sharing services with other organizations; monitoring unit costs constantly; maximizing use of umbrella agreements and electronic commerce facilities; and ensuring flexibility to allow responsiveness to specific country needs and unpredicted demands.

	REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1.	Infrastructure support services operated in a resource-effective-and-efficient manner.	. Average cost of selected operational transactions for general building management and office services	Average cost at end of 2004-2005 biennium	Not in excess of 10% increase in the average cost in 2004-2005
2.	Logistics support functions operated in a resource-effective-and-efficient manner.	. Average cost of selected logistics support functions for printing and distribution, travel, and communications	Average cost at end of 2004-2005 biennium	Not in excess of average cost in 2004-2005

3.	Continuing support provided to regional Governing Bodies and technical meetings in the form of efficient preparation and logistical support.	. Member States' satisfaction regarding the efficient and effective servicing of meetings	NA	90%
4.	General and public health supplies of the highest quality at the best price procured for technical programs and Member States, in the most efficient manner.	. Volume of procurement carried out on behalf of all PAHO offices, based on centrally negotiated contracts lowering unit costs	Percentage of procurement as of the end of 2005	10% increase in direct procurement
		. Percentage of volume of orders through new e-commerce mechanism for streamlining requests for orders	0%	15%
5.	Security and safety of grounds and premises improved.	. Number of PAHO/WHO sites that comply with minimum operating security standards	Complying sites as of end of 2005	All sites
6.	Real estate management and facilities improved.	. Availability of an updated 10-year rolling master plan of real estate projects	Master plan of previous biennium	10-year rolling master plan adopted
		. Proportion of projects implemented with financing from the Real Estate Fund that deviate from recognized best practices for local construction and environmental norms	Percentage of implemented projects that deviate from best practices at end of 2005	0 projects deviate from best practices.

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	11,467,400	2,500,000	13,967,400
2006-2007	11,799,600	4,332,000	16,131,600
Of which:			
Country	0	0	0
Subregional	0	0	0
Regional	11,799,600	4,332,000	16,131,600

GOVERNING BODIES

ISSUES AND CHALLENGES

The formal contribution of the Member States of PAHO/WHO to its work takes place within a series of Governing Bodies at global and regional levels. The work of PAHO/WHO also contributes to and is influenced by the United Nations system as a whole, and by the inter-American system (Organization of American States (OAS) and its specialized agencies). Through different mechanisms, PAHO/WHO is linked to the relevant parts of the wider systems.

As the framing of appropriate public-health policy becomes more complex and crucial, PAHO/WHO's Governing Bodies must be provided, in the most efficient and effective way, with both the inputs and the setting required for informed decision-making at global and regional levels. Careful and deliberate selection of the most pertinent issues, and greater participation and transparency, are essential in order to sharpen the focus of debate during the Governing Body sessions. In drawing up agendas and prioritizing topics for consideration, dialogue among Member States must be complemented by adequate flow of information among regional- and global-level Governing Bodies. Consensus on technical and policy matters remains the key outcome sought at the meetings of the Governing Bodies.

Because of the number and variety of Governing Body sessions, including special working groups or consultations, the requirements for preparation, logistic support, documentation, and information have become more complex, putting more pressure on the limited Governing Body services. While new technologies have facilitated the dissemination of documentation, making it possible, for example, to issue documentation for Governing Body sessions on the Internet, more use needs to be made of other electronic meeting technologies.

The rise in costs of the Governing Body sessions has been kept to a minimum in spite of the increase in this area of work. In accordance with the deliberations of the Working Group on PAHO in the 21st Century and the assessment by the U.N. Joint Inspection Unit, PAHO needs to streamline its Governing Bodies and review their functions, periodicity, and complementarity.

GOAL

To ensure sound policy on international public health and development that responds to the needs of Member States.

OBJECTIVES

To assure the good governance of PAHO through the efficient preparation for and conduct of the regional Governing Body sessions, and effective policy-making of processes at the global and regional levels.

STRATEGIC APPROACHES

Expanding and improving communication and coordination among Member States, and between Member States and the Secretariat; making more effective use of technology and exercising better control throughout the preparation process in order to speed up provision of concise and accurate documentation; carefully reviewing the agendas of Governing Body meetings to ensure their relevance to PAHO/WHO policy development; and developing methods to encourage participation of Member States and the corresponding contribution from accredited organizations.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Resolutions adopted, in particular on policy and strategy, which provide clear orientations to Member States and the Secretariat for their implementation.	• Proportion of resolutions adopted that are implemented at regional and national levels.	85%	90%

		• Increase in health contents in the agendas or resolutions of other bodies in the United Nations or inter-American systems	Nil	At least 1 area of health interest included per year in meetings of the OAS systems
2.	Communication between Member States and the Secretariat improved.	• Frequency of effective use of communication channels between Member States and Governing Bodies at global, regional, and country levels, concerning PAHO/WHO governance	1 major regional consultation per biennium by electronic means	2 major regional consultations per biennium by electronic means
		• Improvements in multilingualism in PAHO/WHO	Web site in the 4 official languages, when required	All Governing Bodies material on web site, in the 4 official languages
		• Proportion of Governing Body meetings held in appropriate official languages	100%	100%
		• Timeliness of Governing Bodies' documentation, in the official languages, according to the Constitution	90%	95%
3.	Better coordination in establishing the work programs of the various Governing Bodies sessions improved.	• Degree of congruence of agendas and resolutions of the regional and global Governing Bodies	Agendas and resolutions of global and regional Governing Bodies coordinated, in order to establish their own agendas	Officers of the Executive Board consider regional committee agendas and resolutions when planning the Board's agenda (January)
		• Effectiveness of the Governing Bodies evaluated and improved	Nil	Assessment of the role of the subcommittees

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	3,991,000	0	3,991,000
2006-2007	4,245,300	1,583,000	5,828,300
Of which:			
Country	0	0	0
Subregional	0	0	0
Regional	4,245,300	1,583,000	5,828,300

EXTERNAL RELATIONS

ISSUES AND CHALLENGES

In promoting integration of a health dimension into social, economic, and environmental development, PAHO seeks to support its Member States. It also does this by joining forces with other bodies of the United Nations and inter-American systems and a range of institutions offering knowledge and experience in other fields. PAHO's corporate approach to cooperation with current and future partners is implemented through its external relations.

To that end, PAHO maintains linkages with an increasingly diverse set of partners: intergovernmental, governmental, and nongovernmental organizations and agencies; regional and subregional political bodies; and diverse institutions and networks at national level. Cooperation with subregional and regional development banks have grown in scope as the latter take on more of a social development thrust. PAHO has a long history of collaboration with bilateral institutions and the European Union, and will strengthen these partnerships.

PAHO has strived to assure the prominence of health on the agenda of the regional international community. The U.N. Regional Directors Working Group has the potential to demonstrate real coordination within the U.N. system. Regional fora, such as the Summits of the Americas, present an important opportunity to highlight and advance the health and equity agenda in the Region. These gatherings also heighten AMRO's profile through its participation, which in turn increases its effectiveness in achieving the goals of the Member States. Other regional summits, such as the Ibero-American Summits and the First Ladies Summits, also have addressed health and equity issues; and AMRO has taken part in the planning of these meetings.

Member States provide the Organization's core resources through assessed contribution, but voluntary contributions play an equally important role in the Secretariat's efforts to support health development in the countries. The introduction of 'one PAHO program budget,' reflecting the totality of the work that the Secretariat will undertake, allows PAHO to better align the voluntary contributions with PAHO's core work. Among the challenges is the negotiation of support at the program level focusing on support for the expected results of the approved 'one program budget' and the acceptance by partners of the PAHO planning and reporting systems. Development of "scalable" programs within the areas of work is another challenge. PAHO needs to seek its fair share of WHO's voluntary contributions, as this Region remains the most inequitable Region with regard to health. Targeted approaches to foundations and the new global health partnerships and initiatives are needed to produce a significant increase in support.

The eighth MDG calls for "a global partnership for development" including raising the Official Development Assistance (ODA) in order to achieve the other goals. In this regard, the private sector and civil society organizations are becoming increasingly important partners in development, and there has been an expansion in the traditional sources of funding, known as Official Development Assistance. Based on the commitments made at the 2002 U.N. Conference on Financing for Development held in Monterrey, these new resources, and some of those freed through the HIPC initiative, will hopefully go to support the health-related and other MDGs.

The challenge for our Region is to increase, or at least maintain, its share of 14% of the health-related ODA at a time when several factors converge to channel the funds to other Regions in need. One of these factors is the tendency of both public and private sources to give most of their funding to new mechanisms for global funding**,** such as the GFATM, which in turn primarily funds countries in Africa. Another factor is that only a small number of countries (four or five at the most) qualify for assistance from many of the bilateral cooperation agencies. Fortunately these usually coincide with most of the Key Countries of PAHO. PAHO needs to highlight the extent to which this approach disregards the inequalities and poverty still present within many countries, and to advocate against the use of national averages for eligibility for bilateral assistance. As bilateral partners decentralize the decision-making for their health cooperation, it becomes imperative that Regional Offices and country offices have the necessary external relations intelligence for building strategic alliances at the country level.

Establishing and improving strategic alliances with our partners will require PAHO to streamline its systems of analyzing, implementing, and reporting on our activities in public health as well as adjusting to trends from project support to program support.

The growth in interactions with partners throughout the Organization raises the question of both strategic management for a corporate approach, and the increasing risk of conflict of interest. Existing rules and methods for the establishment of partnerships need to be developed further, especially in terms of governance, respect for PAHO/WHO's mandate, and the promotion of public health.

PAHO will participate in the global effort to collaborate with nongovernmental organizations and the private sector, to improve support for community public health, advocacy, and documentation of external partners' activities at country level.

PAHO will contribute actively to the harmonization, alignment, and coordination process of international cooperation, in particular with the U.N. system, the development banks, and its principal bilateral partners. PAHO will give specific support to the ministries of health and the national health sector in order to strengthen their leadership role at country level and in international public health.

GOAL

To ensure that health goals are incorporated in overall development policies and that resources for health are increased.

OBJECTIVES

To facilitate the creation and strengthening of strategic alliances and partnerships to promote health on the development agenda and mobilize financial, human, technical, and institutional resources for the Region with emphasis on the Key Countries.

STRATEGIC APPROACHES

Participating in the processes of the Summits and other international and regional fora, with a view to contributing to the adopted decisions; focusing on relationships with sister agencies to develop joint plans and clear sharing of resources and agendas; strengthening capacity for strategic alliances at all levels; providing timely information to influence the health agenda of development partners.

REGIONWIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Relevant international political processes are influenced to take into account the health priorities of this Region and such mandates incorporated into AMRO's work.	. Relevant international political processes are influenced to take into account the health priorities of this Region and such mandates incorporated into AMRO's work	2	3
2. Alliances and partnerships operational.	. Relations established with more NGOs, Civil Society Organizations (CSOs), or foundations working in health, either in official or working relations	Number at end of 2005	At least 10 % more than 2005 level
	. Joint declarations and/or strategic initiatives with U.N. agencies agreed and being implemented	0	4

		. Collaborative programs or agreements are negotiated and signed with bilateral agencies in the biennium	0	4
		. Results of Evaluation of Shared Agenda disseminated and discussed with at least one Governing Body	Number at end of 2005	At least 10 % more
		. Consultations with international financial institutions at country and regional levels each year	Number at end of 2005	At least 10 % more
3.	Capacity of countries and Secretariat to develop strategic alliances and partnerships strengthened.	. National health officials and staff in at least three Key Countries and 3 others trained	0	Staff of 6 countries and 6 country offices

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	3,955,500	522,000	4,477,500
2006-2007	4,639,100	812,000	5,451,100
Of which:			
Country	0	0	0
Subregional	0	0	0
Regional	4,639,100	812,000	5,451,100

DIRECTION

ISSUES AND CHALLENGES

In pursuit of the vision to be a catalyst for change in the health situation in the Region, PAHO will continue to be country focused, striving for "results in country." This presents a challenge to senior management to implement regional activities in such a way that they reflect the priorities and concerns of Member States, and draw on the synergistic strengths of other programs at the regional level, including the Centers, Headquarters, and the country offices.

The direction of PAHO's work during the period 2006-2007 will be influenced by the following:

- Technical priorities within the Strategic Plan, with a special emphasis on the health-related Millennium Development Goals and the priorities of Key Countries and special groups;
- Regional Program Budget Policy (RPBP);
- Alignment with WHO;
- Managerial Strategy.

At all levels, the Framework for Implementation of the Strategy for Technical Cooperation will be applied to ensure that while the unfinished agenda as embodied in the MDGs is pursued, the Secretariat works with countries in two other strategic areas—protecting the gains, and addressing the new challenges. PAHO's thrust to further the application of results-based management (RBM) and development of the 'one program budget' is in keeping with the strategy to be better aligned with WHO.

As called for in the RPBP, the Organization must continue to increase the proportion of resources allocated at country level, while maintaining stewardship of its technical agenda and striving for excellence in this regard. In doing so, an appropriate balance needs to be struck between the provision of global public goods and support to country-level action. Subregional work will be introduced formally for the first time. Initially, this must advance the official subregional health agendas within the political integration institutions and help to strengthen a range of subregional mechanisms that are required to support this vision of countries in the long term. The RPBP provides for flexibility of program management and of funding, and the Organization is committed to transparency in the use of these funds assigned for this purpose.

Five strategic objectives for organization of change provide specificity of direction in our efforts to assure the greatest levels of efficiency and accountability as we focus on results in countries. Executive management's challenge will be to consolidate and mainstream the 11 initiatives in the road map for organization change into the mainstream of PAHO culture and operations.

Public health needs to remain on the agenda for socioeconomic development at all levels in the Region, and the Secretariat must contribute to this through its advocacy, keeping key audiences and all populations informed. The partnership with the media must be nurtured at all levels, and staff must be trained to accomplish this. New initiatives like the regional forum will contribute to this as well as to opening up space for greater participation by unrecognized stakeholders.

The legal interests of the Organization must be protected. As PAHO seeks to work differently for greater impact of its technical cooperation, it must ensure that the appropriate legal frameworks are in place and that the response to requests for legal advice is timely.

GOAL

To advance regional public health and contribute to the attainment of the Millennium Development Goals, through coordinated direction at all levels.

OBJECTIVES

To direct the work of the Organization within the overall framework of the PAHO Constitution, and in keeping with the strategic plan so as to maximize organization-wide contribution to the health development goals of the Member States.

STRATEGIC APPROACHES

- Consolidating the organizational change process and mainstreaming initiatives to transform how PAHO does its core business and achieves results.
- Developing plans and policies through organization-wide participatory process involving Member States and partners.
- Exercising due diligence in stewardship, governance, and oversight.
- Making effective use of a wide range of communication tools and channels to expand dialogue on public health.

	REGION-WIDE EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1.	PAHO responds better to country needs.	. For all Key Countries, Country Cooperation Strategy (CCS) objectives achieved . Level of satisfaction of national partners	Less that 50% of key results or critical success indicators	At least 80% of key results or Country Support Initiative (CSI) achieved.
2.	PAHO has a forum for debates and dialogue.	. Regional forum convened on different topics	1 per biennium	At least 2 per biennium
3.	New modalities of technical cooperation adopted.	. Subregional technical cooperation programs executed		75% expected results (ER) of each sub regional program achieved
4.	Management processes improved.	. Quality of the BPBs deemed satisfactory on first review	30%	60%
		. Recruitment time for fixed staff reduced	NA	10 % reduction on 2005 average
5.	PAHO has become a learning/ knowledge organization.	. Number of 'communities of practice' . % staff contributing to 'communities of practice'	Number in 2004-2005	At least 5 more than operated in 2004-2005 biennium.
6.	Better synergy and coherence among the work of the different parts of the Organization.	. Most of the Areas of Work (AoW) focal points report satisfactory collaboration with the global level in planning and resource coordination	NA	60%
		. Most countries report satisfactory support for selected MDG-related regional expected results (RERs)	NA	At least 75%

7.	Legal status and interests of the Organization protected and good relations with Member Sates maintained.	• Fewer disputes and other legal difficulties	Number of disputes in 2004-2005	10% decrease in the 2004-2005 number of disputes
		• Reduction in the number of cases of noncompliance with rules and regulations	2004-2005 total number of cases	10% decrease in the 2004-2005 number
		• Basic agreements reviewed at least every 15 years	NA	All agreements meeting criterion will have been reviewed
8.	Awareness of Member States and global partners of the work PAHO.	• Increased coverage of PAHO's work in major international, regional, and country media	Number and type of media reporting PAHO's work for the first time.	At least 10% more in the number and type of media reporting PAHO's work
		• Multimedia campaigns executed to support public health issues	All	All
		• Percentage of extrabudgetary initiatives (EBI) executed in the biennium with communication strategies increased	Percentage of EBIs with communication strategies in 2004-2005	Increase by 10 percentage points
9.	Catalytic start-up and flexible funds provided for programs of particular need under the purview of the Regional Director.	• Strategic allocation of the Regional Director's Development Funds toward activities and initiatives that advance the mission of the Organization reported to the EC	All funds allocated as directed by the Regional Director	Funds allocated as directed by the Regional Director
		• Allocation of variable funding among countries, according to criteria approved by SPP, reported to the Executive Committee (EC)		

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	7,183,400	3,000	7,186,400
2006-2007	7,485,200	854,000	8,339,200
Of which:			
Country	0	0	0
Subregional	0	0	0
Regional	7,485,200	854,000	8,339,200

COUNTRY OFFICE OPERATIONS

ISSUES AND CHALLENGES

There are 38 countries served by 27 country offices and the border office in El Paso, Texas. The PAHO/WHO country presence needs to complement or supplement the capacity in the countries and ensure the principle of equity in the distribution of PAHO/WHO resources, both technical and financial.

Determining appropriate PAHO/WHO country presence for every country of the Region has been an on-going challenge that is made more urgent by (1) the imperative of strengthening impact at country level, (2) the limitation of resources and need for efficiency and effectiveness in support and execution, and (2) the Regional Program Budget Policy, which increases the share of resources going to countries, but also shifts resources among the countries to reflect relative health and economic need.

The local environment for the execution of technical cooperation differs in each case. The efficiency of the execution of the TC programs depends on the political, technical, managerial, and administrative support available. Country offices need to be developed to support the technical cooperation demands, ensuring the best use of physical, human, and financial resources to effectively and efficiently implement the approved technical cooperation program.

The use of electronic information and communication technology must be optimized to improve the corporate efficiencies as well as to expand the coverage and impact of TC. It will be important to ensure the involvement of the country offices in the broader area of PAHO/WHO institutional development.

Increasing general operating and other administrative expenses reduce the funds available for technical work. In addition, offices must address the different needs of donors for execution and reporting on extrabudgetary initiatives in the most efficient manner possible, and manage the numerous unplanned demands with often very limited resources.

GOAL

To provide effective and efficient support to Member States for reaching their national health and development goals through an adequate core presence of WHO at country level.

OBJECTIVES

PAHO/WHO country presence is relevant, adequate, and receives the necessary managerial, technical, and administrative support from all levels of the Secretariat.

STRATEGIC APPROACHES

- Working toward optimal country support and PAHO/WHO country presence in each country by carrying out analyses and facilitating the appropriate mix of political, technical, and managerial perspectives in the formulation and execution of corporate policies that have implications for country presence.
- Conducting annual internal country office operations evaluations to continuously improve effectiveness and efficiency.
- Providing institutional memory and information clearinghouse functions regarding administrative procedures.
- Promoting and supporting networking among country offices, to facilitate information sharing and mutual benefit from lessons learned and/or best practices.
- Developing and sharing sound and agile administrative mechanisms and procedures to support decentralized technical cooperation and encouraging a team approach for results-based management.

REGION-WIDE

EXPECTED RESULTS	INDICATORS	BASELINES	TARGETS
1. Efficient and effective PAHO/WHO country presence, consistent with country program.	. Percentage of countries for which criteria for country presence has been systematically defined and applied, based on the new technical cooperation strategy, the technical cooperation program, and the new Regional Program Budget Policy	15%	80%
		3	28
	. Formulation, monitoring, and evaluation of a development plan for each country office aligned to CCSs and according to guidelines developed in 2005	0	28
	. Number of internal evaluation exercises conducted in country offices annually for efficiency and effectiveness of country office operations, carried out jointly (country office and regional level)	0	1
	. System implemented to systematize networking and information-sharing among country offices and the regional and global levels	0 (system being developed)	1

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	19,292,600	714,000	20,006,600
2006-2007	22,096,500	4,000,000	26,096,500
Of which:			
Country	19,031,700	3,470,000	22,501,700
Subregional	2,062,000	500,000	2,562,000
Regional	1,002,800	30,000	1,032,800

TECHNICAL COOPERATION AMONG COUNTRIES

ISSUES AND CHALLENGES

The Technical Cooperation among Countries (TCC) approach helps to strengthen countries' internal capacities, takes advantage of the range of already existing country capacities, and provides opportunities to foster alliances not just with ministries of health but also with other relevant national and local institutions. TCC also allows for the development of social networks to address health determinants in an intersectoral way and, as such, is an effective means to implement a country-focused strategy.

While historically TCC projects have addressed infectious diseases, initiatives are being successfully applied increasingly to address local challenges in other areas, such as for health promotion and community organization programs. In this regard, TCC projects contribute to health not only because of process-related benefits but also as factors that can significantly contribute to national development. A current challenge is to put into practice methodologies that help to define TCC expected results, monitoring, and evaluation of long-term impact.

It is also increasingly necessary to promote and structure TCC projects to be better integrated and participatory, i.e. to be more inclusive regarding the organizations involved (intersectoral institutions, civil society, NGOs, professional associations, and the private sector). At this moment only countries in the Americas participate in the TCC approach, and efforts should be made to include countries in other WHO Regions.

PAHO currently contributes TTC funds as seed money from within country budget allocations, and in the case of the Caribbean subregion, from within subregional budget allocations. Participating countries in the TCC projects leverage these PAHO resources with their own direct and in-kind support. There is need for additional resource mobilization in support of this strategy, which so far has been successful in mobilizing from a few sources.

TCC projects have been increasing in number during the recent biennia. The Andean subregion has the largest proportion of TCC projects (25%), followed by Central America (20%), English Caribbean (18%), and Hispanic Caribbean (16%). The subregions of the Southern Cone and North America register a smaller proportion of projects, 12% and 9% respectively.

Lastly, it is important to either establish and/or strengthen mechanisms to capture and disseminate information and lessons learned from TCC projects.

GOAL

To increase recognition and utilization of existing capacities of Member States for increased horizontal cooperation, on the basis of Pan Americanism, solidarity, and integration principles.

OBJECTIVES

To increase use of the Technical Cooperation among Countries (TCC) strategy and improve management of the projects for enhanced efficiency and effectiveness.

STRATEGIC APPROACHES

- Supporting PAHO/WHO Representatives in their efforts to mainstream the TCC approach among national actors and to have a protagonic role in TCC projects coordination.
- Encouraging PAHO/WHO representatives to nurture positive attitudes towards projects of Technical Cooperation among Countries.
- Supporting PAHO/WHO representatives in the identification, negotiation, and formulation of TCC projects, based on country needs and strengths.
- Promoting advocacy and consensus-building around the TCC approach among national and international partners, including potential partners in other WHO Regions.
- Facilitating the appropriate management of TCC projects by making available the relevant instruments and resources.

- Strengthening institutional memory so that PAHO becomes a clearinghouse for technical interventions and administrative procedures that facilitate the development of TCCs.
- Developing Country Cooperation Strategies (CCS) where TCC becomes a key strategy in the process of national health development.

REGIONWIDE EXPECTED RESULTS		INDICATORS	BASELINES	TARGETS
1.	Expanded use of the TCC approach.	. Number of TCC initiatives	80 per biennium	100 per biennium
2.	Improved planning, implementation, monitoring and evaluation of TCC projects.	. Percentage of projects with an evaluation and final report.	50%	100%
3.	Increased diversity of national institutions in the planning and execution of TCC projects.	. Percentage of TCC projects with participation of organizations other than the ministries of health.	60%	80%
4.	Improved information-sharing of best practices in TCC.	. TCC database fully established, functioning, and accessible with relevant data and information regularly updated and disseminated in Internet. . In-depth case studies carried out.	5	20

RESOURCES (US$)

	Regular Budget	Other Sources	Total
2004-2005	4,048,200	0	4,048,200
2006-2007	2,622,400	2,000,000	4,622,400
Of which:			
Country	2,496,400	2,000,000	4,496,400
Subregional	0	0	0
Regional	126,000	0	0