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BIENNIAL PROGRAM BUDGET 2006-2007 OF THE PAN AMERICAN HEALTH ORGANIZATION: PERFORMANCE ASSESSMENT REPORT

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Acronyms

ACOFAEN	Colombian Association of Nurses Faculties
AGFR	Advisory Group on Financial Resources
ALAPE	Latin American Pediatric Association
ALCA/FTAA	Free Trade Area of the Americas
AMRO	Americas Regional Office
AoW	Area of Work
ART	Antiretroviral Therapy
ARV	Antiretroviral
BNI	Basic Need indicator
BPB	Biennial Program and Budget
BSE	Bovine Spongiform encephalopathy
BWP	Biennial Workplan
CA	Central America
CAH	Child and Adolescent Health
CAN	Andean Community of Nations
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community and Common Market
CAS	Country Accounting Services
CBR	Community-Based Rehabilitation Strategic
CCH	Caribbean Commission on Health
CCS	Country Cooperation Strategy
CD	Communicable Diseases
CDR	Communicable Disease Research
CFC	Country Focus Cooperation
CFNI	Caribbean Food and Nutrition Institute
CIDA/CAN	Canadian International Development Agency
CJD	Creutdeldt-Jakob Disease
CMP	Content Management process
COLABIOCLI	Latin American Confederation of Clinical Biochemistry
COMBI	Communication for Behavioral Impact
COMISCA	Central America Health Ministers Council
CPC	Caribbean Program Coordinator
CDC	Centers for Disease Control and Prevention of the USA
CRID	Regional Disaster Information Centre
CRSF	Caribbean Regional Strategic Framework
CSI	Country Support Initiative
CSO	Civil Society Organizations
CSR	CAREC Surveillance Report
DALY	Disability-Adjusted Life Years

DIMAG	Disaster Mitigation Advisory Group
DOTS	Directly Observed Treatment, short course
DTR	Diurnal Temperature Range
EBI	Extra Budgetary Initiatives
EC	Executive Committee of the PAHO
ECCB	Eastern Caribbean Central Bank
ECLAC	Economic Commission for Latin America and the Caribbean (UN)
EID	Emerging Infectious Diseases
ENESS	Environmental Nicotine Exposure Surveillance System
EONC	Emergency Obstetrical and Neonatal Care
EPHF	Essential Public Health Functions
ePPES	Personnel Performance Evaluation System
EVIPNet	Evidence Informed Policy Networks
FAMIS	Financial Accounting and Management Information System
FCTC	Framework Convention on Tobacco Control
FEPPEN	Pan American Federation of Nursery Professionals
FLACSO	Latin American Faculty of Social Sciences
FLASOG	Latin American Federation of Obstetrics and Gynecology Societies
FMD	Foot-and-Mouth Disease
FNS	Food and Nutrition Security
FO/USMB	United States-Mexico Border, Field office
FOS	Food Safety
FSW	Female sex workers
GAN/ARV	Consultative Group on Antiretroviral Negotiations
GAP	Good Agricultural Practices
GB	Government Bodies of PAHO
GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GPIS	Generic Protocol for Influenza Surveillance
GPIS	Generic Protocol for Influenza Surveillance
GSM	Global Management System of WHO
GTZ	German Technical Cooperation Agency
GYTS	Global Youth Tobacco Survey
HACCP	Hazard Analyses Critical Points Systems
HAS	Health Situation Analysis
HDM/CD	Health Surveillance & Disease Management/Communicable Diseases
HMC	Health and Supportive Municipalities, cities and Communities
HPR	Health promotion Resource
HPS	Health Promoting Schools
IANPHI	Institute of Public Health of the World

ICM	International al Congress of Midwives
ICMS	Integrated Conflict Management System
ICTRP	International Clinical Trials Register Platform
IGWG	Interagency Gender Working Group
IHR	International Health Regulations
ILO	International Labor Organization
IMAI	Integrated Management of Adult and Adolescent Illness
IMCI	Integrated Management of Childhood Illness
INCAP	Institute of Nutrition of Central American and Panama
INJ	Violence, Injuries and Disabilities
INPPAZ	Pan American Institute for Food Protection and Zoonoses
IPSAS	International Public Sector Accounting Standards
IRDIS	Health Research Indicators Initiative
ISDR	International Strategy for Disaster Reduction
ISIS	Integrated Surveillance Information System
ISSA	International Social Security Association
IYCF	Infant and Young Child Feeding
LAC	Latin America and the Caribbean
LACHSR	LAC Health Sector Reform
LatINCLEN	Latin American Branch of the International Clinical Epidemiology network
LOA	Letter of Agreement
LSS	Logistics Support System
MAL	Malaria
MCH	Maternal and Child health
MDA	Mass Drug Administration
MDG	Millennium Development Goal
MDT	Multidrug Therapy
MERCOSUR	Southern Common Market
MH	Mental Health
MNH	Mental Health and Substance
MOU	Memorandum of Understanding
MPS	Making Pregnancy Safer
MSM	Men who have sex with men
NAFTA	North American Free Trade Agreement
NCD	No communicable Diseases
NGO	Nongovernmental Organization
NHA	National Health Authorities
NIC	National Influenza Centers
NIMH	National Institute of mental health
NIPPS	National Influenza Pandemic Preparedness Plans
NUT	Nutrition

OCPC	Office of the Caribbean Program Coordinator
OECC	Office of the Eastern Caribbean Countries
OISS	Ibero-American Organization of Social Security
ORAS-CONHU	Andean Health Agency-Hipólito Unánue Agreement
OS	Other Sources
OWER	WHO Organization-wide Expected Result
PAHO/HQ	Pan-American Health Organization/Headquarter
PAL	Practical Approach to Lung Health
PANDRH	Pan American Network for Drug Regulatory Harmonization
PASB	Pan American Sanitary Bureau
PATIOS	Pan-American Tobacco Information Online System
PB	Program Budget
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHE	Health and Environment
PLWH	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPH	Prevention of Post-Partum Hemorrhage
PPM	Public Private Mix
PPS	Planning, Program Budget & Project Support
PSPS	PAHO Supplier Prequalification System
PWR	PAHO/WHO Representative
RB	Regular Budget
REMSAA	Meeting of Ministers of Health of the Andean Area
RER	Regional-wide Expected Result
RESSCAD	Meeting of the Health Sector of Central America and the Dominican Republic
RHI	Retirees Health Insurance
RHR	Reproductive Health
RICTSAL	Indicator Network of Science and Technology on Health
RIMAIS	Inter-Ministerial Network for Research and Learning
RPBP	Regional Program Budget Policy
RPC	Research Policy and Cooperation
SARS	Severe Acute Respiratory Syndrome
SICA	Central American Integration System
SIEDIS	The information System for Disease and Disability
SIP	Simplified Integrated Prenatal
SISCA	Central America Social Integration System
SIVIN	Integrated Surveillance System of the Nutritional Interventions
SOS	Online Search System
SPBA	Subcommittee on Program, Budget and Administration
SPH	Social Protection in Health

SRH	Public Policies and Plans on Sexual and Reproductive Health
SSOP	Standard Sanitary Operational Procedures
TB	Tuberculosis
TOB	Tobacco
UN	United Nations
UNAIDS	The Joint United Nations Program on HIV/AIDS
USA/CDC	Centers for Disease Control and Prevention of the USA
USAID	United States Agency for International Development
VC	Voluntary Contributions
VCA	Country Variable Allocation
VCPH	Virtual Campus on Public Health
WHD	World Health Day
WHO	World Health Organization
WMH	Gender, Women, and Health

Executive Summary

1. In September of 2005, the Bureau presented the *Proposed Program Budget of the Pan American Health Organization for the Financial Period 2006-2007* to the 46th Directing Council. The Program Budget for the period (Official Document 317) was approved and thereafter became the Bureau's main operational planning document for the period.

2. This Performance Assessment Report provides a comprehensive view of the Bureau's performance in implementing the 2006-2007 Biennial Program Budget. It is presented as a self-assessment by the staff of the Pan American Sanitary Bureau (PASB). This Assessment is part of the PASB's implementation of Results-based Management, and reflects ongoing efforts to maximize accountability and transparency.

3. The Biennial Program Budget for 2006-2007 (PB 06-07, Official Document 317) was the first to comprehensively adopt the thirty six (36) Areas of Work used by WHO for the biennium (with two additional Areas of Work that were region-specific). Building on the *Strategic Plan for the Pan American Sanitary Bureau for the Period 2003-2007* (Document CSP26/10) and the *Managerial Strategy for the Work of the Pan American Sanitary Bureau in the Period 2003-2007* (Document CD44/5), as well as the *WHO Program Budget for 2006-2007*, the PB 06-07 set out the Bureau's Areas of Work (AoWs) and Region-wide Expected Results (RERs) for the aforementioned period. Program budgets are one of the Bureau's key commitments to its Member States whereas programmatic implementation, monitoring, and reporting of the PB 06-07 has been the principal function of the Bureau during the period. This Performance Assessment Report on the Biennial Program Budget 2006-2007 of the Pan American Health Organization (herein also referred to as "Performance Assessment") constitutes the Bureau's post-implementation report of achievements.

4. The PB 06-07 incorporated a results-based approach, with 37 Areas of Work (AoW), 201 Regional-wide Expected Results (RER) and 551 RER-indicators to measure progress. The formulation of the PB 06-07 took into consideration relevant global and regional policy frameworks; evaluations of the achievements of the expected results of the 2002-2003 and 2004-2005 Program Budgets; PAHO's contributions to the achievement of the WHO Organization-wide Expected Results (OWER); and program commitments emanating from the resolutions approved by the Governing Bodies of PAHO and WHO.

5. The PB 06-07 defined PAHO's programmatic response to health development challenges that existed in the Region when the PB was developed. Through its work, the PASB sought to reduce inequities within and among countries, provide appropriate

technical support to address health needs, and meet unique Pan-American health challenges.

Methodology

6. This Assessment was compiled on the basis of individual Area of Work (AoW) performance assessments conducted by each AoW Coordinator. Coordinators completed forms specifically designed for this purpose and the required assessment of achievements regarding the RER indicators defined in the 2006-2007 Program Budget. For 2006-2007, PAHO's planning instruments were not integrated as they are for 2008 and onward; hence Country Offices and Regional Areas did not systematically use the 2006-2007 RERs and indicators in their Work plans. Therefore, the use of "manual" reporting forms was required (similarly to the 2004-2005 Performance Assessment). One issue identified in the assessment for 04-05 is still of relevance: the self-assessment is subjective and has not been independently or systematically verified. As noted, the new planning system for 2008 addresses this weakness, facilitates verification among organizational entities, as well as allows for programmatic auditing, spot-checking and quality control.

7. In order to aggregate achievement levels across all indicators and Areas of Work, a level of achievement was assigned to each indicator, based on the actual vs. target data for the indicator for 2006-2007; the options assigned were 0%, 25%, 50%, 75%, or 100%. For example, indicator 7.1.1 "Number of countries that have an approved plan of action for integrated NCD prevention and control" had a target of 22 countries; only 15 countries achieved this indicator (per the technical area's assessment); 15 represents 68% of 22, therefore this indicator was assigned a 75% achievement level (68% being closer to 75% than 50%). The measurement of the majority of indicators that were measured numerically was a fairly straightforward exercise. Judgments were made in an effort to best reflect the actual information provided for those that are more subjective or text-based.

8. According to the RER indicator achievement level, aggregate levels of achievement could be established for each RER, Area of Work, and the entire Program Budget itself. The summary charts presented in this document are based on this methodology.

Continued……….

9. The Bureau considers any RER indicator, RER or AoW with less than 75% achievement level to have under-performed.

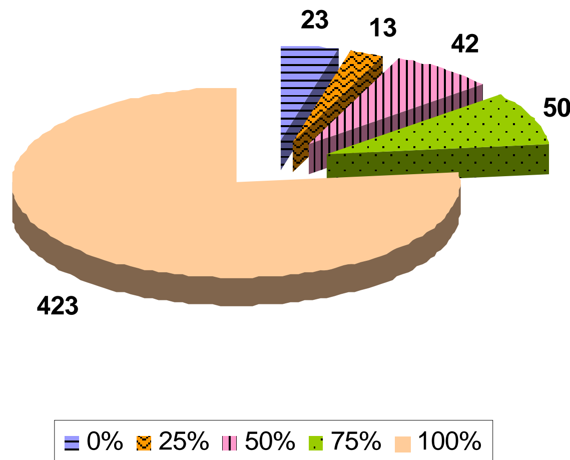
10. The Assessment is a collection of inputs from each AoW Coordinator (i.e. the staff member designated to monitor progress for a given Area of Work) against the expected results and indicators defined in the PB 06-07. Thus it should be clear that the bases for this document are self-assessments of progress, as determined by the Coordinators since January 2008.

11. A total of 38 AoWs were programmed, although the second (Communicable Disease Research, or CDR) was consolidated and merged with the AoW #1. Therefore, in actual fact, there are 37 AoWs counted in this Performance Assessment.

Regional-wide Expected Result (RER) Indicators Achievement

12. Of the 551 RER indicators, based on the methodology described above: 423 indicators (77%) were 100% achieved, 49 indicators (9%) were 75% achieved, 42 indicators (8%) were 50% achieved, 13 indicators (2%) were 25% achieved, and 23 indicators (4%) were 0% achieved. Graph 1 shows the distribution of RER indicators according to their achievement level. 473 out of 551 indicators (86%) show an achievement level of 75% or higher.

Graph 1. Regional-wide Expected Result (RER) Indicators Achievement Levels
(Total = 551 RER Indicators)

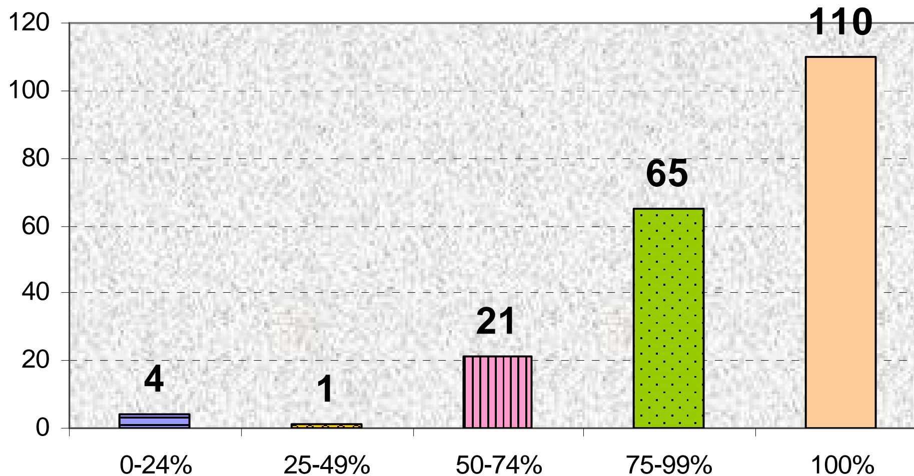


Regional-wide Expected Results (RER) Achievement

13. Graph number 2 shows achievement levels of the Regional-wide Expected Results of the Program Budget 06-07. For each RER, an average was taken of the level of achievement of their indicators in order to arrive at an achievement level (between 0 and 100%). Of the 201 RERs, 110 RERs (55%) were 100% achieved, 65 RERs (32%) were 75% achieved, 21 RERs (10.5%) were 50% achieved, 1 RERs (0.5%) were 25% achieved, and 4 RERs (2%) were 0% achieved.

14. The Bureau considers any RER with less than 75% achievement level to have under-performed; 26 of the 201 RERs (or 13%) fall into this category. 175 out of 201 RERs (87%) show and achievement level of 75% or higher.

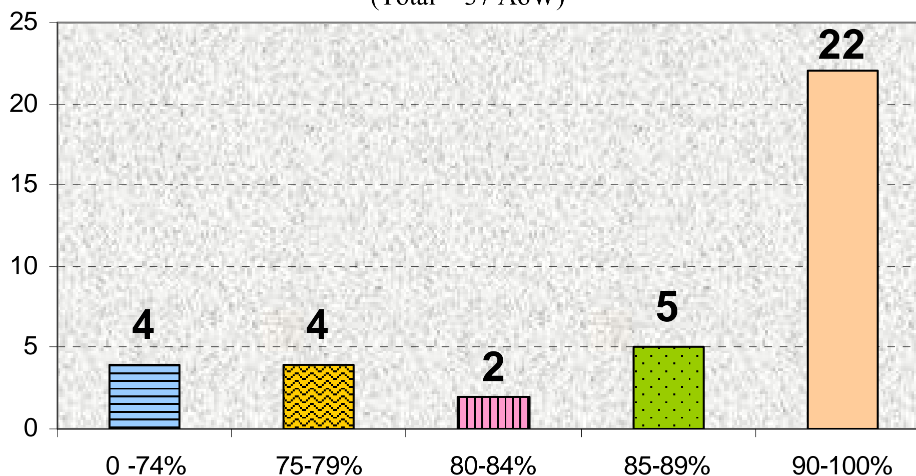
Graph 2. Regional-wide Expected Results (RER) Achievement Levels
(Total = 201 RERs)



Areas of Work (AoW) Achievement

15. By averaging the level of achievement of the indicators in a given Area of Work, it is possible to obtain the level of achievement for that AoW. Table number 3 shows the level of achievement of the Areas of Work.

Graph 3. Areas of Work (AoW) Achievement Levels
(Total = 37 AoW)



16. Of the 37 AoW, 22 AoW (59.4%) were 90% or more achieved, 5 AoW (13.5%) were between 85% and 89% achieved, 2 AoW (5.4%) were between 80% and 84% achieved, 4 AoW (10.8%) were between 75% and 79% achieved, and 4 AoW (10.8%) were 74% or less achieved.

17. The Bureau considers any RER with less than 75% achievement level to have under-performed; only 4 AoW (11%) fall into this category. 33 out of 37 AoW (89%) show and achievement level of 75% or higher.

18. A detailed analysis of each of the under-performing Areas of Work (SCC - Country Cooperation Leadership and Coordination, BMR - Planning, Resource Coordination, and Oversight, HPR - Health Promotion, and IIS - Infrastructure and Logistics) is included in the Annex. In the case of SCC, many indicators that depended on actions outside of the control of the PASB were not fully realized. The BMR achievement level was reduced due to 0% achievement for three indicators related to the evaluation function, which was not developed by the PASB during the 2006-2007 biennium. As the position has been filled already, we should expect this condition to be corrected in the next biennium. In HPR-Health Promotion several RER implementation started at the end of the biennium 2006-2007. For IIS, under-achievement related mostly to external economic factors and purchasing decisions.

19. The formulation of the Biennial Work Plan (BWP) for the next biennium 2008-2009 will be built in biannual milestones associated with each indicator of Expected Results, which are, in turn, linked to the Strategic Plan indicators. While milestones are not guarantees of achievement of the expected results, the PASB will be

able to monitor progress on a biannual basis, thus allowing time to take corrective measures which should improve the overall performance.

20. Table 1 shows the level of achievement by Area of Work.

Table 1. Areas of Work (AoW) Achievement Levels

Area of Work	Achievement Level (percentage)
1. CPC - COMMUNICABLE DISEASES PREVENTION AND CONTROL	92%
3. CSR - EPIDEMIC ALERT AND RESPONSE	96%
4. MAL – MALARIA	98%
5. TUB – TUBERCULOSIS	93%
6. HIV - HIV/AIDS	76%
7. NCD - SURVEILLANCE, PREVENTION AND MANAGEMENT OF CHRONIC, NON COMMUNICABLE DISEASES	96%
8. HPR - HEALTH PROMOTION	68% *
9. MNH - MENTAL HEALTH AND SUBSTANCE ABUSE	94%
10. TOB – TOBACCO	90%
11. NUT – NUTRITION	86%
12. PHE - HEALTH AND ENVIRONMENT	94%
13. FOS - FOOD SAFETY	94%
14. INJ - VIOLENCE, INJURIES AND DISABILITIES	91%
15. RHR - REPRODUCTIVE HEALTH	94%
16. MPS - MAKING PREGNANCY SAFER	98%
17. WMH - GENDER, WOMEN, AND HEALTH	89%
18. CAH - CHILD AND ADOLESCENT HEALTH	86%
19. IVD - IMMUNIZATION AND VACCINE DEVELOPMENT	83%
20. EDM - ESSENTIAL MEDICINES	84%
21. BCT - ESSENTIAL HEALTH TECHNOLOGIES	95%
22. HSD - POLICY-MAKING FOR HEALTH AND DEVELOPMENT	93%
23. HSP - HEALTH SYSTEMS POLICIES AND SERVICE DELIVERY	88%
24. HRH - HUMAN RESOURCES FOR HEALTH	97%
25. HFS - HEALTH FINANCING AND SOCIAL PROTECTION	98%
26. IER - HEALTH INFORMATION, EVIDENCE AND RESEARCH POLICY	91%
27. HAC - EMERGENCY PREPAREDNESS AND RESPONSE	97%
28. SCC - COUNTRY COOPERATION LEADERSHIP AND COORDINATION	73% *

29. KMI - KNOWLEDGE MANAGEMENT AND INFORMATION TECHNOLOGY	**75%**
30. BMR - PLANNING, RESOURCE COORDINATION, AND OVERSIGHT	**69% ***
31. HRS HUMAN RESOURCES MANAGEMENT	**78%**
32. FNS - BUDGET AND FINANCIAL MANAGEMENT	**97%**
33. IIS - INFRASTRUCTURE AND LOGISTICS	**63% ***
34. GBS - GOVERNING BODIES	**100%**
35. REC - EXTERNAL RELATIONS	**92%**
36. DGO – DIRECTION	**100%**
37. COO - COUNTRY OFFICE OPERATIONS	**86%**
38. TCC - TECHNICAL COOPERATION AMONG COUNTRIES	**75%**
Average for All AoWs	**88%**

* Areas of Work (AoW) with less than 75% achievement level have under-performed

Financial Performance

21. To better understand this section the following terminology and conventions will be used:

- The one-program, one-budget approach used for PB 2006-2007 presented a complete picture of the resources needed to implement the technical cooperation program in the biennium and it reflected multiple funding sources:
  - "Regular Budget" (RB) (PAHO Assessed Contributions, miscellaneous Income, and WHO/AMRO Share) and;
  - "Other Sources" (OS) which are made up of primarily voluntary contributions and can be divided into two categories: 1) estimated contributions that can be reasonably expected, either because of established and continuing dialogue with partners and/or traditional donor interest, and 2) an unfunded portion which represents the gap that will need to be the focus of the Bureau's increased resource mobilization efforts.

- The total approved Regular Budget includes: a special allocation called the Country Variable Allocation (VCA) (represents 5% of total country allocation) which is assigned to country programs only and under criteria approved by the SPBA, and a special allocation for the Retirees Health Insurance (RHI). Neither of these two allocations are included in the budget section for the 37 Areas of Work. See table 2 (D) and table 3 (Total-A)

- "Member States funds financing internal projects" refer to money received from Governments to implement projects in their own country. These funds are included in the analysis of this report as Other Sources. It is worth mentioning that this source of contribution amounted to US$161 million, or 47% of the total US$340 million received by the PASB as Other Sources. Since the nature and amount of these funds are difficult to predict, these were not considered in the initial estimation of $531 million of the approved Program Budget 2006-2007.

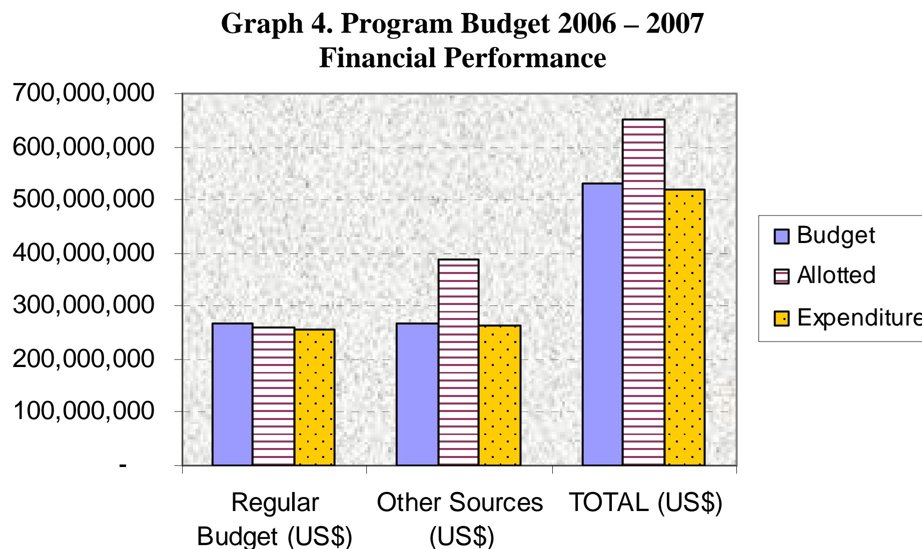
- "Allotted amounts" refer to actual funding authorized by the Budget Office and available for obligation by the allottee (recipient and party responsible for the implementation of the funds). These funds are either from the approved Regular Budget or from Other Sources.

- "Expenditures" refer to the disbursement of appropriated and allotted funds to purchase goods or services.

- "Percentage implemented", refer to the funds expended as a percentage of the allotted amounts.

22. Graph number 4 shows the total funds budgeted, allotted and expended for the Program Budget 06-07 and disaggregated by Regular Budget and Other Sources.

Graph 4. Program Budget 2006 – 2007
Financial Performance



23. PAHO's total budget for 2006-2007 from all sources was $531 million. Of this amount, $265.6 million, or about 50%, was financed from the regular budget (approved assessed contributions from PAHO Member States plus miscellaneous income). The

other 50% represented the estimated needs from all Other Sources in order to fully fund the program budget.

24. The budget was approved in nine appropriation sections representing the programmatic partitions of the budget. These were: 1) Communicable Diseases; 2) Non-Communicable Diseases and Reduction of Risk Factors; 3) Sustainable Development and Environmental Health; 4) Family and Community Health; 5) Health Technologies; 6) Health Systems Development; 7) Knowledge Management and Information Technology; 8) Managerial and Administrative Processes; and 9) Core presence in countries. The nine appropriation sections were further disaggregated programmatically into 37 Areas of Work.

25. In addition to the nine programmatic sections, there were also two separate line items: 1) Country Variable Allocation (representing 5% of the total budget targeted for country level), and 2) Retirees Health Insurance (representing a mandatory cost for PAHO).

26. The regular budget was implemented at 99%. A full financial statement showing the expenditure against budget by appropriation section is included as Statement IV in the Financial Report of the Director for 2006-2007 (Official Document 331, to be submitted first to the 142nd Executive Committee in June 2008).

27. Table 2 shows total approved budget, the allotted and the expenditure, by Regular Budget and Other Sources, including the Country Variable Allocation, the Retirees Health Insurance and the Member States funds financing internal projects.

Table 2. Program Budget 2006-2007
Total Approved Budget, Allotted, and Expenditure

	Regular Budget (US$) (A)	Other Sources (US$) (B)	(RB and OS) TOTAL (US$) (C)=(A+B)	CVA and RHI (US$) * (D)	(RB and OS) Programmatic TOTAL ($US) (E)=(C)-(D)	Members States Funds Financing Internal Projects TOTAL ($US) (F)	(RB and OS) Programmatic without Members States Funds Financing Internal Projects TOTAL ($US) (G)=(E)-(F)
Budget	265,568,000	265,544,000	531,112,000	9,950,000	521,162,000		521,162,000
Allotted	260,758,870	389,435,995	650,194,865	5,140,870	645,053,995	160,702,911	484,351,084
Expenditure	257,277,430	262,876,200	520,153,630	4,746,930	515,406,700	86,372,359	429,034,341

* Country Variable Allocation (CVA) and Retirees Health Insurance (RHI)

28. Table number 3 illustrates that $531 million were approved, $645 million allotted and $515 of expenditure. These figures include activity for all 38 thematic Areas of Work plus amounts related to the Country Variable Allocation (CVA) and the Retirees' Health Insurance (RHI). There is also an additional calculation that highlights the effect of the $161 million of voluntary contributions received for internal projects (Member State contributions funding projects in their own country). This amount merits distinction given the impact that is has on reported allotted figures for Other Sources versus original budget. In the case of Regular Budget funds, there is little difference between the Approved Budget and the allotted amount since the level of these funds are known at the beginning of the period and are programmed accordingly.

Table 3. Program Budget 2006-2007: Total Approved Budget, Allotted, and Expenditure by Area of Work (AoW)

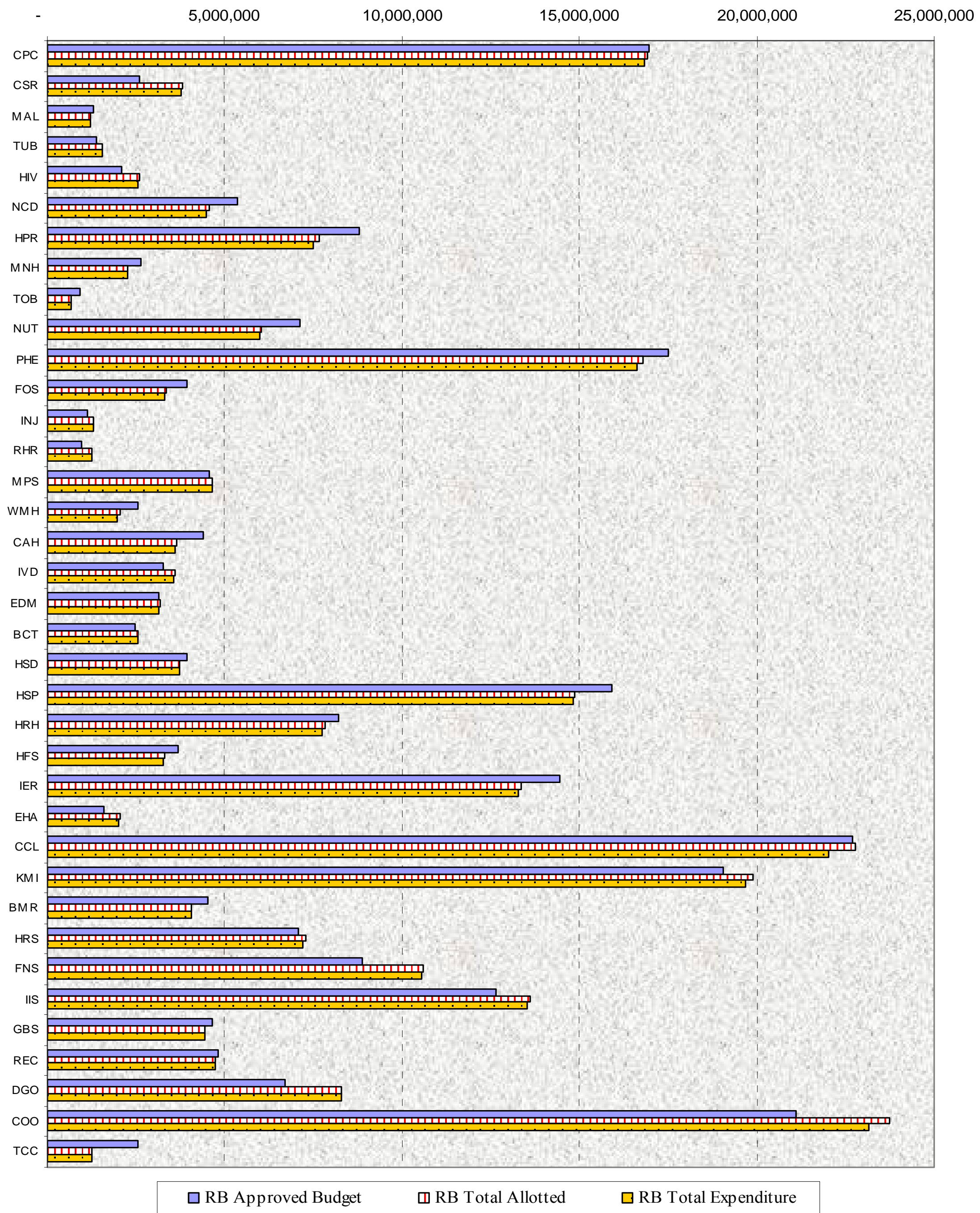
	AoW	RB Approved Budget	RB Total Allotted	RB Total Expenditure	RB % Implemented	OS Approved Budget	OS Total Allotted	OS Total Expenditure	OS % Implemented	(RB and OS) Approved Budget	(RB and OS) Total Allotted	(RB and OS) Total Expenditure	(RB and OS) % Implemented
1	CPC	16,969,600	16,932,054	16,840,100	99.5%	21,184,000	15,522,611	12,238,700	79%	38,153,600	32,454,665	29,078,800	90%
3	CSR	2,608,900	3,829,194	3,784,200	98.8%	5,422,000	25,918,248	18,202,400	70%	8,030,900	29,747,442	21,986,600	74%
4	MAL	1,296,500	1,231,099	1,217,900	98.9%	12,909,000	8,493,423	7,045,700	83%	14,205,500	9,724,522	8,263,600	85%
5	TUB	1,390,100	1,555,315	1,541,000	99.1%	5,973,000	20,149,079	9,818,100	49%	7,363,100	21,704,394	11,359,100	52%
6	HIV	2,081,800	2,602,793	2,535,500	97.4%	35,663,000	25,419,510	17,890,400	70%	37,744,800	28,022,303	20,425,900	73%
7	NCD	5,351,200	4,555,885	4,463,200	98.0%	5,217,000	4,828,190	2,563,500	53%	10,568,200	9,384,075	7,026,700	75%
8	HPR	8,787,100	7,661,164	7,497,900	97.9%	3,319,000	7,518,997	5,496,200	73%	12,106,100	15,180,161	12,994,100	86%
9	MNH	2,643,800	2,269,999	2,262,800	99.7%	3,680,000	1,340,024	804,300	60%	6,323,800	3,610,023	3,067,100	85%
10	TOB	906,800	678,026	666,100	98.2%	1,235,000	2,622,270	1,761,500	67%	2,141,800	3,300,296	2,427,600	74%
11	NUT	7,121,600	6,026,112	5,986,600	99.3%	4,428,000	3,705,607	2,795,100	75%	11,549,600	9,731,719	8,781,700	90%
12	PHE	17,520,700	16,781,746	16,622,500	99.1%	8,492,000	9,040,776	6,104,400	68%	26,012,700	25,822,522	22,726,900	88%
13	FOS	3,929,000	3,360,700	3,309,700	98.5%	3,851,000	681,918	393,500	58%	7,780,000	4,042,618	3,703,200	92%
14	INJ	1,141,700	1,309,203	1,293,400	98.8%	903,000	1,882,462	1,129,400	60%	2,044,700	3,191,665	2,422,800	76%
15	RHR	968,100	1,256,830	1,250,100	99.5%	1,219,000	431,198	307,300	71%	2,187,100	1,688,028	1,557,400	92%
16	MPS	4,558,900	4,640,267	4,636,400	99.9%	2,798,000	6,215,439	3,116,100	50%	7,356,900	10,855,706	7,752,500	71%
17	WMH	2,547,100	2,055,271	1,985,300	96.6%	1,808,000	3,241,825	2,197,000	68%	4,355,100	5,297,096	4,182,300	79%
18	CAH	4,413,800	3,643,703	3,606,800	99.0%	10,130,000	4,376,842	3,889,100	89%	14,543,800	8,020,545	7,495,900	93%
19	IVD	3,271,800	3,596,493	3,556,900	98.9%	20,555,000	35,707,460	28,176,100	79%	23,826,800	39,303,953	31,733,000	81%
20	EDM	3,150,700	3,190,347	3,140,000	98.4%	7,762,000	12,535,592	9,646,600	77%	10,912,700	15,725,939	12,786,600	81%
21	BCT	2,460,100	2,569,789	2,558,400	99.6%	2,002,000	3,706,188	2,166,600	58%	4,462,100	6,275,977	4,725,000	75%
22	HSD	3,917,400	3,743,010	3,736,400	99.8%	10,602,000	45,986,215	27,896,800	61%	14,519,400	49,729,225	31,633,200	64%
23	HSP	15,910,400	14,885,889	14,835,000	99.7%	19,648,000	10,841,207	9,144,000	84%	35,558,400	25,727,096	23,979,000	93%
24	HRH	8,226,400	7,816,633	7,744,100	99.1%	4,934,000	77,772,838	42,340,000	54%	13,160,400	85,589,471	50,084,100	59%
25	HFS	3,677,800	3,300,357	3,270,100	99.1%	3,847,000	3,213,794	2,268,100	71%	7,524,800	6,514,151	5,538,200	85%
26	IER	14,457,500	13,354,464	13,282,800	99.5%	6,087,000	3,684,641	1,979,300	54%	20,544,500	17,039,105	15,262,100	90%
27	EHA	1,597,600	2,032,176	2,005,500	98.7%	27,175,000	30,677,251	20,830,100	68%	28,772,600	32,709,427	22,835,600	70%
28	CCL	22,696,100	22,792,882	22,033,500	96.7%	4,010,000	2,230,911	1,598,500	72%	26,706,100	25,023,793	23,632,000	94%
29	KMI	19,072,100	19,904,343	19,700,700	99.0%	9,896,000	7,530,817	7,441,900	99%	28,968,100	27,435,160	27,142,600	99%
30	BMR	4,529,400	4,070,949	4,052,100	99.5%	1,045,000	580,414	579,700	100%	5,574,400	4,651,363	4,631,800	100%
31	HRS	7,068,800	7,273,380	7,193,400	98.9%	4,295,000	1,955,330	1,894,400	97%	11,363,800	9,228,710	9,087,800	98%
32	FNS	8,887,100	10,598,526	10,535,400	99.4%	1,874,000	4,244,830	4,222,600	99%	10,761,100	14,843,356	14,758,000	99%
33	IIS	12,661,200	13,615,502	13,526,100	99.3%	4,332,000	3,196,456	3,196,500	100%	16,993,200	16,811,958	16,722,600	99%
34	GBS	4,629,300	4,453,110	4,449,500	99.9%	1,583,000	139,846	139,600	100%	6,212,300	4,592,956	4,589,100	100%
35	REC	4,799,900	4,736,818	4,734,500	100.0%	812,000	1,272,036	1,261,800	99%	5,611,900	6,008,854	5,996,300	100%
36	DGO	6,685,200	8,307,287	8,270,600	99.6%	854,000	1,240,672	1,229,200	99%	7,539,200	9,547,959	9,499,800	99%
37	COO	21,124,500	23,728,465	23,165,500	97.6%	4,000,000	1,531,078	1,111,700	73%	25,124,500	25,259,543	24,277,200	96%
38	TCC	2,558,000	1,258,219	1,240,500	98.6%	2,000,000		-		4,558,000	1,258,219	1,240,500	99%
	Subtotal Programmatic	**255,618,000**	**255,618,000**	**252,530,500**	99%	**265,544,000**	**389,435,995**	**262,876,200**	68%	**521,162,000**	**645,053,995**	**515,406,700**	80%
	Add: RHI	5,000,000	3,908,226	3,577,300		-	-	-		5,000,000	3,908,226	3,577,300	
	VCA	4,950,000	1,232,644	1,169,630				-		4,950,000	1,232,644	1,169,630	
	Total - A	**265,568,000**	**260,758,870**	**257,277,430**	99%	**265,544,000**	**389,435,995**	**262,876,200**	68%	**531,112,000**	**650,194,865**	**520,153,630**	80%

Analysis - Programmatic budget without resources assigned by member countries for internal projects

		RB Approved Budget	RB Total Allotted	RB Total Expenditure	RB % Implemented	OS Approved Budget	OS Total Allotted	OS Total Expenditure	OS % Implemented	(RB and OS) Approved Budget	(RB and OS) Total Allotted	(RB and OS) Total Expenditure	(RB and OS) % Implemented
	Subtotal Programmatic	**255,618,000**	**255,618,000**	**252,530,500**		**265,544,000**	**389,435,995**	**262,876,200**		**521,162,000**	**645,053,995**	**515,406,700**	
	Resources from Member States for internal projects						160,702,911	86,372,359		-	**160,702,911**	**86,372,359**	
	Total - B	**255,618,000**	**255,618,000**	**252,530,500**	99%	**265,544,000**	**228,733,084**	**176,503,841**	77%	**521,162,000**	**484,351,084**	**429,034,341**	89%

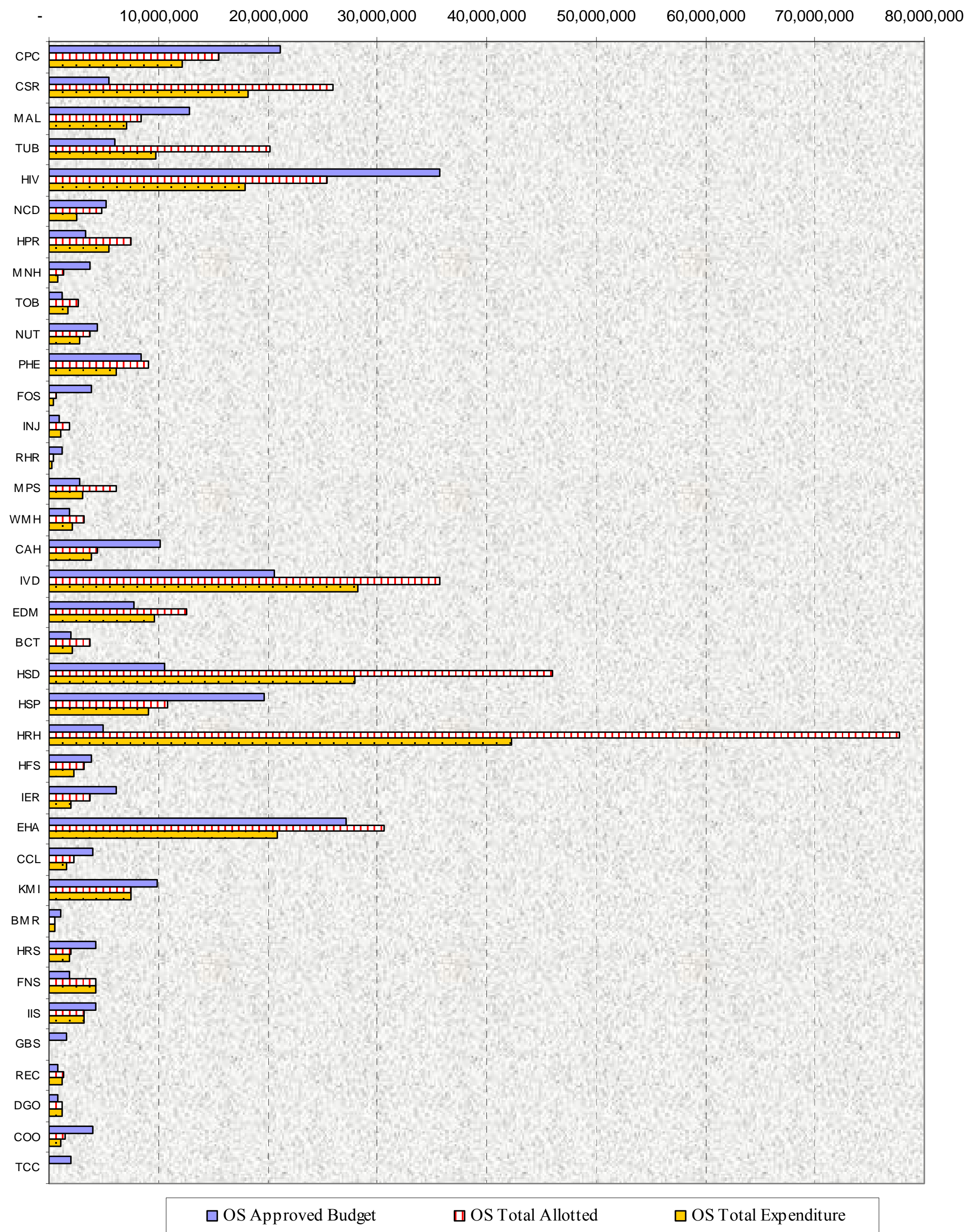
29. Graph number 5 illustrates programmatic implementation for the regular budget by Area of Work. Regular budget expenditures in general corresponded to budgeted amounts.

Graph 5. REGULAR BUDGET – Financial Performance by Areas of Work (AoW)



30. Graph number 6 illustrates financial expenditures versus allotted and budgeted amounts for Other Sources by Area of Work.

Graph 6. OTHER SOURCES – Financial Performance by Areas of Work (AoW)



31. The differences between other sources budget and the allotment values can be explained as follows:

- Difficulty with the estimation of needs during the planning process, as well as the unpredictability of receiving contributions from partners;
- Variance of interest of partners supplying Voluntary Contribution;
- Timing of receipt of resources;
- The level of funds received from Member States for internal projects ($161 million of contributions made by Member States to be implemented in their own country).

32. As the PASB gains experience in planning in this mode, we expect that uncertainties in estimation will be decreased, however most of the other factors are outside the control of the PASB and we should expect them to continue producing a variance between Total Approved Budgets and Allotments.

33. PASB was able to manage an implementation rate of its regular budget of 99%, and 68% implementation of funding from Other Sources, yielding a combined level of implementation of 80% of its total resources. As indicated previously, this is distorted by the high level of funds received from Member States to implement projects in their own countries. If these funds are excluded, the implementation rate for other sources increases to 77%, and the combined level of implementation (all sources) rate increases to 89%.

34. Again, regular budget implementation, although varying between AoW, is very high for Regular Budget, at 99%. The nature of these funds makes possible a higher implementation rate than Other Sources because they are un-earmarked, programmed based and are available from the start of the biennium.

35. Variances between other sources allotted and expenditures can be attributable to:

- The uncertainties stemming from first time forecasting Voluntary Contributions (VC). In some Areas of Work, the level of funding received from Other Sources diverges greatly from budgeted amounts. More specifically, this involves the unpredictable nature of targeted voluntary contributions received from some financial partners. Although some specified resources received were a response to budgeted funding needs, others were primarily initiated by our financial partners, and thus were targeted towards AoWs of primary concern to the donor. Although resources provided for any of PAHO's public health areas are welcomed (based on the assumption of adequate capacity for implementation), these partner-driven contributions are often greater than anticipated in some AoWs, and less in others;

- The in-house efficiency of implementation, also known as absorptive capacity, which is not even among all entities;
- The timing in the receipt of resources from partners. Some transfers were made only in the second year of the biennium;
- VC may span more than one biennium. Expenditures in a given biennium may exaggerate up or down the level of efficiency over the life-of-project period;
- The new expenditure recognition policy implemented (IPSAS), which required a very steep learning curve to adjust to new accounting policies for recording expenditure in a specific financial period.

36. Several measures are being taken in order to improve the level of efficiency in the next biennium 2008-2009:

- Resource gaps will be continuously monitored at the Strategic Objective level and in the Biennial Workplans;
- The Resource Mobilization function will improve dialogue with partners to ensure that VC are properly aligned with planning objectives, are directed towards the identified resource gaps and transfers are timely;
- Monitoring reports of VC with respect to the life-of-project cycle are being produced to complement the biennial information;
- Internal Projects are being separated from other voluntary contribution projects for reporting purposes;
- The Resource Coordination function is being reinforced. This function will periodically analyze status of gaps, in order to orient the resource mobilization function. It will also consider absorptive capacity in order to propose reallocation of resources which, while respecting commitments and fiduciary responsibilities, will increase the likelihood that resources are fully utilized where most needed.

37. In some cases, the difference in funds received versus budgeted is generated in large part by the funds coming from Member States to finance their own projects, as shown in the table number 4 below.

Table 4. Example of Funds coming from Member States to finance their own projects, by AoW

AoW	OS Approved Budget	OS Total Allotted	OS Total Expenditure	OS % Implemented	Member States Financing Internal Projects
CSR	5,422,000	25,918,248	18,202,400	70%	15,430,419
TUB	5,973,000	20,149,079	9,818,100	49%	8,508,600
EDM	7,762,000	12,535,592	9,646,600	77%	6,323,752
HSD	10,602,000	45,986,215	27,896,800	61%	35,657,950
HRH	4,934,000	77,772,838	42,340,000	54%	75,490,473

38. The Bureau is aware that there is impact from Member States financing their own internal projects and has raised the issue with the Governing Bodies. As demonstrated by the considerable funds entrusted to PASB and the growing interest of several Member States in the continued use of this modality, there is a clear need for this type of arrangement. However, the nature of the programming process may be somewhat distorted, as national priorities may not have been identified early enough to be integrated into the corporate planning process. As a result, as seen in Table 4, programmatic groupings (AoW for the biennium under review) may show a degree of Other Source funding far exceeding that identified in the original plan. Nonetheless, the earmarking of these funds precludes their use for overall corporate needs, since they can only be use din the Member State. Hence, there may be a distortion in the level of resources and impact on the AoW. The use of a separate instrument that would allow the separation of the analysis of these funds from the Bureau's more conventional resources should be considered, if indeed this modality will continue to grow as requested by the Member States.

Regional Program Budget Policy (RPBP)

39. The 2006-2007 was the first of three biennia covered in the current Regional Program Budget Policy (RPBP), approved by the Member States on September 2004, during the 45th Directing Council. The Policy has, as one of its objectives, the increase in the level of resources assigned to the country and subregional levels, both amounts being taken from the regional level. The actual level of resources assigned during the biennium shows a much higher percentage going to the country level than was stipulated by the policy, about the same for the subregional, and much less for the regional level.

40. Table number 5 below compares the percentages stipulated in the Regional Program Budget Policy versus actual levels assigned to the three levels. Although much of the work done at the regional and subregional levels is in direct support of the countries, the majority of funding (52%) was provided directly to country programs.

Table 5. Regional Program Budget Policy: targeted versus actual levels assigned for 2006-2007

	RPBP Target	Total allotted
Country	38.0%	51.9%
Regional	55.6%	42.7%
Subregional	6.4%	5.3%
	100.0%	100.0%

Subregional Implementation Analysis

41. The formal introduction of the subregional level acknowledges the processes of integration taking place among Member States at the subregional level; responds to the need for support to achieve subregional health goals; recognizes that some health issues are best addressed through collective action at this level; and seeks to increase the focus on the countries in the Organization's programming.

42. The Regional Program Budget Policy initially recognized five subregional integration processes:

- The Caribbean Community and Common Market (CARICOM)
- The Central American Integration System (SICA)
- The Andean Community of Nations (CAN)
- The Southern Common Market (MERCOSUR)
- The North American Free Trade Agreement (NAFTA)

43. PAHO's technical cooperation at the subregional level, during the biennium 06-07 was provided through:

- New subregional technical cooperation programs (Biennial Program Budget-BPB) in support of subregional health agendas of SICA, CAN and MERCOSUR respectively. This was the first biennium that PAHO implemented BPBs in these subregions.
- The Office of the Caribbean Program Coordinator (OCPC) and the Office of the Eastern Caribbean Countries (OECC), both supporting CARICOM
- The U.S./Mexico Border Health Office (El Paso, Texas), an office created in 1942 and the only one of WHO providing technical cooperation in a border until now; supporting the NAFTA.
- PAHO's subregional centers: Institute of Nutrition of Central America and Panama (INCAP), Caribbean Food and Nutrition Institute (CFNI), and Caribbean Epidemiology Centre (CAREC)

44. In the following paragraphs, the financial implementation by Areas of Work, in the different subregions mentioned is presented. A comparison of the budget differentiating between fixed-term post costs and non-post costs is also presented. PAHO's subregional offices with a physical presence, such as the ones in the Caribbean or the US/Mexico border, have higher budgets to pay for infrastructure and operating

costs. These offices also have a higher percentage of their budget assigned to the post section.

45. Andean Subregion:

**Table 6. Financial Implementation by Area of Work (AoW)
Andean BPB**

AoW	RB Total Allotted	RB Total Expenditure	RB % Implemented
BCT	10,000	9,067	91%
CCL	85,100	74,174	87%
CPC	17,000	15,841	93%
CSR	100,000	60,743	61%
EDM	70,000	66,497	95%
HIV	12,000	11,174	93%
HRH	402,400	383,572	95%
HSP	40,000	40,000	100%
IER	52,800	43,059	82%
KMI	12,000	12,000	100%
PHE	18,000	16,662	93%
Total	**819,300**	**732,790**	**89%**

**Table 7. Financial Implementation by Major Cost Category
Andean BPB**

Cost Category	Allotted	Expenditure
Post	**350,400**	**335,924**
Non-post	**468,900**	**396,866**
Total	**819,300**	**732,790**

46. Central America Subregion

**Table 8. Financial Implementation by Area of Work (AoW)
Central America BPB**

AoW	RB Total Allotted	RB Total Expenditure	RB % Implemented
BMR	27,000	26,895	100%
CCL	128,100	73,830	58%
CSR	20,000	17,006	85%
HFS	10,000	10,000	100%
HRH	342,800	265,563	77%
HSD	27,308	27,268	100%
IER	45,900	45,900	100%
Total	**601,108**	**466,463**	**78%**

**Table 9. Financial Implementation by Major Cost Category
Central America BPB**

Cost Category	Allotted	Expenditure
Post	**292,800**	**220,286**
Non-post	**308,308**	**246,177**
Total	**601,108**	**466,463**

**Table 10. Financial Implementation by Area of Work (AoW)
Institute of Nutrition of Central America and Panama (INCAP) BPB**

AoW	RB Total Allotted	RB Total Expenditure	RB % Implemented
NUT	2,221,572	2,205,773	99%
Total	**2,221,572**	**2,205,773**	**99%**

**Table 11. Financial Implementation by Major Cost Category
Institute of Nutrition of Central America and Panama (INCAP) BPB**

Cost Category	Allotted	Expenditure
Post	**423,672**	**407,873**
Non-post	**1,797,900**	**1,797,900**
Total	**2,221,572**	**2,672,236**

47. Southern Cone Subregion

**Table 12. Financial Implementation by Area of Work (AoW)
Southern Cone BPB**

AoW	RB Total Allotted	RB Total Expenditure	RB % Implemented
CCL	85,200	63,101	74%
CPC	3,000	-	0%
CSR	10,000	9,999	100%
EDM	20,000	10,000	50%
HRH	338,000	222,091	66%
HSD	30,000	29,905	100%
HSP	75,000	57,900	77%
IER	10,000	9,938	99%
PHE	11,774	11,773	100%
Total	**582,974**	**414,707**	**72%**

**Table. 13. Financial Implementation by Major Cost Category
Southern Cone BPB**

Cost Category	Allotted	Expenditure
Post	**288,000**	**204,012**
Non-post	**294,974**	**210,695**
Total	**582,974**	**414,707**

48. Caribbean Subregion

**Table 14. Financial Implementation by Area of Work (AoW)
Caribbean (OCPC and OECC) BPBs**

AoW	RB Total Allotted	RB Total Expenditure	RB Implemented
CCL	1,668,976	1,601,701	96%
CPC	182,665	178,030	97%
CSR	39,000	21,807	56%
HFS	215,729	215,720	100%
HRH	366,600	265,853	73%
HSP	32,257	31,225	97%
IER	815,686	812,144	100%
PHE	534,463	515,494	96%
HPR	395,479	391,751	99%
NCD	201,710	199,589	99%
COO	1,374,404	1,354,413	99%
FOS	320,019	307,900	96%
MNH	25,000	16,980	68%
RHR	394,544	393,500	100%
Total	**6,566,532**	**6,306,105**	**96%**

**Table. 15. Financial Implementation by Major Cost Category
Caribbean (OCPC and OECC) BPB**

Cost Category	Allotted	Expenditure
Post	**4,759,108**	**4,639,435**
Non-post	**1,807,424**	**1,666,670**
Total	**6,566,532**	**6,306,105**

**Table 16. Financial Implementation by Area of Work (AoW)
Caribbean Food and Nutrition Institute (CFNI) BPB**

AoW	RB Total Allotted	RB Total Expenditure	RB Implemented
HIV	113,000	103,213	91%
HPR	35,500	27,142	76%
NCD	64,500	61,381	95%
COO	200,000	198,275	99%
FOS	20,000	16,823	84%
NUT	1,822,882	1,728,058	95%
Total	**2,255,882**	**2,134,892**	**95%**

**Table 17. Financial Implementation by Major Cost Category
Caribbean Food and Nutrition Institute (CFNI) BPB**

Cost Category	Allotted	Expenditure
Post	**1,160,022**	**1,157,093**
Non-post	**1,095,860**	**977,800**
Total	**2,255,882**	**2,134,892**

**Table 18. Financial Implementation by Area of Work (AoW)
Caribbean Epidemiology Centre (CAREC) BPB**

AoW	RB Total Allotted	RB Total Expenditure	RB Implemented
BCT	330,763	257,676	78%
CPC	869,730	867,157	100%
FOS	109,000	106,281	98%
Total	**1,309,493**	**1,231,113**	**94%**

**Table 19. Financial Implementation by Major Cost Category
Caribbean Epidemiology Centre (CAREC) BPB**

Cost Category	Allotted	Expenditure
Post	**1,200,493**	**1,124,833**
Non-post	**109,000**	**106,281**
Total	**1,309,493**	**1,231,113**

49. United States-Mexico Border, Field Office (FO/USMB)

**Table 20. Financial Implementation by Area of Work (AoW)
FO/USMB BPB**

AoW	RB Total Allotted	RB Total Expenditure	RB % Implemented
CCL	664,161	662,160	100%
HSD	86,076	86,076	100%
IER	17,500	17,499	100%
KMI	96,125	96,077	100%
PHE	7,801	7,734	99%
HPR	169,391	167,840	99%
HRS	380,473	380,411	100%
NCD	12,601	11,705	93%
Total	**1,434,128**	**1,429,503**	**100%**

**Table 21. Financial Implementation by Major Cost Category
FO/USMB BPB**

Cost Category	Allotted	Expenditure
Post	**430,128**	**428,301**
Non-post	**1,004,000**	**1,001,202**
Total	**1,434,128**	**1,429,503**

Assessment by Area of Work

50. In keeping with the 2006-2007 Program Budget structure, key achievements for each Area of Work are presented in the Annex. Each AoW has a standard format consisting of:

- Number and Title of the AoW
- AoW Goal and achievements related thereto
- PAHO Objective for the AoW, and achievements related thereto
- Actual end-2007 figures for each RER indicator, with an explanation (obligatory if the 2007 target was not met)
- Lessons Learned
- Financial Execution

Action by the Directing Council

51. The PASB submits this Assessment Report for the consideration and approval of the 48th Directing Council.

Annex

ASSESSMENT BY AREA OF WORK

1. COMMUNICABLE DISEASES PREVENTION AND CONTROL (CPC)
Overall Achievement level: 92%

GOAL: Eliminate the neglected diseases and reduce morbidity, mortality, and disability due to new and emerging communicable diseases.
ACHIEVEMENT OF GOAL: **Though no new neglected disease has been eliminated throughout the entire Region during the biennium, significant advances were made against several neglected diseases, including the elimination of transmission foci of onchocerciasis in Guatemala, Colombia, Ecuador, and Mexico, and the verification by Brazil of the interruption of filariasis in Belém, Paraguay. At least a dozen countries have committed to begin or scale up their deworming efforts against soil-transmitted helminthiasis and schistosomiasis; integrated approaches are being tried in 5 countries. Vectorial transmission of Chagas disease by *Rhodnuis proxilus* has ended in 2 additional countries, and 5 countries have increased their coverage of blood bank screening for Chagas. Four countries enhanced their control efforts against leishmaniasis with PAHO support. At least two countries increased their research capacity on neglected diseases with PAHO's support or developed new intervention methods based on research; emphasis was given on tools for economic analysis and cost-effectiveness research for Chagas disease elimination.**
PAHO OBJECTIVE: Assist countries to strengthen prevention, control and, where appropriate, eradication or elimination of communicable diseases and achieve the key program indicator agreed globally.
ACHIEVEMENT OF PAHO OBJECTIVE: **PAHO assisted nearly all the countries in the Region during this biennium to strengthen their prevention, control and elimination efforts for neglected diseases, in support of global indicators for filariasis and onchocerciasis elimination, leprosy reduction, and regional indicators for Chagas disease elimination and dengue control. Thirteen countries have implemented integrated dengue control programs, and 10 uses COMBI as part of their program. Six countries have implemented the global strategy for leprosy reduction, and four countries follow WHO guidelines for filariasis elimination. A number of countries have strengthened or expanded their control programs for Chagas disease, dengue, leishmaniasis, leprosy and soil-transmitted helminthiasis. During the biennium, 19 countries began to participate in the regional leprosy surveillance program, and several countries now share their deworming coverage surveillance data with PAHO.**

RER 1.1 Increased capacity to plan, implement and monitor programs for prevention and control of dengue especially in key countries.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.1.1	Number of countries adopting and implementing an integrated dengue prevention and control strategy; with recommendations towards health promotion activities	2	13	**14**	**14 countries of the Americas have prepared its national Integrated Management Strategy for dengue prevention and control (EGI-dengue in Spanish) ; six countries in Central America (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama), one in the Caribbean (the Dominican Republic) and seven countries in South America (Venezuela, Colombia, Paraguay, Peru, *Ecuador, Argentina and Brazil). Furthermore, two subregional EGI-dengue have been prepared, one in Central America and another one for MERCOSUR Member States and Associates.**
1.1.2	Number of countries where an external evaluation of the national plan for dengue prevention and control based on an integrated strategy has undertaken in collaboration with PAHO	3	10	**4**	**In this period 4 countries out of 10 programmed, carried out activities for the Monitoring and Evaluation of their national EGI-dengue: Nicaragua, El Salvador, Costa Rica and Brazil. Dengue outbreaks and emergency situations in several countries delayed the evaluation process. This process will continue in the 2008-2009 biennium.**
1.1.3	Number of countries in the Region that have participated in training activities on the COMBI (communication for behavioral impact on dengue) methodology. Behaviors that will lead to the elimination of vector breeding sites)	17	22	**23**	**COMBI workshops were held in Peru, Nicaragua and for 4 French Caribbean countries (Haiti, Martinique, French Guiana and Guadeloupe) in total, 23 trained countries of 22 in plan. A technical note that describes the results obtained with the methodology COMBI was prepared, with the objective of disseminating the results to all the countries and planning the future actions.**
1.1.4	Number of countries where a COMBI plan has been implemented	0	8	**10**	**10 COMBI plans out of 8 planned are being executed, in Costa Rica, Colombia, Brazil, Ecuador, Peru, El Salvador, Guatemala, Nicaragua, the Dominican Republic, and Paraguay.**
1.1.5	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	**9**	**The Web page of DengueNet is being redesigned for the easy incorporation of data. In 2007 a meeting of DengueNet was held in Panama, in order to draft the new lines, contents, and report modalities. Countries such as Paraguay have reincorporated, and Venezuela's application was received. Of the 20 targeted countries, 9 countries are reporting irregularly mainly for technical reasons: El Salvador, Brazil, Cuba, Dominican Republic, Guatemala, Martinique, Mexico, Nicaragua, and**

					Venezuela. They work in the stabilization of the reports.

RER 1.2 Countries yet to eliminate lymphatic filariasis, and onchocerciasis, supported to accelerate efforts towards agreed regional goals					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.2.1	Number of countries at risk where national programs for the elimination of lymphatic filariasis have launched the full Mass Drug Administration (MDA) component according to WHO's guidelines and with technical cooperation from PAHO	2	4	**4**	**Brazil, Haiti, Dominican Republic, and Guyana**
1.2.2	Number of countries where national programs for the elimination of lymphatic filariasis have launched a comprehensive morbidity component with technical cooperation from PAHO	3	4	**4**	**Brazil, Haiti, Dominican Republic, and Guyana**
1.2.3	Number of PAHO-sponsored validation exercises of tools to verify interruption of transmission in lymphatic filariasis, completed for the Region	0	1	**1**	**Brazil**
1.2.4	Number of onchocerciasis endemic countries attaining required treatment coverage rates of ≥85% for a minimum of 6 years, stemming from technical cooperation with PAHO and other global partners	1	4	**5**	**Brazil , Colombia, Ecuador, Guatemala, and Mexico Surpassed.**
1.2.5	Number of countries where PAHO/WHO sponsored or co-sponsored external evaluations of the program to eliminate onchocerciasis have taken place	2	4	**6**	**Brazil, Venezuela, Colombia, Ecuador, Guatemala, and Mexico Surpassed.**
RER 1.3 Conditions will be created to carry out integrated health management/care, and multi-disease based strategies to control geohelminthiasis and schistosomiasis.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.3.1	Number of countries where integrated, multi-disease based plans of action to control geohelminths and/or schistosomiasis have been prepared with	8	10	**12**	**Haiti, Dominican Republic, Belize, Honduras, Nicaragua, Ecuador, Bolivia, Argentina, Guyana, Suriname, Brazil, and St. Lucia**

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
	technical cooperation from PAHO				
1.3.2	Number of countries where PAHO has co-developed or co-financed integrated, multi-disease-based pilot interventions to control geohelminths and schistosomiasis	4	5	**5**	**Honduras, Belize, Brazil, Suriname, Bolivia**
RER 1.4 Activities to eliminate leprosy as a public health problem, as well as the consolidation and sustainability of those activities, will be promoted and evaluated.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.4.1	Number of priority countries that will have implemented the Global Strategy for the reduction of leprosy disease burden and sustainability of the leprosy control activities.	0	6	**6**	**Ecuador, Dominican Republic, Paraguay, Brazil, Trinidad and Tobago, and Jamaica**
1.4.2	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	**4,028**	
1.4.3	Number of countries contributing to regional leprosy surveillance program	0	19	**19**	**Argentina, Bahamas , Belize, Brazil, Colombia, Costa Rica, Chile, El Salvador, Ecuador ,Guatemala, Guyana, Jamaica, Peru, Paraguay, St. Lucia, Trinidad and Tobago, Suriname, Venezuela, and Uruguay**
1.4.4	Number of external program evaluations sponsored or cosponsored by PAHO in the biennium.	0	4	**4**	**Argentina, Ecuador, Dominican Republic, and Paraguay**
RER 1.5 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. In compliance with the Millennium's Objective 6 and Goal 8 reducing the incidence/prevalence, morbidity and mortality of Chagas' disease.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.5.1	Number of countries where interruption of transmission by T. infestans is feasible and has been achieved.	3	5	**3**	**Paraguay interrupted transmission in the Oriental Region (with 90% of Paraguayan population). The Chaco West Region reduced transmission however it's still active. Argentina has active transmission in the provinces of the biogeographical Chaco Region.**
1.5.2	Number of countries where interruption of transmission by T. infestans is not feasible but where transmission has been	0	1	**3**	**Bolivia, Paraguay and Argentina have reduction of vectoral transmission.** **BOL: 40%**

	reduced				**PAR: 90%** **ARG: 50%** **In child (0-5 years old)** **Seroprevalence reduction**
1.5.3	Number of countries where interruption of transmission by R. prolixus is feasible and has been achieved.	1	3	**3**	**Guatemala, Honduras and El Salvador**
1.5.4	Number of countries where interruption of transmission by R. prolixus and other vectors is not feasible, but where transmission has been reduced.	0	2	**2**	**Nicaragua and Costa Rica**
1.5.5	Number of functional subregional initiatives with national control and/or surveillance results	3	5	**5**	
1.5.6	Number of countries recording an increase in the coverage and quality of blood bank screenings for Chagas	15	20	**20**	**Argentina, Chile, Uruguay, Bolivia, Paraguay, Peru, Ecuador, Colombia, Venezuela, Brazil, Guyana, Suriname, Panama, Costa Rica, Nicaragua, Honduras, Belize, Guatemala, Mexico, and El Salvador**

RER 1.6 Conditions will be fostered for eradicating foot-and-mouth disease FMD, protecting free areas, and keeping the Region free of "mad cow" disease (bovine spongiform encephalopathy – BSE).

Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.6.1	Number of countries/zones of the Southern Cone and Brazil (except for Amazon region) free of foot-and-mouth disease.	9	11	**9**	**Some of the countries have zones considered free of FMD.**
1.6.2	Number of countries with epidemiological surveillance systems for vesicular disease that will be sustained throughout the Region	35	35	**35**	
1.6.3	Latin America and the Caribbean will maintain BSE-free status	33	33	**33**	**OIE re-defined free status criteria. No BSE neither CJDv was reported in LAC.**
1.6.4	Number of countries where foot-and-mouth disease programs have been audited	6	11	**11**	**Baseline: Argentina, Bolivia, Brazil, Chile, Paraguay and Uruguay.** **Expected and achieved: Same as above + Colombia, Venezuela, Ecuador, Peru and Guyana.**

RER 1.7 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, and echinoccocosis.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.7.1	Reduction in the number of countries that have yet to eliminate human rabies transmitted by dogs	8	11	**8**	**Main determinates of DTR persistence were identified for each country. Target was re-formulated for 2008-2012.** **Baseline: Bolivia, Brazil, El Salvador, Guatemala, Haiti, Mexico, Dominican Republic, and Venezuela.** **Expected (but not achieved) Bolivia, El Salvador, and Haiti.**
1.7.2	Number of countries in Latin America with rabies surveillance systems reporting regularly to PAHO	18	21	**21**	**Baseline: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, and Venezuela.** **Expected and achieved: same as above + Guyana, Haiti, and Suriname.**
1.7.3	Number of countries in Latin America and the Caribbean with received PAHO technical cooperation to control bovine tuberculosis and echinoccocosis.	12	12	**12**	**Baseline and expected: Argentina, Bolivia, Brazil, Chile, Colombia, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic and Venezuela.**

RER 1.8 Guidelines will be provided for prevention and control of plagues leishmaniasis and rickettsiosis					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.8.1	Number of countries provided with a technical orientation and basis for policy decision for plague, leishmaniasis and rickettsiosis	0	15	**4 for leishmaniasis**	**Technical cooperation provided only to Brazil, Bolivia, Ecuador, and Venezuela because of constraint of financial resources.** **A project to strengthening the projects of leishmaniasis of the `Region of the Americas`, was prepared and presented to Spanish Cooperation, and it will be carried out during 2008.** *There was external funding for CD, but that for leishmaniasis was received late in the biennium (August 2007), so this contributed to the under-achievement of the target*

RER 1.9 New knowledge applied to improve effectiveness of CD programs					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.9.1	Number of new, significant and relevant scientific advances in the biomedical,	0	5	**5**	

	social, economic and public health sciences.				
1.9.2	Number of new and improved intervention methods validated for prevention, diagnosis, treatment of rehabilitation, for the population affected by infectious diseases.	0	2	**2**	
1.9.3	Number of new and improved strategies and policies validated and recommended to use	0	1	**1**	**7 Latin American countries (Paraguay, Argentina, Bolivia, Brazil, Honduras, Guatemala and Uruguay) are committed to develop economic analysis, specifically cost-effectiveness studies, for improving their Chagas disease programs. The development of regional workshops on economic analysis was the strategy used to facilitate the engagement of these countries. However, it is important to engage other countries in the LAC region The lack of financial and human resources was the main impediments to develop the same exercise for other neglected diseases in the LAC region.**
RER 1.10 Support provided for strengthening the capacity for research and its application in endemic countries					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
1.10.1	Number of institutions in Key Countries with developed capacity to propose and implement relevant research activity	3	5	**5**	**Bolivia, Honduras, Guyana, Nicaragua, and Haiti**

Lessons Learned:

- Integrated approaches and multi-disease approaches and integration of tropical disease control into basic primary health care are slowing bearing fruit, but require significant effort and continual follow-up. Intersectoral approaches are gaining interest among decision-makers but the road is still steep.
- Although there is a continuous flow of external funding for communicable diseases in general, financial resources and personnel shortages continue to challenge all national endemic tropical disease control/elimination programs.
- Natural disasters continue to play a key role in disrupting endemic tropical disease control/elimination programs as resources are shifted to attend to such emergencies; this occurs throughout the Region.
- Training, re-training and the development of new human resources remains a major challenge for most if not all national endemic tropical disease control/elimination programs.

- Advocacy and social communication and local buy-in/participation are integral to the success of endemic tropical disease control/elimination programs.
- In the countries that are in the process of implementation of the EGI-dengue exists more intrasectorial coordination (technical and managerial) and inter-programmatic efforts in order to reduce the case-fatality rates and confront the increase of dengue hemorrhagic fever cases; in addition to coordination with other sectors: environment, education, companies, municipal council, and community groups.
- Development of new local projects Communication for behavioral impact related to dengue (methodology *COMBI, Ecosystem Approach to human health (Ecohealth), Ecoclubs, and increase in the capability of resources mobilization at the country level.
- More capability to respond to outbreaks and to respond expectedly to the epidemics, and standardization of criteria for diagnosis of dengue, patients care and entomological indices.
- Institutional resources (human and financing) are crucial to develop the actions.
- The Region demands the development of capacities on health research.
- Priority setting process demands the involvement of several stakeholders, such as policymakers, researchers, representatives of the private sector and international organizations.

Financial Execution

AoW:	**CPC-Communicable Diseases Prevention and Control and CDR and Communicable Disease Research (Consolidated)**			
	Budget	**Allotted**	**Expenditure**	**% Implemented**
Regular Budget	16,969,600	16,932,054	16,840,100	99%
Other Sources	21,184,000	15,522,611	12,238,700	79%
Total (RB & OS)	**38,153,600**	**32,454,665**	**29,078,800**	**90%**

Execution of "Other Sources Budget" is affected by a) Cut at 31 Dec 2007, regardless of actual expiration of grants and b) As a result of IPSAS adoption, only actual disbursements were included. Obligations (commitments) of funds to be disbursed in 2008 are not included.

3. EPIDEMIC ALERT AND RESPONSE (CSR)
Overall Achievement level: 96%

GOAL:
Contribute to improve social and economic well-being of all people of the Region and global health security through action to reduce the impact of communicable disease epidemics on health.

ACHIEVEMENT OF GOAL:
The magnitude and the ensuing social disruption associated to epidemic emergencies have decreased and Member States have been able to cope with the public response with their own resources.

PAHO OBJECTIVE:
To strengthen Member States' capacities to detect, identify and respond rapidly to threats at all levels from epidemic-prone and emerging infectious diseases of known and unknown etiology and are prepared to respond to a national influenza pandemic.

ACHIEVEMENT OF PAHO OBJECTIVE:
PAHO's activities related to the entry into force of the IHR and the pandemic influenza preparedness has enhanced Member States detection sensitivity and timely response has increased even though asymmetry still persists and the laboratory capacity challenges identification of causative agents. Surveillance and containment of resistance to antimicrobial drugs and nosocomial infections are a component of quality of care and laboratory quality assurance in selected Member States.

RER 3.1 Technical cooperation provided for the strengthening of core capacities to detect epidemic-prone diseases and enhance response-readiness as indicated in the IHR, which includes: neuro-invasive diseases caused by arboviruses, viral hemorrhagic fevers, SARS, respiratory diseases, and other emerging zoonotic diseases.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
3.1.1	Number of guidelines produced and disseminated (smallpox, influenza, SARS, polio).	2	6	**6**	
3.1.2	Number of country assessments of core capacities and national plans of action.	4	23	**8**	**WHO did not provide guidelines; PAHO guidelines available in December 2007.**
3.1.3	Number of subregional workshops for development of technical capacity on epidemic prone diseases.	5	15	**34**	• **Emerging Infectious Diseases Networks (6)** • **National Influenza Pandemic Preparedness Plans (4)** • **Rapid Response teams (4)** • **Influenza Surveillance (3)** • **Risk Communication Workshops (9)** • **National Influenza Centers Workshops (2)** • **Exchange of influenza virus (1)**

RER 3.2 Latin American and CAREC Member States supported to develop and implement National Influenza Pandemic Preparedness Plans (NIPPP).					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
3.2.1	Number of countries that received PAHO technical cooperation to complete the development of NIPPP.	3	24	**40**	**All Latin American and Caribbean Member States, plus seven Territories have received training on preparation and assessment of National Influenza Preparedness Plans.**
3.2.2	Number of countries that have disseminated and implemented the NIPPP to the local level.	3	24	**24**	**Countries have held National and Sub National meetings, with the participation of authorities at the national and local level.**

RER 3.3 All Latin American and CAREC Member States reporting to FluNet and sending influenza isolates for characterization					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
3.3.1	Number of countries implementing influenza surveillance and reporting data to FluNet in accordance to established guidelines.	14	20	**23**	**On top of the countries that have laboratories designated as NICs, three extra laboratories not designated as NICS also have reported to FluNet.**
3.3.2	Number of National Influenza Centers sending influenza isolates for characterization to the PAHO/WHO Collaborating Center.	14	20	**20**	

RER 3.4 Systems will be structured for surveillance and response preparedness in animal Influenza (poultry).					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
3.4.1	Number of countries with operational animal Influenza Prevention Plans.	4	10	**10**	

RER 3.5 Effective partnerships sustained through active subregional Emerging Infectious Diseases (EID) alert and response networks and adequate resources mobilized to support them.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
3.5.1	Number of existing subregional EID alert and response networks established by PAHO.	4	4	**4**	**Southern cone, Amazon, Central American , and English Speaking Caribbean**

3.5.2	Number of networks financially supported for annual meetings and the exchange of resources such as training, mobilization of investigative teams, laboratory	0	4	**4**	**USA/CDC continues to provide grant.**
RER 3.6 Procedures established in PAHO for appropriate coordination of alert and response to public health emergencies of regional concern and management of implementation of the revised International Health Regulations.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
3.6.1	Task Force on Epidemic Alert and Response operations with procedures and responsibilities for IHR implementation spelled out	0	1	**1**	**IHR permanent agenda item.**
3.6.2	Number of countries having received technical cooperation for implementation of required core capacities for compliance with the Regulations	0	34	**34**	**Regional office, subregional consultants and PWR offices engaged in the implementation process.**
3.6.3	Percentage of reported outbreaks that is verified and followed-up through collaboration between Member States, the Bureau, and partners of the Subregional EID networks	60%	90%	**100%**	
RER 3.7 Programs for surveillance and containment of resistance to antimicrobial drugs and nosocomial infections will be promoted and supported.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
3.7.1	Number of countries that have plans in place to contain antimicrobial resistance	0	5	**5**	**Brazil, Chile, Guatemala, Paraguay, and Peru**
3.7.2	Number of countries with national norms for nosocomial infection control	3	8	**8**	**Argentina, Brazil, Bolivia, Chile, Guatemala, Paraguay, Peru and Honduras**
3.7.3	Number of studies on cost of hospital infections	13	17	**17**	
3.7.4	Number of countries with at least two health care institutions that follow defined clinical guidelines for treatment with antibiotics	4	7	**7**	**Argentina, Brazil, Bolivia, Chile, Guatemala, Paraguay and Peru**

Lessons Learned:

- Information and knowledge management are key for achieving the objectives. A fluid and transparent stream of communication should be in place within PAHO, PWR Offices and Member States. This element is especially important in public health emergencies.
- PAHO's technical cooperation in influenza preparedness to support Member States in the elaboration, evaluation and implementation of their NIPPPs has allowed raising awareness and conveying key information to national health authorities; homogenizing processes among countries in accordance with WHO standards; helping countries to strengthen core competencies and establish early warning systems for any public health emergency; achieving better integration of surveillance and lab data.
- The completion of NIPPPs did not proceed at the same rate in all countries due to unequal levels of assimilation by the National Health Systems.
- The provision of guidelines and self assessment tools to the countries has facilitated the implementation of standard methodologies for surveillance and preparedness across countries.
- The development of NIPPPs constituted just a first step on the integration and effective management of a multisectoral response at the country level. In some countries it resulted in a valuable opportunity to strengthen coordination among different sectors of government and other key stakeholders that have not worked together in the response to public health emergencies.
- Country assessments of core capacities have demonstrated to be complex and challenging processes as they demand a firm engagement from local health authorities that must decide to allocate their human and financial resources between competing needs.
- Multiple stakeholders from all levels of society should be involved in order to permeating the NIPPPs to the sub national and local level.
- Engagement of PAHO Country offices a team in close collaboration with the specific HDM/CD advisor has shown to be effective to advance the implementation at the local level.
- The preparation of the national health services system, through a comprehensive training strategy, is key for the success of the implementation of the NIPPPs.
- The NIPPPs need to be fully tested with simulations and drills in order to detect and correct possible weaknesses that would threaten the success of its implementation in cases of public health emergencies.

- National workshops have proved more successful to guarantee an appropriate implementation of strategies at the local level, than subregional workshops.
- The introduction of a new Generic Protocol for Influenza Surveillance (GPIS) has resulted in an advance in virological surveillance; the amplification of early warning systems within countries to detect events which may pose public health threats; the reinforcement of laboratory capacity in countries; and in some cases in an higher number of samples shipped to the Regional Reference Laboratory.
- The lack of permanent staff at the regional CSR team at PAHO/HQ challenges the continuity of daily activities for technical cooperation for the Region. At least 4 permanent professionals should be hired for this specific team.
- Consolidation of existing partnerships and expansion of networks is needed to guarantee a continuity of activities.

Financial Execution

AoW: **CSR-Epidemic Alert and Response**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	2,608,900	3,829,194	3,784,200	99%
Other Sources	5,422,000	25,918,248	18,202,400	70%
Total (RB & OS)	**8,030,900**	**29,747,442**	**21,986,600**	**74%**

Execution of "Other Sources Budget" is affected by a) Cut at 31 Dec 2007, regardless of actual expiration of grants and b) As a result of IPSAS adoption, only actual disbursements were included. Obligations (commitments) of funds to be disbursed in 2008 are not included.

4. MALARIA (MAL)
Overall Achievement level: 98%

GOAL:
Halve the burden of malaria by 2010 and reduce it further by 2015 (Millennium Development Goal): “halt and begin to reverse the incidence of malaria.”

ACHIEVEMENT OF GOAL:
Between 2000 and 2007, there has been a 20% reduction in malaria morbidity and a 69% reduction in malaria mortality in the Region.

PAHO OBJECTIVE:
To consolidate, strengthen and intensify the malaria control strategy in the Americas, specifically in the 21 malaria endemic countries and prevent the reintroduction of transmission in nations where transmission has been interrupted.

ACHIEVEMENT OF PAHO OBJECTIVE:
Of the 21 endemic countries, 4 reported a decrease of over 75% in the number of cases; 4 reported a 50 - 74% decrease in cases; 7 others had a less than 50% decrease in the number of cases. Among the non-endemic countries, outbreaks were detected and contained in two countries during 2006-2007.

RER 4.1 Malaria prevention and control strategy implemented and expanded in endemic countries.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
4.1.1	Of 21 malaria endemic countries, number implementing all components of the Global Malaria control strategy within the context of the Roll Back Malaria Initiative.	17	20	**20**	
4.1.2	Number of countries undertaking joint activities in areas of common epidemiological interest.	8	14	**14**	
4.1.3	Of 21 malaria endemic countries, number which have reduced malaria burden by 50% or more in comparison with 2000.	8	12	**8**	**7 additional countries with burden reduced less than 50%.**
4.1.4	Number of countries with high P. falciparum burden implementing antimalarial treatment policies based on evidence of efficacy.	6	8	**8**	

RER 4.2 System of surveillance and routine monitoring of malaria and control measures functioning in all malaria endemic countries.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
4.2.1	Number of endemic countries using epidemiologic indicators for monitoring and evaluating disease burden.	15	18	**18**	
4.2.2	Of the countries where malaria transmission has been interrupted, number undertaking surveillance and reporting information on imported malaria cases.	20	24	**24**	
4.2.3	Number of endemic countries providing annual information on morbidity, mortality, progress, and outcomes.	18	20	**20**	
RER 4.3 Increase advocacy on importance of malaria and efforts to increase resources available for its control.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
4.3.1	Number of eligible malaria-endemic countries with approved proposals to the Global Fund to Fight AIDS, Tuberculosis, and Malaria.	6	8	**10**	
4.3.2	Number of malaria endemic countries supported by the Amazon Network for the Surveillance of Antimalarial Drug Resistance (RAVREDA/Amazon Malaria Initiative).	8	10	**10**	
RER 4.4 Increased involvement in intersectoral efforts.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
4.4.1	Number of endemic countries with malaria efforts that are carried out with and alongside other programs and sectors (e.g. environmental sanitation) in malaria control activities.	8	10	**10**	

Lessons Learned:

During the biennium, experiences of working in various levels emphasized the importance of the following:

- Program alignment and harmonization in all levels of work (global, regional, subregional, country, and grass-roots);
- Maintaining clarity and a common understanding of program objectives and concepts;
- Maintaining programmatic focus / constancy and consistency of efforts;
- Optimizing efforts and results;
- Fostering accountability within the organization and its sphere of influence;
- Maintaining a pro-active approach and better foresight;
- Identifying, enabling, and sustaining champions;
- Bridging gaps between policy and practice;
- Upgrading the health surveillance, monitoring, and evaluation system to facilitate evidence-based development and implementation of policies and interventions that yield the desired results;
- Fostering efficient and close collaboration between programs within institutions (including PAHO) and within the countries to optimize efforts and results;
- Implementing staffing, training, and other human resource management reforms to complement program changes;
- Translating evidence-based recommendations and interventions into implemented policies, as appropriate to country specificities;
- Improving the communication process and extension of advocacy work to all stakeholders and target audiences;
- Clarifying the mechanisms for and reinforcing PAHO's participation in the implementation of the Global Fund country projects (as mandated by Resolution CD46.R13);
- Engaging in a multisectoral, multipronged agenda on urban infrastructure development that will address various health consequences (including malaria);

- Strengthening the commitment to primary health care and intensifying efforts towards the integration of malaria work into the primary health care system;
- Country capacity-building to institutionalize and sustain malaria efforts within the health system;
- Continuous and strengthened monitoring and evaluation efforts;
- Increased investments of all stakeholders, particularly external contributors, to malaria work in the Region and channel them accordingly to interventions that work and yield desired results;
- Building upon the momentum of Malaria Day in the Americas.

Financial Execution

AoW: **MAL-Malaria**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	1,296,500	1,231,099	1,217,900	99%
Other Sources	12,909,000	8,493,423	7,045,700	83%
Total (RB & OS)	**14,205,500**	**9,724,522**	**8,263,600**	**85%**

Execution of "Other Sources Budget" is affected by a) Cut at 31 Dec 2007, regardless of actual expiration of grants and b) As a result of IPSAS adoption, only actual disbursements were included. Obligations (commitments) of funds to be disbursed in 2008 are not included.

5. TUBERCULOSIS (TUB)
Overall Achievement level: 93%

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.

ACHIEVEMENT OF GOAL:
The MDGs have almost been reached already in the Region of the Americas due to the individual and collective efforts of national TB programs and the Regional program in implementing the new Stop TB strategy. These have also contributed to the progress reported on the WHO TB targets which should also be reached shortly.

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

ACHIEVEMENT OF PAHO OBJECTIVE:
With the gradual implementation of the new Stop TB strategy this objective has been met.

RER 5.1 Expanded DOTS coverage and improvement in the quality of its application throughout the Region.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
5.1.1	Percentage of population covered by DOTS throughout the Region	78%	90%	**91%**	**Brazil, Haiti, Colombia, Ecuador Guyana and Paraguay expanded DOTs successfully.**
5.1.2	TB case detection rate	50%	70%	**69%**	**In spite of the increase in DOTS coverage in the Region, Brazil, country that contributes with 35% of the cases, do not report them all under DOTS.**
5.1.3	Treatment success rate under DOTS	81%	85%	**78%**	**Several countries have accelerated the expansion of DOTS but with cohort-based information systems non-compliant with the implementation of DOTS. There are also problems in the quality of the application of the strictly supervised treatment (loss of cases by default, transfer out and not evaluated). Besides, the countries in TB elimination present high case-fatality rates.**
5.1.4	Number of countries implementing PAL	1	6	**10**	**Baseline: Chile** **Actual: Chile, Peru, Bolivia, Nicaragua, El Salvador, Costa Rica, Mexico, Cuba, Brazil, Uruguay.**

5.1.5	Number of countries implementing Public Private Mix (PPM)	0	8	**6**	**Despite 10 countries having PPM plans, only 6 are currently implementing them.**
RER 5.2 Access to treatment for neglected populations and TB-HIV and MDR-TB patients will have increased.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
5.2.1	Number of countries with plans of action for prison populations	6	12	**13**	**Baseline: Peru, Honduras, El Salvador, Brazil, Chile, Uruguay Actual: Peru, Honduras, El Salvador, Brazil, Chile, Uruguay, Bolivia, Dominican Republic, Costa Rica, Guyana, Paraguay, Ecuador, and Mexico.**
5.2.2	Number of countries with active programs for persons deprived of their liberty	4	10	**13**	**Baseline: Peru, Honduras, Brazil, Chile Actual: Peru, Honduras, Brazil, Chile, El Salvador, Uruguay, Bolivia, Dominican Republic, Costa Rica, Guyana, Paraguay, Ecuador, and Mexico.**
5.2.3	Number of countries with plans of action targeting TB-HIV patients	10	16	**20**	**Baseline: Honduras, Dom. Republic, Chile, Belize, Costa Rica, Cuba, El Salvador, Brazil, Argentina, Guyana Actual: Honduras, Dom. Republic, Chile, Belize, Costa Rica, Cuba, El Salvador, Brazil, Nicaragua, Argentina, Guyana, Panama, Venezuela, Ecuador, Peru, Bolivia, Paraguay, Haiti, Uruguay, and Guatemala.**
5.2.4	Number of countries with active programs targeting TB-HIV patients	6	12	**12**	**Baseline: Chile, Belize, Honduras, Brazil, Guyana, Cuba Actual: Chile, Belize, Honduras, Brazil, Guyana, Cuba, Guatemala, Dom. Republic, Panamá, El Salvador, Venezuela, and Uruguay.**
5.2.5	Number of countries with national plans of action targeting indigenous populations	6	8	**10**	**Baseline: Mexico, Brazil, Chile, Peru, Bolivia, Panama Actual: Mexico, Brazil, Chile, Peru, Bolivia, Panamá, Ecuador, Costa Rica, Venezuela, and Colombia.**
5.2.6	Number of countries with active programs targeting indigenous populations	4	8	**9**	**Baseline: Brazil, Peru, Chile, Panama Actual: Brazil, Peru, Chile, Panama, Mexico, Venezuela, Costa Rica, Colombia, and Bolivia.**
5.2.7	Number of countries applying DOTS-Plus strategy*	10	15	**20**	***Currently called Prevention and Control of Multidrug resistance TB: MDR-TB.**
RER 5.3 Improved surveillance and program evaluation systems in place.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
5.3.1	Proportion of countries submitting accurate annual epidemiological surveillance reports	90%	98%	**86%**	**It is very difficult to obtain information from the Caribbean Member States and territories every year, due to their small annual number of TB cases.**

5.3.2	Proportion of countries submitting monitoring reports concerning HIV in TB patients	10%	40%	**10%**	**TB/HIV information now included in the global data collection form.**
5.3.3	Proportion of countries presenting financial reports regarding TB programs	10%	50%	**86%**	

Lessons Learned:

- Implementing the *Stop TB* Strategy in the countries of the Region has allowed us to offer comprehensive, patient-centered care, regardless of whether the patient has a more sensitive or resistant form or one linked to HIV.
- Current initiatives in the Region to incorporate all health providers and to offer standardized care to respiratory patients not ill with TB are all playing a role in strengthening health systems.
- Financial aid to low- and middle-income countries from the Global Fund and other donors is crucial when implementing the *Stop TB* Strategy in those places.
- In some countries, incorporating new initiatives for TB control has had a negative impact on the quality of DOTS implementation; therefore, technical assistance, monitoring, and evaluation activities are key for following up on the progress of TB control in each of the counties—and most especially in the priority countries.

Financial Execution

AoW: TUB-Tuberculosis

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	1,390,100	1,555,315	1,541,000	99%
Other Sources	5,973,000	20,149,079	9,818,100	49%
Total (RB & OS)	**7,363,100**	**21,704,394**	**11,359,100**	**52%**

Execution of "Other Sources Budget" is affected by a) Cut at 31 Dec 2007, regardless of actual expiration of grants and b) As a result of IPSAS adoption, only actual disbursements were included. Obligations (commitments) of funds to be disbursed in 2008 are not included.

6. HIV/AIDS (HIV)
Overall Achievement level: 76%

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

ACHIEVEMENT OF GOAL:
Not achieved. Despite progress made by countries, the epidemic continues to grow.

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

ACHIEVEMENT OF PAHO OBJECTIVE:
All countries and territories (40) in the Region are providing HIV prevention and care programs. However, there is no information available to assess their quality. There are shortcomings, and many countries have not been able to achieve 80% or greater coverage of prevention and care services.

All countries in the Region ratified their commitment with the Universal Access agenda. With support from the UNAIDS Bureau, countries in the Region conducted national and subregional consultations (LA, Caribbean, OECS) with a vast majority of stakeholders. Subregional priorities for technical cooperation, plans and strategic frameworks were developed or reviewed (Central America, Andean Region and the CRSF - Caribbean Regional Strategic Framework).

RER 6.1 Visible leadership and commitment to urgent action to reach the goal of universal access to antiretroviral therapy (ART) at national and regional levels.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
6.1.1	Number of countries that have in place legislation and/or policies that have been developed with PAHO support to reduce stigma and discrimination against people living with HIV/AIDS	10	25	**11**	**Ecuador was supported in the development and approval of the National HIV law.** **Technical cooperation strategy was modified in this area, in alignment with the Regional HIV/STI Plan for the Health Sector. Priority was given to capacity development for the utilization of a Human Rights approach for HIV. Four countries (Jamaica, Suriname, Belize and Guatemala) were supported by PAHO to conduct national training workshops on Human Rights and HIV with the participation of civil society and MOH as well as other actors and institutions. As a result, the Government of Belize asked PAHO to review the emphasis on Rights in draft legislation on HIV comprehensive care.** **Studies on Human Rights and HIV were completed in 5 Central American Countries in collaboration with persons living with**

					HIV and 1 country (Mexico) developed their first anti-homophobia campaign with PAHO's support. The Andean Region conducted with PAHO's support a situation analysis of stigma and discrimination and based on the results, developed a subregional plan for the reduction of stigma and discrimination 2007-2010, which will be presented to the next REMSAA for its approval.
6.1.2	Number of countries assisted by PAHO to implement innovative HIV/AIDS communications strategies	20	30	**30**	**Communication interventions were implemented to support scaling up of services. The Know Your Status Initiative was launched in May 2007, to support efforts by countries to generate demand for HIV testing and counseling. The initiative includes a publication with guidance on the development of Know Your Status campaigns, a web site and a journalism contest for the best story on the challenges of expanding HIV testing and counseling. The OUCH Campaign was implemented in the English Speaking Caribbean, to address issues of discrimination in the health care setting. All countries in the Region benefited from this initiative and have access to the tools and messages developed to implement innovative communication strategies to scale up testing and counseling. Honduras conducted a pilot to identify perceptions on HIV testing among adolescents. Colombia developed a communication strategy for MSM to address barriers to access testing and counseling.**
6.1.3	Number of countries that with PAHO support have integrated a gender approach into HIV/AIDS programs	5	15	**8**	**WHO guidelines on gender and HIV programming and planning were pilot-tested in three countries in the Region (Nicaragua, Belize and Honduras). The guidelines are now being reviewed and adapted for publication. Guidelines will be disseminated to countries in 2008-2009 and technical support provided for its use. Further technical support will be provided to the three pilot countries for implementation of the guidelines.**
6.1.4	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	**11**	**Five consultations were conducted during the biennium by PAHO (Prevention -1-, Pediatric care-1-, integration of HIV into sexual and reproductive health programs and services-2-, standards for generic medicines-1-). In the Andean Region, a subregional technical commission on HIV was established, comprises of ORAS, the National AIDS Program Coordinators, UNAIDS and PAHO. This Commission was recognized by REMSAA through a 2007 resolution. The Commission meets regularly for ongoing consultations on**

					strategies to move forward with the universal access agenda, including the implementation of the Andean Region Plan. **In Central America, the regional coordination mechanism approved by COMISCA (Ministers of Health of the Subregion) and formed by SISCA, chief of national programs, UNAIDS, USAID, CDC-GAP, PAHO, and representatives of civil society, meets periodically 4 times a year and harmonizes the technical cooperation in the area of HIV.**
RER 6.2 Health systems/services strengthening, including the adaptation and application of appropriate tools, supported.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
6.2.1	Number of countries assisted by PAHO to implement operational scaling-up plans	15	25	**25**	**PAHO/WHO supported the review of National Plans under the leadership of the Ministries of Health in 10 priority countries (Belize, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Bolivia, Colombia, Ecuador, Peru) guided by the Regional Plan for the Health Sector. Technical support was provided by the respective PAHO/WHO Country Offices and FCH/AI technical staff (country, subregions and regional level).** **In 2006-2007 evaluation was introduced as a strategic intervention to support health sector planning and scale up interventions. In 2006 the first comprehensive evaluation of the Health System's response to HIV/STI was carried out in the Dominican Republic and a national programming exercise followed. Methodology and tools were developed. In addition, evaluations of PMTCT programs were conducted in seven countries (Guatemala, Honduras, Panama, Trinidad and Tobago, Guyana, Paraguay and the Dominican Republic).**
6.2.2	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	**17**	**The Integrated Management of Adult and Adolescent Illness (IMAI) strategy has been utilized to support the achievement of this target (See also 6.2.6). Two countries (Haiti and Guyana) implemented the strategy in the last biennium). Guyana adapted 5 health care professional modules and two community modules. Guyana also obtained $ 1 million from PEPFAR to implement IMAI in 2007.** **For the rest of the Region, adaptation of the IMAI was completed and materials will be disseminated to countries in 2008-2009 with the necessary technical assistance. In addition, the technical assistance provided to countries for the preparation of proposals to be presented to the GFATM were utilized as opportunities to**

					consider effective integration of HIV treatment and care into PHC services (e.g. St. Lucia). **In the Andean region a joint situation analysis TB/HIV was conducted aiming to develop a strategy and action plan to strengthen join action and services at primary care level.** **Integration/collaboration of TB services with HIV was supported in Trinidad and Tobago, Barbados, St. Vincent& The Grenadines, Antigua & Barbuda, St. Lucia, Grenada and Dominica.** **Belize was supported in the integration of HIV treatment and care and T&C into public services.** **Integration of T&C into family planning clinics was successfully carried out in Trinidad and Tobago.** **Support for the integration of T&C into community health clinics was carried out in St. Vincent and the Grenadines, British Virgin Island, Trinidad and Tobago, Suriname, Guyana and Dominica. Also, support to the expansion of Provider initiated testing and counseling in hospital admissions was carried out in Jamaica.**
6.2.3	Number of countries that develop or update comprehensive care and treatment plans using guidelines elaborated, translated, and/or adapted by PAHO	15	30	**25**	**PAHO/WHO supported the review of National Plans under the leadership of the Ministries of Health in 10 priority countries (Belize, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Bolivia, Colombia, Ecuador, Peru) guided by the Regional Plan for the Health Sector. Technical support was provided by the respective PAHO/WHO Country Offices and FCH/AI technical staff (country, subregions and regional level). The target was not met since the technical support was focused in priority countries during this biennium.**
6.2.4	Number of countries implementing models of non-conventional entry points developed in collaboration with PAHO	2	10	**5**	**Three countries in the Region (Honduras, Nicaragua and Belize) completed a pilot project to utilize Domestic Violence services as entry points for HIV prevention care and treatment. Surveys were conducted and results are available to support decision making process to strengthen health care delivery by avoiding miss opportunities and improving referrals.**
6.2.5	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	**27**	**In addition to the baseline, Ecuador, Colombia and Panama updated and reviewed guidelines on ARV treatment, sexual and reproductive health and psychological support to patients living with HIV. In addition to direct country support four WHO guidelines were translated into Spanish and adapted to the Region. Four IMAI modules for health care professionals have been translated into Spanish and adapted (See 6.2.6). Countries**

					have actively participated in this process through expert consultations and materials, even though not yet published, have been facilitated to countries to lead their national processes upon request. **Belize, Trinidad and Tobago were supported in the development of Testing and guidelines and PMTCT Standard Operational procedures, TB guidelines.** **Guyana and Haiti were supported in the adaptation of the IMAI guidelines to the country.**
6.2.6	Number of training centers in the Region provided with technical support to implement standardized training systems to support care and treatment	5	10	**22**	**Four IMAI modules for health care professionals (General Principles, Acute Care, Chronic Care, and Palliative Care) have been translated into Spanish and adapted in collaboration with ACOFAEN. Two community modules (Flipchart for Patient Education and Caregiver's Booklet) have also been translated and adapted. Some of these materials have been adapted in Kweyol for Haiti.** **Support was provided by PAHO for the establishment of a network of Nursing Schools from LAC with the participation of 8 Nursing School Faculties' Associations (Argentina, Chile, Peru, Venezuela, Ecuador, Colombia, Brazil, Mexico) and 9 National Nursing Schools Faculties (Uruguay, Paraguay, Bolivia, Dominican Republic, Cuba, El Salvador, Honduras, Panama, Guatemala). The network developed an action plan aiming to integrate HIV prevention, care and treatment contents into existing curricula, train teachers, implement interventions among students and develop community outreach programs. IMAI has been utilized as a reference material. Implementation of that plan started in late 2007 and three countries (Colombia, Ecuador, and Chile) conducted national workshops and developed national action plans. This network represents 1,000 nursing schools from the Region. This has been possible through inter-programmatic collaboration between FCH/AI, SHR, and WHO—Human Resources-** **Direct technical and financial support was also provided to El Salvador for the training of 2,500 nursing auxiliaries and community health workers.**

6.2.7	Number of laboratories assisted by PAHO to scale up treatment and monitor patient outcomes	3	6	**22**	**PAHO provided technical support to 18 Laboratories in 11 countries in the Caribbean (Antigua and Barbuda, Dominica, St. Vincent and the Grenadines, Grenada, St. Lucia, St. Kitts and Nevis, Trinidad and Tobago, Guyana, Belize, Suriname and Jamaica. Support varied –from laboratory assessments, training in diagnostic methods including CD4 testing and HIV serology (including rapid HIV testing) and quality assurance, purchase of equipment and kits. In Central America, direct technical support was provided for the implementation of the laboratory component of the SISCA-WB HIV project. This included support to the development of the regional reference laboratory in Panama, and the development of national laboratory networks.**
6.2.8	Number of operational research studies under way to foster evidence-based interventions in health care delivery	2	5	**5**	**Four operational research projects were completed with PAHO's support benefiting 14 Countries. (Behavioral surveillance surveys were completed in 6 Eastern Caribbean countries; Nicaragua, Belize and Honduras completed study on gender based violence and HIV; Peru conducted a study on diagnosis of STIs among PLWH under ART; REDLA+ conducted a study on barriers to care in four countries, Dominican Republic, Colombia, Ecuador and Argentina).**
RER 6.3 The effective and reliable supply of HIV-related medicines and other commodities supported.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
6.3.1	Number of countries that with PAHO support count with updated policies to provide universal access to HIV/AIDS medicines	5	20	**10**	**All countries in the Region ratified their commitment with the Universal Access agenda. As reported in 6.2.2., PAHO/WHO, in collaboration with other UN agencies, supported the review of National Plans under the leadership of the Ministries of Health in 10 priority countries (Belize, El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Bolivia, Colombia, Ecuador, Peru) guided by the Regional Plan for the Health Sector. This review included an analysis and updating of existing policies to facilitate universal access to HIV/AIDS medicines. Technical support was provided by the respective PAHO/WHO Country Offices and FCH/AI technical staff (country, subregion and regional level). .**

6.3.2	Number of countries implementing PAHO/WHO norms in good procurement, storage, and distribution practices	3	15	**17**	**17 countries received technical support and or purchased ARV through the Strategic Fund for Public Health Supplies (Barbados, Belize, Bolivia, Brazil, Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago and Ecuador). We note a steady increase in the amount of drugs purchased through the Strategic Fund (from US$ 3,5M in 2004 to US$ 13.9M in 2006 and nearly US$ 20M in 2007). In 2006, a, Advisory group for ARV negotiations (GAN/ARV) was put in place for which PAHO provides Bureau support.**
RER 6.4 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
6.4.1	Number of new models of prevention for vulnerable groups developed and tested in countries with the support of PAHO	3	5	**4**	**During this biennium one new strategy was developed: Prevention of HIV among TB patients (including IEC and VCT). The adaptation to the English speaking Caribbean of the model for prevention among sex workers *(talking between us)*, was carried out. Additionally, the three prevention models developed in the previous biennium were finalized and are being disseminated. *Cara a Cara* prevention model was tested and adapted at country level (Mexico), *Hablando entre nosotras*, was piloted in El Salvador and an English version was finalized and is pending the pilot test. *Hablemos de salud sexual* for health professionals to facilitate communication with patients on sexual health was also promoted.**
6.4.2	Number of countries trained in new models of prevention for vulnerable groups	6	18	**16**	**Mexico, El Salvador, Bolivia, Colombia, Peru, Panama, Venezuela, Nicaragua, Belize, and the USA were added to the baseline. Training of health care providers with two models of prevention for vulnerable groups (face to face for MSM, and talking between us for SW) was conducted in Mexico, El Salvador and the USA with participation of professionals from other countries of the Region.**

6.4.3	Number of countries implementing new models of prevention of sexually transmitted HIV and STI with the support of PAHO	6	18	**11**	**Mexico, USA, EL Salvador, Belize, and Nicaragua were added to the baseline.** **Training for incorporating strategies for prevention of HIV among TB patients (this includes IEC and VCT interventions). Delays in the finalization and publication of the new models of prevention impeded the achievement of this target. The two tools mentioned above (face to face and talking between us) will be published in the first semester of 2008 and further roll out is anticipated.**
6.4.4	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	**8**	**Support to the training plans was carried out in the Caribbean. Support to the training of health teams for the integration of T&C into community health clinics was carried out in St. Vincent and the Grenadines, British Virgin Island, Trinidad and Tobago, Suriname and Dominica. Also, support to training of providers for expansion of Provider initiated testing and counseling in hospital admissions was carried out in Jamaica.**
6.4.5	Number of countries that have eliminated congenital syphilis with PAHO support	5	20	**5**	**This target was not achieved. However, a technical cooperation strategy is being developed to integrate the elimination of congenital syphilis with the elimination of vertical transmission of HIV, as a comprehensive approach that will facilitate strengthening of the MCH services to achieve these two important goals. To date, even though cost-effective interventions are available, coverage is low, and health response fragmented. Some of the countries with increased coverage of PMTCT, are lagging behind with the prevention of congenital syphilis. PAHO will strengthen its support to countries in the next biennium to foster a comprehensive approach to health care deliver to address these two conditions by levering HIV resources for overall strengthening of MCH services.**
6.4.6	Number of countries with updated policies and programs linking prevention activities to care and treatment	5	15	**10**	**El Salvador, Nicaragua, Honduras, Guatemala, Mexico were added to the baseline, but the target of 15 countries was not achieved.** **An integrated approach to HIV policies, programs and services has been promoted in the development, evaluation and or review of national plans in two priority countries and additional countries of Central America and Mexico. (See 6.2.1). Incorporation in rest of priority countries will be a target for 2008-2009.**

RER 6.5 The production of strategic information and dissemination of the lessons learned supported.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
6.5.1	Number of countries and institutions that will have strengthened their surveillance systems with the support of PAHO	8	16	**16**	**CAREC has provided continuous support to HIV surveillance in Barbados. Behavioral surveillance surveys were completed in 6 Eastern Caribbean countries. Ecuador received support in laboratory algorithms for surveillance. Six countries received training on second generation surveillance in the Andean Region, the Central America Epi-listserv for HIV was established and a subregional workshop was conducted for case definition standardization with the participation of all CA countries in collaboration with WHO, CDC, and the SISCA/BM project. Evaluation of surveillance systems was conducted in the Dominican Republic as part of the evaluation of the Health system response. In El Salvador, a unified information system for HIV surveillance and M&E (SUMEVE) was developed with PAHO support. Standardization of indicators for HIV and STI in Demographic and Health surveys was carried out in all Central American countries with support form PAHO, CDC-Gap, UNAIDS and USAID.**
6.5.2	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	**7**	**Belize received direct support in the development and correction of estimates for HIV. In addition, all countries received support from PAHO in collaboration with UNAIDS to conduct workshops for the development of HIV estimates, including ART needs. A workshop for strengthening patient monitoring system in seven countries (Barbados and OECS countries) was conducted with follow up and support to Dominica, St. Vincent &the Grenadines and Grenada.**
6.5.3	Number of countries supported by PAHO for their national capacity building in the production of strategic information	8	16	**16**	**Many countries in the Region have received PAHO's support to contribute to the universal access report in line with WHO/UNAIDS guidelines. In addition, three countries in central America (Honduras, Guatemala, El Salvador) received direct technical support for the**

					development of M&E institutional plans—Guatemala, Honduras—and software—El Salvador. **The Andean Region conducted a situation analysis of National M&E systems and developed a subregional plan to address national weaknesses and further strengthen National M&E Systems.**

Lessons Learned:

- Overall Health System's strengthening is necessary to achieve and sustain the universal access target.
- PLWHA need to be more involved
- The specific needs of vulnerable groups need to be addressed
- Strong emphasis to be put on prevention and promotion of sexual and reproductive health
- Despite of having access to the financial resources, many countries have sown limited absorption capacity.
- Regional processes to effectively support subregional and country level actions have not been addressed at the pace necessary for appropriate guidance to countries:

Financial Execution

AoW: **HIV- HIV/AIDS**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	2,081,800	2,602,793	2,535,500	97%
Other Sources	35,663,000	25,419,510	17,890,400	70%
Total (RB & OS)	**37,744,800**	**28,022,303**	**20,425,900**	**73%**

7. SURVEILLANCE, PREVENTION AND MANAGEMENT OF CHRONIC, NON COMMUNICABLE DISEASES (NCD)
Overall Achievement level: 96%

GOAL:
To reduce the burden of premature mortality and morbidity related to chronic, non-communicable diseases.

ACHIEVEMENT OF GOAL:
Chronic, non-communicable diseases, namely cardiovascular diseases, cancer and diabetes, continue to be the leading causes of death in Latin America and the Caribbean. The burden of chronic diseases is rapidly increasing with an ageing population, changing lifestyles, and interventions which often lack public health approaches. Countries have limited capacity to respond to the chronic disease burden, especially with many competing public health priorities. On the other hand, many countries and institutions in the Region have begun to make Chronic Diseases and Health Promotion a major policy issue, e.g., Brazil, Chile, Argentina, Uruguay, Central American and Caribbean countries. Increased awareness of and mobilization of the Organization and countries to respond in a comprehensive manner has been the main achievement. In 2008-2009, there is now a need to build on this, develop a clearer blueprint for evidence-based interventions, unify the many actors in a stronger partnership to achieve synergy to turn the epidemic of NCDs and risk factors around, and increase the mobilization of resources to this end.

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
In 2006, PAHO developed a Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet and Physical Activity, which was endorsed by the PAHO Directing Council. The goal of the Strategy is to prevent and reduce the burden of chronic diseases and related risk factors in the Americas. PAHO is providing technical assistance to Member States in four main areas: Policy & Advocacy, Surveillance, Health Promotion and Disease Prevention, and Disease Management. Cross-cutting approaches include communications and training/capacity building. The most significant achievements in the 2006-2007 biennium with respect to the implementation of the Chronic Disease Regional Strategy are as follows:

- **Participating in the Caribbean Summit of Heads of State on Chronic Diseases, which led to a comprehensive Declaration "Uniting to Stop the Epidemic of Chronic Diseases in the Caribbean" and supporting the implementation of the declaration**
- **Strengthening surveillance capacity in countries using the WHO STEPS standard instrument with a total of 22 countries now on board. STEPS surveillance system is standardized. WHO methodology for Risk Factor surveillance, contemplating RF studies to be repeated every 3-5 years. In that way comparison can be made between different time periods and among countries. Actually at global level, 116 countries are implementing the same methodology. The Region of the Americas has started implementing Pan Am STEPS studies since 2006, and by now following advances are present in the Region:**
  - **STEP studies published and promoted for policy purposes: Aruba, Bahamas. Pending Uruguay**
  - **STEP Study presently in course: Dominica, St Kitts and Nevis, Barbados**
  - **In preparatory phase : Dominican Republic, Cuba, Paraguay, Grenada, T & T, Curacao, Turks & Caicos**
  - **In Planning for 2008: BVI, St. Lucia, St Vincent, Guatemala, Panama, C. Rica**
  - **Also, Chile, Argentina and Brazil, are working on harmonization of their data with Pan Am STEPS**
- **Convening the chronic disease program managers from Ministries of Health across the Americas, along with partner organizations, for the**

CARMEN biennial meeting to plan the implementation of the Chronic Disease Regional Strategy.

- **Establishing the Trans Fat Free Americas initiative and convening the major food companies which pledged to eliminate trans fat from the food supply in the Americas by end 2009.**
- **Building country capacity for chronic disease policy development, program management, and surveillance, through the CARMEN schools, with courses in evidence based public health, physical activity, social marketing.**
- **Implementing a Central America Diabetes Initiative and building country capacity for improving surveillance and quality of care for diabetes and other chronic conditions.**
- **Strengthening cervical cancer prevention programs through improved cytology screening and by testing alternative screening and treatment approaches.**
- **Uniting all the PAHO focal points for disease prevention and control to build a collaborative team on chronic diseases across the PAHO headquarters, country offices and centers, and WHO Geneva.**
- **Advancing the implementation of the Framework Convention on Tobacco Control as a pillar of the prevention measures needed**

RER 7.1 Effective guidance and strategies provided for integrated NCD prevention programs, within the framework of the CARMEN network.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
7.1.1	Number of countries that have an approved plan of action for integrated NCD prevention and control	12	22	**15**	**The Chronic Disease Regional Strategy has been used by several countries to develop their own national plans. Nonetheless, not all targeted countries have succeeded to develop their plans.**
7.1.2	Number of countries implementing plans of action	12	18	**15**	**The countries with a national plan have implemented their plans, but the target was not reached.**
7.1.3	Number of countries that have established training programs on NCD prevention and control (e.g. CARMEN schools)	1	11	**17**	**10 ECC countries, along with 7 in Latin America have led a CARMEN school to improve country capacity.**

RER 7.2 Interventions and programs evaluated for integrated prevention, early detection, and management of NCDs.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
7.2.1	Number of countries developing demonstration site for integrated prevention of NCDs	0	5	**7**	**The Chronic Disease Regional Strategy has been used by several countries to develop national plans.**
7.2.2	Number of countries developing regulations and policies for integrated NCD prevention	0	3	**15**	**The countries with a national plan also have established corresponding policies.**

RER 7.3 Local surveillance systems for NCDs and risk conditions established, with particular emphasis on behaviors.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
7.3.1	Number of countries that published periodic data on the prevalence of NCD and NCD risk factors	4	8	**15**	**A total of 22 countries are participating in the STEPS surveillance system.**
7.3.2	Number of countries with information systems to monitor NCDs, their risk factors, and health services	4	8	**15**	

RER 7.4 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, cervical and other types of cancers causing major burden in the Region such as breast, lung, colorectal, stomach and prostate cancer.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
7.4.1	Number of countries with demonstration sites developing a plan to improve quality of care for diabetes, hypertension, cervical and other types of cancers causing major burden in the Region such as breast, lung, colorectal, stomach and prostate cancer.	1	4	**5**	**Central American countries have established demonstration sites for diabetes, hypertension. Most countries in the Americas have established sites for cervical cancer screening.**
7.4.2	Number of demonstration sites which have disseminated the results of the evaluation of quality of care using the chronic care model	1	4	**5**	**Central American countries have disseminated results of their quality of care projects.**

RER 7.5 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 non-communicable diseases.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
7.5.1	Percentage of countries with a budget line for NCD prevention and control in their national health budgets	30%	60%	**60%**	**21 countries have reported having a budget line for NCD in their national health budgets.**

RER 7.6 Normative and operational strengthening of ocular health programs promoted within the framework of health service development.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
7.6.1	Number of countries that have formulated standards and policies for ocular health based on the knowledge generated from rapid surveys	0	2	**5**	
7.6.2	Number of countries that have initiated, strengthened, or reviewed programs for the delivery of ocular services	1	4	**6**	

Lessons Learned:

- Still insufficient awareness of the magnitude of the problem and availability of solutions
- Although some external funds were received for the control of non-communicable diseases, most of them were with donor-driven criteria with little or no flexibility to facilitate the implementation of the strategy. Technical cooperation for non communicable area has been and continues to be challenged by shortages of personnel and financial resources
- However, many deaths can be avoided by a combination of population and individual approaches as per the regional strategy
- The problem cannot be solved by health sector alone; partnership in and out of the health sector is needed in a major new way
- There is still too much fragmentation in countries and in the Organization in the response to the chronic disease problem

Financial Execution

AoW: **NCD- Surveillance, Prevention and Management of Chronic, Non Communicable Diseases**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	5,351,200	4,555,885	4,463,200	98%
Other Sources	5,217,000	4,828,190	2,563,500	53%
Total (RB & OS)	**10,568,200**	**9,384,075**	**7,026,700**	**75%**

Execution of "Other Sources Budget" is affected by a) Cut at 31 Dec 2007, regardless of actual expiration of grants and b) As a result of IPSAS adoption, only actual disbursements were included. Obligations (commitments) of funds to be disbursed in 2008 are not included.

8. HEALTH PROMOTION (HPR)
Overall Achievement level: 68%

<table>
<tr><td colspan="6">GOAL:
To improve equity in health, reduce health risks, promote healthy lifestyles and settings, and respond to the underlying determinants of health.</td></tr>
<tr><td colspan="6">ACHIEVEMENT OF GOAL:
Improve country and community capacities to create conditions that protect and promote the population’s health and living conditions. (Mejorar la capacidad de respuesta de los países y de las comunidades para proteger la salud y las condiciones de vida.)</td></tr>
<tr><td colspan="6">PAHO OBJECTIVE:
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, learn, work, and play.</td></tr>
<tr><td colspan="6">ACHIEVEMENT OF PAHO OBJECTIVE:
Subregions, countries and communities develop interesectoral health promotion plans and programs, including public, private and community representatives and evidence of effective strategies and approaches.</td></tr>
<tr><td colspan="6">RER 8.1 Increased capacity for mainstreaming the health promotion strategy within the Bureau with an emphasis on tobacco, violence, healthy diet, and physical activity.</td></tr>
<tr><td>Ind.#</td><td>Indicator description</td><td>Baseline</td><td>Target</td><td>Actual Dec 2007</td><td>Explanation (obligatory if target not met) or comments</td></tr>
<tr><td>8.1.1</td><td>Guidelines for incorporation of health promotion as a key component of the analytical framework for the review of BPBs and EBIs developed and disseminated to all technical staff.</td><td>0</td><td>2</td><td>0</td><td>This is an objective for 2008-2009 bienniums. The mainstreaming framework is still under development.</td></tr>
<tr><td>8.1.2</td><td>HQ managers and staff in the offices in the key countries taught to apply the guidelines.</td><td>0</td><td>80</td><td>0</td><td>Since the guidelines and framework are still underdevelopment, managers and staff in country offices have not yet been provided with the appropriate orientation.</td></tr>
<tr><td colspan="6">RER 8.2 Increased capacity for healthy public policy and health promotion planning at subregional, national and local levels.</td></tr>
<tr><td>Ind.#</td><td>Indicator description</td><td>Baseline</td><td>Target</td><td>Actual Dec 2007</td><td>Explanation (obligatory if target not met) or comments</td></tr>
<tr><td>8.2.1</td><td>Number of countries supported by PAHO in public policy development and</td><td>2</td><td>6</td><td>5</td><td>Technical support provided to development of national health promotion policies in the Dominican Republic, Panama and</td></tr>
</table>

	planning with targets to address and improve the determinants of health and equity				**Paraguay**
8.2.2	Number of health promotion 'centers of excellence' supported by PAHO in developing mechanisms for community participation and public debate on healthy public policies.	6	10	**7**	**3 centers in Canada, 2 centers in the US, and 1 center each in Colombia and Brazil. Most of the new potential centers identified were in countries already collaborating. It takes time to develop the expertise.**
8.2.3	Number of key countries receiving PAHO support in building and mapping health promotion capacity according to international commitments and the MDG	2	4	**28**	**Antigua and Barbuda, Argentina, Barbados, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Paraguay, Peru, St. Vincent & Grenadines, St. Kitts and Nevis, St. Lucia, Suriname, Bahamas, Trinidad and Tobago, Turks and Caicos.**
8.2.4	Number of subregional integration bodies receiving PAHO support in health promotion.	2	4	**1**	**CARICOM**
RER 8.3 Improve the reorientation of health services by incorporating health promotion in Primary Health Care					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
8.3.1	Number of countries supported by PAHO to incorporate Health Promotion principles and guidelines in Primary Health Care	2	6	**2**	**During the biennium PHC concept and framework was reviewed and the final version approval was done in Buenos Aires meeting, second semester of 2007. Therefore it was not possible to advance in this indicator because the existing PHC concept was not totally applicable and the new one was not established until of 2007.**
8.3.2	Number of countries supported by PAHO that adapted the PAHO model for training PHC workers in the care of the elderly	4	8	**4**	**Not enough efforts were done to accomplish this target.**
8.3.3	Number of countries with models of integrated oral health and PHC developed and tested with PAHO support	6	8	**6**	**Not enough efforts were done to accomplish this target.**
RER 8.4 Country capacity enhanced to engage networks of local authorities, relevant sectors, and community organizations in creating healthy and supportive municipalities, cities, and communities (HMC).					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
8.4.1	Number of priority countries with PAHO	2	5	**4**	**The particular conditions of Hait precluded attaining this**

	support developing, implementing, and evaluating HMC plans to address health targets and the MDGs				**indicator.**
8.4.2	Number of regional and national HMC networks actively functioning with PAHO support	4	8	**9**	**Argentina, Brazil, Canada, Costa Rica, Cuba, El Salvador, Mexico, Paraguay and Peru**
8.4.3	Number of academic institutions in different countries using PAHO guidelines, tools and training materials to support HMC processes	3	6	**8**	**Argentina, Brazil, Canada, Chile, Cuba, Guyana, Mexico and Peru**
8.4.4	Number of countries receiving PAHO support to evaluate HMC initiatives	6	10	**20**	**Anguilla, Argentina, Belize, Brazil, British Virgin Islands, Canada, Chile, Costa Rica, Dominican Republic, El Salvador, Guatemala, Guyana, Honduras, Mexico, Montserrat, Nicaragua, Panama, Peru, Trinidad and Tobago, and the United States**
RER 8.5 Country capacity strengthened to promote healthy school settings and lifestyles, fully engaging young people in and out of school, as well as teachers, parents, and communities.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
8.5.1	Number of countries receiving PAHO support in the planning, implementation and evaluation of Health Promoting Schools (HPS) with an emphasis on hygiene related to the achievement of the MDGs	3	8	**7**	**Honduras, Guatemala, El Salvador, Nicaragua, Panama, Dominican Republic, and Costa Rica**
8.5.2	Number of countries receiving PAHO support for the development of national HPS networks	0	4	**4**	**Chile, Cuba, Brazil and Nicaragua**
8.5.3	Number of countries receiving PAHO support to strengthen surveillance systems for school based risk and protective factors	2	3	**10**	**Ecuador, Uruguay, Colombia, Cayman Islands, St. Lucia, Trinidad and Tobago, St. Vincent, Chile, Venezuela, and Guyana**
8.5.4	Number of academic institutions using PAHO guidelines and documents to support HPS processes	3	6	**6**	

Lessons Learned:

- Developing capacities in health promotion evaluation requires a considerable amount of technical support and ongoing activities to address the issues of high turnover of personnel
- It helps countries to document and analyze their experiences if they are given orientation, templates and incentives.
- True community participation takes time and nurturing
- Countries benefit from sharing experiences and lessons learned

Financial Execution

AoW:	HPR- Health Promotion			
	Budget	**Allotted**	**Expenditure**	**% Implemented**
Regular Budget	8,787,100	7,661,164	7,497,900	98%
Other Sources	3,319,000	7,518,997	5,496,200	73%
Total (RB & OS)	**12,106,100**	**15,180,161**	**12,994,100**	**86%**

9. MENTAL HEALTH AND SUBSTANCE ABUSE (MNH)
Overall Achievement level: 94%

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

ACHIEVEMENT OF GOAL:
In the Region of the Americas, the mental and neurological disorders represent 24% of the total burden of diseases measured in DALY (Disability-adjusted Life Years) and there is a gap of treatment that exceeds 50%. A worldwide rising trend has been observed, which means that this is a challenge that must by confronted by the Region through the expansion of coverage and the quality of services.

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
PAHO has cooperated with the countries of the Region to strengthen an effective implementation of the Policies and Plans of Mental Health, with the objective of improving the delivery of services as well as reduce the treatment gap. 26 countries have a National Mental Health Plan.

RER 9.1 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.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
9.1.1	Number of countries in which mental health and substance abuse information systems have improved with PAHO support	3	6	**6**	**25 countries have reported that they have a National Information System. PAHO has given technical support to the six countries indicated.**
9.1.2	Number of countries where data on the prevalence and burden of mental disorders and substance abuse have been collected and analyzed	8	12	**10**	**World Study of Mental Health: 3 (Colombia, Peru, Mexico) Other studies: Chile, Argentina, Jamaica, Brazil, Cuba, Panama, and Nicaragua.**
9.1.3	Number of countries where information on delivery of services for mental health and substance abuse has been collected and analyzed.	24	34	**25**	**25 countries have information. The Mental Health Information Systems in Latin-American and the Caribbean countries continue to have weaknesses. Procedures have not been standardized at the regional level and the quality of the collected data varies according to the countries. Only some countries have appropriate data. That's why this issue appears in one OSER of the biennium 2008-2009 as a priority.**

RER 9.2 Increased capacity in countries to develop research supporting the implementation of mental health policy and services.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
9.2.1	Number of people from Latin America and the Caribbean (LAC) trained in mental health and substance abuse research through PAHO involvement	36	84	**92**	**Training to young researchers. Two Meetings (Mexico and Jamaica). The countries that have concrete findings of epidemiological research have used them in one way or another for advocacy as well as to support the implementation of National Mental Health Policies and Plans. PAHO is preparing a book that compiles most important epidemiological research conducted in the Region; this book will be ready in 2009.** **The group of young researchers received specific training on research methodology and design of projects, as well as receiving advisory services on their own projects. These researchers are from 8 countries of Latin America and the Caribbean.**
9.2.2	Number of mental health and substance abuse studies supported in LAC	6	9	**9**	**World Study of Mental Health, 3 countries in addition to the baseline.** **Project sponsored by NIMH for young researchers. Several studies were supported.** **Project of Psychosis in Indigenous Population (Guatemala).**
RER 9.3 Strengthened capacity in countries to implement mental health policies and plans.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
9.3.1	Number of people from LAC trained in mental health planning and management	24	114	**Estimate: 120**	**Training supported directly by PAHO: --Short training in specific subjects such as Suicide and Psychosocial Rehabilitation (Central America).** **-Training in disasters for Regional Task Force in Mental Health** **- Support for a Post-Graduate Course in Córdova (Argentina)**
9.3.2	Number of countries where mental health plans were implemented with the support of PAHO	16	20	**18**	**Technical support during the biennium for the design and/or implementation of national plans of mental health: Central America: Nicaragua, Guatemala, El Salvador, Honduras, Panama, Dominican Republic, Mexico (7)** **South America: Argentina, Paraguay, Uruguay, Chile, Ecuador, and Peru (6)** **Caribbean: Guyana, Suriname, Belize, Jamaica, Trinidad and Tobago (5)**

RER 9.4 Countries assisted to develop and evaluate programs to prevent and treat mental disorders and to meet the special needs of vulnerable groups.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
9.4.1	Number of countries that have developed, with PAHO assistance, programs to improve the prevention and treatment of mental disorders	4	8	**18**	**The countries that received technical support for the development of their MH National Policies and Plans. This is an aspect that must be strengthened in the next biennium.**
9.4.2	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	**18**	**The countries that received technical support for the development of its MH National Policies and Plans. There is a specific project for mental health of indigenous populations in Guatemala. This is an aspect that must be strengthened in the next biennium.**
RER 9.5 Strengthened capacity in countries to develop new mental health legislation and protect the human rights of people with mental disorders.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
9.5.1	Number of countries that have reviewed or updated mental health legislation with PAHO support	7	12	**15**	**South America: Argentina, Peru, Chile, Venezuela Central America: Nicaragua, Panama, El Salvador Caribbean: Belize, Barbados, St. Lucia, Bahamas, Grenada, St. Kitts and Nevis, Antigua, St. Vincent and the Grenadines**
9.5.2	Number of countries that have developed specific measures to protect the human rights of people with mental disorders with PAHO support	8	13	**10**	**South America: Argentina, Brazil, Chile, Paraguay, Ecuador Central America: Nicaragua, Panama, El Salvador, Honduras, and Guatemala Caribbean: pending**
RER 9.6 Countries assisted to develop and evaluate programs to prevent and treat substance abuse disorders and to meet the special needs of vulnerable groups.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
9.6.1	Number of targeted countries that have adapted alcohol policy guidelines developed with PAHO support, according to their specific needs	2	4	**4**	**Actions of technical support have been carried out.**
9.6.2	Number of countries that have improved services for substance abuse disorders with PAHO support	2	4	**4**	**-Courses in training for the early identification and treatment of problems related to alcohol in PHC. -Other actions of technical support.**

Lessons Learned:

- The assessment of Mental Health System (using WHO AIMS) opened the door, in many countries, for technical cooperation in the mental health field.
- The most of the countries of the Region have a National Mental Health and Substance Abuse Policy and Plan, but the implementation is very low.
- There are needs of developing of Human Resources in mental health and substance abuse field, especially in PHC.

Financial Execution

AoW: **MNH- Mental Health and Substance Abuse**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	2,643,800	2,269,999	2,262,800	100%
Other Sources	3,680,000	1,340,024	804,300	60%
Total (RB & OS)	**6,323,800**	**3,610,023**	**3,067,100**	**85%**

10. TOBACCO (TOB)
Overall Achievement level: 90%

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

ACHIEVEMENT OF GOAL:
By the end of 2007, 22 Member States had ratified the WHO Framework Convention on Tobacco Control (100% above the target) and 7 Member States already passed national legislation on Smoke-Free environments, Packaging and Labeling of Tobacco Products and Bans on advertisement, promotion and sponsorship of tobacco products in compliance with the FCTC mandates (Art 8, Art 11 and Art 13).

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
The Organization carried out training workshops directed at governmental officials on specific tobacco control policies with the aim of strengthening national capacity to put such policies in place at the country-level. These workshops were on the following policies: (1) Smoke-Free Environments and Human Rights, (2) Packaging and Labeling of tobacco products, (3) WHO FCTC: main mandates. Also, for the first time the Workshop on Tobacco Control in the Region of the Americas was organized with participation of both the focal points of the PAHO/WHO country offices and of the Ministries of Health.
In addition, the Organization continued its work collecting data and evidence in support of effective tobacco control policies in the Region. In a significant effort, the Organization collected information of existing policies at the country level on tobacco control for all 35 PAHO Member States. These data is a valuable instrument to monitor governmental response to the tobacco epidemic in our Region.

RER 10.1 Smoke-free environments extended in the Region.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
10.1.1	Number of countries receiving training to create smoke-free health and education sectors.	5	15	**15**	

RER 10.2 Increased notification, acceptance, approval, formal confirmation or accession by Member States to the Framework Convention.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
10.2.1	Number of Member States that are parties to the Framework Convention.	6	11	**22**	

RER 10.3 Increased production of surveillance data pertaining to youth tobacco use, exposure to second-hand smoke, and/or tobacco control and consumer health policies.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
10.3.1	Number of countries participating in the second round of the Global Youth Tobacco Survey (GYTS)	12	20	**13**	**CDC has selected only 15 countries for the biennium so this was the real target. One country is trying to solve administrative obstacles (Panama) and the other (Costa Rica) has not yet reached an agreement on the budget.**
10.3.2	Number of countries that have updated the Pan American Tobacco Information Online System (PATIOS)	0	30	**35***	*** Even though all the information has been collected, the upload of the information has not yet been completed.**
10.3.3	Number of countries that have completed the Environmental Nicotine Exposure Surveillance System (ENESS)	7	14	**11**	**There were no funds available to do this research in 2007; however, we currently have an agreement with the Johns Hopkins Bloomberg School of Public Health to implement this surveillance in 4 countries during the first semester of 2008.**

Lessons Learned:

- As the WHO FCTC becomes a reality at the national level, the demand from ratifying Member States for technical support from the Regional Office increases. Ratifying States demand more support from the Regional Office in drafting legislation in compliance with specific mandates (Packaging and Labeling, Increasing taxes, Smoking bans, and Advertisement bans) and establishing national coordinating mechanisms that can lead the FCTC process nationally as well as represent their country in the different FCTC-related meetings. The technical team has put a lot of effort during the biennium in providing such support while being understaffed and facing changes in the leadership of the team. Staffing at the regional level should be considered under the FCTC process.
- The Regional Workshop of Tobacco Control showed the need for this kind of activity regularly, and of a close follow up between meetings in order to facilitate the process of tobacco control at country level and at the subregional level, and to keep the commitments for tobacco control high.

Financial Execution

AoW: **TOB-Tobacco**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	906,800	678,026	666,100	98%
Other Sources	1,235,000	2,622,270	1,761,500	67%
Total (RB & OS)	**2,141,800**	**3,300,296**	**2,427,600**	**74%**

11. NUTRITION (NUT)
Overall Achievement level: 86%

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 non-communicable diseases.

ACHIEVEMENT OF GOAL:
PAHO does not directly monitor the MDGs; however in Latin America and the Caribbean region the proportion of people living on less than $1 a day decreased from 10.3% in 1990 to 8.7% in 2004 and the prevalence of children under the age of five who are underweight decreased from 11% in 1990 to 7% in 2005.

PAHO OBJECTIVE:
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. To boost the capacity for strategic analysis of health information, FNS, and development for the targeting of interventions, the promotion and formulation of public policies that will help reduce hunger and malnutrition, and improve the quality of institutional management in the implementation of policies, plans, programs, and projects for the attainment of the MDGs.

ACHIEVEMENT OF PAHO OBJECTIVE:

- **Most of the countries perform breastfeeding and complementary activities however efforts to prevent a decline in the duration of breastfeeding and to improve breastfeeding and complementary feeding practices need to be amplified.**
- **Latin America has made important progress to control micronutrient deficiencies, most of the countries have implemented food fortification programs including universal salt fortification (iodine) and wheat flour fortification (iron) to prevent or control iodine and iron deficiency respectively. However, 11% (98.6 million) of the population in the Americas have insufficient iodine intake; and 30% of preschool age children, 24% of pregnant women and 18% of fertile age women are anemic. The Region must develop innovative strategies to reach pocket of vulnerable population with no access or low consumption of fortified food; it is also needed to redouble efforts to implement sustainable regulatory monitoring systems to assure the quality of fortified food.**
- **Healthy diet and active living throughout the life cycle is being promoted throughout the Region but policies, plans and programs are still needed.**

RER 11.1 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.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
11.1.1	Number of countries with revised national food and nutrition plans based	6	15	**11**	**Three Caribbean countries have not progressed as planned and are in various stages of development. These will be completed in 2008.**

	on national priorities and focused on specific interventions and indicators with allocation of resources				
11.1.2	Number of countries that have developed and launched Food-based Dietary Guidelines	6	8	**9**	
11.1.3	Number of countries with programs for enhancing food security	9	15	**18**	
11.1.4	Number of countries with active nutritional surveillance systems that monitor and evaluate trends	0	8	**10**	**Ten countries at different stages of implementation.**
11.1.5	Number of countries with programs for safe food preparation and storage	0	4	**4**	
RER 11.2 Improved infant and young child nutrition through implementation of the Global Strategy for Infant and Young Child Feeding (IYCF).					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
11.2.1	Number of countries with national plans to implement the Global Strategy for IYCF	7	18	**23**	
11.2.2	Number of countries implementing the WHO Growth Reference Standards	0	15	**15**	
RER 11.3 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).					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
11.3.1	Number of countries implementing fully active regulatory monitoring systems (QC/QA, food labeling, inspection, and product analysis) for food fortification	6	15	**15**	
11.3.2	Number of countries implementing active household/individual monitoring and evaluation systems for food fortification (beyond salt iodization)	3	10	**1**	• **Nicaragua has in place the *Sistema Integrado de Vigilancia de las Intervenciones Nutricionales* (SIVIN) at household, schools and retail shops levels.** • **Dominic Republic and Panama are designing their own systems.** • **Resource constrains prevent the implementation of household and individual monitoring systems in other countries.**

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
11.3.3	Number of countries with programs for decreasing the prevalence of anemia	2	8	**28**	
RER 11.4 Improved diet and physical activity and reduction of nutrition-related non-communicable diseases.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
11.4.1	Number of countries implementing the Global Strategy on Diet and Physical Activity	0	12	**12**	
11.4.2	Number of countries implementing programs that promote physical activity	6	20	**10**	**Countries that have not achieved the indicator are at different stages of implementation.**
11.4.3	Countries implementing programs to promote a healthy diet	2	24	**15**	**Countries that have not achieved the indicator are at different stages of implementation.**
RER 11.5 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
11.5.1	Number of countries with strategies in place to provide nutritional support for people living with HIV/AIDS	0	10	**11**	
11.5.2	Number of countries with comprehensive programs for infant feeding and HIV counseling	0	6	**14**	
RER 11.6 The capacity of the countries of the Central American subregion and of PAHO/WHO priority countries to promote FNS and sustainable development within the framework of MDG 1 has been strengthened by strategic information analysis, public policy development, and improvements in the quality of institutional management in FNS.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
11.6.1	Number of countries with the capacity for strategic information analysis in FNS supporting decision-making and the targeting of policies, plans, programs, and projects.	3	7	**6**	**Missing country still in process of achieving the target**
11.6.2	Number of countries developing public policies to reduce hunger, malnutrition, and poverty	5	7	**8**	
11.6.3	Number of countries with the capacity to	3	7	**7**	

	manage policies, plans, programs, and projects in FNS at the regional, national, and local level, with emphasis on populations living in extreme poverty				

Sistema Integrado de Vigilancia de Intervenciones Nutricionales

Lessons Learned:

- Countries are very interested in implementing the new WHO Child Growth Standards, but need continued technical cooperation and financial assistance to do so correctly.
- Better collaboration is needed with HIV-AIDS Unit to ensure consistent clear messages about infant feeding in the context of HIV.
- Frequent change in the Administration of the State and the Government has caused severe delays in policies being ratified by respective governments.

Financial Execution

AoW: **NUT-Nutrition**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	7,121,600	6,026,112	5,986,600	99%
Other Sources	4,428,000	3,705,607	2,795,100	75%
Total (RB & OS)	**11,549,600**	**9,731,719**	**8,781,700**	**90%**

12. HEALTH AND ENVIRONMENT (PHE)
Overall Achievement level: 94%

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.

ACHIEVEMENT OF GOAL:
Through the inter-sectoral work between Health, Environment, Education, Agricultural and Labor, it has been possible to progress in the different components of Risk Management, including as priority aspects, the dissemination of information, the training of personnel and the interventions on priority environmental health risks.

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:

Mandates:

- **Declaration of Mar del Plata: The Ministers of Health and Environment of the Member States of the Organization of American States set directions for futures actions aimed to achieving the improvement of the Health in the Environment Conditions in the Region and cooperation on priority issues: a) Integrated Management of Water Resources and Solid Waste; b) Sound Management of Chemicals; and c) Children's Environmental Health.**

- **Fourth Summit of the Americas "Creating Jobs to Fight Poverty and Strengthen Democratic Governance." Article 36 establishes "We will promote integrated framework of public environmental, employment, health and social security policies to protect the health and safety of all workers and foster a culture of prevention and control of occupational hazards in the Hemisphere.**

RER 12.1 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.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
12.1.1	Number of countries using PAHO guidance that have conducted risk assessment and management of key risk factors.	10	15	**15**	**DDT/GEF Project** **Proyecto de Iniciativas de Ambientes de Trabajo Saludables.**

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
12.1.2	Number of countries receiving PAHO support that have developed legislation, standards, or guidelines related to environmental health.	18	24	**24**	**Guidelines on Chemical Substance, Air Quality, Water Quality and Solid Waste Management.**
RER 12.2 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
12.2.1	Number of countries implementing action plans on health and environment with PAHO's support.	11	26	**26**	**Regional Plan on Workers' Health.**
12.2.2	Number of countries receiving PAHO support that have strengthened health-sector capacity to manage environmental risk factors	11	16	**16**	**DDT/GEF Project.** **Occupational Injury Prevention.** **National Plan for Elimination of Silicosis.**
RER 12.3 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
12.3.1	Number of countries that have implemented partnership initiatives to tackle environmental health concerns in relation to children, women, and workers.	3	7	**8**	**The MERCOSUR countries - hosted by Argentina - held a global meeting on Children Environmental Health with PAHO-WHO support. The Inter-American Conference of Ministries of Labor strengthened the importance of environmental health protection for workers. In Central America the Intersectoral strategic alliance was reinforced through FUNDACERSO. In Montevideo PAHO supported a UNESCO initiative to respond to the needs of educational health workers and their environmental implications.**
RER 12.4 Countries adequately supported in implementing the Action Plan from the Mar del Plata Meeting on Children Environmental Health as an integrated approach to achieve the goals of the millennium declaration, with particular emphasis on the key countries.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
12.4.1	Number of countries with a national Children Environmental Health profile and plan, including a pediatric unit in environmental health.	3	6	**9**	**Six countries, including pediatric units.** **Three countries without pediatric units.**
12.4.2	Number of countries that create strategic alliances between the health,	1	6	**6**	**Three South American, two Central American, and One Caribbean Country.**

	environment, education and labor sectors as part of the decisions made in Mar del Plata.				
12.4.3	Number of priority countries that develop a costing plan identifying the financial resources needed to reach the MDG targets by 2015.	1	5	**2**	**Dominican Republic with the support of the Millennium Project developed a costing plan. Nicaragua also applied some of the elements of the costing methodology to its national reality. It is important to mention that the exercise was counterproductive as it provided solid argument why countries will be unable to fulfill the MDGs due to lack of resources. This is one of the reasons why PAHO launched the Faces, Voices and Places initiative to tackle MDG achievement in the poorest communities in each country.**

Lessons Learned:

- Partnership initiatives in water, sanitation and solid wastes management have shown to strengthen support for high priority countries in the Region.
- Water safety Plans have shown potential for integrated water cycle management and health.
- The constant change of National Health Authorities in the countries makes it difficult to implement the programs.
- The social actors must participate in the preparation, implementation and evaluation stages of the programs.
- The participation of other sectors is a key issue in the success of the programs.

Financial Execution

AoW: **PHE- Health and Environment**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	17,520,700	16,781,746	16,622,500	99%
Other Sources	8,492,000	9,040,776	6,104,400	68%
Total (RB & OS)	**26,012,700**	**25,822,522**	**22,726,900**	**88%**

13. FOOD SAFETY (FOS)
Overall Achievement level: 94%

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

ACHIEVEMENT OF GOAL:
A progress on promoting economic burden of food borne illnesses and food contamination studies during the biennium, would allow to estimating the contribution of food safety to this goal in the next biennium.

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
Completely achieved as measured by reaching the indicator's targets.

RER 13.1 Strengthened national and regional programs in food-borne disease surveillance, and food hazards monitoring and response.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
13.1.1	Number of countries participating in regional food safety networks (VETA, RILAA, PULSE NET, and WHO SALMSURV and INFOSAN) with PAHO support	20	25	**34**	**29 in RILAA, 13 PulseNet, 28 in INFOSAN, WHO-GSS.**
13.1.2	Number of countries implementing food hazard monitoring plans with PAHO support	6	10	**18**	**18 countries: Microbiological Hazards Monitoring.**
13.1.3	Number of countries implementing food-borne diseases surveillance plans with PAHO support	6	10	**18**	**All countries that participated in subregional courses of WHO-GSS.**
13.1.4	Number of countries that have completed studies on the health and economic burdens associated with food-borne diseases with PAHO support	2	4	**4**	**Country protocols developed and tested in Cuba, and Argentina.**

RER 13.2 Integrated multisectoral food safety policy and systems focusing on health from farm to table promoted, and participation in Codex Alimentarius international standard-setting enhanced.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
13.2.1	Number of countries that have established multisectoral food safety systems and plans in place and operational with PAHO support	2	4	**5**	**Bolivia, Peru, Ecuador developed a complete exercise using the Performance, Vision and Strategy tool in addition to the baseline countries.**
13.2.2	Number of countries that have established or amended policies, plans of action, or legislation for food safety with PAHO support	10	15	**16**	**A subregional harmonized food law developed for Central America.**
13.2.3	Number of countries that have implemented national Codex Alimentarius committees using PAHO/WHO guidelines	5	8	**20**	
RER 13.3 National capacity enhanced to implement Good Agricultural Practices (GAP), Standard Sanitary Operational Procedures (SSOP), and Hazard Analyses Critical Points Systems (HACCP).					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
13.3.1	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 with PAHO support	0	4	**6**	**All Central American countries received intensive training to food inspectors to accomplish the indicator.**
13.3.2	Number of countries implementing food safety plans within the Healthy Market Strategy in the context of healthy settings initiatives	5	8	**6**	**Guyana, Paraguay, Bolivia, Dominican Republic & Haiti are developing the strategy. Activities were initiated in Guatemala and Venezuela. Lack of technical human resources is a common problem in the countries.**
RER 13.4 National capacities strengthened in the areas of risk communication and food safety education.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
13.4.1	Number of countries that have used and evaluated food safety material based upon WHO's "five keys to safer food" in primary schools	2	4	**4**	**Venezuela and Guatemala adapted and validated the guidelines, Translation of the Guatemala Manuals to English & Portuguese. Honduras & Brazil have initiated the strategy.**
13.4.2	Number of countries that have used and evaluated food	2	4	**2**	**Venezuela and Guatemala have incorporated the**

	safety material in the curriculum of primary schools within the context of the healthy settings initiatives				**strategy in the curriculum. Lack of technical and economic resources.**
13.4.3	Number of countries in which guidelines for certification of food handlers based on training and education have been used and validated	0	8	**8**	**All OEC countries, Bahamas & Jamaica.**

Lessons Learned:

- Partnerships with other international agencies and national public health agencies were an excellent strategy to achieve the expected results.
- Successful resource mobilization should continue.
- Strengthening of regional networks increased the AMRO competence in capacity building.
- Development of successful pilot project in food safety education under the healthy setting strategy, Healthy Schools and Healthy Food Markets.
- Very good Interaction and coordination with the WHO Department of Food Safety, Zoonosis, and Food borne Diseases to take forward the WHO Global Food Safety Strategy.
- The closing of INPPAZ and the downsizing of human resources in December of 2005, seriously affected the technical cooperation in food safety.

Financial Execution

AoW: **FOS-Food Safety**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	3,929,000	3,360,700	3,309,700	98%
Other Sources	3,851,000	681,918	393,500	58%
Total (RB & OS)	**7,780,000**	**4,042,618**	**3,703,200**	**92%**

Execution of "Other Sources Budget" is affected by a) Cut at 31 Dec 2007, regardless of actual expiration of grants and b) As a result of IPSAS adoption, only actual disbursements were included. Obligations (commitments) of funds to be disbursed in 2008 are not included.

14. VIOLENCE, INJURIES AND DISABILITIES (INJ)
Overall Achievement level: 91%

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

ACHIEVEMENT OF GOAL:
Significant advances have been made in the Americas: violence prevention projects and injuries information systems have been development din the last two years.
Road safety and crashes prevention is now in the public agenda.
Policies and law against violence against women and children have been approved in almost each country. Institutions and NGOs committed.
Youth development and youth violence prevention networks and project have increased and improved their performance.
International or national coalitions have been reinforced or created.

PAHO OBJECTIVE:
National capacity strengthened for the promotion of peaceful coexistence, prevention of violence and disabilities, promotion of road safety, and promotion and strengthening of rehabilitation services.

ACHIEVEMENT OF PAHO OBJECTIVE:
Despite resources limitations, several countries of the Americas committed to work in this topic.

RER 14.1 Support provided to high-priority countries for the implementation and evaluation of surveillance systems for the major determinants, causes and outcomes of violence, disability and road safety.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
14.1.1	Number of countries supported in collecting data on the determinants, causes and outcomes of road safety and violence	10	15	**15**	**Mexico, Belize, Honduras, Nicaragua, El Salvador, Jamaica, Puerto Rico, Brazil, Colombia, El Salvador, Panama, Argentina, Bolivia, Peru, Venezuela received support from PAHO, not necessarily in every type of injuryl**
14.1.2	Disability information systems implemented in targeted countries of the Region	3	8	**5**	**Health information systems recording data on disability in at least 5 countries in the Region: Nicaragua, Mexico, Cuba, Venezuela, Colombia. The process was not completed in: Guyana, Chile, Argentina, since not be carried out on time technical adjustments in the SIEDIS software in order to adapt it to the information local systems.**

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
RER 14.2 Support provided to selected countries on research to identify effective programs and policies to prevent violence, disability and promote road safety.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.2.1	Number of targeted countries where policy and program research has been carried out with PAHO/WHO input	5	10	**10**	**Note: in every country not necessarily on each type of injury: Bolivia, Honduras, El Salvador, Nicaragua, Colombia, Peru, Panama, Argentina, Guatemala, and Mexico.**
RER 14.3 Guidance provided for multisectoral interventions to prevent violence, disability and promote road safety.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.3.1	Number of targeted countries that have national plans and implementation mechanisms to prevent violence, disability and promote road safety, with PAHO support	10	13	**13**	**Note: in every country not necessarily on each type of injury: Mexico, Venezuela, Jamaica, Chile, Costa Rica, El Salvador, Ecuador, Brazil, Bolivia, and Belize,**.
RER 14.4 Support provided for policy formulation in selected countries for pre-hospital and hospital care for victims of traffic injuries and violence.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.4.1	Number of targeted countries that have national policies for pre-hospital and hospital care of victims of traffic injuries and violence with PAHO support	5	8	**6**	**The WHO guidelines were not translated into Spanish up to the last quarter of 2007.**
RER 14.5 Regional and national initiatives supported to strengthen collaboration between health and other sectors involving organizations in the United Nations system, Members States, private sector and non-governmental organizations.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.5.1	Number of regional and national multisectoral initiatives in operation to prevent violence, disability and increase road safety, with PAHO support	8	12	**15**	**Note: in every country not necessarily on each type of injury: Mexico, Belize, Honduras, Nicaragua, El Salvador, Jamaica, Puerto Rico, Brazil, Columbia, El Salvador, Panama, Argentina, Bolivia, Peru, and Venezuela.**
RER 14.6 Intersectoral policies and defined national care plans for prevention, early intervention, and management of disabilities developed in countries of the Region.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.6.1	Number of targeted countries that have policies, plans and programs on prevention	5	12	**15**	**Policies, plans, and programs on prevention and management of disabilities formulated in at least 15 countries of the Region**

	and management of disabilities				**(includes health and social sector): El Salvador, Nicaragua, Venezuela, Chile, Argentina, Panama, Cuba, Brazil, Mexico, Colombia, Dominican Republic, Costa Rica, Peru, Honduras, and Guyana.**
14.6.2	Plans, standards and programs for the prevention of disability from land mines and for assistance to victims, in place for at-risk countries in the Region by the end of the biennium	2	3	**4**	**Plans and activities on prevention of accidents and assistance of landmines victims developed in the higher-risk countries: El Salvador, Nicaragua, Honduras, and Colombia.**
RER 14.7 Support provided to countries to integrate comprehensive rehabilitation services into primary health care and to implement community-based rehabilitation strategies (CBR)					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.7.1	Number of targeted countries supported to implement strategies to integrate rehabilitation services into primary health care and CBR.	5	12	**10**	**10 countries in the Region supported the implementation of the CBR strategies into primary health care. Chile, Argentina, Venezuela, Cuba, Nicaragua, El Salvador, Panama, Brazil, Costa Rica, Mexico. The lack of interaction among the different sectors involved in care for persons with disability becomes factor of impediment for the implementation of the CBR strategy, which means that the target was not achieved.**
RER 14.8 Support provided for policy formulation in the selected countries about production, distribution, and maintenance of technical assistive devices for people with disability.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.8.1	Number of targeted countries supported to implement national policies on assistive devices.	5	8	**5**	**The 5 countries in the Region have developed plans on assistive devices: Venezuela, Colombia, Brazil, Chile and Mexico. The implementation in other countries has been slow by the lack of the training programs for technical personnel.**
RER 14.9 Defined strategies for promotion of equal opportunity for the people with disability.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
14.9.1	Number of regional and national multisectoral initiatives promoted for the defense and protection of the rights and dignity of persons with disabilities.	5	12	**13**	**Promoted initiatives on equal opportunity and protection of the human rights of persons with disability in at least 13 countries in the Region: Panama, Dominican Republic, Honduras, Paraguay, Chile, Belize, Nicaragua, Argentina, El Salvador, Uruguay, Ecuador, Colombia, and Costa Rica.**

Lessons Learned:

- Budget allocation from governments is a gap to be filled in.
- Studies of the cause and cost of violence and injuries need more development.
- Sustainability of projects needs to be guaranteed.
- Community participation in the processes of public policy construction of care of people with disability ensures the identification and attention of the needs of this group of population.
- The exchange among countries has represented to be an effective cooperation tool upon guaranteeing an adequate knowledge and technology transfer.
- The corporate work has permitted greater effectiveness in the provision of the technical assistance in the disability and rehabilitation issue, sharing the expertise and the inter-programmatic approach, generating synergy of work for effective cooperation.
- The networking with the collaborating Centers and other institutions facilitates timely technical cooperation, effective and quality.

Financial Execution

AoW: **INJ- Violence, Injuries and Disabilities**

	Budget	**Allotted**	**Expenditure**	**% Implemented**
Regular Budget	1,141,700	1,309,203	1,293,400	99%
Other Sources	903,000	1,882,462	1,129,400	60%
Total (RB & OS)	**2,044,700**	**3,191,665**	**2,422,800**	**76%**

15. REPRODUCTIVE HEALTH (RHR)
Overall Achievement level: 94%

GOAL:
For all men and women to attain the highest possible levels of reproductive and sexual health.

ACHIEVEMENT OF GOAL:
There has been progress, although it must be admitted that improvements in the access and quality are necessary.

PAHO OBJECTIVE:
To ensure by 2015 the widest achievable range of safe and effective reproductive and sexual health services across health systems and to integrate them into primary health care.

ACHIEVEMENT OF PAHO OBJECTIVE:
The objectives were totally accomplished with the exception of men involving, basically due to the lack of funds.

RER 15.1 Public policies and plans on sexual and reproductive health (SRH), male involvement, and maternal mortality reduction developed at the national level.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
15.1.1	Number of countries that have developed policies and plans for the improvement of integrated sexual and reproductive health, using PAHO/WHO guidelines	5	8	**8**	
15.1.2	Number of priority countries that have developed a plan to ensure contraceptive security availability	0	4	**4**	

RER 15.2 Evidence-based norms, standards, and guidelines on selected aspects of sexual and reproductive health, developed and disseminated.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
15.2.1	Number of norms, standards, and guidelines on SRH, including contraceptive technology and methods, adapted and disseminated to the countries in the Region	10	15	**15**	

RER 15.3 Alliances, networks, and interagency coordination at regional and country levels in SRH supported.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
15.3.1	Number of countries that have established national committees with stakeholders' in order to monitor progress in implementing public policy and programs concerning SRH health	3	5	**5**	
RER 15.4 Reorientation of services in SRH, including male involvement, and empowering women, families, and communities.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
15.4.1	Number of countries that have developed an integrated SRH model of care including male involvement	0	2	**1**	**Positive experiences about men involving, is being included, but not completely, in Costa Rica and Panama.**
15.4.2	Number of countries that have introduced services for males based on research	0	2	**2**	
RER 15.5 Monitoring, surveillance and evaluation systems for women's health programs strengthened and countries' progress towards the MDGs monitored.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
15.5.1	Number of countries that have introduced surveillance tools. Simplified Integrated Perinatal (SIP) module	7	10	**10**	
15.5.2	Number of studies designed to evaluate the impact gender-based violence on reproductive health morbidity and mortality	0	2	**2**	

Lessons Learned:

- No more money spending on empirical training.
- Trained and stable human resources need.
- In Latin America exist a very strong economic barrier, so universal and free access to quality Sexual and Reproductive Health services is an essential need.

Financial Execution

AoW: **RHR- Reproductive Health**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	968,100	1,256,830	1,250,100	99%
Other Sources	1,219,000	431,198	307,300	71%
Total (RB & OS)	**2,187,100**	**1,688,028**	**1,557,400**	**92%**

16. MAKING PREGNANCY SAFER (MPS)
Overall Achievement level: 98%

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 1000 live births in all countries through a reduction in perinatal mortality by 2015.

ACHIEVEMENT OF GOAL:
There has been a certain decrease on maternal mortality at regional level with a slight reduction of the gap between North America and Latin America, but, at country level, there has been an increase in Haiti and Cuba. Only 3 countries (Guatemala, Haiti and Bolivia) have a child mortality rate over 35 per thousand live births

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

ACHIEVEMENT OF PAHO OBJECTIVE:
In general the objectives were accomplished, in some of them in a greater number of countries to the ones planned, with the exception of PPH indicator (16.2.3.) that has been accomplished partially.

RER 16.1 Guidance provided for the development of public policies and plans for safe motherhood and newborn health.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
16.1.1	Number of priority countries supported to implement a common conceptual regional framework on safe motherhood and newborn health	12	18	**18**	
16.1.2	Case studies on successful intercultural models of maternal and neonatal care at the primary health care level published and disseminated	3	6	**7**	
16.1.3	Priority countries supported to implement policies and programs for improving maternal and neonatal health	2	6	**9**	

RER 16.2 Appropriate evidence-based standards and guidelines on maternal and perinatal health developed or updated, and disseminated.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
16.2.1	Number of standards and guidelines on maternal and perinatal health adapted, updated, and disseminated to the countries in the Region	15	20	**20**	
16.2.2	Number of countries with high maternal mortality ratios that have received technical cooperation to implement maternal and newborn mortality standard, norms and guidelines	11	15	**17**	
16.2.3	Number of priority countries where health workers in urban and rural settings trained as trainers for the prevention of post-partum hemorrhage (PPH) interventions	5	10	**7**	**In 3 countries (Dominican, Guyana and Haiti) that are in different stages of development.**
RER 16.3 Monitoring, surveillance, and evaluation systems for maternal and perinatal programs strengthened and countries' progress towards the related MDGs monitored.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
16.3.1	Number of countries assisted to establish monitoring systems for maternal and neonatal health at national and sub-national levels (including MDG indicators)	2	6	**6**	
16.3.2	Number of countries supported to introduce epidemiological surveillance tools incorporating the Simplified Integrated Perinatal (SIP) module and maternal and neonatal deaths reviews	7	10	**13**	
16.3.3	PAHO report published on the progress of countries towards the MDG for maternal health	0	1	**1**	

RER 16.4 Strengthened provision of high quality emergency obstetrical and neonatal care (EONC) at the first level of referral, ensuring skilled care during pregnancy and childbirth.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
16.4.1	Number of assessments of the quality of EONC completed in priority countries	5	10	**10**	
16.4.2	Number of professional associations, such as the *Federación Latinamericana de Sociedades de Obstetricia y Ginecología* (FLASOG), the International Congress of Midwives (ICM), the *Federacion de Profesionales de Enfermería* (FEPPEN)*),* and the *Asociación Panamericana de Sociedades de Pediatría* (ALAPE)*,* that sign a memorandum of understanding supporting skilled attendance at birth in the Region	0	1	**4**	
16.4.3	Number of priority countries that have established intersectoral national committees, supported by PAHO, and with stakeholders' participation to monitor maternal mortality reduction activities	6	11	**11**	

Lessons Learned:

- It is not justifiable more money spending on empirical training at the Americas level.
- To maintain in time the evidence based successful actions.

Financial Execution

AoW: **MPS- Making Pregnancy Safer**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	4,558,900	4,640,267	4,636,400	100%
Other Sources	2,798,000	6,215,439	3,116,100	50%
Total (RB & OS)	**7,356,900**	**10,855,706**	**7,752,500**	**71%**

17. GENDER, WOMEN, AND HEALTH (WMH)
Overall Achievement level: 89%

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.

ACHIEVEMENT OF GOAL:
Gender and Ethnicity mainstreaming has been achieved up to various levels with PAHO and Member States, and it is expected that the momentum gained will be built upon in the coming biennium. Continued and increased coordination with Executive Management concerning the mainstreaming of gender and ethnicity into the work plans of PAHO and Member States will be essential to ensure further achievement of the goal.

PAHO OBJECTIVE:
To foster the advancement of knowledge and understanding about gender and ethnic inequalities in health.

ACHIEVEMENT OF PAHO OBJECTIVE:
Capacity has been built in PAHO regional units, country offices, and Member States according to set targets by way of development of pertinent tools, use of methods, typical documents, production, use and analysis of pertinent data, and research and policy formulation to such an extent that gender mainstreaming is being integrated as a norm. Knowledge and understanding about ethnicity inequalities is quickly gaining ground and above mentioned methodologies have been established as well for fostering this advancement. Again, continued coordination with Executive Management concerning this objective is essential.

RER 17.1 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.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
17.1.1	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	**19**	
17.1.2	Number of research proposals developed or executed, and best practices and lessons learned to address gender inequities documented	3	7	**7**	**- Research on economic cost of gender based violence in Chile - Research on links of GBV and HIV in Nicaragua, Honduras and Belize - Best practices and lessons learned in Central America countries 1998-2004 - Report on systematization of the experience on gender mainstreaming in health sector reform policies in Chile**

17.1.3	Regional/country statistical database electronically available and updated	2	4	**4**	
17.1.4	Number of national workshops for producers and users of information to integrate gender analysis in health statistics	6	10	**8**	**-Numerous changes in personnel and unit structure, including the unit chief, contributed to certain targets not being met - Workshop in Venezuela to initiate the process on integrating a gender perspective into health statistics - Gender analysis workshop for media practitioners from 10 Caribbean countries - The initiative to foster the integration of a gender perspective into health statistics in the Andean Region, in a subregional approach, is pending**
RER 17.2 Conceptual and methodological framework for the integration of a gender equality perspective into health sector reform policies developed and tested.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
17.2.1	Number of regional/country assessments and methodological tools produced/updated and disseminated to mainstream gender equity in Health Sector Reform	7	14	**12**	**-Numerous changes in personnel and unit structure, including the unit chief, contributed to certain targets not being met - Guidelines for monitoring gender equity in health policies - Conceptual and methodological framework on measuring and valuing unpaid work - Country assessment in Uruguay highlighting the women needs (The assessment of gender in the national profiles on Health Sector Reform is pending) - Systematization of the experience on gender mainstreaming in health sector reform policies in Chile - WHO gender module tool updated and tested in a capacity building workshop for 8 LAC (Uruguay)**
17.2.2	Number of capacity building activities (workshops, virtual fora, and knowledge networks) carried out at HQ and countries to integrate gender in policies and advocacy.	4	8	**8**	**- Three international workshops for capacity building on advocacy for policies - (unpaid) Two international workshops, with participation of Regional and International experts on time use surveys and National System Accounts, were conducted to discuss the conceptual and methodological frameworks on measuring and valuing the unpaid work - Regional virtual fora on GBV and health sector reform**
17.2.3	Number of health policy proposals to promote gender equity prepared by intersectoral networks – fostered by PAHO – to be presented to national	1	2	**2**	

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
	authorities.				
17.2.4	Number of national health and policy reports produced by a PAHO supported monitoring mechanism model (Observatory of Gender Equality in Health).	1	3	**7**	

RER 17.3 PAHO Policy on Gender Equality five-year plan of action implemented.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
17.3.1	Number of technical and administrative PAHO Units systematically applying gender mainstreaming tools and processes to their work.	0	3	**7**	
17.3.2	Number of policy instruments integrating the gender approach.	4	8	**6**	**-PPS indicates that the system is not set up to identify key words in activities; a system of monitoring is now being discussed; several documents were reviewed during the biennium that had gender integrated – leads to conclusion that more than 8 policy instruments are integrating a gender approach** **-First Ladies meeting resolution on gender/ethnic perspective into healthy ageing process; guidelines for action** **- Inter-programmatic International Women's Day event on Cervical Cancer and new HPV vaccines organized at HQ with external partners and broadcasted to national offices – led to policy document submitted to GB on cervical cancer**
17.3.3	Number of countries participating systematically in the mainstreaming process.	0	3	**16+**	**- Caribbean Media Awards – 10 countries participated in gender analysis workshop; annual award on gender awareness in work** **-Capacity building workshop on gender mainstreaming in Uruguay, including 6 countries (Argentina, Brazil, Chile, Paraguay, Peru, Uruguay)** **-Analysis was done on 6 Country or subregional Cooperation Strategy documents, integrating gender equality strategies (El Salvador, Panama, Belize, Trinidad and Tobago, Barbados, Guyana)**

RER 17.4 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.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
17.4.1	Number of countries developing	1	4	**5**	

	framework for advocacy and monitoring GBV policies and legislation				
17.4.2	Number of countries integrating norms and protocols of sexual violence at sectoral level	4	8	**9**	
17.4.3	Number of gender-based violence networks as entry point for HIV/AIDS prevention and treatment (ART) in 3 countries (Honduras, Nicaragua and Belize)	0	6	**6**	**- Research on links of GBV and HIV in Nicaragua, Honduras and Belize - Regional virtual fora on GBV and health sector reform - country studies on HIV and GBV were carried out in Honduras and Nicaragua and currently the reports are being written - Belize the protocol of the study is being revised by the Ethical Committee and the researcher was hired. - Also a manual on gender and HIV based on the WHO guidelines on gender and HIV (preliminary proposal) and the recommendations from the validation at country level (Belize, Honduras and Nicaragua) and the virtual forum, was developed. - Regarding the validation of WHO guidelines on gender and HIV, meetings with stakeholders at national level were held in Nicaragua, Honduras and Belize. A virtual forum took place with representatives from Argentina, Chile, Costa Rica, Brazil, Honduras, Dominican Republic, Mexico, Nicaragua, Guatemala, and Uruguay**
17.4.4	Regional monitoring system (Observatory) of policies and programs on GBV implemented	0	1	**5**	
17.4.5	Virtual course on intrafamily/sexual violence for service providers delivered	2	4	**2**	**- GBV topic was transferred to SDE/RA in June 2007 and personnel changes were made - face-to-face training on GBV for health care providers at national level was given (on-line courses - pending)**
17.4.6	Research on violence during pregnancy carried out in four countries, and results translated into proposals for models of care	0	4	**0**	**- Research and paper written in 2005 with the maternal health unit; - GBV topic was transferred to SDE/RA in June 2007 and personnel changes were made**
RER 17.5 Ethnic-sensitive policies and programs developed and mainstreamed within PAHO and Member States with the participation of stakeholders.					
Ind.#	**Indicator description**	**Baselin e**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**

17.5.1	Number of countries with mechanisms for integrating the ethnic approach in analysis, formulation, and evaluation of policies with participation of civil society	13	18	**17**	**- Brazil, Colombia, Chile, Bolivia** **- Activities also developed in Peru, Uruguay, but the final outcome is in progress. Change of national focal points for ethnicity at the ministry level delayed process**
17.5.2	Number of PAHO technical units integrating systematically the ethnic approach in analysis, formulation, and evaluation of selected best practices	0	3	**3**	
17.5.3	Number of countries producing information on selected ethnic groups	13	18	**17**	**- Bolivia, Colombia, Brazil, Chile** **- Activities were developed also in Peru and Uruguay, but the final outcome is in progress. Change of national focal points for ethnicity at the ministry level delayed process**
17.5.4	Number of regional/country networks created to promote health equity from an ethnic perspective	3	6	**6**	

Lessons Learned:

- The partnership with other UN agencies, government sectors, NGOs, academia, create synergies in addressing gender equality in health.
- The participation of civil society is crucial to warrant the institutionalization of the processes to aim gender mainstreaming in health policies.
- It is imperative to include users (advocates, planners, NGOs, women's ministries, ministries of health) and producers (statistical offices) in the production, analysis and dissemination of gender and ethnicity statistics for planning, policy making, monitoring and advocacy.
- Gender indicators should also include the contributions that men and women make to national health accounts.
- Gender-based violence should be mainstreamed in all policies and programs that address reproductive and sexual health and rights, including HIV.
- Ethnicity indicators and analysis should be accompanied by case studies to reflect cultural practices in health.
- Mainstreaming gender equality within PAHO and Member States health policies and programs—as mandated by the 2005 Gender Equality Policy—requires the implementation of a monitoring system, that includes a baseline study.

Issues and Challenges in the AMRO-WHO/HQ relationship

- Operationalization of the PAHO/AMRO policy in the strategic plan within a climate of changing global, regional and national priorities.
- The need to establish equal linkages with non-traditional partners i.e., gender bureaus, national statistical offices.
- Setting of a monitoring system for PAHO technical areas and country offices accountable for mainstreaming gender, as mandated by the Gender Equality Policy

Financial Execution

AoW:	WMH- Gender, Women, and Health			
	Budget	**Allotted**	**Expenditure**	**% Implemented**
Regular Budget	2,547,100	2,055,271	1,985,300	97%
Other Sources	1,808,000	3,241,825	2,197,000	68%
Total (RB & OS)	**4,355,100**	**5,297,096**	**4,182,300**	**79%**

18. CHILD AND ADOLESCENT HEALTH (CAH)
Overall Achievement level: 86%

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.

ACHIEVEMENT OF GOAL:

- **All PAHO priority and high impact countries have plans and national strategies to achieve MDG 4 using the IMCI strategy and continue to expand coverage in the clinical and community components. This progress will complement achieving the RER SO4 4.5.**
- **HIV Prevalence: we do not have data on HIV prevalence specific to the 15-24 age groups. We have conducted the first studies of Maternal Mortality by age in Central America. We have developed programs and tools to promote physical and metal health in adolescents – Strong Families (*Familias Fuertes*), the soccer, gender and health project (*Jugando por la Salud*) and strengthening youth-adult partnerships - which have been implemented in 12 countries.**

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:

- **Bolivia, Haiti, Honduras, Guyana, and Nicaragua and countries with infant mortality rates greater than 30/1000 continue to expand coverage using the IMCI strategy in the clinical and community components with support of ministries of health, NGOs, other partners, and national agencies. In Peru, Ecuador, and Paraguay, through a partnership with the Canadian International Development Agency (CIDA/CAN) expansion in high-risk and vulnerable population areas, including indigenous population groups is being strengthened. Colombia is integrating the IMCI strategy with TB in high-risk areas. The community component of the IMCI strategy using an integrated approach continues to be strengthened and expanded in the countries using national and local resources. Many community IMCI methodological approaches have been sustained and introduced into national initiatives in Bolivia, Colombia, Peru, Venezuela, Ecuador, Guyana, Nicaragua, Honduras and Paraguay. During the biennium, FCH/CA continued to strengthen the integration and coordination of activities with other FCH units, and areas of the Organization; for example: FCH/AI, FCH/IM, FCH/NUT, FCH/WM, SDE/HS, THS/OS, HRT/EV, and DPC/CD. With limited regional regular funding, extensive partnerships with civil society, foundations and faith-based organizations (CMMB, ARC, BMSF, UNF) and bilaterals (Spain and Canada) provided important financial resources and country networks to strengthen and expand coverage to the IMCI strategy, especially the community component.**
- **Over the course of the biennium, participating countries made significant advances implementing sustained activities at the national, community (especially the household level promoting key family practices), and improving case management training at the clinical and community levels.**
- **The Region achieved a regional transformation of public health work at the community and the family levels by:**
  - **The design and implementation of an innovative social-actor community model**
  - **The improvement of case management knowledge and changing behaviors using key family practices among caretakers to fight underlying causes of diseases and mortality.**

- **An extensive number of new training tools and materials for community IMCI were developed and a series of lessons learned published and disseminated.**

- **In coordination with the WHO Child and Adolescent Health (CAH) and Making Pregnancy Safer (MPS) Departments, a global field test of the new Maternal and Child Health Delivery Channel Survey was held in Peru in June 2007. WHO/CAH and WHO/MPS provided financial support and technical cooperation in coordination with FCH/CA, PWR/Peru, and CIDA/OPS Partnership.**
- **80% of our countries have a National Adolescent Health Program and Plan With support form NORAD, SIDA and GTZ technical cooperation was provided to better integrate responses to adolescent needs, including sexual and reproductive health , HIV/ AIDS and violence prevention.**

RER 18.1 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.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
18.1.1	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	**15**	
18.1.2	Number of countries with infant mortality rates greater than 30/1,000 live births that will be implementing the IMCI neonatal component	6	10	**10**	**Dominican Republic, Ecuador, Bolivia, Nicaragua, Guyana, Paraguay, Guatemala, Panama, Brazil, Colombia.**

RER 18.2 Priority countries will have implemented cost-effective and evidence-based interventions for the achievement of maternal mortality reduction among youth.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
18.2.1	Number of priority countries that have programs for pregnancy prevention and utilize the IMAN/ IMAI approach	5	12 (of which 5 are Key Countri es)	**10**	**Haiti and Bolivia do not have programs for pregnancy prevention due to other health priorities.**
18.2.2	Number of priority countries that incorporate the community components and key family practices of the IMCI strategy in their programs strategies and policies	11	15 (of which 5 are Key Countri es)	**15**	

RER 18.3 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
18.3.1	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	**10**	**Must of the countries are implementing prevention mother to child transmission strategies, including breastfeeding practices and counseling, however the level of implementation varies by country.**
18.3.2	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	**10**	
18.3.3	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	**Program not developed**	**PAHO office in Haiti changed PWR and in the new country cooperation strategy Adolescents are not included as a priority for the PAHO office.**

RER 18.4 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
18.4.1	Number of priority countries that have established national early child development plans	3	8	**8**	**Brazil, Ecuador, Peru, Paraguay, Uruguay, Nicaragua, Guatemala, and Dominican Republic.**
18.4.2	Number of countries that have established national and municipal plans for the promotion of juvenile development and prevention of violence	0	5	**5**	**Excellent results with development of tools and adaptation of TEACH VIP.**

Lessons Learned:

- The launching of the Regional Strategy for Maternal Mortality and Morbidity Reduction encouraged the countries and agencies' commitment toward effective cooperation and resource mobilization, and a similar positive reaction is expected with the Regional Strategy and Plan of Action on Neonatal Health within the Continuum of Maternal, Newborn, and Child Care.

- This integration of human and financial resources strengthened actions in the countries, sustained activities, and created a local capacity contributing to the MDGs.
- Extra-budgetary resources and country commitment provided the stimulus to jump-start many initiatives. Although, EB and Regular funds are now limited, actions are sustained and local capacity created to continue expansion using local resources and networks.
- Child health not an attractive area for donor support although program strategies, interventions and evidence-based information is available which can contribute to MDG4.
- Key elements of community IMCI activities were supported with community leaders and networks, community health workers (CHW), non-governmental organizations (NGOs), families and other social actors and institutions. This work was sustainable promoting WHO/UNICEF Key Family Practices for the prevention of common childhood illnesses as the primary intervention to change behaviors at the family and community level.
- Community IMCI successfully built on existing community-based programs at the district level, promoted equitable access to services, improved access to quality health care at the health facility level, strengthened local capacity and ownership, and made the best and most cost-effective use of scarce resources. The community component of the IMCI strategy was scaled-up to the national level and carrying forward the basic principles of primary health care to contribute to reaching the Millennium Development Goal 4.
- The design and implementation of community actions by social actors was empowering because groups not traditionally working in health became involved in the promotion of the key family practices at the family and community level. This work strengthened links between communities and health services, promoted community participation and empowerment to address child health problems, improve CHW work in the communities, and supported local inter-sector coalitions to sustain local actions.
- Interagency Collaboration has been crucial to advance the agenda in violence prevention at the country level.
- Country focal points are overwhelmed with different activities at the country level which makes implementation and follow-up difficult.
- Integrated strategies, such as IMAN, facilitate the roll out of activities at the country level, however at these strategies are too broader requiring that some special programs be developed to focus on priorities such as ASRH.

Financial Execution

AoW: **CAH-Child and Adolescent Health**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	4,413,800	3,643,703	3,606,800	99%
Other Sources	10,130,000	4,376,842	3,889,100	89%
Total (RB & OS)	**14,543,800**	**8,020,545**	**7,495,900**	**93%**

19. IMMUNIZATION AND VACCINE DEVELOPMENT (IVD)
Overall Achievement level: 83%

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

ACHIEVEMENT OF GOAL:
The vaccination coverage was higher than 90 % in Region of the Americas. With this program and their different strategies, as Vaccination Weekly, AMRO is protecting all age groups.

PAHO OBJECTIVE:
To promote the development of new vaccines and innovation in biological and immunization-related technologies; to ensure greater impact of immunization services, as a component of health delivery systems; to accelerate the control of high-priority vaccine-preventable diseases; and to ensure that the full humanitarian and economic benefits of such initiatives are realized.

ACHIEVEMENT OF PAHO OBJECTIVE:
The new vision of the Immunization program includes not only children but all members of the family and uses vaccination as an opportunity to offer other health services. PAHO Members States are making decisions supported on evidence (epidemiological, economics, social, etc.) and they have been the first to introduce new vaccines (such as rota, pneumo, influenza) that contribute to MDG 4. Additionally PAHO countries have been successful in the Rubella and CRS elimination program, vaccinated more than 145 mill people.

RER 19.1 Countries are supported in achieving and maintaining equitable coverage for all vaccines.

Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
19.1.1	Number of countries where immunization coverage for DPT3, OPV3, MMR, HepB, Hib, and BCG is maintained where >95	16 of 41countries and territories with MMR coverage above 95%	22 countries of 41	**16 countries of 40**	**Data for 2006. MMR coverage fluctuates year to year. Ten countries had MMR coverage 90-94% for 2006. For other vaccines, coverage >95% was maintained in the 16 baseline countries.**
19.1.2	Percentage of municipalities with DPT3 coverage <95% in children less than 1 year of age	45%	40%	**42%**	**Data for 2006. Improvement observed, but time may not have been enough to reach the target.**

RER 19.2 Elimination of rubella and CRS progresses as planned with PAHO support.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
19.2.1	Number of countries implementing elimination strategies.	7	14	**42 countries of 44**	**Brazil and Mexico will finalize elimination campaigns in 2008.**
RER 19.3 Capacity of countries to introduce new vaccines when available is supported.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
19.3.1	Percentage of countries that add new vaccines to their existing schedule with PAHO's technical support	0	30%	**65%**	**High prices of vaccines and no pre-qualification by WHO of some of new vaccines.**
RER 19.4 Improved surveillance and knowledge-sharing on immunization and vaccines.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
19.4.1	Number of countries participating in new integrated surveillance information system (ISIS).	0	15	**0**	**ISIS development delayed. Deployment expected to start in 2008**.
RER 19.5 Improved preparedness for action related to vaccine-preventable threats of national and international concern.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
19.5.1	Percentage of municipalities with measles coverage <95% in children <1 year of age	42%	36%	**36%**	**2006 data (for LAC only). Data for 2007 not available.**
19.5.2	Countries conducting vaccination campaigns on high risk groups with seasonal influenza vaccine or participating in the development of the Influenza Pandemic Preparedness Plans with PAHO's technical support	13	20	**29**	**Includes United States and Canada.**
RER 19.6 Capacity of countries to guarantee the quality of vaccines and biologics and syringes for their populations strengthened.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
19.6.1	Number of countries supported in having national regulatory authorities operational and in compliance with basic regulatory functions according to PAHO/WHO guidelines	2	7	**5**	**Two Regulatory Agencies have changes in internal policies that avoid support them in the compliance of PAHO/WHO Guidelines.**

19.6.2	A network of Quality Control Laboratories organized to assure the quality of vaccine procurement through the PAHO's EPI Revolving Fund	0	1	**1**	

Lessons Learned:

- Regional government bodies must support regional activities.
- Regional and national Plans of Action must be in place.
- Endorsement of polices.
- Financial support depends mostly on national budget.
- New vaccines introduction showed that surveillance, programmatic feasibility, and financial sustainability are necessary.

Financial Execution

AoW: IVD-Immunization and Vaccine Development

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	3,271,800	3,596,493	3,556,900	99%
Other Sources	20,555,000	35,707,460	28,176,100	79%
Total (RB & OS)	**23,826,800**	**39,303,953**	**31,733,000**	**81%**

20. ESSENTIAL MEDICINES (EDM)
Overall Achievement level: 84%

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.					
ACHIEVEMENT OF GOAL: **Achievement of goal. Quality, efficiency and rational use of essential drugs with a financially sustainable strategy were pursued.**					
PAHO OBJECTIVE: 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.					
ACHIEVEMENT OF PAHO OBJECTIVE: **Improved access and regulatory frameworks were promoted in more than 50% of the countries in the Region.**					
RER 20.1 Member States supported in the development, implementation, and monitoring of national drug policies that facilitate accessibility and affordability of drugs.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
20.1.1	Number of countries supported in the development, implementation and evaluation of national drug policies	12	15	**16**	**- Dominican Republic and Ecuador were supported in the policy implementation;** **-Honduras was supported in the policy revision;** **- Panama was supported in the project for the establishment of a Drug Regulatory Agency.** **- The Medicines Policy for Central America was developed and approved in 2007 in the RESSCAD meeting.**
20.1.2	Number of country assessments completed on drug access strategies, including generics.	4	10	**12**	**Five Caribbean countries initiated the level II pharmaceutical sector assessment** **Three Countries (Guatemala, Honduras and Nicaragua) initiated the survey: "The impact of the exclusion on health in access to medicines."**
20.1.3	Number of countries participating in drug access and drug-economics-related training activities	3	10	**18**	**This is the number of countries participating in the trainings in Intellectual property rights and public health.**
20.1.4	Number of countries participating in the Pharmaceutical Clearinghouse	2	8	**2**	**Dominican Republic and Bolivia were part of the original Pharmaceutical Clearinghouse of the Americas. New profiles are pending validation of the evaluating matrix. Two drafts have**

					been developed and a provisional webpage is already up.
RER 20.2 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
20.2.1	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	**0**	**Harmonized regional proposals on drug regulation developed and approved for Good Manufacturing Practices and Good Clinical Practices. The main reason for not achieving the goal is the inability of the countries to take blood collection and processing away from an excessive number of hospital-based blood banks. These blood banks rely on replacement blood donation and, therefore, the donors reach the hospital after the need for blood transfusion has been identified –preventing testing for infectious markers. Efforts continue to be made by PAHO to induce the modification of national blood systems.**
20.2.2	Number of countries with updated regulation for medicinal plants	4	6	**6**	**Canada and Brazil in addition to the baseline countries**
20.2.3	Number of countries participating in a regional plan for drug monitoring pharmacovigilance	6	9	**10**	**The PANDRH Working Group on Pharmacovigilance is developing a regional plan for drug monitoring, countries participating: Argentina, Brazil, Barbados, Colombia, Costa Rica, Cuba, Canada, Panama, United States, and Venezuela.**
20.2.4	Number of countries in which the official drug quality control laboratory participates in a network for the external quality control program	21	21	**21**	**Dec 2007 - 23 OMCL from 21 countries.**
RER 20.3 Member States supported in relation to the rational use of drugs, while awareness about this issue is increased.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
20.3.1	Number of countries with a National Essential Drug List updated during the biennium	0	6	**9**	
20.3.2	Number of national seminars for the incorporation of new methodologies in teaching pharmacotherapies by schools of medicine	3	7	**5**	**Brazil, Peru, Bolivia, Argentina and in Dominican Republic a Regional seminar with the participation of 5 countries was carried out.**

RER 20.4 Member States supported in their improvement of drug supply systems with emphasis on public health services, targeted populations, and cost efficiency.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
20.4.1	Number of countries in which the model for analysis of the supply system has been applied	3	10	**10**	**Partial or complete analysis of elements of the model have been implemented in 10 countries, the methodology applied having been developed in 20.4.2.**
20.4.2	Updated regional guideline for drug supply management for hospital drug supply system	Regional guideline being updated	Regional guideline updated and disseminated	**Regional guideline updated and disseminated**	**In the analysis of needs with partner institutions, it was determined that general procurement and supply management guidelines were required for national systems, which can be used as well for assessment of hospital supply systems.**
20.4.3	Subregional assessments of national drug supply system, including the public and private sector	0	3	**3**	**Specific assessments of supply mechanisms for HIV/AIDS explored and supported in the OECS, Central American Region and ORAS/CHU Region.**

RER 20.5 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
20.5.1	Number of countries in which operating procedures and technical manuals for the Strategic Fund have been implemented	4	10	**18**	**As of December 2007, 18 countries have signed participation agreements with the Strategic Fund.**
20.5.2	Number of countries participating in the Fund, using it as the procurement mechanism for essential public health supplies	4	10	**11**	**In 2007, 11 countries have used the mechanism to purchase more than US$ 20 million of Strategic Public Health Supplies.**
20.5.3	The PAHO supplier prequalification system (PSPS) in place and updated database available on the Web page	PSPS being updated	PSPS in place and updated	**In Process**	**The review of the PSPS has required an extensive and participatory consultative review process involving the participation of national drug regulatory agencies. The PSPS remains a priority for the 2008-2009 biennium.**

Lessons Learned:

- Advocacy work in areas such as access, cost containment strategies including promotion of generic medicines policies, and procurement and supply management can be effective in producing significant results within countries.

- Processes that ensure the participation of countries in the development of global frameworks such as in the area of innovation and intellectual property (IGWG) can produce strategies that correspond to the context and needs of developing countries.
- There is a need to create awareness that access is linked to rational utilization of medicines. Advocacy among health authorities and training for professional practice change in relation with the managing of medicines among health professionals are required.
- Some country experiences in the field of policy, access, innovation and intellectual property and rational use, may be used to orient and push actions in some other countries in these fields.

Financial Execution

AoW: **EDM- Essential Medicines**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	3,150,700	3,190,347	3,140,000	98%
Other Sources	7,762,000	12,535,592	9,646,600	77%
Total (RB & OS)	**10,912,700**	**15,725,939**	**12,786,600**	**81%**

21. ESSENTIAL HEALTH TECHNOLOGIES (BCT)
Overall Achievement level: 95%

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.

ACHIEVEMENT OF GOAL:
Effectiveness and efficiency of laboratories, blood banks, transfusion services, radiological services and medical technologies were pursued.

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
Policy making for laboratory, blood banks, transfusion services, and radiological services was supported in 8 countries. Quality assurance systems for all essential health technologies were strengthened in seven countries.

RER 21.1 Improved quality of clinical laboratory operations.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
21.1.1	The number of countries assisted in the implementation of official operational accreditation systems	3	10	**10**	**-In total 10 countries have been assisted in the implementation of official operational Licensing and accreditation systems. -Following THS/EV and COLABIOCLI advisories, -Argentina, Chile, and Mexico have adopted or homologated ISO norms for Medical Laboratory. -Chile, Colombia and Paraguay have adopted new regulations on Licensing for Medical Laboratories. -Bolivia, Ecuador, Guatemala, Honduras and Panama have updated new proposals for Laboratory Licensing. -Argentina is reviewing a third level of Laboratory Accreditation National Normative.**
21.1.2	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	**20**	**-In close collaboration with HDM/CD, FCH/AI and FCH/IM, 20 Latin American Countries have adopted updated SOPs for at least 10 priority diseases. -HIV diagnostic, CD4 counting, Viral load, TB diagnostic, TB susceptibility testing, Dengue diagnostic, Malaria diagnostic, Helicobacter pylori diagnostic, S. pneumonia, H. influenza and N. meningitides diagnostic and stereotyping.**

RER 21.2 Strengthen networks of Laboratories and National Institutes of Public Health					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
21.2.1	Regional laboratory networks for training, quality assurance and reference supported.	2	3	**3**	**-3 Regional laboratory Networks for training, quality and reference supported are operational in 2007. -The last one refers to a new network based on the surveillance of the resistance to anti-fungical treatment on invasive fungi diseases, in collaboration with the ISC III of Spain.**
21.2.2	A Network of Public Health Institutes established.	0	1	**1**	**The International Network of Public Health Institutions (IANPHI) has been officially created in 2007. THS/EV has supported the Implementation of the Andean Network of Public Health Institutions, one of the components of the regional network.**
RER 21.3 Availability of quality blood improved and capacity for implementation of quality assurance programs increased.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
21.3.1	All the countries in the Region have donation rates above 3/1,000 inhabitants	40	41	**40**	**The donation rate for Haiti in 2007 was 1.5/1,000, up from 1.3 in 2005.**
21.3.2	Number of countries with donation rates over 10/1,000 inhabitants	18	23	**23**	**Canada, United States, Brazil, Chile, Colombia, Costa Rica, Cuba, El Salvador, Mexico, Panama, Uruguay, Venezuela, Aruba, Bahamas, Belize, British Virgin Islands, Cayman Islands, Netherlands Overseas Territories, Dominica, St. Kitts and Nevis, St. Lucia, Suriname and Trinidad and Tobago, reported rates > 10/1,000 in 2005/2006.**
21.3.3	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	**28**	**35 countries screened all blood units for HIV and HBV, 34 for syphilis, 28 for HCV and 11/17 for *T. cruzi* in 2005/2006.**
21.3.4	Number of countries in which national programs ensure that at least 50% of the blood is collected from voluntary, no remunerated donors	8	20	**11**	**Canada, United States, Brazil, Colombia, Costa Rica, Cuba, Aruba, Cayman Islands, Netherlands Overseas Territories, St. Lucia, and Suriname.**
21.3.5	Number of countries in which distance education programs on quality are designed and implemented, and the establishment of national commissions is supported	0	15	**20**	**The support to national blood systems was provided to all countries that participated in meeting held in Nicaragua in October 2006.**

RER 21.4 Strengthened diagnostic imaging and radiation therapy services, enforcement of regulations to protect against ionizing and non-ionizing radiation, and capacity to respond to radiological or nuclear emergencies.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
21.4.1	Number of countries with an evaluation of radiation therapy services	5	7	**7**	**Paraguay and Colombia (Partially) in addition to the baseline countries.**
21.4.2	Number of countries supported to implement policies to protect patients undergoing medical procedures involving radiation	2	4	**5**	**Argentina, Guyana, Trinidad and Tobago in addition to the baseline countries .**
21.4.3	Education and training in quality diagnostic and therapeutic procedures, radiation protection, and radiological emergencies	2	4	**8**	**Costa Rica, Peru, Cuba, Paraguay, Guatemala, Colombia in addition to the baseline countries**
RER 21.5 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
21.5.1	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	**4**	**Mexico, Trinidad & Tobago, 5 ORAS Countries(Venezuela, Colombia, Peru, Ecuador and Bolivia) (Health Technology Assessment)** **Colombia, Peru, Brazil (Heath Technology Management)** **Brazil, Nicaragua, Honduras, Panama (Regulation).**
21.5.2	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	**3**	**Assessment of reuse of single-use devices** **Protocol to validate conformity of syringes with ISO Standards** **Assessment of use of cellular telephones in healthcare (in process).**
21.5.3	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	**4**	**Colombia-United States (Vermont Univ.)** **Peru-United States (Vermont Univ)** **Colombia-United States (SCU)** **Peru-United States(SCU)**

21.5.4	Number of networks in full operation for communication and information exchange on health care technology and regulation in the Region	3	4	**6**	**INFRATECH, INFRACARIB, MED-DEVICES, HTA, EHEALTH, Incidents Report System for Syringes.**

Lessons Learned:

- New technology requires more transparency in the processes of selection and procurement.
- Even though medical technology is one of the most costly inputs to the health care systems, there is not much investment made in having the appropriate human resources capabilities to address problems.
- Participation of other actors (universities, research institutes) with ministries of health assures that better evidence-based decisions are taken.

Financial Execution

AoW: **BCT- Essential Health Technologies**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	2,460,100	2,569,789	2,558,400	100%
Other Sources	2,002,000	3,706,188	2,166,600	58%
Total (RB & OS)	**4,462,100**	**6,275,977**	**4,725,000**	**75%**

22. POLICY-MAKING FOR HEALTH AND DEVELOPMENT (HSD)
Overall Achievement level: 93%

GOAL:
To maximize the positive impact of better health on socioeconomic development in general and for the attainment of the MDGs in particular.

ACHIEVEMENT OF GOAL:
PAHO took a stand among UN agencies in favor of the most vulnerable by working in the poorest and most vulnerable municipalities and communities in each country under the initiative *Faces, Voices and Places*. The Ministers of Health met at the 27th Pan American Sanitary Conference and supported that decision as well as the General Director of WHO, whom highlighted that the underlying premise of the initiatives: progress in reaching the millennium development Goals will not be measured by national averages but by the improvements in life for society's most miserable and least visible communities.

PAHO OBJECTIVE:
To maintain and further secure the centrality of health in a wide range of development agendas and to promote the human-rights approach for the achievement of just and coherent policies at national, subregional, and regional levels, for the elimination of social, gender, and ethnic exclusion in the health systems.

ACHIEVEMENT OF PAHO OBJECTIVE:
At the Summit of the Americas and at the Regional Ministerial Meetings the fact that health was the core for the MDGs attainment was the reaffirmation of the centrality of health in a wide perspective of development. The fact that to implement the *Faces, Voices and Places* initiative required a consensus building among the different Ministers responsible of social development, health and education stressed the importance of health as the key factor for development.

RER 22.1 Countries assisted at the national and subregional levels to increase the priority of health in the development agenda and increase investment in health.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
22.1.1	Number of epidemiological/socio-economic or health research studies undertaken in support of national and subregional initiatives on macroeconomics and health.	2	6	**Achieved**	**Studies of Caribbean Commission for health and Development and Mexican M.E.H. Commission were finished. Commissions in MERCOSUR and Andean countries developed four analysis of the ME and Health situation.**
22.1.2	Number of working groups or commissions on macroeconomic and health in which was a member and/or provided Bureau function.	2 subregional initiatives	Recommendation s of 4 subregional initiatives submitted to relevant authorities	**Achieved**	**The main orientations of the MEH studies in the Region were oriented to analysis of situation and not to develop mater plans for investment in health. Once critical issue was the lack of resources to support the commissions from WHO at the end of the grand for the Global Commission** **Each subregion had a workshop to discuss the Faces,**

					Voices and Places initiative and to transform it to respond to the country and subregional challenges. The Central American workshop was in Nicaragua in November 2006, the South American workshop in Peru in April 2007 and the Caribbean workshop in September 2007. In each one of them the analysis of the micro economics challenges as is reflected in the poorest communities was a key factor.
22.1.3	Number of national and subregional master plans of investment in health, based on the framework of the Commission of Macroeconomics and Health, developed with PAHO's collaboration	2	6	**Partially Achieved**	**Lack of resources from WHO to support substantive work in this area. Available resources transferred to finance subregional initiatives: studies on macroeconomics and investments in health in CAN and MERCOSUR (see main orientation 22.1.2).**
RER 22.2 Improved application of information, knowledge, and tools in essential technical and political areas of the relationship between health and human development.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
22.2.1	Number of countries applying one of the health sector analytical tools or planning frameworks for national health development	7	5	**Achieved**	**With support of PAHO were developed health national plans in Chile, Nicaragua, Peru, Uruguay and Argentina.**
22.2.2	Number of countries supported to apply SWAPs, for development of health sector	2	5	**4**	**Honduras, Bolivia, Guatemala, and Nicaragua**
RER 22.3 Health components of initiatives aimed at reducing poverty and achieving the MDGs monitored and supported at national, subregional and regional levels, in order to improve institutional capacity to develop and implement MDGs oriented public policies and interventions.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
22.3.1	Nationals trained to formulate and evaluate enabling public policies for MDG attainment	0	30	**Achieved**	**In partnership wit the World Bank Institute. PAHO promote the participation of people from the health sector to attend the course "Accelerating progress through the health Millennium Development Goals and other health Outcomes" 12 PAHO staff from MDG related Areas (6 from HQ, 2 from national representations Guatemala and Costa Rica), 2 the State governments from Mexico and 2 staff from the Government of Chile were sponsored by PAHO to attend the two week course. Over 42 PAHO staff from HQ and more than 6 national offices participated in the course on Communities of Practice and Knowledge Management and Dissemination for**

					Faces, Voices and Places offered in collaboration with George Washington's University, Institute of Knowledge Management. **With the George Washington Center PAHO annually receives more than 15 students, young professionals and local government professional that learn about the challenges of health equity under the MDGs framework. A Mayors Guide for the MDG achievement at the municipal level was created to facilitate their understanding and commitment.**
22.3.2	Annual reports on health-related MDGs at national, subregional and regional levels prepared by PAHO alone or in collaboration with other agencies	1	10	**Achieved**	**Together with the other UN agencies and coordinated by ECLAC, PAHO participated in the Reports: MDG 3 a glance on the equality among sexes and woman autonomy in Latin America and the Caribbean. In collaboration with other agencies PAHO's office developed national reports in Ecuador, Bolivia.** **A publication was produced on MDG 3 coordinated by ECLAC and PAHO along with other agencies. PAHO is working with ECLAC in a publication on the MDG 1, 4 and 5 and the draft document is being discussed. PAHO with ECLAC collaboration is producing a Map of Inequalities putting the emphasis on the poorest municipalities in each country. As a way to target critical interventions to the poorest, must vulnerable communities.**
22.3.3	Annual reports on health and poverty reduction at national, subregional and regional levels	1	10	**Achieved**	**Together with the other UN agencies and coordinated by ECLAC, PAHO participate in a report of MDG and health targets with emphasis on poverty reduction. In Argentina, Brazil, Bolivia, Colombia, Costa Rica, Chile, Cuba, Ecuador, El Salvador, Guatemala. Honduras, Mexico, Nicaragua, Panamá, Paraguay, Peru and Uruguay that are working under the Faces, Voices and Places imitative the analysis on health and poverty reduction took place at the municipal level.**

RER 22.4 Strengthened institutional capacity at the national and subregional levels and within the Bureau to integrate human rights approach in health development, and poverty reduction, social inclusion, and human security, policies and legislation.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
22.4.1	Number of PAHO staff at regional and country level taught to use tool for the integration of human rights into development planning.	0	40	**180**	**Up to now, approximately 180 PAHO employees have been trained on human rights instruments and tools.**
22.4.2	Human rights approach included in new PAHO regional programs or initiative related to health and poverty reduction, and extension of social protection in health, and in CCS	0 new regional programs	3 new regional programs	**6 new regional programs**	**Up to now, a human rights approach has been introduced in 6 new programs related with injuries and disability; indigenous peoples, children/adolescents, older persons, HIV and environmental health.**
22.4.3	Human rights approach included in new PAHO regional programs or initiative related to health and poverty reduction, and extension of social protection in health, and in CCS	No CCS use HR approach as of end 2005	50% CCS conducted in 2006-07 apply HR approach	**Fully achieved**	
22.4.4	Monitoring reports on countries' implementation of health related commitments of the UN Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance	0	1 report available on PAHO homepage.	**Fully achieved**	**-In cooperation with ECLAC, GEH has prepared a report on Health Equity and ethnic groups for 15 countries that have desegregated data** **- In cooperation with High Commissioner of Human Rights, AD/GE has prepared a report on the achievements related to the Durban Conference mandates**
22.4.5	Relevant national health legislation evaluated and recommendations made for the promotion of gender and ethnic equality	No data currently available	4	**Fully achieved**	**Recommendations have been submitted using human rights instruments that protect equal protection of women and minorities to review health national laws in 12 countries.** **GEH is currently reviewing health plans and programs for the inclusion of gender and ethnicity.**
RER 22.5 Platforms for consensus building that captures diverse perspectives and foster processes among key scientific, academic, private and civil society, in addition to social and political actors developed and operational.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
22.5.1	Number of PAHO Regional Fora convened and reports of which disseminated widely	0	3	**Achieved**	**Bioethics Forum; Diabetes in the US/Mexico Border Forum; Urban Health Forum.**

22.5.2	Number of Expert Planning Boards functioning	0	2	**Achieved**	**Diabetes M/Expert board; Urban Health planning board**
22.5.3	Active Share Point site enabling virtual sharing and collaboration for the Forum	0	1	**Achieved**	**Virtual Forum Platform developed and in IKM control.** **CSU has a share point set-up and Faces, Voices and Places developed another to address the subregional commitments as well as the communities working under the initiative. In collaboration with IKM the Faces, Voices and Places team developed a community of practice to information knowledge management and collaboration.**
RER 22.6 Capacity for integrating bioethics in health policy/programs increased at national level.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
22.6.1	At least 75% of the countries have commissions or national committees in bioethics	Number of Committees in 2005	At least 27 countries	**25**	**25 countries achieved the goal with the support of the Regional Project of Bioethics are actively functioning.** **In each of the English speaking Caribbean countries the formation of a commission has been postponed.**
22.6.2	Countries supported to use tools, standards and guidelines to include ethics in plans and research	N/A	8	**10**	**In the last year 12 countries were included in the EVIPNet network for the improvement of the utilization of scientific evidence in the decision making process.** **Above target.**
RER 22.7 Commission aimed to generate, and disseminate knowledge and information to improve intersectoral public policies in Health operational, as recommended by the WHO.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
22.7.1	Commission on Social Determinants in Health implemented and functioning in the Region of the Americas and the reports and studies of the Commission disseminated	0	4	**2**	**Brazil and Chile will create their own mechanisms for the National Social Determinants Commission.**

Lessons Learned:

- Intersectoral action is required to achieve at the MDGs at the regional, subregional, national and local level. *Working with health, education, labor, environment, social development and finance is critical to advance the MDGs and ensure increase in the social budget.*
- In order to achieve health equity in the poorest, most vulnerable communities, Ministers of Health must take ownership of this issue, have the political will to make changes, and become strong advocates to engage ministers from other sectors and thus demonstrate that health is at the center of development. Mayors play a very important role along with the NGOs and grassroots organizations to implement sustainable change at the local level.
- MDG monitoring up to now has been done at the national level, however, national averages mask local realities and national inequities, and therefore MDG monitoring must also include local level development and monitoring. In order to do this PAHO is working with ECLAC using the latest census data in the selected countries of the Region using the *Basic Need Indicator* (BNI) to identify the poorest municipalities in each country.

Financial Execution

AoW: **HSD- Policy-Making for Health and Development**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	3,917,400	3,743,010	3,736,400	100%
Other Sources	10,602,000	45,986,215	27,896,800	61%
Total (RB & OS)	**14,519,400**	**49,729,225**	**31,633,200**	**64%**

23. HEALTH SYSTEMS POLICIES AND SERVICE DELIVERY (HSP)
Overall Achievement level: 88%

GOAL: To improve the availability, accessibility, equity, quality, and efficiency of health services, by enhancing their links with the essential public health functions and by strengthening the steering role of national authorities in the organization and management of health systems based on the principles of Primary Health Care.
ACHIEVEMENT OF GOAL: **During the period 2006-2007, countries have advanced significantly in the process of evaluating the leadership and regulation dimensions of the steering role of their National Health Authorities (NHA) and identifying strengthening strategies. National Health Authorities continue to recognize the importance of strengthening their capacity to lead the sector and revitalize legal frameworks as an essential component of an effective policy-making process as a first step towards building more equitable health systems. The main milestone was the approval by all Member-sates of the Health Agenda for the Americas in Panama City, June 2007, which states the Strengthening of National Health Authorities as the first of eight Areas of Action. There was also a significant advance towards the goal of Strengthening Primary Health Care Based Health Systems, as agreed by Member States in Resolution CD 46/13 (2005) on New Orientation for PHC – Declaration of Montevideo.**
PAHO OBJECTIVE: To actively engage in the advancement of goals and commitments established by regional/subregional mandates and agreements on health systems development, and to timely and adequately support countries and regional/subregional entities in their efforts to reinforce mechanisms for coordination of health systems and the integration of health services delivery networks, and to strengthen the leadership and steering role of the ministries of health to enhance overall system performance and plan and manage the 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.
ACHIEVEMENT OF PAHO OBJECTIVE: **37 countries/territories were supported with continued technical cooperation in health policies, systems and services. Main efforts were directed to capacity building at country level: 101 professionals from 13 countries developed capacities to analyze the Health Sector, based on an innovative and comprehensive approach centered in the political economy and overall performance of Health Systems, in the 2006-7 International Courses on Health Systems Development; another 242 national professionals participated in different capacity building workshops; 145 participants from 30 countries in the Latin American and Caribbean Region, in addition to the United States and Canada, participated in the Regional Forum on Scaling Up Health Systems Based on PHC - Strengthening the Steering Role; Integrating Systems and Services; Developing Public Health Capacities, held in November 2007, in Ecuador.** **The regional technical cooperation approach in Health systems and services is currently characterized by inter programmatic collaboration, and particularly the support of the Area of Health Systems Strengthening to substantive program areas. Examples of such collaboration includes shared partnerships in capacity building activities, publications, research and direct cooperation (e.g. forum on the Extension of Social Protection in Health for Mother and Child Populations and Scaling Up Health Systems based on PHC, support in the development of the Regional Nutrition Strategy, policy analysis and development for chronic non-communicable diseases, active participation in the design and implementation of the Policy Observatory for Chronic Diseases with the government of Canada).**

Countries have been receptive to PAHO's recommendations to address the complex issues involved in the improvement of health sector leadership and in the creation of new regulatory frameworks, both in terms of methodology of work (inter and multidisciplinary groups) as well as from the technical perspective. Success factors were the interest of national health authorities and the cooperation, representativeness and ground work of countries offices. The number of countries supported to improve the steering role (Conduct/Lead and Regulation functions) of the ministries of health to enhance overall system performance has increased significantly. Countries recognized the need for guidance in the regulatory process and importance was given to the possibility of sharing experiences among different countries. Eleven countries (Belize, Bolivia, Chile, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Panama, Paraguay, and Uruguay) have reviewed legislation and/or improved regulatory mechanisms to consolidate health systems and reduce inequities in access to health services. Studies to evaluate and strengthen the regulatory component of the steering role and identify lessons learned were conducted in three countries. Workshops to sensitize and build agreements among stake holders when drafting new legislation/regulation were conducted in five countries.

Also, PAHO has been working on the development of a framework for the implementation of integrated health services delivery networks based on the Renewed Primary Health Care (PHC) Strategy. Aruba, Bahamas, Bolivia, Chile, Dominican Republic, Ecuador, Nicaragua, Panama, and Uruguay are working in the design or implementation of their health sector reforms, which emphasis in the integration of public health systems and in the strengthening of the steering role of national health authorities. Decentralization processes have been implemented in Bolivia, Brazil, Colombia, Chile, Ecuador, El Salvador, Guatemala, Honduras, and Peru. A strong component of the work that PAHO has been carrying out in this topic is the integration of public health in health services. Based on the results of second EPHF assessments as well as sub-national assessments, several countries have improved the performance of EPHF functions 5 and 6 (Puerto Rico, Peru, Costa Rica, Dominican Republic, El Salvador, Brazil, Argentina, Colombia, Costa Rica, and Honduras).

The internet has become a powerful mechanism for disseminating information on health systems strengthening to all of the countries in the Region. In 2007, a webpage on Essential Public Health Functions was created, including a myriad of information pertaining to strengthening public health practice. In addition, virtual forums and courses were used to disseminate documents and foment discussion, proving to be an effective mechanism for creating online communities around specific issues. 41 technical documents/tools on health systems issues produced by PAHO were made widely available through the specific web site (www.lachealthsys.org) that received an average of 51,000 visits every month Challenges include lack of technological infrastructure in many countries, limited access to Internet, and lack of skilled human resources to implement technological solutions.

RER 23.1 Documentation, knowledge and information will be collected, organized actively disseminated and made widely available to national authorities, international cooperation agencies, health providers, professional associations, the academic world and civil society

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
23.1.1	Number of countries in which Health Sector Analysis has been completed (accumulated)	7	11	**7**	**Even though the process of completing the Health Sector Analyses was initiated in at least one country (Dominican Republic), changes in government and shifting country priorities prevented the completion of the document.**
23.1.2	Number of countries in which the Health Systems Profile has been updated to the 2005-2007 period (accumulated)	8	24	**12**	**Anguilla, Bolivia, Brazil, British Virgin Islands, Dominican Republic, El Salvador, Guatemala, Guyana, Panama, Paraguay, Puerto Rico, and Trinidad and Tobago updated their profiles based on the revised Methodology for the Elaboration of Health Systems Profiles.**

					All 24 planned Countries (in the Central American and Spanish-speaking Caribbean and in the English- speaking Caribbean) were trained in 2 workshops - Puerto Rico and Belize, but several of them did not complete an updated Health System Profile due to conflicting priorities, particularly the time devoted to the national chapter of Health in the Americas 2007, according to information from the PWRs.
23.1.3	Number of annual visits to the LACHSR webpage	450,000	520,000	**612,000**	**With an average of 51, 000 visits/month, annual visits reached a total of 612,000 during 2007. Also, the Web site underwent significant changes, with the inclusion of new sections and a name change (LACHEALTHSYS Web page).**
23.1.4	Active professionals registered in the Network of Contacts of the LACHSR clearinghouse (accumulated)	850	1000	**1,270**	**There were 1,270 registered users in the system until 2006.** **With the changes introduced in the Web site in 2007, the old registration system was replaced by an updated, more selective database that includes experts in specific issues. Currently a total of 140 users are registered into the system.** **Additional 145 participants in the 2005-6-7 International Courses on Health Systems Development constituted a very active network for exchanging knowledge and sharing experiences.** **The Network of Public Health Authorities for Regulation and Control created as a mechanism for sharing knowledge and resources among countries to strengthen the regulatory function (5 countries participating).**
23.1.5	Number of technical materials, policy briefs, tools and documents on assessments implemented and lessons learned completed and disseminated (per biennium)	30	40	**41**	**All the previously available 30 technical materials continue to be regularly accessed trough PAHO's website.** **At least 10 additional new documents were produced during the biennium. Among them are:** **1. The Steering Role of the National Health Authority in Action: Lessons Learned** **2. Social Protection in Health Schemes for Mother and Child Populations: Lessons Learned from the Latin American Region** **3. Public Health Capacity in Latin America and the Caribbean: Assessment and Strengthening** **4. Is it Possible to Scale-Up Health Systems Based on Primary Health Care? Lessons learned scaling-up vertical programs** **5. Methodological Guidelines – Health Systems Profiles: Monitoring and Analyzing Health Systems Change/Reform**

					6. Steering Role of the National Health Authority: Strengthening its Performance **7. Scaling Up Health Systems Based on Primary Health Care (PHC): Analysis of the Integration of National Programs in the Health System of Peru** **8. Scaling Up Health Systems Based on Primary Health Care (PHC): Analysis of the Integration of National Programs in the Health System of Brazil** **9. Newsletter Strengthening Health Systems and Reforms** **10. Assessment of Public Health Capacity in Peru** **11. LEYES database improved as a tool for knowledge building and information sharing among countries in health legislation and comparative law. 12 countries included in the decentralized production of LEYES database).**
23.1.6	Number of country professionals and advisors from PAHO and other international cooperation agencies trained in the methodologies to develop Health Sector Analysis and/or Health Systems Profiles (per biennium)	30	50	**206**	**At least 50 participants from Central America and Spanish Speaking Caribbean attended the Subregional Training Workshop on Monitoring and Analysis of Health Systems Change/Reform held in Puerto Rico; and at least 30 participants attended the Health Systems Strengthening Seminar on Monitoring Health Systems Change/Health Reforms in the English Speaking Caribbean and Canada. During these two workshops, participants were trained in the updated methodology for the elaboration of Health Systems Profiles.** **101 professionals from 13 countries developed their capacities to analyze the Health Sector, based on an innovative and comprehensive approach centered in the political economy and overall performance of Health Systems, in the 2006-7 International Courses on Health Systems Development.** **A Workshop on Policy Analysis and Decision Making with Emphasis on Chronic Non- Communicable Diseases was attended by 25 participants from the Eastern Caribbean countries. This capacity-building event was an introduction to public policy analysis, policy development, implementation and evaluation with goals aimed at enhancing the skills and competencies in these fields of knowledge and practice as analysts, advisors and decision-makers. While the emphasis is on chronic non-communicable diseases, the methods and tools shared are germane to the design of public health policies**

					in general. The topics highlighted the relevance of agenda-setting in turbulent and complex political environments, models of implementation and evaluation, strategic thinking and foresight.

RER 23.2 Steering role and leadership of health authorities strengthened, and their institutional, organizational and human capacities developed, to enhance overall systems' performance, to plan and manage the coordination and integration of service delivery networks, and to scale up interventions to attain the MDGs and other priority targets.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
23.2.1	Number of countries in which the Guidelines for evaluating the performance of the Steering Role function has been applied and generated interventions to strengthen the Conduct/Lead dimensions (accumulated)	2	6	**11**	**The guidelines for evaluating the performance of the steering role were applied in the Dominican Republic, Ecuador, and El Salvador, generating plans for strengthening the Conduct/Lead dimension.** **Adaptations of the concept framework were developed to strengthen the Conduct/Lead dimensions in Bolivia, Chile, Panama, Paraguay, and Uruguay.** **Studies to evaluate and strengthen the regulatory component of the steering role and identify lessons learned conducted in three countries.** **Workshops to sensitize and build consensus among stake holders when drafting new legislation/ regulation conducted in five countries (Belize, Guatemala, Guyana, Panama and Paraguay).**
23.2.2	Number of country professionals and advisors from PAHO and other international cooperation agencies trained in planning and management of mechanisms for systems coordination and service delivery networks' integration (per biennium)	55	80	**115**	**35 professionals from Europe, Canada, United States and 6 Latin American countries (Brazil, Chile, Colombia, Costa Rica, Nicaragua, and Paraguay) and PAHO staff participated in an expert review workshop meeting in Santiago, Chile to discuss a background document on Policy Options for the Integration of Health Systems and Services Delivery Networks.** **Two Course-Workshops on Health Legislation to train 80 participants (legal counsels of ministries of health, social security institutions, regulatory agencies and parliaments, human rights and consumer advocates, law scholars and academics, and representatives from other ministries and integration schemes) in regulatory issues pertaining to systems coordination and service delivery networks, conducted. Participating countries: Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, Dominican Republic, Ecuador, El**

					Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Panama, Peru, Puerto Rico, Uruguay and Venezuela.
23.2.3	Concept framework on scaling up health systems through the incorporation of PHC strategies and disease-specific vertical programs into integrated delivery networks aiming to attain the MDGs and other priority targets available and disseminated to countries	Concept framework developed and agreed upon by experts	Concept framework disseminated to at least 8 countries	**Concept framework finalized and disseminated to 32 countries**	**The framework was disseminated during the VII Regional Forum on Scaling Up Health Systems Based on PHC - Strengthening the Steering Role; Integrating Systems and Services; Developing Public Health Capacities, held in November 2007, in Ecuador.**
23.2.4	Number of country professionals and advisors from PAHO and other international cooperation agencies trained in planning and management for scaling up health systems through the incorporation of PHC strategies, and disease-specific vertical programs into integrated delivery networks (per biennium)	0	70	**145**	**At least 145 participants attended the VII Regional Forum on Scaling Up Health Systems Based on PHC - Strengthening the Steering Role; Integrating Systems and Services; Developing Public Health Capacities.**
23.2.5	Number of countries and territories in which direct technical cooperation has been provided to enhance overall performance of the system and of health services delivery networks	28	37	**37**	**Continued technical cooperation on health systems and services strengthening was provided to all countries with health services and systems advisors in the Country Office.** **Support from the Regional Office was provided as requested by the PWRs, and focused mostly on Argentina, Aruba, Bahamas, Belize, Bolivia, Brazil, British Virgin Islands, Chile, Colombia, Costa Rica, Cuba, DOR, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Panama, Paraguay, Peru, Puerto Rico, Trinidad and Tobago, Uruguay and Venezuela.** **Direct technical cooperation provided to draft legislation for enhancing the overall performance of the health systems: Constitutional revision (Bolivia), restructuring of health systems (Belize and Guatemala), strengthen regulatory mechanisms for insurance and safe blood (Guatemala, Guyana and Paraguay) and creation/ strengthening of regulatory authorities (Panama and Paraguay).**

RER 23.3 Public Health leadership, infrastructure, and practice strengthened at national and sub national levels including the improvement of human resources competencies in public health.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual**	**Explanation (obligatory if target not met) or comments**

				Dec 2007	
23.3.1	Number of countries in which national/subregional reports reveal improvements in the performance of Essential Public Health Functions #5, 6 and 8	0	6	**9**	**Based on the results of second EPHF assessments as well as sub-national assessments, several countries have improved the performance of EPHF functions 5, 6, or 8: Argentina, Peru, Costa Rica, Dominican Republic, El Salvador, Brazil, Colombia, Mexico and Honduras.**
23.3.2	Number of countries having developed and implemented plans of actions to improve the capacity, infrastructure, and practice of the public health systems with special emphasis in the Essential Public Health Functions #5, 6 and 8 (accumulated)	3	8	**12**	**Argentina, Brazil, Colombia, Costa Rica, Honduras and Peru implemented plans of actions or strategies for strengthening EPHF 5, 6 or 8 during the 06-07 period. Legal frameworks to strengthen the regulatory function of National Health Authorities (EPHF 6) enacted in 8 countries (Bolivia, Chile, Colombia, Ecuador, Nicaragua, Peru, Dominican Republic and Venezuela).**
23.3.3	Number of countries in which a second Essential Public Health Functions assessment has been carried out at national or sub national levels (accumulated)	5	10	**14**	**Several countries in the Region carried out second national EPHF assessments or sub-national evaluations. Among the countries that carried out national assessments are: Puerto Rico, Peru, Costa Rica, Dominican Republic, and El Salvador. Sub-national evaluations were also carried out in Brazil, Argentina, Colombia, Costa Rica, Peru, and Honduras.**
23.3.4	Methodology to estimate expenditures in public health available and disseminated to countries	Developed and pilot tested in 2 countries	Disseminate d to at least 10 countries	**10 countries**	**The methodology was developed and tested in Peru and Costa Rica. Additionally it has been disseminated, and estimates have been prepared for the ECC countries: Antigua and Barbuda, Anguilla, Dominica, Granada, Montserrat, St. Lucia, St. Vincent and the Grenadines, St. Kits and Nevis.**
23.3.5	Number of country professionals and advisors from PAHO and other international cooperation agencies trained in the methodology to estimate expenditures in public health	0	20	**22**	**Participants at the harmonization workshop on public expenditure in health from the MERCOSUR Argentina, Brazil, Uruguay, Paraguay, including Chile, Bolivia, Peru and Venezuela.**
23.3.6	Subregional plans developed and in implementation to strengthen EPHF #10-Research in public health	0	2 subregions	**4 countries**	**The subregional approach didn't prove to be adequate, so TC shifted to the country level.** **National plans to strengthen public health research capacity were elaborated in Brazil, Costa Rica, Peru and Colombia and are currently under implementation.**
23.3.7	Number of countries and territories in which direct technical cooperation has been provided to strengthen the essential	7	14	**19**	**Participants from at least 12 new countries attended the workshop on Findings and Perspectives on the Essential Public Health Functions in the Americas held in Peru, in**

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
	public health functions (accumulated)				**May 2007.**
RER 23.4 Selected countries supported to improve the access, effectiveness, efficiency, safety and user satisfaction of the care provided by the network of integrated health services.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
23.4.1	Piloting of innovative ways of providing health services in distant and/or hardship locations in PAHO's key countries	0	3	**0**	**This target has been just partially achieved because of lack of resources. However, it will be resumed in 2008.**
23.4.2	Number of countries in which a new accreditation system for primary care will have been tested	0	3	**3**	**A set of indicators was defined and a validation of those indicators was carried out in Costa Rica, Brazil and Nicaragua.**
23.4.3	Number of public hospitals in the Region assisted in piloting patient safety strategies	0	12	**66**	**Technical cooperation in Patient Safety includes:** **IBEAS Study on Prevalence of Adverse Effects in Hospitals in Latin America: 64 hospitals (6 Argentina, 7 Costa Rica, 12 Colombia, 5 Peru, and 34 Mexico).** **Pilot Implementation of WHO's Multimodal Strategy for Hand Hygiene: 1 (Costa Rica).** **Pilot of an experience of implementation of an Adverse Events Reporting System: 1 (Peru).** **In 5 hospitals in Brazil (ANVISA) and in 5 hospitals in Argentina we are in the design phase of a project for implementation of WHO Multimodal Strategy for Hand Hygiene. In addition, Brazil incorporated two hospitals for the validation in Portuguese of the IBEAS methodology (Fiocruz), and it is foreseeable that other countries such as Uruguay and Chile will be added in a new edition of IBEAS.**
23.4.4	Number of countries assisted in the development, testing and validation of tools for integrating health services delivery networks	0	3	**5**	**A draft document on Integrated Health Care Delivery Systems has been developed with the objective of providing countries with policy options and tools to deal with the fragmentation of health services. The draft was submitted for peer review during a consultation with over 30 experts from the Region (Brazil, British Virgin Islands, Chile, Nicaragua, and United States), Spain and Belgium.**

Ind.#	Indicator description	Baseline	Target	Actual	Explanation (obligatory if target not met) or comments
RER 23.5 Managerial capabilities of health facilities and health delivery networks strengthened by dissemination of information and knowledge, including appropriate and relevant tools, methodologies, and guidelines to apply evidence-based practices that enhance access, quality, and equity in health service delivery, especially for vulnerable populations.					

				Dec 2007	
23.5.1	Number of countries' health services profile developed	0	15	**0**	**No resources available. Guidelines for the development of health services profiles have been developed and disseminated to all countries for the publication of Health in the Americas 2007.**
23.5.2	Number of basic health services indicators developed and disseminated	4	6	**8**	
23.5.3	Number of countries utilizing decision-making support tools, methods, best practices and guidelines identified and disseminated for organization and management of health services with the support of PAHO	8	10	**15**	
RER 23.6 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 culturally appropriate quality health services.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
23.6.1	Support provided to intrasectoral and intersectoral cooperation networks of indigenous people's health at local, national and regional level	7 local	30 local	**40 local**	
23.6.2	Support provided to intrasectoral and intersectoral cooperation networks of indigenous people's health at local, national and regional level	0 national	7 national	**9 national**	
23.6.3	Support provided to intrasectoral and intersectoral cooperation networks of indigenous people's health at local, national and regional level	0 regional	1 subregional	**1 subregional**	**Support to the Andean BWP**
23.6.4	Number of countries that incorporate health status of their indigenous people in their health information systems and analysis with PAHO support	0	2	**3**	**Brazil, Canada and Guatemala.** **Progress has been made in the development of conceptual frameworks and methodology for the incorporation of ethnicity as a variable. Additional efforts will be carried out in 2008 to include this variable in the health information systems.**

Lessons Learned:

- National Health Authorities continue to recognize the importance of strengthening their capacity to lead the sector and revitalize legal frameworks as an essential component of an effective policy-making process.
- The regulatory function is also considered as an essential component of the steering role and one of the anchors to the leadership of the national health authority.
- New international mandates and challenges require coordinated action between PAHO HQs and Country Offices as well with technical units in developing policies and legal frameworks that are apt to address new commitments.

Financial Execution

AoW: **HSP- Health Systems Policies and Service Delivery**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	15,910,400	14,885,889	14,835,000	100%
Other Sources	19,648,000	10,841,207	9,144,000	84%
Total (RB & OS)	**35,558,400**	**25,727,096**	**23,979,000**	**93%**

24. HUMAN RESOURCES FOR HEALTH (HRH)
Overall Achievement level: 97%

GOAL:
The development of equitable effective and efficient health services through a balanced, better distributed, competent and motivated workforce.

ACHIEVEMENT OF GOAL:
The Biennium 06-07 was extremely productive in terms of communicating to the Member States (1) the strategic character of human resources for health policies to improve the performance of health systems and services and generate desired health outcomes; (2) the need for comprehensive approaches to address HR challenges and issues; (3) the critical leadership or steering role of national health authorities in the planning of the workforce and the intersectoral formulation of HR policy. The dissemination of the Toronto Call to Action for a Decade of Human Resources for Health in the Region, the WHR and World Health Day (WHD) 2006 "Working Together for Health", the round table on HR policy during the Meeting of the Directing Council 2006 and the adoption by the Pan American Sanitary Conference in 2007 of the Regional Goals for Human Resources for Health 2007-2015 illustrate the progress made in positioning the issue of human resources in the health agenda.

PAHO OBJECTIVE:
To support the participatory formulation and implementation of effective human resources policies in health and the optimal management of education and work at the regional, subregional and national levels.

ACHIEVEMENT OF PAHO OBJECTIVE:
Most countries of the Region were involved, with the support of PAHO, in the formulation of national plans of action for a decade of human resources for health, using the 5 critical challenges of the Toronto Call to Action as a common framework. The progress in the development of national plans of action was the object of discussions at the subregional levels and both RESSCAD and REMSA decided to formulate their subregional plans. The Regional Meeting of the Network of Observatories of Human Resources for Health took place in Lima, 2006, and was the most important in terms of participation, including other WHO Regions and African Countries. The Meeting focused on a Shared Vision for the development of national and subregional plans of action. The Caribbean Region celebrated its first Subregional Meeting on the Planning of Human Resources in July 2007, setting the stage for the collaborative development of HR policies. The Andean Countries have begun the process of adopting operational definitions and developing indicators for the monitoring of the Regional Goals 2007-2015. A plan of action has been developed with the ministry of health in Haiti. The strategic alliances developed with Brazil and Canada and the model based on subregional HR Advisors have had a large impact in the Region and in the achievement of main expected results.

RER 24.1 Decade of Human Resources for Health launched and opportunity taken to focus attention on HRH in the Americas.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
24.1.1	A regional framework for addressing challenges of Human Resources in Health in the Americas developed and World Health Day celebrated.	No Framework; preliminary ideas for	Approved regional framework; and program	**Approved regional framework ; and**	**The celebration of WHD 2006 was a success in HQ Washington as well as in many countries and sub-national jurisdictions of the Region.** **A regional framework was developed based on the**

		WHD	of activities executed.	**program of activities executed**	**TOR Call to Action and broadly disseminated throughout the Region.**
24.1.2	Number of policy and technical documents produced by regional consultation groups in relation with the critical challenges for a Decade of Human Resources in Health	0	5	**9**	**Significant policy and technical documents were produced on the migration of health workers, Nursing and PHC, Overview of the Regional Nursing Workforce, Development of the PHWF, Regional Goals for HRH, Careers Paths, Management of HR, Health of Health Workers, Leadership in International Health, Health Human Resources Trends in the Americas: Evidence for Action, between others.**
24.1.3	Regional plan of action developed in consultation with countries, regional, subregional and national professional associations and specialized commissions and activities initiated in countries	0	Approved Plan of Action and related activities in 9 countries	**Approved Plan of Action and related activities in 9 countries.**	**The Regional Goals for Human Resources for Health 2007-2015 were adopted by the PASC. Process was initiated, based on the RG, to develop a Regional Plan of Action with a special emphasis on PHC.**
RER 24.2 Countries supported to use norms, guidelines and methodologies for the development of core data sets and information systems on human resources developed by PAHO.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
24.2.1	Number of countries which have developed a set of core data on HRH using recommended guidelines	6	12	**Exceeded**	**14 Caribbean countries, 6 from CA and 4 from the Andean Region worked actively in the development of core data.**
24.2.2	Process developed for the formal recognition by PAHO/WHO of Observatories of Human Resources in Health or equivalent entities which have contributed to the production of information for policymaking	0	Criteria developed and Process established and publicized	**Criteria developed and Process established and publicized**	
RER 24.3 New models and methodologies for the management of health human resources developed in collaboration with health institutions, programs and services and academic institutions					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
24.3.1	A program of continuing education will be designed and implemented at the subregional level to support the practice of	0	2 subregions	**3 subregions**	**The PAHO online course on HR policy was offered to CA and MERCOSUR countries; the CIRHUS was offered through the Brazilian cooperation to the**

	professionals with leadership positions in the management of human resources in health				**Andean Countries. Process was initiated with Caribbean institutions for the adaptation and translation of the online course.**
24.3.2	Number of training programs in health administration engaged in the review of their curriculum in the management of human resources in health and involved with PAHO in the continuing education program	0	6	**>6**	**4 Schools of Public are developing a national version of the CIRHUS with the support of Brazil; a network was established in ARG with 20 institutions reviewing and developing training programs in HR Management.**
24.3.3	Technical dialogues and documents produced on major issues confronting the management of human resources in health in a changing and globalized work environment (staffing, working relations, retention etc.)	0	4	**4**	**Issues addressed: Working Conditions and Health of the Health Workers; Decent Work and Health; Study of HR Units of MOH; Careers Paths; HR Management.**
RER 24.4 Innovative educational policies, models, systems and programs aimed at improving the performance of in-service health professionals and technicians being developed, shared and implemented collaboratively					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
24.4.1	Number of countries who have developed a learning network aimed at strengthening the competencies of the public health workforce, sharing best practices and resources through a common model and architecture	0	5	**8**	**At the end of the biennium, 8 countries and more than 40 public health institutions were involved in the VCPH.**
24.4.2	Number of professionals trained in a PAHO Program of International Health Leadership	0	10	**5**	**Due to budget constraints, a cohort of 5 professionals was trained in 2006. A strategy paper has been developed on the role of PAHO in Leadership Training in International Health and the 1st draft of a new program.**
24.4.3	Number of professionals trained through PAHO's fellowship and internship programs	0	60	**174**	**The internship program was fully developed during the biennium and welcomed more than 60 participants, including Fulbright Fellows and a special arrangement with Pfizer. We received 43 from other WHO Regions and we organized 12 study tours mainly from China, with 71 participants.**

RER 24.5 Innovative educational policies, models, methodologies and guidelines to improve the quality of education in health sciences at the

undergraduate and graduate levels developed, documented, and implemented					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
24.5.1	Number of schools of medicine formally collaborating with PAHO in identifying and analyzing best practices to prepare physicians responsive to community needs and characteristics	2	7	**16**	**Four Schools of Medicine or Department of Medical Education are leading this process with PAHO, as Collaborating Centers. 12 Schools of Medicine shared their experiences with problem-based, community oriented training.**
24.5.2	Number of countries that have developed and implemented plans for the professionalization of nursing	4	12	**14**	**However, we observe within some countries, jurisdictions that are abandoning these programs because of the budgetary implications of sustaining a broader workforce of reclassified nursing personnel.**
24.5.3	Number of dialogues and technical documents produced on the reinforcement of public health / PHC in nursing curriculum	2	5	**7**	**It is important to highlight the existence of 7 nursing networks related to the MDGs and PHC supported by PAHO.**
24.5.4	Programs and guidelines developed to improve the quality of postgraduate training and continuing education programs in family and community medicine	3	7	**7**	**We developed in collaboration with WONCA LA and Residency Programs in Family Medicine quality development guidelines.**
24.5.5	Number of countries that have adopted and have begun implementation of a PAHO-led strategic plan to reorient education for health technicians and community health workers	0	5	**5**	**Our PAHO/WHO Collaborating Center for Allied Health Professionals in Fiocruz coordinate a network of national training programs.**

Lessons Learned:

- Innovative communication strategies are essential to position and sustain the issue of human resources for health in the political agenda of the countries of the Region. In that sense, a convergence of initiatives such as the JLI of the Rockefeller Foundation, the WHR and WHD 2006, the High Level Forum on MDGs and Health Human Resources empowered national and regional developments and generated new levels of consensus on major challenges and goals. The question is: how do we make up for these global initiatives in the coming year?
- The development of strong leadership and capacity at the professional and institutional levels is essential to implement change in Human Resources policies. With the exception of Cuba, Brazil and Canada, few Ministries of Health of the Region have an effective steering capacity to manage their own human resources (not to talk of the private sector) according to the desired

model of care and to cover the needs of underserved populations. There is an urgent need at the central and decentralized levels of the countries of competent individuals with a comprehensive understanding of the critical challenges to human resources for the coming decade linked to health system change and of supportive policy-making environments.

- The development with the countries of the Region of a common framework for action (the Toronto Call to Action) and a common vision of what we want to achieve (the Regional Goals) provides a comprehensive set of directions to guide policy-making at the national and subregional levels. In turn, they need to encounter a specific expression in each country's reality. They facilitate technical cooperation between countries and with the Organization. However, they exert great pressure on the Organization to mobilize relevant expertise and resources, to support the development of tools and indicators, and to strengthen information systems. This is the great challenge in terms of PAHO/WHO's technical cooperation: to work effectively at all levels of relevant jurisdiction (local, national, subregional, regional), in the 3 core areas of human resources policy and interventions (planning, management, education), from the normative aspects to capacity building and direct assistance, and to manage an increasing complexity of action and learning networks.

Financial Execution

AoW: **HRH- Human Resources for Health**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	8,226,400	7,816,633	7,744,100	99%
Other Sources	4,934,000	77,772,838	42,340,000	54%
Total (RB & OS)	**13,160,400**	**85,589,471**	**50,084,100**	**59%**

25. HEALTH FINANCING AND SOCIAL PROTECTION (HFS)
Overall Achievement level: 98%

GOAL:
Attain equitable access to health services and improved social protection in health through mechanisms of sustainable health financing.

ACHIEVEMENT OF GOAL:
During the period 2006-2007, countries made important progress in acknowledging the need for extending social protection in health (SPH), in establishing and/or consolidating SPH schemes/interventions and mechanisms of sustainable health financing, aiming to attain equitable access to health services. The main milestone was the approval by all Member Sates of the Health Agenda for the Americas in Panama City, June 2007, which states Increasing Social Protection and Access to Quality Health Services as the third of its eight Areas of Action.

PAHO OBJECTIVE:
To support Member States in the analysis, design and implementation of policies and strategies of sustainable and equitable health financing that ensure cost-effective resource allocation practices, extension of social protection in health and improved access to quality health services.

ACHIEVEMENT OF PAHO OBJECTIVE:
After decades of governments strongly focused on the economy and international trade issues, there is now a renewed concern about social topics in the LAC region and social protection is high in the political agenda of most countries. PAHO/WHO has had an important role in promoting the concepts, ideas and technologies to extend social protection in health.
At least 30 countries (The 8 ECCB countries, Argentina, Bahamas, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panamá, Paraguay, Peru, Uruguay, and Venezuela) have used the policy options, guidelines and recommendations developed by PAHO/WHO to improve the social protection, efficiency and/or equity of their financing systems.

RER 25.1 Support countries to understand the situation with respect to social exclusion and inequalities and the economic, financial and expenditure aspects of health.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
25.1.1	Number of countries that have completed studies, with PAHO support, to analyze key aspects of social exclusion in health	9	15	**10**	**Although the target was not achieved, progress was made in the following:** **Characterization of exclusion in health at country level was carried out in one country (Nicaragua).** **Responding to the Member States' demands the focus of technical cooperation shifted to:** **- Local level: characterization of exclusion in health in 20 Municipalities in Honduras** **- New priority issues: analysis of the impact of exclusion in health over the lack of access to medicines at country level in three countries (Guatemala, Honduras and Nicaragua)** **- Regional level: all the ministers of health of the Iberoamerican**

					countries pledged to fight exclusion from health care by signing the Iquique Consensus in Chile in July 2007.
25.1.2	Number of countries that have institutionalized analysis of economic/financial data/indicators for health and social protection	20	30	**34**	**10 countries with specialized health economics/accounts units/ departments (Argentina, Bahamas, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Paraguay, Uruguay)** **CCH3 and the Caribbean Commission on Health and Development strongly utilized economic/financial data and indicators to support their analytical efforts** **94% of the countries/territories have updated to 2004 their data on public expenditure in health.** **77% of the countries/territories have updated to 2004 their data on private expenditure in health.**
25.1.3	Number of technical materials, policy briefs, case studies and documents on social exclusion, inequalities and expenditure and other economic issues in health completed and disseminated	30	35	**54**	**On social exclusion issues: Two publications with case studies on exclusion in health, one technical guideline, three packages with three instruments each (surveys, manuals, research protocols)** **On health economics and financing issues: completed (21) and disseminated (13).**
RER 25.2 National authorities, civil society and other stakeholders supported in promoting policy/social dialogue to identify policy options and improve the decision-making process to expand social and financial protection in health.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
25.2.1	Number of countries in which direct technical cooperation has been provided to promote and organize policy/social dialogue in health	4	10	**10**	**Bolivia, Brazil, Dominican Republic, Ecuador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, and Peru.**
25.2.2	Concept framework and guidelines to organize policy/social dialogue available and disseminated to countries	Concept framework and guidelines developed and pilot tested in 2 countries	Concept framework and guidelines disseminated to at least 10 countries	**Concept framework and guidelines disseminated to 18 countries**	**Book *Diálogo Social como herramienta para la Extensión de la Protección Social en Salud*, published and disseminated to the Spanish and Portuguese speaking countries of Latin America in hard copy and through PAHO's web.**
25.2.3	Number of entities and/or fora for policy/social dialogue functioning at country level with technical support from PAHO	6	12	**12**	**Bahamas, Bolivia, Brazil, Chile, Dominican Republic, Ecuador, El Salvador, Haiti, Guatemala, Mexico, Nicaragua, and Peru**

RER 25.3 Governmental authorities supported and their institutional, organizational, and human capacities strengthened for formulating and implementing public policies, plans, strategies and interventions to improve universal and equitable access or to expand coverage to priority population groups.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
25.3.1	Number of countries in which the process of harmonizing concepts, methodologies and data on health expenditure between MOH, Social Security, Central Bank, Ministry of Planning/Finance and the National Statistics Institute has been institutionalized	13	23	**21**	**Brazil, Ecuador, Mexico, Peru, Chile, Colombia and Costa Rica have advanced significantly in the implementation of Health Satellite Accounts according to SNA93** **Countries from ECCB (8) and MERCOSUR (7) advanced in harmonizing health expenditure data throughout subregional technical cooperation.** **The Dominican Republic advanced in the harmonization process and it's Central bank has a leadership role in the regional effort.**
25.3.2	Concept framework and guidelines for producing Satellite Health Accounts compatible with SNA93 available and disseminated to countries	Concept framework and guidelines developed and agreed upon by experts	Concept framework and guidelines disseminated to at least 10 countries	**Concept framework and guidelines finalized and disseminated at the regional level**	**Agreements and partnerships with ECLAC, ILO, ISSA, OISS, the Interamerican Conference of Social Security, several Central Banks, Social Security entities and national Statistics Institutes were established to improve the quality of data on health economics/ financing and social protection, generated according the UN standards- SNA93.**
25.3.3	Number of countries in which direct technical cooperation has been provided to improve the capacity for analyzing and using economic, financial, and expenditure information related to health in the decision making process (accumulated)	8	16	**18**	**8 Eastern Caribbean countries, Argentina, Bahamas, Brazil, Chile, Colombia, Ecuador, El Salvador, Mexico, Paraguay, and Uruguay.**
25.3.4	Number of countries and territories in which direct technical cooperation has been provided to formulate and implement public policies, plans, strategies and interventions to expand social and financial protection in health	16	24	**26**	**13 countries/territories: Bahamas, Bolivia, Chile, Dominican Republic, Ecuador, Mexico, Netherland Antilles, Panama, Peru, Trinidad and Tobago, and Uruguay, are in the process of setting up National Health Insurance schemes based on the principles of equity, efficiency and social protection.** **3 countries (Columbia, Costa Rica and Mexico) started or strengthened the implementation of Integrated Social Protection Systems (of which social protection in health is a**

					component). **11 countries/territories (Argentina, Belize, Brazil, British Virgin Islands, El Salvador, Haiti, Jamaica, Paraguay, Peru, St. Lucia and Venezuela) have started or have continued the implementation of social protection in health schemes for vulnerable groups of population.** **5 countries (Argentina, Bolivia, Guatemala, Honduras, and Nicaragua) have carried out strategies to extend social protection in health for mother and child populations.**
25.3.5	Analysis of advantages and disadvantages of alternative strategies, schemes and modalities to extend social protection in health to the maternal and infant population available and disseminated to countries	Concept framework developed and agreed upon by experts	Analysis completed and disseminated to at least 20 countries	**Analysis completed and disseminated to all countries**	**The book "Social Protection in Health Schemes for Mother, Newborn and Child populations: Lessons learned from LAC Countries" was published, with a comparative analysis of seven schemes currently in place in the Region, and is available in hard copy and the internet.** **Nearly all of the countries in the Latin American and Caribbean Region, in addition to the United States and Canada, participated in the Regional Forum on Extension of Social Protection in Health for Mother and Child Populations, carried out in 2006.**
RER 25.4 Reorganization of Social Security organizations supported, and their institutional, organizational, and human capacities enhanced to identify, design and implement schemes, programs and mechanisms to extend benefits and to integrate actions with other public entities, particularly the MOH.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
25.4.1	Number of countries in which social security organizations have undergone reorganization, extended their coverage and integrated their actions with other public entities	2	5	**8**	**Belize, Colombia, Costa Rica, Dominican Republic, Panama, Paraguay, Peru, and Uruguay**
25.4.2	Planning tool to support the incorporation of priority disease-specific programs (such as HIV-AIDS, Tuberculosis and Immunization) into the portfolios of entitlements of Social Security organizations available and disseminated to countries	Concept framework develop	Planning tool developed and disseminated to countries of at least 2 subregions	**Planning tool developed and disseminated in 3 Subregions**	**Planning tool developed and disseminated to countries in Central America, Andean Subregion and Southern Cone.** **Regarding HIV/AIDS, research on rights and entitlements of PLA among social security beneficiaries in Central America was carried out, including the elaboration of a case study for Panama.** **Guaranteed portfolios of entitlements defined for Epidemic Respiratory Diseases and Pandemic Influenza.**
25.4.3	Number of subregional entities	1	2	**5**	**AISS, CISS, CIESS, COCISS, OISS**

	conformed by Social Security organizations supported to define and implement horizontal cooperation strategies				
RER 25.5 Design and implementation of guaranteed portfolios of entitlements developed, and promoted within the framework of social/financial protection in health.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
25.5.1	Number of country professionals and advisors from PAHO and other international cooperation agencies trained to design and implement guaranteed portfolios of entitlements	15	60	**74**	**59 country professionals were trained on the development and implementation of guaranteed portfolios of entitlements in workshops held in Paraguay (36 participants) and Colombia (23 participants).**
25.5.2	Number of countries and territories in which direct technical cooperation has been provided to formulate and implement guaranteed portfolios of entitlements	3	7	**7**	**Argentina Colombia, Chile, Ecuador, Panama, Paraguay, and Uruguay: during two workshops, countries received intensive training on the development and implementation of portfolio of entitlements, including for specific conditions such as Epidemic Respiratory Infections and HIV/AIDS, among others.**
25.5.3	Number of countries that have implemented new or improved guaranteed portfolios of entitlements	3	8	**10**	**Argentina, Aruba, Bahamas, Colombia, Chile, Ecuador, Dominican Republic, Panama, Paraguay, and Uruguay**
RER 25.6 Partnerships and alliances established to strengthen national and subregional efforts for building bridges between research and the policy-making in extension of social protection in health.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
25.6.1	Number of peer-reviewed research projects jointly coordinated by researchers and policy-makers supported by PAHO and partners completed and with results disseminated	5 ongoing	5 completed	**5 completed**	**Argentina, Brazil, Colombia (2), Jamaica**
25.6.2	Number of strategies/ interventions to extend social protection in health implemented based on results of research supported by PAHO and partners	0	12	**12**	**Argentina: the Governments of the Province of Buenos Aires and of the 8 municipalities analyzed in the research project established a process of change and review of the strategies and institutional rules for the implementation and monitoring of the Public Health Insurance Scheme and the policies on PHC, at the provincial and municipal levels.** **Brazil: the project was developed jointly with the Executive**

					Secretary of the ministry of heal, and it influenced significantly the Regional Health Plan for the Amazon, published in 2006. **Colombia: the research findings informed the issuance of the Circular 006/Secretary of Health of Bogota aiming at overcoming the barriers to the access for the displaced population.** **Jamaica: the results of the research generated the incorporation of programs for access to drugs for adults and people with chronic diseases, and the inception of public debate on the review of the copayments in PHC.**
25.6.3	Concept framework, research protocol and comparative studies completed to identify the full range of strategies/schemes for extension of social protection in health existing in Latin America and the Caribbean and their advantages/disadvantages	Concept framework and research protocol developed	5 comparative studies completed and disseminated to at least 20 countries	**6 studies completed and disseminated**	**Comparative analysis of the Social Security Institutions' benefits plans was carried out in the six countries of the Andean region (Bolivia, Chile, Ecuador, Colombia, Peru and Venezuela) based on information provided by the countries. The purpose of the analysis is to devise ways to extend social protection in health for the workers that migrate back and forth between these countries. The same analysis has begun for the MERCOSUR countries.** **Policy briefs, comparative case studies and other publications elaborated by PAHO have been used in national policy debate and to guide policy implementation in Bahamas, Bolivia, Colombia, Dominican Republic, Ecuador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru, and Uruguay.**

Lessons Learned:

- Huge inequalities in income and wealth and major disparities in access to essential public infrastructure and services, along with the absence of agreement among a broad spectrum of social and political actors upon a national development strategy, lie beneath the worse-than-expected health results in many LAC countries. Access to health care in LAC countries strongly depends on health systems' architecture –their degree of segmentation and fragmentation- as well as on a broad set of social and economic factors that are well beyond health sector.
- It is possible to position social protection in health high in the countries' political agendas. Our work indicates that with sustained effort and support to social dialogue, sound information and knowledge development, strong advocacy and capacity building, it is feasible to help the countries to change course and put themselves on the track to universal and more equitable access to health care.
- In ethnically diverse countries, and/or those with geographically isolated settlements, removing the economic barrier may not be enough to eliminate exclusion and grant access to health care. Further efforts must be made to reduce or eliminate cultural and geographic barriers.
- A key issue is to help the national health authority to overcome the difficulty on summoning and line up the stakeholders and social actors to support and sustain the efforts aimed at achieving universal access to health care and providing equitable health access for all.
- The development of skills in Economic evaluation/cost effectiveness is fundamental for the development of a better informed decision process at the country level.

Financial Execution

AoW: **HFS- Health Financing and Social Protection**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	3,677,800	3,300,357	3,270,100	99%
Other Sources	3,847,000	3,213,794	2,268,100	71%
Total (RB & OS)	**7,524,800**	**6,514,151**	**5,538,200**	**85%**

26. HEALTH INFORMATION, EVIDENCE AND RESEARCH POLICY (IER)
Overall Achievement level: 91%

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.

ACHIEVEMENT OF GOAL:
PAHO/AMRO has reorganized the work plan of its Research Promotion & Development Unit and aligned it with WHO's in response to calls to strengthen national health research systems, health research governance and policy, and the use and production of research to inform policy. We have gained momentum and created awareness on these issues, and specific strategies, tools, and monitoring and evaluation systems are being implemented.

PAHO OBJECTIVE:
To improve the availability, quality, timely analysis and use of health information at country level; to strengthen the evidence base and analytical capability at national, 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.

ACHIEVEMENT OF PAHO OBJECTIVE:
In response to the Mexico Declaration 2004 issued at the Ministerial Summit on Health Research, WHO's ACHR and its *Subcommittee for the Use of Research Evidence* prepared a series of initiatives and tools to strengthen the use and production of research evidence that informs health policies in a systematic way. PAHO/WHO reorganized its Research Promotion & Development Unit (HSS/RC), incorporated it into the Health Systems Strengthening Area, and aligned its work plans with WHO-HQ's Department of Research Policy and Cooperation (RPC). Work between PAHO/AMRO and WHO-HQ is coordinated and includes joint activities around: the ACHRs; the Evidence Informed Policy Networks (EVIPNet) that were launched in the Region in July 2007 with 10 country offices; the strategies to progress the International Clinical Trials Register Platform (ICTRP) and trial registration in the Region; the evaluation and preparations to implement the Guidelines for WHO Guidelines regionally, and the harmonization and coordination around WHO Collaborating Centers.
During this time HSS/RC has done capacity building activities with technical officers and staff from PAHO/AMRO and Member States, worked towards strengthening national health research systems and the systematic use of quality ethical research in decision making processes, as well as developing sustainable partnerships and networks.

RER 26.1 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.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
26.1.1	Number of countries with adequate health-information systems in line with PAHO recommended international standards. This includes improvement of registration systems and vital	Number of countries currently meeting the standards	5 additional countries meeting the standards	**Achieved**	**WHO-ICTRP Portal launched in 2007; available to all countries. The standards for WHO-ICTRP compliant registers were developed between 2006 and 2007, and a draft proposal for the development of a compliant Primary Regional Register was presented in November**

	statistics				**2007. The portal http://www.who.int/ictrp/search/en/index.html became available in 2007. PAHO participated in ICTRP consultations.** **PAHO provided technical cooperation for the development of ICTRP Compliant Registers. Cuba launched its National Clinical Trial Register in (Nov 2007, as announced at the PASB) and we are working with existing registers like Latinrec, to scale them up.**
26.1.2	Number of countries using data no older than 3 years for monitoring MDGs health-related indicators	Number of countries meeting criterion for the 2005 PAHO publication	At least 10 additional countries meeting the criterion for the 2007 publication	**Achieved**	**The countries prepared and sent the updated information using the core data. The database is disaggregated at subnational level.** **http://www.paho.org/english/dd/ais/BI_2007_ENG.pdf**
26.1.3	Number of countries using disaggregated information at subnational levels	Number of countries using data at first level of disaggregation (State, Province)	At least 60% of the countries using data at first level of disaggregation	**Achieved**	**A total of 9 countries have their databases disaggregated at the subnational level.** **All the countries of the Region sent their basic data and information, the most updated possible, for the preparation of the 2007 basic indicators brochure.** **http://www.paho.org/english/dd/ais/BI_2007_ENG.pdf** **http://www.paho.org/English/SHA/coredata/tabulator/newTabulator.htm.**
26.1.4	Number of countries using disaggregated information at subnational levels	Number of countries using data at first level of disaggregation	At least five countries using data at second level of disaggregation	**Achieved**	**A total of 9 countries have their databases disaggregated at the subnational level.** **All the countries of the Region sent their basic data and information, the most updated possible, for the preparation of the 2007 basic indicators brochure.** **http://www.paho.org/english/dd/ais/BI_2007_ENG.pdf** **http://www.paho.org/English/SHA/coredata/tabulator/newTabulator.htm**

RER 26.2 Availability of knowledge and timely evidence at the country and the Bureau levels, by analyzing, consolidation and publication of existing evidence and facilitating knowledge generation in priority areas for health decision-making.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
26.2.1	Annual update of PAHO and countries core health data and health situation analysis (HAS) disseminated widely	Publication in time for each Directing Council meeting	Publication in time for each annual Directing Council meeting	**Achieved**	**This was fully achieved. Health in the Americas, 2007 Edition was prepared and presented at the Pan American Sanitary Conference 2007 This publication present all the country reports updated.**. http://www.paho.org/English/DD/PUB/HIA_2007.htm
26.2.2	Number of PAHO and country reports in which new evidence is published to redirect health programs or reinforce existing priorities is evident using methodologies and tools proposed by PAHO	Number of publications meeting criterion in the biennium 2004-2005	Number of publications in the biennium 2006-2007	**Not achieved**	**The Baseline was established** **.**
26.2.3	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	**Achieved New publication approved by Directing Council in 2007**	**HSS/RC contributed to the development of Health in the Americas 2007, and authored a section (with BIREME) now available in electronic and print format.**

RER 26.3 Governance and functions of the National Health Research Systems strengthened in order to respond to health system development.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
26.3.1 a)	Regional research agenda developed in cooperation with PAHO/WHO Collaborating Centers is approved by Research Advisory Committee and Governing bodies	Research priority agenda available in PAHO (1997-2000)	A Regional Research Agenda in place for 2006-07	**Not achieved**	**The regional research agenda is being developed. Several countries have defined their health research agenda**
26.3.1 b)	Regional research agenda developed in cooperation with PAHO/WHO		At least 5 countries	**Not achieved.**	**The Regional Research Policy is being developed**

	Collaborating Centers is approved by Research Advisory Committee and Governing bodies		using the Agenda as a framework to produce their National Research Agendas		
26.3.2	At least one collaborative project approved each year, involving countries from each of the 4 subregions and at least one key country	Multicenter projects financed in 2005	One Collaboration Research Project financed each year	**Achieved**	**During 2006-2007 ongoing grants were administered and the following projects completed: 2 multicenter research studies focusing on mental health (4 countries) and Tobacco (2 countries); 2 special projects; 4 capacity building projects; 9 thesis; 3 Primary Care projects; and 8 Millennium Development Goal projects.**
26.3.3	At least two thematic research networks organized and in operation	0	Two thematic research networks financed and implemented.	**Achieved**	**PAHO was engaged in the development of the Inter-Ministerial Network for Research and Learning (RIMAIS), that was approved by the Ministers of Health of Latin America. Its work plan is being developed with technical support from HSS/HR and HSS/RC.** **The Evidence Informed Policy Networks was launched in July 2007, with HSS/RC being its Secretariat and the Unit Chief co-chairing the Global Steering Group for the whole network (that includes Asia and Africa).** **HSS/RC contributed towards a joint meeting of the Iberoamerican Cochrane Network and the Latin American branch of the International Clinical Epidemiology Network—LatINCLEN. These two networks are committed to capacity building, in the Region, on the use of scientific research evidence. PAHO has facilitated high level meetings with INCLEN and the University of West Indies aimed at developing and supporting a cadre of qualified researchers (i.e. epidemiologists, biostatisticians,**

					health economists, research project managers and social scientists) that will support evidence informed policy processes in the Caribbean
26.3.4	PAHO/WHO Collaborating Centers participating in the development and execution of the National Health Research Agendas	Numbers operating at the end of 2005	Four more Collaborating Centers working with the countries on their Research Agenda	**Achieved**	**New collaborating centers have been designated. By Dec 2007 the Region had 202 Collaborating Centers.**

RER 26.4 Networks and partnerships established or strengthened that improve international cooperation for health research.
The HSS/RC Unit underwent important changes and has quickly harmonized its work plans with WHO realigning its technical cooperation to respond to the Mexico Declaration challenges. WHO and HRR/RC has worked in coordination to restructure the communications and processes involving WHO Collaborating Centers. The Grants Program was halted and its continuation is being assessed within the framework of a regional research policy. Intense work has been carried out engaging with networks and establishing partnerships aimed at strengthening national health research systems, health research governance, and the systematic use of research evidence into policy.

Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
26.4.1	Indicators Network of Science and Technology on Health (RICTSAL), organized and in operation	Letter of agreement with the Indicator Network of Science and Technology signed in 2003 and 2005	At least 8 countries participating in the network	**Partial**	**The RICTSAL has not met again and the Unit focused on the development of PAHO's Research Policy for which IRDIS (the Health Research Indicators Initiative) was presented to the 40th ACHR. The designated technical officer responsible for RICTSAL work is no longer supporting HSS/RC and we are awaiting the allocation of skilled staff that will support this work. Contacts were made with the Carlos III Institute (Spain) to contribute towards this initiative.** **Contributions to Health in the Americas include an evaluation of scientific production in the Region, with support from BIREME.**
26.4.2	Indicators Network of Science and Technology on Health (RICTSAL), organized and in operation	Establish-ment of Science & Technology networks in	At least 8 countries participating in the network	**Establishment of Science & Technology networks in twelve (12)**	**The 12 countries are: Argentina, Brazil, Chile, Colombia, Cuba, Ecuador, Mexico, Panama, Paraguay, Peru, Portugal, and Venezuela.** **After the SCIENTI network met in Salvador,**

		five (5) countries in 2004		**countries**	**Brazil (2005) the Secretariat was assumed by Colombia, and PAHO's coordination by BIREME. The network is functioning (www.scienti.net).** **A Latin American Conference on Science and Innovation will take place in April 2008, and is being organized by PAHO, the Global Forum, COHRED, The Brazilian Ministry of Health, the Mexican Ministry of Health, and NICASALUD; the purpose of the meeting is to guide the strengthening of health research systems in Latin America.**
26.4.3	Information on networks of national operational researchers available	Number of national task forces operating at the end of 2005	Five (5) new networks of research collaborators	**Exceeded**	**Activities aimed at aligning networks contributions to Regional workplans have been carried out with LatINCLEN, INCLEN, the Iberoamerican Cochrane Network, US Cochrane Center, Canadian Cochrane Center, Francophone Cochrane Network, the Latin American Forum of Ethics Committees for Health Research, TDR, selected WHO Collaborating Centers and Networks of CCs, the James Lind Library, the James Drane Institute, and several funding and technical cooperation agencies.**
RER 26.5 Capacity for integrating bioethics in health policy/programs increased at national level.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
26.5.1	At least 75% of the countries have commissions or national committees in bioethics	Number of Committees in 2005	Number of Committees	**Achieved: 8 Functional National Committees**	**Argentina, Bolivia Brazil, Colombia, Costa Rica, Dominican Republic, Mexico, and Peru** **Source: PAHO Program of Bioethics.**

Lessons Learned:

- Aligning initiatives to strengthen research capacity and have indicators and monitoring tools has facilitated progress, efficiency, and reaching common goals. The ACHR meetings have been an excellent opportunity to identify common interests, synergies and opportunities to jointly develop solutions.
- Framework agreements and statements by health authorities have greatly contributed to guide workplans (e.g. Mexico Ministerial Summit; Declaration of Salvador; WHA. These have led to Guidelines for Guidelines, ICTRP, EVIPNet, etc.)
- Synergic work between WHO's ERC and PAHO's ERC has helped cement the Regional ERC and is an efficient way of working.
- Regional offices benefit of the coordination by WHO-HQ; WHO-HQ benefits of the contributions, opportunities for collaboration, and resourcing the Regions can bring. This model has allowed greater involvement of local experts in projects, and facilitates adherence. For example, in EVIPNet Americas we have been able to relay on local experts to guide and support the process, offering opportunities and strengthening collaborative systems.

Financial Execution

AoW: **IER- Health Information, Evidence and Research Policy**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	14,457,500	13,354,464	13,282,800	99%
Other Sources	6,087,000	3,684,641	1,979,300	54%
Total (RB & OS)	**20,544,500**	**17,039,105**	**15,262,100**	**90%**

27. EMERGENCY PREPAREDNESS AND RESPONSE (EHA)
Overall Achievement level: 97%

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

ACHIEVEMENT OF GOAL:
PAHO has contributed substantially to the achievement of the goal of reducing the impact of disaster on the health and health systems in Latin America and the Caribbean. Thanks to more than 30 years of investment in strengthening the Ministry of Health of each Member Country to deal effectively with emergency situations and in building capacity of the health workforce today countries are better prepared to deal with such events.

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

ACHIEVEMENT OF PAHO OBJECTIVE:
PAHO has been able to strengthen the capacity of the countries of Latin America and the Caribbean to prepare for disasters. Although today not all countries are performing at the same level, the majority has developed and implemented policies, programs and partnerships to improve the capacity to prepare, respond and mitigate the risks to health during crises (see progress report on national and regional health disaster preparedness and response presented to 47th Directing Council of the Pan American Health Organization—www.paho.org/english/gov/cd/CD47-34-e.pdf).

RER 27.1 Improved disaster preparedness at country level.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
27.1.1	Human resources trained in disaster preparedness	Training in six countries	Training in ten countries	**Training in 28 countries**	**6 CA: El Salvador, Panama, Costa Rica, Honduras, Guatemala, Nicaragua.** **9 SA: Argentina, Uruguay, Paraguay, Bolivia, Chile, Brazil, Ecuador, Colombia, Peru.** **13 CAR: Cayman Islands, Anguilla, Barbados, Bermuda, Jamaica, Trinidad, Grenada, St. Vincent, St. Lucia, St. Kitts and Nevis, Antigua, Guyana and British Virgin Islands.**
27.1.2	Technical and multimedia materials, including print and electronic resources, developed, updated, and distributed	One new publication each year	Four new publications	**Five new publications**	**1. CDROM, *Biblioteca virtual de salud y desastres*** ***2. Preparativos en salud, agua y saneamiento para la respuesta local ante desastres*** **3. *El desafío del sector de agua y saneamiento en la reducción de desastres: mejorar la calidad de vida reduciendo vulnerabilidades***

					4. ¿Cómo reducir el impacto de los desastres en los sistemas de agua y saneamiento rural? ***5. Guía para la Vigilancia y control de la calidad del agua en situaciones de emergencia y desastre.***
27.1.3	Multiple web sites maintained, improved, and updated, reflecting latest information on vulnerability reduction activities in the Region	One new website for regional response team	Two new website for response and one for mitigation	**Two new websites for response and one for mitigation**	**PAHO Central American Disaster webpage** **Web site for the ECHO Project in response to the Bolivia Floods 2007** **Safe Hospital Website**
27.1.4	Partnerships and alliances with others organizations and institutions working in disaster preparedness improved and/or increased	Three MOU with training institutions	Five MOU's with academic institutions.	**Achieved**	**MOU or LOA were signed with the *Facultad Latinoamericana de Ciencias Sociales* (FLACSO), University of West Indies, University of Wisconsin, CRID (Regional Disaster Information Centre) and *Instituto Nacional de Defensa Civil* of Peru**

RER 27.2 Improved level of awareness of disaster mitigation issues and their link to development on the part of health facilities and water systems.

Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
27.2.1	Technical materials on disaster mitigation developed and distributed (in print and electronically)	Two manuals on mitigation	One new manual on functional mitigation	**Two new manuals on functional mitigation**	***Hospital Seguro Frente a Inundaciones*** **Safe hospital DVD** http://www.imss.gob.mx/curso/hospitalseguro/
27.2.2	Disaster mitigation measures incorporated into building codes in the Region	No mechanism of enforcing mitigation measures	Two new hospitals will have check consultants to ensure mitigation measures are included	**Two health facilities**	**Richmond Home (Grenada)** **St. George's new wing (Grenada)**
27.2.3	Vulnerability analysis of priority health facilities and water systems promoted	One manual available	Perform two vulnerability assessment	**Two vulnerability assessments were performed**	**Princess Margaret (Dominica)** **Belleview (Jamaica)**
27.2.4	Country participation in regional and	Ten DIMAG	Twenty	**Fifty DiMAG**	**DiMAG roster**

	subregional activities	(disaster mitigation advisory group) members	DIMAG members	**members**	

RER 27.3 Countries of the Region efficiently manage the aftermath of disasters.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
27.3.1	Dissemination of and training in the new Logistics Support System (LSS) software; LSS software adopted by an increased number of humanitarian agencies and countries	Three countries adopted SUMA as national policy	One UN agency to use LSS/SUMA	**One UN agency used LSS/SUMA**	**UNDP started utilizing LSS/SUMA following the floods in Mexico.**
27.3.2	Support provided for the design and implementation of emergency health projects, together with the timely mobilization of financial and human resources	Three countries received Disaster response team assistance	Five countries to receive assistance from response team	**Seven countries received assistance from the response team**	**The following countries received Health Disaster Response Team assistance: Jamaica, Nicaragua, Suriname, Peru, Mexico, Bolivia, and the Dominican Republic.**
27.3.3	Coordination among agencies and government institutions improved	One MOU with CDERA	Two MOU's with another regional/UN agency.	**Two MOU**	**Agreements with: the *Comunidad Andina de Naciones* (CAN) and the International Strategy for Disaster Reduction (ISDR).**
27.3.4	Timely deployment of human resources in case of emergencies	TEAM deployment within 3 days of a disaster	Pre position teams in countries before a hurricane	**Teams were prepositioned before hurricanes**	**Staff was prepositioned before a hurricane passed in: Dominica, Belize, St. Lucia, Jamaica, Honduras and Nicaragua.**

RER 27.4 Improved partnerships with other organizations and awareness about health disaster preparedness improved within PAHO.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
27.4.1	PAHO response to disasters improved	Emergency operation room in PAHO	Three countries will have an Emergency	**Five countries have an Emergency Operation**	**Jamaica, Suriname, Guatemala, Trinidad and Tobago and Peru**

			Operation room	**Room**	
27.4.2	Disaster mitigation measures incorporated in other unit/division projects	none	Four works with three divisions	**Two works with two divisions**	**Efforts were made to work with other divisions and the following concrete results were achieved: Work together with Health Services-Health System Strengthening towards the Safe Hospital resolution/ GSO, and the publication: *Como reducir el impacto de los desastres en los sistemas de agua y saneamiento* that was prepared together with CEPIS. Inter-programmatic efforts will be strengthened in the coming biennium.**
27.4.3	Training materials and publications developed in conjunction with other divisions/units	none	Two manuals to be developed with two other divisions	**Two manuals developed with two other divisions**	***Guía Práctica de Salud Mental en Situaciones de Desastres* (Mental Health Unit)** ***Guía para la vigilancia y control de la calidad del agua en situaciones de emergencia y desastre* (CEPIS-SDE).**
27.4.4	PAHO country offices strengthened in the management of disasters	Eight offices	Fifteen offices will allocate budget for disaster preparedness	**Nineteen offices allocate budget for disasters**	**Argentina, Belize, Ecuador, Bolivia, Colombia, Costa Rica, Nicaragua, Dominican Republic, Jamaica, United Kingdom Overseas Territories, Grenada, St. Lucia, Barbados, St. Kitts and Nevis, Antigua and Barbuda, Dominica, Suriname, Paraguay and Peru.**
27.4.5	Improved partnerships with other disaster-related institutions at all levels	Three regional meetings participation	Six regional and subregional meetings participation	**Participation in fourteen regional and subregional meetings**	**CDM –CDERA (2006-07), ECHO Caribbean partnership meeting (2007 two), FAHUM (2006-2007) REDLAC; Interhands; CEPREDENAC (2006-2007); ECHO Central American partnership meeting; *Organismo Meteorológico Internacional* (Peru); OCS in Haiti; AECI in Guatemala.**

Lessons Learned:

- The proliferation of global actors working in disaster reduction and response and the growing media focus on adverse events has translated into the internationalization of a number of emergencies that otherwise might have been handled locally.
- AMRO must expand its preparedness efforts from a frequent focus on imminent or seasonal hazards to preparedness of Member States for other issues such as pandemic influenza.
- The rapid assessment of post-disaster health needs continues to pose information management challenges.

Financial Execution

AoW:	**EHA- Emergency Preparedness and Response**			
	Budget	**Allotted**	**Expenditure**	**% Implemented**
Regular Budget	1,597,600	2,032,176	2,005,500	99%
Other Sources	27,175,000	30,677,251	20,830,100	68%
Total (RB & OS)	**28,772,600**	**32,709,427**	**22,835,600**	**70%**

Special note:

- 1) The CDROM, *Biblioteca virtual de salud y desastres* is available in Spanish, English and French (English name: "Health Library for Disasters") . 2) *El desafío del sector de agua y saneamiento en la reducción de desastres: mejorar la calidad de vida reduciendo vulnerabilidades* is available in English: The Challenge in Disaster Reduction for the Water and Sanitation Sector: Improving Quality of Life by Reducing Vulnerabilities. 3) The other three publications are part of an extra budgetary grant addressing specific Andean Region issues and therefore only available in Spanish. In addition the specific needs of the Caribbean have been taken into account in several publications: 1) in collaboration with ICRC: Management of dead bodies after disasters: A field manual for first responders. 2) The Safe Hospitals DVD (mentioned in 21.2.1.) was translated into English and adapted for specific use in the English speaking community.

- The demand of cooperation has and will continue to increase in the area of disaster risk reduction. The Area of Disaster Preparedness has elaborated the following new strategy: a new five-year work in collaboration with some donors, Member States and agencies (Partnership for Health Preparedness). New donors have been approached. Spain has indicated that they will provide supplementary funding to this area for 2008-2009. WHO has agreed to share some of the voluntary contribution some will go towards SO5 (strategic objective for reducing health consequences of disaster and crisis).

28. COUNTRY COOPERATION LEADERSHIP AND COORDINATION (CCL)
Overall Achievement level: 73%

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.

ACHIEVEMENT OF GOAL:
Goal was achieved through great interaction of all levels of the Organization with the health entities of the subregional integration processes.

PAHO OBJECTIVE:
To increase the capacity of the health sector in its steering role to address national health priorities in the framework of subregional, regional, and global collective agreements.

ACHIEVEMENT OF PAHO OBJECTIVE:
Intense communication and exchange of information has been sustained with the subregional integration bodies in all subregions. As a result, PAHO/WHO subregional level for TC has been formalized.

CSU developed managerial guidelines for the subregional BPBs and facilitated three subregional meetings to analyze and define the respective subregional TC programs.

CSU and GPP prepared the chapter on subregional integration processes for Health in the Americas.

RER 28.1 Implementation of strategies to increase national capacity to manage and coordinate national and international cooperation to advance national health development.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
28.1.1	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	21	**8**	**PAHO/WHO has increased its leadership role in supporting national coordination of international cooperation for the health sector, particularly in priority countries. The target was not achieved, however it is convenient to highlight the following: PAHO/WHO representations (PWR) participates in activities sponsored by UN Country Teams devoted to improving coordination among UN Agencies and with National counterparts and NGOs; thematic groups on HIV/AIDS, as well as gender and health thematic groups. In the last biennium a considerable amount of time and resources was devoted to coordination on avian flu and preparation for Pandemic Influenza, among others.**

					Participation of PWRs in these coordination activities is time consuming but important for consensus building, use of common approaches and sharing of technical resources is fostered **PAHO has worked towards strengthening of Health International Relations Office (HIRO), but still more has to be done in the Caribbean subregion and central America.** **Regarding HIRO, there were two sessions organized for MOH staff from BAH, BAR, and VEN. Meetings with staff from Regional level (Governing Bodies, External Relations, Planning and Programming, Country Support, Finance, among others) were held. These meetings allowed participants to understand better how the Organization operates and about key internal processes which could help them at the ministry of health to improve their countries' participation in the Regional processes and to strengthen the relationship with the Organization. These sessions were organized at the request of Member States.**
28.1.2	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	**21**	**Attachments for national staff in offices of international relations in ministries of health were organized and successfully carried out, emphasizing resource mobilization and enhancement of Member States participation in PAHO/WHO Governing Bodies.** **The International Residency Program has been completely overhauled to include as a paramount learning objective particular responsibility of the National Authorities with respect to the coordination and monitoring of external partners.** **A particular effort is being carried out to strengthen the Ministry of Health of Bolivia with respect to international cooperation for national health development.**
28.1.3	Number of countries with new ministers and selected national and subregional health authorities briefed on PAHO's current policies and procedures within six months of entry on duty	20	35	**4**	**Orientation sessions have been arranged for 4 Ministers (Brazil, Costa Rica, Dominican Republic and Suriname), the Executive Secretary of the ORAS-CONHU. Support was also provided to the DD Office in the orientation of the USMB Health Commission (US Section), as well as other provincial or departmental level health authorities (Argentina, Mexico).** **In some countries in which there has been a change of ministers, orientation could not be carried out due to unavailability of ministers (busy agenda).** **Nevertheless, PWRs always brief new Ministers at Country level.**

28.1.4	Number of PWRs participating in staff development programs to strengthen their support to national authorities in coordinating international cooperation	8	21	**29**	**Related training activities carried out as part of the yearly Subregional Manager's meetings, which are chaired by the Director. Both at Regional and Global level there was an important emphasis played on development of competencies for coordination of international cooperation. The 4th Global Meeting of heads of WHO Country Offices (in which all our PWRs took part) devoted a considerable time to develop these competencies and understand the key issues regarding alliances and partnership and its coordination. Similarly, the Regional annual managers meeting assigned a considerable amount of time for training on these coordination issues. These activities definitely resulted in improved coordination for international cooperation at Country level, which external evaluations (e.g. MOPAN) and the Health Cluster coordination in a couple of emergency crises have confirmed.**
28.1.5	Number of countries with national staff trained by PAHO on management of international cooperation and negotiation	8	21	**4**	**As part of the development programs, workshops on RBM, Avian Flu, Pandemic Influenza, Global Fund initiatives were held, to mention some examples. Advocacy should be increased in the future to encourage staff from international cooperation offices to come to PAHO for training.**
RER 28.2 Strengthened strategic country focus for PAHO/WHO technical cooperation programs.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
28.2.1	Policy for Bureau-wide implementation of Country Focus Cooperation (CFC) disseminated to all staff	0	1	**1**	**CCS is the starting point to define priorities and the strategic agenda, which is then used to define the country office program, reflected in the BPB. Most Country programs are now based on the strategic agenda defined by CCS. Hence, all work plans developed for 2008-2009 are aligned with their respective CCS for those countries which already have a CCS.**
28.2.2	CFC best practices shared on Intranet	0	8	**8**	**IKM developed a site for this purpose.**
28.2.3	Number of Member States for which a Country Cooperation Strategy (CCS) has been developed	14	28	**22**	**5 CCS exercises will be carried out in 2008. Some of the pending CCS could not be carried out due to political situation of changing government.**

28.2.4	Number of countries with BPBs that reflect CCS priorities, with appropriate technical and financial resource allocation	5	28	**20**	**There are still more CCS to be developed.**
28.2.5	Number of countries with support for CCS priorities explicitly included and resourced in regional BPBs	0	20	**20**	
RER 28.3 Strengthened support provided to country offices (in the Key) Countries in the mobilization of resources and implementation of the CCS.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
28.3.1	Percentage of regional technical Areas demonstrating inter-programmatic work with the Key Countries	0.5	1	**5**	**Technical areas have responded very well to the need for inter-programmatic work in key countries. Along 2008 some of these experiences will be documented as best practices.**
28.3.2	Number of resource mobilization proposals developed over the biennium that include one or more Key Countries	8	16	**31**	**There were 31 projects approved for the key countries in the biennium.**
RER 28.4 Implementation of strategies to strengthen health and health-related components of subregional integration processes.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
28.4.1	Number of subregional cooperation strategies developed, implemented, and evaluated.	1	4	**1**	**The multi-country strategy for Eastern Caribbean developed in the previous biennium has been applied in the preparation of the next biennium work plan. The subregional CCS for Central America is still being developed. Similarly a CCS for the Andean subregion is under way.**
28.4.2	Number of subregional intersectoral fora at which there is advocacy promoted by PAHO for health or health-related issues	0	4	**4**	**RESSCAD (health sector meeting for Central America) has consolidated as an interinstitutional and intersectoral forum through discussion of subjects like avian and human influenza or human security, which have a strong multisectoral interest.**

Lessons Learned:

- The CCS process has an intrinsic value that allows a common analytical platform and convergence of priorities for TC from all levels of the Organization. As a product, it provides a medium term strategic framework for TC which contributes to continuity and sustainability, as well as responding better to countries.
- The CCS in the Region constitutes a political commitment which sets the stage for increased collaboration and dialogue with the national counterparts and development partners.
- The methodology developed for the orientation of new PWRs proved to be successful due to the involvement of EXM, Area Manager and Unit Chiefs. CSU coordinated the orientation along with HRM/SD.
- Each PWR is given the opportunity to expand his/her area of expertise and make optimal use of the knowledge and experience acquired.

Financial Execution

AoW: **CCL- Country Cooperation Leadership and Coordination**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	22,696,100	22,792,882	22,033,500	97%
Other Sources	4,010,000	2,230,911	1,598,500	72%
Total (RB & OS)	**26,706,100**	**25,023,793**	**23,632,000**	**94%**

29. KNOWLEDGE MANAGEMENT AND INFORMATION TECHNOLOGY (KMI)
Overall Achievement level: 75%

GOAL:
To bridge the Know-Do gap in public health information and knowledge in the Americas.

ACHIEVEMENT OF GOAL:
Generally achieved with the improvement in the Equity of access to information with initiatives such as HINARI:GIFT: Cochrane Collaboration etc

PAHO OBJECTIVE:
Maintain and strengthen PAHO's capability and enabling information technology to develop knowledge, share it through networking and partnerships, and apply it for improved public health technical cooperation.

ACHIEVEMENT OF PAHO OBJECTIVE:
The objective has been achieved with the introduction of new technological platforms such as SharePoint and the virtual collaboration tools together with methodologies such as Brown Bag lunches: Lessons Learned Systems with Partners and existing networks.

RER 29.1 Organizational policies, structures, culture, and staff skills improved for better collaboration, sharing, learning, and networking.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
29.1.1	PAHO-wide Knowledge Management, IT, Internal and External Communication strategies developed and initiated by end 2006	1	4	**4**	**Completed.**
29.1.2	Country-focused KM observatory created and maintained, conducting market research on current and desired states of public health knowledge and the role of the Bureau in bridging the gap between those two states.	0	1	**0**	**Not Completed due to resource constraint.**
29.1.3	IT Governance Board and KM Advisory Board established by end 2006	0	1	**0**	**Board not established - Document completed and awaiting approval by Executive Management.**
29.1.4	Staff training on knowledge management completed by end 2007	0.1	0.7	**70% of Staff from all subregions completed and HQ**	**Training will continue in 2008-2009.**

29.1.5	Knowledge management technical cooperation services for and among Member States defined by March 2006	0	1	**Achieved**	
RER 29.2 Processes for the creation, capturing, and codification of knowledge improved.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
29.2.1	State-of-the-art information developed on priority international public health topics	6	8	**7**	**Completed in relation to Pandemic. Other areas to be worked. Process started with FCH and NCD.**
29.2.2	Content classification taxonomy defined and in use by end 2006	0	1	**1**	**Completed**
29.2.3	Lessons Learned system established to capture expert knowledge by end 2006	0	1	**1**	**Completed**
29.2.4	Best Practice definition and dissemination system available by end 2007	0	1	**Partially Completed**	**Activities will continue next biennium**
RER 29.3 Target and support the sharing of information and knowledge products and services according to the Organization's priorities and the needs and preferences of PAHO's various clienteles.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
29.3.1	Communities of practice in a number of technical areas functioning and linked to the CCS and MDGs by the end of 2006	3	20	**5**	**Communities of Practice established in relation to MDGS;HIV.**
29.3.2	Collaborative tools such as virtual workspaces and e-fora among Member States fully deployed by end 2007	1	4	**4**	**Completed**
29.3.3	Processes and the technology for improved interoperability of information repository defined and implemented by end 2007	0	1	**1**	**Interoperability completed in relation to WEB.**
29.3.4	Structured targeting of PAHO information and knowledge to thematic, geographic and role-based audiences in Member States by the end of 2007	0	1	**Partially**	**Activities will continue next biennium**
RER 29.4 Mechanisms of effective application of knowledge are strengthened.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
29.4.1	Documentation centers in	0	10	**0**	**Not completed. Model presented to all staff. Discussions held**

	Representations changed into Knowledge Centers by end 2006				**with HRM for the change in job functions, etc. Activities will continue next biennium.**
29.4.2	Virtual Heath Library (VHL) implemented with 4 thematic areas and in countries by the end of the biennium	10	15	**15**	**Completed**
29.4.3	Content management process defined and implemented by the end of 2006	0	1	**1**	**New Web with CMP to be launched in Feb 2008**
29.4.4	Expertise Locator system deployed by end 2006	0	1	**1**	**Completed in 2007**
29.4.5	Travel and Mission Reports system deployed by end 2006	0	1	**1**	**Completed. To be deployed first quarter of 2008**
29.4.6	Marketing plan for PAHO/WHO knowledge products completed and products available via the Internet and other traditional sources	0	1	**1**	**Document Completed**
29.4.7	Information sets available and disseminated on selected priority public health topics by end 2007	6	8	**8**	**Completed**
29.4.8	State-of-the-art information is packaged, purposed, promoted, and delivered according to the Organization's priorities and the needs of its clienteles (i.e., decision makers, health workers, donors, academics, general public, et alia)	0	18	**10**	**Not achieved. Maybe the target was too high and not feasible. The activities will continue in 2008-2009 biennium.**
RER 29.5 Maintain and improve information technologies					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments.**
29.5.1	Percent availability of technology infrastructure during core business hours in headquarters and country offices will be maintained	0.98	0.98	**0.98**	**Completed**
29.5.2	Existing information technology systems maintained	25	25	**25**	**Completed**
29.5.3	Number of field offices where communications bandwidth is improved to meet anticipated needs by end 2007	18	36	**36**	**Completed**

29.5.4	Framework to discover and reduce the degree of redundancy in IT products and services across the Organization is established	0	1	**0**	**Governance mechanism defined. Awaiting Executive Management Approval.**
29.5.5	Definition of IT delivery models with appropriate service level agreements at the regional and subregional level completed	0	1	**1**	**Completed. Service delivery model with UNICC established and operational.**

Lessons Learned:

- More formal project management approaches to be used for large projects.
- Timeframes should be set more realistically in relation to available resources.

Financial Execution

AoW: **KMI- Knowledge Management and Information Technology**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	19,072,100	19,904,343	19,700,700	99%
Other Sources	9,896,000	7,530,817	7,441,900	99%
Total (RB & OS)	**28,968,100**	**27,435,160**	**27,142,600**	**99%**

30. PLANNING, RESOURCE COORDINATION, AND OVERSIGHT (BMR)
Overall Achievement level: 69%

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

ACHIEVEMENT OF GOAL:
The PB 06-07 was implemented in support of these goals

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

ACHIEVEMENT OF PAHO OBJECTIVE:
For the 06-07 Biennium, sufficient resources were mobilized in order to implement the 06-07 Program Budget. The Execution in 06-07 continued the trend to "do more with less", minimizing overhead expenses in support of programmatic implementation in order to achieve results.

RER 30.1 PAHO's strategic directions monitored, evaluated, and integrated into biennial program management cycle.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
30.1.1	Final Evaluation of the Strategic Plan for 2003-2007, reviewed by Governing Bodies	0	1	**0**	**Deferred - this evaluation will not be prepared until 2008.**
30.1.2	Draft strategic plan for 2008-2012, reflecting lessons learned, the new WHO Strategic Plan and PAHO in the 21st Century mandates, approved by PASC	0	1	**1**	**The SP 08-12 was approved by the PASC in October 2007.**
30.1.3	BPB 2008-2009 proposal reflecting the new PAHO Strategic Plan approved by PASC	0	1	**1**	**The PB 08-09 was approved by the PASC in October 2007; its contents were in direct alignment with the SP.**
30.1.4	Annual Report of the Director, midterm reviews, and end-of-2006-7 biennium-performance assessments (global and regional) reveal high level of alignment with Strategic Plan and achievement of regional expected results	0	1	**1**	**Accomplished, although 06-07 final report will only be submitted to GB in 2008.**

RER 30.2 Capacity built for planning and program/project cycle management among managers at all levels both internal and externally to the PASB.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
30.2.1	Updated guidelines, manuals, and toolkits for development and management of the project cycle and for programmatic initiatives available on PAHO homepage	Guidelines available as of end 2005	Increase of 50% in number	**Achieved**	**All relevant planning guidelines and approved document made available on the website and/or SharePoint sites.**
30.2.2	Training programs on situation analysis, strategic planning, program/project development, and Result Based Management completed by selected staff at all levels	About 10% staff trained on current arrangements	50% staff trained	**Partially achieved (50%)**	**Training, formal and informal, conducted during the development of plans for 2008 onward; comprehensive RBM training pending due to adjustments in the managerial model.**

RER 30.3 More effective planning and execution of extra budgetary initiatives (EBIs).					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
30.3.1	Approved new EBIs are aligned with the approved Biennial Program Budget	100% new EBI are reviewed for alignment	Maintain 100% review of new initiatives	**100%**	
30.3.2	Increase in the number of programmatic initiatives	Number as of 31/12/05 (4 as of July 05)	Increase number by 50%	**Achieved**	**The number of programmatic initiatives is 7.**
30.3.3	Decrease in the funds returned to donors annually	Returns as of 31/12/05	Decrease 30% per year	**Achieved**	**Percent decreased from 1% to 0.7%.**
30.3.4	Increased evaluation of EBIs	Number of EBI evaluated as of 31/12/05	Increase by 50%	**Not Achieved**	**Evaluation function was not in place during 2006-2007. The post of evaluation officer Could only be filled towards the end of 2007. As a consequence, activities in this topic were postponed.**

RER 30.4 Evaluation program implemented and capacity building in evaluation facilitated.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
30.4.1	Evaluation tool kit and methodologies adapted and disseminated	0	1	**0**	**Evaluation function was resourced at the end of 2007.**

30.4.2	Country and PASB staff trained to conduct or manage evaluations	No systematic approach in place	Program developed and in implementation	**Not achieved**	**Evaluation function was resourced at the end of 2007.**
30.4.3	Evaluation design and results shared by Intranet and Internet	0	1	**0**	**Evaluation function was resourced at the end of 2007.**
RER 30.5 New Resource Mobilization Strategy defined and implemented.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
30.5.1	Approved corporate strategy for resource mobilization disseminated and plan of action developed for all levels of the Bureau	0	2	**2**	**Accomplished**
30.5.2	The number of institutional or umbrella agreements increased	Number of relevant agreements as of 31/12/05 (**4**)	Increase by 50%	**9 (125% increase)**	New agreements: 1. USAID 2. Canada (Umbrella Agreement) 3. CIDA 4. Spain 5. Sweden
30.5.3	The amount of WHO extra budgetary funding increased by 50% of the total for the 2004-2005 biennium	Received as of 31/12/05	Increase by 50%	**Achieved**	**PAHO received more funds from WHO during the biennium.**
30.5.4	New partners incorporated into agreements with PAHO	Number Partners as at 12/05	At least 3 additional partners have signed agreements with PAHO	**4 additional partners**	1. Pfizer 2. EPS-CDC 3. CSIS 4. Directorate Foreign Affairs International Trade (Canada)
RER 30.6 Risks to the Organization identified and mitigated by controls designed to ensure good corporate governance.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
30.6.1	Recommendations of all audits addressed by Bureau	0	0.9	**1**	**All have been addressed.**

Lessons Learned:

- Disparate planning instruments, such as those in place during 06-07, impede RBM and accountability, and result in double reporting at the regional and global levels.
- Maximum participation and consultation is necessary to develop a Strategic Plan that is "owned" by the entire organization, and that is relevant for planning at all levels.
- The planning and reporting burden on offices must be reduced and simplified so that a greater percentage of technical staff time is spent on implementation, especially at country level.

Financial Execution

<u>AoW:</u>	**BMR- Planning, Resource Coordination, and Oversight**			
	Budget	**Allotted**	**Expenditure**	**% Implemented**
Regular Budget	4,529,400	4,070,949	4,052,100	100%
Other Sources	1,045,000	580,414	579,700	100%
Total (RB & OS)	**5,574,400**	**4,651,363**	**4,631,800**	**100%**

31. HUMAN RESOURCES MANAGEMENT (HRS)
Overall Achievement level: 78%

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.

ACHIEVEMENT OF GOAL:
PAHO has taken several important steps towards improving its management of human resources through best practices: a) developing a biennial HR Plan for each office, b) developing generic position descriptions and standardizing on position nomenclature, c) preparing a clear delegation of authority on all HR matters (which will be disseminated in early 2008), d) adopting a competency-based approach to job descriptions and interviews. As well, several offices conducted a strategic assessment and resource alignment exercise. For the HR department, this resulted in a consolidation of the functions into four main pillars, increasing focus on issuance of clear HR policies and on staff well-being initiatives.

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.

ACHIEVEMENT OF PAHO OBJECTIVE:
PAHO improved its ability to attract and efficiently recruit and hire qualified personnel by implementing an HR Planning process, improving the rigor and thoroughness with which interviews and selections are undertaken, and implementing competency-based position descriptions and interviews. As well, policies were issued on such related subjects as rotation and mobility and the hiring of UN retirees.

RER 31.1 New human resources (HR) management developed and its implementation initiated.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
31.1.1	Comprehensive, HR Strategy that aligns organizational structure and all aspects of the HR management process with PAHO's mission, programmatic priorities and managerial strategy available and sensitization initiated	No new HR Strategy	Approved HR Strategy communicated to all staff and all managers educated about its main principles	**Many aspects of the HR Strategy have been developed. They will be consolidated into one cohesive HR Strategy document in 2008.**	**In 2007, the HR department focused on their own realignment exercise, unusually high numbers of vacant posts in the department, and the development of many policy documents, diverting resources from completing a comprehensive HR Strategy. The HR Strategy document will be completed in early 2008 and disseminated thereafter.**
31.1.2	Organizational units are re-profiled in	Number of	All regional	**Some regional**	**New program planning and resource alignment**

	line with strategic directions of programs, managerial strategy; and plan of action developed to address the gap between required and available skills and competencies at all levels.	regional organizational units having completed the exercise for re-profiling at the end of 2005	organizational units completed re-profiling exercise and plan of action developed to address gaps	**units completed their re-profiling exercises.**	**methodology and tools were developed in 2007. As this was underway, re-profiling exercises were temporarily placed on hold. A new organizational management model was announced in late 2007, against which each regional organizational unit is developing its structure and resource alignment plan for 2008-2009.**
31.1.3	Clearly articulated accountabilities for HR management, at all levels of the Bureau, established and available to managers	No table of accountabilities available	Approved table of accountability for HRM disseminated to all managers	**Table of Accountabilities for HR management has been submitted to the Regional Director for approval.**	**The document will be disseminated in early 2008, following approval by the AMRO Regional Director.**
31.1.4	Competency Model strategically validated and implemented	Competency model in early stages of implementation for recruitment	100% utilization in recruiting, evaluation and learning	**Competency Model has been validated and is used 100% in recruiting. Full integration into the performance evaluation and staff learning plans will occur in 2008.**	**Integration into the performance evaluation system (and resulting learning plans) requires software changes to the online performance evaluation system. Other, more urgent, priorities for the limited IT resources required that this aspect of implementing the competency model be moved to 2008-2009.**

RER 31.2 Streamlining of human resources procedures, and improving information systems and HRM in general.

Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
31.2.1	Degree to which web-based systems are used for recruitment of UN staff	All posts for fixed term assignments are advertised online, but	Increase to 100% usage of web-based system for recruitment	**80% met.**	**Web-based tools are used for both fixed term assignments and for identifying candidates for short-term assignments. Full implementation of the Expertise Locator system will allow identification of greater numbers of potential candidates for short-term appointments.**

		not for short-term assignments.	of UN staff		
31.2.2	Degree to which automated performance evaluation system (ePPES) is employed	Currently 0%, ePPES will be implemented effective January 2006	100% - all PAHO offices	**100% in the Regional office**	**After software modifications are completed in 2008, the software will be implemented in the Country Offices.**
31.2.3	Degree to which other TBD automated processes are complete (e.g., Classifications, Hiring, and Document Management)	Currently 0%	100% - all PAHO offices	**20%. The business process analysis is complete and the automation of the processes underway**	**Implementation of automated processes for hiring of temporary staff and UN staff will be completed in 2008.**
31.2.4	Degree to which action requests are identified, tracked, and efficiently closed	No tracking mechanism is in place at present.	All incoming actions are tracked and monitored and timely action is taken	**80% of actions tracked.**	**Most types of actions are tracked; others are to be added in 2008. They will be more systematically tracked and monitored after recruitment of the Front Desk Clerk in 2008.**

RER 31.3 Effective learning programs that meet staff and organizational needs.

Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
31.3.1	Level of staff satisfaction with development opportunities offered at PAHO	Limited number of development opportunities	Expanded availability of learning programs based on assessed demand	**Target met.**	**The PAHO Learning Plan for 2006-07 was targeted to the PAHO Competency Model. Priorities for technical updating were established through requests from managers and individual office learning plans.**
31.3.2	Level of satisfaction with management and leadership capacity at PAHO reported by staff	Limited leadership and management learning	Leadership and management learning	**Target met.**	**All senior managers of PAHO attended two sessions of the Global Leadership Program. Leadership training was also provided at the PAHO Annual Managers Meeting.**

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
		programs available	programs implemented for all senior and middle managers		
31.3.3	Identified learning paths for reaching competencies	None currently existing, as competency model is in early stages of implementation	Specific learning activities/courses/options cross-referenced to PAHO competencies	**Target met.**	**PAHO's 2006-07 Learning Plan was cross referenced by competency and the courses designed for the priority competencies.**
RER 31.4 Work/life conditions improved and health of staff promoted.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
31.4.1	Implementation of additional new policies, programs, or conditions promoting or enabling healthy lifestyles, including work/life balance, among staff	The principle work/life policy in place today is for flexitime	The number of new policies introduced and operational in the biennium	**Target met.**	**Policies on HIV/AIDS and on Mobility benefits were issued. A new organizational structure of the HR department places emphasis on staff well-being issues.**
31.4.2	Health of staff monitored	Not systematically monitored	Sick leave of all staff and units systematically monitored	**Target met.**	**New procedures implemented which require the PAHO/AMRO medical office to systematically monitor all sick leaves over 3 days.**
31.4.3	Degree to which staff are aware of implementation of staff/family friendly policies.	Unknown. The indicator at present is that questions raised by staff are already covered by issued policies	All staff is fully informed and aware of these policies. Questions are limited to clarifications only	**Target met.**	**All staff is fully informed of new policies. Training courses held for all employees on HIV/AIDS in the Workplace policy.**

RER 31.5 Contractual procedures and systems enable the Organization to provide contracts that meet the respective needs of the Organization and the individuals employed under those contracts.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
31.5.1	New types of contracting mechanisms have been developed and relevant information disseminated to management and staff	Current contract mechanisms are under review	Consolidation and simplification of the different contracting mechanisms	**Groundwork completed; changes to be implemented in 2008.**	**Contract reform changes are pending a UN General Assembly decision in early 2008.**
RER 31.6 Reliable staff security systems and procedures to enable the effective and efficient conduct of activities while ensuring the security, safety, and well-being of staff.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
31.6.1	Percentage of staff, at regional and country levels, which are adequately trained in U.N. security management procedures and personal security	Identification through survey & existing documentation of currently trained staff	Achieving 100% training and demonstration of the required knowledge	**Target met.**	**The UN online security course was implemented as mandatory for all professionals and anyone who traveled. Security training sessions were provided to all Washington DC personnel.**
RER 31.7 PAHO's human resources are balanced by gender and nationality.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
31.7.1	Official employment statistics	Statistics at beginning of biennium	Improvement in gender and geographic representation	**Target met.**	**Professional personnel from Recruitment List "A" countries increased by 36%. While in Washington DC the number of professional posts occupied by women decreased by 4%, the number of professional women in the country offices increased by 12%. Significantly, of the 28 PAHO/WHO Representatives in the Country Offices, 50% are female.**

Lessons Learned:

- Effective HR Planning and assessment of staff competencies are critical to achieving the goal of having the "right person, in the right place, at the right time".
- HR management is a responsibility of all managers in the Organization, not just the HR Personnel Specialists and Executive Management. Therefore, increased emphasis must be placed on training all managers in competencies and best practices for HR management.
- Availability of accurate and timely human resource information is essential to the appropriate application of staff rules and regulations. All personnel have a responsibility to ensure that their HR information (or that of their staff) is current and accurate.
- The demands and pace of today's world has increased the stress levels for all staff and their families. To reach its programmatic goals, the Organization must attend to the well-being of their personnel, helping them to manage stress and find effective means to ensure mental and physical health.

Financial Execution

AoW: **HRS- Human Resources Management**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	7,068,800	7,273,380	7,193,400	99%
Other Sources	4,295,000	1,955,330	1,894,400	97%
Total (RB & OS)	**11,363,800**	**9,228,710**	**9,087,800**	**98%**

32. BUDGET AND FINANCIAL MANAGEMENT (FNS)
Overall Achievement level: 97%

GOAL:
To maintain the financial viability of the Organization to ensure that the Bureau 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.

ACHIEVEMENT OF GOAL:
- **Implementation of the Regional Budget Policy for the 2006-2007 biennium which transferred additional financial resources to the PAHO country offices from the Regional Office based on pre-established criteria.**
- **Implementation of the Financial Accountability Framework for the 35 PAHO country representation offices and centers in 2006-2007.**
- **Certification of accounts by the PWRs and center directors for the 2006 accounts and by the PWRs, center directors, area managers, and office directors for the 2007 accounts.**
- **Implementation of an electronic banking platform in 35 country offices and the HQ Office.**

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
- **The PAHO Program Budget was established in a timely manner with implementation and monitoring reports being provided to the Member States, partners, and stakeholders at the Executive Committee meetings in 2006 and 2007.**
- **Automation of processes for (1) partner and stakeholder financial reporting, (2) straight through processing for staff/commercial payments, and (3) Staff Health Insurance explanations of benefits provided to country office staff members via the intranet.**
- **The PAHO governing bodies accepted the 2004-2005 biennial financial reports and the 2006 interim financial report. They were pleased with the unqualified audit opinion on the biennial financial statements for 2004-2005.**
- **The PWRs and area managers responded to the internal and external audit findings and committed to implement the recommendations.**

RER 32.1 Policies and guidance developed for integrated budgetary planning and implementation in line with a results-based management approach.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
32.1.1	Adherence to new policies and guidelines observed in corporate work plans for 2008-2009	0	At least 75% of work plans coherent with new policies and guidelines	**Fully achieved**	

RER 32.2 Efficient and effective management of the Organization's financial resources achieved while striving to maximize earnings within acceptable liquidity and risk parameters.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
32.2.1 a)	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	Interim and biennial Financial Reports finalized by 15 March; biennial financial statements receive an unqualified audit opinion	Interim and biennial Financial Reports finalized by 28 February; biennial financial statements receive an unqualified audit opinion	**Fully achieved**	**The Financial Report of the Director and Report of the External Auditor for 2004-2005 were prepared on time and accepted by the PAHO Member States during the Directing Council in September 2006. The PAHO External Auditor, the National Audit Office of Great Britain and Northern Ireland, provided an unqualified (clear) audit opinion on the biennial accounts for 2004-2005. The Interim Financial Report of the Director for 2006 was accepted by the PAHO Member States during the Pan American Sanitary Conference in October 2007.**
32.2.1 b)	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	2006-2007 portfolio performance equals that of 2004-2005 as compared with segmented benchmarks	2006-2007 performance of portfolio exceeds segmented benchmarks, gross of fees	**Exceeded the benchmark for the short-term segment of the portfolio, but minimally short of the benchmark in the long-term segment of the portfolio.**	**During the 2006-2007 biennium, the Organization's portfolio increased to a high exceeding $400 million. The earnings received on the Organization's short-term portfolio exceeded the benchmark, while the performance of the long-term segment of the portfolio fell minimally short of the benchmark due to PAHO's policy of holding its long-term investments until maturity and not actively trading them. PAHO's earnings on its portfolio reached $23 million, thus far exceeding the budgetary target of $14.5 million for the biennium.**

RER 32.3 Compliance with established financial accounting standards, regulations, and rules ensured within a sound internal control framework.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
32.3.1 a)	Financial regulations and rules are maintained current and consistent with U.N. standards and are followed for all financial management and accounting transactions	PAHO Manual for Field Operations (Finance	Revised financial policies and procedures reflecting best practices are	**Fully achieved.**	**The PAHO Manual for Field Operations' Finance Section was updated in 2006 to reflect the UN's financial regulations, rules, policies, and procedures. In order to prepare for the transition to IPSAS, PAHO revised its financial regulations**

		Section) is updated	integrated into the PAHO Manual for Field Operations (Finance Section) and into training programs for country office and HQ staff		**and provided training to the Headquarters and country office staff members regarding the implementation of the Expenditure Recognition Policy, a critical factor in the implementation of the GSM and IPSAS. Approval was received to implement the monthly accrual of payroll and statutory entitlements effective 1 January 2008. In addition, country offices, centres, as well as regional units and areas were provided with an overview of the requirements of International Public Sector Accounting Standards.**
32.3.1 b)	Financial regulations and rules are maintained current and consistent with U.N. standards and are followed for all financial management and accounting transactions	Biennial visits to country offices are conducted for the review of procedures and supporting documentatio n	Annual visits to country offices are conducted for review of procedures and supporting documentation	**Fully achieved**	**Staff members of the Country Accounting Services team (CAS) visited the 35 PAHO country representation offices. In addition, FMR implemented the Financial Accountability Framework for the 35 PAHO country representation offices in 2006-2007.**
RER 32.4 Effective information systems to manage the financial resources of the Organization and to provide desired financial management information.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
32.4.1	Information systems are enhanced and the hardware is made available to support the financial management and reporting requirements	Financial accounting and staff benefits systems are upgraded/enha nced as needed	The financial accounting and staff benefits systems are systematically upgraded/enhanc ed	**Fully achieved.**	**Real-time, online data was available via the Simplified Online Search system (SOS) which retrieves the budgetary and financial data directly from the Financial Accounting Management and Information System (FAMIS) and the AmpesOmis system in order to provide managers with the financial information required to make well-informed decisions on planning and operational matters. Expenditure Recognition software was created to facilitate the implementation of the new Expenditure Recognition Policy and to interface directly into the corporate accounting system.**

					PAHO has started the process to respond to the WHO GSM. This will probably replace PAHO's current Financial Accounting and Management Information System (FAMIS), as well as the ADPICS Procurement System, and the Simplified Online Search System (SOS).
RER 32.5 Effective and responsive financial administration of supplier contracts, claims, staff salaries and entitlements, and staff members and retirees' benefits.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
32.5.1	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	Payments on contracts/claims are processed within the terms of the agreements	Payments on contracts and claims are processed in order to maximize cash flow while ensuring compliance with legal obligations	**Fully achieved.**	**Expenditures and accounts payable are managed in a timely and accurate manner in order to ensure the timely payment of accounts and thus provide an accurate view of the integrated program budget.**
RER 32.6 The 2006-2007 program budget managed in a timely, informed manner.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
32.6.1	Appropriation, allocation and allotment levels kept within authorized amounts during the course of the biennium	All levels set at 0	Appropriations established do not exceed approved budget at $265,568,000; allocation and allotment levels do not exceed effective working budget amounts established by	**Fully Achieved**	

			the Director		
32.6.2	Required budgetary information and reports submitted to Governing Bodies, Executive Management, and financial partners within established timeframes	Adherence to timeframes equal to compliance rate at end of 2004-2005	At least a 20% increase in timeliness over the 2004-2005 compliance rate	**Fully Achieved**	

Lessons Learned:

- The Advisory Group on Financial Resources (AGFR), although intended to harmonize global funding needs, was not particularly effective. The dialogue among global programmatic networks needs improvement, as does the communication from HQs to Regions on the true availability of resources for distribution.
- The implementation of an electronic banking platform in 35 country offices and the Regional Office is extremely challenging and requires strong support from the implementing bank, as well as from the Organization's information technology department and from the treasury operations unit.
- Training on the new International Public Sector Accounting Standards is critical for the successful implementation of the new accounting standards and should be considered at paradigm shift from UNSAS. Furthermore, successful understanding of the new accounting standards requires repetitive trainings and much hands-on/person-to-person training.

Financial Execution

AoW: **FNS- Budget and Financial Management**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	8,887,100	10,598,526	10,535,400	99%
Other Sources	1,874,000	4,244,830	4,222,600	99%
Total (RB & OS)	**10,761,100**	**14,843,356**	**14,758,000**	**99%**

33. INFRASTRUCTURE AND LOGISTICS (IIS)
Overall Achievement level: 63%

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.					
ACHIEVEMENT OF GOAL: **An important best practice is to increase utilization internal intranet sites by placing operating procedures/instructions & training materials on proper procurement practices for widespread use of the Organization's staff. PAHO procurement did so. GSO also improved distribution of security and travel information for internal usage.**					
PAHO OBJECTIVE: 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.					
ACHIEVEMENT OF PAHO OBJECTIVE: **While providing a wide variety of services, the GSO area examines individual contracts and attempts to reduce or lesson cost increases, however, most infrastructure costs are fairly fixed and unfortunately affected by higher energy costs. Thus overall costs tend to rise. The procurement area has made progress in restraining prices of replacement cars and trucks due to better competition and oversight of vendors.**					
RER 33.1 Infrastructure support services operated in a resource-effective-and-efficient manner.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
33.1.1	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	**Partially achieved (50%)**	**Baseline data: Pest control 392/mo; cleaning staff 8.60/hour; gardening 563/mo; fan coil service 373; dumpster trash 1,450.** **Actual data: Pest 499; cleaning staff 9.35; gardening 583; fan coil service 395; dumpster 1,210.** **Pest control costs up 27%; cleaning staff costs up 8.7%; gardening up 3.6%, fan coil service up 5.9%.; dumpster trash -17%.** **The "real" U.S. inflation rate is approx 5 to 6% per year, spurred by higher energy costs. This crosses all areas. Some areas reflect both**

					inflation and previous low prices (pest control, for example).
RER 33.2 Logistics support functions operated in a resource-effective-and-efficient manner.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
33.2.1	Average cost of selected logistics support functions for printing and distribution, travel, and communications $.0030/copy; $44/ticket	Average cost at end of 2004-2005 biennium	Not in excess of average cost in 2004-2005	**Partially achieved (50%)**	**$.0132/copy; $44/ticket.** **Photo copy click price have risen sharply (over three fold), reflecting vendor push to buy or rent new generation of equipment and increased operating costs obsolete equipment. However, printing volumes continue to decline and this fact tempers the price rise. Service charge for airline tickets remains stable due to long term contract.**
RER 33.3 Continuing support provided to regional Governing Bodies and technical meetings in the form of efficient preparation and logistical support.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
33.3.1	Member States' satisfaction regarding the efficient and effective servicing of meetings	NA	0.9	**Achieved**	**Following directing council meetings, complaints were non-GSO related (documents not placed on intranet site within 6 week deadline) but for GPP.**
RER 33.4 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.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
33.4.1	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	**No real increase**	**Over the past biennia, approximately 85% of all PAHO procurement is for vaccines and syringes, which are centrally negotiated contracts designed to minimize purchase prices. In 2006, approximately $189 million in vaccines & syringes was bought and the 2007 figure is roughly $240 million. The remaining purchases have limited opportunity for central contracts, but PRO plans to continue its efforts to have centrally negotiated contracts for some of the remaining 15% of purchases.**
33.4.2	Percentage of volume of orders through	0	0.15	**0**	**PAHO procurement does not use the WHO e-**

	new e-commerce mechanism for streamlining requests for orders				**commerce system to process orders. The WHO e-commerce system contains numerous catalogs and links to various vendors who are European based and do not provide the goods/services needed within our region. The vast bulk of the PAHO purchases are for vaccines and medicines which are purchased through cost savings contract bidding which is not on the WHO site. PAHO procurement agents make extensive use of the internet to price out potential purchases to ensure the lowest price for a needed item is found. For example, PAHO does make heavy use of the UNOPS Copenhagen site to price all purchase of vehicles for our PWRs.**
RER 33.5 Security and safety of grounds and premises improved.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
33.5.1	Number of PAHO/WHO sites that comply with minimum operating security standards	Complying sites as of end of 2005	All sites	**10%**	**Many of the PWRs are very close to MOSS compliance, but they may lack a small number of radios or other improvements. The 10% compliance rate uses a very strict pass/fail analysis of security standards at various PWRS. However, the majority of PWRs are close to the 100% mandatory requirements and may miss it by lacking, for example, 1 of 10 radios for staff. PAHO policy is to pay for local security costs from the PWR and program budgets. Given decreasing value of US dollar, high local inflation and tight local budgets, PWRs are also sometimes slow to pay for the full security requirements.**
RER 33.6 Real estate management and facilities improved.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
33.6.1	Availability of an updated 10-year rolling master plan of real estate projects	Master plan of previous biennium	10-year rolling master plan adopted	**Achieved**	**Plan updated based on new info.** **Plan now is located on access data base for easier use.**
33.6.2	Proportion of projects implemented with	Percentage of	0 projects	**Achieved**	**One project financed and completed.**

	financing from the Real Estate Fund that deviate from recognized best practices for local construction and environmental norms	implemented projects that deviate from best practices at end of 2005	deviate from best practices.		**Project was on-time and on-budget.**

Lessons Learned:

- If the procurement section is to continue providing quality services, at some point additional staff are needed because the work is becoming more complicated and contracts more complex. Existing staff cannot devote the time needed for quality control at this higher level of demand.
- At some point, general services costs will rise dramatically because of inflation, especially driven by energy costs, cannot be contained. At that point, either the higher costs must be absorbed or the services cut back.

Financial Execution

AoW: **IIS- Infrastructure and Logistics**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	12,661,200	13,615,502	13,526,100	99%
Other Sources	4,332,000	3,196,456	3,196,500	100%
Total (RB & OS)	**16,993,200**	**16,811,958**	**16,722,600**	**99%**

Special note:

The achievement level is low because the annual cost increases in photocopy charges from Xerox; fees for maintenance (such as pest control, trash removal) have exceeded our previously stated price increase goals. It should also be noted that inflation within the U.S. is also growing higher daily and fees for mandatory services are climbing.

The drafting units of the Bureau will often delay submission of documents for Governing Body meetings to ensure the latest figures are available (cost, health statistics etc.), and this delays availability to Member States. However, PAHO Bureau believes that its performance improved substantially for the most recent SPBA due to new leadership in the Deputy Director's office.

34. GOVERNING BODIES (GBS)
Overall Achievement level: 100%

GOAL:
To ensure the development of sound policies on national, regional, and international public health that responds to the needs of Member States.

ACHIEVEMENT OF GOAL:
Successful convocation of all 2006/2007 GB meetings with Ministerial level participation from the four main geographic subregions.

PAHO OBJECTIVE:
To assure the good governance of PAHO through the efficient preparation for and conduct of the regional Governing Body sessions, and effective implementation of decisions of the Governing Bodies.

ACHIEVEMENT OF PAHO OBJECTIVE:
- **Production and implementation of the use of stricter GB Document Production Guidelines.**
- **Cost savings and efficiency achieved in streamlining GB document preparation processes by eliminating précis writing and providing an extensive Final Report.**
- **Simultaneous interpretation and translation of documents in working languages of the particular meeting has aided Member States participation and communication.**

RER 34.1 Resolutions adopted by the Governing Bodies, in particular on policy and strategy, which provide clear orientations to the Organization for their implementation.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
34.1.1	Proportion of resolutions adopted that are implemented at regional and national levels.	0.85	0.9	**0.9**	**This activity is now contained in new BWP.**

RER 34.2 PAHO Governing Bodies Resolutions and Mandates are shared with UN regional institutions and Inter-American Systems and are included in their agendas as appropriate.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
34.2.1	Issues addressed in PAHO resolutions included in the agendas of other regional agencies of the United Nations or the inter-American System	Nil	At least 1 area of health interest included per	**5**	**Congruence of issues dealt with within the UN and Inter American systems.**

			year in meetings of the regional UN and OAS systems		
RER 34.3 Communication between Member States and the Bureau improved.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
34.3.1	Use of modern electronic communication tools between Member States and the Bureau, concerning PAHO/WHO Governing Bodies matters	1 major regional consultation per biennium by electronic means	2 major regional consultation s per biennium by electronic means	**2**	**Initiation of the use of electronic meeting registration systems to facilitate data collection at headquarters.**
34.3.2	Improving the timeliness of Governing Bodies' documentation, in the official languages, according to the Rules of Procedure	0.9	0.95	**0.95**	**The domino effect of country offices being unable to submit documents for collation by technical units in a timely manner and eventually trickles down to GB being unable to significantly improve the timeliness of documentation in official languages. The short timeframe between meetings continues to hinder timely document preparation.**
RER 34.4 Better coordination in establishing the work programs of the various Governing Bodies and improvements in the working sessions.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
34.4.1	Degree of congruence of agendas and resolutions of the regional and global Governing Bodies	Nil	Executive Committee considers WHO Governing Bodies	**Yes**	**High degree of similarity in agenda items especially with those of the UN agencies and organizations within the Inter American system.**

			agendas and resolutions when planning the Executive Committee and Directing Council/PASC agendas		
34.4.2	Pursuant to Governing Bodies directives effectiveness of the sub committees assessed	Nil	Assessment of the role of the subcommittees by the Executive Committee	**Yes**	**Effectiveness of the Subcommittee on Program, Budget, and Administration (SPBA) and the Executive Committee as auxiliary bodies to review and provide feedback on: planning and program budget, policy formulation performance, assessments, evaluations, and oversight activities before presentation to the Directing Council.**

Lessons Learned:

- Cost savings from removal of précis writing.
- Cost savings from the use of *petite équipe* for small meetings.
- Brevity and focus in document preparation with the use of guidelines and templates.
- Need to adhere to a strict timeline for document and meeting preparation in order to avoid delays and last minute complications.

Financial Execution

AoW: **GBS- Governing Bodies**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	4,629,300	4,453,110	4,449,500	100%
Other Sources	1,583,000	139,846	139,600	100%
Total (RB & OS)	**6,212,300**	**4,592,956**	**4,589,100**	**100%**

35. EXTERNAL RELATIONS (REC)
Overall Achievement level: 92%

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

ACHIEVEMENT OF GOAL:
- **Public health issues in PAHO's Region were included in the political agendas and became mandates in the Summit's Declaration (Americas, Iberoamerican and CARICOM Summits of Presidents and Head of States).**

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
- **Bilateral Agencies and Partners are more willing to support PAHO's Plan and Programs shifting from the project to the programmatic approach.**
- **PAHO has strengthened its coordination with the UN Regional Agencies in Latin American and the Caribbean Region.**
- **PAHO has established effective working relationships with think tanks in the WDC area with the aim of advocating for pandemic influenza preparedness planning, child and maternal health (CSIS, Global Health Council, and the Inter-American Dialogue).**

RER 35.1 Health is given priority in high level political regional meetings, with particular emphasis on those priorities arising from PAHO/AMRO's mandates. PAHO/AMRO is relied upon in these fora as the leading expert health agency in the Region.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
35.1.1	Health is included in the agendas and declarations of the Summit of the Americas, the Iberoamerican Summit and First Ladies Summits and other regional high level political meetings	2	3	**3**	
35.1.2	The number of events on which PAHO/AMRO is consulted for its input regarding health issues pertinent to the agenda and formulation of documents for meetings such as those mentioned above	4	5	**5**	

RER 35.2 Alliances and partnerships operational.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
35.2.1	Relations established with more NGOs, Civil Society Organizations (CSOs), or Foundations working in health, either in an official or working relations basis	Number at end of 2005	At least 10 % more than 2005 level	**12.4%**	
35.2.2	Joint declarations and/or strategic initiatives with UN agencies agreed and being implemented	Number at end of 2005	4 additional	**8**	
35.2.3	Collaborative programs or agreements are negotiated and signed with bilateral agencies in the biennium	Number at end of 2005	4 additional	**8**	
35.2.4	Results of Shared Agenda disseminated and discussed with at least one Governing Body	Number at end of 2005	At least 10 % more	**Not Achieved**	**This initiative was left behind in 2006 and no longer exists due to changes in the Organizations management. The Shared Agenda stopped functioning**
35.2.5	Consultations with international financial institutions at country and regional levels each year	Number at end of 2005	At least 10 % more	**15%**	

RER 35.3 Capacity of countries and Bureau to develop strategic alliances and partnerships strengthened.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
35.3.1	National health officials and staff in at least three Key Countries and 3 others trained by PAHO/AMRO	0	Staff of 6 countries and 6 country offices	**10 countries staff**	

RER 35.4 Knowledge of and participation in harmonization and alignment activities within the health sector in the Region is increased.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
35.4.1	National health officials, PWRs and staff at headquarters provided with relevant information and training regarding harmonization, alignment and coordination activities in the health sector in the Region	0	Staff of key PAHO/AMRO countries	**32 PWRs' staff**	**Trough the subregional and regional manager's meeting organized every year.**
35.4.2	PAHO/AMRO is an active participant with other international agencies in harmonization, alignment and coordination meetings and initiatives in health in the region	2	4	**4**	

RER 35.5 Work with all programs within the Organization and with outside partners to create and implement communications strategies and materials and conduct media training.					
35.5.1	Communication components in programs and projects and launches of new programs and initiatives	Number at end of 2005	At least 10 % more	**15%**	
35.5.2	Creation and production of printed materials and expansion of distribution of news releases, fact sheets and other features	Number at end of 2005	At least 10 % more	**15%**	

Lessons Learned:

- Constant policy dialogue with Global, regional and subregional organizations assured the inclusion of health agenda in the political agenda at the highest level.
- Open discussions with the private sector were important to improve mutual knowledge and to build dialogue on different health issues. The dialogue was based in clear rules of procedure included in Guidelines that are constantly revised.
- Resource mobilization activities improved on a constant basis, more funding available for programmatic support was one of the most important successes during the assessment period.

Financial Execution

AoW: **REC- External Relations**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	4,799,900	4,736,818	4,734,500	100%
Other Sources	812,000	1,272,036	1,261,800	99%
Total (RB & OS)	**5,611,900**	**6,008,854**	**5,996,300**	**100%**

36. DIRECTION (DGO)
Overall Achievement level: 100%

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

ACHIEVEMENT OF GOAL:
The Direction of PAHO has worked to achieve the applicable MDGs in the Region, as well as other global and regional health development objectives. 06-07 saw the development of integrated strategic and operational plans in support of these objectives, as well as approval of the Health Agenda for the Americas by all Ministries of Health in the Americas (an effort supported by the Bureau).

PAHO OBJECTIVE:
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.

ACHIEVEMENT OF PAHO OBJECTIVE:
There were several achievements in 2006-2007 reflecting the success, achievement and the effective direction of the Organization. Among the successes are the Health agenda and Strategic Plan that were developed in a highly participatory manor and endorsed by our Governing Bodies; the 2008-2009 Budget was approved with an increase; Country presence was strengthened with the reorganization of the Caribbean Program Coordination Office and the creation of the Eastern Caribbean Program Coordination Office and the creation of posts at country level as well as the continuation of decentralizing regional posts to country offices. An ethics office was established as well as the Integrated Conflict Management System (ICMS) which is chaired by the ethics officer and includes the Manager of HRM, LEG, OMB, and the Staff Association among others. The Faces, Voices and Places Initiative was created to promote the attainment of the MDGs focusing on equity and reaching the excluded. There was a renewed emphasis on Primary Health Care; the Roadmap Initiative was completed producing several products, initiatives and strategies, and the re-election of the Director in October was a reflection of the confidence of the Member Countries in the Director's leadership and an endorsement of her work.

RER 36.1 PAHO responds better to country needs.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
36.1.1	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	**Target Achieved**	**Both process and outcome indicators in TC program for Priority Countries show considerable progress. The Minister of Health of Guyana made a public statement during 27th Pan American Sanitary Conference in this respect. Challenge for next period will be a closer collaboration with IFIs to**

					impact on some underlying factors for Health Systems performance, like Civil Service Career.
RER 36.2 PAHO has a forum for debates and dialogue.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
36.2.1	Regional forum convened on different topics	1 per biennium	At least 2 per biennium	**Target Achieved**	**Two Fora were launched: Forum for Diabetes in the Mexican-American Border Forum for Urban Health.**
RER 36.3 New modalities of technical cooperation adopted.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
36.3.1	Subregional technical cooperation programs executed		75% expected results (ER) of each subregional program achieved	**Target fully achieved**	**Over 80 % of Expected Results were successfully discharged in each subregion. Last Meeting of Health Coordinators for MERCOSUR Subregion included an official statement on satisfactory progress achieved, despite relatively short period for implementation (new level of budget allocation). Challenge for next period will be to encompass all cooperation with a given subregion in a single instrument, regardless of the source of financing, to allow for a more holistic view and management of priorities and resources.**
36.3.2	New orientation of regional program launched	0	3 initiatives approved	**Achieved**	**Examples: TCC, Openlink, CSU network portal**

RER 36.4 Management processes improved.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
36.4.1	Quality of the BPBs deemed satisfactory on first review	0.3	0.6	**0.6**	**Due to preparatory review and modification, majority of Biennial Workplans were approved during first review for approval.**
36.4.2	Recommendations of Joint Inspection Unit's evaluation of RBM in PAHO, implemented	0	0.8	**0.8**	**All applicable recommendations of the JIU report have been implemented, or are planned for implementation in a timely manner.**
36.4.3	Recruitment time for fixed staff reduced	NA	10 % reduction on 2005 average	**34.9% (4.1 months)**	**Given that there was no baseline when the target was set in 2005, for purpose of completing this report, the baseline was set to be the average time that it took to fill positions in 2006, which was 6.3 months from the date of closing of the vacancy notice to the date of selection. In 2007, the average time was significantly reduced to 4.10 months, which correspond to 34.9% reduction in time.**
RER 36.5 PAHO has become a learning/ knowledge organization.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments.**
36.5.1	Number of 'communities of practice'	Number in 2004-2005	At least 5 more than operated in 2004-2005 biennium	**Achieved**	
36.5.2	% staff contributing to 'communities of practice'	N/A	N/A	**10-15%**	**Estimated.**
RER 36.6 Better synergy and coherence among the work of the different parts of the Organization.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments.**
36.6.1	Most of the Areas of Work (AoW) focal points report satisfactory collaboration with the global level in planning and	N/A	0.6	**0.7**	**Where this has been assessed.**

	resource coordination				
36.6.2	Most countries report satisfactory support for selected MDG-related regional expected results (RERs)	N/A	At least 75%	**Achieved**	**Per country office reporting.**

RER 36.7 Legal status and interests of the Organization protected and good relations with Member Sates maintained.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
36.7.1	Fewer disputes and other legal difficulties	Number of disputes in 2004-2005	10% decrease in the 2004-2005 number of disputes	**Achieved**	**Number of filed and pending ILO cases was reduced.**
36.7.2	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	**Achieved**	
36.7.3	Basic agreements reviewed at least every 15 years	NA	All agreements meeting criterion will have been reviewed	**Achieved**	
RER 36.8 Recommendations of special External Audit of 2004 implemented.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments.**
36.8.1	Sustainable capacity for implementing the Integrity and Conflict Management System	No function in PAHO	2 positions for ethics and legal officers established and filled	**Achieved**	**Ethics officer position created and filled; CFS in place.**
36.8.2	Project on Transparency and Accountability implemented	Project out line approved by EXM	100% of project expected result achieved	**Achieved**	
RER 36.9 Awareness of Member States and global partners of the work PAHO.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
36.9.1	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	**Achieved**	**Estimated**

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
36.9.2	Multimedia campaigns executed to support public health issues	All	All	**Achieved**	
36.9.3	Percentage of extra budgetary initiatives (EBI) executed in the biennium with communication strategies increased	Percentage of EBIs with communication strategies in 2004-2005	Increase by 10 percentage points	**Achieved**	
RER 36.10 Catalytic start-up and flexible funds under the purview of the Regional Director provided for programs of particular emergency need.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
36.10.1	Strategic allocation of the Regional Director's Development Fund for initiatives that advance the mission of the Organization, reported to the Executive Committee (EC)	No funds allocated	All funds allocated and disbursed as directed by the Regional Director	**Achieved**	
36.10.2	Allocation of Variable Funding among countries, according to criteria approved by SPP, reported to the EC	No funds allocated	All funds allocated and disbursed by the Regional Director	**Achieved**	

Lessons Learned:

- Building consensus among Member States form the grassroots level upward in support of international goals in public health is fundamental to mobilizing resources and political support for the mission of the Organization (in re: Health Agenda development process).
- Improved technology and streamlined work processes have enabled AMRO to continue to "do more with less". The use of virtual meetings has become a routine cost-saving modality in Region.
- Training of managers to truly manage is essential (as opposed to managers that continue to perform duties related to their technical specialties).
- Major organizational change is possible on a large scale when the rationale is adequately communicated, all parties are involved in the process, and senior management strongly endorses the change (re: the new planning process and instruments).

Financial Execution

AoW: **DGO- Direction**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	6,685,200	8,307,287	8,270,600	100%
Other Sources	854,000	1,240,672	1,229,200	99%
Total (RB & OS)	**7,539,200**	**9,547,959**	**9,499,800**	**99%**

37. COUNTRY OFFICE OPERATIONS (COO)
Overall Achievement level: 86%

GOAL: To provide effective and efficient support to Member States for reaching their national health development goals through an adequate core presence of PAHO/WHO at country level.					
ACHIEVEMENT OF GOAL: **Achieved. Goal was achieved through CCS development in 22 Country offices, apart from continuous support through country offices and coordination across all levels of the Organization.**					
PAHO OBJECTIVE: PAHO/WHO country presence is relevant, adequate, and receives the necessary managerial, technical, and administrative support from all levels of the Bureau and performs effectively.					
ACHIEVEMENT OF PAHO OBJECTIVE: **Achieved. Country Focus policy was endorsed by the AMRO Region's Governing Bodies and it constitutes a priority for Senior Management.**					
RER 37.1 Appropriate and adequate resources provided to country offices for optimal functioning based on established PAHO/WHO country presence.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
37.1.1	Percentage of countries for which criteria for country presence has been systematically defined and established, based on the new technical cooperation strategy, the technical cooperation program, and the new Regional Program Budget Policy	15% 21	80% 28	**20**	**Country presence is permanently analyzed and updated to ensure its consistency with the Strategic Agenda.** **There are 5 CCS to be carried out during 2008.**
37.1.2	Number of offices with staff re-profiling plan implemented as a result of the CCS	7	28	**20**	**Idem.**
37.1.3	Number of offices kept up to date with information technology infrastructure and procedures to maintain alignment and connectivity with PAHO and WHO corporate systems and instruments	21	28	**28**	

RER 37.2 Country Office Development Plan implemented, including Staff Development.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
37.2.1	Formulation, monitoring, implementation, and evaluation of a development plan for each country office aligned to CCSs and according to guidelines developed in 2005	10	28	**12**	**Guidelines are being reviewed to make them more flexible and easier to follow and development plans will continue to be implemented 2008-2009. Some country offices have innovated with the methodology of "optimal groups."**

RER 37.3 Strengthened networking among country offices, WHO country support unit network, and regional and global levels.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments.**
37.3.1	System implemented to systematize networking and information sharing among country offices and regional and global levels	System on Decentralized Technical Cooperation	System expanded to include other topics and levels of the Organization	**Implemented**	**Openlink developed for this purpose. Training will start in 2008.**

RER 37.4 Improved efficiency and effectiveness of administrative services in support of the delivery of technical cooperation.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
37.4.1	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	8	**29**	**BWPs revisions were carried out and regional level and country level worked together not only in the evaluation but also in the planning for 2008-2009.**
37.4.2	Procedures and system established to share information and recommendations derived from monitoring visits to Country Offices with relevant Units and Areas in the Regional Office	0	1	**1**	**Guidelines for Monitoring visits are currently being used.**

Lessons Learned:

- During 2006, a major transformation in Country Presence occurred in the Caribbean Subregion with the restructuring of the former Office for the Caribbean Program Coordination (CPC) and its conversion into two separate organizational units. This decision was taken as a result of the re-profiling exercise undertaken after the CCS for the Eastern Caribbean. This exercise proved to be very unique and many managerial and administrative challenges were raised during the process. Nonetheless, it was a very positive experience. AFRO requested orientation to learn from this process which could help them with their own subregions.

- The subregional level for technical cooperation was established officially by the Regional Committee in 2005, which allows the allocation of resources for the subregional platforms. For the first time, in the biennium 2006-2007, a technical cooperation program was established for each sub-region. This represents a unique experience also within the UN System. In the country offices of each subregion there are inter-country or subregional advisers who provide technical support and complement the technical resources of the Country Offices. Their main responsibility is though, to discharge technical cooperation on health matters and health determinants vis-à-vis the program of subregional integration entities.

- Openlink represents a good tool for information sharing. The Organization is embarking on the re structuring of information and knowledge management processes, thus more coherence and alignment is required in order to avoid duplication of tools, sites and systems for info sharing.

- The review of the BWPs, in particular the peer review approach , represented a very rich process which allowed good exchange of information between regional and country level.

Financial Execution

AoW: **COO-Country Office Operations**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	21,124,500	23,728,465	23,165,500	98%
Other Sources	4,000,000	1,531,078	1,111,700	73%
Total (RB & OS)	**25,124,500**	**25,259,543**	**24,277,200**	**96%**

38. TECHNICAL COOPERATION AMONG COUNTRIES (TCC)
Overall Achievement level: 75%

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.

ACHIEVEMENT OF GOAL:
Achieved. PAHO/WHO continues to support and advocacy for TCC

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

ACHIEVEMENT OF PAHO OBJECTIVE:
TCC has proved to be an efficient and effective mechanism to promote horizontal cooperation. PAHO/WHO succeeded in encouraging countries to use it.

RER 38.1 Expanded use of the TCC approach within subregions and across WHO Regions.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
38.1.1	Number of TCC initiatives	70 per biennium	80 per bienniu m	**40**	**Even though, the number is lower than expected, now the TCC proposals are more substantive and imply a longer period of implementation (sometimes 4-5 years).**
38.1.2	Number of TCC initiatives involving border countries or countries in the same sub-region	25%	35%	**Achieved**	
38.1.3	Number of TCC initiatives involving countries in other WHO Regions	0	2	**1**	**Both Brazil and Cuba are cooperation with Angola through GAVI for polio elimination.** **There is considerable interest for TCC between regions (SIDS, Mega Countries, countries of Portuguese language, etc.).** **Unfortunately the Organization still lacks a mechanism to foster interregional cooperation.**

RER 38.2 Improved planning, implementation, monitoring, and evaluation of TCC projects.

Ind.#	Indicator description	Baseline	Target	Actual Dec 2007	Explanation (obligatory if target not met) or comments
38.2.1	Number of subregions in which TCC training has taken place in line with agreed guidelines	3	4	**4**	

38.2.2	Percentage of projects with an evaluation and final report	0.5	1	**50%**	**Many projects ended by Dec. 2007. It is expected that final reports will be completed by beginning of 2008.**
RER 38.3 Improved TCC project review and approval process.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
38.3.1	Percentage of projects assessed according to agreed criteria within 2 weeks of submission of the final proposal and all necessary supporting documents	0.6	1	**75%**	**Assessment is in process.**
RER 38.4 Increased diversity of national institutions in the planning and execution of TCC projects.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
38.4.1	Percentage of TCC projects with participation of organizations other than the ministries of health	0.6	0.8	**40%**	**Participation of organizations other than the ministries of health is increasing, but still PAHO's main counterpart continues to be the main partner in TCC projects.**
RER 38.5 Improved information sharing of best practices and lessons learned in TCC.					
Ind.#	**Indicator description**	**Baseline**	**Target**	**Actual Dec 2007**	**Explanation (obligatory if target not met) or comments**
38.5.1	TCC database fully established, functioning, and accessible, with relevant data and information updated monthly and disseminated in Internet	0.3	1	**1**	
38.5.2	In-depth TCC case studies carried out	5	20	**20**	

Lessons Learned:

- TCC has been a relevant strategy for PAHO. TCC is an exceptional modality for cooperation in health, whose potential should be applied to help overcome current challenges towards national health development and the achievement of MDGs.

- TCC was also incorporated in the discussions with national counterparts in CCS developed along the biennium, especially in the cases of Brazil and Cuba This represents a great opportunity to strengthen TCC as a techncial cooperation modality among countries. Increasingly there is a manifest interest of countries in AMRO Region to engage in cooperation with other countries in other regions, particularly AFRO.

- The interest on TCC expressed by countries such as Argentina, Brazil and Mexico provides the opportunity to make available a considerable amount of techncial resources coming from middle income countries to support advancement of MDGs among others.

- The value of TCC should be fostered in view of the 30th Anniversary of TCDC in 2008.

Financial Execution

AoW: **TCC- Technical Cooperation among Countries**

	Budget	Allotted	Expenditure	% Implemented
Regular Budget	2,558,000	1,258,219	1,240,500	99%
Other Sources	2,000,000	-	-	-
Total (RB & OS)	**4,558,000**	**1,258,219**	**1,240,500**	**99%**

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