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END-OF-BIENNIUM ASSESSMENT/
SECOND INTERIM PAHO STRATEGIC PLAN 2008-2012
PROGRESS REPORT

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PROGRAM AND BUDGET 2010–2011 END-OF-BIENNIUM ASSESSMENT / SECOND INTERIM PAHO STRATEGIC PLAN 2008–2012: PROGRESS REPORT

I. EXECUTIVE SUMMARY

1. The purpose of this report is to inform the Governing Bodies of the progress made in the implementation of the Strategic Plan 2008–2012. It conforms with the Organization's commitment to accountability and transparency in line with its results-based management framework. The report presents the end-of-biennium assessment for the Program and Budget 2010–2011 and the second interim progress report on the implementation of the PAHO Strategic Plan 2008–2012 (hereafter referred to as the Strategic Plan).

2. The report relies on information provided by the Performance Monitoring and Assessment (PMA) process conducted across the Pan American Sanitary Bureau (PASB). It consists of programmatic and budgetary implementation analyses by Strategic Objective (SO) and by each different level of the Organization. Information on PASB's resource mobilization to cover the funding gap for the approved Program and Budget 2010–2011 also provides an analysis of resource allocation by programmatic priorities.

3. According to the results of the assessment, the Organization continues to make steady progress toward achieving the targets set for 2013 in the Strategic Plan. The end-of-biennium assessment shows that of the 16 Strategic Objectives (SOs), 12 are on track and 4 are at risk. Of the 90 Region-wide Expected Results (RERs), 81 are on track, 8 are at risk, and 1 is in trouble. Of the 256 RER indicator targets, 232 (91%) were achieved; it is noteworthy that over 41% (94) RER indicators exceeded their 2011 targets—and of these, more than half have already met or exceeded their 2013 targets.

4. According to the progress noted in the different SOs, the Region has made important progress towards achieving the public health impact-level targets for 2013 as stated in the Strategic Plan. For example, the Region has made remarkable progress in further reducing infant mortality, with 31 countries having a mortality rate for children under 5 of less than 32.1 deaths per 1,000 live births—consequently exceeding the 2013 target (of 26 countries). In addition, the Region has made progress towards meeting elimination targets for neglected tropical diseases (NTDs), with 14 countries being certified as having interrupted the vectoral transmission of Chagas disease; in 2006, only 3 countries had this certification. The Region has further reduced the number of malaria cases in endemic countries, resulting in an overall reduction of 43% of the total number of cases as compared to the 2000 baseline. There has been a continued decrease of TB incidence, which fell to 29 cases per 100,000 in 2009, compared to 39 cases in 2006. In the Americas, the lives of approximately 174,000 children were saved as a result of

maintaining and expanding immunization coverage. A total of 5 countries achieved a mother-to-child transmission (MTCT) rate for HIV of less than 2%; and 9 countries achieved the universal access target for antiretroviral treatment (ART). Deaths due to noncommunicable diseases (NCDs) dropped to 2.1 million in 2007, compared to 2.4 million in 2000. In addition, 7 countries have managed to reduce their tobacco use by 10%.

5. Despite the significant progress noted above, there are some challenges worth noting. For example, the ongoing impact of the global financial crisis could compromise the countries' ability to continue the progress made thus far in reducing gaps and in maintaining advances achieved in public health; the slow reduction of the maternal mortality rate and the need for increased multisectoral collaboration to address the social determinants of health (which include equity, human rights, and protecting vulnerable groups). The fight against NCDs and lifestyle-related health problems and nutrition and food security remain salient issues. To ensure adequate detection, response, and management of public health emergencies of international concern (PHEICs), countries must strengthen their national core capacities in line with the International Health Regulations (IHR) (2005). Coverage of social protection in health must be increased through adequate and sustainable funding.

6. The approved base program segment of the Program and Budget 2010–2011 (PB) for the biennium was US$ 643 million,[1] of which the Organization had available $583 million (91%) for the biennium. The implementation rate of these funds for the biennium was 89% ($521 million). It is important to note that overall, there is a very good correlation between the implementation rates for programs and budgets: 91% of all RER indicator targets were achieved through implementing 89% of the budgetary funds available for the biennium. Of the $643 million allocated for the approved base programs and budget, $287 million came from the Regular Budget. The difference of $356 million constituted the initial funding gap. By the end of the biennium, the Organization was able to mobilize a further $296 million—thus reducing the funding gap to $60 million.

7. In addition to the base program segment, the PB included two other segments: Outbreak Crisis and Response (OCR) and National Voluntary Contributions (NVCs). During the biennium, the Organization received $48 million for OCR, and another $348 million from NVCs. The implementation rate for these funds was 98% for OCR and 75% for NVCs.

8. Combining the three segments of the PB, the Organization had a grand total of $979 million available for the biennium, with an overall implementation rate of 85%.

[1] Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

9. There has been a positive shift in resource allocation according to the programmatic priority assigned to the various SOs, particularly in 3 of the 5 top-priority SOs (namely maternal and child health, communicable disease prevention and control, and chronic disease prevention and control[2]). However, additional efforts will be needed to improve the alignment of resource allocation with programmatic priorities.

10. During the biennium, PASB continued investing in programs and initiatives to optimize the Organization's resources, including further consolidation of its Results-Based Management (RBM) framework and implementation of the International Public Sector Accounting Standards (IPSAS). Nevertheless, there is a need to address some key issues before fully implementing RBM across the entire Organization. These include further strengthening its accountability component, improving the documentation and application of lessons learned, simplifying the planning process, and strengthening both the quality and coherence of the different components of PAHO's Strategic Plan to better reflect progress towards impact- and outcome-level achievements at all levels of the Organization. In addition, there is a need to continue promoting and implementing the horizontal interprogrammatic approach—particularly for confronting the new challenges.

[2] The terms "noncommunicable diseases" (NCDs), "chronic noncommunicable diseases" (CNCDs), and "chronic diseases" are used synonymously throughout this document and generally throughout the Organization as a whole.

II. INTRODUCTION

11. As established in the PAHO Strategic Plan 2008–2012, the Pan American Sanitary Bureau (PASB) is required every two years to present progress reports to the Organization's Governing Bodies on the Plan's implementation. This report covers the 2010–2011 biennium and represents the second progress report presented to PAHO's Governing Bodies for that period.

12. The report relies on information provided by the Performance Monitoring and Assessment (PMA) process conducted across the PASB. It consists of programmatic and budgetary implementation analyses of the Organization's performance, including an analysis by organizational level (country, subregional, and regional entities) as well as by Strategic Objective (SO). The report also includes information on PASB's resource mobilization to cover the funding gap in the approved Program and Budget 2010–2011, as well as on the allocation of resources by organizational level and by SO.

13. The report incorporates the recommendations provided by Member States on the first progress report for 2008–2009, presented to PAHO's 50th Directing Council in September 2010. It also incorporates the input obtained from the Subcommittee on Program, Budget, and Administration (SPBA). The final report, which will be presented to the 28th Pan American Sanitary Conference (PASC) in September 2012, will include the recommendations from PAHO's 150th Session of the Executive Committee in June 2012.

14. This report is comprised of six sections: Sections I, II, and III cover the executive summary, introduction, and PMA process overview, respectively. Section IV includes the corporate analyses of programmatic and budgetary performance, as well as resource mobilization. Section V includes a summary of the conclusions and recommendations. Finally, Section VI contains Annexes I–IV; the detailed Progress Reports for each of the 16 SOs, with their respective RERs and RER indicators, are included in Annex I.

III. OVERVIEW OF THE PERFORMANCE MONITORING AND ASSESSMENT (PMA) PROCESS IN PAHO

15. The report reflects the assessment conducted at the end of 2010–2011. As established in the Organization's Performance Monitoring and Assessment process (PMA), the assessment involved all PASB entity managers and their teams, as well as the Executive Management (EXM). During this exercise the performance of each of the 69 PASB entities and the progress toward achievement of the 16 Strategic Objectives (SOs), 90 Region-wide Expected Results (RERs), and 256 RER indicators of the PAHO Strategic Plan 2008–2012 were reviewed. This exercise provided the main input for preparation of the progress report that will be presented to PAHO's Governing Bodies during 2012.

16. The assessment includes both quantitative and qualitative methods, described below.

17. First, the achievement of the RER indicator targets set for the end of 2011 is evaluated based on the information provided by the entity managers. This part of the methodology is quantitative—the target was either met or not—and the entity managers are accountable for achievement of the results under their responsibility and for the information they provide. For indicators of the type "number of countries," the reports of the country entity managers are aggregated to find out whether the number of countries required to meet the RER indicator target was achieved. Subsequently, a qualitative analysis of the RERs is undertaken, and finally, on the basis of this information, a qualitative analysis of the SOs is done. In both cases the number of targets of the RER indicators that were achieved is addressed.

18. The following rating criteria have been applied for the programmatic and budgetary monitoring of the RERs and SOs:

- 90–100% implementation rate = Green, or "on track": no impediments or risks are expected to significantly affect progress.
- 75–89% implementation rate = Yellow, or "at risk": progress is in jeopardy and action is required to overcome delays, impediments, and risks.
- <75% implementation rate = Red, or "in trouble": progress is in serious jeopardy due to impediments or risks that could preclude the achievement of targets.

19. Rates of 75% and above for programmatic implementation and 90% for budgetary implementation are considered an acceptable performance at the end of the planning period, as established in the Strategic Plan 2008–2012.

20. A brief description of the methodology used in each component of the report is included below.

Programmatic Assessment

21. *Analysis by SO:* Progress toward the achievement of the Strategic Objectives (SOs), set for the end of the Strategic Plan, is assessed by SO Facilitators. The Facilitators analyze the aggregated level of achievement of the respective RERs and factors contributing to the progress or hindrance of the SO achievement (qualitative assessment), taking into consideration the RER indicator targets achieved (quantitative assessment). The SO Facilitator rates the status of the SO at the end of the biennium and determines whether it is on track, at risk, or in trouble with respect to its achievement by 2013.

22. *Analysis by RER:* The assessment of RERs is done by the RER Facilitators. They assess the level of achievement of the RER indicator targets (quantitative assessment) and factors contributing to or hindering RER achievement (qualitative assessment). The RER Facilitator rates the status of the RER at the end of the biennium with respect to its achievement by 2013, determining whether it is on track, at risk, or in trouble.

23. *Analysis by RER indicator target:* Achievement of the RER indicators is measured by the attainment of their respective targets set for each biennium; that is, they are either achieved or not achieved.

Budgetary Assessment

24. *Budgetary implementation:* This is assessed for the Organization as a whole; by organizational level (country, subregional, and regional entities); by SO; and by source of funds, including both Regular Budget (RB) and Other Sources (OS). The budgetary implementation rate is obtained by dividing expenditures over the total amount of funds available for the biennium.

25. *Mobilization of resources:* The Program and Budget (PB) establishes the estimated amount of funds (planned cost) required to implement the program of work approved by the Governing Bodies for a given biennium. The PB also establishes the estimated amount of funds required for each SO. During the biennium, the PASB mobilizes resources to fill the funding gap of each SO. In line with Results-based Management (RBM), each entity plans the cost of its biennial work plan (regardless of the source of funds) according to the estimated amount of resources required to achieve its expected results and outputs during that biennium. During the biennium, resources are mobilized to fill the funding gap of SOs and entities, which in turn contribute to filling the Organization-wide funding gap. (At any point in the biennium, the difference between the original estimate and the current available resources from any source to fulfill the program is the funding gap.)

IV. PROGRAMMATIC AND BUDGETARY PERFORMANCE

(A) Major Achievements, Challenges, and Lessons Learned

26. The summary below highlights some of the major achievements, challenges, and lessons learned during the 2010–2011 biennium. The SO Progress Reports (in Annex I) include detailed information on each SO.

(1) *Major Achievements and Challenges*

27. The achievements and challenges highlighted below have been identified within the three components of the Strategic Framework for Cooperation laid out in PAHO's Strategic Plan:

- Completing the unfinished agenda
- Protecting the achievements already attained
- Tackling new challenges

(a) *Completing the Unfinished Agenda*

Achievements

(i) The Region of the Americas has witnessed remarkable progress in 2010–2011, in terms of both reducing infant mortality and improving maternal health—thus contributing to the achievement of the United Nations Millennium Development Goals (MDGs) 4 and 5. According to PAHO's Basic Indicators 2010, 31 the countries of the Region had a mortality rate for children under 5 of less than 32.1 per 1,000 live births; consequently, the Region has already exceeded the 2013 target (of 26 countries). Equally noteworthy is the improvement in the number of births attended by skilled health personnel in Latin America and the Caribbean, which now stands at an estimated 92.9%—thus exceeding the 2013 target (of 90%).

(ii) Advances were made towards achieving the regional elimination targets for neglected tropical diseases (NTDs) such as onchocerciasis, Chagas disease, and schistosomiasis. A total of 14 countries have been certified as having interrupted the vectoral transmission of Chagas disease, and Colombia is in the process of receiving certification for having eliminated onchocerciasis.

(iii) Malaria cases continued to decrease in 18 of the 21 endemic countries of the Region. According to the WHO World Malaria Report 2011, reported cases in the Region of the Americas decreased from 1,182,418 in 2000 to 678,164 in 2010—which amounts to a 43% reduction in the number of cases.

Likewise, the 130 deaths reported in that same year constitute a 65% decrease in the number of deaths as compared to the 2000 baseline.

(iv) Since 2006, the continued decrease in tuberculosis (TB) incidence per 100,000 inhabitants (including HIV patients with TB) indicates that the 2013 target of 27 cases of TB incidence will indeed be achieved; actually, in 2009, the number was down to 29.

(v) Ongoing progress has been noted in addressing gender, cultural diversity, human rights, and the health of indigenous peoples and other ethnic groups as well as that of other vulnerable groups. A total of 31 countries are now implementing plans to advance gender in the health sector; 11 countries have reviewed or formulated policies and laws in a manner consistent with international human rights instruments; and 21 countries are implementing policies, plans, or programs to improve the health of indigenous peoples. In addition, some 17 countries have implemented the Faces, Voices, and Places initiative.

(vi) While challenges remain in addressing nutrition and food security issues, 26 countries either have already implemented or are in the process of implementing multisectoral coordination mechanisms, policies, plans, or programs to prevent malnutrition within their national food security and nutrition framework.

Challenges

(i) As noted in the Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity (approved by PAHO's 50th Directing Council in 2010), almost none of the countries are reducing maternal mortality at a rate sufficient to meet the MDG-5 target—including those with lower maternal morbidity and mortality (MMR) figures, such as Canada and the United States. A total of nine countries of the Region have MMR figures above the regional average of 88.9 per 100,000 live births. In addition, 95% of all maternal mortality is preventable—as is indicated by the most frequent causes of death (pregnancy-induced hypertension, hemorrhaging, complications arising from abortions performed in unsafe conditions, obstructive labor, sepsis, and other direct causes).

(ii) While the countries continued to reduce the incidence of malaria, various challenges remain. These include sustaining and strengthening surveillance at all levels of the health system in order to detect malaria threats and consequently trigger appropriate responses with minimal delays. A further challenge lies in identifying resistance to antimalarial medicines (antimalarials).

(iii) The Healthy Settings approach gained momentum under the renewed Health Promotion (HP) agenda, with a focus on the social and environmental determinants of health. However, greater efforts are needed to fully implement the renewed strategy and actions outlined in Health Promoting Schools: Strengthening of the Regional Initiative—Strategies and Lines of Action 2003–2012 as approved by PAHO's Directing Council.

(iv) Intersectoral action remains a challenge to address the social determinants of health (SDH), including issues related to climate change. In 2011, both the Regional Consultation on the Social Determinants of Health and the World Conference on Social Determinants of Health were predominantly attended by the health sector—despite efforts to involve other sectors. Some countries are still not addressing the topic of climate change and health. There is also the challenge of implementing environmentally sound vector management policies.

(v) Challenges in the area of nutrition include the following needs:

- To promote dialogue with multiple actors and counterparts.
- For ministries of health to identify national priorities in nutrition.
- To improve existing databases on nutritional processes for small children.
- To motivate the countries to continue improving their programs.
- To mobilize the necessary political will and financial resources to incorporate indicators of nutritional status into health surveillance systems.
- To mobilize resources for promoting and supporting research as well as for disseminating evidence-based information.

28. It is noted that SO9 (on Nutrition and food security) is at risk of not achieving its targets for 2013.

(b) *Protecting the Achievements Already Attained*

Achievements

(i) The Region of the Americas has continued to maintain and expand immunization coverage, which has resulted in saving the lives of approximately 174,000 children every year. All countries and territories maintain their polio-free status and expect to sustain eradication through 2013 and beyond. They also have achieved the interruption of endemic transmission of measles, rubella, and congenital rubella syndrome (CRS).

(ii) Ongoing progress has been made on implementing the Renewed Primary Health Care Strategy, with 7 countries already implementing the strategy and 18 in the process of doing so.

(iii) The national health authorities continued to strengthen their stewardship and leadership role. A total of 29 countries have formulated policies as well as mid-term and long-term plans. Some 18 countries have established national commissions to monitor compliance with ethical standards in scientific research. In 12 countries, the National Regulatory Authorities (NRAs) for Medicines and Biologicals have been evaluated, and with 4 of them designated as Regional Reference NRAs. A total 17 countries have formulated health-sector policies and national programs for rehabilitation, which are aligned with PAHO/WHO recommendations for disability and rehabilitation, and with the framework of fulfilling the UN Convention on the Rights of the People with Disabilities.

(iv) Countries continued to invest in interventions to improve access to care and quality of care. Some 22 countries have implemented the PAHO/WHO Strategy on Quality of Care and Patient Safety, and 19 countries have incorporated into their national constitutions either the right to health (which enshrines access to medicines) or the right to access to medicines and health technologies.

Challenges

(i) While some progress has been made in expanding social protection and increasing health financing, there is a need to significantly expand coverage of social protection in health through adequate and sustainable funding. This is critical if continued progress is to be made in reducing gaps, protecting the gains already made, and tackling new public health challenges.

(ii) The epidemiological surveillance of vaccine-preventable diseases (VPDs) and the quality of data in periodic reports both need to be strengthened. The impact of vaccination interventions targeting low-coverage municipalities is not easily demonstrated, given that data are still unavailable.

(iii) While countries have advanced in improving the quality of care as well as patient safety, the integration of this initiative across health programs remains a challenge.

(iv) As new priorities in public health are defined, there is a continuing and increasing need to support issues related to policy, regulation, and use of medicines and health technologies—as well as to the integration of intercultural approaches within health policies and systems. Similarly, disease areas and other public health priorities will require significant additional support, using a common approach based on health systems. The

need for integration across technical areas is of the utmost importance—including within the ministries of health—in that it links work done in the area of pharmaceuticals management both with the disease program areas and the countries' health services—as well as within the National Regulatory Authorities.

(v) To implement the Policy on Research for Health, it will be necessary to scale up resources (including funding), partnerships, technical cooperation, and integration of research into health care planning and delivery.

(vi) Expanding South-South cooperation of human resources for health (HRH) has required strengthening coordination among the regional, subregional, and national entities responsible for developing policies, as well as renewing partnerships with the leading countries in HRH for both technical and financial cooperation.

(vii) There has been limited progress made in producing the empirical evidence needed to increase awareness of the impact of catastrophic health expenditure and its consequences on increasing the financial risks of households falling into poverty. It will be necessary to scale up country efforts and technical cooperation, including funding, to support the production of evidence on this topic. There is a lack of data to support equity studies in countries where there are great disparities in the utilization of and access to health services.

(c) *Tackling New Challenges*

Achievements

(i) The estimated incidence rate of HIV infections has continued to fall. In 2010, the estimated rate was 18 cases per 100,000 inhabitants—lower than the established target of 23 per 100,000 for 2013.

(ii) Some 5 countries have reported achieving a mother-to-child transmission (MTCT) rate for HIV of less than 2%; and 7 additional countries are on track, with an HIV-MTCT rate of between 2% and 7%.

(iii) Access to antiretroviral (ARV) treatment has improved. By the end of 2011, 9 countries had achieved the universal access target of having provided coverage to 80% or more of those in need; and an additional 5 countries had an estimated coverage of 70%–79%. Also noteworthy is the increase in the number of countries participating in the PAHO Strategic Fund, which has risen from 21 to 24 countries.

(iv) The Region of the Americas has made important progress in responding to the challenges of noncommunicable diseases (NCDs) and lifestyle-related health problems and behaviors, with increased political and technical commitment for NCDs at regional, subregional, and national levels. This

was heightened with the United Nations High-Level meeting (UNHLM) on Noncommunicable Diseases. The Pan American Forum for Action on NCDs was established as a platform to bring together government, business, and civil society to raise awareness and scale up successful practices. Deaths in Latin America and the Caribbean (LAC) had been reduced to 2.1 million by 2007 (thus meeting the 2013 target); and the mortality rate due to road traffic injuries had been reduced to 15.8 per 100,000 inhabitants (according to figures from 2007). Programs for NCDs have been established in 22 countries, with special emphasis on diabetes, cardiovascular diseases (CVDs), and cancer. Furthermore, the Chronic Care Model has been adopted by over 20 countries to improve the quality of health services for integrated NCD management. In addition, 22 countries now have a national policy or plan for NCDs and have shared experiences through the CARMEN network (the name comes from its Spanish acronym for "Collaborative Action for Risk Factor Prevention and Effective Management of Noncommunicable Diseases").

(v) Over the past four years, the countries of the Americas have made significant progress in implementing the WHO Framework Convention on Tobacco Control (FCTC). Some 7 countries have reduced the prevalence rate of tobacco use by 10%; 11 countries have adopted 100% smoke-free environment legislation; 4 have adopted bans on tobacco advertisement, promotion and sponsorship; and 17 have enacted regulations on the packaging and labeling of tobacco products.

(vi) The Region of the Americas has continued to demonstrate strong leadership in the health sector when responding to disasters, emergencies, and epidemics. Priority has also been given to the area of risk reduction. With the approval by PAHO's 50th Directing Council of the Regional Plan of Action on Safe Hospitals, the health sector became the first sector to have developed a regional plan of action among those contributing to the Hyogo Framework for Action (HFA) for building disaster resilience. In accordance with this plan, 28 countries have implemented the Safe Hospital Index. A Safety Index for Smaller Health Facilities was also designed and implemented. During the biennium, the Region was affected by major catastrophic events. These included earthquakes in Haiti and Chile; cholera in Haiti; floods in Central America, the Dominican Republic, the Bahamas, Bolivia, and Colombia; and a volcanic eruption in Ecuador. The countries responded to these disasters in an effective and solidaristic manner. It is important to note that PAHO, in collaboration with the countries, responded to all emergencies according to established timelines and protocols.

Challenges

(i) Challenges remain to fully operationalize the regional policy and plan for chronic noncommunicable diseases (CNCDs) through a truly multisectoral approach (as outlined in PAHO's Strategy and Plan of Action for an integrated approach to prevention and control of chronic diseases, including diet, physical activity and health, as approved by PAHO's 47th Directing Council in 2006). There is also the need to enhance and continue the integration of CNCDs and their common risk factors with other programs to introduce cross-cutting platforms and thus reduce the downsides associated with vertical approaches. Countries have proven their ability to establish CNCD surveillance. Nonetheless, a major challenge remains in terms of sustainability, since such surveillance requires well-prepared human resources as well as stable financial resources.

(ii) The sustainability of national-level Emergency Preparedness programs will require an ongoing commitment to assigning the necessary human and financial resources.

(iii) Interference by the tobacco industry, including corporate social responsibility campaigns, continues to be a challenge to sustaining and advancing work in tobacco control.

(iv) An increase in alcohol consumption due to investments made by the alcohol industry in increasing their market share in Latin American and the Caribbean constitutes a major challenge for programs addressing a reduction in alcohol use.

(2) ***Main Achievements of PASB's Technical Cooperation***

(a) PASB continued to provide leadership on matters critical to health and engage in partnerships within the United Nations (UN) System on health cluster and alignment, as well as health harmonization issues, at both regional and country level. PASB was actively engaged with countries and partners in the successful United Nations High-level Meeting (NHLM) on Noncommunicable Diseases (NCDs), highlighting the priority that NCDs should have at national, subregional, regional, and global levels. This is illustrated by the Global Conference on the Social Determinants of Health (Rio+20) and by such strategic technical cooperation initiatives as the Safe Motherhood initiative, the Pan American Alliance for Nutrition and Development, the Faces, Voices, and Places initiative, and the development of the Regional Action Plan for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. In addition, Country Cooperation Strategies (CCSs) have been developed for 34 countries and territories, as well as 3 Subregional Cooperation Strategies (SRSs). In the course of 2010–2011, PAHO Governing Bodies (GB) approved 32 Resolutions

endorsing 4 Policies, 15 Strategies and Plans of Action, and 3 Concept Papers, as well as adopting other important decisions on public health issues (these documents can be found on the PAHO website at: http://new.paho.org/hq/index.php?option=com_content&task=view&id=42&Itemid=189).

(b) PASB continued to shape the research agenda and stimulate the generation, dissemination, and application of valuable knowledge though several reports and publications, including, among others, the following:

- Earthquake in Haiti—January 2010: Lessons to be learned for the next massive sudden-onset disaster.
- Thirty Years of Immunization Newsletter: the history of the EPI in the Americas.
- First Regional Report on the Health Situation of Indigenous Young People (PAHO/ECLAC/AECID).

(c) Evaluation and planning for HIV/AIDS response using a health systems perspective has been conducted in 10 countries, and tools to incorporate HIV prevention into national plans were disseminated and applied in 14 countries. Some 7 country studies on inequalities and inequities in access to and utilization of health services have been produced; these studies are key in supporting the evaluation and implementation of policies to reduce health disparities. Furthermore, a virtual platform for a Community of Practice in Primary Health Care (PHC) was established, a regional assessment of PHC was conducted, and an analytical framework/methodology for assessing health system performance with PHC 'lenses' was developed. A virtual course on PHC in English was implemented through PAHO's Virtual Campus in Public Health (VCPH). There was a significant increase in the number of textbooks and materials provided through the Expanded Program of Textbooks and Learning Materials (PALTEX, taken from the name in Spanish, Programa Ampliado de Libros de Texto y Materiales de Instrucción). PALTEX showed an increase of 58 new editions and 93 new titles, for a total of 739 items made available during 2010–2011.

(d) Sustained progress was made in the development of projects, products, and services that strengthen the Organization's role at both regional and global level as an authoritative source of information and knowledge related to health sciences. Among others, worth highlighting are three main initiatives resulting from collective processes:

- The *eHealth* Strategy.
- The Knowledge Management and Communication Strategy.
- The adoption of a Strategic Relationships Networks model.

(e) PASB continued leading the development of norms and standards, as well as promoting and monitoring their implementation. This includes the production of five manuals to support the implementation of Integrated Health Service Delivery Networks (IHSDNs), which encompasses a revitalization of technical cooperation on hospitals within the IHSDN framework at the global, regional, and country levels. This included a proposal for a regional agenda on hospitals; the Global School-based Student Health Survey (GSHS), with the participation of 22 countries; and development of a costing tool, a field guide, and laboratory guidelines for the implementation of the Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis. Similarly, a review of legislation from 11 countries was completed using a human rights approach.

(f) In establishing technical cooperation, catalyzing change, and building sustainable institutional capacity, PASB has been consistently reviewing its processes and exploring new modalities for technical cooperation. For instance, the new modality for technical cooperation with PAHO/WHO Collaborating Centers and National Reference Institutions has improved the Organization's capacity to respond to its Member States. It is also worth noting that the Organization's continual efforts to invest in optimizing the use of its resources—including the use of such information technology as online conferencing via Elluminate, a modern telephone system, and the centralization of information infrastructure—has helped to improve efficiency while still containing operating costs. Additional efforts along these lines include consolidation of the PAHO Domain and PAHO private network, further consolidation of the RBM framework across the Organization, and continued Implementation of International Public Sector Accounting Standards (IPSAS). It is important to note that the Organization received an unqualified Audit Opinion for 2010. In addition, successful negotiations with strategic partners—both traditional and non-traditional—have resulted in PASB having mobilized $70 million over a three-year period (2011–2013).

(g) PASB continued monitoring the health situation and assessing health trends. This was accomplished through ongoing programs and specific initiatives. These include the Public Health Intelligence and Information Platform; yearly publication of the Health Situation in the Americas Basic Indicators and Noncommunicable Diseases Basic Indicators 2011; the Regional Consultation on Social Determinants of Health, where recommendations were defined and disseminated to contribute to the Rio Declaration negotiated by Member States at the World Conference on Social Determinants of Health. The Regional Platform for Access and Innovation for Health was developed and is scheduled to be launched in January 2012 as a regional instrument to support the implementation of the Global Strategy on Public Health, Innovation, and Intellectual Property.

Challenges for PASB Technical Cooperation

(a) While significant progress has been made in PAHO's implementation of RBM—particularly in terms of planning and of performance monitoring and assessment (PMA)—its relevance, coherence, integration, and correlation can be improved across the chain of results ensuing from the Strategic Plan—all the way from SOs to RER indicators. In addition, the PMA process can be better utilized to make the necessary changes to the indicators and targets in light of any changes that might arise in the situation during the implementation of the Strategic Plan.

(b) PASB needs to continue improving and promoting successful models for an integrated approach to technical cooperation, in order to maximize its impact on public health. This includes documenting and evaluating lessons learned.

(c) The lack of an integrated PASB management information system compromises the ability to continue improving on efficiency, and in obtaining quality and timely information for management and decision-making.

(d) The absence of an integrated corporate resource mobilization strategy—coupled with weak mechanisms for engaging non-traditional partners, including the private sector—remains a challenge.

(e) While some partners have recognized the value of a program approach for Voluntary Contributions (VCs), PASB faces continuous challenges with earmarked funding. It is important to continue strengthening the program approach in negotiations for VCs while still balancing the diversity of interests among partners through collective priorities set in the Strategic Plan.

(3) ***Lessons Learned***

(a) The need to strengthen advocacy and solidarity was a valuable lesson learned in the case of advocacy for measles/rubella eradication in global forums—as well as the need for countries to remain vigilant, so that they can quickly address importations to the Region.

(b) A fine example from which lessons can be learned lies in the support and solidarity given by other countries when a country's tobacco legislation was attacked by the tobacco industry; this should be maximized in future initiatives.

(c) Alliances, articulation, cooperation, and coordination were common themes in the lessons learned during this biennium. Some examples include the following:

- Building alliances with countries and agencies was key to the development and launch of the Latin American and Caribbean Network for Health Information Systems (RELACSIS, with the acronym taken from the name in Spanish, Red Latinoamericana y del Caribe para el Fortalecimiento de los Sistemas de Información de salud). RELACSIS was the result of a strategic partnership between the United States Agency for International Development (USAID), PAHO, and Monitoring and Evaluation to Assess and Use Results (MEASURE-Evaluation), with active participation on the part of all the countries involved.
- The success of the strategy of community-based rehabilitation, which was articulated both with the assistance network and with intersectoral participation, has made it possible to provide greater care coverage to meet the needs of persons with disabilities and their families, to promote health promotion and prevention of disability, and also to promote the rehabilitation and social integration of persons with disabilities.
- Another lesson learned was the importance of improving the articulation of the agendas for noncommunicable diseases, sustainable development, and the social determinants of health.

(d) The continuous review and updating of the CCS process has resulted in much-improved strategic agendas, providing key input for the formulation of the next PAHO and WHO strategic plans. Furthermore, CCS has been a valuable input for the United Nations Development Assistance Framework (UNDAF) process, especially to highlight the importance of health in the UN common agenda at country level.

(e) The lessons learned in activities that included collaboration, coordination, cooperation, and networking among both countries and agencies demonstrated the value of these approaches. For example, the renewal of the PAHO/WHO Collaborating Center Network on Occupational Health showed that the core values of collaborating networks and strategic alliances for attaining common goals continue to be effective ways of collaborating, communicating, creating, and innovating with critical thinking among network members. The strategy for network collaboration is relevant: it strengthens leadership and governance, as well as the capacity required for their effective functioning (examples include the HRH Observatory and the Virtual Campus in Public Health). However, this requires both medium- and long-term institutional commitment for its sustainability. The use of social networks in disaster management work yielded positive results and can be enhanced with the development of a strategy for their systematic integration.

(f) Another important lesson worth highlighting is how to maximize recurrent and concurring events and/or build on existing initiatives to improve technical

cooperation and facilitate project implementation. An example of this was the use of World Health Day (WHD) to promote innovative concepts, as demonstrated with the launch of Urban Health initiatives during WHD 2010. In addition, the success of cholera preparedness in the Caribbean was partly due to the previous experience of the Caribbean countries in developing and testing their respective National Influenza Pandemic Plan.

(g) Valuable lessons also were learned in the area of public health policy and plans:

- The value of integrated approaches in technical cooperation was highlighted in the important advances produced in the countries in terms of strengthening policy development and in regulating the use of medicines and health technologies.
- Similarly, it was learned that the integration of activities in the area of neglected infectious diseases (NIDs) into other public health programs is necessary to achieve targets. For instance, most countries continue to evaluate their Essential Public Health Functions (EPHFs) without developing a specific plan for strengthening those that most need to be addressed; this is just one example of the need to strengthen monitoring and evaluation and to improve the quality and relevance of indicators.
- Robust national health research systems enable countries to maximize the benefits of research, and PAHO's Policy on Research has strengthened a systematic approach in its implementation. Quantitative targets may be achieved in some indicators; however, qualitative advances may not be robust enough. For example, countries can develop institutional development plans or design public policies to reduce the financial risk associated with diseases; but the sustainability, efficiency, and quality of these plans and policies remain an issue.

(h) PAHO's role as an authoritative source and broker of evidence-based public health information and knowledge is becoming increasingly essential, given the both overload of health information and the rise in the use of social networks.

(i) The value and importance of tools and guidelines to implement initiatives was identified in the success of the Hospital Safety Index, which demonstrated that low-cost, highly effective practical tools can enhance participation and serve as a stimulus to identify priorities and switch from theory to practice. On the other hand, it was identified that while Member States are committed to the Social Determinants of Health approach, they need concrete tools to move their agenda forward. Finally, one lesson learned was that integration processes are difficult, complex, and long term, requiring extensive systemic changes. Integration does not mean that all network components must be integrated into a single modality, as multiple modalities and degrees of integration can coexist within a single system. What countries require is operational guidelines on how to implement

Integrated Health Services Delivery Networks (IHSDNs); a first step in this direction has been made with the development of five guidelines to support integration processes.

(B) Programmatic Assessment by SO

29. This section includes corporate analysis of the progress towards achieving the 16 SOs, 90 RERs, and 256 RER indicator targets of the Strategic Plan as a whole. The Progress Reports for all the Strategic Objective (SOs), their Region-wide Expected Results (RERs), and their respective RER indicators—with relevant details—is included in Annex I.

Progress made towards achieving the SOs

30. At the end of the second period of implementation of the Strategic Plan 2010-2011, 12 of SOs were on track (green) and 4 were at risk (yellow: SO1, SO9, SO13, and SO14). It is worth noting that there was no SO in trouble (red). The assessment of the RERs and RER indicators indicates an overall improvement in the progress made towards achieving the targets set under each SO. Table 1 presents an overall summary of the status of the RERs and RER indicators for each SO at the end of 2011.

Table 1: Progress Made towards Achieving Strategic Objectives, 2010–2011 Biennium

Strategic Objectives	SO Rating	Status of RERs	Status of RER Indicator Targets
SO1: Communicable diseases		7 out of 9 on track and 2 at risk.	18 out of 22 achieved and 4 not achieved.
SO2: HIV/AIDS, TB, and malaria		5 out of 6 on track and 1 at risk	21 out of 24 achieved and 3 not achieved.
SO3: Chronic noncommunicable diseases (CNCDs)		6 out of 6 on track	26 out of 27 achieved and 1 not achieved.
SO4: Maternal, child, adolescent, and elderly health		8 out of 8 on track	15 out of 15 achieved
SO5: Emergencies and disasters		7 out of 7 on track	17 out of 17 achieved.
SO6: Health promotion and risk factors		6 out of 6 on track	12 out of 14 achieved and 2 not achieved
SO7: Social and economic determinants of health		5 out of 6 on track and 1 at risk	11 out of 12 achieved and 1 not achieved.
SO8: Healthier environment		6 out of 6 on track	13 out of 13 achieved
SO9: Nutrition, food safety, and food security		4 of 6 on track, 1 at risk, and 1 in trouble	10 out of 14 achieved and 4 not achieved
SO10: Health services		3 out of 3 on track	6 out of 7 achieved and 1 not achieved.
SO11: Health systems leadership and governance		5 out of 5 on track	14 out of 14 achieved
SO12: Medical products and technologies		3 out of 3 on track	8 out of 9 achieved and 1 not achieved
SO13: Human resources for health		3 out of 5 on track and 2 at risk.	10 out of 13 achieved and 3 not achieved
SO14: Social protection and financing		4 out of 5 on track and 1 at risk.	8 out of 10 achieved and 2 not achieved
SO15: PAHO/WHO leadership and governance		3 out of 3 on track.	14 out of 15 achieved and 1 not achieved
SO16: Flexible and learning organization		6 out of 6 on track	29 out of 30 achieved and 1 not achieved
PAHO SO Summary	**13 (81%) out of 16 SOs on track**	**81 (90%) out of 90 on track, 8 at risk, and 1 in trouble**	**232 (91%) out of 256 RER indicators met their 2011 targets**

On track At risk

Progress made towards achieving the RERs

31. As noted in Table 1, 81 (90%) of the 90 RERs were on track (green), 8 (10%) were at risk (yellow), and 1 was in trouble (red). The RER in trouble was 9.4, "Development, strengthening and implementation of plans and programs for improving nutrition through the lifecourse." Figure 1 shows the color rating for each RER, and Table 2 contains the 8 RERs rated at risk. Compared to 2008–2009, there was a reduction of 13 in the number of RERs rated as being at risk. However, of the 8 RERs rated at risk, 6 were at risk in 2008–2009 as well. These are marked with asterisks in Table 2 for ease of reference.

32. Figure 1 displays the rating of the SOs and their respective RERs. The SOs with RERs at risk include SO1 (Communicable diseases), SO2 (HIV/AIDS, TB, and malaria), SO7 (Social and economic determinants of health), SO9 (Nutrition, food safety, and food security), SO13 (Human resources for health), and SO14 (Social protection and financing). SO9 is the only one with an RER in trouble (red), as noted above.

Figure 1: Progress Made towards Achieving SOs and RERs, End of Biennium, 2010–2011

SO1: Communicable diseases
SO2: HIV/AIDS, TB, and malaria
SO3: Chronic noncommunicable diseases (CNCDs)
SO4: Maternal, child, adolescent, and elderly health
SO5: Emergencies and disasters
SO6: Health promotion and risk factors
SO7: Social and economic determinants of health
SO8: Healthier environment
SO9: Nutrition, food safety, and food security
SO10: Health services
SO11: Health systems leadership and governance
SO12: Medical products and technologies
SO13: Human resources for health
SO14: Social protection and financing
SO15: PAHO/WHO leadership and governance
SO16: Flexible and learning organization

33. As shown in Table 2, most of the RERs at risk and the one in trouble (RER 9.4) are related to high-level policy, plans, and interventions to scale up and sustain achievements. These require continued political commitment on the part of Member States, as well as advocacy from PASB, to raise their priority within national agendas. Some of these RERs also include new commitments that require additional efforts and

resources from within and beyond the health sector (for example, public policies and financial schemes for social protection, nutrition, and food security, as well as the International Heath Regulations). Close attention needs to be paid to these RERs and their indicators in 2012–2013 in order to address the challenges that hinder progress made in the respective topics.

Table 2: Region-wide Expected Results "At Risk" and "In Trouble," 2010–2011

Strategic Objective	RER No.	RER
SO1: Communicable diseases	1.3	Prevention, control, and elimination of neglected diseases and communicable diseases**
	1.6	International Health Regulations (IHR) and epidemic alert and response**
SO2: HIV/AIDS, TB, and malaria	2.1	Prevention, treatment, and care of HIV/AIDS, TB, and malaria**
SO7: Social and economic determinants of health	7.6	Policies, plans, and programs that apply an intercultural approach based on primary health care, and strategic alliances and partnerships to improve the health and well-being of indigenous peoples and racial/ethnic groups
SO9: Nutrition, food safety, and food security	9.3	Surveillance, monitoring, and evaluation of food security, nutrition, and policy options**
	9.4	Development, strengthening, and implementation of plans and programs for improving nutrition throughout the lifecourse***
SO13: Human resources for health	13.2	Establishment of a set of basic indicators and information systems on human resources for health
	13.3	Formulation and implementation of strategies and incentives to recruit and retain health personnel based on primary health care
SO14: Social protection and financing	14.2	Public policies and financing schemes to reduce the financial risks associated with diseases and accidents**

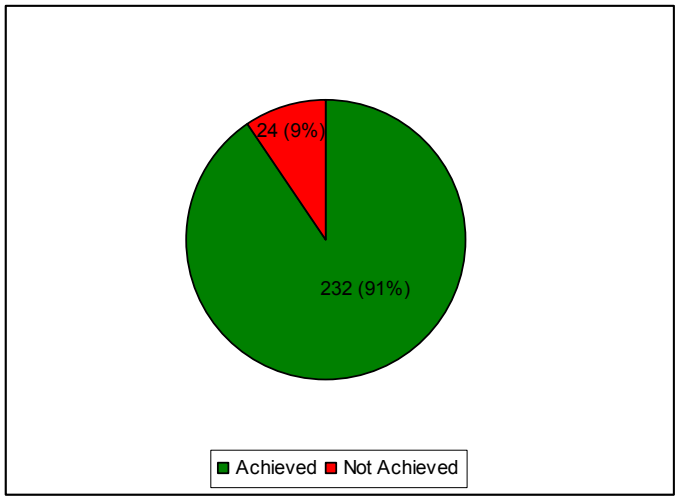
Note: Short titles for RERs are used for ease of reference.
** At risk since 2008–2009; the SO assessment reports included in Annex I provide details on the status of each RER.
*** RER in trouble (9.4 is the only one in trouble).

Status of RER indicators

34. The assessment of the RER indicator targets shows that of a total of 256 indicators, 232 were achieved and 24 were not achieved (Figure 2). This marks an increase of 6 percentage points in targets achieved as compared to the 2008–2009

biennium. It is important to note that of the 232 indicators that achieved their targets, 41% (96 indicators) exceeded their 2011 targets; and over half of these even met or exceeded their 2013 targets. It is also noteworthy that considerable progress was made in the 24 indicators that were not achieved (the methodology used here only considers those that fully met their target as having achieved it; there is no allowance made for partial achievement). The details on each RER indicator are included in the SO Progress Reports in Annex I, including the list of countries that achieved the targets by the end of 2011 for those types of indicators that provide the number of countries that achieved those particular targets. A summary of the RER indicators that did not achieve their targets for 2011 is included in Annex II.

Figure 2: Achievement of RER Indicator Targets, End of Biennium, 2010–2011



(C) Budget and Resource Mobilization

Overall Budget Overview

35. During the biennium, there was a total of $979 million for the three segments of the Program and Budget 2010–2011 (PB): Base Programs ($583 million), Outbreak Crisis and Response (OCR) ($48 million), and National Voluntary Contributions (NVCs)[3] ($348 million). The overall budget implementation was 85% ($830 million out of 979 million). The implementation by segments was as follows: 89% for base programs ($521 million out of $583 million); 98% for OCR ($47 million out of 48 million); and

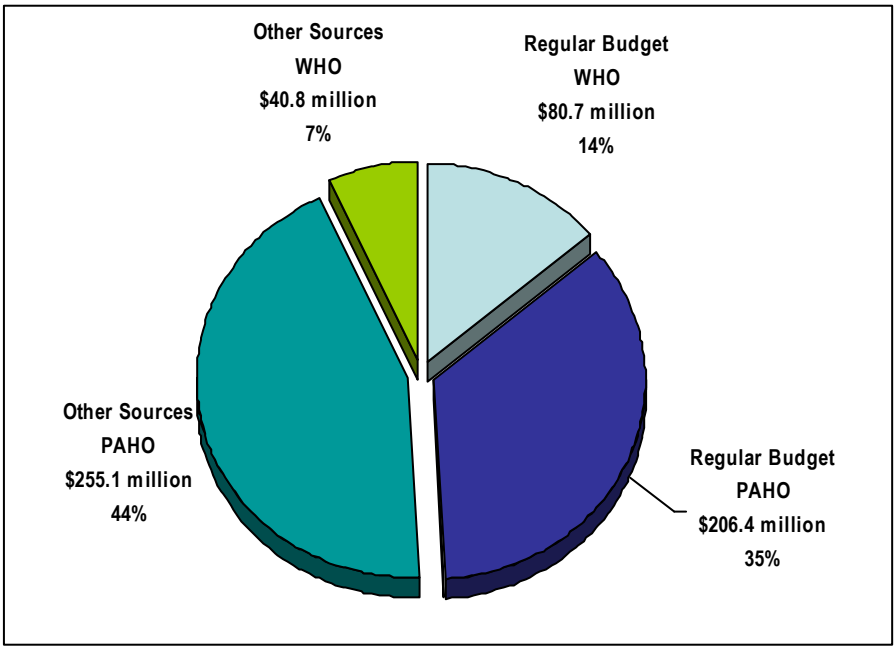
[3] National Voluntary Contributions were formerly identified as "Government-financed-internal projects."

75% for NVCs ($262 million out of 348 million). The analysis of each budget segment is presented below.

Base Programs Segment

36. The approved budget for this segment was $643 million, of which $583 million (91%) was available for the biennium. This represents an increase of $24 million over the amount of funds available in 2008–2009 ($559 million). As shown in Figure 3, of the total amount of funds available for the biennium, 49% or $287 million was approved from the Regular Budget (RB, with $206 million coming from PAHO and 81 million from WHO—i.e., the share earmarked for its Regional Office for the Americas, AMRO, which is PAHO), while 51% or $296 million came from other sources (OS, with $255 million coming from PAHO and 41 million from WHO).

Figure 3: Funds Available for the Biennium 2010–2011, by Source (in US$)



37. Table 3 shows the distribution of the available funds by organizational level. It is noteworthy that the distribution of funds available by organizational level (as a percentage of the total funds available for the biennium) complied with the Regional

Program Budget Policy (RPBP).[4] While this policy applies only to RB funds, it also guided the allocation of OS funds.

Table 3: Budget Overview by Organizational Level, Biennium 2010–2011

Organizational Level	Approved Program Budget 2010–2011 (in thousands of US$)	Funds Available for the Biennium (in thousands of US$)	Funds Available for the Biennium (as a percentage of the Program and Budget 2010-2011)	Distribution of Funds Available (as a percentage of the total funds available)
Country	234,860	236,818	101%	41%
Subregional	43,699	32,249	74%	6%
Regional	364,392	313,947	86%	54%
Total	**642,951**	**583,014**	**91%**	**100%**

38. The total budget implementation of base programs was $521 million (89% of the $583 million that was available for the biennium). As shown in Table 4, the regional level had the highest implementation rate, followed by the country level.

Table 4: Budgetary Implementation by Organizational Level and Source of Funds, End of Biennium, 2010–2011

Organizational Level	Funds Available for the Biennium (in thousands of US$)	Expenditure (in thousands of US$)	Implementation Rate (in %)
Country	236,818	202,576	86%
Subregional	32,249	26,070	81%
Regional	313,947	292,347	93%
Total	**583,014**	**520,993**	**89%**

Resource mobilization

39. Of the $643 million approved for the Program Budget 2010–2011, $287 million was expected from the Regular Budget ($206.4 million from PAHO and 80.7 million from WHO). The difference, $356 million, was the initial funding gap expected to be filled by Other Sources. During the biennium, the Organization was able to mobilize $295 million, thus reducing the funding gap down to $60 million or 17%. Table 5 shows

[4] The RPBP stipulated the following distribution of RB funds for the 2010–2011 biennium: country level, 40%; subregional level, 7%; and regional level, 53%.

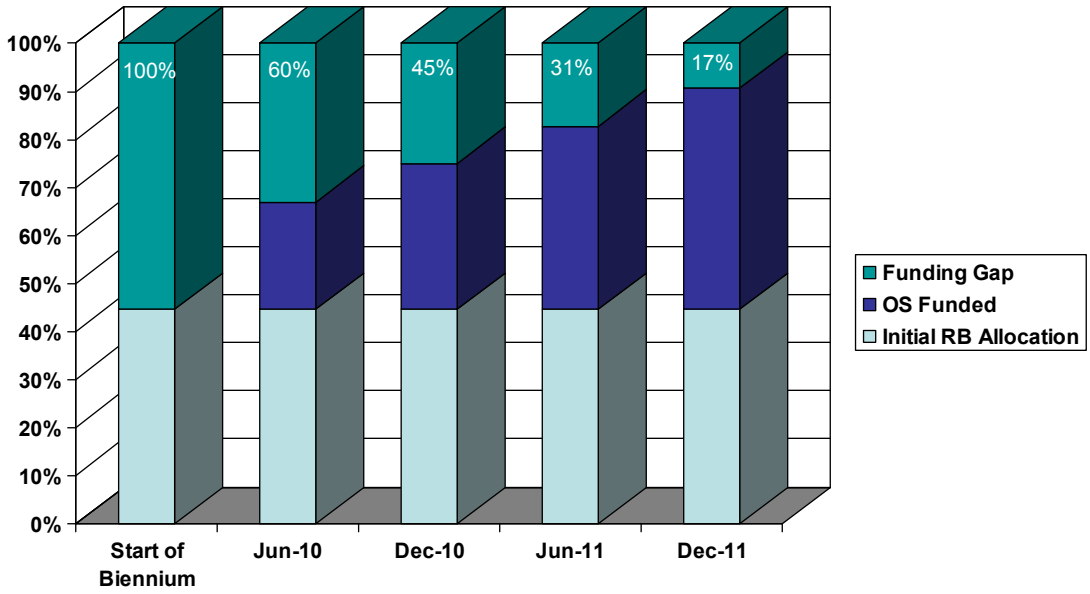
the funding gap at the beginning and at the end of the biennium, and Figure 4 shows the progressive reduction of the funding gap during the biennium. The Organization was successful in mobilizing about 5% ($15 million) more funds from Other Sources compared to 2008–2009. The partners that provided major contributions to reducing the funding gap during 2010–2011 were the following Governments and international organizations:

- Canada, through the Canadian International Development Agency (CIDA), Health Canada, and the Ministry of Foreign Affairs
- Spain, through the Spanish International Cooperation Agency (AECI)
- The United States of America, through the Centers for Disease Control and Prevention (CDC), the Department of State, the Food and Drug Administration (FDA), and the United States Agency for International Development (USAID)
- Sweden, through the Sweden International Development Agency (Sida)
- Norway, through the Norway Development Agency (NORAD)
- The Netherlands
- The European Commission (EC)
- United Nations Agencies, i.e., the United Nations Development Program (UNDP), the World Bank, and the United Nations Population Fund (UNFPA)
- The Global Alliance for Vaccines and Immunizations (GAVI)
- The Pan American Health and Education Foundation (PAHEF)

Table 5: Status of the Funding Gap, End of Biennium, 2010–2011

Funding Type	Beginning of Biennium (in thousands of US$)	End of Biennium (in thousands of US$)
Approved Program and Budget 2010–2011 (PB 10–11)	642,951	642,951
Regular Budget	287,100	286,697
Resources mobilized	0	295,915
Funding gap	(355,851)	(59,936)

Figure 4: Status of the Funding Gap during the Biennium, 2010–2011



Funding by Strategic Objective

40. Figure 5 and Table 6 show the budget by SO, according to the approved base program budget, funds available for the biennium, and expenditure. Of the 16 SOs, 12 obtained over 75% of their expected level of funding. Of the 14 core technical cooperation SOs (SO1–SO14), SO9 (Nutrition, food safety, and food security) had the highest funding rate compared to its approved budget, followed by SO12 (Medical products and technologies) and SO4 (Maternal, child, adolescent, and elderly health). SO15 and SO16 (Enabling functions) also had high funding levels.

41. As shown in Table 6, all SOs had an overall budgetary implementation rate of 75% or above, with the exception of SO4 (74%).

Figure 5: Budget Overview by Strategic Objective, 2010–2011

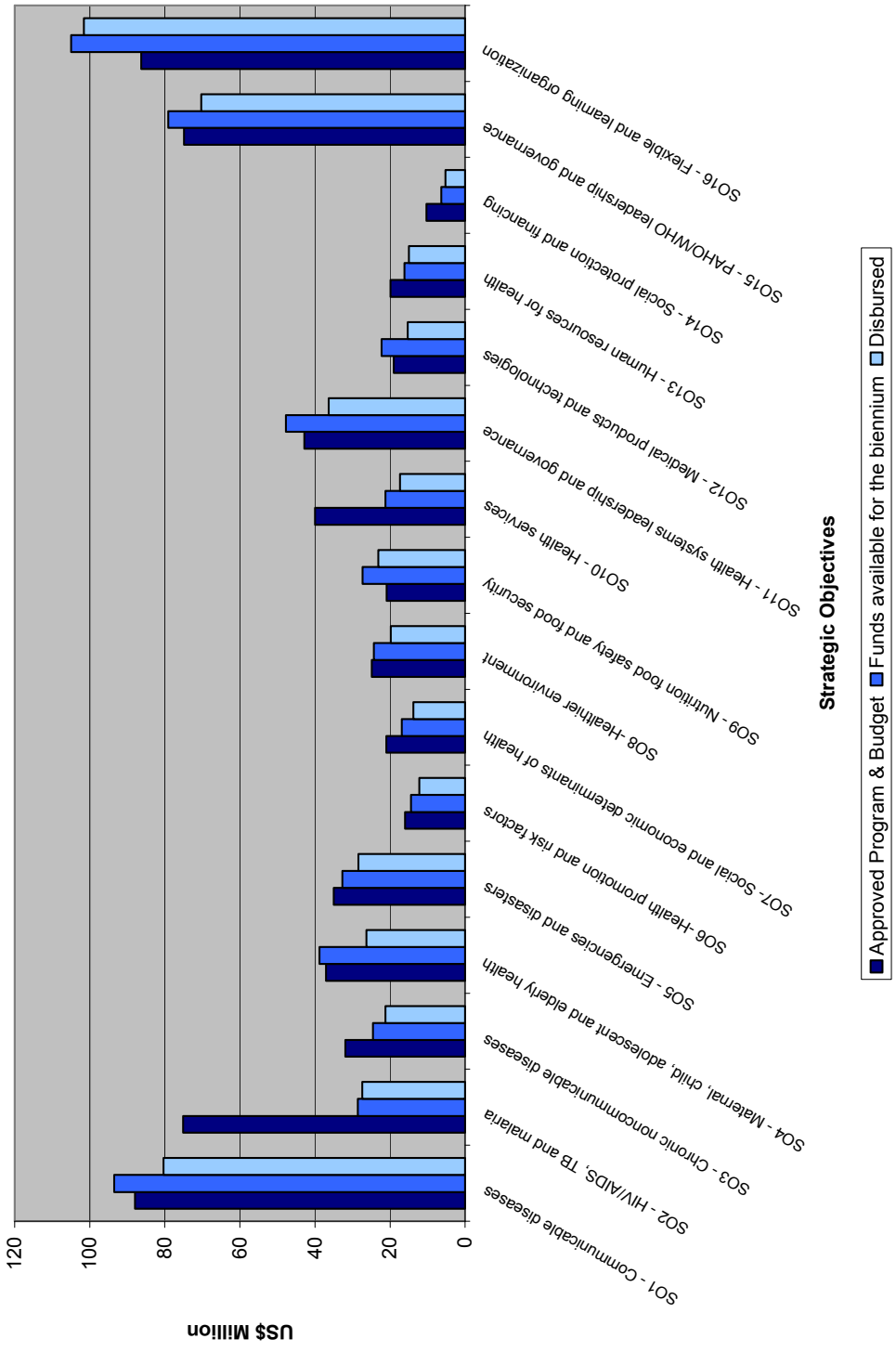


Table 6: Budget by Strategic Objective, End of Biennium, 2010–2011

Strategic Objective	Approved Program and Budget (in millions of US$)	Funds Available for the Biennium (in millions of US$)		Expenditure (in millions of US$)	
		Total	%	Total	%
SO1: Communicable diseases	87.9	90.6	103%	80.8	89.2%
SO2: HIV/AIDS, TB, and malaria	75.1	33.9	45%	30.0	88.5%
SO3: Chronic noncommunicable diseases	31.9	23.8	75%	21.1	88.7%
SO4: Maternal, child, adolescent, and elderly health	37.1	40.6	109%	30.0	73.9%
SO5: Emergencies and disasters	35.0	32.9	94%	27.5	83.6%
SO6: Health promotion and risk factors	16.0	13.6	85%	12.3	90.4%
SO7: Social and economic determinants of health	21.0	17.0	81%	14.8	87.1%
SO8: Healthier environment	24.9	22.7	91%	20.1	88.5%
SO9: Nutrition, food safety, and food security	20.9	28.1	134%	25.4	90.4%
SO10: Health services	40.0	20.6	52%	17.1	83.0%
SO11: Health systems leadership and governance	42.8	39.8	93%	36.9	92.7%
SO12: Medical products and technologies	19.0	21.0	111%	17.8	84.8%
SO13: Human resources for health	19.9	15.2	76%	14.0	92.1%
SO14: Social protection and financing	10.3	6.2	60%	5.9	95.2%
SO15: PAHO/WHO leadership and governance	74.9	75.3	101%	70.0	93.0%
SO16: Flexible and learning organization	86.3	101.7	118%	97.2	95.6%
Total	**643.0**	**583.0**	**91%**	**520.9**	**89.3%**

Analysis of Resource Allocation versus Prioritization of Strategic Objective

42. The Strategic Plan ranked the SOs by programmatic priority (excluding the SOs related to enabling functions SO15 and SO16) to guide resource mobilization and allocation during plan implementation.

43. Table 7 shows the SOs ranked according to their programmatic priority, from 1 (highest priority) to 14 (lowest priority), as approved in the Strategic Plan. It also shows the funds available for each SO for the 2008–2009 and 2010–2011 biennia. The percentage difference between the two biennia shows a positive shift in the allocation of resources among 3 of the 5 top-priority SOs (SO4, SO1, and SO3). In reviewing these figures, it should be noted that the alignment of resources with programmatic priorities is a complex process due to the limited flexibility in the allocation of most resources available to the Organization during a biennium. For instance, over 70% of RB funds are linked to fixed-term posts (FTPs), which are not easily transferred or distributed to different SOs due to the technical association of the posts with their relevant SOs. Also, the majority of Voluntary Contributions received by the Organization continue to be highly earmarked, which restricts PASB's ability to allocate resources according to the priority ranking of SOs as approved in the Strategic Plan. While the Organization continues to make efforts to improve the alignment between programmatic priorities and allocation of resources, this is a gradual process that could take several years to address.

Table 7: Programmatic Priority Ranking vs. Resource Allocation, 2008–2009 and 2010–2011

Strategic Objective	Priority Ranking	Funds Available for the Biennium (millions of US$)		% Difference: 2008–2009 to 2010–2011
		2008–2009	2010–2011	
SO4: Maternal, child, adolescent and elderly health	1	24.7	40.6	64%
SO1: Communicable diseases	2	75.1	90.6	21%
SO2: HIV/AIDS, TB, and malaria	3	34.9	33.9	-3%
SO3: Chronic noncommunicable diseases	4	21.0	23.8	13%
SO7: Social and economic determinants of health	5	17.5	17.0	-3%
SO13: Human resources for health	6	14.8	15.2	3%
SO10: Health services	7	34.4	20.6	-40%
SO8: Healthier environment	8	19.1	22.7	19%
SO6: Health promotion and risk factors	9	14.2	13.6	-4%
SO14: Social protection and financing	10	4.9	6.2	27%
SO11: Health systems leadership and governance	11	31.1	39.8	28%
SO12: Medical products and technologies	12	19.2	21.0	9%
SO5: Emergencies and disasters	13	49.3	32.9	-33%
SO9: Nutrition, food safety, and food security	14	15.8	28.1	78%

Outbreak Crisis and Response (OCR) Segment

44. During the biennium, a total of $48.2 million were available for this segment, which exceeded by over 100% the estimated budget of $22 million presented in the PB 2010-2011. This is due to the unpredictable nature of these funds, which become available in the event that a disaster, emergency, or epidemic/pandemics occurs.

45. As expected, almost all OCR funds were implemented (98%). These funds were used mainly to support countries affected by disasters and emergencies—such as the earthquakes in Haiti and Chile; the floods in Central America, the Dominican Republic, the Bahamas, Bolivia, and Colombia; a volcanic eruption in Ecuador; and the cholera epidemic in Haiti. It is important to note that about 50% of these funds were implemented in Haiti.

National Voluntary Contributions (NVCs)

46. A total of $348 million in NVCs were available under this segment during 2010-2011 to implement national technical cooperation programs in 10 Member States (Argentina, Bolivia, Brazil, Colombia, Ecuador, Guatemala, Honduras, Mexico, Peru, and Suriname). The contributions from each country are included in Table 8.

Table 8: Funding of National Voluntary Contributions by Country

Member State	Funds Available (in US$)
Argentina	5,001,165
Bolivia	61,039
Brazil	318,190,742
Colombia	19,118,255
Ecuador	538,706
Guatemala	35,294
Honduras	312,596
Mexico	2,885,336
Peru	1,696,692
Suriname	93,505
Total	**347,933,330**

47. The amount of NVC funds increased by about 50% compared to the previous biennium (from $230 million in 2008–2009 to $348 million in 2010–2011). Brazil continues to be the major user of this funding modality for technical cooperation, representing over 90% of the total NVC funds.

48. It is important to note that NVC is a modality for funding technical cooperation in a given country to scale up interventions as identified in the Country Cooperation Strategy (CCS). As such, NVC funds are used to address priorities identified in the respective country's CCS and are implemented through the biennial workplans as part of the overall PAHO technical cooperation program with and for each particular country. Consequently, these funds contribute directly to achieving the RER indicator targets in those countries. In addition to the direct contribution in advancing public health priorities

in the countries that use this modality, these funds have also facilitated the exchange of inter-country collaboration—thereby contributing to addressing key common public health issues among countries (for example, the interruption of disease transmission by the Chagas vector in South America).

V. CONCLUSIONS AND RECOMMENDATIONS

49. The 2010–2011 end-of-biennium assessment was the second exercise covering a full biennium within the RBM framework. Significant progress has been made by PASB in consolidating its RBM framework. Nevertheless, there is a need to address certain key issues to fully implement RBM across the Organization. These include further strengthening the accountability component; improving documentation and application of lessons learned; simplifying the planning process; and strengthening both the quality and coverage of SOs, RERs, and RER indicators. A common theme in the reports was the question of having a complete understanding of the relevance of each RER and its respective RER indicators, as well as the targets *vis-à-vis* the technical cooperation undertaken—particularly at country level.

50. The Performance, Monitoring, and Assessment (PMA) exercise was conducted in a participatory manner across the Organization. This process has allowed for the systematic identification of achievements, challenges, and lessons learned. The exercises allowed for implementing the necessary adjustment during the implementation of the Program and Budget 2010–2011. In addition, it served as the basis for developing the Program and Budget 2012–2013 and will provide information on which to base the development of the upcoming Strategic Plan 2014–2019.

51. While notable progress has been made in the quality of both information and reporting, there are key areas (such as maternal health, chronic diseases, mental health, and access to health services) for which there is limited up-to-date, validated data—or absence of data—to adequately measure progress made towards achieving the impact indicators. This constituted a limitation when defining the baselines of the impact and RER indicators, thereby affecting the monitoring and assessment process. In addition, the weak relationship between certain RER indicators and the impact-level SO indicators has affected the consistency of the assessment in demonstrating the progress made towards achieving impact at the SO level.

52. The progress achieved during the 2010–2011 biennium indicates that the Organization continues to make steady progress towards achieving the Strategic Plan targets for 2013. Of the 16 SOs, 12 were on track and 4 were at risk. Of the 90 RERs, 81 were on track, 8 at risk, and 1 in trouble.

53. Of the 256 RER indicators, 232 (91%) met their 2011 targets. Ongoing monitoring and assessment is key to direct interventions for those RER indicators that are lagging behind—especially those that are compromising the achievement of the SOs and RERs for 2013. The factors that contributed to the non-achievement of the 24 indicators that did not meet their 2011 target include the following:

- The quality of some indicators does not allow for an appropriate measurement of the progress made by the countries (e.g., access to health services).
- Some of the targets were unrealistic and did not consider the particular situation in the countries (i.e., IHR and HRH) and the challenges they face when trying to maintain the gains achieved (e.g., for neglected diseases such as rabies).

54. Particular attention needs to be placed on maintaining the gains while still working towards the achievement of unmet targets. There is a need to ensure that when setting indicators and targets, they are realistic and relevant to the situation in the countries, taking into consideration the necessary risks and assumptions.

55. The overall budgetary implementation for 2010–2011, including the three segments of the PB, was 85% ($830 million out of 979 million). The implementation by segment was as follows: 89% for base programs ($521 million out of 583 million); 98% for OCR ($47 million out of 48 million); and 75% for NVCs ($262 million out of 348 million).

56. Of the $643 million approved for the base program segment, $287 million came from the Regular Budget. The difference, $356 million, constituted the initial funding gap. By the end of the biennium, the Organization was able to mobilize $296 million—thus reducing the funding gap to $60 million.

57. An increasing trend is noted in the amount of NVC funds received over the last two biennia (rising from $230 million in 2008–2009 to 348 million in 2010–2011). These funds have contributed to the progress made in achieving public health targets in the countries that are using this modality to finance PAHO's technical cooperation. Further analysis is required on this funding modality and its incorporation into future strategic plans, as well as into the corresponding programs and budgets.

58. Resource coordination and allocation was improved during the biennium. However, there is a need to continue strengthening interprogrammatic coordination to ensure optimal utilization of available resources and more targeted resource mobilization.

59. There is also a need to strengthen the integration of technical cooperation activities, particularly as new initiatives emerge. This was a comment made in most of the analyses conducted by the PAHO Technical Units. It calls for a revision of how to balance vertical programs with an integrated approach to implementing activities.

60. The lessons learned from each SO, RER, and RER indicator should be analyzed to identify successes and failures, thus enabling the Organization to put these lessons to use in improving future planning and budgeting cycles.

VI. ANNEXES

STRATEGIC OBJECTIVE (SO) PROGRESS REPORTS

SO1 Progress Report

SO1: To reduce the health, social, and economic burden of communicable diseases					At risk
Budget Overview					
Approved Budget (PB 10–11)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$87,985,000	**$23,870,000**	**$66,698,379**	**$90,568,379**	**89%**	**103%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Reduction of the mortality rate in children under five years old due to vaccine-preventable diseases in the Region**
Baseline: 47 per 100,000 children under five years old in 2002
Target: 31 per 100,000 by 2013

Although no specific data are available at this time, based on projections for the Region reporting the impact of the introduction of new vaccines on reducing the mortality rate in children under 5 from vaccine-preventable diseases (VPDs), the target should be met by 2013. This result is expected given the high vaccination coverage (generally >80%) achieved by the countries among targeted cohorts against those diseases most commonly associated with childhood death (such as rotavirus, pneumococcus, meningococcus, and *Haemophilus influenzae* type b. Those countries that have not introduced the vaccines have expressed their commitment to do so in the near future. It is estimated that the lives of 174,000 children in the Region of the Americas are saved each year as a result of immunization, and this number is expected to continue to increase with the introduction of new vaccines.

SO indicator 2: **Number of countries maintaining certification of poliomyelitis eradication in the Region**
Baseline: 38 countries in 2006
Target: 38 countries by 2013

Currently, all countries of the Americas maintain their polio-free status and expect to sustain eradication through 2013 and beyond. A plan of action was developed to maintain the Americas free of poliomyelitis during the transition from the pre- to post-eradication eras. The plan includes a comprehensive strategy to enhance all aspects of community protection and epidemiological surveillance. Considering that the Region of the Americas remains at risk of importing the virus from countries where it is still circulating, a regional risk analysis was conducted; and specific strategies have been developed to maintain eradication in the global context. Finally, countries are expected to maintain certification standards for surveillance of acute flaccid paralysis (AFP), in compliance with surveillance indicators, and to report periodically to the regional level.

SO indicator 3: **Number of countries achieving and maintaining the elimination of measles, rubella, congenital rubella syndrome, and neonatal tetanus in the Region**
Baseline: 0 countries in 2006
Target: 38 countries by 2013

At the end of 2011, all 38 countries/territories in the Region had achieved the interruption of endemic transmission of measles, rubella, and congenital rubella syndrome (CRS). In an effort to maintain elimination, all countries are implementing PAHO-recommended interventions, including the periodic implementation of follow-up campaigns, strengthening their rapid response plans to quickly detect and respond to outbreaks, high-quality integrated measles/rubella surveillance that meets surveillance indicators, and targeted vaccination activities aimed at achieving >95% coverage in the municipalities. All countries and territories have also established national commissions and are in the process of finalizing country reports that they will submit to the International Expert Committee during first semester 2012. Likewise, at the Pan American Sanitary Conference (PASC) in September 2012, a progress report will be presented, as well as a plan of action to consolidate this goal.

With respect to the elimination of neonatal tetanus, Haiti is the only country that has not achieved the target; and it is unlikely to achieve it by 2013 unless a plan is developed and implemented in the course of 2012. One major component of the country's plan to eliminate neonatal tetanus is to conduct a vaccination campaign.

SO indicator 4: **Number of countries that have fulfilled the core capacity requirements in surveillance, response, and points of entry, as established in the 2005 International Health Regulations (IHR)**
Baseline: 0 countries in 2007
Target: 35 countries by 2013

Some 26 countries have submitted their annual reports to the World Health Assembly (WHA). Although the countries have achieved greatly varying levels of core capacity, none has fully met all the requirements of the International Health Regulations (IHR).

SO indicator 5: **Reduction in the lethality rate due to dengue (dengue hemorrhagic fever / dengue shock syndrome) in the Region**
Baseline: 1.3% in 2006
Target: 1.0% by 2013

The current fatality rate is 0.071 under the new WHO classification. The introduction of this new dengue classification in 2010 implies an important change both in case management and in the evolution of the disease. The denominator of the actual rate is the total number of dengue cases. Therefore, the actual rate is 0.070, with a reduction in the proportion of severe cases that fell from 2.62% in 2006 to 1.65% in 2011). This indicates that, at times when the disease has been more serious, there was success in preventing cases from becoming severe dengue cases. Better case management and follow-up explain this achievement.

When the original indicator for this document was created, it was not anticipated that a change in classification would occur in the future. With the new classification, no more reference is made to dengue hemorrhagic fever/ dengue shock syndrome, as was previously stated for this indicator.

Over the past five years, there has not only been an increase in deaths from dengue, but also an increase in the total number of dengue cases. The trend for the indicator is downward (less than 1%). Therefore, it is not considered that the transition to the new classification will be of any great consequence.

An additional advantage is that the new classification is being used at global level, such that regional data from the Americas can now be compared to the rest of the regions.

SO indicator 6: **Number of countries with certification of Chagas disease vector transmission interrupted, in the 21 endemic countries in the Region**
Baseline: 3 countries in 2006
Target: 15 countries by 2013

To date, 14 countries are certified as having interrupted the vectoral transmission of Chagas disease (Argentina, Belize, Bolivia, Brazil, Chile, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Peru, and Uruguay).

SO indicator 7: **Number of endemic countries in the Region with onchocerciasis elimination certification.**
Baseline: 0 of the 6 endemic countries
Target: 1 country by 2013

Colombia officially requested certification for onchocerciasis elimination.

2010–2011 SO Assessment

This SO is assessed as being at risk, but significant progress has been made at the RER level during this biennium. Of the 9 RERs, 7 were assessed as being on track (green) and 2 as being at risk (yellow); the 2 at risk are RER 1.3, related to neglected zoonotic diseases, and RER 1.6, related to IHR implementation. Of the 22 RER indicator targets, 18 were achieved and 4 were not. It is important to note that of the 18 indicators achieved, 7 have exceeded the 2011 target; and of these 7 indicators, 5 have already achieved the 2013 target

Main Achievements

- PAHO has collaborated with Haitian authorities to develop a country plan of action for the upcoming measles/rubella/polio follow-up campaign, to protect the gains made thus far in eliminating these diseases—while at the same time, strengthening routine vaccination services in the country.
- Hispaniola's response to the cholera outbreak: Due to the lack of knowledge of and experience with cholera in Hispaniola, PAHO ensured the immediate deployment of experts for case management, infection control, water and sanitary hygiene (WASH), and epidemiological surveillance. The samples and isolates identified by the National Public Health Laboratory (LNSP) were channeled to the International Reference Centers for confirmation. In Haiti, alert and response systems were consequently developed and implemented, with eight decentralized teams deployed in the field at the peak of the outbreak from late 2010 to early 2011. In the Dominican Republic, the focus has been on quality of care in case management and on strengthening the safe water distribution network in the provinces. At the same time, the cholera response plans in the rest of the Caribbean and Central America have been reviewed and updated using data based on the information from Hispaniola.
- Steady efforts have been made in the area of Infection Prevention and Control (IPC) in the English-speaking Caribbean countries: Belize, Guyana, and Trinidad and Tobago are currently consolidating their national plans and interventions.
- Early warning capacity is in place in Member States and PAHO Country Offices.
- A PAHO book, Thirty Years of the Immunization Newsletter: The History of the EPI in the Americas, was published on the Expanded Program on Immunization (EPI). It highlights experiences and lessons learned that have made the Immunization Program of the Americas one of the most successful life-saving initiatives in the world.
- Advances have been made towards achieving regional elimination targets for neglected infectious diseases (NIDs) such as onchocerciasis, Chagas disease, and schistosomiasis.
- A regional consensus was achieved in 2011 on a uniform approach to monitoring the IHR. One of the main challenges faced for IHR monitoring has been the lack of a standardized monitoring tool at global level. The

initiative taken by the MERCOSUR Member Countries—which led to their developing the core capacities assessment and planning toolkit in 2008, with other countries of the Region subsequently following their example—had a critical impact on IHR implementation in the Americas. All 35 States Parties in the Region have conducted at least one assessment of their core capacities as detailed in Annex 1 of the IHR, which focuses on surveillance and response (IHR Annex 1.A)—and, to a lesser extent and in a less systematic manner, on designated points of entry (IHR Annex 1.B). As a result of these assessments, by the end of 2011, at least 30 of the 35 States Parties had conducted planning activities and developed and/or coordinated the adjustment of relevant existing plans in order to establish core capacity by 15 June 2012. Also by the end of 2011, at least 10 States Parties had conducted costing exercises on their plans.

- A strengthened multidisciplinary and collaborative approach has been adopted between the Regional Alert and Response Team, PAHO's technical experts, and PAHO/WHO Representative Offices, to detect, assess, and verify public health threats on a 24/7 basis.
- PAHO's role has been strengthened as an IHR focal point: Regarding public health events of international concern (PHEICs), 710 events were assessed; and 61 epidemiological alerts, 30 reports, 4 interactive maps, and 39 advisories and recommendations on international public health threats were issued.
- Laboratory capacity has increased: New resistance mechanisms have been detected with support from the horizontal collaboration of the Antimicrobial Resistance Surveillance Network.

Main Challenges

- The impact of vaccination interventions targeting low-coverage municipalities is not easily demonstrated, given that data are still unavailable and countries continue to carry out action plans aimed at reaching these vulnerable populations.
- There is a need to strengthen epidemiological surveillance of vaccine-preventable diseases and ensure the quality of data in periodic reports.
- Insufficient resources at the national and international levels endanger the achievement of NID elimination targets and make it difficult to achieve core capacities for IHR and alert and response activities for public health events of international concern on a 24/7 basis.
- There is a limited number of specialized human resources who are trained to respond to public health risks.
- There is a need to strengthen multidisciplinary collaboration across PAHO areas to assess and verify events, to fully comply with PAHO's mandate.
- A high level of advocacy must be maintained to guide ministries of health in making informed decisions on extending the deadline for IHR implementation.
- There is a need to identify synergies and partnerships and to review human resources policies, so as to secure the establishment and maintenance of competencies in field epidemiology and other public health–related disciplines.

Lessons Learned

- Collaboration with strategic partners is critical to supporting the revitalization of the immunization program in Haiti.
- Advocacy for measles/rubella eradication must continue in global forums, and countries must remain vigilant to quickly address cases imported to the Region.
- Integration of NID activities in other public health programs is necessary to achieve targets.
- Research has been key in fostering a stronger and more targeted response for preventing and controlling priority infectious diseases.
- World Health Day 2011 put antimicrobial resistance in the spotlight and facilitated technical cooperation activities at the country level

SO1 Region-wide Expected Results (RER) Progress Report

RER 1.1: Member States supported through technical cooperation to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies; strengthen immunization services; and integrate other essential family and child health interventions with immunization	**On track**

RER Assessment
(3 out of 4 RER indicator targets achieved, with 2 exceeded and 1 not achieved)

PAHO worked in collaboration with Member States and strategic partners to strengthen and maintain the credibility of immunization (IM) programs by providing equitable, quality services to all individuals. Technical cooperation provided during 2010-2011 supported vaccination coverage improvements at all levels, while simultaneously prioritizing effective interventions to reach at-risk areas and overcome challenges that continue to impede access to IM services. Continuous efforts have ensured that the PAHO Revolving Fund (RF) maintains its visibility to procure quality, safe vaccines at the lowest possible cost. The vast experiences of the Americas in introducing new vaccines and strengthening surveillance have been shared with other WHO regions. These achievements have been made evident through the countries' efforts and through fulfillment of the RER 1.1 indicators for 2010–2011. The indicator related to low-coverage municipalities continues to present challenges, despite country efforts and resource mobilization with partners. Although it is expected that data available in 2012 will demonstrate marked improvements, countries will continue to implement interventions to increase vaccination coverage in these areas over the upcoming biennium.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments[5]
1.1.1: Number of countries achieving more than 95% vaccination coverage at national level (DPT3 as a tracer)	20	22	27	25	2009 Baseline: ABM, ANI, ARG, BAH, BLZ, BRA, CUB, DOM, ECU, ELS, GRA, GUY, MEX, NIC, PAN, SAL, SAV, SCN, TRT, USA 2011 Target: HON, PER Honduras, a 2011 target country, successfully reached 96% coverage with the DPT3 vaccine. Peru, also a 2011 target country, identified coverage gaps at the municipality level and will continue to strengthen efforts to improve coverage in those same target municipalities. During 2011, although 3 countries fell from the baseline (ELS, MEX, and USA), an additional 10 countries and territories (BOL, CHI, FDA, GUT, HON, JAM, PAR, SUR, TCA, and VEN) achieved over 95% coverage, resulting in a total of 27 countries and territories achieving the target for this indicator. Hence, the anticipated target of 22 countries by the

[5] The list of countries included in this column corresponds to the information available at the close of the assessment.

					end of 2011 was exceeded by 5 countries. Countries that did not achieve coverage goals have nonetheless planned interventions to reach unvaccinated populations. It is recommended that countries continue to develop and implement action plans for the Expanded Program on Immunization (EPI) to ensure high coverage in 2012–2013
1.1.2: Percentage of municipalities with vaccination coverage level less than 95% in Latin America and the Caribbean (DPT3 as a tracer using baseline of 15, 076 municipalities in 2005)	44%	34%	42%	32%	Although a 2% improvement was observed, 42% of all municipalities in Latin American and Caribbean (LAC) countries reported coverage under 95%. It is expected that data from 2011 (available in April 2012) will demonstrate a decline in the number of low-coverage municipalities, given the following: (1) Technical cooperation was provided to countries with the highest number of at-risk municipalities (BRA, COL, HAI, PER, and VEN) (2) Countries continue to develop and implement plans of action to ensure homogeneous coverage. (3) Partners continue to provide support by prioritizing high coverage in these areas.
1.1.3: Number of countries that have included pneumococcal and/or rotavirus sentinel surveillance in their national epidemiological system	5	10	18	15	2009 Baseline: BRA, ECU, ELS, NIC, PAN 2011 Target: BLZ, BOL, COR, GUY, HON, MEX, PAR, URU A total of 18 countries confirmed that pneumococcal and/or rotavirus sentinel surveillance had been established in their national systems during the biennium. They included all 5 baseline countries, the 8 target countries for 2011, plus 5 additional countries: COL, DOR, GUT, PER, and VEN.

1.1.4: Number of countries that purchase the vaccines for their National Immunization Program through the PAHO Revolving Fund for Vaccine Procurement	32/38	33/38	34/38	34/38	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, GRA, GUT, GUY, HON, JAM, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, VEN 2011 Target: CHI, NEA At the end of 2011, a total of 34 countries and territories were purchasing vaccines for their national immunization programs through the PAHO Revolving Fund (RF). The most recent addition is CHI, which purchased almost all its vaccines through the RF in 2010 and plans to continue to do so in 2012. In addition, NEA has confirmed that they obtain vaccines through the Revolving Fund.

RER 1.2: Member States supported through technical cooperation to maintain measles elimination and polio eradication; and achieve rubella, congenital rubella syndrome (CRS), and neonatal tetanus elimination	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved)

Technical cooperation was provided to complement country efforts in maintaining measles/rubella/CRS elimination and polio eradication in the Region. All countries have implemented vaccination and surveillance interventions to maintain these achievements. The Plan of Action to Maintain the Americas Free of Polio during the transition from the pre- to post-eradication eras was developed to enhance community protection and surveillance. The implementation of this plan will also require that countries maintain certification standards for surveillance of acute flaccid paralysis (AFP). The Region achieved the elimination of endemic rubella/CRS in 2010 and is on track for achieving the documentation and verification of measles/rubella/CRS elimination in 2012. A primary challenge is the constant threat of imported cases, which increase the risk that endemic measles/rubella transmission will be reestablished. Countries must remain vigilant in order to quickly detect and respond to such importations.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.2.1: Number of countries with surveillance activities and vaccination to maintain the polio eradication	38/38	38/38	38/38	38/38	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, GRA, GUT, GUY, HAI, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, SCN, SAL, SAV, SUR, TRT, URU, USA, VEN 2011 Target: Maintenance

					All 38 countries currently carry out surveillance and vaccination activities to maintain polio eradication, as well as to minimize the risk of reintroduction of wild poliovirus in the Region. Although HAI postponed its polio (and measles/rubella) campaign until March 2012, the country includes the polio vaccine in its routine program and continues to report AFP surveillance on a weekly basis.
1.2.2: Number of countries that have implemented interventions to achieve rubella and Congenital Rubella Syndrome (CRS) elimination	38/38	38/38	38/38	38/38	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SCN, SAL, SAV, SUR, TRT, URU, USA, VEN 2011 Target: FDA, NEA All 38 countries and territories have implemented interventions to achieve rubella and CRS elimination, having made significant progress in documenting and verifying the elimination of these diseases. Only HAI and MEX did not achieve the indicator target, despite having successfully implemented the PAHO-recommended interventions for elimination.
RER 1.3: Member States supported through technical cooperation to provide access for all populations to interventions for the prevention, control, and elimination of neglected communicable diseases, including zoonotic diseases					**At risk**
RER Assessment (3 out of 5 RER indicator targets achieved, with 1 exceeded and 2 not achieved)					
Important advances have been made towards the achievement of this RER and its indicators. With respect to leprosy, 18 countries achieved targets either for elimination or for maintenance of baselines; but Argentina fell from the baseline. For human rabies, the elimination target for the biennium was achieved in 2011. For zoonotic diseases, countries continue to develop, update, and test preparedness plans. With respect to Chagas disease, three of the four target countries achieved interruption of transmission and/or certification of elimination (Colombia did not). Argentina and Nicaragua recovered their baseline status. In addition, the elimination or interruption of transmission of secondary vectors was achieved in some baseline countries. The new guidelines on neglected infectious diseases (NIDs) have been disseminated and their implementation started in all target countries. Significant progress has been made individually for trachoma, filariasis, schistosomiasis, and onchocerciasis; the most recent advance was the certification of elimination of onchocerciasis in Colombia. Mobilization of financial and human resources for NIDs remains a challenge to achieving the targets by 2015, as mandated by Resolution CD49.R19, “Elimination of Neglected Diseases and Other Poverty-Related Infections” approved by PAHO’s 49th Directing Council in 2009.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.3.1: Number of countries that have eliminated leprosy at national and subnational levels as a public health concern	17/24	19/24	18/24	24/24	2009 Baseline: ARG, COR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PER, SAL, SUR, TRT, URU 2011 Target: COL, CUB, DOR Out of 19 countries, 18 either achieved or maintained their elimination status at subnational level. While ARG fell from the baseline, CUB and COL achieved the targets in 2011. CUB also is close to elimination at the second subnational level. Although DOR did not achieve the target in 2011, it did formulate a plan and will work to achieve the target by 2013. BRA is the only country in the Region that has not achieved the target at national level. BOL, DOR, PAR and VEN will have to work towards achieving the target at subnational level. The target for leprosy in the previous biennium (2008–2009) was related to the implementation of the new WHO leprosy strategy, an element that was formulated at that time. Following the revision of the PAHO Strategic Plan 2008–2012, the indicator was enhanced to show an improved, but stricter, level of achievement—including leprosy elimination at subnational level—as part of the indicator. The case of ARG shows the importance of continuing advocacy in the countries to maintain achievements. After falling from the baseline, a technical mission in October 2011 assessed the country's national leprosy program and made recommendations. ARG started adapting guidelines for patient care, which demonstrates their willingness to recover this indicator. The regional level is monitoring progress on implementing the recommendations. Technical missions have already been established for the remaining target countries set for 2013.

1.3.2: Number of countries that have eliminated human rabies transmitted by dogs	14	16	17	18	2009 Baseline: ARG, BLZ, CHI, COL, COR, ECU, GUY, HON, NIC, PAN, PAR, PER, SUR, URU 2011 Target: CUB, ELS, MEX, VEN In 2011, 17 countries eliminated human rabies transmitted by dogs, including 4 target countries: CUB, ELS, MEX, and VEN. PER is in the process of recovering its status of baseline country; it declared most of its national territory free of human rabies transmitted by dogs, except for the departments of Puno and Madre de Dios.
1.3.3: Number of countries that maintain surveillance and preparedness for emerging or reemerging zoonotic diseases	13	19	20	23	2009 Baseline: ARG, BLZ, BRA, CHI, COL, COR, DOR, ECU, HON, MEX, PAN, PAR, TRT 2011 Target: CUB, DOM, GUT, NIC, PER, URU, VEN 20 countries carried out surveillance and preparedness for emerging or reemerging zoonotic diseases. PAR is working to regain baseline status.
1.3.4: Number of countries with Domiciliary Infestation Index by their main *Triatominae* vectors lower than 1%	11/21	15/21	12/21	18/21	2009 Baseline: ARG, BRA, CHI, ELS, GUT, HON, MEX, NIC, PAR, PER, URU 2011 Target: BLZ, BOL, COL, COR (Need to recover ARG and NIC, which dropped from 2009 baseline status) Despite the non-achievement of this indicator, advances made in the fight against Chagas disease have been considerable. According to the target set by the Domiciliary Infestation Index, 12 out of 21 countries achieved the target by lowering household infestation by their main *Triatominae* vectors to lower than 1%. From the 2011target countries, BLZ, BOL, and COR reached the target. Considerable technical cooperation efforts were also aimed at recovering countries that were previously at baseline; ARG and NIC also achieved the target. All other baseline countries maintained their status. In 2013, efforts to achieve the target will be made in COL, ECU, PAN, and VEN; and the groundwork will be set for further efforts in GUY and SUR.

					It is important to emphasize the need for the countries to maintain their achievements. Otherwise, technical cooperation will have to be redirected towards recovering countries that have already achieved results. It is also necessary to point out that Chagas disease does not solely refer to just one type of vector. In those countries where transmission by the primary vector has been interrupted, control activities have shifted towards controlling secondary vectors. It is expected that the challenge for the 2012–2013 biennium will be greater, as most target countries are located around the Amazon basin. Climate changes that promote vector proliferation, the persistence of social determinants, difficulty in accessing affected areas, and political challenges all prevent more rapid advances from being made in this indicator.
1.3.5: Number of countries that have adopted programs or strategies for the surveillance, prevention, control, or elimination of neglected diseases	3	7	7	11	2009 Baseline: GUY, MEX, SUR 2011 Target: HON, BRA, DOR, HAI Some 7 countries achieved their target, including all target countries for 2011. BRA started a national program on NIDs, implementing a plan of action in Recife, and consolidated activities in oncho-cerciasis and trachoma. DOR implemented surveillance of lymphatic filariasis (LF) and malaria (MAL) in areas bordering HAI, and it also started preparations for a national survey on soil-transmitted helminthiasis (STH) and schistosomiasis (SCH). HAI integrated LF-MAL vector control and started STH deworming. HON consolidated a national plan to fight NIDs, developing a technical group and a MAL-STH survey. All targets for 2013 have advanced as well.

RER 1.4: Member States supported through technical cooperation to enhance their capacity to carry out communicable diseases surveillance and response, as part of a comprehensive surveillance and health information system	**On track**

RER Assessment
(3 out of 3 RER indicator targets achieved, with 1 exceeding the target)

Countries in the Region continue to work at enhancing their surveillance systems. The mandate of the International Health Regulations (IHR) requires countries to build, strengthen, and maintain capacities for surveillance of and response to communicable diseases. Therefore, multiple efforts across SO1 are contributing to strengthening this expected result. Countries are engaged in improving their surveillance systems at both national and local levels, progressing at different levels in their integration. Most countries and territories of the Region, including target countries, report on immunization surveillance; and PAHO ensures that feedback will be provided to ensure the availability of information that is both quality and timely. The countries of the Region continue to enhance their surveillance of infection prevention and control as well as antimicrobial resistance, at national and hospital levels alike. This enhanced capacity for detection has been demonstrated by the fact that outbreaks in health care facilities are being detected and reported more frequently. As countries advance in their surveillance systems, it is a challenge to refine the indicators to determine appropriate means of verification and ensure close monitoring of countries that are falling behind in the process.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.4.1: Number of countries with a surveillance system for all communicable diseases of public health importance for the country	16	18	18	20	2009 Baseline: ARG, BLZ, BOL, BRA, CAN, CHI, COR, CUB, ECU, HON, MEX, NIC, PAN, PER, USA, VEN 2011 Target: DOR, ELS The target countries achieved the indicator and all baseline countries maintained their status. Considering the extremely broad area that it covers, most of the indicators in SO1 are partially but directly related; as such, they contribute to achieving it. For the next PAHO Strategic Plan 2008–2012, a suggestion is made to review this indicator in order to determine more specific means of verification that can be monitored together with it.
1.4.2: Number of countries that submit the joint reporting forms on immunization surveillance and monitoring to the Pan American Sanitary Bureau, in accordance with established timelines	18/38	19/38	34/38	20/38	2009 Baseline: ARG, BAH, BLZ, BOL, CAN, COL, CUB, ELS, GUT, GUY, HAI, HON, JAM, NIC, PAR, PER, URU, VEN 2011 Target: ECU, TRT A total of 34 countries (ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, and VEN) plus 2 territories (ABM and NEA) submitted

					joint reporting forms on immunization surveillance and monitoring. This includes the target countries for 2011 (TRT) and 2013 (COR), respectively. All countries of the Region receive feedback from PAHO/FCH/IM) upon receipt of the Joint Reporting Forms to ensure quality and timely country-level data.
1.4.3: Number of countries routinely implementing antimicrobial resistance (AMR) surveillance and interventions for AMR containment, including health care–associated infections	22/35	24/35	24/35	27/35	2009 Baseline: ARG, BAR, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, HON, MEX, NIC, PAN, PAR, PER, URU, USA, VEN 2011 Target: GUY, BLZ BLZ strengthened the IPC program at national and hospital levels. GUY achieved the indicator for HIV resistance surveillance as well as infection control (IC).

RER 1.5: Member States supported through technical cooperation to enhance their research capacity and to develop, validate and make available and accessible new knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases	**On track**

RER Assessment
(1 out of 1 RER indicator targets achieved)

Despite some limitations regarding funding and human resources, particularly due to the WHO/TDR financial crisis, this RER was nonetheless achieved. Capacity was strengthened and research performed in target countries as well as in other countries of the Region. Such tools as quantitative real-time polymerase chain reaction (qPCR) as a biomarker of Chagas disease cure were evaluated using different methods. In addition, this technique was standardized with the participation of 20 countries of the Region and 1 country from Europe. Systematic reviews and priorities were defined for leishmaniasis, rabies, and leptospirosis. Networking between researchers on innovative vector control was also established.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.5.1: Number of countries that have implemented operational research in accordance with the research priorities in communicable diseases	2/33	3/33	3/33	5/33	2009 Baseline: BRA, CHI 2011 Target: ARG, PER Target country ARG achieved its target. In addition, important progress has been made in PER, and work will be continued with this country during the next biennium. Besides target countries, other LAC countries received support. Difficulties in reaching the targets set for 2013 remain, due to a shortage of funding and human resources. Mobilization of resources is in place to curb this risk.

RER 1.6: Member States supported through technical cooperation to achieve the core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern	**At risk**

RER Assessment
(1 out of 2 RER indicator targets achieved and 1 not achieved)

The deadline for establishing IHR core capacity is June 2012. The definition of core capacity in IHR is very broad and covers all hazards; to date, no ministry of health (MoH) in the Region has achieved it. The at-risk status of this RER can also be attributed to differing obligations, timelines, and means of verification set by the IHR, making the determination of MoHs with core capacity possible only after June 2012. It is anticipated that countries will request a two-year extension in 2012, a decision that is both political and technical in nature. If the decision to request an extension is based on a solid action plan, it should be regarded as positive and consistent with public health preparedness as an intrinsically dynamic process. To this end, PAHO should provide the MoHs with guidance to help them make informed decisions on extending the deadline; to mobilize resources for implementing MoH action plans; to identify procedures for IHR implementation and long-term monitoring (the regional consensus reached in 2011 on the monitoring approach is a major achievement); to maintain high-level advocacy; to communicate the public health benefits of IHR compliance; and to identify synergies and partnerships aimed at reviewing human resources policies that will secure both the establishment and maintenance of competencies in field epidemiology.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.6.1: Number of countries that have achieved the core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005)	0	17	0	25	2009 Baseline: 0 2011 Target: ANI, ARG, BAH, BAR, BRA, CAN, CHI, COL, COR, DOM, ELS, GUT, PAN, PER, TRT, URU, USA From a baseline of 0, 0 was achieved. Of the MoHs, 26 out of 35 MoHs submitted an annual report to the World Health Assembly (WHA). Despite a great degree of variability as to the level of core capacity achieved so far, none of the countries has fully achieved it. On the basis of feedback received from the MoHs and priorities defined by PAHO, an updated list of 25 targets for 2013 has been established. WHO did not require any reporting on the achievement of core capacities before May 2012. PAHO is currently accompanying the countries in their decision-making process regarding requests for extending the deadline for achieving core capacities. Extending this deadline is both a technical and a political decision. Therefore, PAHO will have a better idea of both a baseline and a level of achievement for this indicator after the World Health Assembly in May 2012.

					In the previous biennium, this indicator referred to countries assessing core capacities. With the revision of the PAHO Strategic Plan 2008–2012, a decision was made to change the indicator into "achievement of core capacities." This is, by far, a stricter indicator—and therefore, one much harder to achieve. In addition, the lack of definition of an assessment tool at global level has prevented any better measurement of this achievement. PAHO believes that any request to extend the deadline is a positive situation when it is supported by the preparation of an adequate action plan. A good plan will set a clear roadmap for continued improvements in capacities for surveillance and response and will make the process a dynamic one, consistent with the dynamic situations being monitored under the IHR.
1.6.2: Number of countries that maintain training programs focusing on the strengthening of outbreak response capacities	17	21	21	23	2009 Baseline: ARG, BRA, CAN, CHI, COL, COR, CUB, DOR, FDA, ELS, GUT, HON, MEX, NIC, PAN, PER, USA 2011 Target: BLZ, BOL, ECU, PAR The target countries achieved this indicator. There is a need to globally promote alternative models for the establishment and maintenance of competencies in field epidemiology, with due efforts made in the areas of resource mobilization and internal consciousness-raising activities. As a result, the support PAHO has offered to Member States has been limited, though it has been provided in target countries. The priority for the next biennium includes sustaining the program in PAR, defining a strategy for URU, and engaging with the United States Centers for Disease Prevention and Control (CDC) to review the setup of the Field Epidemiology Training Program (FETP) in Central America.

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

RER Assessment
(3 out of 3 RER indicator targets were achieved, with 2 exceeded)

Since second semester 2010, all Member States have incorporated Standard Operating Procedures (SOPs) into their preparedness plans for rapid response teams during an influenza pandemic. In light of this, PAHO is continuing its efforts to preserve the progress made and strengthen the countries' capacity for intensified nationwide surveillance of acute respiratory infections (SARI). This means providing information for action, so that national and local decision-makers can use it to activate Regional Response Teams (RRTs). Detection of epidemic-prone viral pathogens has been achieved in Member States located in areas endemic for yellow fever and flavivirus; and this achievement will be maintained. Continuous work is being done to produce a standardized protocol for flavivirus diagnostic testing in the Americas; an expert meeting was held this past August in Pergamino, Argentina, with the objective of facilitating this consensus. Interventions have been made, and strategies for dengue control have been achieved. These continue on track and focus on establishing integrated management strategies for dengue (EGI-Dengue) in target countries, on evaluation and implementation in baseline countries, and on carrying out training sessions in new clinical guidelines for treating dengue patients. Given that the vector for the Chikungunya and dengue viruses are one and the same, and the two diseases have a similar clinical profile, joint regional training sessions were implemented.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.7.1: Number of countries that have national preparedness plans and standard operating procedures in place for rapid response teams against pandemic influenza	23/35	31/35	35/35	35/35	2009 Baseline: ARG, BOL, BRA, CAN, CHI, COL, COR, CUB, ECU, ELS, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PER, TRT, URU, USA, VEN 2011 Target: ANI, BAH, BAR, BLZ, DOM, DOR, HAI, PAR, SAL, SAV, SCN, SUR The target was achieved by 35 countries. The following countries received training and set up SOPs for their rapid response teams (RRTs): ANI, BLZ, COL, GRA, and SUR. During the next biennium, the focus will continue to be on implementation, monitoring, and evaluation of hospital-based SARI surveillance programs, to ensure the capture of timely, information for decision-making and proper action. Efforts will continue to maintain and strengthen capacity in the countries.

1.7.2: Number of countries with basic capacity to detect epidemic prone viral pathogens according to the PAHO/WHO's epidemiological surveillance guidelines	4	10	10	12	2009 Baseline: ARG, BRA, PER, VEN 2011 Target: BOL, COL, ECU, PAN, PAR, TRT All target countries achieved this indicator. During the next biennium, continued efforts will be made aimed at maintaining capacity in the countries, working with the target countries for 2013, GUY and SUR. Additional focus will be placed on ensuring the Region's preparedness for the possible introduction of the Chikungunya virus.
1.7.3: Number of countries implementing interventions and strategies for dengue control according to PAHO/WHO guidelines	17	21	22	23	2009 Baseline: ARG, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, HON, MEX, NIC, PAN, PAR, PER, PUR, URU, VEN 2011 Target: GUY, TRT The target countries for 2011, GUY and TRT, achieved this indicator. GUY developed EGI-dengue in March 2011; and TRT, in May 2011. Both strategies are being duly implemented. New WHO dengue guidelines were distributed throughout the Region. In addition, new treatment guidelines for dengue patients were adapted, developed, and distributed. Training on these new guidelines was completed in four subregions (the Southern Cone, the Andean and, Central American subregions, and in MEX and the Hispanic Caribbean).

RER 1.8: Regional and Subregional capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern	**On track**

RER Assessment
(1 out of 1 RER indicator targets achieved and exceeded)

In this biennium, it has been possible to detect, verify, and evaluate 710 public health events of international concern (PHEICs) within the time recommended by the IHR (i.e., within no more than 48 hours). This collective achievement at all organizational levels allowed for compliance with IHR requirements and should be regarded as a priority in all areas involved. In order to alert Member States of public health risks, 61 epidemiological alerts were issued, as well as 39 notifications and recommendations, 30 reports, and 4 interactive maps. The Alert and Response Operations (ARO) team maintained its 24/7 operation to guarantee early detection and response to PHEICs. To verify the needed functionality for a timely response by Member States, periodic communication tests were maintained with all 35 IHR Focal Points in the Region. An alert and response website was redesigned to make information more accessible to Member States and to facilitate the identification, evaluation, and dissemination of event information.

RER Indicator	Baseline in 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.8.1: Percentage of public health events of international importance verified in the time recommended by the International Health Regulations	90%	95%	100%	98%	By the end of 2011, 100% of all public health events of international concern were verified within 48 hours of their detection. This was accomplished through multidisciplinary collaborative work among the ARO team, PAHO technical experts across the various technical areas, and PAHO Country Offices. In this biennium, 710 events were assessed, 156 of which required verification from Member States.

RER 1.9: Effective operations and response by Member States and international community to declared emergencies situations due to epidemic- and pandemic-prone diseases	**On track**

RER Assessment
(1 of 1 RER indicator targets achieved)

In order to promote a coordinated response from the Region, and in line with the IHR mandate, PAHO continues to provide support to countries during public health events. Technical cooperation was provided to several countries, especially to HAI and DOR on the island of Hispaniola during the cholera outbreak. Guidelines were issued and other preparedness efforts undertaken against potential outbreaks of such diseases as plague and leptospirosis and the possible occurrence of *E. coli*. Standard Operating Procedures (SOPs) for deployments in cases of public health emergencies have been disseminated to partners in the Global Outbreak Alert and Response Network (GOARN) throughout the Region. Lessons learned and recommendations to move forward with regionalization of GOARN were agreed upon in June 2011 during a meeting held in Brasilia, BRA. Contingency funding is required, especially to facilitate a timely initial response during emergencies.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
1.9.1: Percentage of PASB International Health Regulations–compliant responses based on requests for support from Member States during emergencies or epidemics	100%	100%	100 %	100%	Technical cooperation was provided for cholera in HAI and DOR (in 2010 and 2011); for dengue in BRA, COL, GUT, HON, PUR, and VEN (in 2010) and in BAH, COR, PAN, PER, and SAL (in 2011); in PAN, for equine encephalitis in 2010, and KPC-type carbapenemases in 2011; and in PER, for plague in 2010 and hantavirus in 2011. Preparedness efforts (strengthening laboratory capacity, developing protocols, etc.) against any possible occurrence of an *E. coli* outbreak in the Region took place following the European outbreak.

SO2 Progress Report

SO2: To combat HIV/AIDS, tuberculosis and malaria					On track
Budget Overview					
Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$75,059,000	**$6,823,000**	**$27,098,018**	**$33,921,018**	**89%**	**45%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012.

SO indicator 1: **Reduction of the incidence rate of HIV infections in the Region**
Baseline: 24 new infections per 100,000 inhabitants
Target: 23 new infections or less per 100,000 inhabitants by 2013 (in accordance with the Millennium Development Goal).

According to 2011 data from the Joint United Nations Programme on HIV/AIDS (UNAIDS), new HIV infections in the Caribbean were reduced by one-third based on the 2001 levels (falling from 21,000 infections to approximately 12,000 in 2010). Countries with the greatest estimated declines are the following: the Dominican Republic and Jamaica, with a 25% decrease; and Haiti, where the reduction was about 12%.

Over the same period, Latin American countries experienced a similar decline in new HIV infections among adults and children (dropping from 99,000 to 92,000). Finally, in the United States, the number of new infections remained relatively stable between 2006 and 2009, according to the Centers for Disease Control and Prevention (CDC) *(Source:* Prejean et al, PLoS One 2011, 6 [8]: e17502).

Taking the Region of the Americas as a whole, the estimated incidence rate for 2010 has been 18 per 100,000 inhabitants. (*Source:* Numerator: WHO/UNAIDS/UNICEF. Global HIV/AIDS response. Epidemic update and health sector progress towards Universal Access. 2011; Denominator: United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2010 Revision. 2011). This figure is lower than the established target of 23 per 100,000. Still greater efforts should be made for North America and Latin America regarding the reduction of new HIV infections.

SO indicator 2: **Access to antiretroviral treatment in Latin America and the Caribbean, based on needs assessments**
Baseline: 72% in 2006
Target: 80% by 2013 (as per the Regional HIV/STI Plan for the Health Sector, 2006—2015)

For Latin America and the Caribbean (low- and middle-income countries), coverage for antiretroviral therapy (ART), based on the WHO guidelines from 2010 (treatment initiation at CD4 count of <350cells/mm3) was 50% (46%–59%) for 2009. Using the WHO guidelines from 2006 (patients eligible for treatment are only those with a CD4 count of <200cells/mm3), the 2009 coverage would have been 67% (61%–78%) (*Source:* WHO/UNICEF/UNAIDS Towards universal access: scaling up priority HIV/AIDS interventions in the health sector, 2009).

In 2010, ART coverage increased to 63%. While the number of countries achieving universal access is on track, the regional goal for 2013 of 80% may not be achieved, given that some of the countries with the highest number of persons in need of treatment (Colombia, Guatemala, Haiti, Honduras, Peru, and Venezuela) currently have an

ART coverage of under 60%. Brazil is close to achieving universal access (70% in 2010); but given that this country represents 30% of all ART needs, this 10% gap has a great impact on regional coverage.

SO indicator 3: **Number of countries that have achieved less than 5% of incidence of mother-to-child transmission of HIV**
Baseline: 3 countries in 2006
Target: 16 countries by 2013 (as per the Regional HIV/STI Plan for the Health Sector 2006–2015)

Although the majority of countries overall have well-performing programs in place for preventing mother-to-child-transmission (PMTCT) of HIV, and relatively high PMTCT coverage figures at national level, there are still great disparities within countries among PMTCT sites regarding the quality of health services. According to PAHO/WHO estimates from 2010, the rate for mother-to-child HIV transmission in Latin America and the Caribbean is greater than 15%—thus remaining much higher than the elimination target of 2%. Five countries have reported achieving less than a 2% HIV mother-to-child transmission (MTCT) rate, and 7 additional countries are on track (with an HIV MTCT rate of between 2% and 7%) (*Source:* PAHO. 2010 Situation Analysis. Elimination of Mother to child transmission of HIV and congenital syphilis in the Americas. 2011).
A greater effort will need to be made in order to achieve the target established in the Strategic Plan of less than a 5% incidence of HIV mother-to-child transmission in 26 countries by 2013.

SO indicator 4: **Number of countries that have an incidence of congenital syphilis (CS)of less than 0.5 cases per 1, 000 live births**
Baseline: 2 countries in 2006
Target: 26 countries by 2013

Among the 8 target countries (Argentina, Brazil, Dominican Republic, El Salvador, Guyana, Mexico, Peru, and Venezuela), only Guyana reports having met the target, while Peru reported 0.7 cases per 1,000. The remaining countries have shown an advanced state of progress: according to country reports, another 10 countries report having achieved the target of a congenital syphilis incidence rate of less than 0.5 per 1,000 live births (Anguilla, Antigua and Barbuda, Bahamas, Canada, Chile, Cuba, Guadeloupe, Panama, and the United States).

Epidemiological surveillance of syphilis is being promoted through the use of the Perinatal Information System (SIP), where HIV surveillance will also be included. A certification process is being developed and will be piloted in selected countries in 2012.

The challenges consist of strengthening the integration of HIV and sexual and reproductive health programs in the countries, and obtaining additional funding to implement specific strategies (advocacy, availability of rapid tests, etc.) in order to achieve the respective targets of the Elimination Initiative.

SO indicator 5: **Reduction of tuberculosis (TB) incidence in the Region**
Baseline: 39 cases per 100, 000 inhabitants in 2005
Target: 27 per 100, 000 by 2013 (in accordance with the MDG)

According to the WHO Global tuberculosis control report 2010, TB incidence per 100 000 inhabitants in the Region of the Americas (including HIV patients) was estimated at 29 (27–31) in 2009. Based on the decreasing trend during previous years (with their respective figures of 33, 32, and 31 in 2006, 2007, and 2008), it seems highly probable that the Region will reach the incidence target of 27 new TB infections per 100,000 inhabitants by 2013.

SO indicator 6: **Reduction of the number of annually reported cases of malaria in the Region**
Baseline: 903, 931 cases in 2006
Target: 402, 536 by 2013

According to the PAHO 2010 Malaria Report, the number of reported cases in the Region dropped from 1,044, 073 in 2000 to 565, 892 in 2009, for a 52% reduction in the number of cases—accompanied by 122 deaths in the same year, for a 68% decrease relative to the 2000 baseline., Details from that same period show reductions of over

50% in the number of reported cases observed in 12 countries (Argentina, Belize, Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, and Suriname). Six additional countries (Brazil, Colombia, Guyana, French Guiana, Panama, and Peru) showed smaller reductions (of under 50%) in the number of confirmed malaria cases. Unfortunately, three countries continue to report increases in their total number of cases (Dominican Republic, Haiti, and Venezuela).

SO indicator 7: **Number of countries retaining their malaria non-endemic status**
Baseline: 19 countries in 2007
Target: 19 countries by 2013

Eighteen out of 21 endemic countries and territories achieved significant reductions in the number of malaria cases between 2000 and 2010 (ranging from a 24% reduction in FRG and a nearly 100% reduction in PAR). In 20 countries, there has been a downward trend since 2005 when compared to data from 2010. According to the WHO World Malaria Report 2011, reported cases of malaria in the Region decreased by 43%, from 1,182,418 in 2000 to 678,164 in 2010 (based on data submitted to PAHO by the countries).

2010–2011 Assessment

This SO is on track with 5 out 6 RERs on track and 1 is at risk; 21 out of 24 RER indicator targets were achieved by the end of 2011.

Main Achievements

- During the 2010–2011 biennium, HIV response has shown remarkable progress in moving towards more efficient use of resources allocated to improve access to treatment and increase prevention efforts. In detail, countries have advanced in the following: political commitment and provision of ART for PMTCT, with PAHO efforts being focused on certain high-burden priority countries that are still lagging behind (Dominican Republic, Haiti, and Guatemala). ARV treatment has progressed, but changes in eligibility criteria for ART (driven by rapidly evolving scientific evidence) have resulted in expanded pools of patients in immediate need of treatment and decreased rates of coverage. In addition, tools to incorporate HIV prevention into national plans have been disseminated and applied by 14 countries. HIV case-based and most-at-risk populations (MARP) surveillance has been strengthened. All countries had surveillance data disaggregated by age and sex data, while 9 countries reviewed their surveillance systems and 5 conducted new surveys among men who have sex with men (MSM), sex workers (SWs), and transgender groups. The HIV Drug Resistance (HIVDR) Strategy is being scaled up in all subregions. Evaluations and planning using a health systems perspective have been conducted in several countries (Barbados, Bolivia, Jamaica, Nicaragua, Paraguay, Peru, and Trinidad and Tobago); and PAHO has provided technical cooperation (TC) in national planning exercises in two countries (Guatemala and Venezuela).
- Coordination with partners has been successful, mainly with the United States Centers for Disease Control and Prevention (CDC), United Nations Children's Fund (UNICEF), Joint United Nations Program on HIV/AIDS (UNAIDS), International Planned Parenthood Federation (IPPF), and the United Nations Educational, Scientific and Cultural Organisation (UNESCO)—as well as technical cooperation with such subregional entities as the Southern Cone Common Market (MERCOSUR), Andean Health Agency (ORAS), and the Council of Central American Ministers of Health's Regional Coordination Mechanism (COMISCA/MCR).
- Much progress has been made towards achievement of the targets indicated in the Regional Strategic Plan for Malaria in the Americas 2006–2010, with a 43% reduction in the number of reported cases and a 65% decrease in the number of deaths attributed to the disease between 2000 and 2010. Also, 18 out of 21 endemic countries in the Region have achieved significant reductions in the number of new malaria cases, with a downward trend in 20 countries since 2005. The Strategy and Plan of Action for Malaria 2011–2015 builds upon these achievements and includes the following targets: reduction of morbidity by 75% and of malaria deaths by 25%; implementation of elimination with a possible reversal of the existing trend in 3 countries; and prevention of reintroduction in malaria-free countries.

- Progress has been made in TB case detection, with most of the countries implementing specifically designed strategies for continuous improvement of the case detection rate. Furthermore, all countries and territories are involved in TB activities—especially in surveillance. This is particularly important for small territories in the Region that did not have systematic surveillance before. Surveillance is key to any successful implementation of TB control measures and to monitoring the achievement of targets. To respond to TB drug resistance in the Region, many countries are also introducing more complex surveillance on TB resistance.

Main Challenges

- The global crisis has diminished the capacity of major donors (especially the Global Fund to Fight AIDS, TB and Malaria, hereafter simply referred to as the "Global Fund") to provide funding to countries in the Region. A major priority for PAHO is to work with the countries and partners to promote a more sustainable and efficient response, mainly geared towards rationalizing treatment and integrating responsewithin the framework of a broader health system response.
- There is a need to review and update malaria policies and strategic frameworks in the countries so that they reflect the work carried out in the Region. This should, include complex emergencies, prevention and control, pre-elimination, elimination, and prevention of reintroduction.
- There is also a need for sustained and strengthened surveillance at all levels of the health system, in order to detect malaria threats and trigger appropriate responses with minimal delay, as well as to identify resistance to antimalarial medicines.
- New ways and means need to be sought to better harmonize TB activities and resources between the regional level and PAHO Country Offices in terms of the response to national priorities.
- There is a need for all partners and stakeholders to redouble their efforts to foster the development, accessibility, and use of evidence-based interventions carried out by malaria stakeholders and initiatives.
- Despite progress made on the part of the countries vis-à-vis the cure rate for TB, the target has not yet been met and further efforts are required.
- In terms of internal operations within PAHO, challenges in terms of linkages in and among target countries continue to persist for both malaria and tuberculosis.
- Regular budget allocation for malaria and tuberculosis has declined, leading to the current situation of having over 95% external funding from very few donors.

Lessons Learned

- Regarding the HIV response, coordination with partners and interprogrammatic work has resulted in more effective results and action at country level, as well as in the ability to achieve results in a context of constrained resources.
- Regarding malaria response, the Region uses a number of important mechanisms to document and implement best practices. In addition, it promotes:
  (i) collaborative work with 13 countries in Global Fund projects;
  (ii) integrated efforts made concerning related health concerns (e.g. neglected infectious diseases, vector-borne diseases, etc.); and
  (iii) South-South collaborations (e.g. cross-border country cooperation).
- The technical cooperation with national TB and malaria programs on implementing national strategic plans should be strengthened, which includes securing additional national resources for TB and malaria control. Additional issues that merit consideration are complex emergencies and the specific circumstances of individual countries, including national policies and mandates as well as commitment to various cross-cutting issues.
- There needs to be better definition of targets in response to country needs, as well as targeted technical cooperation in TB and malaria.

SO2 RER Progress Report

RER 2.1: Member States supported through technical cooperation for the prevention of, and treatment, support and care for patients with HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, hard-to-reach and vulnerable populations	**At risk**

RER Assessment
(4 out of 7 RER indicator targets achieved, with 2 exceeding the 2011 target)

HIV/AIDS, tuberculosis and malaria control programs are confronted with various challenges. Changes in eligibility criteria for ART are driven by rapidly evolving scientific evidence, and have resulted in expanded pools of patients in immediate need of treatment who are faced with decreased coverage. Efforts to optimize ART regimens will have to be intensified, especially in countries with dependence on external funding. Despite high rates of detection for new TB cases, the desired treatment success rate of 85% was not achieved in as many countries as planned—which calls for additional targeted efforts. The elimination target for congenital syphilis remains a problem for many countries, especially in view of the limited coordination and integration achieved by HIV and Sexual and Reproductive Health (SRH) programs. The Dual Elimination Initiative (mother-to-child transmission of both HIV and congenital syphilis), which was endorsed by Member States in December 2010, is expected not only strengthen but also accelerate integration and synergies between these two programs. Remarkable progress has been achieved in malaria control, with the Regional Plan implemented by 28 endemic and non-endemic countries. Newly approved Resolution CD51.R9, "Strategy and Plan of Action for Malaria"—approved by PAHO's 51st Directing Council—will help guide the work carried out with all countries, including achievement of the 2013 targets.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
2.1.1: Number of countries that provide prophylactic antiretroviral treatment to at least 80% of the estimated HIV positive pregnant women	10	12	13	17	2009 Baseline: ANI, ARG, BAH, BAR, BLZ, CAN, CHI, CUB, DOM, SAV, SCN, TCA 2011 Target: BRA, JAM, PAN, PER Of the 2011 target countries, only BRA achieved 80% coverage of prophylactic treatment programs for HIV positive pregnant women (PMTCT). Significantly, however, according to the most recent published estimates from WHO, more than 12 countries in the Region have achieved coverage greater than 80% and therefore, this target is considered to have been achieved.

2.1.2: Number of countries that provide antiretroviral treatment to at least 80% of the population estimated to be in need as per PAHO/WHO guidelines	7	12	9	15	2009 Baseline: BAH, BAR, BRA, CAN, CHI, COR, CUB 2011 Target: BLZ, ELS, MEX, PAN, PER, URU Due to the changes in WHO guidelines that recommend treating people living with HIV earlier, there are now more people in need of treatment, for which reason the coverage target of 80% could not be achieved. Currently, the following nine countries provide ART to 80% or more patients in need: ABM, ANI, BAH, BAR, CAN, CHI, NIC, PUR, and USA. In addition, ART coverage is estimated at 70%–79% in ARG, BRA, DOR, MEX, and URU. The main challenge is to ensure sustainability and optimal use of ARVs, even in countries with universal access.
2.1.3: Number of countries implementing components of the Global Malaria Control Strategy, within the context of the Roll Back Malaria initiative and PAHO's Regional Plan for Malaria in the Americas 2006–2010	23	28	28	33	2009 Baseline: ARG, BAH, BLZ, BOL, BRA, COL, COR, DOR, ECU, ELS, FDA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, VEN 2011 Target: BAR, GRA, SAL, SAV, TRT All Caribbean countries as well as other non-endemic countries participated in the Regional Prevention and Control Meeting. It is noteworthy that 28 countries (endemic and non-endemic alike) implemented the main components of the WHO Global Strategy (the Roll Back Malaria initiative and PAHO's Regional Strategic Plan for Malaria in the Americas 2006–2010). The new Malaria Strategy and Action Plan 2011–2012—in conjunction with PAHO's 51st Directing Council's recently approved Resolution CD51.R9, "Strategy and Plan of Action for Malaria"—are guiding further work with countries.

2.1.4: Number of countries detecting 70% of estimated cases of pulmonary tuberculosis through a positive TB smear test	21/27	23/27	25/27	26/27	2009 Baseline: ARG, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, HON, JAM, MEX, NIC, PAN, PER, PUR, SAL, SCN, URU, USA 2011 Target: CAN, ELS, GUY, PAR In 2010, 25 countries reported detection of at least 70% of all pulmonary TB cases by means of a smear test. In detail, not only did the countries identified as targets for 2011 and 2013 (BAH, CAN, ELS, GUY, PAR, and TRT) report such an achievement, but so did ANI, DOM, and GRA. However, it should be noted that—due to the change of the indicator definition as well as the limited number of cases—ARG, BOL, SAL, and SCN have no longer been able to achieve this target.
2.1.5: Number of countries with a treatment success rate of 85% for tuberculosis cohort patients	11/27	16/27	9/27	23/27	2009 Baseline: BAR, BOL, CHI, COR, CUB, ELS, GUT, HON, NIC, PER, SCN, URU 2011 Target: ANI, DOM, MEX, SAV, USA Only nine countries (BAR, BOL, CUB, DOM, DOR, ELS, HON, MEX, and NIC) have managed to maintain a TB treatment success rate of 85% (for the 2009 cohort). Main challenges were quality issues with the Directly Observed Treatment Shortcourse (DOTS) strategy, the fact that WHO collected data earlier than in previous years, and also the huge variations in treatment success rate due to the scarce number of patients.
2.1.6: Number of countries that have achieved the regional target for elimination of congenital syphilis	7	15	8	26	2009 Baseline: BAH, BLZ, CHI, COR, CUB, PAN, URU 2011 Target: ARG, BRA, COL, DOR, ELS, FEP, MEX, PER, VEN Among the eight 2011 target countries (ARG, BRA, DOR, ELS, GUY, MEX, PER, and VEN), only GUY reported achieving this target (of less than 0.5 congenital syphilis cases per 1,000 live births). Noteworthy is that PER reported 0.7 cases per 1,000. The remaining countries have made promising progress. Thanks to the implementation of the Perinatal Information System (SIP), the epidemiological surveillance of syphilis and HIV is being improved. The main

					challenges are insufficient financial resources and strengthening the linkages between HIV programs and sexual and reproductive health programs.
2.1.7: Number of countries with quantifiable targets in their health plans for prevention and control of HIV and other sexually transmitted infections	6	11	14	14	2009 Baseline: BRA, CHI, COL, COR, GUT, ELS 2011 Target: BLZ, DOR, HON, JAM, MEX, PAR, PER Direct technical cooperation, development of training tools, and training allowed for updating prevention programs in the following 14 countries: ARG, BOL, BRA, CHI, DOR, ELS, GUT, HON, MEX, NIC, PAN, PAR, PER, and URU. This kind of updating strengthened intra- and intersectoral work and allowed for integrating prevention into the Continuum of Comprehensive Care for All—and, particularly, for those who are at the epicenter of the epidemic.

RER 2.2: Member States supported through technical cooperation to develop and expand gender-sensitive policies and plans for HIV/AIDS, malaria and TB prevention, support, treatment, and care	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target)

A well-established methodology based on health systems perspectives has supported a comprehensive review of HIV responses in several countries, and this has resulted in proper alignment of country plans and policies with the recommended framework for universal access. Coordinated efforts between HIV and TB programs have resulted in more countries than expected having adopted and implemented recommendations for HIV-TB collaborative activities. However, additional efforts are required to increase coverage of collaborative activities and bring them up to suitable levels.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
2.2.1: Number of countries with health sector policies and medium-term plans in response to HIV in accordance with the Universal Access Framework	40	40	40	40	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, GRA, GUT, GUY, HAI, HON, JAM, MEX, NCA, NEA, NIC, PAN, PAR, PER, SCN, SAL, SAV, SUR, TCA, TRT, USA, URU, VEN 2011 Target: N/A During the 2010–2011biennium, technical support was provided to evaluate national HIV response—including the response of the health sector—to the following seven countries: BAR, BOL, JAM, NIC, PAR, PER, and TRT.

2.2.2: Number of countries implementing the WHO 12 collaborative activities against HIV/AIDS and tuberculosis	9	20	22	30	2009 Baseline: BRA, CAN, COL, COR, CUB, ELS, GUY, URU, USA 2011 Target: BOL, DOR, ECU, HAI, HON, MEX, NIC, PAN, PAR, PER, TRT A total of 22 countries are currently implementing HIV-TB collaborative activities: BAH, BLZ, BOL, BRA, CAN, COL, COR, CUB, DOR, ECU, ELS, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, URU, USA, and VEN. It should be noted that, although COR had not reported, it nevertheless had a program for joint activities in place, as was verified during a recent evaluation.

RER 2.3: Member States supported through technical cooperation to develop and implement policies and programs to improve equitable access to quality essential medicines, diagnostics, and other commodities for the prevention and treatment of HIV, tuberculosis, and malaria	**On track**

RER Assessment
(3 out of 3 RER indicator targets achieved, with 1 exceeding the 2011 target and even achieving the 2013 target)

This RER has been achieved, with target countries in each of the RER Indicators reporting their achievement of the stated targets set for the biennium. Seven target countries either revised or updated diagnostic and treatment guidelines for TB, and the countries reported important advances in the use of the PAHO Strategic Fund as a mechanism for promoting access to HIV/AIDS public health supplies throughout the Region. In this regard, the Strategic Fund is entering its fourth year of annual bids for HIV/AIDS medicines; and needs for technical support have been identified in the countries to strengthen procurement and supply management of strategic public health supplies. This is done in collaboration with various partners, including the Global Fund. Target countries reported implementing quality-assured HIV screening of donated blood. During the biennium, the Region has greatly advanced in ensuring such screening and in implementing the Regional Plan for Blood Transfusion Safety. Results were presented and recognized by PAHO's 51st Directing Council in 2011. The development of the follow-up regional plan is commencing, in which improving HIV screening will remain a priority.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
2.3.1: Number of countries implementing WHO revised/updated diagnostic and treatment guidelines on tuberculosis	3/27	10/27	14/27	14/27	2009 Baseline: CAN, MEX, USA 2011 Target: BOL, DOR, ECU, GUT, GUY, HAI, HON, NIC Fourteen countries (BLZ, BOL, CAN, COL, DOR, ECU, ELS, GUY, HAI, HON, MEX, NIC, PAR, and USA) have updated their TB diagnostic and treatment protocols, in conformity with the latest WHO guidelines.
2.3.2: Number of countries that participate in the Strategic Fund mechanism for	19	20	20	21	2009 Baseline: BAR, BLZ, BOL, BRA, DOR, ECU, ELS, FEP, GUT, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, TRT 2011 Target: CHI, COR

affordable essential medicines for HIV/AIDS					The Strategic Fund mechanism allowed for improving access to essential HIV/AIDS medicines in all of the above countries.
2.3.3: Number of countries implementing quality-assured HIV screening of all donated blood	35	37	37	40	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, JAM, NCA, NEA, NIC, PAN, PER, SAL, SAV, SCN, SUR, TCA, TRT, USA, VEN 2011 Target: PAR, PER In PAR and PER, all donated blood is currently screened for HIV.
RER 2.4: Regional and national surveillance, monitoring, and evaluation systems strengthened and expanded to track progress towards targets and resource allocations for HIV, malaria, and tuberculosis control; and to determine the impact of control efforts and the evolution of drug resistance					**On track**
RER Assessment (5 out of 5 RER indicator targets achieved, with 3 exceeding the 2011 target)					
The availability of surveillance data for HIV, malaria, and tuberculosis that is disaggregated by sex is now common in every country in the Region of the Americas. Similarly, there is routine surveillance for drug resistance (antiretroviral, antimalarial, and antitubercular) in the target countries. This is expanding to other countries, along with increasing laboratory capacity all across the Region. As a conclusion, it can be said that these targets were successfully achieved for all three programs, with a very low number of target countries that did not meet the goals. Since such data are key for characterizing the evolving dynamics of these diseases in the Region, it is recommended that both baseline and target countries link to this indicator.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
2.4.1: Number of countries reporting HIV surveillance data disaggregated by sex and age to PAHO/WHO	30	32	33	33	2009 Baseline: ABM, ARG, BAH, BAR, BLZ, BOL, CAN, CHI, COL, COR, DOR, ECU, ELS, GUT, GUY, HON, JAM, MEX, NCA, NIC, PAN, PAR, PER, SAV, TRT, URU, USA 2011 Target: BRA, CUB, DOM, GRA, HAI, SAL, SUR, VEN Except for SUR, all countries have reported disaggregated data for AIDS cases. Similarly, with the exception of SAL, every country from the above list reported on progress indicators for response to the epidemic and provided data disaggregated by sex and age. Both PAHO and the countries have worked to

					strengthen HIV surveillance and monitoring (BLZ, COR, ECU, ELS, HON, JAM, PAR, SUR, TRT, and URU) and monitoring among the populations most at risk (BOL, ECU, CHI, and PAR).
2.4.2: Number of countries reporting tuberculosis surveillance data disaggregated by sex and age to PAHO/WHO	30	34	40	37	2009 Baseline: ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, PUR, SAL, SUR, TRT, URU, USA, VEN 2011 Target: GRA, SAV, SCN All Member States (except SUR), along with PUR and all territories, have submitted their reports as per the agreement with WHO—thereby exceeding the 2011 and 2013 targets. Work in ongoing with SUR to meet this target.
2.4.3: Number of countries reporting malaria surveillance data disaggregated by sex and age to PAHO/WHO	21/21	21/21	21/21	21/21	2009 Baseline: ARG, BLZ, BOL, BRA, COL, COR, DOR, ECU, ELS, FDA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, VEN 2011 Target: Maintenance Every country report produced disaggregated data on malaria that have been consolidated in both the PAHO Report and the WHO Global Report on malaria.
2.4.4: Number of countries reporting HIV drug resistance surveillance data to PAHO/WHO, as per PAHO/WHO guidelines	8	7	20	16	2009 Baseline: BAH, BLZ, DOM, GRA, GUY, HAI, SAV, SUR 2011 Target: ANI, BAR, DOR, ELS, JAM, NIC, PER, SAL, SCN, TRT, VEN Surveillance of HIV drug resistance (HIVDR) is spreading to all subregions, thanks to Early Warning Indicator (EWI) monitoring (ARG, BOL, BRA, ECU, TRT, and VEN) and HIVDR surveys (GUY, HAI, and MEX). The HIVDR Laboratory at the Oswaldo Cruz Foundation (FIOCRUZ, in BRA) gained accreditation to join the Network of WHO HIVDR Labs. The key challenge here is long-term sustainability, given that the availability of funding for HIVDR is limited at country level—and that several grants from the Bill and Melinda Gates Foundation will not be renewed in 2012.

2.4.5: Number of countries reporting tuberculosis drug resistance surveillance data to PAHO/WHO, as per PAHO/WHO guidelines	19/27	22/27	23/27	27/27	2009 Baseline: BLZ, BRA, CAN, CHI, COL, COR, CUB, ECU, ELS, GUT, HAI, HON, MEX, NIC, PAN, PAR, PER, URU, USA 2011 Target: ARG, DOR A total of 23 countries not only met but exceeded this indicator. In addition to the countries targeted for 2011, BLZ, BOL, CHI, PAN, and VEN also reached the goal. , It bears mentioning that ARG, BLZ, and PER only reported partial surveillance of drug-resistant tuberculosis (DR-TB); however, full information is available thanks to country visits, which will be included in the regional report on DR-TB.
2.4.6: Number of countries reporting malaria drug resistance surveillance data to PAHO/WHO, as per PAHO/WHO guidelines	13/21	17/21	17/21	20/21	2009 Baseline: BLZ, BOL, BRA, COL, ECU, GUT, GUY, HON, NIC, PAN, PER, SUR, VEN 2011 Target: COR, DOR, ELS, MEX The 17 countries where malaria is endemic, (which includes the 2011 target countries) have carried out studies on drug efficacy and resistance.

RER 2.5: Member States supported through technical cooperation to (a) sustain political commitment and mobilization of resources through advocacy and nurturing of partnerships on HIV, malaria, and tuberculosis at country and regional levels; (b) increase the engagement of communities and affected persons to maximize the reach and performance of HIV/AIDS, tuberculosis, and malaria control programs	**On track**

RER Assessment
(4 out of 4 RER indicator targets achieved, with 1 exceeding the 2011 target)

Under this RER, there was very strong alignment among the regional teams and national counterparts in terms of efforts made. All technical teams report 100% achievement of all targets. However, linkage to this RER by the target countries must be sustained so that activities related to advocacy, partnerships, resource mobilization, and increased community participation continue to be prioritized.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
2.5.1: Number of countries with functional coordination mechanisms for HIV/AIDS	40	40	40	40	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, PUR, SAL, SAV, SCN, SUR, TRT, URU, USA, VEN 2011 Target: Maintenance

					In all 40 countries enumerated above, the national HIV response (including oversight of Global Fund grants) is being coordinated by a unique mechanism that includes representatives from the national authorities, civil society (including networks of people living with HIV), and the United Nations System, which includes PAHO.
2.5.2: Number of countries with functional coordination mechanisms for tuberculosis	8/27	12/27	13/27	15/27	2009 Baseline: BOL, BRA, CAN, COL, ELS, HON, MEX, PER 2011 Target: DOR, ECU, NIC,PAR (need to recover COL and HON as part of the baseline. A total of 13 countries have functional TB coordination mechanisms (which led to the 2011 target being exceeded). Countries such as BRA, CAN, DOR, MEX, and PER (2011) have national Stop TB Alliances; COL and URU have anti-TB Leagues; BOL, BRA, COL, DOR, ECU, ELS, HON, NIC, and PAR have Country Coordinating Mechanisms (bringing together all relevant partners
2.5.3: Number of countries with functional coordination mechanisms for malaria	21/21	21/21	21/21	21/21	2009 Baseline: ARG, BLZ, BOL, BRA, COL, COR, DOR, ECU, ELS, FDA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, VEN 2011 Target: Maintenance Every malaria-endemic country (for a total of 21) has several coordination mechanisms and multiple partners in its malaria response. Of interest is the fact that the coordination mechanisms are providing more results in countries receiving external funding.
2.5.4: Maintain the number of countries involving communities, persons affected by the disease, civil-society organizations and the private sector in planning, design, implementation and evaluation of programs against HIV/AIDS	40	40	40	40	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, PUR, SCN, SAL, SAV, SUR, TRT, USA, URU, VEN 2011 Target: Maintenance Several capacity-building activities at country level have received support from the regional level; these include training peer educators and community leaders in HIV prevention.

RER 2.6: New knowledge, intervention tools and strategies developed, validated, available, and accessible to meet priority needs for the prevention and control of HIV, tuberculosis, and malaria, with Latin American and Caribbean countries increasingly involved in this research	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved)

Both technical teams (Tuberculosis and Malaria) that are linked to this indicator reported 100% achievement of its target. Generating new and/or improved interventions and strategies should be reinforced to address evolving challenges. In addition, appropriate resources must be invested: the scientific research required for providing evidence calls for substantial funding.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
2.6.1: Number of new or improved interventions and implementation strategies for tuberculosis whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions	2	2	2	3	All countries are implementing the Public-Private Mix (PPM) for TB, with special involvement on the part of the social security system and of prisons. Nine countries are currently implementing the Practical Approach to Lung Health (PAL). In addition to these two initiatives, new methods to diagnose TB drug resistance (TB-DR) are being implemented in several countries.
2.6.2: Number of new or improved interventions and implementation strategies for malaria whose effectiveness has been determined and evidence made available to appropriate institutions for policy decisions	1	2	2	2	Based on new evidence for treatment with chloroquine from *in vivo* studies (adequate clinical and parasitological response), HON and NIC have reviewed their current treatment protocol for *Plasmodium falciparum*. In addition, a program to assure malaria diagnosis was established in coordination with national reference laboratories in HON and PER.

SO3 Progress Report

SO3: To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence, and injuries					On Track
Budget Overview					
Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$31,944,000	**$10,960,000**	**$12,834,946**	**$23,794,946**	**89%**	**74%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Reduction in the estimated annual number of deaths related to major chronic noncommunicable diseases (NCDs) such as cardiovascular diseases, cancer, chronic respiratory diseases and diabetes in Latin America and the Caribbean.**
Baseline: 2.4 million deaths in 2000
Target: 2.1 million deaths by 2013

Data show that the target to reduce NCD deaths in LAC was met in 2007. There were 2.1 million deaths from NCDs in LAC in 2007.

This indicator was created many years ago by WHO using an estimated average of number of deaths from major NCDs as a baseline for 2000 and target 2013. In fact, the reported number of deaths by major NCDs in LAC was around 1.7 million in 2000. As the population is aging in the Region, the absolute number of deaths is increasing; but the risk is decreasing in almost all countries. This is a lesson learned for future target-setting. However, the adjusted mortality rate from major NCDs decreased by 7.1% between 2000 to 2007 (about 1% per year), and with intensified effort, this rate can be further improved. This overall decrease is due mostly to decreasing rates in countries like Argentina, Brazil, Chile, Uruguay, etc. In countries that have not yet completed their epidemiological transition—like Guatemala, Guyana, Paraguay and Peru—premature mortality rates from NCDs are actually increasing, and special efforts will be needed. However, in countries like Mexico and some Caribbean countries—which have completed their epidemiological transition—the overall NCD mortality is still increasing, especially due to diabetes.

SO indicator 2: **Reduction in the treatment gap in persons suffering from mental disorders (psychosis, bipolar disorder, depression, anxiety, and alcoholism)**
Baseline: 62% of persons suffering from mental disorders who do not receive treatment
Target: 47% by 2013

Epidemiological studies on treatment gaps in LAC are being compiled, which will allow for analyzing the current situation of said gaps. It has been demonstrated that the development of a community model for mental health—with specialized services linked to primary care accompanied by well-designed psychosocial and medicinal interventions aimed at selected priority conditions (for example, depression, and epilepsy as experienced in the Americas)—can substantially bridge the treatment gap (up to levels between 30% and 50%). During the period analyzed in the PAHO Strategic Plan 2008–2012, pilot experiences have been developed in several countries of the Region, such as Honduras (epilepsy) and Panama (depression and epilepsy), with the aforementioned encouraging results. The great challenge for the future is large-scale implementation—particularly in the poorer countries—of interventions that are both necessary and appropriate (PAHO has disseminated the methodology

and validated tools throughout the Region). In addition, approval by Member States at the PAHO Directing Council of both the Strategy and Plan of Action on Mental Health and the Strategy and Plan of Action on Epilepsy have laid the foundation for political backing and created a roadmap for future actions, with reference made to developing services and reducing gaps.

SO indicator 3: **Halt the current increasing trends in mortality rates due to road traffic injuries in the Region**
Baseline: 16.7 per 100, 000 inhabitants in 2000-2004 (estimated average)
Target: 14.7 per 100, 000 inhabitants by 2013

It is expected that the 2013 target will be met, since data from 2007 already showed a reduction in the mortality rate, which had fallen to 15.8. This number, however, is compromised by the increase in the motorcycle injuries. This information will be updated for the final version of this report, which will be presented to the Pan American Sanitary Conference (PASC) in September 2012—accompanied by the quadrennial publication, Health In the Americas.

SO indicator 4: **Number of countries/territories in the Region that have reduced Decayed, Missing, and Filled Teeth at Age 12 (DMFT-12) Score**
Baseline: DMFT-12 scores of >5 in 2 countries/territories, of 3–5 in 8 countries/territories, and of <3 in 29 countries/territories, in 2004
Target: DMFT-12 scores of >5 in 0 countries/territories, of 3–5 in 2 countries/territories, and of <3 in 37 countries/territories, by 2013

As of 2011, data shows the following achievements: a DMFT-12 of >5 in 1 country; of 3-4 in 8 countries, and of <3 in 34 countries. It is expected that 2013 target will be met.

2010–2011 Assessment

Strategic Objective 3 is considered to be at risk, but significant progress has been made at RER level during this biennium. All of its 6 RERs are on track and 26 out of 27 RER indicator targets for 2011 achieved.

Main Achievements

- There has been an increase in political and technical commitment to fight NCDs at regional, subregional, and national levels alike, mainly as a result of the United Nations High-Level meeting (UNHLM) on NCDs. Both a UN resolution and a UN political declaration were approved at this high-level summit, thus providing a unique opportunity for PAHO's technical areas to be positioned into the broader NCD context. This will enable PAHO to help countries develop cost-effective interventions for addressing chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries, disabilities, and ocular and oral health.
- Country capacity in the area of chronic disease (NCD) policy has improved, and 22 countries now have a national policy or plan for NCDs, as a result of technical cooperation and sharing experiences via the CARMEN network (the name comes from its Spanish acronym for "Collaborative Action for Risk Factor Prevention and Effective Management of Noncommunicable Diseases").
- Evidence-based guide for priorities in cardiovascular health were developed.
- Country capacity for NCD and risk factor surveillance has improved, and a comprehensive NCD situation report has been prepared as part of the Basic Indicators publications.
- There is now more information available and greater awareness of the costs of NCDs, as a result of studies by WHO and the World Economic Forum that were commissioned for the UNHLM on NCDs. In Latin America and the Caribbean, collaboration has been established with the Economic Commission for Latin America and the

Caribbean (ECLAC), the Organization for Economic Co-operation and Development (OECD), the Public Health Agency of Canada (PHAC), and the University of Washington (UW) to undertake national NCD costing studies and to improve capacity for priority-setting.

- NCD programs have been established in 22 countries that are devoted specifically to diabetes, cardiovascular diseases, and cancer.
- The Pan American Forum for Action on NCDs was established as a platform to bring together government, business, and civil society to raise awareness and scale up successful practices.
- The Chronic Care Model has been adopted by over 20 countries to improve the quality of health services for integrated NCD Management.
- An evaluation of the mental health situation in LAC was concluded, providing PAHO with a baseline for the next biennium (RER 3.1).
- The Strategy and Plan of Action for Epilepsy was approved by PAHO's 51st Directing Council in 2011 (RER 3.2).
- In the Americas, 17 countries have formulated health-sector policies and national programs for rehabilitation, which are aligned with PAHO/WHO recommendations for disability and rehabilitation and in line with the framework of fulfilling the UN Convention on the Rights of the People with Disabilities.
- For the countries of the Hipólito Hunanue Convention, a subregional policy has been developed that focuses on people with disabilities. The World Report on Disabilities has been disseminated throughout the Region.

Main Challenges

- The challenge remains to secure sustainable, long-term funding at all levels, as well as to secure other resources commensurate with the burden of disease, increase investments—especially for NCD 'best buys'—and support countries in implementing the outcomes resulting from the UNHLM on NCDs.
- Challenges remain to fully operationalize NCD policy and the Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet and Physical Activity, through an approach this is truly multisectoral.
- Another challenge is to sustain the ongoing collection and analysis of NCDs and their risk factors, and to then utilize this data for NCD programs, policy, planning, and monitoring and evaluation (M&E).
- An additional challenge is to build capacity and ensure that adequate resources be available for in-country costing and cost-effectiveness studies as well as for priority-setting on NCDs.
- Another challenge involves increasing NCD program coverage, effectiveness, and follow-up care, including access to NCD medications, to ensure that persons with chronic conditions are diagnosed early, managed well, and involved in their own care.
- The challenge remains to expand the use of the Chronic Care Model and integrate the model as part of the routine delivery of health care services, especially in primary care settings.
- NCD surveillance constitutes an additional challenge. This encompasses violence, mental health, and disability as priorities, keeping them within the health information system with appropriately designated human and financial resources.
- The challenge remains to implement the recommendations of the World Report on Disabilities.

Lessons Learned

- Intensify coordination and leadership across relevant program areas in the organization, for more concerted and coordinated action for NCD prevention and control.
- Fully implement the next phase of the Pan American Forum for Action on Chronic Diseases as an initiative that will function as a resource mobilization mechanism.
- Prioritize NCD policy and programs within the country Biennial Workplans (BWPs).
- Continue to advocate for NCDs as a priority public health issue in national health and development programs; this will call for leadership, resources, and a multi-sectoral and multi-stakeholder approach.

- Strengthen country mortality data as well as NCD and risk factor surveys; strengthen data on NCD incidence; develop innovative approaches.
- Enhance collaboration among the HSS/HHP Health Economics Project, the United Nations Economic Commission for Latin America and the Caribbean (ECLAC), and other partners to develop cost analysis studies.
- Consider the creation of an NCDs Special Cluster for 'one-stop shopping. '
- Incorporate the Chronic Care Model into PAHO's technical cooperation aimed at strengthening the health system and primary care.
- Countries have proved their ability to establish NCD surveillance. The challenge lies in its sustainability, given that this requires well-prepared human resources as well as stable financial resources.
- The development the strategy of community-based rehabilitation, articulated through the help network and intersectoral participation, has made it possible to provide greater coverage for the care needs of persons with disabilities and their families. This strategy also pushes for health promotion and disability prevention, rehabilitation, and the social integration of persons with disabilities.

SO3 RER Progress Report

RER 3.1: Member States supported through technical cooperation to increase political, financial and technical commitment to address chronic noncommunicable conditions, mental and behavioral disorders, violence, road safety, and disabilities	**On track**

RER Assessment
(5 out of 5 RER indicator targets achieved, with 1 exceeding the 2011 target)

All RER indicators have been achieved, reflecting that Member States have increased their political and technical commitments in response to the urgent need to better address these priority public health issues. However, the challenge remains to secure sustainable, long-term financial resources. The UN High Level Meeting (UNHLM) on NCDs provided a strong impetus for advancement in this RER. For violence, the focus on gender-based violence has increased. The challenge for the next biennium will be to ensure that these institutional development mechanisms are applied to national public health programs in such a way as to fully operationalize them, as well as to increase investment and resources—especially for cost-effective 'best buys.' The challenge is also to reposition the issue as a development issue that requires a comprehensive approach entailing an all-out effort not only on the part of government but also of society as a whole.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
3.1.1: Number of countries implementing institutional development mechanisms (human/budget resources, training, intersectoral partnerships) related to violence	15	20	20	24	2009 Baseline: ARG, BOL, BRA, CAN, CHI, COR, ECU, ELS, GUT, JAM, MEX, NIC, PAR, URU, USA 2011 Target: BAR, DOM, PAN, PER, TRT A total of 20 countries reached this indicator. Actions focus on three levels: intersectoral public policies (BOL, CHI, ELS, NIC, PAN, PER); health plans, either national (NIC, TRT) or, sectoral (NIC, PAR); and community action (DOM). Some countries have placed an emphasis on preventing gender-based violence (BAR, DOM, GRA, and PAN).

3.1.2: Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to mental health	28	27	27	29	2009 Baseline: ARG, BAH, BLZ, BOL, BRA, CAN, CHI, COR, CUB, DOR, ECU, ELS, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SUR, TRT, URU, USA, VEN2 011 Target: Maintenance A total of 30 countries completed an assessment of their mental health (MH) systems. Three subregional reports were finalized and the regional report was drafted. The countries are working on the recommendations of the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS).
3.1.3: Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to chronic diseases	24	31	36	38	2009 Baseline: BAH, BAR, BOL, BRA, CAN, CHI, COL, COR, CUB, ECU, GUT, GUY, HAI, JAM, MEX, NIC, PAN, PAR, PER, SAL, SUR, TRT, URU, VEN 2011 Target: ABM, ANI, ARG, BLZ, FEP, SAV, SCN A total of 36 countries reached this indicator. In addition to the target countries, 5 additional countries met this RER indicator (DOM, DOR, ELS, GRA, and HON). The UN High-Level Meeting on NCDs provided a political and technical imperative for countries to accelerate strengthening their NCD programs.
3.1.4: Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to disabilities	14	19	19	24	2009 Baseline: ARG, BRA, CHI, COL, CUB, DOR, GUY, ECU, ELS, HON, MEX, NIC, PAN, VEN 2011 Target: BOL, GUT, PAR, TRT, URU A total of 19 countries reached this indicator. The countries have moved forward in formulating comprehensive institutional responses to meet the care demands of persons with disabilities, using an intersectoral approach.
3.1.5: Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to road safety	15	18	18	21	2009 Baseline:*:* ARG, BOL, BRA, CAN, CHI, COR, ECU, ELS, GUT, JAM, MEX, NIC, PAR, URU, USA 2011 Target:*:* DOR, GUY, TRT A total of 18 countries have reached this indicator. In the course of 2011, 20 countries launched Road Safety Decade (2011-–2020) and made commitments to

					improving road safety.

RER 3.2: Member States supported through technical cooperation for the development and implementation of policies, strategies, and regulations regarding chronic noncommunicable conditions, mental and behavioral disorders, violence, road safety, disabilities, and oral diseases	**On track**

RER Assessment
(6 out of 7 RER indicator targets achieved, with 3 exceeding the 2011 target)

Of the RER indicator targets, 6 out of the 7 were reached, with the exception of road safety. Progress is ongoing in Member States to implement their national plans and strategies on violence, disabilities, mental health, NCDs, blindness, and oral health. The challenge will be to sustain on an ongoing basis the implementation of these national strategies and plans. The challenge is also to build capacity for such priority-setting using tools as cost-effectiveness analysis.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
3.2.1: Number of countries implementing a multisectoral national plan to prevent interpersonal and gender based violence aligned with PAHO/WHO Guidelines	17	20	20	23	2009 Baseline: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, ELS, GUT, HON, JAM, MEX, PAN, PER, USA, VEN 2011 Target: FEP, NIC, URU This indicator was reached in 20 countries. An important achievement worthy of highlighting here is the securing of funds from a private foundation to strengthen primary prevention of violence against women and children in COR, ELS, and GUT.
3.2.2: Number of countries implementing a national plan on disability management and rehabilitation, according to PAHO/WHO guidelines	8	16	16	25	2009 Baseline: ARG, BRA, CUB, DOR, HON, MEX, NIC, VEN 2011 Target: COL, ECU, ELS, GUY, PAN, PAR, TRT, URU This indicator was reached in 16 countries. COL and ELS have made extraordinary progress in implementing their national plans on disability and rehabilitation, especially in consolidating the baseline and defining intersectoral strategies for the

					health sector to address the needs of persons with disabilities. Outstanding substantive achievements can be seen in BOL, CHI, and COR, all related to their strategy of community-based rehabilitation (CBR) and their review of national plans.
3.2.3: Number of countries implementing a national mental health plan, according to PAHO/WHO guidelines	29	29	29	30	2009 Baseline: ANI, ARG, BAR, BOL, BLZ, BRA, CAN, CHI, COR, CUB, DOR, DOM, ECU, ELS, GRA, GUT GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SUR, URU, USA, VEN 2011 Target: Maintenance This indicator was maintained in 29 countries. PAHO is supporting the MoH in the process of implementing National MoH Plans. This is a key component of the regional Strategy and Plan of Action on Mental Health adopted by PAHO's 49th Directing Council in 2009.
3.2.4: Number of countries implementing a national plan for the prevention and control of chronic noncommunicable diseases, according to the PAHO Integrated Chronic Disease Prevention and Control Approach, including Diet and Physical Activity	30	32	35	36	2009 Baseline: ABM, ARG, BAR, BLZ BOL, CAN, CHI, COL, CUB, DOM, ECU, ELS, GRA, GUT,GUY, HAI, JAM, MEX, NCA, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, USA, VEN 2011 Target: FEP, NIC The two target countries plus ANI, COR, and HON) achieved this indicator by developing country plans and policies related to NCDs. The next challenge will be the operationalization of the plans, funding, multi-stakeholder collaboration, etc.
3.2.5: Number of countries implementing a national plan for the prevention of blindness and visual impairment, according to PAHO/WHO guidelines	11	21	24	26	2009 Baseline: BRA, CAN, COL, CUB, DOM, ECU, ELS, GUY, MEX, PAR, PER, SAL, USA, VEN 2011 Target: ARG, BAR, GRA, GUT, JAM, NIC, PAN A total of 24 countries are currently implementing national plans to prevent blindness. In addition to the target for 2011, 3 more countries that were not in the baseline (BLZ, SAV, and SCN) are also implementing national plans. This constitutes important progress made towards reaching the 2013 target.

3.2.6: Number of countries implementing a national plan for the prevention of oral diseases, according to PAHO/WHO guidelines	29	31	34	35	2009 Baseline: ABM, ARG, BAH, BAR BRA,, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SCN, SUR, TRT, URU, USA, VEN 2011 Target: BLZ, BOL, HAI Some 34 countries reached this indicator. Dramatic improvements and gains in oral health have been verified through national oral health surveys in 34 countries that have achieved the goal of DMFT ≤3. Not only have 34 countries achieved their goal, but furthermore 8 countries report a DMFT of ≤1; and 14 countries, of ≤2—thus demonstrating further improvements. There are only 6 countries with a DMFT of ≤ 4; and 3, with a DMFT of ≤ 5.2.
3.2.7: Number of countries implementing a multisectoral national plan to prevent road traffic injuries, aligned with PAHO/WHO Guidelines	17	20	18	23	2009 Baseline: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, ELS, GUT, HON, JAM, MEX, PAN, PER, USA, VEN 2011 Target: NIC, PAR, URU This indicator was reached in 18 countries. 11 countries prepared a plan for Road Safety Decade. PAR and PAN made important progress in terms of developing an intersectoral approach, as well as in publishing and disseminating their plans.
RER 3.3: Member States supported through technical cooperation to improve their capacity to collect, analyze, disseminate, and use data on the magnitude, causes, and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries, and disabilities					**On track**
RER Assessment (5 out of 5 RER indicator targets achieved, with 1 exceeding the 2011 target)					
The assessment shows that the RER is on track, having met all its indicator targets for 2011. Collaboration was developed with CDC on violence. Prior fulfillment of the indicator devoted to including information on NCDs and their risk factors enabled the countries of the Region to prepare for the United Nations High-Level Meeting on Noncommunicable Diseases.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
3.3.1: Number of countries that have a national health information system that includes indicators of interpersonal and gender-based violence	16	18	18	22	2009 Baseline: ARG, BAR, BLZ, BRA, CAN, COL, COR, ECU, ELS, GUT, JAM, MEX, NIC, PAN, USA, VEN 2011 Target: BOL, PER This indicator was reached in 18 countries. Two important efforts include the following: (1) collaboration with CDC to improve surveillance systems on violence; and (2) a comparative analysis of data on violence against women in 12 countries of the Region.
3.3.2: Number of countries that have a national health information system that includes indicators of mental health	10	14	14	20	2009 Baseline: ARG, BLZ, BRA, CHI, COL, ECU, NIC, PAN, URU, VEN 2011 Target: BOL, ELS, GUT, PAR The indicator was reached in 14 countries. There are several countries (which are not part of the baseline) working on improving mental health (MH) information systems. Regional guidelines on MH information were published and disseminated. The countries have indicated that they are working to improve the availability of MH information.
3.3.3: Number of countries that have a national health information system that includes indicators of disabilities	22	23	23	26	2009 Baseline: BAR, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ELS, GRA, JAM, MEX, NIC, PAN, PER, SAL, SAV, URU, USA, VEN 2011 Target: GUY This indicator was reached in 23 countries. GUY advanced with a proposal for systematizing the availability of health-sector disability data. ARG and HON completed a methodology for an information registry on disability that would in turn generate disability indicators.
3.3.4: Number of countries that have a national health information system that includes indicators of chronic, noncommunicable conditions and their risk factors	28	31	34	33	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, CHI, COL, COR, CUB, DOM, DOR, ECU, GRA, GUY, HAI, JAM, MEX, PAN, PAR, SAV, SCN, SUR, URU, USA, VEN 2011 Target: ELS, HON, PER, SAL, TRT A total of 34 countries produced indicators for NCDs and their risk factors (target countries plus NCA, NIC, and TCA).

					Target countries have incorporated NCDs and certain risk factors as part of their own Basic Data set. Based on this data, PAHO has published the NCD Basic Indicators brochure.
3.3.5: Number of countries that have a national health information system that includes indicators of road traffic injuries	16	18	18	22	2009 Baseline: ARG, BAR, BLZ, BRA, CAN, COL, COR, ECU, ELS, GUT, JAM, MEX, NIC, PAN, USA, VEN 2011 Target: FEP, PAR A total of 18 countries reached this indicator. Some 29 countries participated in training on data collection for road safety; and 32 have already collected the data that will be part of Global Status Report of Road Safety in 2012.
RER 3.4: Improved evidence compiled by the Bureau on the cost-effectiveness of interventions to address chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries, disabilities, and oral health					**On track**
RER Assessment (5 out of 5 RER indicator targets achieved, with 1 exceeding the target for 2011)					
Progress was made to achieve all five indicators. The methodologies used to improve evidence on cost-effective interventions to address NCDs are provided by four indicators, and there is evidence from epidemiological data for one indicator. Data on cost-effective interventions by addressing multiple, interdisciplinary, cost-effective NCD interventions could be improved, given that the disease burden is shifting to NCDs and their risk factors. This places a significant strain on health systems and creates a need to have information on hand to promote, implement, and disseminate cost-effective approaches.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
3.4.1: Number of cost analysis studies on interventions related to mental and neurological disorders	2	2	2	3	In the 2008–2009 biennium, two studies were conducted and are still valid. During the 2010–2011 biennium, a book was published with a compilation of epidemiological studies on mental disorders in LAC. These epidemiological studies are focused on morbidity, mortality, disability, and assessment of services—but not on cost-effectiveness. For the 2012–2013 biennium, work is underway on studies devoted to treatment gaps and assessment of programs and services.

3.4.2: Number of countries with cost analysis studies on violence conducted and disseminated	10	12	12	15	2009 Baseline: BLZ, BRA, CAN, CHI, COL, COR, ELS, HON, PER, USA 2011 Target: ARG, FEP Some 12 countries reached this indicator, but progress is heterogeneous regarding the depth of the projects. This represents an inherent difficulty on the subject , which challenges the capacity of the Organization to support it. This means that the participation of PAHO/WHO Collaborating Centers has been important, in that they have managed to advance initiatives in the countries. Noteworthy lessons have been learned in ARG and BLZ.
3.4.3: Number of countries with cost analysis studies on oral health conducted and disseminated	6	8	8	9	2009 Baseline: BOL, COL, ECU, HAI, PAR, URU 2011 Target: JAM, MEX Cost-effective economic evaluations for increasing oral health services on a large scale were conducted in eight countries through the PRAT Project and the Communities Free of Caries Initiative. Progress is being made in scaling up of the multi-country project for six additional countries to integrate oral health into NCDs through primary health care approaches.
3.4.4: Number of countries with cost analysis studies on chronic noncommunicable conditions conducted and disseminated	11	14	14	18	2009 Baseline: ARG, BAH, BAR, BRA, CAN, CHI, COL, JAM, MEX, TRT, USA 2011 Target: FEP, NIC, PER Cost studies on NCDs have been reviewed by 14 countries. PAHO held a regional workshop on the economic dimensions of NCDs, together with the Economic Commission for Latin America and the Caribbean (ECLAC), the Organization for Economic Cooperation and Development (OECD), and the Public Health Agency of Canada (PHAC). Countries are beginning to consider conducting their own national NCD economic studies to strengthen their ability to generate the evidence to deal with the NCD epidemic.

3.4.5: Number of countries with cost analysis studies on road safety conducted and disseminated	8	10	11	12	2009 Baseline: BLZ, CAN, BRA, CHI, COL, ELS, MEX, USA 2011 Target: ARG, VEN Some 11 countries reached this indicator (the target countries plus PAN). ARG made progress on improving a methodology for cost analysis of road traffic injuries.
RER 3.5: Member States supported through technical cooperation for the preparation and implementation of multisectoral, population-wide programs to promote mental health and road safety and prevent chronic noncommunicable conditions, mental and behavioral disorders, violence, and injuries, as well as hearing and visual impairment, including blindness					**On track**
RER Assessment (3 out of 3 RER indicators achieved, exceeding their 2011 targets)					
The countries have indicated that they are strengthening and expanding the implementation of their NCD programs and plans. The targets were achieved for the indicators related to disabilities and mental health (in terms of promotion and prevention).					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
3.5.1: Number of countries implementing multisectoral, population-wide programs to prevent of disabilities	6	11	15	15	2009 Baseline: ARG, CHI, CUB, MEX, NIC, PAN 2011 Target: BLZ, COL, DOR, PAR, VEN A total of 15 countries reached this indicator (the target countries plus ARG, BOL, COR, and ECU). COL has completed its proposal for strengthening activities related to health promotion and disability prevention by using a PHC approach.
3.5.2: Number of countries implementing interventions to promote mental health and the prevention of mental disorders and substance abuse	5	11	12	15	2009 Baseline: BOL, BRA, GUY, PAN, TRT 2011 Target: BLZ, ECU, ELS, NIC, PAR, PER A total of 12 countries reached this indicator (the target countries plus PUR). Regional guidelines on mental health (MH) prevention and promotion were published and disseminated. All countries have integrated the promotion-prevention component into their respective National Mental Health Plan.

3.5.3: Number of countries implementing multisectoral, population-wide programs to promote the prevention of chronic diseases	10	21	22	31	2009 Baseline: BRA, CHI, COR, CUB, ECU, ELS, FEP, GUT, GUY, JAM 2011 Target: ARG, BAR, BLZ, BOL, MEX, NIC, PAR, PER, PUR, SUR, TRT Some 22 countries reached this indicator (the target countries plus URU). All countries have indicated that they are strengthening and expanding the implementation of their NCD programs and plans.
RER 3.6: Member States supported through technical cooperation to strengthen their health and social systems for the integrated prevention and management of chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries, and disabilities					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved, exceeding the target for 2011—with 1 even exceeding the 2013 target)					
All countries report training primary health care providers to improve quality of care for people with NCDs; and four additional countries report meeting the indicator related to NCDs. We consider that the target of the indicator related to tobacco cessation was achieved.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
3.6.1: Number of countries implementing integrated primary health-care strategies to improve quality of care for chronic noncommunicable diseases according to WHO's innovative Care for Chronic Conditions	20	24	28	32	2009 Baseline: BAH, BAR, BLZ, BRA, CAN, CHI, COR, CUB, ELS, GRA, GUT, HON, JAM, NIC, MEX, PAR, PER, SAL, TRT, USA 2011 Target: BOL, FEP, GUY, PAN, SUR Some 28 countries reached this indicator (target countries plus ABM, ARG, BOL, and ECU). All countries report training primary care health providers in quality improvement for NCDs, including application of the Chronic Care Passport.
3.6.2: Number of countries with tobacco cessation support incorporated into primary health care services according to the WHO Global Report of the Tobacco Epidemic	6	8	17	9	2009 Baseline: ARG, BRA, CUB, MEX, SUR, URU 2011 Target: BAH, PAN A total of 17 countries reached this indicator: PAN (target) plus CAN, COR, ECU, ELS, GUT, JAM, PAN, PAR, USA, and VEN. Even though this seems to be a major advancement, it needs to acknowledged that there is now a new means of verification available. This is not an indicator that had received too much attention from the countries.

SO4 Progress Report

SO4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, and childhood and adolescence; to improve sexual and reproductive health; and to promote active and healthy aging for all individuals	**On track**

Budget Overview

Approved Budget (PB 2010–2011)	Funds Available			Expenditure (%)	Funded (%)
	RB	OS	Total		
$37,132,000	$12,990,000	$27,591,970	$40,581,970	74%	109%

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

The Region of the Americas has witnessed remarkable progress in 2010–2011, both in reducing infant mortality and in improving maternal health—thus contributing to the achievement of MDGs 4 and 5 as detailed below.

Notwithstanding these advancements, the number of preventable maternal deaths in the Region still accounts for 95% of all the lives lost due to maternity. This situation is inadmissible and reveals that the maternal mortality ratio is a summary indicator of the inequities in different spheres of life and therefore a matter that needs to be addressed at the public policy level and beyond the access to quality services.

Under these circumstances, PAHO has taken the leadership to promote the implementation of the accountability framework and recommendations put forward by the Commission on Information and Accountability for Women's and Children's Health (established at the request of UN Secretary-General).

The Commission was called by the UN Secretary General due to the urgency to increase the impact of resources devoted to women's and children's health. The accountability framework responds to the international framework of the right to health and other related human rights, and calls for action in a number of subjects outside the mandate of health entities, like vital events, economic analysis of resources tracking, strengthening or creating national accountability mechanisms that are transparent, and inclusive of all stakeholders, and the necessary remedial actions, among others.

SO Indicator 1: Proportion of births attended by skilled birth attendants in Latin America and the Caribbean
Baseline: 85% in 2006
Target: 90% by 2013

During this biennium, Latin America and the Caribbean experienced a remarkable improvement in the proportion of births attended by skilled health personnel, which is currently estimated at 92.9%.

SO Indicator 2: **Reduction in the number of countries in the Region reporting a maternal mortality ratio above 100 per 100,000 live births**
Baseline: 10 countries
Target: 6 countries by 2013

According to PAHO Basic Indicators 2011, only four countries (GUT, DOR, PAR and JAM) reported estimated Maternal Mortality Rate (MMR) exceeding 100 per 100,000 live births, but five countries (HON, NIC, PAN, HAI, BOL) have not reported updated information. As noted in the Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity (approved by the Directing Council in 2010), almost none of the

LAC countries are reducing maternal mortality at a sufficient rate to meet the MDG5 target, if the current trend prevails. However, 95% of LAC maternal mortality is preventable as indicated by the most frequent causes of death (pregnancy induced hypertension, hemorrhage, complication of abortions in unsafe conditions, obstructive labor, sepsis, and other direct causes).

SO Indicator 3: **Number of countries in LAC with an under-5 mortality rate of 32.1 per 1,000 live births or less**
Baseline: 21 countries in 2006
Target: 26 countries by 2013

According to PAHO Basic Indicators 2010, 31 countries in the Region had a mortality rate for children under 5 of less than 32.1 per 1,000 live births; consequently, the Region has already exceeded the 2013 target (of 26 countries).

However, there are countries/territories that require special focus, either because of high infant mortality (as in Bolivia, Dominican Republic, Guyana, Haiti, and Trinidad and Tobago), or because they have not reported any estimates of this rate (Bermuda, Guadeloupe, French Guiana, Martinique, Puerto Rico, and other Caribbean islands).

SO Indicator 4: **Number of countries in LAC with a contraceptive prevalence rate above 60% (as a proxy measure for access to sexual and reproductive health services)**
Baseline: 13 countries in 2006
Target: 21 countries by 2013

In the Region, access to sexual and reproductive health has improved; and today, 14 countries have a rate of contraceptive use of over 60%. Still, progress should be scaled up to reach the goal of 21 countries in 2013.

SO Indicator 5: **Number of countries in LAC with an adolescent fertility rate (defined as the annual number of live births per 1,000 females aged 15-19) of 75.6 per 1,000 or less**
Baseline: 8 countries in 2006
Target: 13 countries by 2013

Although most countries have developed national plans to prevent teenage pregnancy, only 10 countries have succeeded in bringing down the adolescent fertility rate to lower than 76.5 per 1,000. As yet, there has been no removal of the legal and cultural barriers that create obstacles to accessing reproductive health services—especially for the most vulnerable population. Neither have sufficient human and financial resources been allocated.

SO Indicator 5: **Number of countries in the Region where 50% or more of the older adult population (60 years or older in Latin America and the Caribbean, 65 or older in the United States and Canada) receive services adapted to their health needs**
Baseline: 9 countries in 2006
Target: 15 countries by 2013

In addition to the 9 countries in the baseline, 6 additional countries are now progressing towards the establishment of policies to ensure services adapted to the health needs of older adults.

2010–2011 SO Assessment

This SO is rated on track, with its 8 RERs on track and having met all 15 RER indicator targets for 2011.

Efforts to promote better health at key stages of the lifecourse in a sustainable way have been successful, as evidenced by:
(a) compliance with all targets, both at country and regional levels; and
(b) improvement of the epidemiological indicators, with subsequent impact at the population-wide level.

Main Achievements

- PAHO Resolution CD51.R12, "Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity," was approved; and from a lifecourse approach, there was successful implementation of the other regional lifecourse plans.
- There was improvement in interprogrammatic work with other PAHO entities, as well as collaborative efforts to establish strategic alliances: a memorandum of understanding (MoU) and a plan of action with UNICEF, as well as a joint project with the World Bank and Enfants du Monde. A new Pan American Network for the Health of Indigenous Young People was launched.
- The first regional report on the Initiative for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis was finalized; and a costing tool, a field guide, and laboratory guidelines were developed.
- Two major reports were published and launched: the First Regional Report on the Health Situation of Indigenous Young People (published by PAHO, the Economic Commission for Latin America and the Caribbean [ECLAC], and the Spanish International Cooperation Agency [AECID]) and the Report on Sexual and Reproductive Health of Indigenous Youth in Selected Countries.
- The Guidelines for the Continuum of Care of Women and Newborns were updated. Developed and disseminated were a self-instructional manual on monitoring fetal growth, the manual on Maternal Waiting Homes, the Perinatal Information System for Users, and Analysis and Advantages of Information. A Training of trainers (TOT) course was conducted in eight countries, along with several workshops on neonatal and child health.
- Some 423 TOT sessions were held to train the trainers in more than 9 countries within the framework of the Continuum of Care of Women and Newborns, and the Perinatal Information System. Some 280 professionals were trained in adolescent health using a distance education package that was expanded to include gender rights and an intercultural approach.
- The Safe Motherhood initiative was launched during 2010 and 2011, which included the Motherhood exhibition by Bru Rovira, the Regional Best Practices Contest (in which 17 countries participated), and the Regional Safe Motherhood Photography Contest (in which 21 countries participated).As part of PAHO's 51st Directing Council, there was a panel discussion featuring Dr. Michelle Bachelet, Her Royal Majesty The Infanta Cristina of Spain, Dr. Margaret Chan (Director General of WHO), Dr. Laura Laski, and Dr. Aníbal Faundes.
- Within the framework of Spanish Cooperation, the Third International Technical Annual Meeting was held at CLAP/WR, with representatives from 16 countries (including FCH/PAHO focal points and Sexual and Reproductive Health coordinators from the MoH). The meeting addressed an evaluation of progress made in the 2010–2011 workplan and developed new lines of cooperation for the next biennium. The International Meeting in Health Systems and Services to Respond to Adolescents' Needs was conducted jointly with HSS to develop plans to improve adolescent health; some 21 countries participated.

Main Challenge

The ambitious targets established on the Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity require greater financial investment (including a greater allocation of PAHO staff time) and also require better integration of work among PAHO technical areas (for example, to ensure timely access to safe blood and to essential medicines and supplies, to properly train personnel, etc.).

Lessons Learned

- The integration of projects and entities requires both efforts and a common vision, with joint planning. Technical cooperation in this area calls for expertise at country level, with efforts made to provide continued education by introducing and using new technologies. Institutionalization at the level of ministerial information systems is *the* key step. This needs to be addressed as a priority in the Region, despite the fact that it requires a notable investment in terms of financial and human resources in order to meet the standards defined both in the *Plan of Action to Accelerate Reduction of Maternal Mortality and Severe Maternal Morbidity* and in the indicators requested by the Commission on Information and Accountability. Similarly, the development of guidelines and standards involves ongoing activity in terms of technical cooperation, for which the availability of financial resources is crucial.

- The main challenges are to guarantee universal access to comprehensive reproductive health services to allow for the required policy reviews, find sustainable funding, and promote an enabling environment (through continuous advocacy). Noteworthy is the controversy surrounding how to deal with the topic of abortion in national policies—an issue that is impairing more rapid progress in many countries.

SO4 RER Progress Report

RER 4.1: Member States supported through technical cooperation to develop comprehensive policies, plans, and strategies that promote universal access to a continuum of care throughout the lifecourse; to integrate service delivery; and to strengthen coordination with civil society, the private sector, and partnerships with UN and Inter-American system agencies and others (e.g., NGOs)	**On track**

RER Assessment
(3 out of 3 RER indicator targets achieved)

All target countries have made progress in developing policies, plans, and strategies to promote the continuum of care throughout the lifecourse. In addition, coordination has been strengthened with strategic partners— such as UNICEF, UNFPA, and the World Bank—on issues of maternal health and child and adolescent health. Coordination has also been strengthened with over 50 universities and with specialized agencies on healthy aging. Although it has been necessary to overcome many difficulties in mobilizing financial resources, it is remarkable that every single goal has been met.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.1.1: Number of countries that have an integrated policy on universal access to effective interventions for improving maternal, newborn, and child health	2	3	3	4	2009 Baseline: HON, NIC 2011 Target: BOL BOL, HON, and NIC all have an integrated policy on universal access to improve maternal, newborn, and child health. In addition, 12 additional countries (ABM, ARG, BRA, CHI, CUB, ELS, GUT, PAR, PER, TRT, URU, and VEN) have made a commitment to developing a more elaborate policy in this area.

4.1.2: Number of countries that have a policy of universal access to sexual and reproductive health	10	13	13	16	2009 Baseline: ARG, BLZ, CAN, CHI, CUB, COR, ECU, GUY, HON, PER, URU 2011 Target: BOL, ELS BOL, HON, and ELS all developed policies in sexual and reproductive health, with technical support from CLAP. After many years of advocacy, countries have expanded the reproductive rights framework to improve social protection systems. The main challenge is sustainable funding.
4.1.3: Number of countries that have a policy on the promotion of active and healthy aging	15	17	17	18	2009 Baseline: ARG, BAR, BLZ, BRA, CAN, CHI, COR, CUB, ECU, JAM, MEX, PAN, TRT, URU, USA 2011 Target: BOL, PER, SCN In addition to the 15 countries in the baseline, both Bolivia and Peru also have a policy for promoting active, healthy aging. SCN has advanced the development of such a policy (which is now at its final discussion stage, prior to approval). In addition, 8 more countries (ABM, ANI, DOM, DOR, GRA, PUR, SAL, and SAV) have demonstrated a strong commitment to the healthy aging agenda and are moving forward towards defining a policy.
RER 4.2: Member States supported through technical cooperation to strengthen national/local capacity to produce new evidence and interventions; and to improve the surveillance and information systems in sexual and reproductive heath, as well as in maternal, neonatal, child, adolescent, and older adult health					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target and even achieving the 2013 target)					
The institutionalization of the Perinatal Information System (SIP) at ministerial level is a key step in consolidation country systems. This is an ongoing process that constantly demands investment in terms of human and financial resources, as does even more so the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity—not to mention the indicators requested by the Commission on Information and Accountability.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.2.1: Number of countries that implement information systems and surveillance systems to track sexual and reproductive health, maternal, neonatal and adolescent health, with information disaggregated by age, sex and ethnicity	15	17	20	20	2009 Baseline: ARG, BAH, BAR, BOL, CUB, ECU, ELS, GUT, HON, JAM, NIC, PAN, SAV, SCN, URU 2011 Target: BLZ, FEP, GUY, HAI, VEN The target was exceeded. In addition to the 20 countries listed above, another 6 also reached the target (BRA, DOR, MEX, PAR, SUR, and TRT). Institutionalizing the Perinatal Information System (SIP) at ministerial level is a key step in the countries' consolidation systems and requires a permanent investment in terms of both financial and human resources.
4.2.2: Number of PASB systematic reviews on best practices, operational research, and standards of care	5	7	7	10	There have been 7 operational research projects completed on syphilis in ELS, GUY, HON, NIC, PAN, PAR, and URU; and 2 of them have been published (ELS and URU). Also, HON was able to carry out an operational research project to characterize the population terminated through abortion. Such studies were based on data collected by the SIP that simultaneously contributed to its improvement. The challenge is to train local personnel (to provide them with skills in operational research).
RER 4.3: Member States supported through technical cooperation to reinforce actions that ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods					**On track**
RER Assessment (1 out of 1 RER indicator targets achieved)					
Technical cooperation in this matter is an ongoing activity, as new evidence appears constantly that calls for updated training for the personnel involved. The main challenge is limited funding, which impairs more rapid progress and the scaling up of various successful experiences.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.3.1: Number of countries adapting and utilizing PAHO/WHO-endorsed technical and managerial norms and guidelines for increasing coverage with skilled care at birth, including prenatal, postnatal, and newborn care	12	21	21	23	2009 Baseline: ARG, BRA, CAN, CHI, COR, CUB, ECU, HON, PAN, TRT, URU, USA 2011 Target: BLZ, DOR, ELS, GUY, HAI, MEX, NIC, PER, VEN Completed by ARG, BOL, DOR, ELS, GUY, HON, NIC, PAR, PER, and URU. CLAP began the revision of BLZ's Neonatal Technical Guide, VEN's Neonatal and Obstetric Guidelines, as well as holding training in MEX and VEN for skilled care for pregnant women and newborns. Technical cooperation in this matter is an ongoing activity; new evidence appears constantly and requires up-to-date training for the health workforce.
RER 4.4: Member States supported through technical cooperation to improve neonatal health					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved)					
First, CLAP has developed, tested and validated neonatal care guidelines in six countries of the Region. A multimedia tool to facilitate the dissemination and training on the subject is also in process. Second, several countries received support to develop neonatal action plans with a Continuum of Care approach, based on to the regional document approved by the PAHO Directing Council. These action plans have provided guidance for country activities. Third, inter-agency partnerships in newborn health were fostered at country level to support health ministries in the implementation of their action plans. Finally, guidelines and tools for supervision, monitoring, and evaluation of neonatal interventions have been adopted in health facilities and are being used to measure the quality of services.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.4.1: Number of countries with at least 50% of selected districts implementing interventions for neonatal survival and health	6	12	12	18	2009 Baseline: BOL, DOR, ECU, NIC, PAR, PER 2011 Target: ARG, BRA, GUT, GUY, HON, PAN This indicator was exceeded; not only have the 12 countries listed above complied but also 3 additional ones have done so. There has been great progress made in the implementation of evidence-based neonatal interventions in the districts selected in the country action plans.
4.4.2: Number of guidelines and tools developed and disseminated to improve neonatal care and survival	6	6	13	9	A total of 13 countries are implementing new guidelines to improve newborn care and survival. For this purpose, CLAP has developed a training model that was validated in ECU, HAI, MEX, and VEN. CLAP also provided support to BLZ and VEN for reviewing their neonatal guidelines. A proposal is also being developed for distance learning using multimedia tools. The module was well received by participants, since it covers real needs. The challenges are access to virtual technology, as well as the personnel and funds to run the module.

RER 4.5: Member States supported through technical cooperation to improve child health and development, taking into consideration international agreements	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved, with 1 exceeding both the 2011 and 2013 targets

On one hand, all countries concerned have made remarkable progress in the expansion and sustainability of the Integrated Management of Childhood Illness (IMCI) strategy. A Regional Workshop for the Introduction and Orientation of the LiST (Lives-Saved Tool) for Strategic Planning was held in seven countries. An IMCI mapping exercise was completed, with updated results from eight countries. This concluded the 2011 report and inventory of IMCI expansion activities in various geographical areas.

On the other hand, 11 countries are implementing integrated key family practices into their national and local health programs—many within a lifecourse approach. Regional capacity-building for the implementation and evaluation of key family practices was held in December 2011 in Ecuador. Such a meeting provided an opportunity to launch the National Maternal, Neonatal, and Child Health Facility Survey, which measures the quality of care at the first level of care as well as caretaker knowledge among those caring for children under 5.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.5.1: Number of countries that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts	11	11	17	13	2009 Baseline: BLZ, BOL, COL, DOR, ECU, ELS, GUY, HON, NIC, PAR, PER 2011 Target: GUT Besides the 11 baseline countries and Guatemala (the country targeted for 2011), 5 additional countries (ARG, CHI, HAI, PAN, and VEN) have expanded coverage of the Integrated Management of Childhood Illness (IMCI) strategy to more than 75% of their districts.
4.5.2: Number of countries implementing the WHO/PAHO Key Family Practices approach at the community level to strengthen primary health care	10	11	11	13	2009 Baseline: BOL, COL, DOR, ECU, ELS, GUY, HON, NIC, PAR, PER 2011 Target: GUT A total of 11 countries are implementing the PAHO/WHO strategies for Key Family Practices in their national and local health programs—most of them within a lifecourse approach. A regional training exercise was held in Ecuador in December 2011. Also, within the context of the National Health Survey, an evaluation was initiated to assess the quality of service delivery in health care centers and the knowledge of caregivers on the clinical management of children under 5.
RER 4.6: Member States supported through technical cooperation for the implementation of policies and strategies on adolescent health and development					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved, with 1 indicator even exceeding the 2013 target)					
All target countries have achieved both the milestone and the indicator, and most countries have made progress. The challenge is to maintain advocacy and increase the financial and technical resources necessary to ensure process sustainability.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.6.1: Number of countries with a functioning adolescent and youth health and development program	12	16	16	17	2009 Baseline: ARG, BLZ, BRA, CAN, ELS, GUT, GUY, HON, MEX, NIC, PER, VEN 2011 Target: BOL, COR, CUB, ECU, TRT This goal is considered as achieved, since 14 countries (ARG, BAH, BLZ, BOL, BRA, COR, CUB, ECU, ELS, GUT, GUY, MEX, NIC, and SUR) all reported having reached it. There is evidence that HON will meet it during first trimester 2012. VEN has not reported, but there is a person in charge of the program and specific funding has been allocated for it. PER and CAN have not reported.
4.6.2: Number of countries implementing a comprehensive package of norms and standards to provide adequate health services for young people's health and development (e.g. Integrated Management of Adolescent Needs [IMAN])	10	14	20	15	2009 Baseline: CHI, DOR, ECU, ELS, GUT, HON, NIC, PAN, PER, VEN 2011 Target: ARG, BOL, GUY, JAM, PAR In addition to the 10 2009 target countries (CHI, DOR, ECU, ELS, GUT, HON, NIC, PAN, PER, and VEN) and the 4 2011 target countries (ARG, BOL, GUY, JAM, and PAR), there were 6 additional countries (ABM, ANI, BAR, COL, DOM, and GRA) that also applied the Integrated Management of Adolescent Needs (IMAN) strategy.
RER 4.7: Member States supported through technical cooperation to implement Reproductive Health Strategies to improve prenatal, perinatal, postpartum, and neonatal care, and provide high-quality reproductive health services					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved)					
After many years of advocacy, countries have expanded access to comprehensive reproductive health in the context of women's rights. To avoid setbacks in this process, the main challenge is to continue advocacy for consolidation and funding for sustainability. The unresolved controversies revolving around abortion have made for slow progress in this regard.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.7.1: Number of countries that have adopted strategies to provide comprehensive reproductive health care	8	14	14	15	2009 Baseline: ARG, BRA, CHI, COL, ECU, PAN, URU, VEN 2011 Target: BLZ, GUY, HON, JAM, MEX, PER The goal was exceeded: in addition to the 6 2011 target countries (BLZ, GUY, HON, JAM, MEX, and PER), another 7 achieved it (BOL, COR, CUB, DOR, ELS, NIC, and PAR). After many years of advocacy, countries have expanded access to comprehensive reproductive health in the context of women's rights. BOL, ECU, and ELS have completed the process of adapting their strategies. To avoid setbacks, the main challenge is continuing advocacy for consolidation and funding for sustainability.
4.7.2: Number of countries that have reviewed public health policies related to sexual and reproductive health	10	11	11	12	2009 Baseline: ARG, BRA, CHI, COL, ECU, ELS, MEX, NIC, PAR, URU 2011 Target: BOL, VEN BOL has met the target and VEN is in the process of approval. One challenge remains in translating the promotion of safe abortion—as included in WHO's strategic vision in sexual and reproductive health and rights—into national policies, since abortion is a controversial issue in many countries
RER 4.8: Member States supported through technical cooperation to increase advocacy for aging as a public health issue, and to maintain maximum functional capacity throughout the lifecourse					**On track**
RER Assessment (1 out of 1 RER indicator targets achieved)					
The target countries have made significant progress in promoting healthy aging and its recognition as a public health priority. Bolivia, Ecuador, and Peru may be taken as examples for their successful experiences in multisectoral programs at the community level.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
4.8.1: Number of countries that have implemented multisectoral community-based programs with a focus on strengthening primary health-care capacity to address healthy aging	7	10	10	12	2009 Baseline: ARG, CAN, CHI, COR, CUB, JAM, USA 2011 Target: BOL, ECU, PAN, PER, PUR This indicator was reached. PER, ECU, and BOL have developed successful experiences with multisectoral programs at community level. PAN and PUR have also made important advances.

SO5 Progress Report

SO5: To reduce the health consequences of emergencies, disasters, crises, and conflicts, and to minimize their social and economic impact	**On track**

Budget Overview

Base Program Funds

Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
34,981,000	**$4,013,000**	**$28,866,960**	**$32,879,960**	**84%**	**94%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Crude daily mortality**
Target: Daily mortality of populations affected by major emergencies maintained below 1 per 10,000 during initial emergency response phase

SO indicator 2: **Access to functioning health services**
Target: Affected health networks become operational within one month following a natural disaster

Both SO5 indicators are on track to be achieved and were achieved during this biennium. In all the emergencies to date during the period assessed, the daily mortality was below 1 per 10,000. In Haiti, the mortality rate due to the collapse of physical infrastructure was higher than this ratio; however, the daily mortality rate was below 1 per 10,000 inhabitants during the initial emergency response phase, which is what the indicator measures.

The second indicator measures access to functional health services. All health networks became operational within one month following disasters that occurred during the period reported. In Haiti, the availability of health care during the initial response phase was above pre-disaster level. In rehabilitation and reconstruction, substantial progress has being accomplished. In the case of Chile, it took only six months to recover more than 95% of the beds lost due to the earthquake, thus reflecting the capacity of the health system in that country. These indicators were met thanks to years of constant investments made by the Region in disaster reduction.

In this biennium, all small- and medium-scale disasters were mostly dealt with by national resources. Commitment on the part of governments have increased—especially with the approval of the Plan of Action for Safe Hospitals 2010–2015, the participation of governments in the Regional Disaster Response Team, and the permanent release of staff to develop guidelines and support training. Although major progress was made and targets met, the demands for risk reduction and disaster management have increased at a quicker pace than has development of the countries' capacities. Countries will have to double their commitments to their own disaster programs, mainstream the topic in their institutions, establish priorities, and mobilize funds for national disaster management in order to meet the population's demands—as well as international expectations (including humanitarian reform).

2010–2011 SO Assessment
This SO is on track, along with its 7 RERs and 17 RER indicators met. All RER indicators, as measured by the different AMPES entities and verified by RER indicator facilitators, show sufficient countries as having achieved the target indicators. Their success in reaching the goals is due to different factors, but mainly to the following: in-depth planning (setting realistic goals), the level and intensity of disasters that have increased countries' interest and participation in disaster management, and increased cooperation in-house. Below there is a summary of major achievements, challenges, and lessons learned. **Main Achievements** • Approval, by PAHO's 50th Directing Council, of the Plan of Action for Safe Hospitals: with this plan, the health sector became the first sector to have developed a regional plan of action (being among those contributing to the Hyogo Framework for Action for Building Disaster Resilience). • Response provided to all affected countries within the target of 24 hours: Events during this biennium include the following: earthquake and cholera epidemic in Haiti; earthquake in Chile; Hurricanes Irene in the Bahamas and Tomás in Saint Vincent and the Grenadines and in Saint Lucia; floods in Central America (El Salvador, Guatemala, Honduras, and Nicaragua); Tropical Depression 12-E; floods in Bolivia, Colombia, Nicaragua, etc. • All preparedness and mitigation goals were achieved as per RER indicators, despite this having been the most demanding biennium in response operations. • Development of the Safety Index for Smaller Health Facilities: This assessment tool is more appropriate for less complex facilities, including primary care hospitals. It is designed to ensure that a facility will be able to continue providing services following an adverse event. • A new partnership with the World Bank (WB) for reconstruction work in Haiti has been developed (Health Sector Disaster Risk Reduction [DRR]). • The Self-Assessment Tool for Disaster Risk Reduction has been developed. • An Alert and Response System was established in Haiti, with field presence (work with other PAHO technical areas, with strong coordination). • A Needs Assessment Exercise for Cholera Preparedness was conducted by 20 Caribbean territories. • The Hospital Safety Index was applied by 29 Countries and territories: most of them are implementing corrective measures in priority health facilities. • Earthquake in Haiti—January 2010: Lessons to Be Learned for the Next Massive Sudden-Onset Disaster: This major publication involved the participation of high-level international researchers and writers, and more than 150 interviews—followed by a high-level review group. This book presents lessons to be learned from Haiti, with the aim of improving the health sector response in the event of major, sudden-onset disasters in the future. It also identifies opportunities provided by the disaster for making significant changes in health services in Haiti. • The Health Cluster is still active in Haiti and producing regular Health Cluster information • The Virtual Course for the Application of the Hospital Safety Index was developed and is available online.

Main Challenges

- Even if the grand total of resources mobilized for disaster management was the highest ever for a biennium in this Organization, there are concerns regarding difficulties in mobilizing funding for DRR**,** which have been exacerbated by the financial crisis. There is increasing pressure to obtain these funds from development agencies. As stated in the previous assessment, DRR should fall under the umbrella of development donors. In-house support is needed to include DRR in these resource mobilization endeavors. There are more donors, but there is also less funding per donor.
- Support was provided for the implementation of the new corporate response strategy, which was prepared by KMC, PED, and other PAHO technical areas and is now pending approval by EXM.
- Amount of human resources vis-à-vis the number of projects and level of funding (including OCR): The number of projects has significantly increased, with more projects with smaller budgets in US$—which generates a tremendous amount of administrative and reporting work.
- Coordination of activities with the new overall structure and SO structure from WHO/HQ**:** WHO/HQ has changed their structure, modifying SO5. However, this has had no major consequences in the Region as yet, and PAHO has not had to modify its strategy.
- Sustainability of interventions in light of attrition in the MoHs constitutes yet another challenge.

Lessons Learned

- After more than 20 years of working on vulnerability reduction in health facilities and developing detailed and extensive tools and methodologies to assess the vulnerability of health facilities, very few countries have initiated health disaster mitigation measures. The development of a simple tool, such as the Hospital Safety Index, has demonstrated that low-cost, highly effective practical tools can enhance participation and serve as a stimulus to identify priorities and to transform theory into practice.
- The prevalence of disasters (both in number and magnitude) increases interest in the subject, as can be observed in the level of commitment shown by PAHO Country Offices and Member States (both in terms of linkage and the level of activities).
- Building on existing structures facilitates project implementation: The success of cholera preparedness efforts in the Caribbean was partly due to the previous experience of Caribbean countries in developing and testing their national influenza pandemic plans. An overwhelming number of actors could have a negative effect on the health response.
- A mechanism to ensure more effective participation of Health Cluster actors must be implemented.
- It has become necessary to capitalize on events in the countries and to couple related activities when delivering technical cooperation, e.g., applying the Hospital Safety Index when developing health disaster plans, health sector disaster-related training with simulation exercises, and mental health services in times of disaster that include core mental health activities.
- There is a need to develop a strategy to incorporate social networks into disaster management work.

SO5 RER Progress Report

RER 5.1: Member States and partners supported through technical cooperation for the development and strengthening of emergency preparedness plans and programs at all levels	**On track**

RER Assessment
(3 out of 3 indicator targets achieved and exceeded)

In fact, all indicators had additional countries that reached the indicator target. This RER reflects most of the Organization's preparedness and mitigation work, and the fact that all indicators have been achieved—even after having to respond to the unprecedented events in Haiti (both the massive earthquake and the cholera epidemic) and severe floods in Central America and Colombia—shows the Organization's commitment to disaster risk reduction. It is worth mentioning that, during the assessed period, PAHO's 50th Directing Council approved Resolution CD50.R15, "Plan of Action for Safe Hospitals"—thus facilitating Member States as they go about adopting a national risk reduction policy, as well as working towards achieving the goal that all new hospitals will continue their operations during disasters. As of December 2011, a total of 29 Member Countries and Territories have applied the Hospital Safety Index; and most of them are implementing corrective measures in priority health facilities. The main challenges for the next biennium lie in maintaining the baseline and continuing to provide progressively higher-quality technical cooperation in times of limited financial and human resources.

RER Indicator	2009 Baseline	Target 2011	Achieved end 2011	Target 2013	Comments
5.1.1: Number of countries that have developed and evaluated disaster preparedness plans for the health sector	31	34	36	35	2009 Baseline: ABM, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, ECU, ELS, FDA, FEP, GUT, GUY, HON, MEX, NEA, NIC, PAN, PAR, PER, SAL, SUR, TRT, URU, USA 2011 Target: DOR, JAM, SCN This indicator was both met and exceeded. All target countries (DOR, JAM, and SCN) plus two additional ones (GRA and SAV) achieved it. This indicator is also on track to be exceeded by the end of 2013. HAI worked towards reaching this indicator and will continue to work over the next biennium. VEN decided to evaluate its health disaster preparedness plan during the next biennium.

5.1.2: Number of countries implementing programs for reducing the vulnerability of health infrastructures	21	24	28	30	2009 Baseline: ARG, BOL, CAN, COL, COR, CUB, ECU, ELS, FDA, FEP, GUT, HON, JAM, MEX, NIC, PAN, PAR, PER, TCA, TRT, USA 2011 Target: BLZ, CHI, DOR, VEN This indicator was both met and exceeded. The Safe Hospitals Initiative prompted many more countries to reach this indicator when compared to the required number. The target countries (BLZ, CHI, and DOR) plus four more (BAR, DOM, GRA, and SAL) all achieved the indicator by the end of 2011. Six additional countries (ABM, ANI, SAV, SCN, SUR, and VEN) made good progress and are well advanced towards reaching this indicator by 2013. Other countries—including BRA, GUY, HAI, and URU— are also scheduled to work on this indicator during the next biennium.
5.1.3: Number of countries that report having a health disaster program with full time staff and specific budget	13	14	15	15	2009 Baseline: ARG, CAN, COL, ECU, FDA, FEP, HON, MEX, PAN, PER, TRT, USA, VEN 2011 Target: BLZ, BOL This indicator was both met and exceeded. One more country with a health disaster program with full-time staff and a specific budget was needed by 2011. BLZ and BOL reported reaching this RER indicator, having exceeding the goal for this period and already achieving the indicator for the coming biennium. Work during 2012–2013 will focus on maintaining the baseline and, if possible, exceeding the indicator target in one or more additional countries.

RER 5.2: Timely and appropriate support provided to Member States for immediate assistance to populations affected by crisis	**On track**

RER Assessment
(2 out of 2 indicator targets achieved)

This RER, at its inception, corresponded to response activities (see the title). Beginning with this biennium (2010–2011), with the adoption of a new RER (5.7) encompassing humanitarian response and with OCR funding, this RER was left to reflect readiness activities alone. WHO/HQ is planning to drop this RER for the next biennium. Despite the high level of response operations in the Region of the Americas (in terms of both number and magnitude), the Region continued to improve its own readiness. In October 2011, a Regional Health Disaster Coordinator Meeting was held in Mexico, where countries requested additional support from PAHO for their readiness activities. Training activities were provided mainly through the Health Cluster and the Response Disaster Response Team (and all their subcategories), with cholera preparedness and response training offered (not only in Haiti and the Dominican Republic, but also in the rest of Caribbean and in Central America). The limited number of human resources available in a disaster is linked to the fact that countries are reluctant to release their staff—especially during the hurricane season. This RER's indicators and the RER are on track to be achieved by the end of 2013. For more on response, see RER 5.7.

RER Indicator	2009 Baseline	Target 2011	Achieved	Target 2013	Comments
5.2.1: Number of Regional training programs on emergency response operations	6	7	7	7	This indicator was met. PAHO provided seven regional training programs on response operations. The Regional Disaster Response Team Training session took place in November 2011. The other six training programs are as follows: Health Cluster Coordinator Training (last carried out in June 2011), Preparedness and Response to a Cholera Outbreak (which trained over 100 persons), Supply Management and Logistics Support System (SUMA/LSS), Regional Response Team for Epidemics, Regional Logistics Training (Logistics Platform), Regional Response Team for WASH (i.e., Water and Sanitary Hygiene).

5.2.2: Percentage of emergencies where a response to emergencies is initiated within 24 hours of the request	100%	100%	100%	100%	This indicator was met. During this biennium, response was initiated within the requirements of this indicator in BAH, DOR, and HAI (for both the earthquake and the cholera epidemic)—as well as for the floods in Central America (GUT, HON, NIC, and SAL) Other disasters during this biennium included BOL (floods) CHI (earthquake), COL (floods), and NIC and PAN (floods). In addition, technical support was provided to the countries following the Tsunami in Japan (a nuclear accident, in collaboration with HSS) and the volcanic eruption in ECU.

RER 5.3: Member States supported through technical cooperation for reducing health sector risk in disasters and ensuring the quickest recovery of affected populations	**On track**

RER Assessment
(2 out of 2 indicator targets achieved)

PAHO involvement in reconstruction has increased over the past years. During this biennium, funds for recovery were secured for DOR following the 2008 hurricane, and an agreement was signed with the World Bank (WB) for funding from the United Kingdom Department of International Development (DFID) to ensure that mitigation measures are incorporated into all new hospitals in Haiti. With this funding, one person was seconded to the Haitian MoH's Infrastructure Unit. In an attempt to increase cholera control and prevention in DOR, specific activities focused on the most vulnerable populations, such as prisoners in overcrowded correction facilities. Following the project, no more cholera cases were reported.

PAHO participated in developing the Post-Disaster Needs Assessment (PDNA) for Haiti, with the recruitment of a high-level expert. In addition, the PDNA has an operational component for health. During this biennium, two Consolidated Appeal Processes (CAPs) were launched for Haiti; and in both, the health sector was well represented. CAP 2011 had a good response. However, the response for CAP 2012 is not clear, as funds are generally diverted to immediate response needs.

RER Indicator	2009 Baseline	Target 2011	Achieved	Target 2013	Comments
5.3.1: Percentage of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component	100%	100%	100%	100%	This indicator was met. During the biennium, PAHO health assessments in response to floods in Central America and Hurricane Irene in BAH included a gender component. All the assessments carried out in this biennium included a gender component. For example, the PAHO health assessments, in response to the cholera epidemic in HAI and DOR, included a gender component. The health assessment on the volcanic eruption in ARG and CHI included data on gender, age, and ethnic groups.

5.3.2: Percentage of humanitarian action plans for complex emergencies and consolidated appeals with strategic and operational components for health included	100%	100%	100%	100%	This indicator was met. All UN humanitarian action plans included a health component. During this biennium, HAI prepared a Flash Appeal and two CAPs. In addition, in all the other UN appeals, the health sector was well represented. Another Flash Appeal was prepared for ELS, with a health component. In addition, COL prepared a Humanitarian Action Plan where a specific component is devoted to the health sector.

RER 5.4: Member States supported through coordinated technical cooperation for strengthening preparedness, recovery and risk reduction in areas such as communicable disease, mental health, health services, food safety, and nuclear radiation	**On track**

RER Assessment
(2 out of 2 indicator targets achieved)

The RER is on track to be achieved by the end of 2013. This is the RER where the Organization's interprogrammatic activities in disaster management are best reflected. From the H1N1 response in 2009, through the response to the Haiti earthquake and cholera, to the recent floods in Central America, the collaboration between different technical areas—and especially between PED, SDE, and HSD—has dramatically improved. Examples of this strong collaboration include the Alert and Response System created in HAI following the cholera epidemic (HSD, SDE, PED, and PROMESS), with teams deployed in the field; the coordination to provide technical advice to the countries of the Region following the Japan radiation disaster (HSS and PED); and the participation of different technical areas in the Health Cluster—just to mention a few. Also—in coordination with HSD, KMC, and PED—a new corporate response strategy was developed establishing three levels of activation; it is expected to be approved in due course by EXM.

RER Indicator	2009 Baseline	Target 2011	Achieved	Target 2013	Comments
5.4.1: Percentage of emergency-affected countries where a comprehensive communicable disease risk assessment has been conducted and an epidemiological profile and toolkit developed and disseminated to partner agencies	100%	100%	100%	100%	Together with HSD, all countries affected by emergencies had a communicable disease risk assessment conducted whenever needed. Risk assessments of the reemergence of cholera were carried out in HAI and DOR, in the context of the rainy season and following the floods in Central America. The Caribbean Epidemiology Centre (CAREC) performed weekly risk assessments based on data received from the countries. Activities were added as deemed necessary.

5.4.2: Percentage of emergencies where coordinated technical cooperation (PASB task force) is provided, when needed	100%	100%	100%	100%	During this semester, the PASB Task Force was convened to coordinate the response to floods in Central America. During this biennium, the PASB Task Force was also convened to coordinate the response to the earthquake and cholera epidemic in HAI, the earthquake in CHI, and the oil spill in the Gulf of Mexico.

RER 5.5: Member States supported through technical cooperation to strengthen national preparedness and establish alert and response mechanisms for food safety and environmental health emergencies	**On track**

RER Assessment
(3 out of 3 indicator targets achieved**)**

This RER is the RER with the most uncertain outcome of all the 7 RERs in this SO vis-à-vis the targets for 2013. All countries of the Region are actively participating in the Global Foodborne Infections Network. Tasks during this period were aimed at achieving a proper foodborne disease emergency response in the countries. Food safety–related emergencies were included in the Event Management System during this biennium. The challenge remains to having additional countries appoint formal focal points for the International Food Safety Authorities Network (INFOSAN). The development of health sector emergency response plans for radiological and chemical accidents in the Dominican Republic, Jamaica, and the Northern Caribbean guarantees coordination with other actors in reducing the health impact of these types of emergencies. Two of the indicators in this RER (5.5.1 and 5.5.2) were included at the request of WHO—but they are now in the process of being dropped by WHO. Nonetheless, PAHO intends to continue working on these matters with the Member Countries. Due to funding and other priorities, however, targets may not be achieved by the end of 2013.

RER Indicator	2009 Baseline	Target 2011	Achieved	Target 2013	Comments
5.5.1: Number of countries with capacity to respond to food safety emergencies	19	24	24	30	2009 Baseline: ARG, BOL, BRA, CAN, CHI, COL, COR, CUB, ECU, GUT, HON, MEX, NIC, PAN, PAR, PER, URU, USA, VEN 2011 Target: BAH, BLZ, DOR, ELS, TRT This indicator was met, as the five target countries (BAH, BLZ, DOR, ELS, and TRT) report having reached it. Even though the indicator was achieved for this biennium, there may be some concerns regarding the achievement of this indicator during the next biennium. This RER Indicator was added at the request of WHO/HQ, though now WHO/HQ is dropping it. Nevertheless, PAHO expects to continue working with the countries on this matter.

5.5.2: Number of countries with national plans for preparedness, and alert and response activities in respect to chemical, radiological and environmental health emergencies	24	26	26	28	2009 Baseline: ABM, ARG, BAR, BOL, BRA, CAN, CHI, COR, CUB, ECU, ELS, FDA, FEP, GUT, HON, MEX, NEA, NIC, PAN, PAR, PER, TRT, URU. USA 2011 Target: DOR, JAM The indicator was met, as the two target countries (DOR and JAM) report having achieved it. This indicator was also included at the request from WHO/HQ, though now it will be deleted from the WHO workplan. However, the Region is nonetheless on target to achieve it. In addition, NCA—which was not one of the target countries—also achieved this indicator, thus increasing the baseline for the next biennium to 27 countries.
5.5.3: Number of countries with focal points for the International Food Safety Authorities Network	29	30	30	32	2009 Baseline: ABM, ANI, ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COR, CUB, DOR, ECU, ELS, FDA, FEP, GRA, GUT, JAM, MEX, NEA, NIC, PAR, PER, SCN, SAL, TRT, USA, URU, VEN 2011 Target: Maintenance As stated in prior assessments during the previous biennium, only one country was supposed to appoint a Focal Point for INFOSAN. However, DOR and GUT achieved this result by 2009—both for that biennium and for 2010–2011. The challenge for the next biennium would be to have two additional countries with INFOSAN Focal Points.

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

RER Assessment
(3 out of 3 indicator targets achieved)

This RER is on track to be achieved by the end of 2013. It is expected that WHO will not include this RER in the next biennium. However, PAHO considers that—as it reflects important work being carried out by the Organization—this RER should continue to be part of the PAHO Strategic Plan 2008–2012 at least during the next biennium. This is a cross-cutting RER, given that it establishes strong collaborative relationships in disaster management from the global level down to the local level—which has an impact on the entire technical cooperation program (preparedness, mitigation, and response). During this biennium, PAHO has been successful in maintaining or developing partnerships with disaster management organizations. PAHO also published appropriate and timely reports following all emergencies in the Region, and even on the health

effects of the radiological emergency in Japan. Furthermore, a report—not required in the agreements with the donors—was published following the first 2 and 9 months after the earthquake in Haiti. PAHO continues to provide a Health Cluster Bulletin for HAI and played an important role in the Global Health Cluster by providing a Cluster leader for operations in Pakistan.

RER Indicator	2009 Baseline	Target 2011	Achieved	Target 2013	Comments
5.6.1: Percentage of emergencies where the United Nations Health Cluster, as defined by the UN Humanitarian Reform, is operational if called upon	100%	100%	100%	100%	The United Nations Health Cluster, as defined by the UN Humanitarian Reform, is operational in all emergencies where it was called upon (COL, DOR, and HAI).
5.6.2: Number of emergency-related regional interagency mechanisms and working groups where PAHO/WHO is actively involved	8	9	9	10	PAHO is actively involved in fluid partnerships and working groups: the Andean Committee for Disaster Prevention and Response (CAPRADE); the Coordinating Center for the Prevention of Natural Disasters in Central America (CEPREDENAC); the Global Health Cluster, the Caribbean Disaster Emergency Management Agency (CDEMA); the World Bank's Disaster Mitigation Advisory Group (WB/DiMAG); the Regional Disaster Information Center (CRID); the Latin American and Caribbean Humanitarian Information Network (REDHUM); the Regional Inter-Agency Task Force on Risk, Emergency and Disasters in Latin America and the Caribbean (REDLAC); the United Nations International Strategy for Disaster Reduction (UNISDR), and—for obtaining generous donations—www.saberdonar.org (encompassing the entire UN system plus a broad spectrum of NGOs).
5.6.3: Percentage of disasters in which UN and country-originated reports include health information	100%	100%	100%	100%	UN and country-originated disaster reports included health information. The most relevant disasters during this biennial reporting period included HAI (earthquake and cholera epidemic), CHI (earthquake); Central America, BOL, and COL (floods), and BAH (Hurricane Irene). The countries of the Region were informed of the radiological emergency in Japan and provided with appropriate technical information.

RER 5.7: Acute, rehabilitation, and recovery operations implemented in a timely and effective manner, when needed	**On track**

RER Assessment
(2 out of 2 indicator targets achieved**)**

The earthquake in Haiti constituted the most massive humanitarian effort ever made by PAHO as well as by the humanitarian community in general; a record number of persons were deployed and funds mobilized. Coordination was ensured despite the difficulties, the main challenge being the overwhelming number of actors that responded and their different levels of expertise and capacities.

This was followed by an additional surge in activities due to the cholera epidemic in October 2010, where a decentralized approach (based on field teams) has proved to be successful. PAHO provided assistance to Pakistan by providing human resources for leadership roles.

A main challenge is the interest on the part of donors to provide overwhelming support for disasters with a high level of visibility, but not for activities related to readiness and institutional strengthening in between disasters. Consequently, many activities have to stop after the funds expire. Regarding the floods in Central America, where the estimated rainfall was greater than that of Hurricane Mitch, the response of the international community was limited due to different factors, including political issues.

RER Indicator	2009 Baseline	Target 2011	Achieved	Target 2013	Comments
5.7.1: Percentage of emergencies for which PAHO/WHO mobilizes national and international resources for operations when needed	100%	100%	100%	100%	All emergencies that requested PAHO support had a response initiated within 24 hours. HAI (earthquake and cholera); DOR, CHI, GUT, Central America (floods); and BAH (Hurricane Irene), etc. The Region had two major disasters during first semester 2010, followed by the cholera epidemic during second semester of that same year.
5.7.2: Percentage of recovery operations for which health interventions are implemented, when needed	100%	100%	100%	100%	The HAI CAP 2011 and the new HAI CAP 2012 both include a health component. A project has been developed to provide support and advice on reconstruction in HAI, within the framework of the PAHO-WB/DFID initiative. The PDNA carried out in HAI includes a health component, and PAHO participates in all recovery discussions and meetings in HAI.

SO6 Progress Report

SO6: To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions	On track

Budget Overview

Approved Budget (PB 2010–2011)	Funds Available			Expenditure (%)	Funded (%)
	RB	OS	Total		
$15,962,000	$7,290,000	$6,269,697	$13,559,697	91%	85%

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

Strategic Objective (SO) 6 is on track to achieve its 2013 targets. All six of the Region-wide Expected Results (RERs) are rated as being on track.

SO indicator 1: **Number of countries reporting a 10% reduction in the prevalence rate of tobacco use**
Baseline: 3 countries in 2007
Target: 10 countries by 2013 (applies to 20 countries that have information in the WHO Database)

The Region is on track to reach the target of 10 countries reporting a 10% reduction in the prevalence of tobacco use by 2013. Some 7 countries reduced their prevalence by 10% or more between 2007 and 2009.

SO indicator 2: **Number of countries that have stabilized or reduced the prevalence of adult obesity among males and females**
Baseline: 0 countries in 2007.
Target: 5 countries by 2013 (this indicator applies to 15 countries with current national representative data in the WHO Global Database on Obesity)

To date, two countries have either stabilized or reduced the prevalence of adult obesity among females. The target for this indicator is for five countries to have stabilized or reduced the prevalence of adult obesity among males and females by 2013.

SO indicator 3: **Number of countries that have decreased the non-desirable outcomes of unprotected sex, as measured by a reduction in the estimated prevalence rate of HIV cases in young people aged 15–24 years to 0.46/100 or less for females and 0.79/100 or less for males in Latin America, and 3.30/100 or less for females and 2.51/100 or less for males in the Caribbean**
Baseline for Latin America: 11 countries in 2006
Target for Latin America: 20 countries by 2013
Baseline for the Caribbean: 4 countries in 2006
Target for the Caribbean: 7 countries by 2013

The Latin American target is at risk because only 12 countries have reduced the estimated prevalence rate; but the Caribbean target has already been exceeded, with 9 countries having reduced their estimated prevalence rate.

2010–2011 Assessment

SO 6 is rated as being on track for 2010–2011, with all 6 of its RERs on track and 12 of its 14 RER indicators having achieved their targets for 2011.

Notable progress has been made in the Region of the Americas on health promotion, with initiatives on urban health, promotion of physical activity and healthy diets, and promotion of safer sexual behavior. Advances have been made in the improved surveillance of risk factors and in regulations on tobacco and alcohol. Though it is currently on track, achievement of SO 6 by 2013 will depend on the availability of human and financial resources over the next biennium to enable it to complete its work.

Main Achievements

- During this biennium, several resolutions related to SO 6 were approved by the PAHO Directing Council.

  They include the following:

  - a Strategy and Plan of Action on Urban Health
  - a Plan of Action on Road Safety
  - a Strategy on Substance Use and Public Health
  - a Resolution on "Strengthening the capacity of Member States to Implement the provisions and guidelines of the WHO Framework Convention on Tobacco Control"
  - a Plan of Action on Psychoactive Substance Use and Public Health
  - a Plan of Action to Reduce the Harmful use of Alcohol

- Other major achievements for this biennium include the following:

  - World Health Day (WHD) 2010 on Urbanism and Healthy Living, plus the completion of training in the Urban Health Equity Assessment and Response Tool (Urban HEART) in 27 countries.
  - The Global School-based Standardized Surveillance System was introduced in 11 additional countries, with implementation completed in 5 countries. As of the end of 2011, 22 countries in the Region are now part of the Global School-Based Student Health Survey (GSHS). The Americas Region is also the fastest of the WHO Regions in implementing the GSHS, having attained close to full coverage in LAC.
  - Regarding national risk factor surveillance systems, countries have been generating data in a standardized manner guided by PAHO instruments.
  - In the area of tobacco control, during this biennium 2 additional countries became parties to the WHO Framework Convention on Tobacco Control (FCTC). In addition, 7 additional countries adopted 100% smoke-free environment (SFE) legislation, 3 additional countries adopted bans on tobacco advertisement, promotion and sponsorship, and 6 additional countries now have regulations on tobacco product packaging and labeling.
  - Regarding alcohol and substance use, a total of 23 countries participated in the Global Meeting of National Counterparts in 2011; and 8 countries adopted legislative or normative changes for reducing the harmful use of alcohol.
  - There has also been advancement in the area of sexual health, with an increased interest in incorporating the promotion of the sexual health agenda into the countries' national plans.

Main Challenges

- One of the challenges encountered during this biennium was organizing and sustaining health promotion initiatives.
- The Healthy Settings approach gained momentum under the renewed Health Promotion (HP) agenda, with a focus on the Social and Environmental Determinants of Health. However, efforts are needed during the next biennium to produce a renewed Health-Promoting Schools (HP Schools) strategy endorsed by the PAHO Directing Council at the countries' request.
- Ensuring the sustainability of risk factor (RF) surveillance systems by collecting good information and using it for country RF reduction interventions constitutes an additional challenge. It is also recommended that noncommunicable disease (NCD) surveillance be maintained as a priority within health information systems and that regular resources be designated for it.
- For tobacco control initiatives, interference by the tobacco industry—including corporate social responsibility campaigns—continues to be a challenge.
- In the area of alcohol use, the challenge remains of an increase in alcohol consumption in the Region due to investments made by the alcohol industry to increase their market share in Latin American and Caribbean countries.

Lessons Learned

- World Health Day (WHD) can be used to promote innovative concepts, as was accomplished with the launch of Urban Health initiatives during WHD 2010.
- The consolidation of the HP School Networks requires both time and technical cooperation. Global agendas revolving around the Social Determinants of Health and noncommunicable diseases (NCDs) call for delivery channels—such as the existing HP networks—to reach the settings where people work, live, and learn.
- While countries have proved their ability to establish RF and NCD surveillance, sustainability continues to be a challenge, as it requires well-trained human and stable and financial resources.
- With adequate resources, the target of a region-wide standardized global school surveillance system can be achieved soon in the Americas.
- On the issue of tobacco control, a very positive element was the support and solidarity given by other countries when another country's tobacco legislation was attacked by the tobacco industry.
- Regarding alcohol use, this topic still needs to be better understood as a major issue for health, including within the health sector.
- On the promotion of sexual health, technical cooperation on promoting safer sexual behaviors is a component that requires closer articulation with other UN agencies—the United Nations Population Fund (UNFPA), the United Nations Development Fund (UNDP), the United Nations Educational, Cultural, and Scientific Organisation (UNESCO), and the United Nations Children's Fund (UNICEF)—as well as with other stakeholders.

SO6 RER Progress Report

RER 6.1: To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions	**On track**

RER Assessment
(3 out of 3 RER indicator targets achieved, with 1 exceeding both the 2011 and 2013 targets)

RER 6.1 is on track. It achieved all of its 2011 targets and even surpassed one of its 2013 targets. There was notable progress made in adopting health promotion as a strategy and urban health and schools as a field of policy and practice. Countries still face the challenge of organizational development and continuity, but the synergy received from recent mandates ensuing from the 51st PAHO Directing Council (CD51) will help.

Major regional achievements include publications on health promotion trends, forums on health promotion and urban health, approval of the Strategy and Plan of Action on Urban Health, and the provision of tools to ensure equity in urban planning. Other important achievements were the contributions to the United Nations High-Level Meeting on Noncommunicable Disease Prevention and Control (UNHLM on NCDs), with the White Paper on NCDs followed by the successful implementation of the Wellness Week initiative in 23 cities in the Americas. The launching of the online course on health promotion is a resource that will be mainstreamed throughout the entire Organization.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
6.1.1: Number of countries that have health promotion policies and plans with resources allocated	18	18	25	20	2009 Baseline: ARG, BAH, BAR, BLZ BOL, BRA, CAN, CHI, COR, DOR, FEP, GUY, HON, MEX, PER, SAV, TRT, USA 2011 Target: COL, CUB, ECU, ELS, JAM, PAN, PAR, URU The targets for 2011 and 2013 were exceeded. All the baseline countries maintained the indicator, and 7 of the 8 target countries achieved it during this biennium (COL, ECU, ELS, JAM, PAN, PAR, and URU). CUB did not achieve it during this biennium. However, CUB will be included as a target country for 2012–2013. Although NIC was not a target country, it still managed to reach the indicator over 2010–2011. Countries have advanced in the development of national policies and plans, having transformed theory into action by providing health promotion services, intersectoral policies on the social determinants of health (SDH)

					and environmental health, support to the Healthy Settings initiative (including support to Healthy Municipalities and Healthy Schools initiatives). They have also provided support to additional programs in the areas of vector-borne diseases (VBDs), violence, dengue, HIV, sexual and reproductive health, and NCDs
6.1.2: Number of countries with Healthy Schools Networks (or equivalent)	10	13	13	15	2009 Baseline: ARG, BAH, CAN, CHI, COL, CUB, ECU, ELS, FEP, MEX 2011 Target: BLZ, GUY, PER, URU The 2011 target was achieved. Three of the target countries met the indicator (BLZ, GUY, and PER). URU is likely to achieve the target in first semester 2012.
6.1.3: Number of countries that adopt the PAHO/WHO urban health conceptual framework	2	4	5	5	2009 Baseline: ARG, BRA 2011 Target: CHI, FEP, MEX The 2011 target has been exceeded. The three target countries met the indicator during this biennium. ARG has an active network of healthy municipalities and has been developing policies on urban health, contributing to the Urban Health Forum. BRA has actively put into place the Healthy Municipality initiative at the subnational level. The countries also show cases that illustrate the future implementation of the Strategy and Plan of Action on Urban Health. COL and SUR also achieved this indicator, even though they were not target countries. ELS has acted on urban health, considering it in its policies and addressing primary care as well as people living in slums.

RER 6.2: Member States supported through technical cooperation to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools, and operating procedures followed by their dissemination	**On track**

RER Assessment
(2 out of 3 RER indicator targets achieved, with 2 exceeding the 2011 target and 1 not achieved)

RER 6.2 is on track. The importance of this RER has been recognized by both governments and professionals, and PAHO technical cooperation is well received and appreciated. The end-of-biennium evaluation shows that, despite limited resources, the linked countries—as well as additional ones—have succeeded in generating data that has been both collected and analyzed according to the standardized methodology recommended. For the next biennium, attention needs to be focused on the sustainability of risk factor surveillance, by continuing to build a system of sound information and using it for country interventions aimed at reducing risk factors. Knowledge of the varying levels of risk factors among different population groups is an essential starting point for planning interventions on risk factor reduction and control.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
6.2.1: Number of countries that have developed a functioning national surveillance system using PanAm STEPs (Pan American Stepwise approach to Chronic Disease Risk Factor Surveillance) methodology for regular reports on major health risk factors in adults	10	15	17	20	2009 Baseline: ARG, BAH, BLZ, BRA, CHI, COR, GUT, NEA, PAR, URU 2011 Target: ABM, BAR, DOM, SCN, TRT The 2011 target was exceeded. All of the baseline countries achieved the indicator and show good progress being made in the implementation of PanAm STEPS. The target countries have also met the indicator. JAM and PAN, target countries for 2013, reached the indicator early. Thus, they are included among the country count of those that achieved it in 2011. In addition, several non-target countries achieved the indicator in the course of this biennium (BOL, GRA, NCA, and NIC).
6.2.2: Number of countries that have developed a functioning national	11	23	16	30	2009 Baseline: ABM, CHI, COL, GUT, GUY, ECU, SAV, SAL, TRT, URU, VEN 2011 Target: ARG, BLZ, COR, ECU, ELS, FDA, GRA, MEX, NCA, NIC, PER, SCN, SUR

surveillance system using school-based student health survey (Global School Health Survey) and are producing regular reports on major health risk factors in youth					The 2011 target was not achieved during this biennium. The following five target countries did reach the indicator: BLZ, COR, PER, SCN, and SUR. ELS is likely to reach the target in early 2012.
6.2.3: Number of countries that have implemented the standardized indicators for chronic diseases and risk factors in the PAHO Regional Core Health Data and Country Profile Initiative	8	10	12	12	2009 Baseline: ARG, BAH, BAR, BLZ, BRA, CAN, CHI, USA 2011 Target: ABM, DOM, JAM The 2011 target was exceeded. The three target countries (ABM, DOM, and JAM) achieved the target. PAR, a target country for 2013, reached it early. The Regional Program on Chronic Disease Prevention and Control has indicators in two of PAHO's statistical publications: Core Health Data and Regional NCD Basic Data.
RER 6.3: Member States supported through technical cooperation on evidence-based and ethical policies, strategies, programs, and guidelines for preventing and reducing tobacco use and related problems					**On track**
RER Assessment (3 out of 4 RER indicator targets achieved, with 2 exceeding the 2011 target and 1 that did not achieve it)					
RER 6.3 is on track. During the biennium, the number of Parties to the WHO Framework Convention on Tobacco Control (FCTC) has increased to 29. Two countries that are not Parties to the Convention (ARG and ELS) passed comprehensive tobacco control legislation. The Caribbean is still the subregion that has made the least advancement in this area. However, adding to the Smoke-Free Environment (SFE) legislation passed by Barbados and Trinidad and Tobago, two other countries (ANT and Guyana) have prepared draft legislation to be presented to their Parliament; and Suriname has SFE legislation under discussion in theirs. Again, the biggest challenge is the interference of the tobacco industry. This takes on many different forms, ranging from subtle pressure on governments to Corporate Social Responsibility initiatives at country level that make countries dependent on money from the tobacco industry. The target for tobacco surveillance was not achieved because the donor made a decision to revise the surveys and complete them over the next biennium.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
6.3.1: Number of countries that have adopted a smoke-free legislation which includes all public places and all workplaces (public and private), consistent with the WHO Framework Convention on Tobacco Control	5	5	11	7	2009 Baseline: CAN, COL, GUT, PAN, URU 2011 Target: BLZ, HON, PAR, PER, TRT, VEN The 2011 and 2013 targets were exceeded. Of the 6 target countries, 4 of them achieved the target (HON, PER, TRT, and VEN). BAR and ECU, target countries for 2013, reached the target early and thus are included among the countries that achieved this indicator by 2011. BLZ and PAR will be targets for 2013. Three non-target countries also achieved the indicator during this biennium (ARG, BRA, and ELS).
6.3.2: Number of countries that have adopted bans on advertisement, promotion and sponsorship of tobacco products consistent with the WHO Framework Convention on Tobacco Control	3	3	4	4	2009 Baseline: COL, PAN, URU 2011 Target: ECU The 2011 target was exceeded and the 2013 target was achieved. ECU passed a very comprehensive ban on tobacco advertisement, promotion, and sponsorship. ARG, BRA, and ELS also passed a total ban, even though they were not target countries.
6.3.3: Number of countries with regulations on packaging and labeling of tobacco products consistent with the WHO Framework Convention on Tobacco Control	10	17	17	23	2009 Baseline: BRA, CAN, CHI, COL, CUB, JAM, MEX, PAN, URU, VEN 2011 Target: ARG, ECU, ELS, HON, NIC, PER, TRT The 2011 target was achieved. All seven target countries achieved the target during this biennium, and all baseline countries maintained the indicator. Two non-target countries also achieved the indicator during this period (BOL and USA).

6.3.4: Number of countries that have updated at least one of the components of the Global Tobacco Surveillance System (GTSS)	20	28	24	35	2009 Baseline: BAH, BAR, BLZ, BRA, CHI, COR, DOM, ECU, ELS, GRA, GUT, GUY, HON, JAM, PAR, SAL,SUR, TRT, URU, VEN 2011 Target: ANI, ARG, BOL, COL, CUB, DOR, SCN The 2011 target was not achieved. Four of the target countries reached the target this biennium (ARG, CUB, DOR, and SCN). The other target countries did not meet it because the CDC and WHO requested that they postpone their surveys and review the entire questionnaire. In exchange, three Data-to-Action Workshops were conducted to disseminate surveillance data.
RER 6.4: Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing alcohol, drugs, and other psycho-active substance use and related problems					**On track**
RER Assessment (1 out of 1 RER indicator target achieved)					
RER 6.4 is on track. A major achievement during this biennium was the approval by PAHO's 51st Directing Council of a Plan of Action on Psychoactive Substance Use and Public Health (CD51.R7) and a Plan of Action to Reduce the Harmful use of Alcohol (CD51.R14). The target countries all achieved the indicator and many additional non-target countries are working to reach it.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
6.4.1: Number of countries that have implemented policies, plans, or programs for preventing public health problems caused by alcohol, drugs and other psychoactive substance use	13	16	16	20	2009 Baseline: BLZ, BOL, BRA, CAN, COR, DOR, FEP, HON, NIC, PAN, PER, URU, USA 2011 Target: CHI, GUT, VEN The 2011 target was achieved. CHI, GUT, and VEN met the indicator. GUT has been receiving technical cooperation for three years through the PAHO-VALENCIA project, which includes providing support for research, training professionals in PHC, and holding a national workshop on alcohol policy development. Work was also carried out with the following countries: ABM, BAR, ELS, GUY, PAR, and TRT.

RER 6.5: Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs, and guidelines for preventing and reducing unhealthy diets and physical inactivity, and related problems					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target)					
RER 6.5 is on track. The two RER indicators were achieved. The target countries implemented national policies to promote healthy diet and physical activity. Another important achievement was the countries' contributions to the United Nations High-Level Meeting on Noncommunicable Disease Prevention and Control (UNHLM on NCDs), with the Aruba Consultation. In addition, guidelines and surveillance actions were developed on healthy diet and physical activity, and these dimensions were central to the Wellness Week initiative in 23 cities.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
6.5.1: Number of countries that have implemented national policies to promote healthy diet and physical activity according to PAHO/WHO guidelines	10	15	16	20	2009 Baseline: BAH, BRA, CAN, CHI, COL, COR, FEP, GUT, MEX, USA 2011 Target: ARG, BLZ, ECU, JAM, PER, TRT, URU, VEN The 2011 target was exceeded. Of the 8 target countries, 6 of them achieved the target (ARG, BLZ, ECU, PER, TRT, and URU). The countries used PAHO/WHO resolutions when formulating their municipal and national strategies. BLZ included the topics of healthy diet and physical activity in the national policy that it was developing.
6.5.2: Number of countries that have created pedestrian and bike-friendly environments, as well as physical activity promotion programs in at least one of their major cities	5	13	13	18	2009 Baseline: CAN, COL, GUT, PAN, URU 2011 Target: ARG, BLZ, CHI, FEP, JAM, MEX, TRT, USA The 2011 target was achieved. Three target countries (BLZ, JAM, and TRT) met the target. Five additional non-target countries (BOL, BRA, ELS, NEA, and PAR) made progress towards reaching this RER indicator by virtue of their active involvement in providing pedestrian- and bike-friendly environments. ELS has developed pedestrian-friendly environments in San Salvador and Santa Tecla. NEA disseminated educational materials through the media.

RER 6.6: Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for promoting safer sex	**On track**

RER Assessment
(1 out of 1 RER indicator targets achieved, with 2013 target already met)

RER 6.6 is on track. In addition to the program activities, several additional technical cooperation activities took place. Among these are the development of a blueprint for promoting sexual health and the rights of young girls, publication of a document on comprehensive sexuality education (the Madrid Declaration), and a consultation on providing comprehensive health services for transgender populations.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
6.6.1: Number of countries that have implemented new or improved interventions at individual, family and community levels to promote safer sexual behaviors	9	10	11	11	2009 Baseline: BLZ, COL, COR, ELS, JAM, HON, MEX, NIC, PER 2011 Target: CHI, GUT The 2011 target was exceeded. During this biennium, all 9 baseline countries maintained the indicator, and the 2 target countries met it. CHI and GUT are carrying out new or improved interventions to promote safer sexual behaviors. In the case of GUT, a comprehensive sexual curriculum has been implemented. CHI has conducted training in this area for primary health care providers.

SO7 Progress Report

SO7: To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights–based approaches	On track

Budget Overview

Approved Budget (PB 2010–2011)	Funds Available			Expenditure (%)	Funded (%)
	RB	OS	Total		
$20,960,000	$7,970,000	$9,052,789	$17,022,789	87%	81%

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

Strategic Objective (SO) 7 is on track to achieve its 2013 targets.

SO indicator 1: **Number of countries with national health indicators disaggregated by sex and age, and including the Gini coefficient and the Lorenz curve**
Baseline: 3 countries in 2007
Target: 6 countries by 2013

The Region is on track to meet its goal in six countries, with national health indicators disaggregated by sex and age, and set to include the Gini coefficient and the Lorenz curve by 2013.

SO indicator 2: **Number of countries that have developed public policies for non-health sectors that address health conditions**
Baseline: 7 countries in 2007
Target: 20 countries by 2013

The target of 20 countries having developed public policies for non-health sectors that address health conditions is on track.

SO indicator 3: **Number of countries that have national development and poverty reduction plans integrating health, nutrition, and education**
Baseline: 3 countries in 2007
Target: 6 countries by 2013

The target of six countries that have national development and poverty reduction plans integrating health, nutrition, and education is on track to be achieved by 2013.

2010–2011 Assessment

SO7 is rated as being on track, with 5 of its 6 RERs on track, and 1 at risk. 11 of its 12 RER indicator targets for 2011 were met.

Great progress has been made in addressing the Social Determinants of Health (SDH), with a Regional Consultation on the Social Determinants of Health in Costa Rica and the World Conference on Social Determinants of Health in Brazil. The Cross-Organizational Team (COT) assigned to working with the Millennium Development Goals (MDGs) and the Faces, Voices, and Places initiative (FVP) continue to address

health inequities. Advances have also been made in including human rights, gender, and intercultural approaches to health. Though it is on track, the achievement of SO 7 by 2013 will depend on the availability of human and financial resources over the next biennium to complete the work.

Main Achievements

- The Regional Consultation on SDH was held, where recommendations were defined and disseminated, resulting in the Rio Declaration that was negotiated by Member States at the World Conference on Social Determinants of Health.
- The COT on MDGs was created.
- The Faces, Voices, and Places (FVP) initiative was expanded to 23 countries, as well as inside the countries through national networks.
- There has been considerable improvement in the development of axiomatic, methodological, and instrumental approaches for generating, analyzing, and monitoring socioeconomic inequalities in health among Member Countries—particularly in making disaggregated data available at the geographic, demographic, socioeconomic, and health levels.
- PAHO's 50th Directing Council approved Resolution CD50.R8, "Health and Human Rights."
- A total of 38 intersectoral country consultations were conducted to contribute to the Progress Report on the Implementation of the Plan of Action for the Gender Equality Policy.
- The First Technical Advisory Group (TAG) on Cultural Diversity convened to validate the PAHO concept paper and strategy on indigenous peoples, Afrodescendants, and other ethnic/racial groups

Main Challenges

- Intersectoral action remains a challenge: both the Regional Consultation on the Social Determinants of Health and the World Conference on Social Determinants of Health were predominantly attended by the health sector, despite efforts to involve other sectors.
- Defining the most important systematized intervention for the FVP initiative remains a challenge for the COT on MDGs. How can the FVP initiative be made sustainable at the local level?
- Considerably more efforts are required to institutionalize both the ongoing collection of internally consistent disaggregated data and the periodic assessment and monitoring, both quantitative and qualitative, of socioeconomic inequalities in health—particularly in relation to assessing potential impacts attributable to political action on social determinants of health.

Lessons Learned

- Member-States are committed to SDH but need concrete tools to move their agenda forward.
- It is important to have different technical areas working in collaboration to advance the MDGs and respond to SDH.
- It is also important to offer continued education and training for local actors through the Health and Local Development Diploma. Critical mass among the public health workforce—Region-wide—for the application of the most current methods, techniques, and instruments to measure, analyze, and monitor health inequalities is fundamental for creating both professional competencies and institutional capabilities capable of taking action on the social determinants of health.
- Providing individual country support has proved to be effective for sensitizing countries.
- Trends documents are important for tracing the contribution of human rights to public health.

SO7 RER Progress Report

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

RER Assessment
(1 out of 1 RER indicator targets achieved and even exceeding the 2011 targets)

The major event this biennium was the World Conference on the Social Determinants of Health, held in Rio de Janeiro, Brazil, in October 2011, During this event, Member States agreed to the Rio Declaration, which has been translated into all four PAHO official languages and disseminated throughout the Region. In preparation for the Conference, three Regional Consultations on the topic were conducted to discuss progress and challenges and to define a set of regional recommendations. Moreover, a total of seven case studies were prepared for the World Conference and published on the conference website. The objective of these case studies was to document how countries have addressed inequities through the SDH approach.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
7.1.1: Number of countries that have implemented a national strategy for addressing key policy recommend-tions of the Commission on the Social Determinants of Health	4	10	11	12	2009 Baseline: CUB, ECU, GUT, PAR 2011 Target: ARG, BLZ, BRA, COL, COR, ELS, FEP, PER The 2011 target was exceeded. Of the 8 target countries, 7 of them achieved the 2011 target (ARG, BRA, COL, COR, ELS, FEP, and PER). A number of countries implemented a national strategy in line with the recommendations of the Commission on Social Determinants of Health. The national strategies differ among countries: some countries have focused their efforts on cash-transfer programs; others, on establishing national commissions on SDH to encourage intersectoral action; and yet others, on investing in social policies to reduce inequities.

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

RER Assessment
(3 out of 3 RER indicator targets achieved, including 1 exceeding the 2011 target)

The Regional Consultation on the Social Determinants of Health took place in Costa Rica in August 2011. It helped identify priorities and positions and involve civil society in preparation for the World Conference on Social Determinants of Health that took place in Rio de Janeiro, Brazil, in October 2011. The participation of 1,100 people from more than 110 countries, including 60 ministers of health, and the multitudinous presence of NGOs from around the world made the importance of health equity evident indeed. There was overall commitment to strengthening the Rio Declaration and its five axes: governance, social participation, the role of the health sector in reducing health inequities, global action, and monitoring and evaluation. For our Region, where inequity is a challenge, the SDH approach puts emphasis on health and local development by working on the most vulnerable municipalities within the framework of the Faces, Voices and Places (FVP) Initiative, linking social promotion and community participation to respond to SDH and involving young people in the process of creating awareness and participating in reducing inequity at community level.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
7.2.1: Number of published country experiences on tackling social determinants for health equity	8	10	11	12	2009 Baseline: BOL, COR, ECU, GUT, NIC, PAN, PER, URU 2011 Target: BRA, COL, FEP The 2011 target was exceeded. Two target countries achieved the target (BRA and COL). CHI, a 2013 target country, met the target early, bringing the total for this biennium to three countries that have reached this indicator. A total of seven case studies were prepared by the countries, documenting progress and achievements in addressing inequities through the SDH approach. These studies formed part of the background papers for the World Conference on Social Determinants of Health.

7.2.2: Number of countries implementing at least one systematized intervention for the most vulnerable communities, as defined by the PASB's MDGs Cross-Organizational Team	N/A	6	6	12	2009 Baseline: N/A 2011 Target: CHI, COL, FEP, MEX, PAN, PER The 2011 target was achieved. Six countries carried out systematized interventions at the local level to advance different MDGs (CHI, COL, FEP, MEX, PAN, and PER). The main achievement was the creation and the activities of the PAHO Cross-Organizational Team on MDGs, which allows for collaborative work between different PAHO technical areas and teams. It places emphasis on the best way to help the countries achieve the MDGs by responding to the social determinants of health.
7.2.3: Number of countries which have implemented the Faces, Voices and Places initiative	15	13	17	15	2009 Baseline: ARG, BOL, BRA, CHI, COR, CUB, ECU, ELS, GUT, HON, NIC, PAN, PAR, PER, URU 2011 Target: BLZ, COL, JAM The 2011 and 2013 targets were exceeded. The main achievements were the expansion of the FVP initiative—not just to 23 countries but also inside those countries, where a network of municipalities working with FVP is developing. Managing to provide sufficient support to local governments' efforts to advance the MDGs that respond to the social determinants of health will be a challenge for PAHO.
RER 7.3: Social and economic data relevant to health collated and analyzed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability)					**On track**
RER Assessment (1 out of 1 RER indicator targets exceeded)					
There has been considerable improvement in the development of axiomatic, methodological, and instrumental approaches for generating, analyzing, and monitoring socioeconomic inequalities in health among Member Countries. Particular emphasis has been placed on the need to make disaggregated data available at the geographic, demographic, socioeconomic, and health levels, in synergy with activities aimed at strengthening national capacities for health situation analysis (RER 11.3) within the SDH framework. Considerably more efforts are required to institutionalize both the ongoing collection of internally-consistent disaggregated data and the periodic assessment and monitoring, both quantitative and qualitative, of socioeconomic inequalities in					

health—particularly in relation to assessing potential impacts attributable to political action taken to address social determinants of health. Critical mass among the public health workforce for the application of the most current methods, techniques, and instruments to measure, analyze, and monitor health inequalities needs to be achieved Region-wide.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
7.3.1: Number of countries that have published reports incorporating disaggregated health data at subnational level to analyze and evaluate health equity	4	6	7	9	2009 Baseline: BOL, BRA, CHI, PER 2011 Target: NIC, PAR, VEN The 2011 target was exceeded. All three target countries achieved the indicator (NIC, PAR, and VEN). In addition, nine non-target countries also generated and published disaggregated data (geo-graphical, socioeconomic, demographic, and health) suitable for analyzing health inequalities.

RER 7.4: Ethics- and human rights–based approaches to health promoted within PAHO/WHO and at national, regional and global levels	**On track**

RER Assessment
(1 out of 1 RER indicator target exceeded)

One achievement was the collaboration between the PAHO Human Rights team (PAHO/GDR/HR) with the working group from the Organization of American States (OAS) to formulate a Regional Convention on the Rights of Older Persons. Another achievement consisted of working with SDE and the Inter-American Commission on Human Rights on preparing a technical opinion on the right to water for indigenous peoples in mining settings (in Central America). Yet another achievement was the presentation to the OAS Treaty Body on Economic, Social and Cultural Rights of new developments in establishing regional progress indicators on the right to health. PAHO/GDR also provided support in the reform of the following laws and plans aimed at introducing human rights norms in their respective countries: National Plan of Action on HIV (El Salvador); National HIV Law (El Salvador); updating regulations in the Mental Health Law (Argentina); National Public Health Law (Peru); draft for a National Law on Tobacco Control (Paraguay), and a draft Mental Health Law (Trinidad and Tobago, Belize). Together with FCH, GDR completed a trends analysis on the right to sexual and reproductive health and other related human rights of young people. In addition, FCH and GDR jointly published an analysis of the response of the maternal health system (Bolivia), using human rights treaties.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
7.4.1: Number of countries using: 1) international and regional human rights norms and standards; and 2) human rights tools and technical guidance documents produced by PAHO/WHO to review and/or formulate national laws, policies and/or plans that advance health and reduce gaps in health equity and discrimination	9	11	12	18	2009 Baseline: ARG, BLZ, CAN, CHI, COL, ELS, PAN, PER, USA 2011 Target: ABM, ECU, GUT The 2011 target was exceeded. 12 countries are in the process of reviewing or formulating national plans, policies and/or laws in a manner consistent with international human rights instruments. The three target countries for this biennium (ABM, GUT, and ECU) have achieved this indicator. In addition, the following non-target countries also met this indicator: BOL, NIC, PAR, and TRT.
RER 7.5: Gender analysis and responsive actions incorporated into PAHO/WHO's normative work and technical cooperation provided to Member States for formulation of gender-sensitive policies and programs					**On track**
RER Assessment (3 out of 3 RER indicator targets achieved, with 2 exceeding the 2011 and 2013 targets)					
The Progress Report on the Implementation of the Plan of Action 2009-2014 for the Gender Equality Policy was finalized, providing useful insights into the achievements and challenges of integrating gender into policies and programs. GDR succeeded in implementing a strategy for mainstreaming cross-cutting priorities (CCPs) into PAHO corporate processes. The Virtual Course on Gender and Health will serve as an additional tool for contributing to the integration of gender. GDR's work with the subregions was highlighted by the two letters of agreement (LoAs) signed with the Council of Women's Ministries of Central America (COMMCA), to provide support to these ministers as they go about integrating gender within the Central American integration processes of the Central American Integration System (SICA). One challenge has been that the similarity between indicators 7.5.1 and 7.5.3 has led to some difficulty in monitoring and reporting progress.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
7.5.1: Number of countries that are implementing plans for advancing gender in the health sector	6	12	32	18	2009 Baseline: BOL, ECU,GUT, HON, PER, SUR 2011 Target: BAR, BLZ, COL, FEP, GUY, NIC, PAN, PAR, TRT The 2011 target was exceeded. The indicator has been achieved in a total of 26 countries, far beyond the target of 6 for this biennium. This includes the following target countries: BAR, BLZ, COL, FEP, GUY, NIC, PAN, PAR, and TRT—in addition to ABM, ANI, ARG, BRA, CHI, COR, CUB, DOM, DOR, ELS, GRA, JAM, SAL, SAV, SCN, URU, and VEN.

7.5.2: Number of tools and guidance documents developed or updated by PASB to include gender equality in health analysis, programming, monitoring, or research	15	22	22	28	Profiles on the health of men and women in two subregions (the Central American and Andean) as well as in several countries were launched through the networks of the Council of Women's Ministries of Central America (COMMCA) and the Network of Andean Women's Ministers (REMMA), along with the United Nations Population Fund (UNFPA) and UN Women. The Virtual Course on Gender and Health was also developed.
7.5.3: Number of PASB entities that include gender perspectives in their situation analysis, plans, or monitoring mechanisms	6	15	21	20	2009 Baseline: CFS, FCH, HSD, HRM, PBR, SDE 2011 Target: BOL, CAM, ECU, GUT, GUY, HON, NIC, PAR, PED, SUR A total of 21 countries and entities achieved this indicator, of which 8 were target countries/entities: BOL, CAM, ECU, GUT, GUY, HON, PAR, and PED. An additional 6 countries/entities also achieved this indicator: BLZ, COR, ERP, FCH, GBO, GEH, HSD, HSS, PAN, PBR, PER, SDE, and URU.
RER 7.6: Member States supported through technical cooperation to develop policies, plans and programs that apply an intercultural approach based on primary health care and that seek to establish strategic alliances with relevant stakeholders and partners to improve the health and well-being of indigenous peoples and racial/ethnic groups					**At risk**
RER Assessment (2 out of 3 RER indicator targets achieved, with 1 exceeding the 2013 target)					
GDR provided technical support to indigenous and ethnic/racial policies, plans, and programs. Significant progress was made with the First Cultural Diversity Technical Advisory Group (TAG), the First World Summit of African Descendants, the Regional Conference on Afrodescendants and Health, and the First Regional Forum on Human Resources for Health and Indigenous Peoples. In collaboration with CELADE/ECLAC, UNFPA, indigenous/Afrodescendant experts, and MoHs and civil society, GDR developed guidelines on including ethnic/racial variables into regional health statistics. With GDR support, the countries of the Andean subregion began developing plans, programs, or policies for to ensure the health of Afrodescendants and other ethnic/racial groups. There remains a challenge regarding the overlap of RER indicators 7.6.1 and 7.6.1 which has led to some difficult in monitoring and reporting the progress of these indicators.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
7.6.1: Number of countries that implement policies, plans or programs to improve the health of indigenous peoples	9/21	12/21	20/21	19/21	2009 Baseline: BRA, COL, ECU, BOL, CAN, COR, ELS, DOM, PAN 2011 Target: FEP, GUT, CHI, PER, VEN, BLZ The 2011 target was exceeded. 13 entities (including 11 countries) have achieved this indicator: AND, ARG, CHI, FEP, GEH, GUT, GUY, HON, MEX, NIC, PAR, PER, and VEN.
7.6.2: Number of countries that include ethnic variables within their health information systems	8	13	15	15	2009 Baseline: ARG, BOL, BRA, CAN, COL, GUT, PAR, USA 2011 Target: BLZ, CHI, COR The 2011 target was exceeded. A total of 9 entities (7 of which were countries) have achieved this indicator: AND, ECU, GEH, GUY, HON, MEX, and PER. This includes 3 of the target countries: BLZ, CHI, and COR. Of the remaining target countries, 4 of them (CHI, ECU, GUT, and PAR) are piloting the collection of data on indigen-ous peoples, Afrodescendants, and other ethnic populations. The pilot in BOL is in the process of being evaluated.
7.6.3:.Number of countries that implement policies, plans or programs to improve the health of specific ethnic/racial groups	10	14	10	16	2009 Baseline: ARG, BOL, BRA, CAN, COL, CHI, GUT, MEX, PAN, USA 2011 Target: BLZ, NIC The 2011 target was not achieved for this indicator. Progress is ongoing in six countries of the Andean Subregion (BOL, CHI, COL, ECU, PER, and VEN). They are developing an in-depth analysis of the sociodemographic health situation of their Afrodescendant populations. BOL, BRA, COL, and ECU have achieved this indicator; however, the two target countries have not.

SO8 Progress Report

SO8: To promote a healthier environment, intensify primary prevention, and influence public policies in all sectors so as to address the root causes of environmental threats to health	On track

Budget Overview

Approved Budget (PB 2010–2011)	Funds Available			Expenditure (%)	Funded (%)
	RB	OS	Total		
$24,934,000	$12,297,000	$10,379,649	$22,676,649	89%	91%

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the *PAHO Strategic Plan 2008–2012*

Strategic Objective (SO) 8 is on track to achieve its 2013 targets.

SO indicator 1: **Proportion of urban and rural populations with access to improved water sources in the Region**
Baseline: 95% of urban and 69% of rural populations in 2002
Target: 96% of urban and 77% of rural populations by 2013 (as per the Millennium Development Goals [MDGs])

The target of reaching 96% of urban and 77% of rural populations with access to improved water sources in the Region by 2013 (as per the MDGs) is on track.

SO indicator 2: **Proportion of urban and rural populations with access to improved sanitation in the Region**
Baseline: 84% of urban and 44% of rural populations in 2002
Target: 90% of urban and 48% of rural populations by 2013 (as per the MDGs)

The goal of having 90% of urban and 48% of rural populations with access to improved sanitation in the Region by 2013 (as per the MDGs) is rated as being at risk.

SO indicator 3: **Number of countries implementing national plans on Workers Health (based on the WHO Workers' Health: Global Plan of Action, 2007)**
Baseline: 10 countries in 2007
Target: 20 countries by 2013

The target of having 20 countries implementing National Plans on Workers' Health by 2013 (based on the WHO Workers' Health: Global Plan of Action, 2007) is on track.

SO indicator 4: **Number of countries with toxicological information centers**
Baseline: 14 countries in 2006 (estimated).
Target: 24 countries by 2013

Currently, there are 19 countries that have toxicological information centers.

SO indicator 5: **Reduction in the attributable factor of the burden of diarrheal diseases among children/adolescents age 0–19 years, due to environmental causes**
Baseline: 94% in 2002 (estimated)
Target: 84% by 2013 (following the Methodology for Assessment of Environmental Burden of Disease developed by WHO, measured by the factors attributable to DALYs)

The 2013 target is on track for a reduction down to 84% in factors attributable to the burden of diarrheal diseases among children and adolescents ages 0–19 years due to environmental causes.

SO indicator 6: **Number of environmental health policies on chemical substances, air quality, and drinking water adopted by the countries of the Region**
Baseline: 11, 7, 13, respectively, in 2007
Target: 20, 12, 20, respectively, by 2013

This indicator is on track. Some 24 countries have legislation on pesticides, 10 countries have national air quality programs, and 15 countries have included the right to water in national legislation.

2010–2011 Assessment

SO8 is rated as being on track, with all 6 of its RERs on track and its 13 RER indicator targets for 2011 achieved—with 7 even being exceeded.

Important progress has been made in preparing for the upcoming UN Rio+20 Conference on Sustainable Development. In addition, the following have all contributed to addressing the root causes of environmental threats to health in the Region: the approval of a Strategy and Plan of Action on Climate Change, regional work on pesticides, strengthening network of PAHO/WHO Collaborating Centers on Workers' Health, and progress made in primary prevention initiatives—as well as continued progress in water and sanitation issues. Though SO8 is on track, its achievement by 2013 will depend on the availability of human and financial resources during the next biennium to complete the necessary work.

Main Achievements

- The Strategy and Plan of Action on Climate Change was approved by PAHO's 51st Directing Council.
- Other achievements that took place during this biennium included contributions made to Health in the Americas, completion of the health chapter of the ECLAC inter-agency publication for the Rio+20 conference, carrying out country consultations for the PAHO Rio+20 document, and organizing a side event on water and the social determinants of health at the World Conference on Social Determinants of Health.
- Several publications were also produced during this biennium. These include the Report of the Regional Assessment of Urban Solid Waste Management in Latin America and the Caribbean 2010 (original title in Spanish*: Informe de la evaluación regional del manejo de residuos sólidos urbanos en América Latina y el Caribe 2010*), in collaboration with the Inter-American Development Bank (IDB) and the Inter-American Association of Sanitary and Environmental Engineering (AIDIS); Water and Sanitation: Evidence for public policies focused on human rights and public health results (title in Spanish: *Agua y saneamiento: Evidencias para políticas publicas con enfoque en derechos humanos y resultados en salud pública*); and a Spanish translation of the Guidelines on Situation Analysis for Public Health Pesticide Management for the Americas Region (Spanish title: *Directrices para el análisis de la gestión de los plagucidas de uso en salud pública*).
- The PAHO Regional Technical Team on Water and Sanitation (ETRAS, for its acronym in Spanish) was established.
- A Regional Meeting on Pesticides was held in GUT with the WHO Pesticide Evaluation Scheme (WHOPES) and the PAHO Health Surveillance and Disease Prevention and Control Area (HSD).

- Two countries, Ecuador and Guatemala, finalized situation analyses, and each approved a National Action Plan for the Sound Management of Public Health Pesticides.
- A project with the United Nations Environment Programme Global Environment Facility (UNEP-GEF) was completed. It involved the repacking of more than 130 tons of DDT and other obsolete pesticides in 8 countries.
- On the topic of occupational health, 25 countries were involved in protecting the health of health care workers through national programs for preventing needle-stick injuries. Logistical and technical support for improving occupational and environmental health services and surveillance systems was successfully completed in 20 countries.

Main Challenges

- The challenge remains to reach the Latin American and Caribbean workforce in need of comprehensive health services, to protect them from occupational and environmental hazards. New activities and programs are necessary for covering working populations in the informal sector and changing vulnerable labor conditions throughout the Region.
- Some countries are still not addressing the topic of climate change and health. This includes the challenge of implementing environmentally sound vector management policies.

Lessons Learned

- There is a need to improve the linkage among agendas for noncommunicable diseases, sustainable development, and the social determinants of health.
- The Determinants of Health and Risks Cross-Organizational Team (COT) has the potential to help improve the implementation of SO8.
- On the topic of occupational health, there is a strong need to protect the workforce in the health care sector. Empowering these workers will allow them to get involved in solving their own workplace problems. In addition, there is still a need to improve the registration and follow-up of incidents and accidents in the health care workforce—particularly in developing Latin American and Caribbean countries and in remote rural areas. The renewal of the Collaborating Center Network on Occupational Health showed that the core values of collaborating networks and strategic alliances for attaining common goals continue to be as follows: collaborating, communicating, creating, and innovating with critical thinking among network members.

SO8 RER Progress Report

RER 8.1: Evidence-based assessments, norms and guidance on priority environmental health risks (e.g., air quality, chemical substances, electro-magnetic fields (EMF), radon, drinking water, waste water re-use) disseminated	**On track**
RER Assessment (4 out of 4 RER indicator targets achieved, exceeding the 2011 targets)	
RER 8.1 is on track. Achievements include the publication of a policy brief on water and sanitation and a report on vulnerability to climate change. The Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS) survey was implemented in 12 countries in the Region. The 4th edition of the WHO Guidelines for Drinking-water Quality was promoted in order to help with the achievement of Millennium Development Goal (MDG) 7.	

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
8.1.1: Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year	3	4	6	7	The 2011 target was exceeded. Assessments were conducted by COL, GUY, and SUR.
8.1.2: Number of international environmental agreements whose implementation is supported by PASB	5	5	8	6	The 2011 and 2013 targets were exceeded. Agreements were implemented on climate change, chemical safety, and Agenda 21, with support from the PASB.
8.1.3: Number of countries implementing WHO norms, standards or guidelines on occupational or environmental health	18	21	22	24	2009 Baseline: ARG, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, GUT, HON, MEX, NIC, PAN, PAR, PER, URU, VEN 2011 Target: ANI, ELS, GUY, JAM The 2011 target was exceeded. All baseline countries maintained their achievements, and the four target countries for the 2010–2011 biennium all achieved the indicator (ANI, ELS, GUY, and JAM). TRT conducted a project to control biological hazards and bioterrorism and is planning to continue the project into the next biennium.
8.1.4: Number of countries implementing WHO guidelines on drinking water towards MDG 7	10	11	12	14	2009 Baseline: ARG, BLZ, BRA, CHI, COL, ECU, MEX, PAN, URU, VEN 2011 Target: GUT, TRT The 2011 target was both achieved and exceeded. The two target countries (GUT and TRT) achieved the indicator during this biennium.. An additional 16 non-target countries, as well as 1 subregional entity, carried out work on this indicator.

RER 8.2: Member States supported through technical cooperation for the implementation of primary prevention interventions that reduce environmental health risks, enhance safety, and promote public health—including in specific settings and among vulnerable population groups (e.g., children, older adults)	**On track**

RER Assessment
(1 out of 1 RER indicator targets achieved, exceeding both the 2011 and 2013 targets)

RER 8.2 is on track. Important advances were made in various key areas, such as Healthy Housing, Water Safety and Sanitation, Workers' Health and Occupational Safety, and Community Involvement. These occurred mostly in rural settings.

Another achievement was the involvement of 25 countries in initiatives aimed at protecting the health of health care workers, including national programs on preventing needle-stick injuries and increasing vaccination coverage to protect against the hepatitis B virus (HBV).

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
8.2.1: Number of countries implementing primary prevention interventions for reducing environmental risks to health in workplaces, homes or urban settings	7	8	12	10	2009 Baseline: BRA, CHI, DOR, PER, TRT, URU, VEN 2011 Target: BLZ, ECU, GUT The 2011 and 2013 targets were exceeded. Of the target countries, 3 of them met the target (BLZ, ECU, and GUT) and 2 of the 2013 target countries achieved the target early (ARG and COL). In addition, 18 non-target countries carried out work aimed at reaching this indicator during the biennium.

RER 8.3: Member States supported through technical cooperation to strengthen occupational and environmental health policy-making, planning of preventive interventions, service delivery, and surveillance	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved, with 1 exceeding both the 2011 and 2013 targets)

RER 8.3 is on track. Logistical and technical support for improving occupational and environmental health services and surveillance systems was successfully completed in 20 countries. The PAHO/WHO Collaborating Centers Network on Occupational Health was renewed and added several new institutions, particularly from Latin American countries—thus demonstrating that acknowledging and making a commitment to these centers in their efforts to help and collaborate for the improvement of workers' health is indeed a worthy effort.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
8.3.1: Number of countries receiving technical and logistical support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance	8	17	17	20	2009 Baseline: BRA, CHI, DOR, ECU, PER, TRT, URU, VEN 2011 Target: ARG, BLZ, BOL, COL, FEP, GUT, GUY, JAM, MEX, NIC, PAN, PAR The 2011 target was achieved. Of the target countries, 9 out of 12 met this indicator during this biennium (ARG, BLZ, BOL, FEP, GUT, GUY, NIC, PAN, and PAR). Another 9 non-target countries also carried out work on this indicator during the biennium (ANI, COR, CUB, DOM, ELS, HAI, HON, SAL, and SUR). COL, MEX, and JAM will be target countries during the 2012–2013 biennium.
8.3.2: Number of national organizations or collaborating or reference centers implementing PAHO/WHO-led initiatives at country level to reduce occupational risks	4	5	15	6	The 2011 target was exceeded. The Collaborating Centers Network on Occupational Health expanded to 15 centers during this biennium. Of these active centers, 10 out of 15 attended the Regional SDE Collaborating Centers Meeting held in Durham, North Carolina, USA. Coverage with the health sector initiative has risen to include 20 countries, 9 of which are from the Caribbean. The Silicosis Initiative is currently being developed in BRA, CHI, COL, COR, and PER under the guidance of the National Institute for Occupational Safety and Health (NIOSH) and the Global Collaborating Centers Network.

RER 8.4: Guidance, tools, and initiatives created to support the health sector to influence policies in priority sectors (e.g., energy, transport, agriculture), assess health impacts, determine costs and benefits of policy alternatives in those sectors, and harness non-health sector investments to improve health	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target)

RER 8.4 is on track. Several initiatives have been developed and consultations have taken place with other sectors, such as training in health and tourism (on developing of a manual for training trainers). Another achievement was the translation of the Reducing Vulnerability of Drinking Water Supply and Sanitation in Central America Disaster: Risk Management Manual (original title in Spanish: Reducción de la Vulnerabilidad de los Sistemas de Agua Potable y Saneamiento ante desastres en Centro América: Manual de Gestión de Riesgos), with the collaboration of non-health sectors. Other achievements include strengthening the Healthy Housing initiative as well as the contributions that were made to the Inter-Agency Report on the Social Dimensions of Climate Change for the COP 17 Climate Change Conference.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
8.4.1: Number of regional, subregional and national initiatives implemented in other sectors that take health into account, using PASB technical and logistical support	3	3	3	4	The 2011 target was achieved last biennium. This biennium, PAHO implemented various regional and national initiatives and events to promote the areas of Water and Sanitation, Health and Tourism, and Healthy Housing. The Regional Project for the Evaluation of the Management of Urban Solid Waste was conducted during this biennium, and a report on the initiative was produced: Report of the Regional Assessment of Urban Solid Waste Management in Latin America and the Caribbean 2010 (original title in Spanish: *Informe de la evaluación regional del manejo de residuos sólidos urbanos en América Latina y el Caribe 2010*).
8.4.2: Number of PAHO/WHO guidelines and tools produced intersectorally for global environmental health protection	2	3	4	4	The 2011 target was exceeded. PAHO contributed to the Inter-Agency Report on the Social Dimensions of Climate Change for the COP 17 Climate Change Conference. PAHO also produced an updated version of the Guidelines on Situation Analysis for Public Health Pesticide Management for the Region of the Americas (Spanish title: *Directrices para el análisis de la gestión de los plaguicidas de uso en salud pública*).
RER 8.5: Health sector leadership enhanced to promote a healthier environment and influence public policies in all sectors to address the root causes of environmental threats to health, by responding to emerging and reemerging environmental health concerns arising from development, evolving technologies, other global environmental changes, and consumption and production patterns					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved)					
RER 8.5 is on track. The toolkit to measure sustainable development (Rio+20) was implemented in the countries, and SDE successfully conducted a Regional Consultation in Brazil where 17 countries participated. A Regional Report is being prepared as a contribution to the Rio+20 Conference.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
8.5.1: Number of regular high-level fora on health and environment for regional policymakers and stakeholders supported by PASB	1	3	3	4	The 2011 target has been achieved. In addition, the following fora received support: (a) A high-level regional meeting for Rio+20 organized by ECLAC (b) A PAHO regional preparatory meeting for Rio+20 aimed at Ministries of Health (c) The 16th Conference of Parties to the Climate Change Convention, organized jointly with the Government of Mexico and WHO (COP 16)
8.5.2: Number of current PASB five-year reports on environmental health available, including key health drivers and trends, and their implications	N/A	1	1	2	The 2011 target was achieved. A draft of Health in the Americas was completed.
RER 8.6: Member States supported through technical cooperation to develop evidence-based policies, strategies and recommendations for identifying, preventing, and tackling public health problems resulting from climate change					**On Track**
RER Assessment (2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target)					
RER 8.6 is on track. The Strategy and Plan of Action and Resolution on Climate Change and Health was approved by PAHO's 51st Directing Council, and training activities and implementation of this plan will be initiated together with the countries (e.g., a successful course was conducted in Uruguay with MERCOSUR).					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
8.6.1: Number of studies or reports on the public health effects of climate change published or co-published by PAHO or peer reviewed publications of authors/institutions based in Latin America and the Caribbean	N/A	1	2	2	The 2011 target was exceeded. BRA and ECU achieved the indicator. A few additional countries (BAH, BOL, and GUY) are also developing studies on climate change and health.

8.6.2: Number of countries that have implemented plans to enable the health sector to respond to the health effects of climate change	N/A	3	3	5	2009 Baseline: N/A 2011 Target: BOL, BRA, COR, COL, PER
					The 2011 target was achieved. Of the target countries, 3 out of 5 reached the target during this biennium (COL, COR, and PER). Other countries and entities worked on this indicator, with successful results (BAR, CHI, CRB, ECU, ELS, NIC, PAR, PED, and SAM). BRA has carried out important activities in this area and will be included as a target country for 2013.

SO9 Progress Report

SO9: To improve nutrition, food safety and food security throughout the lifecourse, and in support of public health and sustainable development	At risk

Budget Overview

Approved Budget (PB 2010–2011)	Funds Available			Expenditure (%)	Funded (%)
	RB	OS	Total		
$20,941,000	$12,846,000	15,262,061	$28,108,061	90%	134%

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Proportion of underweight children under 5 years of age in Latin America and the Caribbean**
Baseline: 7.5% in 2002 (using the 7-year period of 1995–2002)
Target: 4.7% by 2013

Activities carried out as part of this strategic objective have helped to reduce malnutrition in all its forms; the available information shows a -0.46 annual reduction in underweight, which declined from 7.5% in 2002 to 3.3% in 2010 (Lutter CK, Chaparro CM, Muñoz S. Progress towards Millennium Development Goal 1 in Latin America and the Caribbean: the importance of the choice of indicator for undernutrition. Bull. World Health Organ. 2011 Jan 1; 89(1): 22-30).

SO indicator 2: **Proportion of stunted children under 5 years of age in Latin America and the Caribbean.**
Baseline: 11.8% in 2005
Target: 8.8% by 2013

In the Region of the Americas, there has been a -0.51 annual reduction in the proportion of stunting, which declined from 23.7% in 1990 to 13.5% in 2010 (Lutter CK, Chaparro CM, Muñoz S. Progress towards Millennium Development Goal 1 in Latin America and the Caribbean: the importance of the choice of indicator for undernutrition. Bull. World Health Organ. 2011 Jan 1; 89(1): 22-30).

SO indicator 3: **Proportion of children under 5 years of age with anemia in Latin America and the Caribbean**
Baseline: 29.3% in 2005
Target: 25.3% by 2013

The prevalence of anemia in pregnant women in the Region has declined over the past ten years (from 43.2% to 28.1%); changes were not observed, however, in children under 5 (34.0% to 32.9%), or in women of childbearing age (20.3% to 21.1%). Although no recent data is available on Vitamin A deficiency, the most recent estimates from WHO indicate that this can be considered a slight to moderate problem in the Region; the same is true of iodine deficiency (PAHO/FCH/HL/11.3.e Anemia in Latin America and the Caribbean, 2009).

SO indicator 4: **Proportion of overweight and obese children under 5 years of age in Latin America and the Caribbean in those countries where information is available**
Baseline: 4% in 2003 (using the 3-year periods of 2000–2003)
Target: 4% or less by 2013

Although excess weight and obesity are expected to increase in all age groups, available estimates do not suggest an increase in the prevalence of excess weight or obesity in children under five between 1990 and 2010 (6.8% to 6.9%) (De Onis M, Lobstein T. Defining obesity risk status in the general childhood population: which cut-offs should we use? Int J of Pediatric Obesity, 2010; 5:458-460).

SO indicator 5: **Reduction in the number of foodborne diarrheal disease cases per 100,000 inhabitants in the Region**
Baseline: 4,467 in 2006
Target: 4,020 by 2013

An estimated average 1.03 cases of acute gastroenteritis per person per year in the Region of the Americas. According to data reported in studies from the United States, Australia, and Canada, respectively, 26%, 32%, and 36% of episodes of gastroenteritis are attributable to food transmission. Extrapolating from the highest of these figures, or 36% (the most conservative situation), yields an estimated 3,347 cases per 100,000 inhabitants in the Region, which would mean that the target established for this indicator has been reached.

2010–2011 SO Assessment

This SO is considered at risk since four of its six RERS are in progress, one is at risk and one is in trouble. Of the 14 indicators of the RER, 10 have reached the 2011 target and four have not. Significantly, of the indicators that reached the target, three exceeded it in 2011.

Main Achievements

- The majority of the countries of the Region (26 in total) have prepared or are in the process of implementing coordination mechanisms, policies, plans, or intersectoral programs to prevent malnutrition, many of them based on the food and nutritional security approach.
- WHO growth curves adopted in 19 countries; numerous documents published and disseminated describing the situation of the Region.
- Expansion of the network of breast milk banks and of the number of countries that monitor the Code, and renewed commitment to the Baby-friendly Hospitals Initiative.
- Adoption of guidelines for the implementation of internal and external monitoring systems for food fortification programs; review of fortification programs for salt in Central America and for sugar in ECU and DOR; recognition by countries of global, regional and subregional agreements for diet-related chronic disease prevention.

Main Challenges

- Promote closer ties with counterparts in the Ministry of Health and other sectors in order to identify national priorities, establish the link between the RER and the indicator in the work plan, and identify activities, products, and services that are included in our counterparts' work plan.
- Pursue various activities at the same time and ensure a quality end product. Achieve positive funding outcomes for the numerous proposals that have been drafted. It is important to improve databases on nutritional processes for the youngest children (baseline from the Baby-friendly Hospitals Initiative and other infant feeding policies) in order to motivate countries to continue to improve their programs.
- Mobilize political will and secure budget allocations to incorporate nutritional status indicators into health surveillance systems; mobilize resources to promote and support research and the publication of evidence-based information.

Lessons Learned

Aside from preventing mother-to-child transmission of HIV, HIV infection, emergencies, and nutrition are not a priority for the majority of countries. There is a palpable need to improve coordination with health services in order to mobilize national resources and channel them toward improving the quality and coverage of nutrition programs. It is worth noting that the number of nutritional indicators is very high relative to the human resources available to compile them.

SO9 RER Progress Report

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

RER Assessment
(2 out of 2 RER indicator targets achieved)

Virtually the majority of the countries of the Region have developed, or are in the process of implementing, coordination mechanisms, policies, plans, and intersectoral programs to prevent malnutrition, many of them based on the food and nutritional security approach. The Regional strategy and plan of action on nutrition in health and development 2006-2015, the Strategy and plan of action for the reduction of chronic malnutrition, and the Pan American Alliance on Nutrition and Development have served as a frame of reference for incorporating the social determinants approach into national initiatives. There is growing awareness of the need to create supra-ministerial coordinating bodies that include, in addition to the ministry of health, the ministries of the environment, housing, education, agriculture, commerce, economy, finances, labor, and development. It is also necessary to share experiences among countries and foster cooperation among them.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
9.1.1: Number of countries that have coordination mechanisms to promote	23	26	26	30	2009 Baseline: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, HON, JAM, MEX, NIC, PAN, PAR, PER, URU, USA, VEN 2011 Target: BAH, BAR, GUY, TRT

intersectoral approaches and actions in the area of food safety, food security and nutrition					In addition to the 23 countries that achieved the target in 2009, three more countries achieved it in 2011, with significant progress in the implementation of intersectoral policies and programs: GUY and TRT, which were originally identified as target countries, as well as HAI. Although BAH and BAR were not linked to the indicator, both made substantial progress in intersectoral policy-making to address excess weight and obesity.
9.1.2: Number of countries that have implemented nutrition, food-safety and food security interventions	15	20	20	25	2009 Baseline: ARG, BLZ, BRA, CHI, COL, COR, ECU, ELS, FEP, GUT, GUY, HON, MEX, PAN, TRT 2011 Target: CUB, NIC, PER, URU, VEN All five countries (CUB, NIC, PER, URU, VEN) achieved the target and made progress in the implementation of intersectoral programs or interventions in the area of nutrition, food safety, and food security; BOL, DOR, and PAR also achieved the target.
RER 9.2: Member States supported through technical cooperation to increase their capacity to assess and respond to all forms of malnutrition and to zoonotic and non-zoonotic foodborne diseases, as well as to promote healthy dietary practices					**On track**
RER Assessment (1 out of 1 of RER indicator targets achieved)					
Both the target and baseline countries moved forward in the adoption of guidelines and standards, especially those related to food safety and surveillance systems for foodborne diseases. In general, guidelines or or standards to evaluate and respond to the main nutritional deficiencies are addressed as part of other indicators.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
9.2.1: Number of countries implementing nutrition and food safety norms, and guidelines	19	25	25	30	2009 Baseline: ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, DOR, ELS, GUT, HON, JAM, NIC, PAN, PAR, PER, SAL 2011 Target: CUB, ECU, GUY, HAI, MEX

according to global and regional mandates					Given that, in addition to five of the seven countries originally included in the target (CUB, ECU, GUY, HAI, MEX), DOM and SAV, also achieved it, this indicator is considered to have been achieved. ANI also made significant progress.

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

RER Assessment
(2 out of 3 RER indicator targets achieved)

The Region has made significant progress in relation to accessible nutritional information and, with that, a growing number of countries are already using WHO growth charts and have: i) national nutritional surveys (BEL, COL, DOR, GUT, MEX); ii) updated demographic and health surveys (ELS, GUT, PER); iii) data from nutrition surveillance systems (ELS, GUT, PAN, PAR); iv) up-to-date information on prevention programs for iodine deficiencies (PAN). Nonetheless, the main challenge is to mobilize the political will to ensure a sustainable budget allocation with which to incorporate nutritional status indicators into health surveillance systems, on the one hand, and support research and the publication of evidence-based information, on the other. Funding shortfalls, coupled with the difficulties the national counterpart is facing in mobilizing resources, has delayed implementation of planned activities.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
9.3.1: Number of countries that have adopted and implemented the WHO Child Growth Standards	16	20	19	25	2009 Baseline: ARG, BOL, BRA, CHI, COL, COR, DOR, ECU, ELS, GUT, HON, NIC, PAN, PAR, URU, VEN 2011 Target: BLZ, GUY, HAI, PER While four countries are linked, only three (BLZ, GUY, PER) achieved the target. HAI reported that it had not achieved it, but had made significant progress, such as the design and distribution of a new health card that incorporates the new standards.
9.3.2: Number of countries that have nationally representative surveillance data on one major form of malnutrition	15	20	21	22	2009 Baseline: ARG, BOL, CAN, CHI, COR, HON, JAM, MEX, NIC, PAN, PER, SAL, URU, USA, VEN 2011 Target: BLZ, COR, CUB, ECU, ELS, GUT, HAI, PAR The target was achieved in 21 countries: of the 15 included in the 2009 baseline, however, COR reported that it had not achieved it; six of the target countries for 2011 (BLZ, CUB, ELS, GUT, ECU, PAR) did achieve it, as did COL, a target country for 2013. It is necessary to redouble support for HAI so that it can move toward the achievement of this result.

9.3.3: Number of countries that produce evidence based information in nutrition and food security	15	20	20	22	2009 Baseline: ARG, BAR, BLZ, CAN, CHI, COL, COR, DOR, ELS, GUT, JAM, MEX, NIC, PAN, USA 2011 Target: ECU, HON, PAR, PER, VEN The target was achieved in 20 countries, including 15 from the baseline, four target countries for 2011 (HON, PAR, PER, VEN), and one target country for 2013 (BRA). While ECU was not linked to the indicator, it has made progress in the publication on the nutritional status of older adults.
RER 9.4: Member States supported through technical cooperation for the development, strengthening and implementation of nutrition plans and programs aimed at improving nutrition throughout the lifecourse, in stable and emergency situations					**In trouble**
RER Assessment (2 out of 5 RER indicators achieved, even exceeding the 2011 target; but 3 indicators not achieved)					
In general terms, the Region is progressing very slowly toward public policies that ensure national nutrition programs with a lifecourse approach. The main stumbling block is a perception that this issue is not a priority and its consequent absence from the policy agenda of many governments. Nonetheless, the most significant achievements include the following: • the campaign to promote breastfeeding carried out as part of the World Cup in soccer; • the increase in the number of breast milk banks; • reactivation of the baby-friendly hospital initiative; • adoption of guidelines for the implementation of internal and external monitoring systems for food fortification programs; • review of salt fortification programs in Central American countries and in sugar programs in Ecuador and the Dominican Republic; • recognition by countries of global, regional, and subregional agreements for the prevention of diet-related chronic diseases.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
9.4.1: Number of countries that have implemented at least 3 high-priority actions	12	17	18	20	2009 Baseline: ARG, BLZ, BOL, COL, ELS, GUT, GUY, HON, NIC, PAR, PER, SAV 2011 Target: COR, DOR, ECU, PAN, TRT, VEN

recommended by the Global Strategy for Infant and Young Child Feeding					Six out of six countries (COR, DOR, ECU, PAN, TRT, VEN) reached the milestone and made progress towards the achievement of the indicator, as did MEX. The most important achievement is the increase in the number of breast milk banks that have been established and are operating, in addition to the Code monitoring reports and certification of baby-friendly hospitals.
9.4.2: Number of countries that have implemented strategies to prevent and control micronutrient malnutrition	16	21	19	25	2009 Baseline: ARG, BAH, BLZ, BOL, BRA, CHI, COL, COR, DOR, ELS, GUT, HON, JAM, NIC, PAN, PER 2011 Target: ABM, DOM, ECU, GUY, PAR, VEN Two of the 21 countries needed are missing, since only three of the target countries for 2011 (ECU, PAR, VEN) achieved the indicator. GUY could not move forward because the project was not approved. HAI made progress in reviewing fortification programs, especially for wheat flour.
9.4.3: Number of countries that have developed national programs that implement strategies for promotion of healthy dietary practices in order to prevent diet-related chronic diseases	16	19	20	25	2009 Baseline: ARG, BAH, BLZ, BRA, CHI, COL, COR, ELS, GUT, HON, JAM, NIC, PAN, PER, URU, VEN 2011 Target: ABM, ANI, BOL, DOM, DOR, ECU, FEP The target was achieved in twenty countries. Unfortunately, BLZ, which is in the baseline, reported that it had not reached it. Five of the seven target countries for 2011 (ANI, BOL, DOM, DOR, ECU) achieved the target, as did SAL. ABM and FEP were not linked, however. It is worth noting that the countries of the Caribbean made significant progress in policy discussions for preventing diet-related chronic diseases.
9.4.4: Number of countries that have incorporated nutritional interventions in their comprehensive	15	20	16	25	2009 Baseline: ARG, BAH, BLZ, BRA, CHI, COL, COR, ELS, GUT, JAM, NIC, PAN, PER, SCN, TRT 2011 Target: ANI, ECU, GRA, GUY, SAV, SUR

response programs for HIV/AIDS and other epidemics					Two of the six countries (GUY, SUR) achieved the milestone.
9.4.5: Number of countries that have national preparedness and response plans for food and nutrition emergencies	16	20	17	25	2009 Baseline: BAH, BLZ, BRA, CHI, COL, COR, DOR, ELS, GUT, GUY, HON, JAM, NIC, PAN, PAR, PER 2011 Target: ANI, BAR, CUB, DOM, ECU Of the baseline countries, BLZ reported that it had not achieved the indicator. Only two of the five target countries for 2011 (CUB, ECU) achieved it.
RER 9.5: Zoonotic and non-zoonotic foodborne diseases, as well as foot-and-mouth disease surveillance, prevention, and control systems strengthened and food hazard monitoring programs established					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved)					
During the 2010-2011 biennium, intersectoral collaboration was consolidated throughout the Region between the public health sector, including epidemiologists and clinical laboratories, and the agriculture and livestock sector and its food analysis laboratories. The annual WHO-GFN and PulseNet workshops played a key role in this progress. Eight South American countries are implementing integrated projects for antimicrobial resistance surveillance, and projects to improve Salmonella control are underway in three Central American countries. Specifically, Ecuador is implementing a project to strengthen integrated surveillance of foodborne diseases in eight provinces. Jamaica and Grenada are finalizing a manuscript on the burden of foodborne diseases, which will become the basis for strengthening the capacity for epidemiological surveillance in those countries.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
9.5.1: Number of countries that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne diseases	21	23	23	30	2009 Baseline: ANI, ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ELS, GUT, MEX, NIC, PAR, PER, TRT, URU, USA, VEN 2011 Target: ECU, GRA, JAM Twenty-three countries fulfilled the indicator but only 7 Caribbean countries are sending reports to SIRVETA (BAH, BAR, CUB, DOR, TRI). It should be pointed out that six studies on the burden of disease have not been digitalized in SIRVETA (BAR, STL, DOM, GUY, TRI, GRE) due to a lack of resources, because they were not approved by the CDC. Means of verification: http://ww3.panaftosa.org.br/sirveta/; article by Pérez et al.*Int J Food Microbiol*. 2011 (in press).

9.5.2: Number of South American countries that have achieved at least 75% of the Hemispheric Foot-and-mouth Disease Eradication Plan objectives	6/11	9/11	9/11	11/11	2009 Baseline: CHI, COL, GUY, PAR, PER, URU 2011 Target: ARG, BOL, BRA The indicator is considered to have been achieved, as reported by the nine countries. It should be noted, however, that PAR declared a health emergency for foot-and-mouth disease on 19 September 2011 and temporarily suspended its disease-free country status.
RER 9.6: Technical cooperation provided to National Codex Alimentarius Committees and the Codex Commission of Latin America and the Caribbean					**On track**
RER Assessment (1 out of 1 RER indicator targets achieved)					
The 40 baseline countries continue to adhere to Codex regulations concerning food safety.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
9.6.1: Number of countries adopting Codex Alimentarius Meetings' resolutions	40	40	40	40	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, PUR, SAL, SAV, SCN, SUR, TRT, URU, USA, VEN 2011 Target: Maintenance The 40 baseline countries continue to adhere to Codex regulations concerning food safety.

SO10 PROGRESS REPORT

SO10: To improve the organization, management and delivery of health services				On track	
Budget Overview					
Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$39,960,000	**$7,904,000**	**$12,779,088**	**$20,683,088**	**83%**	**52%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Percentage of rural population living more than one hour away from a first level of care center, in six countries of the Region where a study was completed**
Baseline: 10.6% in 2004
Target: 7% by 2013

SO indicator 2: **Percentage of population covered by the health care network in six countries of the Region where a study was completed**
Baseline: 30% in 2004
Target: 40% by 2013

Note: The healthcare network includes all health services {public, social security, community, private, etc.) in the respective country.

This SO's 10 impact indicators were based on the Exclusion in Health studies conducted in 6 countries of the Americas (Dominican Republic, Ecuador, Guatemala, Honduras, Paraguay, and Peru) between 2001 and 2003. These studies were carried out by national teams using an econometric analysis of exclusion based on health variables in the countries. Two of the indicators used in these studies were selected as SO 10 impact indicators. Data for these indicators came from a variety of sources (demographic surveys, international organization statistics, and country reports).

However, such studies have not been replicated, and thus the information to report on the progress of these indicators is not readily available at this time. One indicator that could be used to show where the Region stands in terms of health services coverage is the "Population coverage by health sector provider, countries of the Americas, selected years," compiled for Health in the Americas 2012. Such information will be included in the final version of the report that will be presented in September 2012 at the 28th Pan American Sanitary Conference.

Progress made on SO 10 can also be measured using health outcome indicators that are highly sensitive to access to and coverage of health services—such as reducing maternal mortality and neonatal mortality rates—for which the Region made significant progress in 2010–2011, as reported in SO4.

2010–2011 Assessment

Of the 3 RERs, 3 are on track; and of the 7 indicator targets, 6 were met. Overall, there has been very good progress made in improving the organization, management, and delivery of health services in the Region of the Americas. Countries have advanced with the implementation of Primary Health Care (PHC)–based systems, the integration of health service delivery networks, and the implementation of quality of care and patient safety programs.

Main Achievements

- Significant progress on the renewal of PHC has been made: this includes developing a Community of Practice in PHC (virtual platform), conducting a regional assessment of PHC, developing an analytical framework/methodology for health system performance assessment with PHC 'lenses,' and holding a virtual course on PHC in English through the Virtual Campus in Public Health (VCPH).
- Five manuals were produced to support the implementation of Integrated Health Service Delivery Networks (IHSDNs). There was a revitalization of technical cooperation in hospitals within the IHSDN framework at the global, regional, and country levels—including a proposal for a regional agenda on hospitals.
- The English-speaking Caribbean is making important progress in Essential Public Health Functions (EPHF) Initiative; the follow-up assessments conducted in 2010–2011 show substantial progress made when compared to previous assessments.
- Countries are advancing towards integrating vertical programs within their health systems. In particular, efforts are being made to integrate mental health programs within PHC, especially in the English-speaking Caribbean (Antigua and Barbuda, Barbados, Dominica, Grenada, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago).

- There has been a reactivation of the strategy on quality of care and patient safety, with several activities carried out during the biennium. A compilation of legislation on this topic from Latin American countries was prepared; a pilot virtual course has been developed and implemented; and a systematic review of adverse events in primary care was elaborated, among others.

Main Challenges

- Enhanced and continued integration of NCDs and their common risk factors, as well as other programs, is needed to introduce cross-cutting platforms—as well as to reduce the downsides associated with vertical approaches. The COT on Model of Care could help to address this challenge.
- There is a need to mobilize further resources in support of such regional initiatives as Essential Public Health Functions (EPHF) and Productive Management Methodology for Health Services (PMMHS), among other topics that are not as attractive to donor funding.
- Intercultural approaches need to be integrated within health policies and systems (the only RER indicator under this SO reports non-achievement of target).
- There is a need to ensure that quality of care and patient safety is integrated across health programs and not seen as just another separate component.
- There are challenges regarding the interpretation of which topics ought to be addressed under different RER indicators (particularly regarding RER indicators 10.1.1 and 10.1.4). Continuous dialogue between the regional level and the Country Offices should be in place to clarify the boundaries between them.

Lessons Learned

- Most countries continue to evaluate the EPHF without developing any specific plan for strengthening those functions that need to be addressed. The regional level can play an important role in providing support to countries as they go about elaborating their agendas to strengthen EPHF, based on successful experiences (as was the case in Brazil).

- Integration processes are difficult, complex, and long term, requiring extensive systemic changes. Integration does not mean that all network components must be integrated into a single modality, as multiple modalities and degrees of integration can coexist within a single system. The lesson learned is that countries require operational guidelines on how to implement Integrated Health Services Delivery Networks (IHSDNs); a first step in this direction has been made with the development of five manuals to support integration processes.
- The experience thus far shows that baseline countries should be encouraged to link to the indicators and develop their own actions to sustain progress. Otherwise, setbacks in achievements may occur.

SO10 RER Progress Report

RER 10.1: Member States supported through technical cooperation to strengthen health systems based on Primary Health Care, promoting equitable access to health services of good quality, with priority given to vulnerable population groups	**On track**

RER Assessment
(3 out of 4 RER indicator targets achieved, with 1 exceeding the 2011 target)

Overall, there has been very good progress in implementing PHC-based health systems in the Region of the Americas. At the country level, many countries are advocating for the renewal of PHC and implementing health planning and reporting, health information systems, reorganization of health services, and training of health personnel using a PHC approach. There have also been important advances in assessing EPHF and in integrating vertical programs into the health system. At the regional level, there has been significant progress in developing policy options and strategies for implementing the four PHC reforms outlined in the World Health Report (WHR) 2008: developing a framework and methodology for health system performance assessment with PHC lenses, assessing the situation of PHC in the Americas, creating a COP in PHC, and documenting lessons learned in integrating disease-specific programs into health systems. There has been modest progress made in the incorporation of the intercultural approach into health systems.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
10.1.1: Number of countries that document the strengthening of their health systems based on Primary Health Care, in accordance with the Declaration of Montevideo and PAHO/WHO's Position Paper	18	21	21	23	2009 Baseline: ABM, ANI, ARG, BAR, BRA, CHI, COR, CUB, DOM, ECU, GRA, GUT, NIC, SAL, SAV, SCN, URU, VEN 2011 Target: PAN, PAR, PER PAN, PAR, and PER achieved the target for 2011. Relevant advances have also been made in BAR, BRA, and URU. A situation assessment of the implementation of the PHC Renewal Strategy is ongoing, with the participation of 20 Member Countries. Results will be published in 2012.

10.1.2: Number of countries that show improvement in the performance of the steering role as measured by the assessment of Essential Public Health Functions	8	11	11	14	2009 Baseline: ARG, BAR, BRA, COL, GUY, MEX, NIC, PAR 2011 Target: ELS, PER, SCN ELS, PER, and SCN have achieved the target. Although SCN has not yet implemented its improvement plan, the country has clearly improved EPHF, as can be seen in the measurements carried out in this year in the second assessment, as opposed to those from the previous assessment.
10.1.3: Number of countries that integrate an intercultural approach in the development of policies and health systems based on PHC	3	5	4	8	2009 Baseline: BOL, ECU, GUT 2011 Target: CUB, VEN CUB achieved the target but VEN did not.
10.1.4: Number of countries that use the Renewed Primary Health Care strategy in their population-based programs and priority disease control initiatives	N/A	6	7	12	2009 Baseline: N/A 2011 Target: BLZ, BRA, CHI, COR, CUB, ECU, PER BLZ, BRA, CHI, COR, CUB, ECU, and PER reached the indicator, exceeding the target for 2011. Some 18 additional countries also report progress achieved. Several countries have made efforts to apply the PHC strategy for strengthening mental health services.

RER 10.2: Member States supported through technical cooperation to strengthen organizational and managerial practices in health services' institutions and networks, to improve performance and to achieve collaboration and synergy between public and private providers	**On Track**
RER Assessment (2 out of 2 RER indicator targets achieved, with 1 exceeding both the 2011 and 2013 targets)	
The combined achievements of the PAHO Country Offices, the Regional Team, and its external collaborators has made this a biennium with significant progress made in strengthening health service organization and management in the Region. Member States have fully adopted Integrated Health Services Delivery Networks (IHSDNs) as a key framework for health services. In addition, HSS/IS has completed the development of a five-module virtual course on Productive Management Methodology for Health Services (PMMHS). A situation analysis of emergency medical services has been completed in 14 countries. There are Strategic Intervention Programs in place in two hospitals (in ECU and SAL) utilizing the PMMHS framework and tools.	

Finally, the Initiative for the Development of a Regional Agenda for Hospitals in IHSDNs has been launched. The achievements reflected in this report and the work done by HSS/IS in promoting PAHO's framework—both regionally and globally—is making a significant impact.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
10.2.1: Number of countries that have implemented strategies to strengthen health services management	14	17	17	20	2009 Baseline: ABM, ANI, BAH, BLZ, CHI, COL, COR, ECU, ELS, GUT, NIC, PAN, PER, TRT 2011 Target: HON, MEX, SAL HON, MEX, and SAL have achieved the target. HON has begun a process to strengthen health services management in one of the country's Social Security (IHSS) hospitals. SAL conducted a workshop on Production, Efficiency, Resources, and Costs (PERC).
10.2.2: Number of countries that have adopted PAHO/WHO policy recommendations to integrate health services networks, including public and non-public providers	9	10	15	13	2009 Baseline: BRA, CHI, COR, CUB, ECU, GUT, MEX, PER, URU 2011 Target: BLZ, COL, JAM, PAN, PAR, TRT This target has been exceeded. Six countries have achieved the indicator and shown substantial progress in implementing the recommendations to integrate health service delivery networks. At the regional level, HSS/IS is about to complete production of five guidebooks that will provide support for the implementation of IHSDNs and document country experiences and lessons learned in implementing IHSDNs.

RER 10.3: Member States supported through technical cooperation to strengthen programs for the improvement of quality of care and patient safety	**On track**

RER Assessment
(1 out of 1 RER indicator targets achieved)

There have been significant advances made in this topic in the Region, with several activities taking place during the biennium. A compilation of legislation from Latin American countries and Spain was prepared; and a pilot virtual course was developed with experts from ARG, COL, COR, and MEX. When the course was offered through the Virtual Campus of Public Health, there were 53 participants from 17 countries. In addition, a document on notification systems was elaborated with the involvement of eight countries of the Region. Furthermore, a systematic review of adverse events in primary care was prepared, and a proposal for the investigation of adverse events in outpatient settings was developed. A major challenge is the integration of

quality of care across the entire health system. As a first step in this direction, a regional meeting was held with the participation of ministries of health and program managers. The objective was to identify mechanisms for strengthening integration of quality of care throughout health systems.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
10.3.1: Number of countries that show progress in programs for the improvement of quality of care, including patient safety	19	22	22	24	2009 Baseline: ABM, ANI, ARG, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, ECU, ELS, GRA, GUT, MEX, PER, TRT 2011 Target: DOR, PAN, SAL The three target countries achieved the indicator. In DOR, a biosafety evaluation was completed in five prioritized hospitals. In PAN, a network of hospitals is developing patient safety tools, such as hand washing, surgical checklists, etc. In SAL, quality care programs were developed for the country's regional health services, Saint Jude's Hospital, Victoria Hospital, and Tapion Hospital. The Quality of Care and Patient Safety (QCPS) Program has made advances in nearly all the countries in the Region.

SO11 Progress Report

SO11: To strengthen leadership, governance, and the evidence base of health systems				On track	
Budget Overview					
Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$42,482,000	**$30,227,000**	**$9,545,179**	**$39,772,179**	**93%**	**93%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Number of countries with legislation aimed at increasing access to health (non-personal services and public health) and health care**

Besides the countries in the baseline for 2007 and 2009 (Argentina, Belize, Brazil, Colombia, Cuba, French Departments in the Americas, Peru, and Trinidad and Tobago), the Dominican Republic, Ecuador, and Honduras reported having reviewed their legislation. Guyana, Mexico, and Paraguay also report making progress in reviewing their legislation. Hence, no problems are anticipated in reaching the 2013 target in 15 countries.

SO indicator 2: **Number of countries that have established national health objectives to improve health outcomes**
Baseline: 3 countries in 2007
Target: 10 countries by 2013

This indicator has been achieved. By 2011, 29 countries had formulated policies and mid-term and long-term plans or had defined national health objectives. It will be important to maintain and monitor these policies, plans, and objectives and to keep them updated during the next biennium.

SO indicator 3: **Number of countries that have implemented monitoring and performance evaluation of health information systems that comply with PAHO/WHO and Health Metrics Network standards**
Baseline: 3 countries in 2007
Target: 15 countries by 2013

In 2011, 10 countries have carried out monitoring and have conducted performance evaluation of health information systems. Thus, this indicator is on track for achieving the goal by 2013.

SO indicator 4: **Number of countries incorporating knowledge management and technology-based health strategies to strengthen their health systems**
Baseline: 10 countries in 2007
Target: 20 countries by 2013

This indicator is on track to achieve the target of 20 countries having incorporated knowledge management and technology-based health strategies to strengthen their health systems by the end of 2013 (SO indicator 4)—especially considering that 12 countries had already done so by 2011.

SO indicator 5: **Number of countries that fulfill the commitment made at the Mexico Summit to devote at least 2% of the public health budget to research**
Baseline: 0 countries in 2006
Target: 10 countries by 2013

Canada and the United States have already achieved this target in the Americas. By 2005, Argentina, Chile, Cuba, Mexico, Panama, and Venezuela were making the largest investments in health research and development as a proportion of their national health spending (ranging from approximately 0.65% to 1.35%). Since the Mexico Summit, a positive trend has been seen in countries such as Argentina, Brazil, and Mexico. Countries are dangerously lagging behind in the achievement of the 2013 target and will need not only to receive extra support to achieve this indicator, but also to scale up the national commitment to achieving this target.

2010–2011 Assessment

SO11 is rated as being on track, with its 5 RERs on track and all of its 14 RER indicator targets achieved for 2011. Important advances were made in 2010–2011 while also maintaining progress made in strengthening health information systems, analysis, and databases—as well as creating and/or maintaining different platforms to access and exchange health information at all levels. No anticipated challenges are foreseen in meeting the targets for the next biennium, as long as there are sufficient resources to provide the necessary technical cooperation—especially for those initiatives requiring strong regional support, and as long as countries continue to invest efforts to maintain and expand on the gains achieved.

Main Achievements

- With regard to RER indicators 11.1.1, 11.2.1, 11.2.2, 11.3.1, 11.3.4, and 11.5.3, main achievements include reviewing legislative frameworks, maintaining core health data, updating and increasing the use of mortality and birth databases, 100% of the countries preparing their health situation analyses in time for the publication of Health in the Americas 2012, monitoring health-related MDG indicators, strengthening the Latin American and Caribbean Network for Health Information Systems (RELACSIS) and the Regional Health Observatory, and increasing technical cooperation to English-speaking Caribbean countries to improve health information systems.
- Significant progress has been made in the implementation of PAHO's Policy on Research for Health through effective partnerships and through the integration of research into PAHO's technical cooperation. Research governance has been strengthened in at least five countries. In addition, there is now better organized and more accessible data to describe national health research systems in Member States. PAHO is at the forefront of monitoring and improving national health research systems, implementing tools for knowledge translation, and promoting the use and development of health systems research.
- Frameworks and tools for the analysis of health legislation have been developed and reviewed. Some examples are the following: URU passed a law that contributes to the consolidation of the National Integrated Health System, and DOR and HON enacted legislation to strengthen the stewardship of the National Health Authority and strengthen their regulations on human talent and medical devices.
- There has been progress made in the implementation of the National Health Policies, Strategies and Plans—Global Learning Programme (NHPSP-GLP) initiative in the Region, with PAHO adapting materials developed by WHO to the context of the Region.
- With regard to RER indicators 11.1.1, 11.2.1, 11.2.2, 11.3.1, 11.3.4, and 11.5.3, main achievements include reviewing legislative frameworks, maintaining core health data, updating and increasing the use of mortality and birth databases, 100% of the countries preparing their health situation analyses in time for the publication of Health in the Americas 2012, monitoring health-related MDG indicators, strengthening the Latin American and Caribbean Network for Health Information Systems (RELACSIS)

and the Regional Health Observatory, and increasing technical cooperation to English-speaking Caribbean countries to improve health information systems.

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- There has been progress made in the implementation of the National Health Policies, Strategies and Plans—Global Learning Programme (NHPSP-GLP) initiative in the Region, with PAHO adapting materials developed by WHO to the context of the Region.
- There has been sustained progress in the development of projects, products, and services that strengthen the Organization's role at both the regional and global levels as an authoritative source of information and knowledge related to the health sciences. Among others, three major initiatives resulting from collective processes are worth highlighting:
  (1) the *eHealth* strategy;
  (2) the Knowledge Management and Communication Strategy, and
  (3) the adoption of a Strategic Relationships Networks model.

Main Challenges

- Continue reducing the fragmentation of health information systems, thus increasing the reliability of data, its systematic and regular production at the national and subnational levels, and improving the countries' analytical capacity. Expand and improve access to health information as well as the use of information for decision-making. Expand and improve access to health information.
- External funding for health is still highly fragmented and/or outside of the scope of national budgets and plans. Therefore, there is a need for continuous technical cooperation for the NHPSP-GLP initiative in the Region.
- To implement the Policy on Research for Health, it is necessary to scale up resources (including funding), partnerships, technical cooperation and integration of research into health care planning and delivery. There is a need to keep the focus on policy implementation and advancement as well as on monitoring and evaluation mechanisms. An additional need is to enhance indicators and prioritize strategies as established in the workplan and in policy documents.
- The work with national bioethics commissions encounters political difficulties (both regarding their establishment and their ongoing work), which may hamper the achievement of RER indicator 11.4.2 (which deals with the number of countries with national commissions aimed at monitoring compliance with ethical standards in scientific research).

Lessons Learned

- Countries have made a commitment to improving legislation on different topics. Workshops with intersectoral groups have proven to be a positive step. However, since the revision of legislation entails technical as well as political components, continuous follow-up by the PAHO Country Offices is essential to achieve enactment of the legislations drafted thus far.

- Robust national health research systems enable countries to maximize the benefits of research, and PAHO's Policy on Research for Health strengthens them with a systems approach in its implementation. This requires protecting the achievements, securing sufficient resources for policy implementation, engaging Member States, and monitoring and evaluation. Key to an adequate implementation of PAHO's Policy on Research for Health, with the goal of meeting its objectives, are regional coordination and stable and adequate resources.
- PAHO's role as an authoritative source and broker of evidence-based public health information and knowledge is becoming increasingly essential with the overload of health information and the rise in the use of social networks.
- Building alliances with countries and agencies played a key role in the development and launching of the Latin American and Caribbean Network for Health Information Systems (RELACSIS, taken from its name in Spanish). RELACSIS constitutes the culmination of five years of the strengthening and improvement cycle for health information systems (HIS). It came about as the result of a strategic partnership between the United States Agency for International Development (USAID), PAHO, and MEASURE Evaluation, accompanied by active participation on the part of all the countries involved.

SO11 RER Progress Report

RER 11.1: Member States supported through technical cooperation to strengthen the capacity of the national health authority to perform its steering role; improving policy analysis, formulation, regulation, strategic planning, implementation of health system changes; and enhancing intersectoral and inter-institutional coordination at national and local levels	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target)

Progress has been made in three countries in reviewing and updating legislation within the framework of constitutional reforms, as well as on specific topics. Workshops were organized and comparative health legislation analyses produced to improve capacity-building in the development of health legislation. In addition, the implementation of the National Health Policies, Strategies, and Plan (NHPSP) Initiative in the WHO/AMRO Region has been advancing steadily. Two workshops related to the fast-track phase of the NHPSP-GLP were held in the Region. A major achievement has been the adaptation of the original materials developed by WHO on NHPSP-GLP to meet regional needs and content. In addition, a Virtual Course on Public Policies Management in Health is under development and will be available to Member States by first quarter 2012.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
11.1.1: Number of countries that have updated their legislations and regulatory frameworks	8	10	11	12	2009 Baseline: ARG, BLZ, BRA, COL, CUB, FDA, PER, TRT 2011 Target: DOR, ECU The target has been exceeded. In addition to the two target countries (DOR and ECU), a third country (HON) also achieved the indicator. Progress has also been sustained in BLZ, BRA, CUB, FDA, PER, and TRT.

11.1.2: Number of countries that have formulated policies, mid-term and long-term plans or defined national health objectives	18	29	29	35	2009 Baseline: BAR, CAN, COR, CUB, DOM, DOR, ELS, GUY, HAI, HON, JAM, MEX, NIC, PAR, SAV, SUR, USA, VEN 2011 Target: ARG, BAH, BOL, BRA, CHI, COL, ECU, PAN, PER, TRT, URU The target was fully achieved. Progress has been made in building capacity at the level of the PAHO Country Offices to support the formulation of national health policies, strategies, and plans. Two workshops related to the fast-track phase of the NHPSP-GLP were held for the AMRO Region.
RER 11.2: Member States supported through technical cooperation for improving health information systems at regional and national levels					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved)					
Health Information Systems have been continuously strengthened. The creation of RELACSIS has allowed for training to take place in the countries as well as for establishing guidelines for a Regional Capacity-Building Plan in partnership with Family of International Classifications (FIC) Collaborating Centers. The work with basic health indicators has been successfully maintained in Spanish-speaking countries. For the next biennium, one of the challenges will be the incorporation of the English-speaking Caribbean countries. One lesson learned is that the launching of RELACSIS constituted the culmination of five years of efforts aimed at the HIS strengthening and improvement cycle, as well as a strategic alliance between USAID, PAHO and MEASURE Evaluation—but most importantly, of an alliance with all the countries involved in this process.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
11.2.1: Number of countries that have implemented processes to strengthen the quality and coverage of their health information systems	7	10	10	15	2009 Baseline DOR, GUT, HON, MEX, NIC, PAR, PER 2011 Target: BLZ, ECU, ELS The target was fully achieved. The creation of RELACSIS allowed for capacity-building in countries with the most critical gaps, as well as the creation of guidelines for a Regional Training Plan. The Regional Plan of Action for Strengthening Vital and Health Statistics hopes to evaluate coverage and quality indicators in 2013, following the respective resolution. Worth highlighting are the partnerships with CAREC, USAID, MEASURE Evaluation, CIDA, and ECLAC to manage and finance the Regional Plan of Action for Strengthening Vital and Health Statistics.

11.2.2 Number of countries that have implemented the PAHO Regional Core Health Data	16	19	19	27	2009 Baseline: ARG, BLZ, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, HON, MEX, NIC, PAN, PER 2011 Target: BOL, PAR PUR The target was fully achieved. Work at national level on basic indicators is being successfully maintained in the Spanish-speaking countries. The 2013 targets will expand this work to the English-speaking countries, with possible challenges such as funding, continuous communication with countries through the PWR offices, and ensuring that priority is given to this topic by the national governments.
RER 11.3: Member States supported through technical cooperation to increase equitable access to, and dissemination and utilization of, health-relevant information, knowledge, and scientific evidence for decision-making					**On track**
RER Assessment (5 out of 5 RER indicator targets achieved)					
Updating the country chapters for Health in the Americas (HIA) 2012 provided an excellent opportunity to monitor progress made on reaching the MDGs and to update the health situation analysis in all countries of the Region. With regard to the Virtual Health Library, the target was achieved. One lesson learned is the need to continue working closely with technical counterparts—both at PAHO/HQ and at the PAHO Country Offices—to monitor goals.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
11.3.1: Number of countries that update their health situation analysis at least every two years	7	9	9	10	2009 Baseline: BRA, CUB, ECU, FEP, MEX, NIC, VEN 2011 Target: ELS, GUY The target was fully achieved; moreover, during this biennium the preparation of country chapters for Health in the Americas 2012 allowed practically every country to update its health situation analysis.

11.3.2: Number of countries that participate in initiatives tending to strengthen the appropriation, production, and use of results from research to inform in policies and practices.	3	6	6	8	2009 Baseline: BRA, COR, TRT 2011 Target: FEP, PAR, PER The target was fully achieved. Countries that have established teams capable of completing knowledge translation tools and processes include—in addition to the target countries:—ARG, BRA, CHI, and ECU.
11.3.3: Number of countries that have access to essential scientific information and knowledge as measured by access to Virtual Health Libraries (VHLs) at national and regional levels	15	21	23	25	2009 Baseline: ARG, BOL, BLZ, BRA, CAN, CHI, COL, COR, CUB, DOR, ELS, JAM, MEX, PER, USA 2011 Target: ECU, FEP, GUT, GUY, HON, PAR, NIC, URU The target was exceeded. In addition to the six target countries (FEP, GUT, GUY, HON, PAR, and URU), ECU and NIC also achieved the indicator. Progress has also been sustained in BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ELS, MEX, and PER.
11.3.4: Number of countries monitoring the health related Millennium Development Goals	25	34	34	36	2009 Baseline: ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, VEN 2011 Target: ABM (ANU and BVI), ANI, BAH, BAR, GRA, SCN, SAL, SAV The target was fully achieved. Updating of country chapters for HIA 2012 provided an excellent opportunity to monitor progress. Two years away from the 2013 deadline to achieve the targets, it is likely that the countries will intensify their efforts to measure progress, thus increasing the demand for technical cooperation to strengthen their analytical capacity. CAN and USA should not be counted as target countries, since they do not monitor the MDGs according to the agreements.

RER 11.4: Member States supported through technical cooperation for facilitating the generation and transfer of knowledge in priority areas, including public health and health systems research, and ensuring that the products meet WHO ethical standards	**On track**

RER Assessment
(2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target)

Significant progress has been made in this RER, with calls for action leading to specific activities that resulted in enhancing capacities in the areas of research governance and stewardship—as well as in research being translated into both policy and practice. Capacity-building took place in how to take advantage of health systems research, and thus the two indicators for this biennium were achieved. Major achievements include data on governance and policies organized for over 30 countries and the PASB; 26 Member States listing research priorities; data being available on ethics regulations from 16 member states and the PASB; and over 1000 ethics review committees being identified, thus making it possible to formulate a target for capacity-building for enhanced research standards. Standards for research in the PASB were strengthened. Regional activities addressed quality, governance, human resources, standards, and knowledge translation. These were implemented through strategic partnerships (e.g., Conferences on Research and Innovation for Health, the Regional Meeting for National Bioethics Commissions of the Americas, the International Clinical Trials Registry Platform (ICTRP)–Americas, the Network for Evidence-Based Policies in the Americas (EVIPNet Americas), and guidelines for technical recommendations formulated with such key partners as the PAHO/WHO Collaborating Centers.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
11.4.1: Number of countries that have a national health research system with the characteristics (indicators) defined by PAHO	2	4	5	5	2009 Baseline: BRA, COR 2011 Target: CUB, ECU, PAR The target was exceeded. A structure has been established for better research governance. There are more data that is better organized and accessible to describe national health research systems in Member States. PAHO is at the forefront of monitoring and improving national health research systems, implementing tools for knowledge translation and promoting health systems research use and development.

11.4.2: Number of countries with national commissions aimed at monitoring compliance with ethical standards in scientific research	15	18	18	20	2009 Baseline: ARG, BOL, BRA, CHI, COL, COR, CUB, DOM, ECU, MEX, PAN, PAR PER, URU, VEN 2011 Target: BLZ, JAM, TRT The target was fully achieved. The BLZ ethics commission has been established, along with guidelines. JAM has a well-established National Bioethics Commission, which has lately become one of the most active in the Region. The TRT Bioethics Commission is in the final stages and will be completed next year. There are challenges in the measurement of this indicator, as the work is shared between WHO (for support for technical matters) and UNESCO (for establishing the commissions).
RER 11.5: PAHO is the authoritative source and broker of evidence-based public health information and knowledge, providing essential health knowledge and advocacy material to Member States, health partners and other stakeholders					**On track**
RER Assessment (3 out of 3 RER indicator targets achieved, with 1 exceeding the 2011 target)					
PAHO has continued to make progress in developing projects, products, and services that strengthen its role as an authoritative source of health science information and knowledge at both the regional and global levels. Among others, three important outcomes resulting from collective processes are worth highlighting: (1) The *eHealth* strategy was recently approved by PAHO's 51st Directing Council. (2) The knowledge management and communication strategy for all PAHO entities was approved by EXM. (3) A model for Strategic Relationship Networks was adopted following discussions at the annual Managers Meeting in Punta Cana. This reinforces other initiatives, such as those connected to research policy, development of an editorial policy, and various standards and procedures for working as a knowledge-based organization. The PAHO Regional Health Information Platform (PHIP) is operational and consolidated as planned. A major challenge is achieving interoperability among the main PAHO corporate initiatives, such as PAHO Web 2.0, the VCPH, and the VHL.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
11.5.1: Number of hits to PAHO's web page	30 million	35 million	Exceeded	40 million	Although this 'target' was poorly defined, given that the metrics should be measured differently based on a bibliometric analysis of the use of information and not merely the number of hits, the target was nonetheless exceeded.

11.5.2: Maintain the number of countries that have access to evidence-based, health information and advocacy material for the effective delivery of health programs as reflected in the country cooperation strategies	35	33	35	33	2009 Baseline: ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, USA, VEN 2011 Target: Maintenance Maintenance in the 35 countries was achieved.
11.5.3: PAHO Regional Information Platform created, integrating all the PASB technical health databases and information from health and development partners	Integration of all PASB technical health databases	Integra-tion of health and devel-opment partners informa-tion	Yes	Platform created and fully opera-tional	The PAHO Regional Health Information Platform (PHIP) is now operational and consolidated as designed and planned. The PHIP integrates data from PASB health programs across the Organization as well as data from such development partners as the United Nations Statistics Division (UNSD), the World Bank (WB), the Organisation for Economic Co-operation and Development (OECD), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), and the Institute for Health Metrics and Evaluation (IHME). PHIP data and Information products are available at the Health Observatory portal at http://www.paho.org/rho. For more information, see https://sites.paho.org/rho or http://ais.paho.org.
11.5.4: Number of Communities of Practice established and in use in the PASB entities	10	15	15	15	The Organization has continued to implement the Communities of Practice (CoP) methodology. The CoP on Primary Health Care is worth highlighting, as it is one of the largest in the Organization; it is currently under development.

SO 12 Progress Report

SO12: To ensure improved access, quality, and use of medical products and technologies					On track
Budget Overview					
Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$18,963,000	**$7,154,000**	**$13,895,278**	**$21,049,278**	**85%**	**111%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Number of countries in Latin America and the Caribbean where access to essential medical products and technologies is recognized in national constitutions or legislation**
Baseline: 6 countries in 2006
Target: 14 countries by 2013

The 2013 target for this SO has been met: 19 countries have either the right to health (which enshrines access to medicines) or the right to access to medicines and health technologies, as incorporated in the national constitutions. In addition, such countries as Argentina, Colombia, Costa Rica, Ecuador, El Salvador, Panama, and Venezuela have signed international treaties of constitutional importance.

SO indicator 2: **Number of countries in Latin America and the Caribbean where the quality of medical products and technologies is monitored by the national regulatory authority**
Baseline: 5 countries in 2006
Target: 10 countries by 2013

The 2013 target for this SO indicator has been met: over 12 countries are effectively monitoring the quality and safety of medicines and medical products through their national regulatory authorities (NRAs). In 2010, PAHO's *50th Directing Council* adopted Resolution CD50.R9, "Strengthening Regulatory Capacity for Medicines and Biologicals," calling on all Member States to strengthen their national capacity and promote exchange between regulatory authorities. At present, PAHO considers four NRAs to be worthy to act as PAHO Regional Reference Authorities (those of Argentina, Brazil, Colombia, and Cuba). In addition, both the United States Food and Drug Administration (FDA) and Health Canada are now PAHO/WHO Collaborating Centers in Regulatory Affairs; and Chile, the Dominican Republic, Mexico, and Panama are considered to have effectively implemented regulatory functions within their NRAs.

SO indicator 3: **Number of countries in LAC where public sector procurement systems include planning, procurement, and distribution of quality medical products and technologies**
Baseline: 6 countries in 2006
Target: 16 countries by 2013

By the end of 2011, 21 countries had either established or strengthened public sector procurement systems (Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guyana, Haiti, Honduras, Mexico, Nicaragua, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Venezuela). There has been a move during the last biennium towards integrating

procurement systems—especially for medicines and health technologies associated with HIV, TB, and malaria—within national procurement and supply management systems. Examples of this in the countries include Brazil (Popular Pharmacy), Chile (reorganization of the Central Supply Agency for the National Health Service [CENABAST]), and Peru (General Directorate of Medicines, Supplies and Drugs [DIGEMID]). Another example is how Argentina and Ecuador are in the process of implementing important organizational changes to their national procurement mechanisms for essential medicines. A similar example is how the Central American countries are working together on the harmonization and simplification of prequalification procedures for the selection of supplies and products.

SO indicator 4: **Number of countries in Latin America and the Caribbean where the national regulatory authorities have the capacity to perform the following basic functions, as measured by international standards: *(a)* licensing; *(b)* pharmacosurveillance; *(c)* lot release system; *(d)* access to a quality control laboratory; *(e)* inspection of manufacturers; and *(f)* evaluation of clinical results**
Baseline: 14 countries with basic-level, 6 with intermediate-level, and 2 with high-level regulatory functions in place in 2006
Target: 10 countries with basic-level, 7 with intermediate-level, and 7 with high-level regulatory functions in place by 2013

At present, six countries (Argentina, Brazil, Canada, Colombia, Cuba, and the United States) have implemented high-level regulatory functions. Four others are quickly building their capacity (Chile, Dominican Republic, Mexico, and Panama). The indicator is also on track for achievement by the countries with basic- and intermediate-level regulatory functions.

2010–2011 Assessment

This SO is on track, with 3 of its 3 RERs on track and 8 of its 9 RER indicator targets for 2011 achieved.

Very good progress is being made to achieve SO12, as indicated by the advances reported at the end of the 2010–2011 biennium. Countries are prioritizing the areas covered under this SO and have achieved their targets set, with support from PASB/HSS. In all cases, targets have either been fully or partially met.

The Region continues to move to strengthen pharmaceutical and health technology policy, strengthen regulatory capacity, and promote the appropriate and rational use of medicines in health technologies—a trend that we anticipate will continue into 2012–2013. RER 12.1 has advanced well, with countries prioritizing the development of pharmaceutical policies, strengthening of national procurement and supply systems for medicines, and increasingly making use of the PAHO Strategic Fund. Countries are prioritizing methodologies for health technology assessment linked to strategies aimed at improving use. Countries have prioritized RER 12.2, aimed at strengthening regulatory capacity—especially for medicines and vaccines—by focusing on core regulatory functions.

In addition, the countries have adopted norms through the Pan American Network for Drug Regulatory Harmonization (PANDHR), as well as international norms for radiation safety. There is an increased level of cooperation among countries in this area. Future challenges include regulation of medical devices and biotechnological products.

Finally, regarding RER 12.3, important advances have been made: norms to incorporate health technologies linked with technology assessment were being prioritized in 17 countries at the end of 2011 (Argentina, Bahamas, Bolivia, Brazil, Colombia, Cuba, Chile, Costa Rica, Ecuador, Guyana, Jamaica, Mexico, Nicaragua, Panama, Suriname, Trinidad and Tobago, and Uruguay). In addition, strategies promoting the rational use of medicines are under implementation in a number of countries, and there is increased awareness of issues surrounding antimicrobial resistance. Challenges remain in achieving the 2013 target of RER indicator 12.1.4; it is considered that the target should be reassessed based on the outcomes of the

external evaluation of the Regional Program for Blood Transfusion Safety and within the context of the development of the future plan.

Main Achievements

- PAHO's 50th Directing Council approved Resolution CD50.R9, "Strengthening National Regulatory Authorities for Medicines and Biologicals" (2010). This resulted from the evaluation of 12 NRAs, with 4 of them designated as regional reference NRAs. In addition, cooperation agreements were signed with three NRAs (the National Health Surveillance Agency [ANVISA-Brazil], National Drug, Food, and Medical Technology Administration [ANMAT-Argentina], and the Food and Drug Administration [FDA-United States]). PAHO organized the VI International Conference of PANDHR with over 300 participants from the Region, resulting in the identification of priority areas of work in the regulation and quality of medicines and health technologies.
- An evaluation of the Regional Plan of Action for Transfusion Safety 2006–2010 was conducted by an external evaluation group, with results presented to the PAHO 51st Directing Council as a basis for the development of the future Regional Plan.
- Development of the Regional Platform for Access and Innovation for Health is scheduled to be launched in January 2012 as a regional instrument to support the implementation of the Global Strategy on Public Health, Innovation and Intellectual Property.
- The launch of the Regional Strategy for the Rational Use of Medicines took place, with proposals under development in three countries (Bolivia, Chile, and Nicaragua). This includes a comprehensive approach to coordinating regulatory, educational, management, and research actions following a PHC approach.
- The Regional Network for Health Technology Assessment was also established and launched, with cooperation agreements signed with the Brazilian National Health Surveillance Agency (ANVISA) and the Canadian Agency for Drugs and Technologies in Health (CADTH).
- The number of countries participating in the PAHO Strategic Fund increased from 21 to 24.
- Continued education and training was made available through virtual courses on pharmaceutical services and pharmacovigilance, among other topics.

Main Challenges

- PAHO needs to be prepared to respond to the rising demand for technical cooperation from countries, given the increased interest in SO12 and the advances made by Member States. The loss of financing for the Caribbean is of particular concern, as political support has been built in the development of a Regional Strategy that was recently endorsed by the Caribbean Caucus of Ministers. It is expected that greater efforts will be required in 2012–2013 to establish strategic partnerships to ensure implementation of SO12. As a means to mobilize additional resources for the countries, additional resources will need to be invested by the countries themselves to consolidate their achievements.
- As new priorities in public health are defined, there is a continuous and increasing need to provide support for issues related to policy and to the regulation and use of medicines and health technologies. Disease areas and other public health priorities (maternal mortality reduction) will require significant additional support in the aforementioned areas of work, using a common approach based on health systems. The need for integration across PAHO technical areas on this issue is of the utmost importance. This extends to the ministries of health, linking their work in pharmaceutical management with the disease program areas and health services, as well as within the national regulatory authorities.

Lessons Learned

- An integrated approach to strengthening policy development and the regulation and use of medicines and health technologies has produced important advances in the countries.
- To date, linking the regional workplan with subregional integration mechanisms and national needs has been an effective strategy to ensure achievement of the targets.
- New strategic partnerships, combined with a resource mobilization strategy, will be required for 2012-2013 to offset considerable reductions in the number of grants that supported the workplan in the area of medicines and health technologies.

SO12 RER Progress Report

RER 12.1: Member States supported through technical cooperation to promote and assure an equitable access to medical products and health technologies and the corresponding technological innovation	**On track**

RER Assessment
(4 out of 5 RER indicator targets achieved, with 1 exceeding the 2011 target).

The countries have advanced well in this RER during the biennium. A number of countries have adopted new pharmaceutical policies to improve access to essential medicines, while others have completed the analysis of the pharmaceutical sector to guide future development. Considerable efforts have been made by the countries to improve national procurement and supply management systems to ensure better integration. Important advances have also been made in the area of health technology assessment, whereby countries are developing systems to strengthen the decision-making process for the assessment and incorporation of health technologies into health systems. The Strategic Fund has reported increased activity both in the number of countries participating in it and in the total volume of strategic public health supplies. An external evaluation of the regional workplan in blood during the last five years reported important achievements in this area, ranging from an increase in voluntary blood donations to an improvement in the quality and screening of blood and blood products—despite the fact that this very ambitious target was not met during the biennium and is unlikely to be met in 2012–2013.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
12.1.1: Number of countries that have implemented policies promoting the access to, or technological innovation for medical products	23/36	25/36	27/36	27/36	2009 Baseline: ARG, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, GUT, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, TRT, URU, VEN 2011 Target: BAH, ELS, GRA, SUR The target has been exceeded. BAH, ELS, GRA, and SUR have achieved the indicator BAH developed a pharmaceutical profile and is currently working on a plan to improve access to medicines, including 11 chronic conditions. ELS prepared a policy document and developed the country's

					pharmaceutical profile. GRA has also completed and submitted the country's pharmaceutical profile. SUR has produced a pharmaceutical policy, developed the profile, and carried out a study on the pharmaceutical situation.
12.1.2: Number of countries that have established or strengthened their national systems of procurement, production or distribution of medical products	18/36	21/36	21/36	24/36	2009 Baseline: ARG, BAR,BLZ, BOL, BRA, COR, CUB, DOR, ECU, ELS, GUY, HAI, MEX, NIC, PER, SUR, TRT, VEN 2011 Target: BAH, HON, SAV The target countries (BAH, HON, and SAV) achieved the indicator. BAH carried out a study on the price of medicines to improve public sector procurement; HON elaborated a list of medical supplies to support public procurement. SAV developed a training course to improve capacities on good practices for the storage of medical products.
12.1.3: Number of countries with 100% voluntary non-remunerated blood donations	5	12	6	17	2009 Baseline: CAN, CUB, NEA, SUR, USA 2011 Target: ANI, GUY, HAI, NIC, PAR The target was not achieved. Although significant progress was made by the target countries, only NIC achieved this indicator. Given this situation, the indicator is considered to be overly ambitious and should be modified to better reflect the reality in the countries and the progress that it is possible to achieve during the time period under consideration.
12.1.4: Number of countries that have tools to evaluate access to health technologies	10	15	20	20	2009 Baseline: ARG, BRA, CHI, COL, COR, CUB, MEX, PER, TRT, URU 2011 Target: BLZ, BOL, HAI, NIC, VEN The target has been achieved. VEN has participated in the adoption of a subregional policy for health technology assessment and the development of methodological guidelines. There have been important advances made on this indicator during the biennium, with new cooperation agreements with 14 countries of the Region (the Pan American Network for Evaluation of Health Technologies [RedETSA]) and other bilateral

					agreements (such as with the Canadian Agency for Drugs and Technologies in Health [CADTH]).
12.1.5 Number of countries using the PAHO Strategic Fund of Essential Public Health Supplies	11	15	15	18	2009 Baseline: ARG, BOL, BRA, DOR, ECU, ELS, HON, NIC, PAN, PAR, PER 2011 Target: BLZ, GUT, HAI, VEN The four target countries achieved the indicator. BLZ, GUT, and VEN actively used the Strategic Fund to procure strategic public health supplies. HAI and other countries in the Region, including the Caribbean countries, are using the prices of annual bids as a reference. The Strategic Fund has advanced significantly during this biennium.
RER 12.2: Member States supported through technical cooperation to promote and assure the quality, safety and efficacy of medical products and health technologies					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved)					
With the adoption and endorsement of Resolution CD 50.R9, “Strengthening of Regulatory Capacity for Medicines and Biologicals” at PAHO’s 50th PAHO Directing Council in 2010, there has been considerable activity within the countries related to this RER. A number of countries have been working to complete assessments of core regulatory functions; and of these, Argentina, Brazil, Colombia, and Cuba have been designated as National Regulatory Authorities (NRAs) capable as acting as Regional Reference Authorities. In addition, institutional development programs for other NRAs are under development to strengthen capacity, which will be supported by the NRAs of reference. Countries have been working on developing new norms and standards for medicines, medical devices, and regulation of biologicals. The latter two areas remain a challenge for the countries, especially for those NRAs with fewer resources, and will require special focus over the next biennium. Nonetheless, the RER has been successfully achieved by the countries.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
12.2.1: Number of countries evaluated in their regulatory functions for medical products	3	9	9	13	2009 Baseline: CUB, COR, MEX 2011 Target: ARG, BOL, BRA, CHI, COL, PAN The target for 2011 was achieved. ARG and COL are considered Reference Regulatory Authorities, based on evaluations completed along with CUB (baseline) and BRA. PAN and CHI have also been working to strengthen their regulatory capacity.

12.2.2: Number of countries that have implemented international rules, norms, standards or guidelines on quality, safety and efficacy of health technologies	7	10	10	14	2009 Baseline: ARG, BRA, CHI, COL, CUB, MEX, PER 2011 Target: BAR, COR, URU The target countries achieved the indicator. The countries have adopted important norms on drug quality and safety. BAR has been actively participating in PANDHR and has endorsed new international norms through the network for the regulation of medicines and biologicals.
RER 12.3: Member States supported through technical cooperation to promote and assure the rational and efficacious use of cost-effective medical products and health technologies, based on the best evidence available					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved)					
Progress has been made in this RER in the area of guidelines to support the incorporation of health technologies into health systems, as well as in the promotion of the use of essential medicines. Baseline countries continue to successfully maintain their status, with more countries realizing the importance of defining methods and norms for the systematic evaluation and incorporation of health technologies into health systems. The Bahamas, Jamaica, and Suriname have achieved RER indicator 12.3.1; and Argentina, Guatemala, and Saint Vincent and the Grenadines have achieved RER indicator 12.3.2. Many countries linking to the RER are reporting important advances in the promotion of the rational use of medicines, which is critical to the improvement of the quality of care and rationalization of products within health systems.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
12.3.1: Number of countries that have norms to define the incorporation of health technologies	14/36	17/36	17/36	20/36	2009 Baseline: ARG, BOL, BRA, COL, CHI, COR, CUB, ECU, GUY, MEX, NIC, PAN, TRT, URU 2011 Target: BAH, JAM, SUR BAH, JAM, and SUR have achieved the indicator target. In BAH, a situation analysis was completed, and norms are being developed to incorporate equipment into the health system. In SUR, advances were reported in terms of assessments being conducted and guidelines being developed for radiation therapy and diagnostics.

12.3.2: Number of countries that use a list of essential medicines updated within the last five years as the basis for public procurement	24	27	27	28	2009 Baseline: BAH, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GRA, GUY, HON, MEX, NIC, PAN, PAR, PER, SAL, SUR, TRT, URU 2011 Target: ARG, HAI, SAV The target has been fully achieved. In addition, 12 baseline countries continue to consolidate the use of essential medicines lists to guide procurement decisions at the national level (BLZ, BOL, BRA, CUB, ECU, GUY, HON, MEX, NIC, PAN, PAR, and TRT).

SO13 Progress Report

SO13: To ensure an available, competent, responsive and productive health workforce to improve health outcomes	At Risk

Budget Overview

Approved Budget (PB 2010–2011)	Funds Available			Expenditure (%)	Funded (%)
	RB	OS	Total		
$19,954,000	$8,832,000	$6,347,033	$15,179,035	92%	76%

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

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

By the end of 2011, 22 countries had achieved the target density of 25 health workers (physicians, nurses and midwives) per 10,000 inhabitants; three more countries have the potential to achieve the target by 2013; and it is unlikely that 10 countries will achieve the target by 2013. In other words, 25 countries (71%) have already achieved the indicator or are expected to do so by the end of 2013. In retrospect, achieving a minimum density of 25/10,000 health workers in 100% of the countries was too ambitious. And, while it is an important measurement, it is somewhat restrictive and does not reflect other important variables related to human resources for health, such as the competence of the health workforce, response capacity, quality, and so forth. These variables are better represented by the RER indicators, which had been achieved as of the end of 2011. According to the end of biennium assessment of this Strategic Objective, the 2011 target had been achieved in 10 of the total of 13 indicators. As far as the indicators that were not achieved, it is worth pointing out the following: for indicator 13.3.1 (number of countries that have established a career path policy for health workers), 2 of the 3 countries needed to achieve the 2011 target had done so; the same is true of indicator 13.5.2 (number of countries that participate in bilateral or multilateral agreements that address health worker migration), in which 1 of the 3 countries needed did not achieve the target.

Without a doubt, significant and sustained progress has been made in the development of HRH policies, plans, and strategies in the Region since the 2005-2006 biennium. There are still concerns, however, about sustaining the achievements made up to now in the next biennium (2012-2013). There are structural limitations on the effective use of HRH for political, institutional, and financial reasons. The dynamics and expansion of HRH are to a large extent contingent on the education sector and job markets, which tend to be resistant to change.

2010-–2011 Assessment

This SO has been rated "at risk" despite the significant progress that has been made during this biennium. Of the five RERs, three are "on track" and two are "at risk," and only three of the 13 indicators for the RER were not achieved. During the biennium, the health policies of the countries have given a satisfactory degree of visibility and priority to the issue of human resources for health, given the critical role they play in expanding coverage among vulnerable or remote populations and in implementing the renewed Primary Health Care strategy. In general terms, this period is characterized by a transition from policies toward plans for human resources for health and, through this process, identification and establishment of mechanisms for coordination between the health sector and the higher education sector, and to a lesser extent, with the ministries of finance and labor.

Main Achievements

- The steering capacity of national health authorities in the area of human resources for health has been consolidated by incorporating strategic functions such as planning and consensus-building/negotiation with other sectors and social stakeholders.
- A process of connecting medical residency programs to primary health care has been established. Plans are underway to expand coverage through family and community-based health teams. The First Regional Forum on Human Resources for Health and Indigenous Populations was held. Progress has been made in elevating the level of health work and addressing working conditions.
- Substantive progress has been made in the use of information and communications technologies (ICT) and in cyberlearning networks; the Ibero-American Network on Migration of Health Professionals (RIMPS) was launched. A new modality of Leaders in International Health Program (PLSI) was consolidated, and 31 countries participated in the first 4 years.
- The Expanded Textbook and Instructional Materials Program (PALTEX) was very active during the biennium, providing materials and high-quality basic medical equipment through its 530 service centers in the Region. In 2010/11 alone, its inventory was expanded to include 58 new editions and 93 new titles; the program now has a total of 739 titles. The PALTEX website was redesigned. WHO and the Region of Africa (AFRO) are actively collaborating on the development of an African version of the program (AFRITEX).

Main Challenges

- Coordination among the regional, subregional (including UNASUR), and national policy-making entities for HRH; renewed partnerships between leading countries in HRH issues for horizontal technical and financial cooperation, which would facilitate expansion of South-South cooperation on HRH.
- The resistance of health education sectors, primarily medical education, to the PHC approach; the disappearance of the department of human resources for health of WHO/Geneva.
- The adjustment to the reduction in regional funding, identification of new funding sources, and resource mobilization; identification of funds to support the PLSI and its gradual decentralization toward the countries.

Lessons Learned

The strategy of cooperating through networks such as the HRH Observatory and the Virtual Public Health Campus (VPHC) for the improvement of governance, leadership, and the capacities required for their efficient performance is apt but requires an institutional commitment in the medium/long term in order to ensure their sustainability and gradual decentralization; the strategy of subregional advisers on human resources has yielded good results and significant progress; initiatives such as the Regional Network of Observatories and the PLSI require regular evaluation and updating in order to keep pace with a rapidly changing environment.

SO13 RER Progress Report

RER 13.1: Member States supported through technical cooperation to develop human resources plans and policies to improve the performance of health systems based on primary health care and the achievement of the Millennium Development Goals (MDGs)	**On track**

RER Assessment
(2 out of 2 RER indicators exceeded their 2011 targets)

The indicators reflect that the established objectives have been achieved, although some countries should make an effort to link their milestones with the indicators. The main challenge is to continue to move forward with horizontal cooperation processes that allow countries to share their experiences, and in particular, to learn about and share successful experiences in policy-making and planning.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
13.1.1: Number of countries with national policies for strengthening the health workforce, with active participation of stakeholders and governments.	16	19	23	28	2009 Baseline: BLZ, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GRA, JAM, PAR, PER, PUR, VEN 2011 Target: BOL, GUY, NIC, SAL, URU The target has been exceeded. The three target countries (URU, BOL, NIC) achieved the indicator, as did SAL and GUY. Five more countries made significant progress on their plans for human resources for health, which are in draft form or in the final approval process (ABM, ARG, BAR, DOM, SAV).
13.1.2: Number of countries with horizontal cooperation processes for the fulfillment of regional goals in human resources in health	3	4	5	6	2009 Baseline: BRA, CAN, USA 2011 Target: CUB, ECU The goal has been exceeded. CUB has demonstrated tangible horizontal cooperation initiatives. ECU established the Andean Health Agency as a cooperation mechanism and has achieved the indicator.

RER 13.2: Member States supported through technical cooperation to establish a set of basic indicators and information systems on human resources for health	**At risk**

RER Assessment
(1 out of 2 RER indicators achieved, exceeding its 2011 targets; but 1 not achieved)

In general, significant progress has been made in establishing information systems on HRH with basic indicators. The target for indicator 1 has been achieved. The target was not achieved in indicator 2; nonetheless, the countries included in the target made significant progress, especially Mexico and Guyana. Securing the participation of 31 countries of the Region in the network of observatories is an ambitious objective. Although it was not achieved, progress was made. It is necessary to bear in mind that the observatory initiative is undergoing a process of redefinition, which entails transitioning from an advocacy role to an entity for the management and exchange of relevant information on human resources for health. Still, the indicators reflect a sustained process of countries establishing information systems on human resources for health. The challenge lies in making progress in improving them and in standardizing the information among countries. The regional network of observatories should also be strengthened as a mechanism for cooperation and information exchange.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
13.2.1: Number of countries that have established a database to monitor situations and trends of the health workforce, updated at least every two years	18	23	24	29	2009 Baseline: ARG, BAR, BLZ, BRA, CAN, COL, COR, CUB, DOR, ECU, ELS, FEP, GRA, JAM, MEX, PAR, PER, URU 2011 Target: ABM, GUY, HON, NIC, SAL, TRT The target has been exceeded. Five of the target countries achieved the indicator (HON, NIC, SAL, ABM and TRT), as did GUY.
13.2.2: Number of countries participating in the Human Resources for Health Observatories Network for the production of information and evidence for decision-making	27	31	28	36	2009 Baseline: ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COL, CUB, DOR, COR, ECU, ELS, GRA, GUT, HON, JAM, NIC, PAR, PER, PUR, SAL, TRT, URU, USA, VEN 2011 Target: FEP, GUY, MEX MEX is in the process of setting up its observatory in the coming months. GUY also has shown progress. It is necessary to bear in mind that the observatory initiative is currently undergoing a redefinition process.

RER 13.3: Member States supported through technical cooperation to formulate and implement strategies and incentives to recruit and retain health personnel in order to attend to the needs of health systems based on renewed primary health care	**At risk**

RER Assessment
(1 out of 2 RER indicators achieved, and 1 not achieved)

During the period, the debate over strategies to improve employment conditions and contracts was engaged in nearly all of the countries that have offices of strategic management of human resources for health. The health professions are recognized as one of the primary mechanisms for stabilizing labor relations. In addition to this mechanism, others such as collective agreements are being used. A crucial factor in the development of health career paths has to do with the preceding process of nationalizing the positions, posts, and wages matrix.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
13.3.1: Number of countries that have established a career path policy for health workers	7	10	9	14	2009 Baseline: ARG, BRA, CHI, DOR, ECU, NIC, PAR 2011 Target: COL, GUT, PER Two target countries (GUT, PER) achieved the indicator. GUT has prepared an initial draft of a bill on the health career and has presented it in the National Congress. PER has created a commission to prepare draft legislation. While they have not completely achieved the target, they have made important progress. COL did not pursue any activities in this regard. It is recommended that this initiative be relaunched as long as funding is available to continue this work.
13.3.2: Number of countries with human resources management policies and systems to improve the quality of employment in the health sector	8	13	13	17	2009 Baseline: ARG, BRA, CHI, DOR, ECU, GUY. NIC, PER 2011 Target: BLZ, BOL, COR, ELS, PAR The target has been achieved. The main challenge is to ensure that more countries develop retention and incentives policies tied to the establishment of goals and the functioning of units for strategic management of human resources for health. Financial constraints have hampered a sustained cooperation process, which means that other mechanisms for action are required.

RER 13.4: Member States supported through technical cooperation to strengthen education systems and strategies at the national level, with a view to develop and maintain health workers' competencies, centered on Primary Health Care	**On track**

RER Assessment
(5 out of 5 RER indicator targets achieved, with 2 exceeding their 2011 targets)

Progress is observed in improving health workers' competencies in the countries, and significant achievements have been made with the active involvement of the virtual courses offered through the VPHC, the constant demand for courses coming from a growing number of students, and the opening of country nodes. To date, 31 countries have taken part in the PLSI, with a total of 185 participants. The public health competencies that have been established with groups of institutions and experts contribute to the achievement of this RER and they will guide the countries in their new policies to reorient their training programs. PALTEX and the fellowships program continue to support these learning processes. The countries have made progress in reorienting education toward PHC and several of them, together with professional associations, have signed the "Commitment of Cartagena de Indias" to strengthen this reorientation. Significant progress has also been made in the accreditation of medical education programs and health ministries have engaged educational institutions for joint decision-making on the development of human resources for health.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
13.4.1: Number of countries with joint planning mechanisms between training institutions and health services organizations	9	15	15	23	2009 Baseline: ARG, BRA, CAN, COL, CUB, ECU, GUT, MEX, PER 2011 Target: BLZ, FEP, GUY, HON, JAM, NIC The target was achieved. The countries of the Region, especially BRA and ARG (baseline) have made significant progress in establishing coordination mechanisms between the ministry of health and the ministry of education.
13.4.2: Number of countries with policies that reorient health sciences education towards primary health care	7	10	10	13	2009 Baseline: ARG, BOL, BRA CUB, NIC, PER, VEN 2011 Target: BLZ, ECU, URU The target was achieved. URU has made significant progress in reorienting medical education toward PHC in conjunction with the ministry of education.
13.4.3: Number of countries that have established learning	9	12	12	15	2009 Baseline: ARG, BRA, CHI, COL, COR, CUB, JAM, MEX, PER 2011 Target: ECU, PAR, URU

networks to improve the public health competencies of their staff					The target was achieved. URU, PAR, and ECU have set up their Virtual Public Health Campuses. All the countries of Latin America and some countries of the Caribbean are participating actively in the courses offered by the VPHC. Sufficient progress has been observed in the countries of the Region, which have established some type of virtual network for training and for improving public health competencies. PALTEX supports these processes.
13.4.4: Number of countries participating in the PAHO Leaders in International Health program	20	25	26	25	2009 Baseline: ARG, BLZ, BOL, BRA, CHI, COL, CUB, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PER, SAV, SCN, TRT 2011 Target: ABM, BAH, COR, DOM, FEP, GRA, PAN, PAR, SAL, URU, VEN The target has been exceeded. The five target countries achieved the indicator, as did ABM, COR, DOM, GRE, FEP, and PAN. It is impossible to predict which countries will be the target for this indicator since participation in the PLSI is decided through a competitive selection process. Total number of countries that have participated in the PLSI: 31. The main challenge for 2012 is to have sufficient funding available to support the participants.
13.4.5 Number of countries with accreditation systems for health sciences education programs	13	16	25	20	2009 Baseline:, ABM, ANI, BAR, BLZ, CAN, DOM, GRA, JAM, SAL, SAV, SCN, TRT, USA 2011 Target: ARG, BRA, CHI, COL, COR, FEP, MEX, PAN, PAR The target has been exceeded. In addition to the three target countries (ARG, CHI, and FEP), six other countries achieved it (BRA, COL, COR, MEX, PAN and PAR). Several countries are working on the accreditation of their educational programs, particularly medical

					education. During the biennium, the HR project published a book containing up-to-date relevant information from each country.

RER 13.5: Member States supported with technical cooperation regarding the international migration of health workers	**On track**

RER Assessment
(1 out of 2 RER indicators achieved and 1 not achieved)

Follow-up studies and analyses of the migration of health workers have been carried out in Latin America, the Andean Subregion, parts of the English-speaking Caribbean, and the United States. The three regional targets on human resources that relate to migration were measured to establish the baseline. Two regional studies on the migration of nurses were published. The majority of the countries are familiar with the WHO Code of Practice on the International Recruitment of Health Workers and are committed to enforcing it. The Ibero-American Network of Migration of Health Professionals (RIMPS) has been created, comprising all the countries of Latin America, Spain, Portugal, and Andorra. The regional compilation of migration laws was finalized. Although one indicator of this RER was not achieved (due to nonfulfillment by a single country), enough progress has been made to warrant a positive general assessment.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
13.5.1: Number of countries that analyze and monitor the dynamics of health worker migration	11	15	15	20	2009 Baseline: BLZ, BOL, CHI, COL, COR, ECU, ELS, JAM, PER, URU, VEN 2011 Target: DOR, ELS, NIC, TRT The target was achieved. Sustained progress has been made in several countries, such as BLZ, BOL, CHI, ECU, and PER. In addition, CHI, COR, JAM, URU, COL, and ELS are working in an analysis of personnel migration. Regional processes related to the WHO Code of Practice are in progress.

13.5.2: Number of countries that participate in bilateral or multilateral agreements that address health worker migration	7	10	9	16	2009 Baseline: CAN, COL, JAM, PER, TRT, URU, VEN 2011 Target: BLZ, BOL, ECU ECU and BOL achieved the target. URU participated actively in the creation of the RIMPS. The Andean region defined strategic lines of work. The main regional achievements include the creation of the RIMPS, which includes the majority of the countries of LA, SPA, POR and Andorra, and the commitment of the majority of the countries to the WHO Code of Practice. The main challenge is to achieve the active participation of all countries in both initiatives.

SO14 Progress Report

SO14: To extend social protection through fair, adequate, and sustainable financing					At risk
Budget Overview					
Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$10,274,000	**$4,996,000**	**$1,206,035**	**$6,202,035**	**95%**	**60%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO indicator 1: **Increase in the percentage of population covered by any type of social protection scheme in the Region**
Baseline: 46% in 2003
Target: 60% by 2013

The countries are lagging behind in this indicator. According to data from the period 2010–2011, it is estimated that 47.8% of the population is covered by a scheme for social protection in health. The progress made since 2003 has been very modest; and therefore, it is anticipated that this indicator most likely will not be met by 2013.

SO indicator 2: **Increase in the percentage of public expenditure for health, including primary health care expenditure for the countries where this information is available**
Baseline: 3.1% in 2006
Target: 5% by 2013

The countries are lagging behind in this indicator. In 2010, the countries' public expenditure in health as a percentage of their gross domestic product (GDP) was 4.1%. Countries will require extra support to achieve the target of 5% by 2013. It will be necessary to scale up country efforts and technical cooperation to support achievement of the 5% target by 2013.

SO indicator 3: **Decrease in out-of-pocket expenditures in health as a percentage of the total health expenditure for those countries where this information is available**
Baseline: 52% of the national expenditure in health in 2006
Target: 40% by 2013 (the OECD average for industrialized countries is 20%)

In 2010, out-of-pocket expenditure as a percentage of total health expenditure was 47%. It will be difficult for countries to achieve the 2013 goal. Thus, it will be necessary to scale up country efforts and technical cooperation to support the achievement of this indicator.

2010–2011 Assessment

This SO is rated at risk, with 4 of its 5 RERs on track and 1 at risk. Out of a total of 10 RER indicators, 8 met their 2011 targets. Despite the fact that 8 of these 10 indicators have been achieved, there are still major issues related to the sustainability and quality of processes as well as to the ability to maintain progress into the next biennium. There were challenges in the implementation of this SO throughout the biennium, partly caused by lack of sustainable and sufficient funding, human resource shortages, and insufficient use of health financing information for decision-making.

Main Achievements

- There is now growing interest in health financing issues spurred by the launch of the World Health Report 2010. This has led such countries as Colombia, El Salvador, Haiti, Mexico, Peru, and Uruguay placing the topic of universal coverage and health systems financing on their agenda for discussion.
- Seven country studies (Brazil, Canada, Chile, Colombia, Jamaica, Mexico, and Peru) have been produced on inequalities and inequities in access to and utilization of health services. These studies are key to supporting the evaluation and implementation of policies to reduce health disparities.
- Access to maternal and child health in Haiti has undergone expansion through the implementation of the Free Infant Care (SOG) and Free Obstetric Care (SIG) programs, thanks to substantial financial support from the Canadian International Development Agency (CIDA), through an agreement for $$20 million.
- The majority of countries are producing information on health expenditure and financing on a regular basis, although challenges remain in the use of this information for decision-making.
- Some countries in the Region—such as Guatemala, Panama, and Paraguay—report progress made in the effective use of the aid provided as well as in harmonization and alignment, as demonstrated in a report commissioned by the Core Evaluation Team of the Paris Declaration.

Main Challenges

- There has been little progress made in producing the empirical evidence necessary to increase awareness of the impact of catastrophic health expenditure and its consequences on increasing the financial risk of individual households incurring poverty. It will be necessary to scale up country efforts and technical cooperation, including funding, to support the production of evidence on this topic.
- There is a lack of data to support equity studies in countries where there are great disparities in utilization of and access to health services.
- This SO has suffered from chronic underfunding throughout the biennium and has experienced several challenges related to staff (reassignments, vacancies, and shortages).

Lessons Learned

- The collaborative work developed between the PAHO Country Office in Costa Rica and the regional level in assessing the financial situation of the Costa Rican Social Security System (CCSS) yielded excellent results, providing crucial information for decision-makers in the country.
- Quantitative targets may be achieved in some indicators; however qualitative advances may not be robust enough. For example, countries can develop institutional development plans or design public policies to reduce the financial risk associated with diseases; but the sustainability, efficiency, and quality of these plans and policies remain an issue.

SO14 RER Progress Report

RER 14.1: Member States supported through technical cooperation to develop institutional capacities to improve the financing of their health systems	**On track**
RER Assessment (1 out of 1 RER indicator targets achieved)	
Major achievements were the incorporation of representatives from English-speaking countries into the Network of Health Economic Units (HEU), as well as the implementation of the first Ibero-American Conference of Health Economics Units. As mentioned in the assessment of the RER indicator below, the two target countries for 2010–2011 (Ecuador and El Salvador) have achieved the indicator. Factors hindering progress include changes in government administrations that have resulted in the elimination or loss of support for existing HEU. Costa Rica eliminated its HEU. El Salvador closed down its HEU and has just reopened it over the past six months.	

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
14.1.1: Number of countries with institutional development plans to improve the performance of financing mechanisms	10	12	12	15	2009 Baseline: BAH, BLZ, BRA, CHI, COL, COR, DOM, MEX, PAR, PER 2011 Target: ECU, ELS This target was fully achieved. No major challenges were experienced in this indicator. A Health Economic Unit/ Department has been established at the MoH of Ecuador. In ELS, the Health Accounts group at the MoH has produced up-to-date information on National Health Expenditure Accounts (NHExp).

RER 14.2: Member States supported through technical cooperation to evaluate the relationship between catastrophic expenses in health and poverty; and to design public policies or financing schemes in health to reduce the financial risks associated with diseases and accidents	**At risk**
RER Assessment (1 out of 3 RER indicator targets achieved and 2 not achieved)	
The completion of country case studies on PAHO's framework for assessing the impact of catastrophic health expenditure (RER indicator 14.2.1) was necessary to support development of public policies to eliminate or reduce the financial risks associated with diseases and accidents (RER indicator 14.2.3). Thus, non-achievement of indicator 14.2.1 adversely affected indicator 14.2.3. There has been little progress made in producing the necessary empirical evidence to increase awareness of the impact of catastrophic health expenditure and its consequences on the increasing financial risks of households incurring poverty. An important achievement has been the production and dissemination of seven country studies (Brazil, Canada, Chile, Colombia, Jamaica, Mexico, and Peru) on inequalities and inequities in access to and utilization of health services. Additional resources should be devoted to support activities related to this RER.	

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
14.2.1: Number of completed country studies applying the PAHO evaluation framework to assess household capacity to meet health expenditures	3	5	3	7	The main activities for this indicator were not achieved due to insufficient funding. CHI completed a study using the PAHO framework to assess the catastrophic nature of health expenditures. BOL has begun the study but has not yet completed it.
14.2.2: Number of countries with studies on catastrophic expenses in health, poverty and inequalities	2	3	3	6	2009 Baseline: BRA, CHI 2011 Target: MEX The target was fully achieved. Mexico has completed its study on Equity in Utilization of Health Services and presented the results in a meeting with high-level officials from the Secretariat of Health, the Mexican Social Security Institute (IMSS), and the PWR-MEX.
14.2.3: Number of countries with public policies or financing schemes for the reduction or elimination of the financial risk associated with diseases and accidents	2	4	3	8	2009 Baseline: CHI, URU 2011 Target: DOR, ECU One of the target countries (DOR) has achieved the target in creating social health insurance mechanisms to reduce financial risks; however, efficiency and sustainability remain an issue. ECU did not achieve the target; nonetheless, the issue was included in public policy debate as part of ongoing proposals to restructure the system of public health care services.

RER 14.3: Technical cooperation provided to Member States in the development and use of national health expenditure and health system financing information	**On track**

RER Assessment
(3 out of 3 RER indicator targets achieved,
with 2 exceeding the 2011 target and 1 already having achieved the 2013 target)

Good progress was seen in this RER. A major achievement relates to fact that most countries are now producing information on health expenditure and financing on a regular basis. A major challenge is to increase country capacity to use the results of expenditure studies to support changes in the health system as well as in public policies to achieve universal coverage. Indeed, this is where additional support from PAHO can be crucial, in translating evidence into action. A scaling-down of activities on health and health satellite accounts associated with limited funding and changing priorities during 2012–2013 could hinder the sustainability of these achievements.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
14.3.1: Number of countries reporting up-to-date information on financing and health expenditure to the PAHO's Regional Core Health Data Initiative and WHO's World Health Report's (WHR's) Statistical Annex	29/35	33/35	33/35	35/35	2009 Baseline: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ELS, GUT, GUY, HON, JAM, MEX, NCA, NEA, NIC, PAN, PAR, TRT, URU, VEN 2011 Target: ECU, PER, SAL, SCN All of the 33 countries have achieved the indicator and reported up-to-date information on health expenditure to the WHO annual World Health Statistics consultation process for updating data.
14.3.2: Number of countries that have institutionalized the periodic production of Health Accounts / National Health Accounts harmonized with the UN statistical system	16	21	24	24	2009 Baseline: ABM, ANI, BAR, BRA, CAN, CHI, COL, DOM, ECU, GRA, MEX, PAR, SAL, SAV, SCN, USA 2011 Target: BAH, BLZ, BOL, ELS, GUT, HON, NIC, TRT The target has been exceeded. In addition to the five target countries that achieved the indicator (BAH, BLZ, ELS, GUT, and HON), other countries that have also reached this indicator include BOL, NIC, and TRT.

14.3.3: Number of countries with studies on expenditure and financing of public health systems or social health insurance	N/A	10	11	15	2009 Baseline: N/A 2011 Target: CAN, CHI, DOM, ECU, GRA, HON, PAR, SAL, SAV, SCN, VEN The target was exceeded (11 countries achieved the indicator).
RER 14.4 Member States supported through technical cooperation to reduce social exclusion, extend social protection in health, strengthen public and social insurance, and improve programs and strategies to expand coverage.					**On track**
RER Assessment (2 out of 2 RER indicator targets achieved, with 1 exceeding the 2011 target and even meeting the 2013 target)					
Important progress has been made in this RER in the Region during this biennium. Countries continue to be active in the area of Social Protection in Health (SPH), with Uruguay expanding social protection to priority groups through their National Health Insurance scheme .Haiti expanded access to maternal and child health through the SIG and SOG; and a major achievement for Haiti has been the approval of a $20 million project funded by Canada for free access to health care to pregnant women and children under 5. PAHO continues to provide strong leadership in the field of SPH; however, additional human resources are needed to keep up with activities at the regional, subregional and country levels.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
14.4.1: Number of countries with insurance schemes and other mechanisms to expand social protection in health	10	11	12	12	2009 Baseline: ARG, BAR, BRA, CHI, COL, COR, ECU, MEX, NEA, PER 2011 Target: BLZ, HAI The target was exceeded. HAI has successfully implemented both its SOG and SIG, thus having financing schemes in place for providing free obstetric and pediatric services under a contract management model.
14.4.2: Number of countries with updated information to formulate policies for the expansion of social protection in health	13	15	15	16	2009 Baseline: BOL, BRA, CHI, COL, DOR, ECU, GUT, HON, MEX, NIC, PAR, PER, VEN 2011 Target: COR, ELS The target was fully achieved. COR and ELS have substantially improved information models that can be applied to policy formulation. In COR, a recent study made it possible to update information on the funding situation of the Costa Rican Social Security System (CCSS). ELS updated its study on social exclusion in health.

RER 14.5: Member States supported through technical cooperation to align and harmonize international health cooperation	**On track**

RER Assessment
(1 out of 1 RER indicator targets achieved)

A report commissioned by the Core Evaluation Team of the Paris Declaration (PD) found that the effectiveness of aid has improved only to a certain extent, and there are still measures that need to be addressed to improve the overall contribution of development aid in the Region. In Panama, the general perception is positive: aid has been more effective; aid management has improved; cooperation with donors has been more inclusive and effective. Panama feels that the PD has helped strengthen national institutional capacities; support the strengthening of social capital; and contribute to efforts to reduce exclusion, gender equality, and the achievement of better development results at the national level. Guatemala also shows progress in these fields. In other countries, respondents see limited or no progress at all made to improve gender equality, support institutional strengthening, and reduce exclusion—not to mention the achievement of better development results in general. In the case of Honduras, for example, respondents indicate that the effectiveness of aid has not improved over the past five years, and most respondents say an adverse political context has limited aid effectiveness. The same is the case in Haiti, where the effectiveness of the aid provided has been aggravated in the aftermath of the earthquake and the complex dynamics of the subsequent response.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
14.5.1: Number of countries that show improvement in levels of harmonization and alignment of international health cooperation, as measured by internationally agreed standards and instruments	5	7	7	8	2009 Baseline: BLZ, BOL, HAI, HON, NIC 2011 Target: GUT, PAN The two target countries (GUT and PAN) achieved the indicator. Sustained progress also was made in BLZ, HON, and NIC. HAI was dropped from the baseline. ELS also reports substantive contributions to this RER indicator.

SO15 Progress Report

SO15: To provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the United Nations system and other stakeholders to fulfill the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO's Eleventh General Programme of Work, and the Health Agenda for the Americas	On track

Budget Overview

Approved Budget (PB 2010–2011)	Funds Available			Expenditure (%)	Funded (%)
	RB	OS	Total		
$74,885,000	$65555000	$9,749,753	$75,304,753	93%	101%

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

SO Indicator 1: **Number of countries implementing at least 30% of health policy-related resolutions adopted by the Pan American Sanitary Conference and the PAHO Directing Council during the 2007-2011 period**
Baseline: 0 countries in 2007
Target: 19 countries by 2013

The target was exceeded, with almost all countries of the Region implementing resolutions adopted by PAHO's Governing Bodies, considering that 60% of its resolutions are related to health policy resolutions.

SO indicator 2: **Number of countries reporting a Country Cooperation Strategy (CCS) agreed upon by the government, with a qualitative assessment of the degree to which PAHO/WHO resources are harmonized with partners and aligned with national health and development strategies**
Baseline: 0 countries in 2007
Target: 30 countries by 2013

The target was exceeded, with 34 countries and territories having a Country Cooperation Strategy developed at the end of 2011. During 2010–2011, in addition to the new CCS developed, 9 countries had updated their CCSs.

SO indicator 3: **Number of countries in Latin America and the Caribbean that achieve the "Official Development Assistance for Health" targets of the Paris Declaration related to harmonization and alignment, as adapted by WHO and its partners**
Baseline: 0 countries
Target: 5 countries by 2013

A total of 11 LAC countries have developed country reports on their advancements in promoting the aid effectiveness agenda, using the targets from the Paris Declaration that were presented in at the High-Level Forum on Aid Effectiveness in Busan, Republic of Korea, in 2011.

2010–2011 Assessment

This SO is rated as being on track, with 3 out of 3 RERs on track, and 14 of its 15 RER indicator targets achieved.

The areas included in this SO are leadership and governance: i.e., PAHO's presence in the countries to provide technical cooperation and the Organization's relationship with both the UN system and the international community. PASB performance to accomplish this SO was positive and achieved its targets during the 2010–2011 biennium; but the PASB will need to continue working over the next biennium to scale up achievements. Some major achievements are the following: PAHO's presence at international high-level meetings was enhanced through technical participation in preparatory meetings, which was reflected in their declarations or resolutions that included health issues; PAHO's relationship with major partners (CAN, Spain, and USA) has been strengthened; and PAHO has made significant progress in establishing and maintaining good collaboration with a broad range of civil society partners. PAHO's engagement in the UN reform process was enhanced during this biennium through the Organization's active participation in the preparation of the new UN Development Assistance Framework (UNDAF) in the Region.

Main Achievements

- The leadership of PAHO as part of the UN system has been effective at both regional and country levels on health cluster and alignment and harmonization issues.
- All Country Teams have at least two international technical staff members. Further decentralization and/or strengthening of PAHO's country presence was achieved in the Caribbean subregion.
- Latin America and the Caribbean was fully involved at the United Nations High-level Meeting (NHLM) on Noncommunicable Diseases (NCDs), a fact that reflects the priority of NCDs in the agenda at country, subregional, and regional levels.
- Technical and financial resources mobilized from traditional and non-traditional partners include three key bilateral strategic partners (AECID, CIDA, and USAID) amounting to over US$70 million over a three-year period (2011–2013).

Main Challenges

- There is a lack of adequate financing to guarantee core country presence aimed at ensuring appropriate human resources to deliver technical cooperation programs within the framework of the Country Cooperation Strategy.
- There is also a lack of a proper Resource Mobilization Strategy targeting both the international community and national resources.
- Engagement with private sector companies that are deemed harmful to public health is weak; greater efforts need to be made to persuade them to improve their business models.
- Another weakness lies in the Pan American Health and Education Foundation's (PAHEF's) alignment with PAHO's mission.
- PAHO needs to work at greater participation in the UNDP's Multi-donors Trust Fund (MDTF) now available for the Region.
- PAHO's capacity to support LAC countries activities in South-South and triangular cooperation is weak.

Lessons Learned

- Further reiterations of CCS processes have resulted in a greatly improved strategic agenda, providing opportunities to contribute to a better formulation of PAHO's next Strategic Plan.
- Sustaining a strategic dialogue with our partners involves much more than holding well-staged, well-scripted public meetings.
- The CCS can provide valuable input for the United Nations Development Assistance Framework (UNDAF) process, especially to include health issues in the UN agenda at country level.

SO15 RER Progress Report

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

RER Assessment
(4 out of 5 RER indicator targets achieved)

The overall performance of the PASB on this RER is positive, considering the progress made by their various entities: Governing Bodies (GBO); External Relations and Partnerships (ERP); Internal Oversight and Evaluation Services (IES); Gender, Ethnicity, and Human Rights (GDR); and Legal (LEG). The target for indicator 15.1.5 was not achieved (as in the previous assessment) because 26 entities need to link to this indicator. Nevertheless, the 17 entities that are linked to this RER indicator achieved their targets. Hence, PASB is on track to achieve this expected result by the end of the period dealt with in the PAHO Strategic Plan 2008–2012.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
15.1.1: Percentage of PAHO Governing Bodies resolutions adopted that focus on health policy and strategies	45%	50%	60%	55%	Of the resolutions adopted by the PAHO Directing Council, 60% are directly related to public health policy and strategies.
15.1.2: Percentage of all oversight projects completed which evaluate and improve processes for risk management, control, and governance	35%	70%	70%	90%	The number of oversight assignments is on track for the second of three biennia. With its current level of resources, PASB fully expects to continue meeting this target.
15.1.3: Number of PASB entities implementing leadership and management initiatives (coordination and negotiation of technical cooperation with partners, technical cooperation among countries [TCC], advocacy for the PAHO/WHO mission,	57/69	61/69	61/69	69/69	The target was achieved by 80% of these entities by the end of the biennium.

and Biennial Workplans, and reports) on time and within budget					
15.1.4: Percentage of Governing Bodies and Member States legal inquiries addressed within 10 working days	90%	95%	95%	100%	PASB has worked to ensure proper implementation of PAHO's rules and regulations. Highlights include the following PASB achievements: • provided support for EXM's examination, evaluation, and strengthening of PAHO Regional Pan American Centers • provided support to PAHO Technical Units, PWRs, and Member States in the development of international health law • facilitated improved relations with subregional entities • expanded and promoted PAHO's Revolving and Strategic Funds • negotiated favorable new terms in agreements made with the countries
15.1.5: Number of PASB entities that have linked each cross-cutting priority to at least 30% of their products and services in their Biennial Workplans	N/A	40/54	18/54	54/54	PASB has put forth considerable effort for this indicator. Nevertheless, greater support is needed.

RER 15.2: Effective PAHO/WHO country presence established to implement the PAHO/WHO Country Cooperation Strategies (CCS) that are (1) aligned with Member States' national health and development agendas, and (2) harmonized with the United Nations Country Team and other development partners	**On track**

RER Assessment
(6 out of 6 RER indicator targets achieved)

PASB has continued in its work to guide Country Offices through a comprehensive framework that will guarantee PAHO's effective and efficient presence in the countries. Overall, the Organization's strategic country presence has been monitored and supported by the EXM level. This has resulted in better availability of the relevant human resources, delivery of, technical cooperation, and better enablement of functions at country level, consistent with the Country Focus Policy.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
15.2.1: Number of countries using Country Cooperation Strategies (CCS) as a basis for defining the Organization's country presence and its respective Biennial Workplan	30	32	34	35	2009 Baseline: ABM, ANI, ARG, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ELS, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, TRT, URU, VEN 2011 Target: BAH, CAN, ECU, SUR The target was exceeded, with two additional countries both achieving it. In addition to the new CCS developed, nine countries updated their CCSs.
15.2.2: Number of countries where the CCS is used as reference for harmonizing cooperation in health with the UN country teams and other development partners	30	32	34	35	2009 Baseline: ABM, ANI, ARG, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ELS, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, TRT, URU, VEN 2011 Target: BAH, CAN, ECU, SUR There has been an increasing alignment between CCSs and the UNDAFs.

15.2.3: Number of countries where the Biennial Workplan (BWP) is evaluated jointly with government and other relevant partners	20	30	31	35	2009 Baseline: ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, HON, GUT, GUY, JAM, NIC, PAN, PAR, PER, TRT, URU 2011 Target: ABM, ANI, BAH, BAR, DOM, GRA, MEX, NEA, SAV, SAL, SCN The joint evaluation with counterparts is carried out with precise regularity by all PAHO Country Offices. Based on their area of competence, PASB entities will continue to join all these evaluation processes selectively, either virtually or physically.
15.2.4: Number of PASB subregions that have a Subregional Cooperation Strategy (SCS)	1/5	3/5	3/5	4/5	The Health Agenda for Central America remains in force, and the respective strategic plan is undergoing implementation. The MoU with MERCOSUR is being implemented. The Subregional Cooperation Strategy (SCS) for the Caribbean has been released and serves as the framework for technical cooperation programs in the Caribbean. There is a SCS for both the Andean and the Caribbean subregions.
15.2.5: Number of PASB country and subregional entities with improved administrative support, physical infrastructure, transport, office equipment, furnishings, and information technology (IT) equipment as programmed in their Biennial Workplans	25/29	27/29	27/29	29/29	PASB devotes considerable funding to improve buildings and maintain/ improve IT infrastructure and other operational activities that aid in delivering technical cooperation.

15.2.6: Number of PASB country and subregional entities that have implemented policies and plans to improve personnel health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) compliance	25/29	27/29	27/29	29/29	This indicator covers not only security but a variety of non-physical procedures and practices to improve staff conditions. From HQ level, PASB has provided funds to 13 PWRs, with one more pending.
RER 15.3: Regional health and development mechanisms established, including partnerships, international health, and advocacy, to provide more sustained and predictable technical and financial resources for health in support of the Health Agenda for the Americas					**On track**
RER Assessment (4 out of 4 RER indicator targets achieved)					
As an ongoing RER, performance on the part of PASB entities has remained positive during 2010–2011. In 2011, UNDAF documents were signed in the Dominican Republic, El Salvador, Honduras, Jamaica, and Peru—with PAHO's active participation as part of the United Nations Country Team (UNCT). Health was reflected on these UNDAFs, constituting the framework for UN work at country level. Belize, Bolivia, Colombia, Costa Rica, Cuba, Mexico, and Nicaragua are on track to finalize their UNDAFs by the deadline expected and have started planning for new UNDAF funding in 2013.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
15.3.1: Number of countries where PAHO/WHO maintains its leadership or active engagement in health and development partnerships (formal and informal), including those in the context of the United Nations System reform	27/27	27/27	27/27	27/27	PASB achieved this target by the end of the biennium in all 27 country offices.
15.3.2: Number of agreements with bilateral and multilateral organizations and other partners, including UN agencies, supporting the Health Agenda for the Americas	10	17	17	25	PASB finalized extra-budgetary funding agreements with three of PAHO's key bilateral strategic partners (AECID, CIDA, and USAID), amounting to over $50 million over a three-year period (2011–2013). PASB has made significant progress in establishing and maintaining good collaboration with a broad range of

					civil society partners: e.g., the American Public Health Agency (APHA); faith-based organizations such as the Brothers of Charity, the Church of Jesus Christ of the Latter-day Saints (LDS), and the Seventh Day Adventist Church—as well as with the Global Health Council and various 'think tanks.'
15.3.3: Percentage of Summit's Declarations reflecting commitment in advancing the Health Agenda for the Americas 2008–2017	50%	70%	70%	75%	During the past biennium, subregional, regional, and global summits have all reflected a commitment to health. A relevant sample of this was the United Nations General Assembly Special Session on the on the Prevention and Control of Noncommunicable Diseases (UNGASS on NCDs), which was held in New York. PAHO and LAC countries were well represented in this event, with active participation.
15.3.4: Percentage of country requests for PAHO support to mobilize technical and financial resources from external partners, which PAHO has fulfilled	85%	90%	90%	95%	Country requests for support for development proposals were processed as a matter of course to provide ongoing services. It is noteworthy that the time needed to complete reviews has declined by 30% over the past few years.

SO16 Progress Report

SO16: To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carryout its mandate more efficiently and effectively					On track
Budget Overview					
Approved Budget (PB 2010–2011)	**Funds Available**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
$86,275,000	**$63,373,000**	**$38,337,817**	**$101,710,817**	**96%**	**118%**

Progress made towards achieving the SO by 2013

Progress made towards achieving the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012

***SO indicator 1*: Percentage of Region-wide Expected Results (RERs) achieved under Strategic Objectives 1–15, as measured by the RER indicators**

Baseline: N/A
Target: 80% of RERs achieved by 2013

The number of RERs on track increased from 76% in 2008–2009 to 87% in 2010–2011. Regarding the RER indicator targets, 88% were achieved at the end of 2009 and 90% at the end of 2011. At this rate, it is expected that the Organization will meet the target for 2013. However, it is important to note that the gains made during previous biennia need to be maintained; and the challenges affecting progress in RERs at risk and in trouble also need be addressed during 2012–2013.

***SO indicator 2:* Cost-effectiveness of the enabling functions of the Organization, as measured by the percentage of the total PAHO budget represented by this SO**
Baseline: 17% in 2006-2007 biennium
Target: 15% by 2013

In 2010–2011, SO16 had 17.5 % of the total funds available for the biennium ($599.1 million). This represented a 20.2% reduction compared to 2008–2009, despite the fact that there were major projects (i.e. the PASB Management Information System [PMIS]), with significant funding programmed under this SO.

2010–2011 Assessment

This SO is on track with all 6 of its RERs on track, and 29 out of 30 RER indicator targets achieved during the biennium. Overall, SO 16 has been successful in reaching its targets for this biennium, as can be seen below in the main achievements. However, major challenges lay ahead with the preparation, migration and implementation of the PMIS and the simultaneous improvement of all relevant processes. Also, in a period of tight budgets, the continued emphasis on Results-Based Management (RBM)—with the introduction of Enterprise Risk Management (ERP)—should ensure the most efficient use of resources to attain our Expected Results, as stated in the PAHO Strategic Plan 2008–2012.

Main Achievements

- International Public Sector Accounting Standards(IPSAS) implemented; online RBM Training held; Program Budget (PB) 2012–2013 approved by PAHO's 51st Directing Council.
- Unqualified Audit Opinion for 2010.
- Successful and continual improvement of the Performance Monitoring and Assessment (PMA) process.
- An increased percentage of Voluntary Contributions that are not earmarked.
- Human Resources Planning Methodology improved for the entire organization; time frame for selection process shortened.
- Enterprise Risk Management Plan (ERP) approved by EXM.
- Increased consultation on the part of the Ethics Office.
- Consolidation of the PAHO Domain with the PAHO private network making significant progress over this biennium, with the majority of staff appearing to be satisfied with managerial and administrative support services; continuous improvement of PAHO physical infrastructure throughout the Region, thus improving the safety and security of all PAHO employees.

Main Challenges

- Preparation, migration, and implementation of the PASB Management Information System (PMIS).
- Maintaining operations while recruiting two top managerial positions in administration (Human Resources Management and Information and Technology Systems) for about half of the biennium.
- Implementation of the Enterprise Risk Management Plan throughout the Organization as a management tool for all entities.
- Quality of translations a continued area of concern due to the departure and turnover of translation staff.

Lessons Learned

- Need to continue engaging administrators through periodic meetings of the Administrative Optimal groups that make up the engine that runs the administrators' network.
- More direct customer feedback through surveys or automated systems that gather responsiveness more efficiently and objectively to be encouraged for managerial and administrative support services.
- Need to establish a follow-up system for recommendations for all audits, Country Office and Center transfers, and CCSs.

SO16 RER Progress Report

RER 16.1: PASB is a results-based organization, whose work is guided by strategic and operational plans that build on lessons learned, reflect country and subregional needs, are developed jointly across the Organization, and are effectively used to monitor performance and evaluate results	**On track**
RER Assessment (5 out of 5 RER indicator targets achieved, with 2 exceeding their 2011 targets)	
The online training for PAHO's Results-based Management framework was implemented and available for PASB personnel training. The new PAHO Program and Budget 2012–2013 (PB 2012–2013) was approved by PAHO's 51st Directing Council, with an increase of 3.2% in assessed contributions. The goal of 100% progress made towards resource reallocation goals among the three PASB levels per PAHO Regional Program Budget Policy was achieved. Approximately 90% of the PASB entities achieved over 75% of their OSERs. All (100%) of the	

Performance Monitoring and Assessment Reports were presented on time to the PASB/EXM. RER 16.1 was fully achieved, as measured through the achievement of all RER indicators targets as shown below. We think that this RER will be fully achieved at the end of 2013 if performance is maintained at the high level that it is now.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
16.1.1: PAHO's Results-Based Management (RBM) framework implemented	RBM framework approved by EXM	PASB personnel training in RBM completed	Training completed	RBM Framework Implemented	Online training for RBM as been available since June 2011. In addition, other training was provided through a range of blended approaches over the past biennium. This includes face-to-face training supporting the Biennial Workplans (BWPs) and Performance Monitoring and Assess-ment (PMA) preparation, as well as several virtual training sessions via Elluminate.
16.1.2: The PAHO Strategic Plan (SP), and Program and Budget documents (constructed with the RBM framework, taking into account the country-focus policy and lessons learned, and with the involvement of all levels of PAHO) are approved by the Governing Bodies	PB 2010-2011 approved by PAHO Governing Bodies	PB 2012-2013 approved by PAHO Governing Bodies	Yes	SP 2013-2017 approved by PAHO Governing Bodies	The PB 2012–2013 (constructed within the RBM framework, taking into account the country-focus policy and lessons learned, and with the involvement of all PAHO levels) was approved by PAHO's 51st Directing Council.
16.1.3: Percentage of progress made towards resource reallocation goals among the three PASB levels, per PAHO Regional Program Budget Policy (RPBP)	67%	100%	100%	100%	The RPBP was fully implemented for the Regular Budget (RB). While the policy only applied to the RB, it was also used to guide the allocation of Voluntary Contributions (VC) funds, to the fullest extent possible.
16.1.4: Percentage of PASB entities that achieve over 75% of their OSERs	50%	75%	90%	90%	Some 62 entities (90%) achieved at least 75% of their OSER indicator targets.

16.1.5: Percentage of performance monitoring and assessment reports on expected results contained in the Strategic Plan and Program Budget documents submitted in a timely fashion to the PASB Executive Management, following a peer review	80%	90%	100%	100%	All (100%) of the PMA reports have been provided in a timely fashion.

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

RER Assessment
(6 out of 6 RER indicator targets achieved, with 3 exceeding their 2011 targets)

During the 2010–2011 biennium, significant progress has been made in achieving the targets regarding the RER 16.2 indicators for the 2010–2011 biennium. Some achievements include the following:

- Completion of the first IPSAS-compliant Financial Statements, with a total revenue of $932 million and an unqualified audit opinion.
- Achievement of the target of 75% of the Strategic Objectives received over 75% of their budgeted amounts.
- Finalization of VCs agreements with PAHO's three key bilateral partners (AECID, CIDA, and USAID).
- Reduction of VC funds returned to partners from 0.8% in 2008–2009 to 0.5% ($1.5 million) in 2010–2011, thereby exceeding the 2011 target of 0.70%.
- 89% budget implementation achieved by over 80% of entities (56 out of 69) during 2010–2011, with an overall budget implementation for the Organization for this biennium of 89%.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
16.2.1: International Public Sector Accounting Standards (IPSAS) implemented in PAHO	IPSAS approved by Member States	IPSAS implemented	Yes	IPSAS implemented	PAHO transitioned from United Nations System Accounting Standards (UNSAS) to IPSAS beginning on 1 January 2010. The statements for the 2010 financial reporting period were prepared, for the first time in accordance with IPSAS.
16.2.2: Percentage of strategic objectives meeting at least 75% of their unfunded gap at the end of the biennium	50%	60%	75%	70%	Some 75% of the SOs exceeded 75% of their budgeted amounts. SOs 2 (39%), 10 (45%), 13 (65%), and 14 (60%) did not meet this level of funding.

16.2.3: Percentage of Voluntary Contributions that are not earmarked (funds that are flexible with restrictions no further than the SO level)	10%	13%	44%	15%	PAHO finalized VCs agreements with our three key bilateral partners (AECID, CIDA, and USAID), utilizing a programmatic approach that amounts to over $78 million over a three-year period (2011–2013). The actual percentage of VCs that are not earmarked is 44% for 2010–2011, which exceeded the target.
16.2.4: Percentage of PAHO Voluntary Contribution funds (both earmarked and not earmarked) returned to partners	0.80%	0.7%	0.5%	0.5%	The total funds returned to partners during 2010–2011 (i.e., up to 31 December 2011) was $1.5 million. Thus, the amount returned to partners represents 0.5% of the total funds available.
16.2.5: Sound financial practices as evidenced by an unqualified audit opinion	Unqualified audit opinion	Unqualified Audit Opinion	Yes	Unqualified audit opinion	PAHO has received an unqualified audit opinion on the 2010 IPSAS-compliant Financial Statements. Financial Statements for 2010 were presented to the Governing Bodies at PAHO's 51st Directing Council.
16.2.6 Percentage of PASB entities that have implemented at least 90% of their programmed amount in their Biennial Workplans	75%	80%	80%	90%	Over 80% (56 entities) implemented at least 90% of their program budget in 2010–2011.
RER 16.3: Human resource policies and practices promote (a) attracting and retaining qualified people with competencies required by the Organization, (b) effective and equitable performance and human resource management, (c) staff development, and (d) ethical behavior					**On track**
RER Assessment (5 out of 5 RER indicator targets achieved, with 2 exceeding their 2011 targets)					
Notwithstanding the departure of the Human Resources Manager in February 2011, coupled with the heavy workload faced by that Area, all indicators were met under RER 16.3. Significant changes were made with the development and implementation of important policies and workflows (e.g., HR Plans). These have had a significant and positive impact on the Organization. The major challenge faced by the department in the coming biennium is the implementation of the HR Module in the PMIS project. HRM will continue to focus its efforts on its role as a strategic partner within the Organization, developing talent for management through a succession of planning practices.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
16.3.1: Percentage of PASB entities with human resource plans approved by Executive Management	75%	98%	98%	100%	The planning process has improved considerably, with active participation from PAHO Technical Areas and Country Offices. This is in large part due to the new planning tool. HR plans that were not yet finalized require further discussions with EXM due to ongoing structural changes.
16.3.2: Percentage of staff assuming a new position (with post description–based competency) or moving to a new location during a biennium in accordance with HR strategy	50%	70%	100%	75%	This target was exceeded, as the percentage achieved was 100%. All staff assuming new positions were competency based and hired in accordance with the individual Plans and according to the approved HR Strategy.
16.3.3: Percentage of Selection Committees working with new framework approved by EXM, which includes psychometric evaluation for key positions	100%	100%	100%	100%	The target was achieved for all advertised managerial positions at the P-5 level and above.
16.3.4: Percentage of PASB workforce that has filed a formal grievance or been the subject of a formal disciplinary action	<1%	<1%	<1%	<1%	The target was achieved. At the end of 2011, the PAHO Board of Appeals (BOA) had five appeal cases pending—all of which are ready for consideration—and a recommendation by the BOA, which is less than 1%. With the implementation of new procedures for the BOA, we anticipate that these five cases will be resolved quickly and any new cases filed will move forward.
16.3.5: Number of queries received per year raising ethical issues that reflect a higher level of awareness regarding ethical behavior	80	120	160	150	In 2011, the PAHO Ethics office received a total of 95 consultations; and in 2010, 65 consultations—for a grand total of 160 consultations during the 2010–2011 biennium.

RER 16.4: Information systems management strategies, policies and practices in place to ensure reliable, secure and cost-effective solutions, while meeting the changing needs of the PASB	**On track**

RER Assessment
(3 out of 3 RER indicator targets achieved)

The Domain Consolidation and PAHO Private Network rollouts continued, with estimated completion dates of 1st and 3rd quarters 2012, respectively. Extensive resources have been spent rolling out the new Intranet. These projects have provided support for achieving the ta indicated in this RER. ITS has also announced the first step for an ICT Improvement of Services Plan that includes a new service request tool for all Country Offices and Regional Pan American Centers, as well as improved project management tools. These initiatives will further facilitate the progress made in these indicators, as well as achievement of the indicator targets.

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
16.4.1: Percentage of significant IT-related proposals, projects, and applications managed on a regular basis through portfolio management processes	40%	60%	60%	80%	This target has been achieved, with BIREME being the only one not able to accomplish its goals.
16.4.2: Level of compliance with service level targets agreed upon for managed IT-related services	50%	60%	60%	75%	The majority of countries have met their service level targets, assisted by the improvements in infrastructure and telecommunications efforts currently being rolled out by ITS.
16.4.3: Number of PAHO/WHO country and subregional entities, and Regional Pan American Centers using consistent, near real-time management information	35/35	35/35	35/35	35/35	All offices continue to have consistent near real-time manage-ment information. This is also being continuously strengthened by im-provements in the telecommunications infrastructure now being implemented in all Country Offices and Regional Pan American Centers.

RER 16.5: Managerial and administrative support services, including procurement, strengthened to enable the effective and efficient functioning of the Organization					**On track**
RER Assessment (5 out of 5 RER indicator targets achieved, with 2 exceeding their 2011 targets)					
All service-oriented entities included in this RER have measured their progress through customer feedback. This customer feedback was measured through surveys, transactions, and use of established policies. Using this variety of feedback indicators, the RER has met the indicator targets for 2011. However, in the future, more direct customer feedback through surveys or automated systems that gather responsiveness more efficiently and objectively will be encouraged. Significant changes have been made in the procurement area to respond to the evolving needs of the Organization in terms of purchasing and contracting activities.					
RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
16.5.1: Level of user satisfaction with selected managerial and administrative services (including security, travel, transport, mail services, health services, cleaning, and food services), as measured through biennial surveys	Medium (satisfac-tion rated 50%-75%)	High (satisfaction rated over 75%)	75%	High (satisfaction rated over 75%)	The target was at least 75% achieved in selected services(Cafeteria, Cleaning, Travel Services, and Mail Room) at PAHO/HQ, as per the results of periodic surveys involving all HQ staff.
16.5.2: Percentage of standard operating procedures utilized by PASB personnel during regional emergencies	50%	75%	100%	100%	All countries declaring a disaster situation, activating Special Emergency Procedures (SEP), and requesting ext-ensions did so in accordance with PAHO/WHO e-Manual Chapter X.11 on “Crisis Operations.”
16.5.3: Percentage of internal benchmarks met or exceeded for Translation Services	70%	75%	100%	80%	All (100%) of translateion requests were handled in a timely manner. Quality control levels are not adequate, however. Computer-assisted translation tools are not maintained properly due to staff attrition.

16.5.4: A new procurement management system implemented to measure and monitor compliance with procurement best practices, including targeted training, improved statistical reporting and expanded bidder lists, service-level agreements, and procedural improvements	Guiding principles elaborated	Business rules elaborated	Yes	Procurement management system implemented	The Guiding Rules and Business Rules were elaborated. Procurement policies, procedures, and systems were reviewed; and accountability tools, implemented. The next step is the implementation and dissemination of the new policies and procedures. When it comes to systems, several improvements have been made in our current system (ADPICS) to allow us to measure performance and implement the E-tendering system to ensure alignment with best procurement practices. Training was also carried out.
16.5.5: Percentage of PASB internal requests for legal advice and services acted upon within 10 working days of receipt	90%	95%	95%	100%	LEG receives and responds to more than 1,000 legal inquiries a year. It is currently in the process of developing a new LEG e-process to enter queries. This automated system will enable LEG to improve its response time by better tracking and assigning inquiries. The direct and constant interactions with internal clients will help LEG deliver a truly enhanced customer service experience.
RER 16.6: PASB strengthened through institutional development reforms and a physical working environment that is conducive to the well-being and safety of staff					**On track**
RER Assessment (5 out of 6 RER indicator targets achieved, with 1 exceeding its 2011 target)					
This RER has been very successful in all the issues dealing with the physical working environment, infrastructure, and employee health. Since the new PMIS system will incorporate the competency assessment and individual learning plan modules, a decision was made to wait for the implementation of the new HR system, which will provide for the integration of these capabilities within the Personnel Performance Evaluation System for employees (PPES). This made indicator 16.6.6 incomplete.					

RER Indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments
16.6.1: Corporate performance scorecard implemented	Scorecard developed	Scorecard implemented	Yes	Scorecard implemented	The corporate per-formance scorecard was implemented during 2010.
16.6.2: Percentage of contracts under the PASB infrastructure capital plan for approved project(s) for which all work is substantially completed on a timely basis	100%	100%	100%	100%	This target was completely achieved (100%), which is equivalent to eight projects completed on a timely basis. Pictures were presented to Member States at PAHO's 51st Directing Council in September 2011 (BLZ, CHI, ELS, GUY, HAI, NIC, PAN, TRT).
16.6.3: Percentage of HQ and Regional Pan American Centers physical facilities that have implemented policies and plans to improve personnel health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) compliance	75%	80%	80%	100%	As per the recent report submitted by UNDSS/NY, PAHO/HQ and Regional Pan American Centers have applied policies and plans to improve safety and security in the workplace.
16.6.4: Percentage of PASB regional entities and PAHO Regional Pan American Centers that improve and maintain their physical infrastructure, office equipment, furnishings, information technology equipment and transport, as programmed in their Biennial Workplans	90%	95%	100%	100%	Money and staff time has been dedicated to improve the operating environment at PAHO/HQ, through AM departments, and at all the PAHO Country Offices through the PWRs. ITS provided new computers and software for all PWRs and for HQ. The Master Capital Investment Fund and the Holding Account focused on major building projects, ranging from the newly constructed Emergency Operations Center (EOC) at HQ to renovations for newly relocated PWR offices or repairs to existing ones. As part of the Holding Account, the MOSS Project provided radios, satellite phones, and security upgrades at numerous PWRs.

16.6.5: Number of HR policies and practices that address work-life balance, health, and safety of the PAHO workforce developed and implemented	6	10	10	14	The following 10 programs were implemented: (1) Free Yoga Classes (2) Sport Club Open House (3) Gym Discounts (4) Cope and Thrive sessions (5) Cope and Thrive sessions (6) Cope and Thrive sessions (7) Cholera in Haiti (8) Time for your flu shot flyer (9) Domestic Violence Awareness Event (10) Pandemic Influenza
16.6.6: New HR performance planning and evaluation system Implemented that enables effective performance management and integrated with the PAHO Strategic Plan	Software purchased and imple-mentation plan in place	Implement-ation in all PAHO entities linked to Staff Development Plans	No	360-degree evaluations implemented	In view of the fact that the new PMIS system will incorporate the competency assessment and the individual learning plan modules, a decision was made to wait for the implementation of the new human resource (HR) system, which will provide the integration of these capabilities with the PPES.

RER INDICATOR TARGETS NOT ACHIEVED IN 2010–2011

RER indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments[6]
1.1.2: Percentage of municipalities with vaccination coverage level less than 95% in Latin America and the Caribbean (DPT3 as a tracer using baseline of 15,076 municipalities in 2005)	44%	34%	42%	32%	Although a 2% decrease was observed between 2009 and 2011, it is expected that data revised in mid-2012 should demonstrate a decline in the number of low-coverage municipalities.
1.3.1: Number of countries that have eliminated leprosy at national and sub-national levels as a public health concern	17/24	19/24	18/24	24/24	This indicator was short one country to achieve the 2011 target. Despite the fact that 2 additional countries achieved the indicator target, one country fell from the baseline.
1.3.4: Number of countries with Domiciliary Infestation Index by their main *Triatominae* vectors lower than 1%	11/21	15/21	12/21	18/21	This indicator was short 3 countries to achieve the 2011 target. Despite the fact that 3 additional countries achieved the indicator target, 2 fell from the baseline. The gap to meet the 2013 target is noted.
1.6.1: Number of countries that have achieved the core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005)	0	17	0	25	The absence of a global assessment tool prevented a comprehensive measurement of progress made on all the IHR requirements. Countries are considering requesting an extension of the May 2012 deadline to meet core capacities. This indicator was modified in 2009 in the amended version of the Strategic Plan, both to make it more specific and to measure achievement of core capacities rather than their assessment—thereby making it more challenging to meet. Since no country achieved this RER indicator target by the end of 2011; and considering the extensions being requested by the countries for implementing IHR requirements, it

[6] Additional details on each indicator are provided in the SO Progress Reports in Annex I.

RER indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments[6]
					is unlikely that this indicator target will be met by 2013.
2.1.2: Number of countries that provide antiretroviral treatment to at least 80% of the population estimated to be in need as per PAHO/WHO guidelines	7	12	9	15	In addition to the 9 countries with 80% coverage, there are 5 countries that have achieved a coverage of between 70% and 79%. The change in WHO guidelines increased the number of persons requiring treatment at an earlier stage, thereby making this indicator target more challenging to achieve. The gap to achieve the 2013 target doubled from 3 to 6 countries.
2.1.5 Number of countries with a treatment success rate of 85% for tuberculosis cohort patients	11/27	16/27	9/27	23/27	Despite the fact that 3 additional countries achieved the indicator target, 5 fell from the baseline. This resulted in doubling the gap to achieve the 2013 target.
2.1.6 Number of countries that have achieved the regional target for elimination of congenital syphilis	7	15	8	26	The baseline was maintained, but only one additional country achieved the indicator target. Important progress is reported in 7 other countries. The gap to achieve the 2013 target tripled.
3.2.7 Number of countries implementing a multisectoral national plan to prevent road traffic injuries, aligned with PAHO/WHO Guidelines	17	20	18	23	Only one additional non-baseline country achieved the indicator target.
6.2.2 Number of countries that have developed a functioning national surveillance system using the School-Based Student Health Survey (Global School Health Survey) and are producing regular reports on major health risk factors in youth	11	23	16	30	The gap to achieve the target doubled with the non-achievement of the target in 2011.
6.3.4 Number of countries that have updated at least one of the components of the Global Tobacco Surveillance System (GTSS)	20	28	24	35	The delay in conducting the survey as planned affected the rate of achievement. This increased the gap for achieving the 2013 target to 11 countries.

RER indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments[6]
7.6.3 Number of countries that implement policies, plans or programs to improve the health of specific ethnic/racial groups	10	14	11	16	While progress is reported in 3 additional non-baseline countries, only one achieved the indicator target. This doubled the gap for achieving the 2013 target.
9.3.1 Number of countries that have adopted and implemented the WHO Child Growth Standards	16	20	19	25	This indicator was short only one country to achieve the 2011 target. Nonetheless, significant progress was reported in the country that did not achieve the target.
9.4.2 Number of countries that have implemented strategies to prevent and control micronutrient malnutrition	16	21	19	25	The non-achievement of the 2011 target doubled the gap for achieving the 2013 target.
9.4.4 Number of countries that have incorporated nutritional interventions in their comprehensive response programs for HIV/AIDS and other epidemics	15	20	17	25	The delay in implementing programmed activities in the 4 target countries for 2010–2011 affected the achievement of the target. This resulted in increasing the gap for achieving the 2013 target to 8 countries.
9.4.5 Number of countries that have national preparedness and response plans for food and nutrition emergencies	16	20	17	25	Although 2 additional countries achieved the indicator target, one fell from the baseline. This increased the gap to 8 countries needed to achieve the 2013 target.
10.1.3 Number of countries that integrate an intercultural approach in the development of policies and health systems based on PHC	3	5	4	8	This indicator was short one country to achieve the target.
12.1.3 Number of countries with 100% voluntary non-remunerated blood donations	5	12	6	17	While significant progress was made in the target countries during 2010–2011, only one additional country achieved the target. It is noted that this indicator is ambitious and is not likely to be achieved by 2013, since it does not reflect the reality in the countries.

RER indicator	Baseline 2009	Target 2011	Achieved end 2011	Target 2013	Comments[6]
13.2.2 Number of countries participating in the Human Resources for Health Observatories network for the production of information and evidence for decision-making	27	31	28	36	Progress was made in 2 additional countries, but only one achieved the target. It is noted that the Human Resources for Health Observatory is under review.
13.3.1 Number of countries that have established a career path policy for health workers	7	10	9	14	This indicator was short one country to achieve the 2011 target.
13.5.2 Number of countries that participate in bilateral or multilateral agreements that address health worker migration	7	10	9	16	This indicator was short one country to achieve the 2011 target.
14.2.1 Number of completed country studies applying the PAHO evaluation framework to assess household capacity to meet health expenditures	3	5	3	7	Challenges related to funding affected the completion of all the studies planned.
14.2.3 Number of countries with public policies or financing schemes for the reduction or elimination of the financial risks associated with diseases and accidents	2	4	3	8	This indicator was short one country to achieve the 2011 target. However, progress was made in the country that did not achieve the target.
15.1.5 Number of PASB entities that have linked each cross-cutting priority to at least 30% of their products and services in their Biennial Workplans	N/A	40/54	18/54	54/54	While progress was made, greater support and guidance is needed to properly reflect the cross-cutting issues in the biennial work plans at all levels.
16.6.6 New HR performance planning and evaluation system which enables effective performance management and integrated with PAHO Strategic Plan implemented	Software purchased and implementation plan in place	Implementation in all PASB entities linked to staff development plans	Not achieved	360-degree evaluations implemented	Implementation was delayed due to the development of the new PAHO Management Information System (PMIS).

COUNTRIES AND TERRITORIES

ABM	Anguilla, British Virgin Islands, and Montserrat (United Kingdom Overseas Territories)
ANI	Antigua and Barbuda
ARG	Argentina
ANU	Anguilla
BAH	Bahamas
BAR	Barbados
BLZ	Belize
BOL	Bolivia (Plurinational State of)
BRA	Brazil
CAN	Canada
CHI	Chile
COL	Colombia
COR	Costa Rica
CUB	Cuba
DOM	Dominica
DOR	Dominican Republic
ECU	Ecuador
ELS	El Salvador
FDA	French Departments in the Americas
FEP	United States–Mexico Border Field Office in El Paso, Texas
GRA	Grenada
GUT	Guatemala
GUY	Guyana
HAI	Haiti
HON	Honduras
JAM	Jamaica
MEX	Mexico
NCA	Northern Caribbean (Bermuda and the Cayman Islands)
NEA	Netherlands Antilles
NIC	Nicaragua
PAN	Panama
PAR	Paraguay
PER	Peru
PUR	Puerto Rico
SAL	Saint Lucia
SAV	Saint Vincent and the Grenadines
SCN	Saint Kitts and Nevis
SUR	Suriname
TCA	Turks and Caicos Islands
TRT	Trinidad and Tobago
URU	Uruguay
USA	United States of America
VEN	Venezuela (Bolivarian Republic of)

ACRONYMS

AECI	Spanish Agency for International Cooperation [*Agencia Espanola de Cooperación Internacional*]
AIDS	Acquired Immune Deficiency Syndrome
AMRO	WHO Regional Office for the Americas
ART	Antiretroviral treatment
ARV	Antiretroviral
CARMEN	Collaborative Action for Risk Factor Prevention and Effective Management of Noncommunicable Diseases [*Conjunto de Acciones para la Reducción Multifactorial de las Enfermedades No Transmisibles*]
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention (United States)
CELADE	Latin American and Caribbean Demographic Center [*Centro Latinoamericano y Caribeño de Demografía*]
CEPAL	Economic Commission for Latin America and the Caribbean [*Comisión Económica para América Latina y el Caribe*]
CIDA	Canadian International Development Agency
CNCD	Chronic noncommunicable disease
DTP	Diphtheria, tetanus and pertussis
EC	European Commission
EPHFs	Essential Public Health Functions
EPI	Expanded Program on Immunization
EXM	PASB Executive Management
FCTC	Framework Convention on Tobacco Control
FDA	United States Food and Drugs Administration
FTP	Fixed-term post
GAVI	Global Alliance for Vaccines and Immunization
GBO	Governing Bodies Office (at PAHO)
GSHS	Global School-based Student Health Survey
GTSS	Global Tobacco Surveillance System
HFA	Hyogo Framework for Action
HIV	Human Immunodeficiency Virus
HP	Health Promotion
HRH	Human Resources for Health
IHR	International Health Regulations
IHSDNs	Integrated Health Service Delivery Networks
IPSAS	International Public Sector Accounting Standards
IT	Information Technology
LAC	Latin America and the Caribbean
MDGs	Millennium Development Goals
MEASURE	Monitoring and Evaluation to Assess and Use Results (used in MEASURE-Evaluation)
MMR	Maternal Mortality Rate

ACRONYMS

MTCT	Mother-to-child transmission
NCD	Noncommunicable disease
NID	Neglected infectious disease
NORAD	Norway Development Agency
NRA	National Regulatory Authority
NTD	Neglected tropical disease
NVC	National Voluntary Contributions
OCR	Outbreak Crisis and Response
OS	Other Sources
PAHEF	Pan American Health and Education Foundation
PAHO	Pan American Health Organization
PALTEX	Expanded Program on Textbooks and Instructional Materials [*Programa Ampliado de Libros de Texto y Materiales de Instrucción*]
PASB	Pan American Sanitary Bureau
PB	Program and Budget
PHC	Primary Health Care
PMA	Performance Monitoring and Assessment
PMIS	PAHO Management Information System
RB	Regular Budget
RBM	Results-based Management
RELACSIS	Latin American and Caribbean Network for Health Information Systems [*Red Latinoamericana y del Caribe para el Fortalecimiento de los Sistemas de Información de salud*]
RER	Region-wide Expected Result
RPBP	Regional Program Budget Policy
SCS	Subregional Cooperation Strategy
SDH	Social determinants of health
Sida	Swedish International Development Agency
SO	Strategic Objective
SPBA	Subcommittee on Program, Budget, and Administration
TB	Tuberculosis
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNHLM	United Nations High-level Meeting
USAID	United States Agency for International Development
VC	Voluntary Contribution
VCPH	Virtual Campus in Public Health
VPD	Vaccine-preventable disease
WHD	World Health Day
WHO	World Health Organization

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